Agenda
Mangum City Hospital Authority Amended
July 26, 2022 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 July 26,2022, 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

SWEARING IN AND SEATING OF NEW TRUSTEE

1. Swearing in of Ronnie Webb for Trustee of Mangum City Hospital Authority.
2. Welcoming and seating of new Trustee Ronnie Webb.

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.

3. Approve May 24, 2022 MCHA meeting minutes.
4. Approve June 28, 2022 minutes
5. Approve May 12, 2022 Quality meeting minutes.
6. Approve June 16, 2022 Quality meeting minutes.
7. Approve June 21, 2022 Medical Staff meeting minutes.
8. Approve May 19, 2022 Medical Staff meeting minutes.
9. Approve May 2022 claims and July 2022 estimated claims.
10. Approve June 2022 claims and August 2022 estimated claims.
11. Approve May 2022 Quality report.
12. Approve June 22 Quality report.
13. Approve May 2022 Clinic report.
14. Approve May 2022 CCO report.
15. Approve May 2022 CEO report.
16. Approve the following forms, policies and procedures previously approved through May 2022 by Corporate, on 6/16/2022 by Quality Control and on 6/21/2022 by Med Staff.

    Dietary Manual:

Food & Nutrition Services Table of Contents

Introduction of Philosophy & Standards
General Employee Information
Sanitation Schedules
Infection Control for Food & Nutrition Services
Fire & Prevention for Food & Nutrition Services
Pest Control & Prevention for Food & Nutrition Services
Dish Care: Dish Machine and Manual Warewashing
Food Handling & Kitchen Safety
General Storage
Food from Outside Sources
Nourishment Room
Accepting Food Deliveries
Mealtimes & Guest Trays
Menu & Recipes
Diet Orders
Nutritional (oral) Supplementation
Emergency Operation Plan
Nutrition Assessment & Documentation
Authorization of Nutrition Order Writing
Nutrition Screening Process
Contracted Meal Service (Seiling only)
Competency Based Orientation
Daily Cleaning Schedule
Weekly Cleaning Schedule
Dish Machine Temperature & Sanitizer Log
Sanitizer Bucket Test Strip
Food Temperature Log
Refrigerator Temperature Log
Freezer Temperature Log
Inventory Form*
Guest Tray Approval Form
Menu Substitution Log
Nutrition Initial Assessment
Nutrition Progress Note
Nutrition Screening Tool

Credentialing Manual:

- MRMC Pre-Authorization Form
- Primary Source Verification
- Credentialing Checklist
- Application for Temporary Privileges (Used for Care of Specific Patients)
- Credentialing Packet
- Telephone Contact Report Form
- Continuing Medical Education Record
- Application for Reappointment
- Emergency Privileges Form
- HICS -253 Volunteer Registration
- Credentialing and Privileging Process (Mangum Specific)
- Medical Staff Membership and Categories
- Basic Credentialing File and Maintenance
- Application to the Medical Staff
- Physician Assistance and APRNs
- Professional Education
- Adverse Credentialing Decisions
- Fair Hearing Appeals Process for Privileging
- Expedited Appointment and Reappointment Process
- Privileging Process
- Peer Recommendations for Privileging Decisions
- Emergency Privileging

Respiratory Protection Program Evaluation Check list

Respiratory Protection Program Evaluation Summary for 2021

Respiratory Protection Program Hazard Assessment

17. Approve the following forms, policies and procedures previously approved through June 2022 by Corporate, on 7/14/2022 by Quality Control and on 7/21/2022 by Med Staff.

Swing Bed Policy Manual/Case Management Policy Manual

Incomplete Records Policy

Patient Request for Restrictions on Use/Disclosure of PHI and Request for Confidential Communications

340B Program Policy

Mangum Quality Review Evaluation Plan 2022

Paid Time Off (PTO) Policy

PTO Donation Authorization Form

FURTHER DISCUSSION

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

REPORTS

18. June 2022 Financial Report
19. Approve June 2022 Clinic Report
20. June 2022 CCO Report
21. June 2022 CEO Report

OTHER ITEMS

22. Discussion and possible action on the Cardinal Health 340B agreement.
23. Discussion and possible action on the Eli Lilly, Novo Nordisk and AstraZeneca 340B manufacturing agreements.
24. Discussion and possible action on the Mangum Drug Co. PharmaForce Contract Pharmacy Configuration agreement.
25. Discussion and possible action to approve the Puckett's Discount Pharmacy PharmaForce Contract Pharmacy Configuration agreement.
26. Discussion and possible action on the Critical Alert nurse call system change order.
27. Discussion and possible action on the renewal of the Greer County Health Department X-Ray services agreement.
28. Discussion and possible action on the Oklahoma Blood Institute blood bank contract.
29. Discussion and possible action on an OKCH reimbursement agreement.
30. Discussion and possible action on a Stericycle agreement.
31. Discussion and Possible action to approve the lease agreement between the City of Mangum and Mangum City Hospital Authority for the David Caley Memorial Medical Annex.
32. Discussion and possible action to approve the CPSI-Evident interface agreement.

EXECUTIVE SESSION

33. Discussion and possible action regarding the review and approval of medical staff privileges/credentials/contracts of the following providers with possible executive session in accordance with 25 O.S. 307(B)(1):

    Jeff Phillips, PA - Allied Health Professional - Courtesy Privileges

OPEN SESSION

34. 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 11**:**30 p.m. on the 25th day of July 2022, by the Secretary of the Mangum City Hospital Authority.

_____
Billie Chilson, Secretary

OATH OF OFFICE

I, Ronnie Webb do solemnly swear (or affirm) that I will support, obey, and defend the Constitution of the United States of America and the Constitution of the State of Oklahoma, and that I will not knowingly receive, directly or indirectly, any money or other valuable thing, for the performance or nonperformance of any act or duty pertaining to my office, other than the compensation allowed by law; I further swear (or affirm) that I will faithfully discharge my duties as Trustee of Mangum City Hospital Board to the best of my ability.

_____

Principal (Ronnie Webb)

Subscribed and sworn before me this 28th day of June 2022.

_____

Notary Public

My commission expires _____

Minutes
Mangum City Hospital Authority Regular Session
June 28, 2022 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 May 24, 2022, 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.

No Meeting was held due to a lack of a quorum.

Carson Vanzant, Chairman

Billie Chilson, City Clerk

Quality Committee Meeting Minutes

Date: 05/12/2022	**Time: 11:44**	**Recorder: Denise Jackson**	**Reporting Period Discussed: April 2022**

Members Present

Chairperson:			**CEO: Dale Clayton**		**Medical Representative: Dr. Chiaffitelli**		
Name	**Title**	**Name**	**Title**	**Name**	**Title**	**Name**	**Title**
Heather Larson	Respiratory	Josey Kenmore	Mat.	Tonya Bowen	Lab Manager	Jared Ballard	IT
Sarah Dillahunty	Dietary	Daniel Coffin	CCO	Kaye Hamilton	Credentialing	Claudia	Infection
Pam Esparza	Radiology	Jennifer Dryer	HIM	Kasi Hiley	Bus./RCM Dir		Clinic Manager
Erin Johnson	Case Management	Shelly Bowman	HR	Chealsea Church	Pharamcy	Lynda James	Pharamcy LPN

TOPIC	**FINDINGS/CONCLUSIONS**	**ACTIONS/RECOMMENDATIONS**	**FOLLOW-UP**
Call to Order	first/second	Erin Johnson/Claudia Collard	
Review of Minutes	review/approve April min for March data	Dr C. /Chealsea Church	
Review of Committee Meetings			
A. EOC/Patient Safety Committee	flooring in med room/nurse break area to be replaced when tile is ordered, replacement of 20 amps has started,glass on west hallway cut and ready for install,provider office flooring needs replaced, replacemnt of celing tiles in patient areas has started		
B. Infection Control Committee	No hospital aquired infections to report for the month. Compliant on PPE and hand washing.		
C. Pharmacy & Therapeutics Committee	59 after hrs access for the reporting period, 12 med errors for the reporting period, no adverse drug reactions for the rpeorting period	CNO provided education to nursing staff reguarding medication errors	
D. HIM/Credentials Committee	Contiune to work on process for missing concents, DIA credentialing for the month (multiple changes at DIA)		
E. Utilization Review Committee	tot ER 118, 0 OBS, 15 acute, 11 swing, tot admit 26, tot d/c 22, tot pt days 303, avg daily census 10		
F. Compliance Committee	working on schedule of meetings		

Old Business	Revised Patient Consent for COVID-19 Emergency Use Medications and Treatment Standing Orders: Bebtelovimab Revised COVID-19 Standing Orders Standing Orders: Sotrovimab Rehabilitation Services Policies (Manuel)– see adgenda, Claudia Collard New Infection Prevention Nurse	Approved 4/14/2022	
New Business	Survey Round Tool (updated)	Dr. C/ Erin Johnson	
Quality Assurance/Performance Improvement			
Volume & Utilization			
A. Hospital Activity	tot ER 118, 0 OBS, 15 acute, 11 swing, tot admit 26, tot d/c 22, tot pt days 303, avg daily census 10		
B. Blood Utilization	7 units transfused with no issues reported, noted increase in outpatient blood transfuions from clinic		
Care Management			
A. CAH/ER Re-Admits	0 - 30 day readmission	Contiune to educate patients on disease process and progress towards discharge	
B. Discharge Follow Up Phone	7/7 completed on patients d/c home		
C. Patient Discharge Safety	7/7 completed on patients d/c home		
D. IDT Meeting Documentation	0/8 ALL IDT notes audited were incomplete by various departments	new case manager/cco will talk with staff and encourage staff to complete notes in same day. Dicussed inportance of compliance with note completion	
E. Case Management Assessment	96% (25/26 audited) - CM reports 1 not done due to patient admited on Friday and d/c on the weekend	No action required.	
Risk Management			

A. Incidents	FALLS; Pt was seen in the ED and released, pt was using appropriate DME upon exit and fell in parking lot, employee was entering buliding and noted patient post fall. Employee offered a nurse or returning to the ED, pt was adamate that they were okay and did not need any futher care x multiple attempts. Pt left in personal vehicle. Employee reported to ER RN and CNO. ER RN called and followed up with patient the next day, patient contiunes to report that they are okay and do not need any futher care. In-patient beame weak during transfer and was slid to the ground with nursing assist, no injuries noted/denied any pain with assessment. AMA - 1 inpatient left AMA, pt became very aggitated with staff as they prefered a non-safe method of patient care, when staff attempted to educate patient, patient bacame more aggitated and became threating towrds staff. Patient was able to be redirected and calmed for short period of time but returned to aggitated and threating, police were called/patient did sign out AMA and was assited out of facility by police. Other: 1 pt was given a food that they were allergic to, pt reported to staff and food was removed from pt room	FALLS; monitor for any potential fall risks, offer care when needed. Use appropraite number of staff for all transfers. AMA - staff will contiune to provide safe patient care to all MRMC patients and educate patients/family as need. Will contiune to monitor for threating behavior from patients and family/police notification by staff as warrents. OTHER - Process for identification of food allergies in place/tray care system being used, education to dietary staff on monitoring for allergies/nursing staff eduation on eval of tray prior to delivery to patient wil contiune to monitor process	
B. Reported Complaints	no complaints for the the month of April		
C. Reported Grievances	no grievances for the the month of April	Grievance from 2/22/22 completed on 3/14/22 with no substantiated findings/final grievance response	

D. Patient Falls Without Injury	2 falls w/o injury for the reporting period; Pt was seen in the ED and released, pt was using appropriate DME upon exit and fell in parking lot, employee was entering buliding and noted patient post fall. Employee offered a nurse or returning to the ED, pt was adamate that they were okay and did not need any futher care x multiple attempts. Pt left in personal vehicle. Employee reported to ER RN and CNO. ER RN called and followed up with patient the next day, patient contiunes to report that they are okay and do not need any futher care. In-patient beame weak during transfer and was slid to the ground with nursing assist, no injuries noted/denied any pain with assessment	monitor for any potential fall risks, offer care when needed. Use appropraite number of staff for all transfers	
E. Patient Falls With Minor Injury	no falls with major injury for the reporting period		
F. Patient Falls With Major	0		
G. Fall Risk Assessment	1		
H. Mortality Rate	3 deaths for the reporting period; 2 inpatient; pt admitted to swing, declined overall. DNR in place, pt expired while in-patient. 1 pt to ed unresponsive extensive health issues/family desires comfort care, admitted for comfort care, expired while inpatient. 1 ER patient; pt brought to ed with CPR in progress, CPR attempts in ED unsuccessful. Pt expired in the ED		
I. Deaths Within 24 Hours of	1 pt to ed unresponsive extensive health	none	
J. OPO Notification/Tissue Donation	inpatient x 2 deaths were not candidate for donation, er death was sent to ME - no donations to	none	
M. EDTC Measures	8/11 complete - 3 chart did not reflect all data was sent to transfering facility (home meds)	will contiune to educate nursing and providers on making sure all elements are in charts as well as documentation to reflect all information sent to receiving facility and monitor for trends	
Nursing			
A. Critical Tests/Labs	41 critical labs / 2154 total labs for the month		
B. Restraints	none in reporting period		

C. RN Assessments	19/20 (95%)		
D. Code Blue	2 code blues for the reporting period		
Emergency Department			
A. ED Log & Visits	118 er visits for the month		
B. MSE	N/A (quarterly data reporting)		
C. EMTALA Form	10 completed		
D. Triage	19/20 (95%)		
E. Triage ESI Accuracy	19/20 (95%)		
F. ED Discharge/ Transfer	19/20 (95%)		
G. ED Readmit	1 re-admit for the reporting period. Pt d/c from er, retunred to ED w/I 72 hrs	nursing will contiune to educate patients on dx process and anticipated discharge	
H. ED Transfers	11 transfers reported for the month; transferred to higher level of care for; pneumothorax, NSTEMI x 4, Bowel obstruction x 2, EOD, meningioma, acute abdomen (futher testing needed), elevated cardiac enzymes/dyspnea		
I. Stroke Management Measures	none in reporting period		
J. Stroke Brain CT Scan	none in reporting period		
K. Suicide Management Measures	1 patients to the ED for SI/SH, evaluation completed by LMHP. Pt transferred to in-pt psych care	Nursing to be educated on documenation expectations for er charts	
L. STEMI Management Measures	none in reporting period		
M. Chest Pain Measures	33%; noted delay in ekg/chest xray when patient presents with vague chest pain, non-typical cardiac. MD will often order as a rule out measure. Also note trend with ekg without time, met with RT director to discuss issue: pt info is being covered by pt sticker	RT director took dates and chart info to meet with and educate RTs on not covering this info with sticker, will continue to monitor over all process. CNO is setting up mock cardiac/stroke with partnering agencies, this may lead to some disconnect with times.	
N. ED Departure	n/a		
Pharmacy & Medication Safety			
A. After Hours Access	59 after hrs access for the reporting period, verified by pharmacy		
B. Adverse Drug Reactions	none in reporting period		

C. Medication Errors	12 for reporting period; 9 x nurse failed to admin meds per orders. 3 x Nurse failed to document administration of meds	CCO re-educated staff members regarding 6 rights of med adminisrtations as well as per P&P NUR-017	Pharm/CCO to monitor
D. Bar Code Scanning	awaiting install of new scanners		
Respiratory Care Services			
A. Ventilator Days	none in reporting period		
B. Ventilator Wean Rate	none in reporting period		
C. Patient Self-Decannulation	none in reporting period		
D. Respiratory Care Equipment	HMEs 0, inner cannulas 0, suction set up 0, neb/masks 27, trach collars 0, vent circuts 0, trach 0, closed suction 0		
Wound Care Services			
A. Development of Pressure Ulcer	none in reporting period		
B. Wound Healing Improvement	10/10 wounds		
C. Wound Care Documentation	100% (4/4 intial assessments and 5/5 d/c assessments)		
Radiology			
A. Radiology Films	10/147 repeated - Clipped anatomy, patient motion.	No action needed.	
B. Imaging	20/ 0 repeated		
C. Radiation Dosimeter Report	6/6 (100%) Reports are received quarterly. All techs withing range.		
Lab			
A. Lab Reports	2/2154 rejected; Qunatity not sufficient/Expired tube sent to LabCorp	Lab Manger Instructed staff to collect more specimen. Instructed team to check all expiration dates in lab.	
B. Blood Culture Contaminants	none in reporting period		
Infection Control & Employee Health			
A. CAUTI's	0/58; none in reporting period		
B. CLABSI'S	0/40; none in reporting period		
C. HA MDROs	0/303 total pt days; none in reporting period		
D. HA C. diff	0/303 total pt days; none in reporting period		
E. Hospital Acquired Infections	0/303 total pt days; none in reporting period		

F. Hand Hygiene/PPE & Isolation Surveillance	90% Hand Hygeine compliance (18/20); 80% Compliance with PPE (16/20). Variation most likely due to increased surveillance and FT IP. Still meets Benchmark of 80%	Continue monitoring staff for adherence to protocols. Just in time teaching to be done when deficit identified.	
H. Patient Vaccinations	1 patient eligible for Pneumonia vaccine; administered in-house.		
I. Ventilator Associated Events	none in reporting period		
J. Employee Health	1. 1 fall in employee office resulting in LLE laceration; sutured in ER and RTW. 2. 4 cases N/V/D GI illness (1 emp x 2) resulting in 8 missed shifts. 3. 1 case Fever/Cough/Sore Throat - Negative Covid and Influenza testing - resulting in 3 missed shifts. 4. 1 non-work related injury (knee pain) resulting in 1 missed shift. 5. 1 missed shift to care for family member (child). 6. 1 W/C case ongoing and pending MRI for further evaluation (to be scheduled). 7. 2nd Hepatitis B administered to employee. 8. 7 TSTs performed with negative results. 9. 11 total days missed due to employee illness/injury.	1. First report to W/C carrier; no further follow up needed. Sutures removed in ER. 2. Continue screening of all employees with s/s reportable illnesses for purposes of infection prevention. 3. Follow W/C case with respect to pending MRI to determine scheduled date. Continue to work with Stonetrust Adjuster as needed. 4. Employee due for 3rd Hepatitis B immunization 10/1/2022; added to log as reminder. 5. Continue to administer Tb screens prior to employee start dates with follow up as required.	
K. Employee COVID 19 Vaccination Indicators	Reporting data tool has been updated, data collection simplified for reporting more accuarte numbers. 100 out of total 103 staff with known vaccination status/exemption resulting in 97% compliance.	Continue to obtain vaccine status from incoming new hires. Obtain exemptions as applicable.	
HIM			
A. H&P's	100% (26/26 complete)		
B. Discharge Summaries	100% (22/22 complete) -all complete within alotted time frame		
C. Progress Notes (Swing &	100% (50/50 swb and 35/35 acute)		
D. Consent to Treat	83% (120/145) 25 ER concents missing	We have had several meetings over this. Starting next month, i will be logging whether they are being missed at day time, night time or weekend.	

E. Swing bed Indicators	64% (7/11) There are four Social Histories missing	HIM has emailed Erin Johnson, case manager, and informed her.	
F. E-prescribing System	100% (494/494)		
G. Legibility of Records	100% (145/145)		
H. Transition of Care	100% (7/7)		
Dietary			
A.	100% (180/180)		
B.	100% (180/180)		
Therapy			
A. Therapy Indicators	100% (5/5 discharges and 9/9 with assistive		
B. Therapy Visits	141 visits completed/ 155 planned		
C. Standardized Assessment Outcomes	100% (6/6)		
Human Resources			
A. Compliance	100% (2 new employees)		
Registration Services			
Registration Services	only found a few registration errors registration staying top of getting all info	RCM Manager and Cohesive Director have put processes in place and they are working, registration clerk is using the auditing tool and we are making progress	HIM/RCM Manger/CNO/QM to monitor processses
Environmental Services			
A. Terminal Room Cleans	6/6 completed		
Materials Management			
A. Materials Management Indicators	37 orders for the month - 31 ORDERS ON BACKORDER - 12 late order due to back order	MM following up weekly on back orders	
Plant Operations			
A. Fire Safety Management	100% (24/24)		
B. Transfer Switch Monthly	100% (1/1)		
C. Generator Monthly Checks	100% (1/1)		
Information Technology			
A. IT Indicators	5 IT malfunctions/2 power issues/50 other - implementing web client	slowly introducing web client to people	
Outpatient Services			

A. Outpatient Therapy Services	30 out patient sessions preformed for the month		
B. Outpatient Wound Services	9 outpatient wound services for the month		
Contract Services			
Contract Services	N/A		
Credentialing/New Appointments			
A. Credentialing/New Appointment Updates	Multiple DIA provider changes to go through Med Staff this month		
Adjournment			
A. Adjournment	05/12/2022 at 11:54	Dr. C/ Erin Johnson	

Quality Committee Meeting Minutes

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Date: 06/16/2022	**Time: 12:01**	**Recorder: Denise Jackson**	**Reporting Period Discussed: May 2022**

Members Present

Chairperson:			**CEO: Dale Clayton**		**Medical Representative: Dr. Chiaffitelli**	
Name	**Title**	**Name**	**Title**	**Name**	**Title**	**Name**
Heather Larson	Respiratory	Josey Kenmore	Mat.	Tonya Bowen	Lab Manager	Jared Ballard
Caitlin	Dietary	Daniel Coffin	CCO	Kaye Hamilton	Credentialing	Claudia Collard
Pam Esparza	Radiology	Jennifer Dryer	HIM	Kasi Hiley	Bus./RCM Dir	Brittany W.
Chasity Howell/Erin Johnson (phone)	Case Management	Shelly Bowman	HR	Chealsea Church	Pharamcy	Lynda James

TOPIC	**FINDINGS/CONCLUSIONS**	**ACTIONS/RECOMMENDATIONS**
Call to Order	first/second	Dale Clayton/Lynda James
Review of Minutes	review/approve April min for May	Dr C/Chealsea Chruch
Review of Committee Meetings		
A. EOC/Patient Safety Committee	replacement started for damanged ceiling due to electric repairs, nurse call malfunction in rm 23 due to water leak, broken pipe in boiler room 6/12/22 - fixed	
B. Infection Control Committee	no hospital aquired infections to report for the the month	
C. Pharmacy & Therapeutics Committee	$10957 for the month with $5600 in high cost meds. IVP xanax/lasix/ ct contrast shortage	ordering contract whenever possible, will monitor current stock closely
D. HIM/Credentials Committee	Jeff Phillips PA - recredentailing for the month. Work continues on sorting old medical records in storage	
E. Utilization Review Committee	tot ER 144, 0 OBS, 13 acute, 13 swing, tot admit 26, tot d/c 26, tot pt days 320, avg daily census 10	
F. Compliance Committee	working on schedule of meetings	
Old Business	Surevy Round Tool (updated)	Approved in May 2022

New Business	Dietary Manuel: •Food & Nutrition Services Table of Contents •Introduction of Philosophy & Standards •General Employee Information •Sanitation Schedules •Infection Control for Food & Nutrition Services •Fire & Prevention for Food & Nutrition Services •Pest Control & Prevention for Food & Nutrition Services •Dish Care: Dish Machine and Manual Warewashing •Food Handling & Kitchen Safety •General Storage •Food from Outside Sources •Nourishment Room •Accepting Food Deliveries •Mealtimes & Guest Trays •Menu & Recipes •Diet Orders •Nutritional (oral) Supplementation •Emergency Operation Plan •Nutrition Assessment & Documentation •Authorization of Nutrition Order Writing •Nutrition Screening Process •Contracted Meal Service (Seiling only) •Competency Based Orientation •Daily Cleaning Schedule •Weekly Cleaning Schedule •Dish Machine Temperature & Sanitizer Log •Sanitizer Bucket Test Strip •Food Temperature Log •Refrigerator Temperature Log	
Quality Assurance/Performance Improvement		
Volume & Utilization		
A. Hospital Activity	tot ER 144, 0 OBS, 13 acute, 13 swing, tot admit 26, tot d/c 26, tot pt days 320, avg daily census 10	
B. Blood Utilization	6 units ordered and administered without issue	
Care Management		

A. CAH/ER Re-Admits	4 - 1) readmit after surgery at Jackson County Memorial Hospital 2) readmit after being admitted to Saint Anthony's hospital by Dr. Morgan 3) readmit after being sent to Integris Canadian valley for G.I. bleed. 4) readmit after surgery at Great Plains regional Medical Center	Continue to educate patient and family on dx/dx processes as need. CM to continue to provide resources as needed for patient d/c home
B. Discharge Follow Up Phone Calls	10/13 - 3 patients left AMA	
C. Patient Discharge Safety Checklist	10/13 - 3 patients left AMA	
D. IDT Meeting Documentation	8/10 - various dept are not completing IDT note for IDT. CM to provide education.	
E. Case Management Assessment	100% - (26/26)	
Risk Management		

A. Incidents	AMA - 3 ER pt - 1) pt to ed for vomiting, provider wanted to admit due to dx in er, however pt was not local and desired to return to home state for futher treatment. risks/benefits explained/ama signed 2) pt to ed for rever/dyspnea. Evlatuation shows sepsis, pt was agreeable to treatment in the er initally. pt had espisodes of anxiety while in the ed, staff was able to clam/redirect pt. pt became very anxious wanting to leave, staff made aware that current treatment had about 30 min left, pt agreeable to completeing IV treatment but signed ama and would not stay for futher care. risks/benefits explained 3) pt to ed for ha/dizziness. pt has been seen by multiple medical facilities over the past 2 weeks approx, reports that since being home symptoms have not improved.all appropriate testing/assements done while in the ed, pt cleared for d/c. family desired additional treatment/testing/admintance despite negative diagnostic results/lack of symptoms for qualifing hospital admit. Providered provided edication to family and pt multiple times, however family became upset and demanded ama/pt agreeadble with ama, ama signed, risks/benefits discussed; 3 IN-PT AMA - 1.) pt admitted for opoid toxicity, pt began demanding that all benzos/opoids be resumed, provider explained current dx and agreed to resume pm dose of zyprexa only. pt begame very upset the next day demanding all meds be resumed, provider again explained dx. pt demanded that meds be resumed or they would leave, provider did not resume meds/pt signed out ama. risks/benefits explained. 2.) pt admitted for codp,	AMA - all ama pt had risks/benefits presented at time of ama, encouraged to return to ed as needed, discharge education will contiune to be provided to pt based on specific dx/needs, staff will contiune to provide safe patient care to all MRMC patients and educate patients/family as need.
B. Reported Complaints	0	
C. Reported Grievances	0	
D. Patient Falls Without Injury	3	

E. Patient Falls With Minor Injury	none	
F. Patient Falls With Major Injury	0	
G. Fall Risk Assessment	3	
H. Mortality Rate	none	
I. Deaths Within 24 Hours of Admit	none	
J. OPO Notification/Tissue Donation	none	
M. EDTC Measures	78% (7/9)	
Nursing		
A. Critical Tests/Labs	100% (37/37)	
B. Restraints	none	
C. RN Assessments	95% (19/20)	
D. Code Blue	none	
Emergency Department		
A. ED Log & Visits	144	
B. MSE	n/a	
C. EMTALA Form	9	
D. Triage	95%	
E. Triage ESI Accuracy	90%	
F. ED Discharge/ Transfer Nursing	95%	
G. ED Readmit	0	
H. ED Transfers	9 - transferred to higher level of care for; cardiac syncope d/t severe tachycardia, si/sh x 2, plureal effusion/anasrca, femer fx, dm uncontrolled (requiring ICU), acute chole., hip fx, acute appendicitis	Dr. C would like these cases followed, look for oppertunites to bring pts back to MRMC for skilled services when possible. CM will monitor and follow up with these pts and recieving hospitals (CNO sent email to CM during meeting in reguards to this plan) QM will assist CM when needed. WIll monitor to see if readmits increase, follow up in 30 and 60 days
I. Stroke Management Measures	0	
J. Stroke Brain CT Scan	0	
K. Suicide Management Measures	2 pts to the er for psych issues, 2 pt transferred for in-pt treatment per LMPH evaluation/recommendations	

L. STEMI Management Measures	100%	some delay due to difficulty finding accepting hospital,
M. Chest Pain Measures	7/9 ECG w/I 5 minutes = 78%; 4/9 = 44% chest xray w/I 30 min - Noted delay in testing with non-typical chest pain. Delay in chest x-ray noted with no pattern	Times on EKG improved greatly with meetings between QM/CNO/RT director, RT director has educated staff on proper time and date stamp on EKG as well as quick response time. Will meet with Rad director to discuss times and monitor for trends in delay of chest xray, may need to provide re-education to all staff on chest pain protocol, including providers
N. ED Departure	x	
Pharmacy & Medication Safety		
A. After Hours Access	95 - 18 times for medications not stocked in MedDispense; and 3 times for no reason when medications were in MedDispense	
B. Adverse Drug Reactions	none	
C. Medication Errors	1 - enema administered but not documented as given	
D. Bar Code Scanning	awaiting install of new scanners	
Respiratory Care Services		
A. Ventilator Days	none	
B. Ventilator Wean Rate	none	
C. Patient Self-Decannulation Rate	none	
D. Respiratory Care Equipment	HMEs 0, inner cannulas 0, suction set up 0, neb/masks 21, trach collars 0, vent circuts 0, trach 0, closed suction 0	
Wound Care Services		
A. Development of Pressure Ulcer	none	
B. Wound Healing Improvement	2 wounds	
C. Wound Care Documentation	100%	
Radiology		
A. Radiology Films	156 / 12 repeated due to clipped anatomy/patient motion	The patient was moved to aquire all the anatomy, patient was asked to hold still
B. Imaging	22 / 0 repeated	
C. Radiation Dosimeter Report	6	
Lab		
A. Lab Reports	2459 labs for the reporting period	
B. Blood Culture Contaminants	none	

Infection Control & Employee Health		
A. CAUTI's	0	
B. CLABSI'S	0	
C. HA MDROs	0	
D. HA C. diff	0	
E. Hospital Acquired Infections By	0	
F. Hand Hygiene/PPE & Isolation Surveillance	90% (20/22)- patients in isolation 22, total isolation days 87	1. Continue monitoring staff for adherence to protocols. 2. Provide Just In Time teaching to be done when deficit identified.
H. Patient Vaccinations	Out of flu season, no eligible patients for pneumonia	
I. Ventilator Associated Events	0	
J. Employee Health	1. No new events/injuries; 1 ongoing W/C case. 2. 2 employees with GI s/s of N/V/D resulting in 2 missed shifts. 3. 4 N95 Fit tests performed.	
K. Employee COVID 19 Vaccination Indicators	COVID vaccine status - 100%	
HIM		
A. H&P's	100% (26/26)	
B. Discharge Summaries	100% (27/27)	now complete, delayed due to providers out, 1 missed
C. Progress Notes (Swing & Acute)	100% (20/20 SWB - 30/30 Acute)	
D. Consent to Treat	96% (163/170) 7 er concents missing; HIM is	
E. Swing bed Indicators	54% (7/13) - 6 social hx missing, New CM is aware, education has been provided both locally and from Corporate on correct procedure for completion of social hx	
F. E-prescribing System	100%	
G. Legibility of Records	100%	
H. Transition of Care	100%	
Dietary		

A.	0% (0/93) - Wash temperature must be at least 165 degrees F per Chapter 257. Manufacturer directions state wash temperature minimum is at least 150 degrees F which that was only met 17/93 times. All other temperatures were noted as <150 degrees F. Corrective action - reported to QM, met with manufacture company, revisited state regs.	Dietician will monitor temps/recording process close, contiune to educate staff as needed.
B.	97% - (90/93) three values were missing, education provided to current employees by Corperate Supervisor	Dietician will monitor temps/recording process close, contiune to educate staff as needed.
Therapy		
A. Therapy Indicators	100%	
B. Therapy Visits	PT - 165, OT - 115, ST - 0	
C. Standardized Assessment Outcomes	90% (9/10) 1 pt discharged not a PLOF due to requiring a higher level of care	
Human Resources		
A. Compliance	1 employee hired w/o PALS/ACLS, given time frame for completion. Met goal and is now certified	
Registration Services		
Registration Services	Noted a few regristration errors for the month, corrected when possible	
Environmental Services		
A. Terminal Room Cleans	7	
Materials Management		
A. Materials Management Indicators	33 orders for the month - 21 ORDERS ON BACKORDER, 1 late order from vendor, 1 recall (JIF peanut butter products; products destroyed)	
Plant Operations		
A. Fire Safety Management	100%	
B. Transfer Switch Monthly Checks	100%	
C. Generator Monthly Checks	100%	
Information Technology		
A. IT Indicators	3 malfunctions/ 3 power failure/ 30 other - outages due to storm	
Outpatient Services		

A. Outpatient Therapy Services	37 treatments preformed/46 planned treatments	
B. Outpatient Wound Services	15	
Contract Services		
Contract Services	none	
Credentialing/New Appointments		
A. Credentialing/New Appointment	Jeff Phillips PA - recredentailing	
Adjournment		
A. Adjournment	06/16/2022 @ 12:11	Dale Clayton/Lynda James

Mangum Regional Medical Center
Medical Staff Meeting
June 21, 2022

MEMBERS PRESENT:

John Chiaffitelli, DO, Medical Director
William Gregory Morgan, III, MD

Absent:
Guest:

ALLIED HEALTH PROVIDER PRESENT:

Mary Barnes, APRN
David Arles, APRN
Sara McDade, APRN

NON-MEMBERS PRESENT:
Chelsea Church, PhD
Denise Jackson, RN, Quality Director
Chasity Howell, RN Utilization Review
Cindy Nelms, LPN,
Karly Banker, LPN
Kaye Hamilton, Medical Staff Coordinator

1. Call to order
    a. The meeting was called to order at 12:12 am by Dr. John Chiaffitelli, Medical Director.

2. Acceptance of minutes
    a. The minutes of the May 19, 2022, 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. CEO report – Dale Clayton, CEO

- Leadership continues to update staff and Providers regarding new policies and regulations.
- Covid is less of a concern however vigilance is still the focus.
- Hospital Staff and Operations Overview
    - Patient care continues to be outstanding thanks to an outstanding staff.
    - Open positions include CNA, LPN, RN and RT.
    - Recently hired core staff include a CNA and an RN.
    - Critical Alert nurse call system is close to completion. This is the final major improvement enabled by grant funds.
    - Our average daily census for the month was 10.
    - Emergency Department assisted 144 patients up from 118 last month.
    - Employees continued to receive free meals compliments of Cohesive.
    - We continue to put an emphasis on social media presence and other outreach efforts for the Hospital and the Clinic.
    - Hospital Week was an outstanding success! Thanks Shelly Bowman!
- Contracts, Agreements and Appointments to be presented to the Governing Board:
    - David Caley Annex lease agreement
    - Cardinal Health 340B agreement
    - Eli Lilly, Novo Nordisk and AstraZeneca 340B manufacturing agreements.
    - Critical Alert nurse call system change order.
    - Greer County Health Department X-Ray services agreement.
    - Oklahoma Blood Institute blood bank contract.

Written report remains in the minutes.

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

    a. Nursing

Excellent Patient Care

- Monthly Education topics included effective clinical communication via the SBAR tool by Lippincott Procedures.
- MRMC Emergency Department provided care to a potential stroke patient. The team was able to initiate and IV, draw blood for specimens and complete the CT in under ten minutes!

- MRMC Infection Prevention proudly reports continued excellent performance as evidenced by Zero prevalence of Hospital Acquired Infections, Catheter Associated Urinary Tract Infections or Central Line Associated Blood Stream Infections.
- Our Activities Director continues to delight patients with Manicure Mondays. Manicures almost trump Bingo on Fridays.
- MRMC Outpatient Wound Services reports 100% of the wounds treated have remarkable evidence of improvement.
- 7 out of 8 patients that were discharged from Inpatient Therapy services enjoyed a full return to Prior Level of Functioning.

Excellent Client Service

- Patients continue to rely on MRMC as their local hospital. Patient days increased from 303 days in April to 320 days in May. This represents an average daily census of 10. In addition, MRMC Emergency Department provided care to 144 patients in May
- A random sampling of the ED Triages proved that 95% of Emergency patients were triaged within 5 minutes or less from their time of arrival.
- May COVID-19 Stats at MRMC: Swabs (26-PCR & 46-Antigen) with 0 Positive PCR & 6 Positive Antigen.
- 100% of the discharged patients from MRMC Outpatient Therapy Services exhibited improvement in standardized assessment scores. This scoring relates to the patient's functional ability.

Preserve Rural Jobs

- Open Positions include Full Time RT, RN, LPN and CNA.
- For the clinical team MRMC continues to pursue core staff members from the area.
- Recruiting efforts included posting of positions on mangumregional.net and Facebook as well as Indeed.
- For hospital week staff were able to enjoy catered meals, games and daily prizes. The grand prize of the week was a big screen TV.

Written report remains in minutes.

c. Infection Control

- New Business:
  a. Updated COVID visitation guidelines (4/21/2022).
- Data:
  a, N/A
- Policy & Procedures:
  a. N/A
- Education/In Services
  a. Staff Education – ACLS/PALS, BLS, Certification classes held throughout April by Mary Barnes, APRN.

b. New Covid Visitation Guidelines

- Updates: No updates at this time.
- Annual Items:
  a. N/A
- Any additional recommendations from committee:
  a. Evaluation due to be done annually.

  Written report remains in minutes.

d. Environment of Care and Safety Report

i. Evaluation and Approval of Annual Plans –

i.i. Old Business - -

a. Evaluation and approval of Annual Plans-Plans will be presented in May meeting.
b. Continuing to work on the building. Flooring in Nurses break area and Med Prep room – Rescheduled - additional tile will need to be ordered.
c. 15 AMP Receptacles – all 15 AMP Receptacles will be replaced with 20 AMP Receptacles throughout Hospital – replacement has started.
d. Replace all receptacles on generator circuit at Clinic with red receptacles.
e. Glass on west hallway entry cracked- glass cut ready to install.
f. ER Provider office flooring needing replaced
g. Damaged ceiling tile in patient area due to headwall installation – replacement started-Complete 4/20/2022.
h. Ceiling tile above AC in Xray Control room have water spots- Replaced 4/14/2022 – Replaced again on 5/10/2022.
i. Verify all space heaters are appropriate type for use. – Complete 4/15/2022
j. Covers needed for shelving in Cafeteria - - Backordered.
k. Areas in ED need new calking and penetrations repaired - - Complete 5/10/2022.

i.i.i. New Business

a. None

Written report remains in minutes.

e. Laboratory

i. Tissue Report – Approved – May, 2022

i.i. Transfusion Report – Approved – May, 2022

f. Radiology

i. There was a total of – 256 X-Rays/CT/US

i.i. Nothing up for approval

i.i.i. Updates:

- We are now able to do Cardiac Scoring on the CT machine.

Written report remains in minutes.

g. Pharmacy
   i. Verbal Report by Pharmacist.
   i.i. Bebtelovimab is in house
   i.i.i. Clinimix received and in the Pharmacy
   i.v. Normal Saline in stock but still on the backorder list.
   v. IV Contrast received but still on the backorder list.

h. Physical Therapy
   i. No report.

i. Emergency Department
   i. No report

j. Quality Assessment Performance Improvement

Risk

- Risk Management
  1. Grievance – 0
  2. 3 - Fall with no injury
  3. 0 - Fall with minor injury
  4. Death – In Patient (0%)
     Emergency Department 0 (0%)
  5. AMA/LWBS – 6/0

- Quality
  - Quality Minutes from previous month included as attachment.
  - Policy Revisions:
    MRMC – Respiratory Protection Evaluation Checklist
    MRMC – Respiratory Protection Evaluation Summary for 2021
  - MRMC – Program Hazard Assessment
  - MRMC – Dietary Manual – Table of Contents/Attached
  - MRMC – Credentialing Manual – Policies Listed as follows: MRMC-Pre-Authorization Form, Primary Source Verification, Credentialing Checklist, Application for Temporary Privileges (Used for Care of Specific Patients), Credentialing Packet, Telephone Contact Report Form, Continuing Medical Education Record, Application for Reappointment, Emergency Privileges Form, HICS – 253 Volunteer Registration, Credentialing and Privileging Process (Mangum Specific), Medical Staff Membership and Categories, Basic Credentialing File and Maintenance, Application to the Medical Staff, Physician Assistance and APRNs, Professional Education, Adverse Credentialing Decisions, Fair Hearing Appeals Process for Privileging,

Expedited Appointment and Reappointment Process, Privileging Process, Peer Recommendations for Privileging Decisions, Emergency Privileging

- HIM – H&P – Completion 26/26 = 100%. Discharge Summary – Completion 27/27 = 100%
- Med event – 1
- Afterhours access was 95.
- Compliance
  Written report remains in minutes.

k. Utilization Review
   i. Total Patient days for May: 320
   i.i. Total Medicare days for May: 280
   i.i.i. Total Medicaid days for May: 3
   i.v. Total Swing Bed days for May: 259
   v. Total Medicare SB days for May: 259

Average Length of Stay for Medicare Patients/Swing Bed Stays was 10.2.
Written report remains in the minutes.

Motion made by Dr. John Chiaffitelli, Medical Director to approve Committee Reports for May, 2022.

6. New Business
   a. Review & Consideration of Approval of Evaluation Checklist : MRMC – MRMC - Respiratory Protection Evaluation Checklist
      i.Motion: made by John Chiaffitelli. DO, Medical Director, to approve MRMC - Respiratory Protection Evaluation Checklist.
   b Review & Consideration of Approval of Evaluation Summary for 2021: MRMC – Respiratory Protection Program Evaluation Summary for 2021
      i.Motion: made by John Chiaffitelli, DO, Medical Director, to approve MRMC - Respiratory Protection Program Evaluation Summary for 2021.
   c Review & Consideration of Approval of Assessment: MRMC – Program Hazard Assessment
      i.Motion: made by John Chiaffitelli, DO, Medical Director, to approve MRMC - Program Hazard Assessment.
   d. Review & Consideration of Approval of Policies & Procedures: MRMC – Dietary Manual – Table of Contents for Dietary Policies & Procedures is attached.
      i.Motion: made by John Chiaffitelli, DO, Medical Director, to approve MRMC - Dietary Manual – Table of Contents is attached.
   e. Review & Consideration of Approval of Policies & Procedures: MRMC – Credentialing Manual – Policies listed as follows: MRMC – Pre-Authorization Form, Primary Source Verification, Credentialing Checklist, Application for Temporary Privileges (Used for Care of Specific Patients), Credentialing Packet, Telephone Contact Report Form, Continuing Medical Education Record, Application for Reappointment, Emergency Privileges Form, HICS – 253 Volunteer Registration, Credentialing and Privileging Process (Mangum Specific), Medical Staff Membership and Categories, Basic Credentialing File and Maintenance, Application to the Medical Staff, Physician Assistance and APRNs, Professional Education, Adverse Credentialing

Decisions, Fair Hearing Appeals Process for Privileging, Expedited Appointment and Reappointment Process, Privileging Process, Peer Recommendations for Privileging Decisions, Emergency Privileging

7. Adjourn
    a. Dr. Chiaffitelli made a motion to adjourn the meeting at 12:28 pm.

_____ _____

Medical Director/Chief of Staff Date

Mangum Regional Medical Center
Medical Staff Meeting
May 19, 2022

MEMBERS PRESENT:

John Chiaffitelli, DO, Medical Director
William Gregory Morgan, III, MD

Absent:
Guest:

ALLIED HEALTH PROVIDER PRESENT:

Mary Barnes, APRN
David Arles, APRN

NON-MEMBERS PRESENT:

Chelsea Church, PhD
Dale Clayton, CEO
Daniel Coffin, CCO
Denise Jackson, RN, Quality Director
Erin Johnson, LPN, Utilization Review
Karlie Bowles, RN
Lynda James, LPN, Drug Tech
Kaye Hamilton, Medical Staff Coordinator

1. Call to order
    a. The meeting was called to order at 11:51 am by Dr. John Chiaffitelli, Medical Director.

2. Acceptance of minutes
    a. The minutes of the April 21, 2022, 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. CEO report – Dale Clayton, CEO

- Leadership continues to update staff and Providers regarding new policies and regulations.
- Covid is less of a concern however vigilance is still the focus.
- Hospital Staff and Operations Overview
    - Patient care continues to be outstanding.
    - Open positions include RT, CNA, LPN, and RN.
    - Recently hired core staff include an CNA and RN.
    - Our average daily census for the month was 10.
    - Emergency Department assisted 118 patients.
    - A Marketing Plan has been implemented with a strong focus on social media.
- Contracts, Agreements and Appointments to be presented to the Governing Board:
    - Western Commerce Bank Insurance Finance Agreement
    - Mangum Drug Co. 340B Addendum
    - Puckett's Discount Drug 340B Addendum
    - UHC VACCN Amendment
    - Organogenisis Loan Agreement for Freezer Refrigerator
    - BCBS Plan 65 Addendum
    - Aramark Agreement
    - Pitney Bowes Agreement
    - eClinical Works Agreement
    - Mangum Regional Medical Center's Three – Year Strategic Plan (2022 – 2025)
    - MRMC – EOC Survey Tool
    - DIA – Schedule 1 List of Providers
      Written report remains in the minutes.

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

    a. Nursing

Excellent Patient Care

- Monthly Education topics included a Clinical Staff Meeting with areas which included but not to Allergy, Vitals and Results communication, Order entry and Insulin education.
- We are continuing to educate our staff in the care of higher acuity patients. During the month of April, we did not transfer out any Acute or SWB patients with needs of a higher level of care.
- MRMC continued installation and education of the New Critical Alert Call System.

- MRMC Emergency Department provided appropriate stabilization and prompt transfer for 4 NSTEMI patients to optimize their chances of positive outcomes.
- We constantly look for areas we can improve upon. For the past 3 months, we have consistently met our benchmark of 100% for the reporting of critical lab results. This means from the time the RN is called a critical lab result, we have reached the Provider and received further orders within one hour ensuring we provide efficient, appropriate, and excellent patient care.
- We had two code blues for the month of April – both of which had successful outcomes regarding ACLS standards.
- Of the 118 ER patients seen during April, we reviewed a sampling of records which revealed 95% of the time, the patient was triaged in less than 5 minutes from the time they entered the ER door. Our benchmark is 90% and we are consistently meeting or exceeding that each month. We are endeavoring to consistently exceed the goal and meet 100%.

Excellent Client Service

- Patients continue to rely on MRMC as their local hospital. Patient days increased from 256 days in March to 303 days in April. This represents an average daily census of 10. In addition, MRMC Emergency Department provided care to 118 patients in April.
- March COVID-19 Stats at MRMC: Swabs (18-PCR & 34-Antigen) with 1 Positive PCR & 1 Positive Antigen.

Preserve Rural Jobs

- Open Positions include Full Time RT, RN, LPN and CNA.
- MRMC has new updates to the Core Staff! CNA and RN
- For the clinical team MRMC continues to pursue core staff members from the area.
- Recruiting efforts included posting of positions on mangumregional.net and Facebook as well as Indeed.
- Cohesive Health Care Management and Consulting coordinates with MRMC Dietary team to provide delicious meals free of charge to on-duty staff.
- During the Rattlesnake Derby, our CEO represented the hospital by openly communicating the excellent care, great teamwork, and cutting-edge technologies available at Mangum Regional Medical Center.

Written report remains in minutes.

c. Infection Control

- New Business:
  a. Approval of incoming IP Director, Claudia Collard.
- Data:
  a, N/A
- Policy & Procedures:

a. N/A

- Education/In Services
  a. Staff Education – Skills Fair on 3/23,3/24, & 3/25 for CAUTI, CLABSI. Continue on spot education as well as staff training.
- Updates: No updates at this time.
- Annual Items:
  a. N/A
- Any additional recommendations from committee:
  a. Evaluation due to be done annually.

Written report remains in minutes.

d. Environment of Care and Safety Report

i. Evaluation and Approval of Annual Plans –

i.i. Old Business - -

a. Evaluation and approval of Annual Plans-Plans will be presented in April meeting.
Continuing to work on the building. Flooring in Nurses break area and Med Prep room – Rescheduled - additional tile will need to be ordered.

b. 15 AMP Receptacles – all 15 AMP Receptacles will be replaced with 20 AMP Receptacles throughout Hospital – replacement has started.
c. Ceiling in SW Room of Lab needs repaired – Complete 3-14-2022
d. Replace all receptacles on generator circuit at Clinic with red receptacles.
e. Glass on double door of main hall cracked – Replaced 3-18-2022.
f. Glass on west hallway entry cracked- glass cut ready to install.
g. ER Provider office flooring needing replaced
h. Damaged ceiling tile in patient area due to headwall installation – replacement started.
i. Ceiling tile above AC in Xray Control room have water spots.
j. Verify all space heaters are appropriate type for use.
k. Covers needed for shelving in Cafeteria.
l. Areas in ED need new calking and penetrations repaired.

i.i.i. New Business

a. None

Written report remains in minutes.

e. Laboratory

i. Tissue Report – Approved – April, 2022
i.i. Transfusion Report – Approved – April, 2022

f. Radiology

i. There was a total of – 238 X-Rays/CT/US
i.i. Nothing up for approval
i.i.i. Updates:
- No new updates

Written report remains in minutes.

g. Pharmacy
i. Verbal Report by Pharmacist.
i.i. Bebtelovimab is in house
i.i.i. Clinimix received
i.v. Normal Saline received from Carneigie and still on the backorder list.
v. IV Contrast shortage and still on the backorder list.

h. Physical Therapy
i. No report.

i. Emergency Department
i. No report

j. Quality Assessment Performance Improvement
Risk
- Risk Management
  1. Grievance – 0
  2. 2 - Fall with no injury
  3. 0 - Fall with minor injury
  4. Death – In Patient 2 (9%)
     Emergency Department 1 (1%)
  5. AMA/LWBS – 1/0

- Quality
  - Quality Minutes from previous month included as attachment.
  - Policy Revisions:
    MRMC – EOC Survey Rounds Tool

- HIM – H&P – Completion 26/26 = 100%. Discharge Summary – Completion 22/22 = 100%
- Med event – 12
- Afterhours access was 59.
- Compliance

Written report remains in minutes.

k. Utilization Review
i. Total Patient days for April: 303
i.i. Total Medicare days for April: 295
i.i.i. Total Medicaid days for April: 3
i.v. Total Swing Bed days for April: 258

v. Total Medicare SB days for April: 258
Average Length of Stay for Medicare Patients/Swing Bed Stays was 19.1.
Written report remains in the minutes.
Motion made by Dr. John Chiaffitelli, Medical Director to approve Committee Reports for April, 2022.

6. New Business
   a. Review & Consideration of Approval of Survey Rounds Tool: MRMC – EOC Survey Rounds Tool
      i.Motion: made by John Chiaffitelli. DO, Medical Director, to approve MRMC - EOC Survey Rounds Tool.

7. Adjourn
   a. Dr. Chiaffitelli made a motion to adjourn the meeting at 12:06 pm.

_____ _____
Medical Director/Chief of Staff Date

Mangum Regional Medical Center
July 2022 Estimated Claims

Vendor	Description	Estimated Amount
ADCRAFT	Plant Ops Supplies	500.00
ALIMED	Misc supplies	9,312.19
AMBS CALL CENTER	Hotline	100.00
ANESTHESIA SERVICE INC	Service	5,500.00
APEX	COVID Capital	107,462.73
ARAMARK	Linens purch svs	18,000.00
ASD HEALTHCARE	Pharmacy Supplies	15,000.00
AT&T	Fax Service	3,500.00
Avanan, INC	COVID Capital	16,800.00
BARRY DAVENPORT	1099 Provider	20,000.00
BAXTER HEALTHCARE	Pharmacy Supplies	3,500.00
BIO-RAD LABORATORIES INC	Supplies	3,500.00
BKD LLP	Finance purch svs	16,093.00
BLUTH FAMILY MEDICINE	1099 Provider	5,300.00
C & C	Supplies	1,500.00
C&S INSTRUMENTS LLC	Supplies	200.00
CABLES AND SENSORS	Supplies	500.00
CARDINAL 110 LLC	Pharmacy Supplies	60,000.00
CARNEGIE TRI-COUNTY MUN. HOSP	Pharmacy Supplies	6,000.00
CARRIER CORP	Repairs/maintenance	2,000.00
CENTERPOINT ENERGY ARKLA	Utilities	2,500.00
CINTAS CORPORATION #628	Supplies	8,500.00
CITY OF MANGUM	Utilities & property taxes	12,000.00
CLIFFORD POWER SYSTEMS INC	Plant Ops Compliance	1,000.00
COHESIVE HEALTHCARE MGMT	Mgmt and provider Fees	250,000.00
COHESIVE HEALTHCARE RESOURCES	Payroll	550,000.00
COHESIVE MEDIRYDE LLC	Mgmt Transportation Service	10,000.00
COHESIVE REVOPS	Billing purch svs	70,000.00
COHESIVE STAFFING SOLUTIONS	Mgmt Staffing Service	350,000.00
COMMERCIAL MEDICAL ELECTRONICS	Quarterly PM service	2,500.00
COMPLIANCE CONSULTANTS	Lab Consultant	1,000.00
CONEXUS SOLUTIONS LLC	Agency Staffing	50,000.00
CONTEMPORARY HEALTHCARE SVCS	1099 Provider	34,000.00
CONTROL FIRE SYSTEMS CO	Repairs/maintenance	260.00
CONTROL SOLUTIONS	Supplies	500.00
CORRY KENDALL, ATTORNEY AT LAW	Legal Fees	8,500.00
CPSI	EHR software	40,000.00
CULLIGAN WATER CONDITIONING	RHC purch svs	150.00
DAN'S HEATING & AIR CONDITIONI	maintenance	1,000.00
DOBSON TECHNOLOGIES TRANSPORT	Internet	1,809.00
DOERNER SAUNDERS DANIEL ANDERS	Legal Fees	6,000.00
DR. MORGAN	1099 Provider	9,532.00

Vendor	Description	Estimated Amount
EMD MILLIPORE CORPORATION	lab supplies	300.00
F1 INFORMATION TECHNOLOGIES IN	IT Support Services	5,856.00
FEDEX	Postage	500.00
FFF ENTERPRISES	Pharmacy Supplies	500.00
FIRE EXTINGUISHER SALES & SERV	Repairs/maintenance	200.00
FIRSTCARE MEDICAL SERVICES, PC	1099 Provider	28,848.00
FOX BUILDING SUPPLY	Plant Ops Supplies	1,500.00
GEORGE BROS TERMITE & PEST CON	Pest Control Service	600.00
GLOBAL EQUIPMENT COMPANY INC.	Supplies	1,000.00
GRAINGER	Maintenance Supplies	4,500.00
GREER COUNTY CHAMBER OF	Hwy Sign	400.00
HAC INC	Dietary Supplies	1,000.00
HAMILTON MEDICAL INC.	Patient Supplies	1,200.00
HEALTH CARE LOGISTICS	Patient Supplies	800.00
HEALTHSTREAM	Employee education/training	841.75
HEARTLAND PATHOLOGY CONSULTANT	Lab Consultant	2,000.00
HENGST PRINTING	Pharmacy Supplies	250.00
HENRY SCHEIN	Lab Supplies	10,000.00
HICKS MEDIA	Advertising	279.00
HILL-ROM COMPANY, INC	Patient Supplies	1,500.00
HOSPITAL EQUIPMENT RENTAL COMP	Equipment rental	3,155.00
ICU MEDICAL SALES INC.	COVID Capital, misc supplies	1,000.00
IMPERIAL, LLC.-LAWTON	Dietary Purchased Service	500.00
INQUISEEK	RHC consulting service	500.00
INSIGHT DIRECT USA INC.	Supplies	750.00
J. & K. LOFTIS	Rent house	850.00
JANUS SUPPLY CO	Housekeeping Supplies, based in Altus	2,700.00
JNP MEDICAL SERVICES LLC	1099 Provider	2,500.00
KAY ELECTRIC	Repairs/maintenance	1,000.00
KCI USA	Patient Supplies	1,000.00
LABCORP	Lab purch svs	15,000.00
LAMPTON WELDING SUPPLY	Patient Supplies	6,500.00
LANGUAGE LINE SERVICES INC	Translation service	260.00
LOCKE SUPPLY	Plant Ops Supplies	1,500.00
LOWES	Supplies	1,000.00
MANGUM DRUG CO.	Pharmacy Supplies	200.00
MCABEE FOX ROOFING LLC	Roof Replacement	11,000.00
MCKESSON / PSS - DALLAS	Patient Care/Lab Supplies	30,000.00
MEASUREMENT SPECIALTIES INC	supplies	175.00
MEDICAL DEVICE DEPOT, INC	COVID equip list	1,000.00
MEDLINE INDUSTRIES	Patient Care Supplies	35,000.00
MEDTOX DIAGNOSTICS, INC	Lab supplies	1,500.00
MISC EMPLOYEE REIMBURSEMENTS	To reimburse employees for travel and sup	3,500.00
MOUNTAINEER MEDICAL	Patient Supplies	500.00

Vendor	Description	Estimated Amount
NATIONAL RECALL ALERT CENTER	Safety and Compliance Data sheets	1,190.00
NEXTIVA, INC.	Phone utility	6,000.00
NP RESOURCES	1099 Provider	2,500.00
NUANCE COMMUNICATIONS INC	Supplies	600.00
OFFICE DEPOT	Office Equipment	500.00
OK STATE BOARD	Credentialing	300.00
OKLAHOMA BLOOD INSTITUTE	Blood bank	7,500.00
ORGANOGENESIS INC	skin graph contract	18,000.00
ORTHO-CLINICAL DIAGNOSTICS INC	Laboratory Supplies	2,000.00
PARA HEALTHCARE	CDM Review service	7,500.00
PARTSSOURCE INC,	Misc Supplies	1,234.30
PATIENT REFUNDS	Credits due to payors	5,500.00
PHILADELPHIA INSURANCE COMPANY	Property ins	6,000.00
PHILIPS HEALTHCARE	Supplies	1,200.00
PIPETTE COM	Lab maintenance/repair	500.00
PITNEY BOWES GLOBAL FINANCIAL	Postage rental	360.00
PRESS GANEY ASSOCIATES, INC	Purchased Service	1,600.00
PUCKETT DISCOUNT PHARMACY	Pharmacy Supplies	500.00
RAMSEY AND GRAY, PC	Legal Fees	6,270.00
Reyes Electric	COVID Capital/Repairs	25,000.00
ROCHE DIAGNOSTICS CORPORATION	Patient Supplies	2,400.00
ROYAL MEDIA NETWORK, INC	Lab Supplies	2,160.00
RUSSELL ELECTRIC & SECURITY	Repairs/maintenance	1,000.00
SBM MOBILE PRACTICE INC.	1099 Provider	32,000.00
SCHAPEN LLC	RHC rent	1,750.00
SCRUBS AND SPORTS	Employee appreciation	273.94
SECURITY CHECK	Backgrouns check svs	1,500.00
SHRED-IT	Secure doc disposal	2,500.00
SIZEWISE	equipment rental	1,000.00
SMAART MEDICAL SYSTEMS INC	Radiology interface/Radiologist provider	7,500.00
SMARTSIGN	Patient Supplies	212.00
SOMSS LLC	JEFF BRAND 1099 Provider	25,000.00
SOUTHWEST HOT STEAM CLEANING	Quarterly PM service	375.00
SPARKLIGHT BUSINESS	Cable service	1,200.00
STANDLEY	Printer Lease	500.00
STANDLEY SYSTEMS LLC	Printer Lease	7,000.00
STAPLES ADVANTAGE	Office Supplies	2,500.00
STERICYCLE INC	Waste Disposal svs	8,000.00
STRYKER SALES CORPORATION	ISTAT PM	1,200.00
SYSMEX AMERICA INC	Lab PM Contract	8,439.00
TECUMSEH OXYGEN & MEDICAL SUPP	Supplies	5,000.00
TELEFLEX	Supplies	500.00
THE COMPLIANCE TEAM	RHC Consultant	500.00
TOUCHPOINT MEDICAL, INC	pharmacy purch svs	6,000.00

Vendor	Description	Estimated Amount
TRENT ELLIOTT	1099 Provider	20,000.00
TSYS	CC processing service	2,000.00
ULINE	Supplies	116.00
ULTRA-CHEM INC	housekeeping supplies	600.00
UMPQUA	Lab Eq Note	4,400.00
US FOODSERVICE-OKLAHOMA CITY	Food and supplies	10,000.00
US MED-EQUIP LLC	Swing bed eq rental	10,000.00
VITAL SYSTEMS OF OKLAHOMA, INC	Swing bed purch service	8,000.00
WESTERN COMMERCE BANK	Insurance	6,800.00
WOLTERS KLUWER HEALTH	Employee education/training	5,279.61
	TOTAL Estimated	**2,166,643.52**

Mangum Regional Medical Center
Claims List
June 2022

Check#	Ck Date	Amount	Paid To	Expense Description
17415	6/28/2022	38.19	AARP	Patient Refund
17366	6/14/2022	390.09	ANESTHESIA SERVICE INC	Patient Supplies
17429	6/28/2022	735.71	ANESTHESIA SERVICE INC	Patient Supplies
16782	6/14/2022	(4.00)	PATIENT REFUND	Patient Refund
17430	6/28/2022	21,492.55	APEX MEDICAL GAS SYSTEMS, INC	COVID Capital
17352	6/7/2022	2,222.45	ARAMARK	Linens - rental
17367	6/14/2022	2,222.45	ARAMARK	Linens - rental
17431	6/28/2022	2,222.45	ARAMARK	Linens - rental
17416	6/28/2022	3.24	ATTN:FINANCE DEPARTMENT	Patient Refund
17397	6/21/2022	5,760.00	BARRY DAVENPORT	1099 Provider
17417	6/28/2022	102.77	BCBS OF ILLINOIS	Patient Refund
17368	6/14/2022	745.96	BIO-RAD LABORATORIES INC	Lab Supplies
17369	6/14/2022	500.00	BKD LLP	Purch svs
17398	6/21/2022	2,400.00	BLUTH FAMILY MEDICINE, LLC	1099 Provider
17399	6/21/2022	1,219.98	C & C	Supplies
17370	6/14/2022	5,000.00	CARDINAL HEALTH 110, LLC	Pharmacy Supplies
17400	6/21/2022	5,000.00	CARDINAL HEALTH 110, LLC	Pharmacy Supplies
17371	6/14/2022	428.37	CARNEGIE TRI-COUNTY MUN. HOSP	Pharmacy Supplies
901218	6/7/2022	903.16	CENTERPOINT ENERGY ARKLA	Gas
17418	6/28/2022	24.64	CHAMP VA	Patient Refund
17353	6/7/2022	876.36	CINTAS CORPORATION #628	Housekeeping supply rental
17372	6/14/2022	876.36	CINTAS CORPORATION #628	Housekeeping supply rental
17432	6/28/2022	876.36	CINTAS CORPORATION #628	Housekeeping supply rental
17354	6/7/2022	6,341.14	CITY OF MANGUM	Utilities
17355	6/7/2022	305,000.00	COHESIVE HEALTHCARE RESOURCES	Payment on Old Debt
17401	6/21/2022	305,000.00	COHESIVE HEALTHCARE RESOURCES	Payment on Old Debt
17402	6/21/2022	53,611.49	COHESIVE REVOPS INTEGRATION	Billing Purch svs
17373	6/14/2022	125,000.00	COHESIVE STAFFING SOLUTIONS	Payment on Old Debt
17433	6/28/2022	125,000.00	COHESIVE STAFFING SOLUTIONS	Payment on Old Debt
17356	6/7/2022	4,120.00	CONEXUS SOLUTIONS LLC	Payment on Old Debt-contract labor
17374	6/14/2022	3,400.00	CONEXUS SOLUTIONS LLC	Payment on Old Debt-contract labor
17403	6/21/2022	6,800.00	CONEXUS SOLUTIONS LLC	Payment on Old Debt-contract labor
17434	6/28/2022	3,400.00	CONEXUS SOLUTIONS LLC	Payment on Old Debt-contract labor
17357	6/7/2022	4,750.00	CONTEMPORARY HEALTHCARE SVCS	1099 provider
17404	6/21/2022	7,800.00	CONTEMPORARY HEALTHCARE SVCS	1099 provider
17435	6/28/2022	1,326.15	CORRY KENDALL, ATTORNEY AT LAW	Legal Fees
17405	6/21/2022	32,035.70	CPSI	EHR payable and monthly support
17358	6/7/2022	26.00	CULLIGAN WATER CONDITIONING	RHC purch svs
17436	6/28/2022	12.00	CULLIGAN WATER CONDITIONING	RHC purch svs
17406	6/21/2022	1,809.00	DOBSON TECHNOLOGIES TRANSPORT	Internet
17359	6/7/2022	4,766.67	DR W. GREGORY MORGAN III	1099 Provider
17437	6/28/2022	2,928.00	F1 INFORMATION TECHNOLOGIES IN	Software license fee
17438	6/28/2022	187.53	FEDEX	Postage
17360	6/7/2022	9,615.38	FIRSTCARE MEDICAL SERVICES, PC	1099 Provider
17407	6/21/2022	9,615.38	FIRSTCARE MEDICAL SERVICES, PC	1099 Provider
16785	6/14/2022	(15.00)	PATIENT REFUND	Patient Refund
17375	6/14/2022	160.00	GEORGE BROS TERMITE & PEST CON	Plant Ops Purch svs
17439	6/28/2022	160.00	GEORGE BROS TERMITE & PEST CON	Plant Ops Purch svs
901219	6/10/2022	576.99	GLOBAL PAYMENTS INTEGRATED	CC processing
17376	6/14/2022	1,422.61	GRAINGER	supplies
17440	6/28/2022	1,124.02	GRAINGER	supplies

Check#	Ck Date	Amount	Paid To	Expense Description
17441	6/28/2022	212.31	HAC INC	Dietary Food
17419	6/28/2022	15.00	PATIENT REFUND	Patient Refund
17420	6/28/2022	1,307.96	HC HP ADMINISTRATOR	Patient Refund
16799	6/14/2022	(1,177.01)	HEALTHCHOICE	Patient Refund
17421	6/28/2022	346.44	HEALTHCHOICE	Patient Refund
17422	6/28/2022	81.26	HEALTHCHOICE	Patient Refund
17442	6/28/2022	1,000.00	HEARTLAND PATHOLOGY CONSULTANT	Lab consultant
17443	6/28/2022	8,036.28	HENRY SCHEIN	Patient supplies
17377	6/14/2022	200.00	HIBCC	340B Applications
901216	6/1/2022	3,155.00	HOSPITAL EQUIPMENT RENTAL COMP	Equipment Lease
17378	6/14/2022	68.10	IMPERIAL, LLC.-LAWTON	Dietary Purchased Svs
17379	6/14/2022	443.80	JANUS SUPPLY CO	Cleaning Supplies
17444	6/28/2022	850.00	JIMALL & KANISHA' LOFTIS	Rent House
17445	6/28/2022	41.96	JOSEY KENMORE	Employee Reimbursement
17380	6/14/2022	995.06	KAY ELECTRIC	Repairs
17381	6/14/2022	4,690.50	LABCORP	Lab purch svs
17446	6/28/2022	3,679.17	LABCORP	Lab purch svs
17382	6/14/2022	1,166.56	LAMPTON WELDING SUPPLY	Patient Supplies
17383	6/14/2022	130.00	LANGUAGE LINE SERVICES INC	Transcription svs
16801	6/14/2022	(4.00)	PATIENT REFUND	Patient Refund
17384	6/14/2022	133.60	LOCKE SUPPLY	Supplies
17408	6/21/2022	414.75	MARK CHAPMAN	Employee Reimbursement
17385	6/14/2022	80.00	MARY BARNES, APRN	Employee Reimbursement
901222	6/10/2022	9,027.44	MCKESSON / PSS - DALLAS	Patient Care/Lab Supplies
901230	6/24/2022	10,929.44	MCKESSON / PSS - DALLAS	Patient Care/Lab Supplies
17387	6/14/2022	4,250.02	MEDLINE INDUSTRIES	Patient Care Supplies
17448	6/28/2022	3,216.53	MEDLINE INDUSTRIES	Patient Care Supplies
17423	6/28/2022	17.00	MUTUAL OF OMAHA	Patient Refund
17424	6/28/2022	12.14	MUTUAL OF OMAHA	Patient Refund
901217	6/1/2022	42.50	NATIONAL DATA BANK	Credentialing
901225	6/14/2022	2.50	NATIONAL DATA BANK	Credentialing
17361	6/7/2022	2,055.39	NEXTIVA, INC.	Phone service
17425	6/28/2022	2.24	OHCA - ADJUSTMENTS	Patient Refund
17426	6/28/2022	13.34	OHCA-ADJUSTMENTS	Patient Refund
17388	6/14/2022	510.20	OKLAHOMA BLOOD INSTITUTE	Blood bank supplies
17449	6/28/2022	75.00	OKLAHOMA DEPARTMENT OF LABOR	Maintenance
17389	6/14/2022	120.00	OKLAHOMA MEDICAL LICENSURE	Credentialing
17390	6/14/2022	125.00	OKLAHOMA STATE DEPT OF HEALTH	License
17391	6/14/2022	3,760.00	ORGANOGENESIS INC	Wound Care supplies
17392	6/14/2022	2,909.00	PARA HEALTHCARE ANALYTICS, LLC	Charge master review svs
16784	6/14/2022	(5.00)	PATIENT REFUND	Patient Refund
16800	6/14/2022	(4.00)	PATIENT REFUND	Patient Refund
901224	6/13/2022	6,417.75	PHILADELPHIA INSURANCE COMPANY	Property Insurance
17409	6/21/2022	13,100.00	REYES ELECTRIC LLC	Purch svs
17410	6/21/2022	2,160.00	ROYAL MEDIA NETWORK, INC	Lab Supplies
17427	6/28/2022	45.64	PATIENT REFUND	Patient Refund
17362	6/7/2022	8,200.00	SBM MOBILE PRACTICE, INC	1099 Provider
17411	6/21/2022	9,600.00	SBM MOBILE PRACTICE, INC	1099 Provider
17450	6/28/2022	1,750.00	SCHAPEN LLC	RHC rent
17428	6/28/2022	348.69	PATIENT REFUND	Patient Refund
16810	6/14/2022	(4.00)	PATIENT REFUND	Patient Refund
17363	6/7/2022	9,800.00	SOMSS LLC	1099 Provider
17412	6/21/2022	3,600.00	SOMSS LLC	1099 Provider
17413	6/21/2022	350.00	SOUTHWEST HOT STEAM CLEANING	Dietary purch svs

Check#	Ck Date	Amount	Paid To	Expense Description
17393	6/14/2022	303.53	SPARKLIGHT BUSINESS	Cable
17451	6/28/2022	445.94	SPARKLIGHT BUSINESS	Cable
17414	6/21/2022	2,098.12	STANDLEY SYSTEMS LLC	Printer Rental
17452	6/28/2022	2,261.24	STANDLEY SYSTEMS LLC	Printer Rental
17394	6/14/2022	765.07	STAPLES ADVANTAGE	Office Supplies
17453	6/28/2022	869.19	STAPLES ADVANTAGE	Office Supplies
17364	6/7/2022	497.14	STERICYCLE / SHRED-IT	Document Disposal
17395	6/14/2022	2,902.16	STERICYCLE INC	Waste Disposal
17365	6/7/2022	4,760.00	TRENT ELLIOTT	1099 provider
901226	6/23/2022	4,310.82	UMPQUA BANK VENDOR FINANCE	Lab eq note payable
901223	6/10/2022	1,681.76	US FOODSERVICE-OKLAHOMA CITY	Dietary Food
901231	6/24/2022	5,083.61	US FOODSERVICE-OKLAHOMA CITY	Dietary Food
17396	6/14/2022	2,565.00	VITAL SYSTEMS OF OKLAHOMA, INC	Purch svs
17454	6/28/2022	1,710.00	VITAL SYSTEMS OF OKLAHOMA, INC	Purch svs
901227	6/23/2022	6,512.77	WESTERN COMMERCE BANK (OHA INS	OHA Insurance
	TOTAL	**1,225,070.06**		

Mangum Regional Medical Center
August 2022 Estimated Claims

Vendor	Description	Estimated Amount
ADCRAFT	Plant Ops Supplies	500.00
ALIMED	Misc supplies	9,312.19
AMBS CALL CENTER	Hotline	100.00
ANESTHESIA SERVICE INC	Service	5,500.00
APEX MEDICAL GAS SYSTEMS, INC	COVID Capital	107,462.73
ARAMARK	Linens purch svs	18,000.00
ASD HEALTHCARE	Pharmacy Supplies	15,000.00
AT&T	Fax Service	3,500.00
AVANAN, INC.	COVID Capital	16,800.00
BADGE BUDDIES LLC	Supplies	142.56
BARRY DAVENPORT	1099 Provider	20,000.00
BAXTER HEALTHCARE	Pharmacy Supplies	3,500.00
BIO-RAD LABORATORIES INC	Supplies	3,500.00
BKD LLP	Finance purch svs	16,093.00
BLUTH FAMILY MEDICINE, LLC	1099 Provider	5,300.00
C & C	Supplies	1,500.00
C&S INSTRUMENTS LLC	Supplies	200.00
CABLES AND SENSORS	Supplies	500.00
CARDINAL 110 LLC	Pharmacy Supplies	60,000.00
CARNEGIE TRI-COUNTY MUN. HOSP	Pharmacy Supplies	6,000.00
CARRIER CORP	Repairs/maintenance	2,000.00
CENTERPOINT ENERGY ARKLA	Utilities	2,500.00
CINTAS CORPORATION #628	Supplies	8,500.00
CITY OF MANGUM	Utilities & property taxes	12,000.00
CLIFFORD POWER SYSTEMS INC	Plant Ops Compliance	1,000.00
COHESIVE HEALTHCARE MGMT	Mgmt and provider Fees	250,000.00
COHESIVE HEALTHCARE RESOURCES	Payroll	550,000.00
COHESIVE MEDIRYDE LLC	Mgmt Transportation Service	10,000.00
COHESIVE STAFFING SOLUTIONS	Mgmt Staffing Service	350,000.00
COMMERCIAL MEDICAL ELECTRONICS	Quarterly PM service	2,500.00
COMPLIANCE CONSULTANTS	Lab Consultant	1,000.00
CONEXUS SOLUTIONS LLC	Agency Staffing	50,000.00
CONTEMPORARY HEALTHCARE SVCS	1099 Provider	34,000.00
CONTROL FIRE SYSTEMS CO	Repairs/maintenance	260.00
CONTROL SOLUTIONS	Supplies	500.00
CORRY KENDALL, ATTORNEY AT LAW	Legal Fees	8,500.00
CPSI	EHR software	40,000.00
CULLIGAN WATER CONDITIONING	RHC purch svs	150.00
DAN'S HEATING & AIR CONDITIONI	maintenance	1,000.00
DOBSON TECHNOLOGIES TRANSPORT	Internet	1,809.00
DOERNER SAUNDERS DANIEL ANDERS	Legal Fees	6,000.00
DR. MORGAN	1099 Provider	9,532.00

Vendor	Description	Estimated Amount
eCLINICAL WORKS, LLC	RHC EMR	250.00
EMD MILLIPORE CORPORATION	lab supplies	300.00
EQUALIZE RCM REVOPS	Billing purch svs	70,000.00
F1 INFORMATION TECHNOLOGIES IN	IT Support Services	5,856.00
FEDEX	Postage	500.00
FFF ENTERPRISES	Pharmacy Supplies	500.00
FIRE EXTINGUISHER SALES & SERV	Repairs/maintenance	200.00
FIRSTCARE MEDICAL SERVICES, PC	1099 Provider	28,848.00
FLOWERS UNLIMITED	Other	198.18
FOX BUILDING SUPPLY	Plant Ops Supplies	1,500.00
GEORGE BROS TERMITE & PEST CON	Pest Control Service	600.00
GLOBAL EQUIPMENT COMPANY INC.	Supplies	1,000.00
GRAINGER	Maintenance Supplies	4,500.00
GREER COUNTY CHAMBER OF	Hwy Sign	400.00
HAC INC	Dietary Supplies	1,000.00
HAMILTON MEDICAL INC.	Patient Supplies	1,200.00
HEALTH CARE LOGISTICS	Patient Supplies	800.00
HEALTHSTREAM	Employee education/training	841.75
HEARTLAND PATHOLOGY CONSULTANT	Lab Consultant	2,000.00
HENGST PRINTING	Pharmacy Supplies	250.00
HENRY SCHEIN	Lab Supplies	10,000.00
HICKS MEDIA	Advertising	279.00
HILL-ROM COMPANY, INC	Patient Supplies	1,500.00
HOSPITAL EQUIPMENT RENTAL COMP	Equipment rental	3,155.00
ICU MEDICAL SALES INC.	COVID Capital, misc supplies	1,000.00
IMPERIAL, LLC.-LAWTON	Dietary Purchased Service	500.00
INQUISEEK	RHC consulting service	500.00
INSIGHT DIRECT USA INC.	Supplies	750.00
JIMALL & KANISHA' LOFTIS	Rent house	850.00
JANUS SUPPLY CO	Housekeeping Supplies, based in Altus	2,700.00
JNP MEDICAL SERVICES LLC	1099 Provider	2,500.00
KAY ELECTRIC	Repairs/maintenance	1,000.00
KCI USA	Patient Supplies	1,000.00
KING GUIDE PUBLICATIONS INC	Advertising	100.00
LABCORP	Lab purch svs	15,000.00
LAMPTON WELDING SUPPLY	Patient Supplies	6,500.00
LANGUAGE LINE SERVICES INC	Translation service	260.00
LOCKE SUPPLY	Plant Ops Supplies	1,500.00
LOWES	Supplies	1,000.00
MANGUM DRUG CO.	Pharmacy Supplies	200.00
MCABEE FOX ROOFING LLC	Roof Replacement	11,000.00
MCKESSON / PSS - DALLAS	Patient Care/Lab Supplies	30,000.00
MEASUREMENT SPECIALTIES INC	supplies	175.00
MEDICAL DEVICE DEPOT, INC	COVID equip list	1,000.00

Vendor	Description	Estimated Amount
MEDLINE INDUSTRIES	Patient Care Supplies	35,000.00
MEDTOX DIAGNOSTICS, INC	Lab supplies	1,500.00
MISC EMPLOYEE REIMBURSEMENTS	To reimburse employees for travel and sup	3,500.00
MOUNTAINEER MEDICAL	Patient Supplies	500.00
NATIONAL RECALL ALERT CENTER	Safety and Compliance Data sheets	1,190.00
NEXTIVA, INC.	Phone utility	6,000.00
NP RESOURCES	1099 Provider	2,500.00
NUANCE COMMUNICATIONS INC	Supplies	600.00
OFFICE DEPOT	Office Equipment	500.00
OK STATE BOARD	Credentialing	300.00
OKLAHOMA BLOOD INSTITUTE	Blood bank	7,500.00
ORGANOGENESIS INC	skin graph contract	18,000.00
ORTHO-CLINICAL DIAGNOSTICS INC	Laboratory Supplies	2,000.00
PARA HEALTHCARE ANALYTICS, LLC	CDM Review service	7,500.00
PARTSSOURCE INC,	Misc Supplies	1,234.30
PATIENT REFUNDS	Credits due to payors	5,500.00
PHILADELPHIA INSURANCE COMPANY	Property ins	6,000.00
PHILIPS HEALTHCARE	Supplies	1,200.00
PIPETTE COM	Lab maintenance/repair	500.00
PITNEY BOWES GLOBAL FINANCIAL	Postage rental	360.00
PRESS GANEY ASSOCIATES, INC	Purchased Service	1,600.00
PUCKETT DISCOUNT PHARMACY	Pharmacy Supplies	500.00
RAMSEY AND GRAY, PC	Legal Fees	6,270.00
REYES ELECTRIC LLC	COVID Capital/Repairs	25,000.00
ROCHE DIAGNOSTICS CORPORATION	Patient Supplies	2,400.00
ROYAL MEDIA NETWORK, INC	Lab Supplies	2,160.00
RUSSELL ELECTRIC & SECURITY	Repairs/maintenance	1,000.00
SBM MOBILE PRACTICE, INC	1099 Provider	32,000.00
SCHAPEN LLC	RHC rent	1,750.00
SCRUBS AND SPORTS	Employee appreciation	273.94
SECURITY CHECK	Backgrouns check svs	1,500.00
SHRED-IT	Secure doc disposal	2,500.00
SIZEWISE	equipment rental	1,000.00
SMAART MEDICAL SYSTEMS INC	Radiology interface/Radiologist provider	7,500.00
SMARTSIGN	Patient Supplies	212.00
SOMSS LLC	JEFF BRAND 1099 Provider	25,000.00
SOUTHWEST HOT STEAM CLEANING	Quarterly PM service	375.00
SPACELABS HEALTHCARE LLC	Patient Supplies	360.36
SPARKLIGHT BUSINESS	Cable service	1,200.00
STANDLEY	Printer Lease	500.00
STANDLEY SYSTEMS LLC	Printer Lease	7,000.00
STAPLES ADVANTAGE	Office Supplies	2,500.00
STERICYCLE INC	Waste Disposal svs	8,000.00
STRYKER SALES CORPORATION	ISTAT PM	1,200.00

Vendor	Description	Estimated Amount
SYSMEX AMERICA INC	Lab PM Contract	8,439.00
TECUMSEH OXYGEN & MEDICAL SUPP	Supplies	5,000.00
TELEFLEX	Supplies	500.00
THE COMPLIANCE TEAM	RHC Consultant	500.00
TOUCHPOINT MEDICAL, INC	pharmacy purch svs	6,000.00
TRENT ELLIOTT	1099 Provider	20,000.00
TSYS	CC processing service	2,000.00
ULINE	Supplies	116.00
ULTRA-CHEM INC	housekeeping supplies	600.00
UMPQUA BANK VENDOR FINANCE	Lab Eq Note	4,400.00
US FOODSERVICE-OKLAHOMA CITY	Food and supplies	10,000.00
US MED-EQUIP LLC	Swing bed eq rental	10,000.00
VITAL SYSTEMS OF OKLAHOMA, INC	Swing bed purch service	8,000.00
WESTERN COMMERCE BANK (OHA INS	Insurance	6,800.00
WOLTERS KLUWER HEALTH	Employee education/training	5,279.61
WORTH HYDROCHEM	Water Treatment	686.00
	TOTAL Estimated	**2,158,968.43**

Mangum Regional Medical Center
Governing Board Summary
May Quality Data 06/16/2022

Hospital Activity

- Hospital Admission
  - Acute Care Admits: 13 – down from April (15)
  - Swing-Bed Admits: 13 – up from April (11)
  - Total Discharges: 26 – down from April (22)
- Total Patient Days, ED Visits, ADC
  - Total Patient: 320 - up from April (303)
  - ED Visits: 144 - up from April (118)
  - Average Daily Census: 10 – no change from April (10)

AMA/LWBS

- AMA: 6 – up from April (6)
- LWBS: 0 – no change from April (0)

Type of Count (AMA/LWBS)	Count	Brief Description of Event	Actions
AMA	6	AMA 3 ER pt. - 1) pt. to ed for vomiting, provider wanted to admit due to dx in er, however pt. was not local and desired to return to home state for further treatment. risks/benefits explained/ama signed 2) pt. to ed for fever/dyspnea. Evaluation shows sepsis, pt. was agreeable to treatment in the er initially. pt. had episodes of anxiety while in the ed, staff was able to calm/redirect pt. pt. became very anxious wanting to leave, staff made aware that current treatment had about 30 min left, pt. agreeable to completing IV treatment but signed ama and would not stay for further care. risks/benefits explained 3) pt. to ed for ha/dizziness. pt. has been seen by multiple medical facilities over the past 2 weeks approx., reports that since being home symptoms have not improved. All appropriate testing/assessments done while in the ed, pt. cleared for d/c. family desired additional treatment/testing/admittance despite negative diagnostic results/lack of symptoms for qualifying hospital admit. Provider provided education to family and pt. multiple times, however family	AMA - all ama pt. had risks/benefits presented at time of ama, encouraged to return to ed as needed, discharge education will continue to be provided to pt. based on specific dx/needs, staff will continue to provide safe patient care to all MRMC patients and educate patients/family as need.

		became upset and demanded ama/pt. agreeable with ama, ama signed, risks/benefits discussed; 3 IN-PT AMA - 1.) pt. admitted for opioid toxicity, pt. began demanding that all benzos/opioids be resumed, provider explained current dx and agreed to resume pm dose of Zyprexa only. pt. became very upset the next day demanding all meds be resumed, provider again explained dx. pt. demanded that meds be resumed, or they would leave, provider did not resume meds/pt. signed out ama. risks/benefits explained. 2.) pt. admitted for copd, during the stay pt. had elevated b/p. routine meds given, with no improvement noted. provider aware with new orders obtained/administered. recheck of b/p with continued elevated b/p noted, pt. demanded to leave, provider and nurse spoke with pt. about current state and med changes, pt. continued with desire to leave. ama signed. risks/benefits explained. 3) pt. admitted for uncontrolled dm/ileus, pt. npo due to ileus tolerating well. pt. expressed desire to eat, diet advanced after exam cleared pt. for advancement. pt. contacted family via phone, when family arrived at the facility, pt. demanded to go home. provider discussed dx with patient as well as risks/benefits, pt. signed out ama.	
LWBS	0	none	none

Care Management

- 30 Day Readmissions
    - 4 for May

Event	Count	Comments	Actions
Readmit	4	1) readmit after surgery at Jackson County Memorial Hospital 2) readmit after being admitted to Saint Anthony's hospital by Dr. Morgan 3) readmit after being sent to Integris Canadian valley for G.I. bleed. 4) readmit after surgery at Great Plains regional Medical Center	None – pt's required higher level of care, returned for continued/skilled care

Risk Management

- Incidents
  - Falls without Injury
  - AMA/LWBS
  - Other Events

Incident Type	Count	Brief Description of Event & Outcome	Actions
Falls without injury	3	See below	
AMA/LWBS	6/0	See above	
Other events	2	1.) Nurse to room to assist pt. with restroom use, noted skin tear to hand, pt. reports that hand hit table during initial transfer. first aide administered. 2.) Dietician noted that dishwasher temps have been recorded incorrectly. Immediate corrective action: notified maintance to check dishwasher, notified manufacture for on-site check, re-visited state regulations. No harm as it was adequately preforming washes within regs.	1.) pt. encouraged to be mindful with position changes, staff will provide skin care regularly 2.) Dietician provided education to MRMC dietary staff on regs/current temp requirements and correct temp monitoring for dishwasher

- Complaints and Grievances
  - 0 grievance

Brief Description of Complaint/Grievance & Outcome	Actions
None for May	None

- Patient Falls
  - Fall with no injury – 3
  - Fall with minor injury – 0
  - Fall with major injury – 0

Count	Brief Description of Event & Outcome	Actions
3 FWOI	1.) during transfer with assist x 2, pt. became weak and no longer to bear weight. Pt was assisted to the floor. No injuries noted/reported. 2.) pt. slid off the bed while attempting to transfer self independently to the bsc. f. No injuries noted/reported. assisted back to bed without incident. 3.) pt. attempting to transfer independently, slid down on the bed and to the floor. all precautions in place; nonskid socks/bed alarm, low bed, call light in reach. no injuries noted/reported	educated to transfer with appropriate number of staff when need, education provided to patients to call for assist with all transfers, staff will continue to monitor all fall precautions that were in place prior to the fall to make sure they remain in place at all times
0 Fall w/minor injury	None	None

- Mortality Rate
  - Acute/Swing-Bed Deaths
    - 0 (0%) (YTD = 9%)
  - Emergency Department Deaths
    - 0 (0%) (YTD = (0%)

Count	Brief Description of Event & Outcome	Actions
0 acute 0 swing	None for the reporting period	none
0 ER	None for the reporting period	none

- Organ Bank Notifications within 60 minutes of Death (Benchmark 100%)
  - 0 notification within 60 minutes of death/ 0 death for reporting period

Count	Compliance	Action
0	None for the reporting period	none

Infection Control

- Catheter Associated Urinary Tract Infections (CAUTIs) – 0
- Central Line Associated Primary Bloodstream Infections (CLABSIs) – 0

Type of Event (CLABSI/CAUTI)	Count	Brief Description of Event & Outcome	Actions
None			
None			

Health Information Management

- History & Physical Completion (Benchmark 100%)
  - 26/26= 100 %
- Discharge Summary Completion (Benchmark 100%)
  - 27/27 = 100 %

Type of Documentation (H&P/Discharge)	Count	Actions
H&P	26	none
Discharge Summary	27	none

Nursing

- Code Blue
  - 0
- Transfers
  - Acute Transfers – 0
  - ED Transfers – 9

Event	Count	Comments	Actions
Acute Transfers	0	none	Continue operating capacities for this CAH.
ED Transfers	9	9 - transferred to higher level of care for; cardiac syncope d/t severe tachycardia, si/sh x 2, pleural effusion/anasarca, femur fx., dm uncontrolled (requiring ICU), acute chole., hip fx., acute appendicitis	Continue operating capacities for this CAH.

Mangum Regional Medical Center
Governing Board Summary
June Quality Data 07/14/2022

Hospital Activity

- Hospital Admission
  - Acute Care Admits: 17 – up from May (13)
  - Swing-Bed Admits: 12 – down from May (13)
  - Total Discharges: 24 – down from May (26)
- Total Patient Days, ED Visits, ADC
  - Total Patient: 292 - down from May (303)
  - ED Visits: 144 – no change from May (144)
  - Average Daily Census: 10 – no change from May (10)

AMA/LWBS

- AMA: 3 – down from May (6)
- LWBS: 0 – no change from May (0)

Type of Count (AMA/LWBS)	Count	Brief Description of Event	Actions
AMA	3	3 AMA; 1 ER - 1.) pt to ed for generalized concerns, patient became anxious and tired of waiting. Pt left AMA, did not sign AMA. 2 in-pt - 1.) pt admitted to in-pt for IV ABT, after 1 day pt reports feeling better and requested to go home. Provider educated on risks and benefits AMA signed. 2.) pt admitted to in-pt for hyperglycemia, uncontrolled. education attempts by staff for patient non-compliance with hospital prescribed regime were met with resistance/aggression/belligerence. Patient became very upset after staff education and demanded to leave, education provided to patient on risks/benefits/compliance, ama signed. Police notification: police were notified to assist patient out of facility for patient behavior after unsuccessful attempt to deescalate patient's behavior	AMA - all ama pt had risks/benefits presented at time of ama, encouraged to return to ed as needed, discharge education will continue to be provided to pt based on specific dx/needs.
LWBS	0	none	none

Care Management

- 30 Day Readmissions
  - 2 for June

Event	Count	Comments	Actions
Readmit	2	1) Patient readmitted after discharge to OU Medical for Nephrostomy tube replacement and was unable to be inpatient to have procedure completed. 2) Patient's family requested discharge to home with family and Triad Home Health. Patient stable when discharged and returned 5 days later with differing diagnosis of left-sided abdominal/flank pain.	None – pt's required higher level of care, returned for continued/skilled care

Risk Management

- Incidents
  - Falls without Injury
  - AMA/LWBS
  - Other Events

Incident Type	Count	Brief Description of Event & Outcome	Actions
Falls without injury	1	See below	
AMA/LWBS	3/0	See above	
Other events	0		

- Complaints and Grievances
  - 0 grievance

Brief Description of Complaint/Grievance & Outcome	Actions
None for June	None

- Patient Falls
  - Fall with no injury – 1
  - Fall with minor injury – 1
  - Fall with major injury – 0

Count	Brief Description of Event & Outcome	Actions
1 FWOI	1 - Pt was being assisted by PT during a transfer, prior to completing the transfer. Patient went to sit in the chair, chair began to move out from under the patient. Patient was assisted to the floor with no reported injury or pain.	PT to check to ensure DME is properly ensure prior to all transfers
1 Fall w/minor injury	1. patient taken outside by family member, family reported that when they were returning inside that patient fell back and hit head. Pt was assessed by nurse, noted to have a small, raised area to the back of the right side of head. No change in LOC noted, provider made aware of patient fall with head CT ordered. CT normal.	pt/family education on safe transfers/ambulation

- Mortality Rate
  - Acute/Swing-Bed Deaths
    - 0 (0%) (YTD = 8%)
  - Emergency Department Deaths
    - 0 (0%) (YTD = (0%)

Count	Brief Description of Event & Outcome	Actions
0 acute 0 swing	None for the reporting period	none
0 ER	None for the reporting period	none

- Organ Bank Notifications within 60 minutes of Death (Benchmark 100%)
  - 0 notification within 60 minutes of death/ 0 death for reporting period

Count	Compliance	Action
0	None for the reporting period	none

Infection Control

- Catheter Associated Urinary Tract Infections (CAUTIs) – 0
- Central Line Associated Primary Bloodstream Infections (CLABSIs) – 0

Type of Event (CLABSI/CAUTI)	Count	Brief Description of Event & Outcome	Actions
None			
None			

Health Information Management

- History & Physical Completion (Benchmark 100%)
  - 27/28= 96 %
- Discharge Summary Completion (Benchmark 100%)
  - 23/26 = 88 %

Type of Documentation (H&P/Discharge)	Count	Actions
H&P	27	provider aware of need for H&P completion
Discharge Summary	23	3 acute missing d/c summary, providers aware of need for completion

Nursing

- Code Blue
  - 0
- Transfers
  - Acute Transfers – 0
  - ED Transfers – 12

Event	Count	Comments	Actions
Acute Transfers	0	none	Continue operating capacities for this CAH.
ED Transfers	12	12 - transferred to higher level of care for: resp distress, AMS/dialysis, NSTEMI, appendicitis, Septic shock, LE fxr, Resp distress/peds, Anaphylaxis, oncology, hypoxia/meth abuse, GI bleed, TIA v CVA	Continue operating capacities for this CAH.

Clinic Operations Report

Mangum Family Medical Clinic

May 2022

Clinic Operations

- ECW implementation initiated with tentative go live date of August 1st.
- Next Available: New= next day; Established = same day

Quality Report

- 4 patient satisfaction surveys returned, all excellent
- All quality metrics noted as compliant

Outreach

- Multi school physicals performed or set to be performed.
- Media blitz including paper and social media

Summary

- Numbers trending in right direction.
- Staff working to improve “no show” rate of 18%

	Jan	Feb	Mar	Apr	May	June	July	YTD Avg
Total Clinic Visits	154	97	150	160	180			148
Total Clinic Productive Hours	NA	128	133	135	140			134
Total Visits per Productive Hour		.76	1.13	1.19	1.28			1.10
New Patient Clinic Encounters	13	12	27	22	39			22.6
Walk-Ins	29	18	24	31	80			36.4
Nurse Only Visits	11	3	0	0	3			3.4
Telehealth Visits Completed	0	0	0	0	0			0
Annual Well Visits	0	1	0	0	0			.2
No Shows	22	28	22	23	33			25.6

Year At A Glance	May 21	May 22
Total Clinic Visits	202	180
Total Clinic Productive Hours	127.55	140
Total Visits per Productive Hour	1.58	1.28
New Patient Clinic Encounters	15	39
Walk-Ins	93	80
Nurse Only Visits	13	3
Telehealth Visits Completed	0	0
Annual Well Visits	2	0
No Shows	14	33

Providers by the number:

Forster: 180 19 days = 9.5 pts per day

Mangum Regional Medical Center

Chief Clinical Officer Report
May 2022

Excellent Patient Care

- Monthly Education topics included effective clinical communication via the SBAR tool by Lippincott Procedures
- MRMC Emergency Department provided care to a potential stroke patient. The team was able to initiate an IV, draw blood for specimens and complete the CT in under ten minutes!
- MRMC Infection Prevention proudly reports continued excellent performance as evidenced by **Zero** prevalence of Hospital Acquired Infections, Catheter Associated Urinary Tract Infections or Central Line Associated Blood Stream Infections.
- Our Activities Director continues to delight patients with **Manicure Mondays**. *Manicures almost trump Bingo on Fridays.*
- MRMC Outpatient Wound Services reports 100% of the wounds treated have remarkable evidence of improvement.
- 7 out of 8 patients that were discharged from Inpatient Therapy services enjoyed a full return to Prior Level of Functioning.

Excellent Client Service

- Patients continue to rely on MRMC as their local hospital. Patient days increased from 303 days in April to 320 days in May. This represents an average daily census of 10. In addition, MRMC Emergency Department provided care to 144 patients in May.
- A random sampling of the ED Triages proved that 95% of Emergency patients were triaged within 5 minutes or less from their time of arrival.
- May COVID-19 Stats at MRMC: Swabs (26-PCR & 46-Antigen) with 0 Positive PCR & 6 Positive Antigen.
- 100% of the discharged patients from MRMC Outpatient Therapy Services exhibited improvement in standardized assessment scores. This scoring relates to the patient's functional ability.

Preserve Rural Healthcare

Mangum Regional Medical Center												
2022 Monthly Census Comparison												
	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec/21
Inpatient	39	15	21	26	26							30
Swing Bed	16	3	9	11	13							17
Observation	1	2	0	0	0							1
Emergency Room	187	114	121	118	144							166
Lab Completed	2833	1888	2031	2154	2459							3082
Rad Completed	264	196	215	238								267
Ventilator Days	4	5	0	0	0							10

Mangum Regional Medical Center

Chief Clinical Officer Report
May 2022

Preserve Rural Jobs

- Open Positions include Full Time RT, RN, LPN, and CNA.
- For the clinical team MRMC continues to pursue core staff members from the area.
- Recruiting efforts included positing of positions on mangumregional.net and Facebook as well Indeed.
- For hospital week staff were able to enjoy catered meals, games, and daily prizes. The grand prize of the week was a **BIG SCREEN TV**!

Mangum Regional Medical Center

COHESIVE HEALTHCARE MANAGEMENT + CONSULTING

Chief Executive Officer Report
May 2022

COVID Overview

- ✓ Leadership continues to update staff and providers regarding new policies and regulations.
- ✓ Covid is less of a concern however vigilance is still the focus.

Staff and Operations Overview

- ✓ Patient care continues to be outstanding thanks to an outstanding staff.
- ✓ Open positions include CNA, LPN, RN and RT.
- ✓ Recently hired core staff include an RN and a CNA.
- ✓ Critical Alert nurse call system is close to completion. This is the final major improvement enabled by grant funds.
- ✓ Our average daily census for the month was 10.
- ✓ Emergency Department assisted 144 patients up from 118 last month.
- ✓ Employees continued to receive free meals compliments of Cohesive.
- ✓ We continue to put an emphasis on social media presence and other outreach efforts for the Hospital and the Clinic.
- ✓ Hospital Week was an outstanding success! Thanks Shelly Bowman!

Contracts, Agreements and Appointments for Governing Board Approval

- ✓ PharmaForce Mangum Drug Configuration agreement.
- ✓ Cardinal Health 340B agreement.
- ✓ Eli Lilly, Novo Nordisk and AstraZeneca 340B manufacturing agreements.
- ✓ Critical Alert nurse call system change order.
- ✓ Greer County Health Department X-Ray services agreement.
- ✓ Oklahoma Blood Institute blood bank contract.
- ✓ OKCH Medicare/Medicaid reimbursement contract.
- ✓ Stericycle addendum for pharmaceutical Hazardous Waste disposal.

Clinic Operations Report

Mangum Family Medical Clinic

June 2022

Clinic Operations

- ECW implementation progressing. Data migration set to begin soon.
- Clinic's desire to see all patient's same day. If for some reason not able, Provider has the final say.

Quality Report

- Metrics continue to be monitored. All within good standing
-

Outreach

- Over 50+ sports physicals performed in clinic within 2 days. More to come.
- Continue with social media and advertisement in local paper.

Summary

- Numbers stable despite primary provider out for surgery.
- Staff working to improve "no show" rate of 22%

	Jan	Feb	Mar	Apr	May	June	July	YTD Avg
Total Clinic Visits	154	97	150	160	180	160		150
Total Clinic Productive Hours	NA	128	133	135	140	151.5		137.4
Total Visits per Productive Hour		.76	1.13	1.19	1.28	1.05		1.09
New Patient Clinic Encounters	13	12	27	22	39	33		24.3
Walk-Ins	29	18	24	31	80	48		38.3
Nurse Only Visits	11	3	0	0	3	0		2.8
Telehealth Visits Completed	0	0	0	0	0	0		0
Annual Well Visits	0	1	0	0	0	0		.16
No Shows	22	28	22	23	33	35		27

Year At A Glance	June 21	June 22
Total Clinic Visits	286	160
Total Clinic Productive Hours	175	134
Total Visits per Productive Hour	1.63	1.05
New Patient Clinic Encounters	28	33
Walk-Ins	166	48
Nurse Only Visits	16	0
Telehealth Visits Completed	2	0
Annual Well Visits	0	0
No Shows	22	35

Providers by the number:

Forster: 108 12 days = 9 pts per day ; 50+ sports physicals

Whithold: 18 2 days = 9

Brand: 34 4 days = 8.5

Mangum Regional Medical Center

Chief Clinical Officer Report
June 2022

Excellent Patient Care

- Monthly Education included a skills fair with topics covered included: TPN, Transmission Based Precautions, PPE and G-tube feeding. Air Evac provided Stroke education.
- MRMC Emergency Services coordinated with Greer EMS and Air Evac to conduct a mock code STROKE. Through coordinated efforts, the mock patient received prompt assessment in the field, rapid imaging and was transferred to flight team in 36 minutes!
- MRMC Infection Prevention proudly reports continued excellent performance as evidenced by **Zero** prevalence of Hospital Acquired Infections, Catheter Associated Urinary Tract Infections or Central Line Associated Blood Stream Infections.
- There have been zero hospital acquired wounds. The wound care team continues to ensure overall wound progression.

Excellent Client Service

- Patients continue to rely on MRMC as their local hospital. Patient days increased from 303 days in April to 320 days in May. This represents an average daily census of 10. In addition, MRMC Emergency Department provided care to 144 patients in May.
- May COVID-19 Stats at MRMC: Swabs (26-PCR & 46-Antigen) with 0 Positive PCR & 6 Positive Antigen.
- 100% of the discharged patients from MRMC Outpatient Therapy Services exhibited improvement in standardized assessment scores. This scoring relates to the patient's functional ability.
- Case management received a report from a patient and family member. They claim that they have been to many other facilities but have never received the personal, compassionate care that they have been given while at MRMC

Preserve Rural Healthcare

Mangum Regional Medical Center												
2022 Monthly Census Comparison												
	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec/21
Inpatient	39	15	21	26	26	29						30
Swing Bed	16	3	9	11	13	12						17
Observation	1	2	0	0	0	0						1
Emergency Room	187	114	121	118	144	144						166
Lab Completed	2833	1888	2031	2154	2459	2653						3082
Rad Completed	264	196	215	238	256	216						267
Ventilator Days	4	5	0	0	0	0						10

Mangum Regional Medical Center

Chief Clinical Officer Report
June 2022

Preserve Rural Jobs

- Open Positions include Full Time RT, RN, LPN, and CNA.
- For the clinical team MRMC continues to pursue core staff members from the area.
- New Core staff members have been added to the dietary team. MRMC receives compliments daily regarding the enhanced service and quality of the meals served.
- Recruiting efforts included positing of positions on mangumregional.net and Facebook as well Indeed.

Mangum Regional Medical Center

COHESIVE HEALTHCARE MANAGEMENT + CONSULTING

Chief Executive Officer Report
June 2022

COVID Overview

- ✓ Leadership continues to update staff and providers regarding new policies and regulations.
- ✓ Covid is less of a concern however vigilance is still the focus.

Staff and Operations Overview

- ✓ Patient care continues to be outstanding thanks to an outstanding staff.
- ✓ Open positions include Dietary, CNA, LPN, RN and RT.
- ✓ Recently hired staff include CNA, LPN, Monitor Techs and Dietary staff.
- ✓ Critical Alert nurse call system is close to completion. This is the final major improvement enabled by grant funds.
- ✓ Our average daily census for the month was 10.
- ✓ Emergency Department assisted 144 patients.
- ✓ Employees continued to receive free meals compliments of Cohesive.
- ✓ We continue to put an emphasis on social media presence and other outreach efforts for the Hospital and the Clinic.

Contracts, Agreements and Appointments for Governing Board Approval

- ✓ PharmaForce Mangum Drug Configuration agreement.
- ✓ Cardinal Health 340B agreement.
- ✓ Eli Lilly, Novo Nordisk and AstraZeneca 340B manufacturing agreements.
- ✓ Critical Alert nurse call system change order.
- ✓ Greer County Health Department X-Ray services agreement.
- ✓ Oklahoma Blood Institute blood bank contract.
- ✓ OKCH Medicare/Medicaid reimbursement contract.
- ✓ Stericycle addendum for pharmaceutical Hazardous Waste disposal.
- ✓ Discussion and possible action to approve a credit card for MRMC operations.
- ✓ Discussion and possible action to approve the lease agreement between the City of Mangum and the Mangum City Hospital Authority for the David Caley Memorial Medical Annex.
- ✓ Discussion and possible action to approve the CPSI-Evident interface agreement.

Hospital Vendor Contract Summary Sheet

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

2. **Name of Contract: Cardinal 340B Covered Entity/Contracted Pharmacy**

3. **Contract Parties: Cardinal Health, Mangum Regional Med Center and Mangum Drug Co.**

4. **Contract Type Services: 340B Prescription Pricing**

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

6. **Contract Summary: Agreement allows PharmaForce, MRMC 340B Third Party Administrator to coordinate 340B priced prescriptions between MRMC, Mangum Drug Co. and their wholesaler, Cardinal Health**

7. **Cost:** ☒ N/A

8. **Prior Cost:** ☒ N/A

9. **Term:** N/A

10. **Termination Clause:** N/A

11. **Other:**

Cardinal Health
Pharmaceutical Distribution
7000 Cardinal Place
Dublin, Ohio 43017

cardinalhealth.com

May 27, 2022

Mangum City Hospital Authority
1 Wickersham Drive
Mangum, OK 73554

Re: Addition of New Facility Location to Participating Member Letter of Participation

Dear Mangum City Hospital Authority:

As you know, Mangum City Hospital Authority and Cardinal Health 110, LLC and Cardinal Health 112, LLC (collectively, "**Cardinal Health**") are parties to that certain Participating Member Letter of Participation that was effective as of September 1, 2020 (the "**Agreement**").

I am writing on behalf of Cardinal Health to memorialize our recent communications regarding the addition of Participating Member facility location(s) to the Agreement. Specifically, upon full execution of this letter agreement, the parties hereby acknowledge and agree that the facility(ies) listed below shall each be deemed to be a Participating Member facility(ies) under the Agreement and that the Participating Member facility(ies) shall begin purchasing their Primary Requirements of Rx Products (as such terms are defined in the Agreement) from Cardinal Health in accordance with the terms and conditions of the Agreement.

Customer represents that (i) it has the authority to contractually bind the below Facilities to the terms and conditions of the Agreement, and (ii) except with respect to any 340B contract pharmacy, none of the below Facilities are subject to another prime vendor agreement with Cardinal Health for the purchase of Rx Products as of the date of this letter. Cardinal Health may remove the applicable Facility upon written notice to Customer in the event any of the foregoing representations is not true.

Bill to Facility	Ship to Facility	HRSA ID	Number of Scheduled Deliveries Per Week (1 or 5)*
Mangum Regional Medical Center Mangum City Hospital Authority – Mangum Family Clinic 1 Wickersham Drive Mangum, OK 73554	Mangum Drug Co. 109 S Oklahoma Ave Mangum, OK 73554	CAH371330-00	5

If any Facility listed above has average monthly net purchases of Rx Products from Cardinal Health of less than $50,000 during a given calendar quarter, then Cardinal Health reserves the right to adjust the delivery schedule for such Facility upon written notice to Customer.

Please indicate Mangum City Hospital Authority's agreement with the terms and conditions stated in this letter agreement by signing below.

[Signature Page Follows]

Sincerely,

CARDINAL HEALTH 110, LLC
CARDINAL HEALTH 112, LLC

Agreed to, confirmed and accepted by:

MANGUM CITY HOSPITAL AUTHORITY

By: _____

Name: _____

Title: _____

Date: _____

CARDINAL HEALTH 110, LLC
CARDINAL HEALTH 112, LLC

By: _____

Name: _____

Title: _____

Date: _____

Hospital Vendor Contract Summary Sheet

1. ☐ **Existing Vendor** ☒ **New Vendor**
2. **Name of Contract:** 340B Limited Distribution Contract
3. **Contract Parties: MRMC, Pucketts and Eli Lilly**
4. **Contract Type Services:** Pharmaceuticals
5. **Impacted Hospital Departments: Finance/Pharmacy**
6. **Contract Summary: Manufacturing agreement that limits shipment locations to one contract pharmacy.**
7. **Cost: N/A**
8. **Prior Cost: N/A**
9. **Term: N/A**
10. **Termination Clause:**
11. **Other:**

Eli Lilly and Company
340B Limited Distribution Contract Pharmacy Selection Form

Eli Lilly and Company, at its sole discretion, will allow an eligible 340B covered entity[1] that does not have any in-house pharmacy location set up as a shipping address in the OPA database, to designate one contract pharmacy location that may be used as a "ship to" location for 340B priced product. This election is to be made with respect to the Parent 340B ID and will apply to any child sites. Lilly retains the right to change this discretionary discount practice at any time. The 340B covered entity remains responsible for all aspects of 340B program compliance with respect to product billed to the covered entity, regardless of the shipping location.

Name of 340B Covered Entity ("Institution"): Mangum Regional Medical Center
To be valid, form must be completed by an individual employed by the Institution. Please submit name and address information in the same format as reflected in the HRSA database.

Address: 1 Wickersham Drive

City, State, Zip Code: Mangum, OK 73554

Phone #: (580) 782-3353 **340B ID:** CAH371330-00

Current Authorized Wholesaler: McKesson **City/State:** Irving, Texas

Secondary Authorized Wholesaler: _____ **City/State:** _____

Contract Pharmacy: Contracted pharmacy must be listed as a valid contracted Pharmacy on the 340B record listed above (Institution) on HRSA database.

Name of Contract Pharmacy: Puckett Discount Pharmacy

Address: 101 N. Louis T. Hle Ave. P.O. Box 148

City, State, Zip Code: Mangum, OK 73554

DEA: AP2000874

Contract Pharmacy Selection Declaration:
By signing this document, Institution is acknowledging that this Contract Pharmacy is the only shipping destination for product purchased under this agreement. If Institution requires a change to their Contract Pharmacy Selection, a new 340B Limited Distribution Contract Pharmacy Selection Form must be submitted to Lilly.

Contract Pharmacy Selection Updates:
Institution is limited to changing Contract Pharmacy selection once per calendar year unless selected Contract Pharmacy is no longer eligible on HRSA database.

Effective Date: 7/1/2022
The Contract Pharmacy Selection Form must be submitted to 340B@lilly.com at least five (5) business days prior to the Effective Date.

Institution acknowledges its obligation to comply with all applicable laws and regulation regarding the purchase of Products under this form, including the requirements of 42 U.S.C. 256b. Institution is hereby informed that there may be an obligation to report discounts to the Department of Health and Human Services or applicable state agency. See 42 C.F.R. 1001.952 (h)(1), (3). Institution agrees to forgo all other discounts for the same products. Institution hereby recognizes that should any discount be provided by Lilly to Institution in error, Lilly is hereby authorized to invoice Institution to collect any discount provided in error to Institution. Institution agrees to pay such invoice within thirty (30) days of receipt of an invoice. Institution reserves the right to review all information used by Lilly in determining the amount of discounts provided in error. Institution agrees to allow Lilly and/or its auditor to have access to any information in Institution's control that relates to Lilly Products necessary to audit 340B purchases.

Authorized Representative of Institution (Signature)	**Title of Authorized Representative**
Authorized Representative of Institution (Printed Name)	**Date of Signature**

Please send completed form to Eli Lilly and Company at 340B@lilly.com

[1] The term 340B Covered Entity is inclusive of the Parent and Child Sites.

Hospital Vendor Contract Summary Sheet

1. ☐ **Existing Vendor** ☒ **New Vendor**
2. **Name of Contract:** 340B Limited Distribution Contract
3. **Contract Parties: MRMC, Pucketts and Novo Nordisk**
4. **Contract Type Services:** Pharmaceuticals
5. **Impacted Hospital Departments: Finance/Pharmacy**
6. **Contract Summary: Manufacturing agreement that limits shipment locations to one contract pharmacy.**
7. **Cost: N/A**
8. **Prior Cost: N/A**
9. **Term: N/A**
10. **Termination Clause:**
11. **Other:**

340B Contract Pharmacy Selection Form

Novo Nordisk Inc. (labeler codes 00169 and 71090) and Novo Nordisk Pharma, Inc. (labeler code 73070) (collectively, "Novo Nordisk") will no longer facilitate "bill-to/ship-to" distribution of 340B discounted product to a contract pharmacy of any of the six "hospital" covered entity types[1], effective January 1, 2021.

If a hospital covered entity does not have an in-house pharmacy capable of dispensing products to outpatients, it may designate a single independent contract pharmacy to which Novo Nordisk products may be shipped.[2] A hospital covered entity may also designate a single wholly owned (100%) contract pharmacy[3] to which Novo Nordisk products may be shipped, whether or not it also has an in-house outpatient pharmacy. No covered entity shall be permitted to designate both a wholly owned contract pharmacy and a contract pharmacy that is not wholly owned. Contract pharmacies designated by covered entities must be registered and active in HRSA's 340B OPAIS database. The one contract pharmacy designation shall apply to the parent and all related child sites collectively.

Please submit this completed Contract Pharmacy Selection Form to Novo Nordisk at 340Binfo@novonordisk.com for designation of one contract pharmacy. **All informational fields in this form and a signature are required for contract pharmacy designation.**

Please select the one contract pharmacy designation that is applicable:

[X] Independent Contract Pharmacy [ ] Wholly Owned Contract Pharmacy

340B Covered Entity Name: Mangum Regional Medical Center **340BID:** CAH371330-00

Billing Information

Address: 1 Wickersham Drive

City: Mangum **State:** OK **Zip Code:** 73554

Please list names, city and state for authorized wholesaler(s) below:

Mckesson
Irving, TX

Contract Pharmacy Name: Puckett Discount Pharmacy **Contract Pharmacy HRSA ID:**

Contract Pharmacy must be listed as a valid Contract Pharmacy on the 340B record listed above (Covered Entity) on HRSA database.

Address: 101 N. Louis Tithe Ave P.O. Box 148

City: Mangum **State:** OK **Zip Code:** 73554

DEA: AP2000784 **HIN:**

Novo Nordisk will process complete Contract Pharmacy Selection Forms within seven business days of receipt of the completed form. Failure to populate all required fields will delay the processing of the Contract Pharmacy Selection Form and may require resubmission. Contract Pharmacy designations will be valid for one year and can be re-designated once per calendar year.

Declaration For Covered Entity Wholly Owned Contract Pharmacy Designations:
By signing this document, the covered entity acknowledges that the covered entity and contract pharmacy identified on this form have the same corporate ownership, and that the covered entity wholly owns the identified contract pharmacy and qualifies for the exception as described in this selection form. If there are any changes to the ownership structure of any of the identified contract pharmacies, the covered entity agrees to notify Novo Nordisk within two (2) business days.

Declaration For Covered Entity Independent Contract Pharmacy Designations:
By signing this document, covered entity acknowledges that it has no in-house outpatient dispensing pharmacy, and that the contract pharmacy identified in this form is the only shipping destination for Novo Nordisk product purchased through the 340B Drug Discount Program.

Covered Entity Authorized Representative Signature **Date of Signature**

Printed Name & Title

[1] Children's Hospitals (PED), Critical Access Hospitals (CAH), Disproportionate Share Hospitals (DSH), Free Standing Cancer Hospitals (CAN), Rural Referral Centers (RRC), and Sole Community Hospitals (SCH).

[2] If a covered entity has on-site shipping location to receive 340B product that is not a contract pharmacy, it is considered an in-house pharmacy.

[3] Novo Nordisk reserves the right to request proof of ownership and to terminate contract pharmacy selection and/or deny a request to designate a single wholly owned contract pharmacy if the information is not provided within three business days.

Hospital Vendor Contract Summary Sheet

1. ☐ **Existing Vendor** ☒ **New Vendor**
2. **Name of Contract:** 340B Limited Distribution Contract
3. **Contract Parties: MRMC, Pucketts and AstraZeneca**
4. **Contract Type Services:** Pharmaceuticals
5. **Impacted Hospital Departments: Finance/Pharmacy**
6. **Contract Summary: Manufacturing agreement that limits shipment locations to one contract pharmacy.**
7. **Cost: N/A**
8. **Prior Cost: N/A**
9. **Term: N/A**
10. **Termination Clause:**
11. **Other:**

AstraZeneca Pharmaceuticals, LP
340B Limited Distribution Contract Pharmacy Selection Form

AstraZeneca, at its sole discretion, will allow an eligible 340B covered entity[1] that does not have any in-house pharmacy location set up as a shipping address in the OPA database, to designate one contract pharmacy location that may be used as a "ship to" location for 340B priced product. This election is to be made with respect to the Parent 340B ID and will apply to any child sites. AstraZeneca retains the right to change this discretionary discount practice at any time. The 340B covered entity remains responsible for all aspects of 340B program compliance with respect to product billed to the covered entity, regardless of the shipping location.

Name of 340B Covered Entity ("Institution"): Mangum Regional Medical Center

To be valid, form **must** be completed by an individual employed by the Institution . Please submit name and address information in the same format as reflected in the HRSA data base.

Address: 1 Wickersham Drive

City, State, Zip Code: Mangum, OK 73554

Phone #: (580) 782-3353 340B ID: CAH371330-00

Current Authorized Wholesaler: McKesson City, State: Irving, Texas

Secondary Authorized Wholesaler: City, State:

Contract Pharmacy:

Contracted pharmacy **must** be listed as a valid contracted Pharmacy on the 340B record listed above (Institution) on HRSA database.

Name of Contract Pharmacy: Puckett Discount Pharmacy

Address: 101 N Louis Tittle Ave P.O Box 148

City, State, Zip Code: Mangum OK 73554

HIN (if available): DEA: AP2000874

Contract Pharmacy Selection Declaration:
By signing this document , Institution is acknowledging that this Contract Pharmacy is the only shipping destination for product purchased under this agreement. If Institution requires a change to their Contract Pharmacy Selection, a new 340B Limited Distribution Contract Pharmacy Selection Form must be submitted to AstraZeneca

Effective Date: 7/1/2022
The Contract Pharmacy Selection Form must be submitted to membership@astrazeneca.com at least ten (10) business days prior to the Effective Date.

Institution acknowledges its obligation to comply with all applicable laws and regulation regarding the purchase of Products under this form, including the requirements of 42 U.S.C. 256b. Institution is hereby informed that there may be an obligation to report discounts to the Department of Health and Human Services or applicable state agency. See 42 C.F.R. 1001.952 (h)(1), (3). Institution hereby recognizes that should any discount be provided by AstraZeneca to Institution in error, AstraZeneca is hereby authorized to invoice Institution to collect any discount provided in error to Institution. Institution agrees to pay such invoice within thirty (30) days of receipt of an invoice . Institution reserves the right to review all information used by AstraZeneca in determining the amount of discounts provided in error.

Authorized Representative of Institution (Signature) **Title**

Authorized Representative of Institution (Printed Name) **Date**

Please send completed form to AstraZeneca at membership@astrazeneca.com

[1] The term 340B Covered Entity is inclusive of the Parent and Child Sites.

Hospital Vendor Contract Summary Sheet

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

2. **Name of Contract:** PharmaForce Contract Configuration

3. **Contract Parties:** PharmaForce, Mangum Drug Co. & MCHA/MRMC

4. **Contract Type Services:** Prescription Dispensing

5. **Impacted Hospital Departments:** Pharmacy

6. **Contract Summary:** Contract sets out dispensing fees and sharing of revenues between the pharmacy and the hospital.

7. **Cost:** ☒ Third party**,** $15 plus 25% of total reimbursement for brand drugs; Cash $15 flat fee brand and generic. Pharmacy pays to MRMC.

8. **Prior Cost:** ☒ N/A

9. **Term:** Ongoing

10. **Termination Clause:** Anytime with 30 days notice

11. **Other:**

PharmaForce™

Contract Pharmacy Configuration Sign Off Form

Entity Name:	Mangum Regional Medical Center
OPAID:	CAH371330-00

Applicable Pharmacies					
Name	**NPI**	**Claims Start Date (*PharmaForce Contracted Fees begin accruing*)**	**Dispensing Fees**	**Pharmacy Payment Option**	**Manufacturer Exclusions (*Please see Tab 2 Manufacturer Blocks)***
Mangum Drug Co, LLC	1992350524	9/1/2022	Third Party, Brand Only: $15.00 + 25% of the Total Reimbursement; Cash, Brand Only: $15.00	Pharmacy pays Entity	EXCLUDE BI, NOVO NORDISK, UCB, BMS, UNITED THERAPUETICS, ASTRA ZENECA

Configurations			
	Yes	**No**	**N/A**
Exclude C2	X		
Exclude C3		X	
Exclude C4		X	
Exclude C5		X	
Apply PharmaForce's orphan drug list? (if applicable)	X		
For Profit (winners only)	X		

Look Back Period	
Full Time	365
Part Time	365
Referal	365

Medicaid Carve out				
Carve-Out Medicaid				
BIN#	**PCN**	**Group**	**Reason**	**Start Date**
10579	OKA01		Medicaid	
610084	DRTXPROD	MEDICAID	Medicaid	
610084	DRTXPROD	CSHCN	Medicaid	
610084	DRTXPROD	KHC	Medicaid	
610084	DRTXPRODKH	MEDICAID	Medicaid	
610084	DRTXPRODKH	CSHCN	Medicaid	
610084	DRTXPRODKH	KHC	Medicaid	
610517			Medicaid	
17606	P027017606	ARMEDICAID	Medicaid	

"* As of this date, fees will be incurred as $0.03 per claim received from pharmacy. If PharmaForce needs to request historical claims data, the switch provider will charge entity an additional fee which will be quoted to entity

• It is ultimately the covered entity's responsibility to ensure accuracy and 340B program compliance. Please carefully review the information listed. Please let PharmaForce know if there are changes we should make to your account.

• It is the covered entity's responsibility to advise PharmaForce if you desire changes to any part of your 340B program, including fees, filters, prescriber panels, patient data, and/or Medicaid carve-in or carve-out classifications.

• Entity agrees to pay contract PharmaForce fees as of claim start date."

Signature Date

Hospital Vendor Contract Summary Sheet

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

2. **Name of Contract:** PharmaForce Contract Configuration

3. **Contract Parties:** PharmaForce, Pucketts Discount Drug & MCHA/MRMC

4. **Contract Type Services:** Prescription Dispensing

5. **Impacted Hospital Departments:** Pharmacy

6. **Contract Summary:** Contract sets out dispensing fees and sharing of revenues between the pharmacy and the hospital.

7. **Cost:** ☒ Third party**,** $15 plus 25% of total reimbursement for brand drugs; Cash $15 flat fee brand and generic. Pharmacy pays to MRMC.

8. **Prior Cost:** ☒ N/A

9. **Term:** Ongoing

10. **Termination Clause:** Anytime with 30 days notice

11. **Other:**

PharmaForce™

Contract Pharmacy Configuration Sign Off Form

Entity Name:	MANGUM REGIONAL MEDICAL CENTER
OPAID:	CAH371330-00

Applicable Pharmacies

Name	NPI	Claims Start Date * (Switch Fees of $0.03 per claim start accruing)	Dispensing Fees	Pharmacy Payment Option	Manufacturer Exclusions (Eli Lilly, Sanofi, AstraZeneca, Merck, NovoNordisk, Boehringer Ingelheim, United Therapeutics, UCB, Amgen, Abbvie, Bristol Myers Squibb & Pfizer)
PUCKETT DISCOUNT PHARMACY	1821083809	6/1/2022	Third party: $15.00 + 25% of the total reimbursement for brand drugs. Cash: $15.00 flat fee brand and generic	Pharmacy pays Entity	Exclude United Therapeutics

Configurations

	Yes	No	N/A
Exclude C2	X		
Exclude C3		X	
Exclude C4		X	
Exclude C5		X	
Apply PharmaForce's orphan drug list? (if applicable)	X		
For Profit (winners only)	X		

Look Back Period

Full Time	365
Part Time	365
Referal	365

Medicaid Carve out

Carve-Out Medicaid	Yes			
BIN#	**PCN**	**Group**	**Reason**	**Start Date**
010579	OKA01		Medicaid	1/1/2020
610084	DRTXPROD	MEDICAID	Medicaid	1/1/2020
610084	DRTXPROD	CSHCN	Medicaid	1/1/2020
610084	DRTXPROD	KHC	Medicaid	1/1/2020
610084	DRTXPRODKH	MEDICAID	Medicaid	1/1/2020
610084	DRTXPRODKH	CSHCN	Medicaid	1/1/2020
610084	DRTXPRODKH	KHC	Medicaid	1/1/2020
610517			Medicaid	1/1/2020
017606	P027017606	ARMEDICAID	Medicaid	1/1/2020

"* As of this date, fees will be incurred as $0.03 per claim received from pharmacy. If PharmaForce needs to request historical claims data, the switch provider will charge entity an additional fee which will be quoted to entity

- It is ultimately the covered entity's responsibility to ensure accuracy and 340B program compliance. Please carefully review the information listed. Please let PharmaForce know if there are changes we should make to your account.

- It is the covered entity's responsibility to advise PharmaForce if you desire changes to any part of your 340B program, including fees, filters, prescriber panels, patient data, and/or Medicaid carve-in or carve-out classifications.

- Entity agrees to pay contract PharmaForce fees as of claim start date."

Signature _____ Date _____

Hospital Vendor Contract Summary Sheet

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

2. **Name of Contract: Change Order**

3. **Contract Parties: Critical Alert and MRMC**

4. **Contract Type Services: Nurse Call System**

5. **Impacted Hospital Departments: Nursing/Patients**

6. **Contract Summary: This is a change order adding devices required to satisfy State Health Dept. Compliance for Nurse Call systems UL1069 code requirements.**

7. **Cost: $10,439.62**

8. **Prior Cost: $160,132.00**

9. **Term: Capital Asset/Purchase**

10. **Termination Clause: N/A**

11. **Other:**

The following devices are being proposed to be added to the nurse call scope to meet the State Health compliance for nurse call UL1069 code requirements.

Male Locker Room/Female Locker Room/Sterile Room/Dictation Room

Patient Room 18 (being used as a staff lounge)

Patient Room 5 (Being used for Covid wing)

SCS-5231 Staff Call Station

Device to be installed - SCS-5231

- This device will be able to call to the nurse's station and will be able to be alerted of any emergency (Staff Emergency, Code Blue) calls in the unit.

PACU

CDL-5006 Corridor Dome Lights - LED

Devices to be installed - SCS-5431/CDL-5006

- These devices will be used to call to the nurse's station and can initiate Emergency and Code Blue alerts.

STAFF LOCKER ROOM

EPS-5003-1 Stand Alone Emergency Pull Switch

CDL-5003 Corridor Dome Lights - LED

EPS-5003/CDL-5003

- This is an emergency pull station and dome light that will be available to staff in the locker room by the shower room.

SHOWER ROOM

CBS-5000 Code Blue Pull Switch

CBS-5000

- This is a code blue pull station in the Shower Room.

EMERGENCY DEPT. NURSE'S STATION

ZDL-5001 Zone Dome Light

ZDL-5001

This a device located in the ceiling to enunciate General, Emergency, and Code Blue alerts (can be filtered for Emergency and Code Blue only) generated from other units in the facility at the Emergency Dept nurse's station.

Change date 8/10/2021 Rev 21

critical alert
better communications. better outcomes.

CHANGE ORDER

Prepared By	**Sean Cross**	**Sales Order #**	20201147
Date	***5/19/2022***	**Change Order ID**	A
Cost Center		**PO#**	29512
		Job Number	

Reason for Change Order

Nurse Call Equipment Add

Hospital / Customer Contact

Mangum Regional Medical Center-Craig Peters

Bill To:

Mangum Regional Medical Center
P.O. Box 280
Mangum, OK 73554

Ship To:

Att: Craig Peters
Mangum Regional Medical Center
1 Wickersham Drive
Mangum, OK 73554

SHIPPING INSTRUCTIONS

	Check Box		
Ship When Ready (SWR)	☑	**EXPEDITE?**	**No**
		NEXT DAY AM or PM?	
Hold Shipment	☐	**Ground (check box)**	
Reason/date:		*2-3 days*	☐
		7-10 days	☐

ADD

Item #	Description	Qty	
SCS-5231-B	Staff Call Station - Bundle	6	
SCS-5431-B	Staff Call Station - Bundle	1	
CDL-5006-B	Corridor Dome Light 6 LED - Bundle	1	
CDL-5003-B	Corridor Dome Light 3 LED - Bundle	1	
EPS-5003-1-B	Stand Alone Emergency Pull Switch - Bundle	1	
CBS-5000-B	**Code Blue Bundle switch**	1	
ZDL-5001-B	Corridor Zone Light - Bundle	1	
LAB-1500	Engineering Labor	2	
LAB-800	Configuration Labor	4	
LAB-PM	PM Labor	2	
LAB-PARTNER	Partner Provided Labor	1	
047-00101	M Cable Plenum 2 Cond, 18AWG	2	
047-00144G	Category 5E, UTP Plenum Green	2	
047-00104	E-Plenum 8 Conductor, 22AWG	1	
047-00108	C Cable plenum 5 Cond 22AWG	1	
	Subtotal		$10,283.62
	Expedited Fee (10%)	**10%**	$0.00
	Shipping and Handling	*	156
	Sales Tax (if applicable)	**0%**	
		Total ADDS	$10,439.62

* If no Shipping and Handling added above, then CA will prepay and add to invoice

DELETE

Item #	Description	Qty	Shipping
N/A	N/A		N/A
N/A	N/A		N/A
	Subtotal		
	Restocking Fee (20%)	0%	$0.00
	Sales Tax (if applicable)	0%	
		Total DELETES	$0.00

RMA # for returns (N/A if unshipped) ***N/A***

	CHANGE ORDER SUMMARY	ADDS	DELETES
	Totals above	$10,439.62	$0.00
**	Discount		0%
	Charge to Customer		$10,439.62
***	**Credit to Customer**		$0.00

*** Credit will be issued upon receipt & testing of items returned

Customer Signature	
Customer Print Name:	
Title:	

Email Notification PM Always **Customer** ☐ **Salesperson** ☐

Customer Email:

Added Scope:	Add additional Nurse Call device to the project
Detail	

Hospital Vendor Contract Summary Sheet

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

2. **Name of Contract: AGREEMENT**

3. **Contract Parties: Greer County Health Department and MRMC**

4. **Contract Type Services: X-Rays**

5. **Impacted Hospital Departments: Radiology**

6. **Contract Summary: MRMC will be paid $30.00 per view of PA or Lateral X-Rays upon receipt of invoices.**

7. **Cost: N/A**

8. **Prior Cost: N/A**

9. **Term: July1, 2022 to June 30, 2023**

10. **Termination Clause: Either party upon 30 days written notice.**

11. **Other:**

OKLAHOMA
State Department
of Health

AGREEMENT

THIS AGREEMENT, ENTERED INTO BETWEEN THE **GREER COUNTY HEALTH DEPARTMENT (GCHD)** AND **MANGUM REGIONAL MEDICAL CENTER (MRMC)** IS FOR THE PURPOSE OF PROVIDING X-RAY SERVICES AT FOR PATIENTS DESIGNATED TO RECEIVE SUCH SERVICES FROM THE GREER COUNTY HEALTH DEPARTMENT.

THIS AGREEMENT IS MADE PURSUANT TO AUTHORITY IN TITLE 63, SECTION 206.1, OKLAHOMA STATUES 1970 SUPPLEMENT.

IT IS AGREED THAT THE MANGUM REGIONAL MEDICAL CENTER:

1. WILL PROVIDE THE SERVICES SPECIFIED IN THE AGREEMENT.

    A. X-RAYS TO BE TAKEN AND PROCESSED

    (BUT NOT READ).

    B. FILM TO BE PICKED UP BY GCHD TO MAIL TO THE

    GENERAL COMMUNICABLE DISEASE DIVISION,

    OSDH.

2. WILL MAINTAIN PATIENTS RECORDS IN A MANNER

    THAT IS HIPAA COMPLIANT.

3. WILL PROVIDE THE SERVICES WITHOUT DISTINCTION

    AS TO THE PATIENTS RACE, COLOR OR NATIONAL ORIGIN.

IT IS FURTHER AGREED THAT UPON RECEIPT OF THE SERVICES SET FORTH **MANGUM REGIONAL MEDICAL CENTER** WILL BE PAID AT THE RATE OF **$30.00 PER VIEW OF PA or LATERAL X-RAYS**. PAYMENT SHALL BE MADE UPON RECEIPT OF INVOICES EACH MONTH INDICATING THE DATE OF SERVICES RENDERED, NAME OF PATIENT SERVICES RENDERED FOR, AS WELL AS TYPE AND NUMBER OF X-RAYS TAKEN.

THIS AGREEMENT COVERS THE PERIOD OF **JULY 1, 2022 TO JUNE 30, 2023**. THIS AGREEMENT MAY BE CANCELLED BY EITHER PARTY UPON THIRTY (30) DAYS WRITTEN NOTICE.

Greer County Health Department
PO Box 1/2100 N Louis Tittle Ave
Mangum OK 73554
580-782-5531 580-782-5438 Fax

OKLAHOMA
State Department
of Health

TB X-RAY AGREEMENT, CONTINUED

Incorporated herein in its entirety, and made a part of this contract, is the Business Associate Agreement signed between the Parties.

APPROVED:

MANGUM REGIONAL MEDICAL CENTER — DATE

BRANDIE COMBS, REGIONAL DIRECTOR — DATE 5-17-22

GREER COUNTY HEALTH DEPARTMENT

GREER COUNTY COMMISSIONERS:

Chairman — Member

Member

ATTEST:

County Clerk

Greer County Health Department
PO Box 1/2100 N Louis Tittle Ave
Mangum OK 73554
580-782-5531 580-782-5438 Fax

Hospital Vendor Contract Summary Sheet

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

2. **Name of Contract: THE OKLAHOMA BLOOD INSTITUTE**

3. **Contract Parties: OSBI/MRMC**

4. **Contract Type Services:** The procurement of blood, blood components and related services

5. **Impacted Hospital Departments:** Laboratory (Blood Bank Dept.)

6. **Contract Summary:** Allows the lab to send all blood bank samples to them for any blood bank need. The lab will have on hand units for emergency release only!

7. **Cost: Patients will be billed according to what is done by OBI by the hospital. Lab will no longer have any blood bank cost for reagents or supplies in that department.**

8. **Term: July 31, 2026 Automatically renews from year to year after that.**

9. **Termination Clause: If any party fails to fulfill any one or more of it obligations.**

10. **Other: none**

AGREEMENT BETWEEN
Mangum City Hospital Authority
DBA: Mangum Regional Medical Center
AND
THE OKLAHOMA BLOOD INSTITUTE

THIS AGREEMENT is entered into as of _____, by Mangum City Hospital Authority DBA: Mangum Regional Medical Center, 1 Wickersham Drive Mangum, OK 73554 ("Facility") and the Sylvan N. Goldman Center, Oklahoma Blood Institute, an Oklahoma not for profit corporation with its principal office located at 1001 North Lincoln Boulevard, Oklahoma City, OK, 73104 ("Blood Institute").

The Facility desires to utilize the services of the Blood Institute for the procurement of blood, blood components and related services. The charges and fees payable to the Blood Institute for blood and blood components are to compensate the Blood Institute for its direct and indirect costs incurred for the administrative, medical, and technical services provided in the drawing, processing, storage, and delivery of blood or blood components; for donor recruitment; and, for the maintenance of an inventory of blood and blood components (collectively, "blood services").

The Facility and the Blood Institute agree as follows:

1. Provision of Blood and Blood Components. During the term of this agreement the Facility will obtain from the Blood Institute all of the blood components required by the Facility in its daily operations and the Blood Institute will supply all such blood components and services, subject to Paragraph 5 herein. These products and services are for the sole use of the Facility and will be utilized only within the Facility's facility at the address above and the Facility's affiliated facilities.

2. Processing and Services Fees. The Facility shall pay to the Blood Institute the processing and services fees shown on the attached Schedule 2.0.

   2.1 Fee Increases. The Blood Institute, in its sole discretion, may increase the fees paid by the Facility during the term of this agreement if one or more of the following should occur:

      (a) The U.S. Food and Drug Administration ("FDA") mandates, endorses, or licenses the implementation of a new test; or

      (b) Significant change occurs in the cost of compliance with blood banking industry standards, in either the technology used in product manufacturing, or testing, or the offering of new products for patient use.

   2.2 Fees for Extended Term. The Blood Institute may increase the processing and services fees in each year by up to four percent, excluding the increased cost of any new test.

2.3 Notice of Changes. The Blood Institute will provide the Facility with at least 30 days written notice of any changes to the fees payable under this agreement.

3. Billing and Payment. The Blood Institute will provide an itemized monthly statement of charges to the Facility as of the last day of the month, unless the Facility has requested semi-monthly billing. Payment in full is expected no later than thirty (30) days from the date of the invoice. A prompt payment discount of 0.5% will be applied to all invoices paid within ten (10) days of the invoice date. A late penalty of 1.5% per month will be added to each invoice not paid within 30 days from the date of the invoice**.** At the Blood Institute's discretion, the late payment penalty may be suspended for a reasonable period of time in order to resolve any good faith disputes over payment.

4. Sample Labeling Requirements. The Facility shall provide properly identified blood samples in sufficient volume to the Blood Institute for laboratory testing in accordance with the Blood Institute's SOPs and AABB and FDA guidelines. The Blood Institute may refuse mislabeled samples and require the Facility to collect new, properly labeled samples. If multiple mislabeled samples are received from the Facility, then the Blood Institute may suspend cross-matching services until the Facility can provide reasonably satisfactory written assurance to the Blood Institute that corrective action has been implemented.

5. Transfusion Records. A copy of the blood administration record (Bag Tag) documenting the transfusion of the product must be maintained at the facility in accordance with AABB & regulatory guidelines.

6. Delivery and Storage. It shall be the responsibility of the Facility to make arrangements with the Blood Institute for the pickup and delivery of blood samples and components. Once the components have left the Blood Institute's premises, it shall be the responsibility of the Facility tomaintain the proper storage temperature of the components according to AABB and FDA guidelines.The Facility shall store blood components only in a refrigerator that is approved for blood product storage. The Facility will monitor the storage unit and immediately notify the Blood Institute if any blood component has not been maintained at the appropriate temperature. The Facility will returnsuch component in accordance with the Facility's SOPs.

7. Peer Review. The Facility is responsible for the peer review of its transfusion practices. Upon request, the Blood Institute can provide transfusion related statistical data compilations for the Facility's review. If Facility is not able to perform peer review of its transfusion practices, Blood Institute can provide this service.

8. Quality Standards and Regulatory Compliance. The Blood Institute shall maintain standards of performance consistent with its experience, research, and expertise in blood banking. Both parties shall maintain standards of performance in accordance with the applicable recommendations of the Center for Biologics Evaluation and Research (CBER) of the FDA, the applicable requirements of all applicable state regulatory agencies, and to comply with all other applicable laws, rules, and regulations. The Facility shall notify the Blood Institute as soon as practicable of any adverse reactions resulting from the transfusion of any blood product it receives from the Blood Institute. The Facility shall maintain a record of the adverse reaction, conduct an investigation and provide a completed Investigation of Suspected Transfusion Reaction Form (OBI-CL-FORM 255) to the Blood Institute, as required by 21 CFR §606.170(a). Both parties shall comply with

OSHA Bloodborne Pathogen Exposure Final Rule 29 C.F.R. Part 1910.1030, effective March 2, 1996, and any subsequent revisions thereof. Compliance Statements are included in Schedule 8.0. All of the foregoing requirements are collectively referred to as the "Regulations."

9. Records and Patient Information. The Facility will provide the Blood Institute with all transfusion records and patient information necessary for the provision of products and services under this agreement. The parties will use and disclose protected health information in accordance with and as required by the Health Insurance Portability and Accountability Act of 1996, as amended by the Health Information Technology for Economic & Clinical Health Act and the implementing regulations thereunder, as they may be amended from time to time (collectively, "HIPAA"), and will execute the Business Associate Agreement set forth in the attached Exhibit A. The Blood Institute will provide the Facility such information as may be required by FDA recommended guidelines for look back and product recalls.

10. Indemnification.

    10.1 The Blood Institute shall indemnify the Facility and its officers, directors, employees, and agents and hold each of them harmless from liability to and claims by third parties, including reasonable attorneys' fees, to the extent that they result from or arise in connection with the negligence or willful misconduct of the Blood Institute or its officers, directors, employees, or agents in the performance of this agreement.

    10.2 The Facility shall indemnify the Blood Institute and its officers, directors, employees, and agents and hold each of them harmless from liability to and claims by third parties, including reasonable attorneys' fees, to the extent that they may result from or arise in connection with the negligence or willful misconduct of the Facility or its officers, directors, employees, or agents.

11. Insurance. Each of the parties shall, at its own expense, maintain in effect a policy of professional liability insurance with coverage in the amount of not less than $1,000,000 per claim and $3,000,000 per occurrence. This coverage shall insure a party and its employees against liability for damages directly or indirectly related to the performance of any services and other respective obligations under this agreement. Each party shall provide the other with a certificate from the insurance carrier evidencing the required coverage. With the Blood Institute's prior written consent, the Facility may opt to self-insure as to specifically identified risks. Each party shall notify the other of any adverse change in insurance coverage required by this agreement.

12. Force Majeure. Neither party will be liable for any failure to perform its obligations (except payment obligations) for any reason beyond the party's reasonable control, including acts of terrorism, strikes, fires, explosion, flood, riot, lock out, injunction, interruption of transportation, unavoidable accidents, or a significant change in any applicable law or regulation.

13. Affirmative Action. The Blood Institute wishes to comply with the provisions of Executive Order 11246 of September 24, 1965; Executive Order 11375 of October 13, 1967;

Executive Order 11758 of January 15, 1974; Section 503 of the Rehabilitation Act of 1973; the Vietnam Era Veterans Readjustment Act of 1974, as amended, 38 U.S.C. 4212 (formerly 2012); and the implementing regulations at 41 CFR Chapter 60. The Facility will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, handicap, or status as a disabled veteran or a veteran of the Vietnam Era. This policy not to discriminate in employment includes hiring, transfer, training during employment, and rates of pay.

14. Term. The term of this agreement will begin _____, and continue through July 31, 2026 (the "Initial Term"). After the Initial Term, the Agreement automatically renews from year to year (a "Successive Term") unless a Party provides written notice of termination at least thirty (30) days before the expiration of the Initial Term or any Successive Term. All terms and conditions of this Agreement shall remain in effect during any Successive Term. The Initial Term and any Successive Terms shall be referred to as the Term. Processing and services fees may be adjusted each year as provided in Section 2.

15. Confidentiality. Both parties acknowledge that the terms, conditions, and fee schedules of this agreement are confidential. This confidential information shall not be disclosed to any officer, director, employee, or agent of a party, except as necessary in carrying out the person's respective duties under this agreement. This confidential information shall not be used other than in connection with this agreement. Additionally, the parties shall keep confidential, and not divulge to anyone else any of the proprietary, confidential information of the other party, including information relating to such matters as finances, methods of operation and competition, pricing, marketing plans and strategies, operational requirements and information concerning personnel, referral sources, patients and suppliers.

16. Construction and Governing Law. The rule of construction that a document is to be construed most strictly against the party who drafted the document shall not be applicable because all parties participated in the preparation of this agreement. "Includes" and "including" are not limiting. The laws of the State of Oklahoma shall govern this agreement and the legal relations between the parties without giving effect to any conflict of law provision (whether of the State of Oklahoma or any other jurisdiction) that would cause the application of the law of any other jurisdiction.

17. No Assignment. Neither party may assign its rights or delegate its duties under this agreement without the prior written consent of the other party; such consent shall not be unreasonably withheld.

18. No Third Party Beneficiaries. Nothing in this agreement, express or implied, is intended to confer upon any person, firm, or corporation, other than the parties named herein, any right, remedy, or claim under or by reason of this agreement, as third party beneficiaries or otherwise.

19. Termination. A Party may unilaterally terminate this Agreement: (a) if the other Party fails to fulfill any one or more of its obligations under this Agreement ("Breach") and the Breach continues for a period of thirty (30) days after the non-breaching Party sends written notice of the Breach, (b) if any of the Regulations are amended in a way that precludes a Party from performing its obligations under this Agreement, effective upon the effective date of the amended Regulation; (c) if a Party ceases to operate or otherwise function as a business; or (d) if a Party fails to maintain professional liability insurance as required

herein. The Blood Institute may unilaterally terminate this Agreement upon notice to the Facility if (x) the Facility's state license to operate as a hospital in Oklahoma is suspended, terminated, or revoked by the State Department of Health, or (y) the Facility is excluded from participation in Medicare, Medicaid, or any other federal health care program. Termination of this agreement pursuant to this provision shall not constitute an election of remedies, and the terminating party shall retain all rights and remedies that may be available at law or in equity with respect to the default by the other party. Upon termination, the Facility shall, within 15 days of the termination date, pay the Blood Institute any and all amounts owing for blood products and related services provided through the date of termination.

20. Entire Agreement; Amendments; Waiver. This agreement is the final expression of the entire agreement of the parties. This agreement supersedes all prior agreements and understandings between the parties. This agreement may not be amended, modified, or waived except by a written agreement designated as such and signed by the party against whom it is to be enforced. The failure of a party to insist upon the strict observance or performance of any of the provisions of this agreement or to exercise any right or remedy shall not impair any such right or remedy or be construed as a waiver or relinquishment thereof with respect to subsequent defaults.

21. Counterparts. This agreement may be executed in one or more counterparts, each of which will be deemed to be an original copy of this agreement and all of which, when taken together, will constitute one and the same agreement. The exchange of copies of this agreement and of signature pages by facsimile transmission shall constitute effective execution and delivery of this agreement and may be used in lieu of the original agreement for all purposes.

22. Inventory Control. If applicable, a minimum standing inventory of transfusable blood products will be agreed upon between the Blood Institute and the Facility. Such inventory shall be maintained at the Facility by the Blood Institute on a consistent basis, in the amount and varieties of types necessary to meet the routine needs of the Facility. The Facility will promptly notify the Blood Institute of any requests for specialized blood products, services, or variations to the Facility's standing inventory. Such requests may be subject to the Blood Institute's medical review and approval.

23. Credit/Return Policy (If applicable) Regular communication between the Facility and the Blood Institute must occur to prevent the expiration and destruction of blood or blood components. Credit will only be issued in accordance with the guidelines stated on the attached Credit/Return Policy, Schedule 23.0. The Blood Institute may modify the Credit/Return policy during the term of this agreement by giving 30-days written notice to the Facility.

24. Donor Source. Only blood donations from volunteer donors will be utilized in the preparation of blood products for transfusion.

25. Charges by Facility. The Facility fees provided in this agreement are intended to defer the Blood Institute's previously described operational costs. This agreement does not restrict the Facility's ability to add service charges as it deems reasonable and prudent to ensure proper patient service and as may be permitted by applicable law.

26. Notice. Any notice, consent or communication required or permitted to be given under this Agreement shall be deemed to have been duly given if in writing and either delivered personally, sent by electronic transmission, or sent by United States first class mail, postage prepaid to the addresses set forth in the introduction of this Agreement.

27. Binding Effect. This agreement shall be binding upon, and inure to the benefit of, the parties and their respective legal representatives, successors, and assigns.

28. Survivability of Terms. The terms and provisions and each party's obligations and/or agreements under Sections 9, 10 and 15 shall survive any termination or expiration of this Agreement and will be construed as agreements independent of any other provisions of this Agreement.

FOR: THE FACILITY

_____
Signature

_____
Date

_____
Print Name

_____
Print Title

FOR: THE BLOOD INSTITUTE

_____
John Armitage, M.D., President and CEO

_____
Date

Schedule 8.0
COMPLIANCE STATEMENTS

The Oklahoma Blood Institute (OBI) manufacturers Blood and Blood Products under Food and Drug Administration (FDA) license number 0766. Each OBI facility has an FDA assigned Establishment Identification Number (FEIN) and is inspected by the FDA to evaluate Current Good Manufacturing Practices (CGMP) and compliance with relevant sections of 21 CFR 200, 600, 800 and 1200.

AABB Blood Bank and Transfusion Services accreditation is maintained by OBI. In accordance with the Social Security Act and 42 CFR Parts 422.156, 422.157 and 422.158 the Health Care Financing Administration has granted AABB deemed status with the Centers for Medicare and Medicaid Services (CMS). Therefore, AABB standards have been found to meet or exceed all relevant CMS requirements for participation. AABB bi-annual assessments evaluate OBI against these standards.

Infectious Disease Testing is provided under CLIA number 37D0470358 and Immunohematology Testing is provided under CLIA number 37D2175055 in the headquarters location in Oklahoma City. Immunohematology Testing is also provided under CLIA number 37D0931105 in the Tulsa location, CLIA number 04D2096885 in the Little Rock location, and CLIA number 45D0507042 in the Coffee Memorial Blood Center location. CLIA compliance inspections and renewals are performed bi-annually by the AABB. OBI Laboratories participate in CMS approved proficiency testing programs. AABB Immunohematology Laboratory Accreditation is maintained by the Clinical Laboratories in Oklahoma City, Tulsa, Little Rock, and Coffee Memorial Blood Center.

OBI maintains a Quality Plan, Quality Manual, Emergency Preparedness and Disaster Plan, Transfusion Associated Disease Investigation Procedures, Look-Back Procedures (HCV and HIV), and Consignee Notification Procedures for Positive Test Results, Market Recalls and Market Withdrawals for non-conforming blood or blood components. Initial consignee notifications occur in accordance with federal and state statutes and regulations. Specifically within 3 calendar days if the blood collecting establishment supplied blood and blood components collected from a donor who tested negative at the time of donation but tests reactive for evidence of HIV or HCV infection on a later donation or who is determined to be at increased risk for transmitting HIV or HCV infection; within 3 calendar days after the blood collecting establishment supplied blood and blood components collected from an infectious donor, whenever records are available; and within 45 days of the test, of the results of the supplemental (additional, more specific) test for HIV or HCV, as relevant, or other follow-up testing required by FDA. These documents can be made available for reference during relevant facility inspections.

Except for apheresis platelets treated using an FDA-approved pathogen reduction process, OBI performs bacterial detection testing on all apheresis platelet components. This test is a culture that is incubated throughout the shelf life of the product.

OBI maintains a Privacy Policy, Notification of Privacy Practices and Business Associate Agreements that include relevant requirements identified in 45 CFR 164, Health Insurance Portability and Accountability Act (HIPAA) of 1996 and the Information Technology for Economic and Clinical Health (HITECH) Act of 2009.

<u>For Regulatory or Compliance Issues, Call</u>
AVP, Quality Management (405) 297-5526
Compliance Officer (405) 297-5733

Schedule 23.0
BLOOD PRODUCTS CREDIT/RETURN POLICY
OKLAHOMA BLOOD INSTITUTE

The following blood products may be returned for credit or exchange to the Oklahoma Blood Institute in accordance with the following established guidelines:

Product	**Timeframe**
	Restrictions required to receive credit:
LEUKOREDUCED RED CELLS	a. Stored at 1 to 6 degrees Centigrade as documented by a continuous recording device;
	b. The blood container has not been entered;
	c. Product storage has met all other applicable CBER/FDA and AABB requirements;
	d. At least one crossmatch segment remains attached; and,
	e. Greater than 7 days of shelf life is remaining before the product outdates/expires.
LEUKOREDUCED PLATELETS (Single donor) (Apheresis-derived)	Greater than 24 hours of shelf life providing such products have been: a. Stored at 20 to 24 degrees Centigrade as documented by a continuous recording device; b. Stored with continuous agitation
	If less than 24 hours, OBI will assist Facility in offering the product to another facility [provided products have also been stored at 22 degrees Centigrade, plus or minus 2 degrees]. If successful, credit will be issued to Facility; if unsuccessful, credit will not be issued. *This policy provision will not apply where the product had 48 hours or less of remaining shelf life when supplied to Facility by OBI.* ***The Large Volume Delayed Sampling (LVDS) fee effective August 1, 2021 is non-refundable for returned platelets.***
PLASMA and PLASMA PRODUCTS	Plasma and Plasma Products will not be accepted for credit.
MODIFIED PRODUCTS	Products modified by Blood Institute or Facility will not be accepted for credit.
Autologous Units	No returns will be accepted/credited.

BLOOD PRODUCTS CREDIT/RETURN POLICY *
OKLAHOMA BLOOD INSTITUTE

The following blood products may be returned for credit or exchange to the Oklahoma Blood Institute in accordance with the following established guidelines:

Product	**Timeframe**
	Restrictions required to receive credit:
LEUKOREDUCED RED CELLS	a. Stored at 1 to 6 degrees Centigrade as documented by a continuous recording device;
	b. The blood container has not been entered;
	c. Product storage has met all other applicable CBER/FDA and AABB requirements;
	d. At least one crossmatch segment remains attached; and,
	e. Greater than 7 days of shelf life is remaining before the product outdates/expires.
LEUKOREDUCED PLATELETS (Single donor) (Apheresis-derived)	Greater than 24 hours of shelf life providing such products have been: a. Stored at 20 to 24 degrees Centigrade as documented by a continuous recording device; b. Stored with continuous agitation.
	If less than 24 hours, OBI will assist Facility in offering the product to another facility [provided products have also been stored at 22 degrees Centigrade, plus or minus 2 degrees]. If successful, credit will be issued to Facility; if unsuccessful, credit will not be issued. This policy provision will not apply where the product had 48 hours or less of remaining shelf life when supplied to Facility by OBI. ***The Large Volume Delayed Sampling (LVDS) fee effective August 1, 2021 is non-refundable for returned platelets.***
PLASMA AND PLASMA PRODUCTS	Plasma and Plasma Products will not be accepted for credit.
MODIFIED PRODUCTS	Products modified by Blood Institute or Facility will not be accepted for credit.
Autologous Units	No returns will be accepted/credited.

***Please post in the Blood Bank**

Exhibit A
BUSINESS ASSOCIATE AGREEMENT

THIS AGREEMENT is entered into as of _____, by Mangum City Hospital Authority DBA: Mangum Regional Medical Center, 1 Wickersham Drive Mangum, OK 73554 ("Facility") and the Sylvan N. Goldman Center, Oklahoma Blood Institute, an Oklahoma not for profit corporation with its principal office located at 1001 North Lincoln Boulevard, Oklahoma City, OK, 73104 ("Blood Institute").

A. The Blood Institute provides services for the procurement of blood and blood components and related services (the "Services") for the Facility pursuant to a written agreement between the parties (the "Services Agreement").

B. The Blood Institute and the Facility are subject to the privacy and security requirements of the Health Insurance Portability and Accountability Act of 1996, the Health Information Technology for Economic & Clinical Health Act, and the implementing regulations promulgated thereunder, as amended from time to time (collectively, "HIPAA").

C. To facilitate the provision of Services by the Blood Institute, it may be necessary for the Facility to disclose protected health information concerning its patients to the Blood Institute. "Protected health information" is demographic information collected from a patient which (a) is created or received by the Facility, (b) relates to the past, present or future physical or mental health condition, the provision of health care or the past, present or future payment for the provision of health care of a patient, and (c) identifies the patient, or the information can be used to identify the patient. "Protected health information" includes information that is transmitted, maintained or received electronically. Demographic information that identifies the patient or that could be used to identify a patient includes: name, street address, city, county, precinct, zip code, birth date, admission date, discharge date, date of death, telephone number, fax number, email address, social security number, medical record number, health plan beneficiary number, account number, certificate/license numbers, vehicle identifier and serial number, and full face photographic images and any comparable images.

D. The Facility wishes to obtain satisfactory assurances from the Blood Institute that the Blood Institute will safeguard protected health information from misuse and unauthorized disclosure and that the Blood Institute will assist the Facility in complying with other requirements related to protected health information.

In consideration of the covenants, terms and conditions set forth in this Agreement, the Facility and the Blood Institute agree as follows:

1. Protected Health Information. The Blood Institute and the Facility shall appropriately safeguard from misuse and unauthorized disclosure all data that is protected health information.

2. Business Associate Standards. By virtue of this Agreement, the Blood Institute may receive protected health information on behalf of Facility, and is thereby subject to the "business associate" standards set forth herein. The Blood Institute may use and disclose protected health information it receives from the Facility, in accordance with HIPAA, strictly for the following purposes, and only to the extent necessary for the Blood Institute to perform its obligations under the Services Agreement:

a. The Blood Institute may use and disclose protected health information it receives from the Facility (i) in the proper management and administration of the Blood Institute; (ii) as required by law; (iii) to carry out its legal responsibilities; (iv) to perform blood banking and transfusion services in accordance with recognized standards of care; or, (iv) to other person(s) who provide reasonable written assurances that the information will be held confidentially, under the same conditions and restrictions that apply to the Blood Institute, and used or further disclosed only as required by law or for the purpose for which it was disclosed to such person, and that such person(s) will notify the Blood Institute of any instances which it is aware or becomes aware that the confidentiality of the information has been breached;

b. The Blood Institute may use and disclose protected health information it receives from Facility to provide data aggregation services relating to the health care operations of the Facility;

c. The Blood Institute may use and disclose protected health information it receives from the Facility for purposes related to the testing and analysis of specimens and for internal operational purposes, including: conducting quality assessment and improvement activities; conducting or arranging for medical review, legal services or auditing functions; business planning, development and management; implementing and conducting compliance programs; performing aggregate data analysis; and conducting due diligence in connection with the sale of part or all of the business.

d. With respect to information that it has received from Facility, the Blood Institute shall:

(i) Not use or further disclose the information other than as permitted or required by this Agreement or as required by law, not copy, duplicate or otherwise reproduce any part of the information except as required to perform services under the Services Agreement, and comply with the HIPAA privacy regulations with respect to any obligations under HIPAA that the Blood Institute is performing on behalf of the Facility;

(ii) Promptly report to Facility if the Blood Institute becomes aware of any use or disclosure of protected health information not permitted by this Agreement or any other security incident related to the protected health information, and take all necessary actions to promptly remedy the situation and to minimize any adverse consequences of such use, disclosure or security incident;

(iii) Ensure that any agents, representatives, subcontractors or others to whom the Blood Institute provides protected health information received from, or created or received by the Blood Institute on behalf of the Facility (each, a “Subcontractor”) enters into a written agreement with Blood Institute that imposes the same obligations on Subcontractor that are imposed on Blood Institute under this Business Associate Agreement;

(iv) Make available protected health information in accordance with 45 CFR 164.524;

(v) Make available protected health information for amendment and incorporate any amendments to protected health information in accordance with 45 CFR 164.526;

(vi) Make available the information required to provide an accounting of disclosures in accordance with 45 CFR 164.528;

(vii) Make its internal practices, books and records relating to the use and disclosure of protected health information received from, or created or received by the Blood Institute on behalf of the Facility, available to the Secretary of the Department of Health and Human Services for purposes of determining the Facility's compliance with 45 CFR 164.500 – 534; and,

(viii) At termination of this Agreement, if feasible, return, destroy or permanently delete all protected health information received from, or created or received by the Blood Institute on behalf of the Facility that the Blood Institute still maintains in any form and retain no copies of such information, except (A) the Blood Institute may retain, use and disclose such protected health information to meet quality standards and public health and regulatory requirements related to its blood banking and transfusion services, or (B) the Blood Institute may retain such protected health information if return or destruction is not feasible and the Blood Institute extends the protections of this Agreement to retained information and limits further uses and disclosures to the purposes that make return or destruction infeasible.

e. Facility shall be responsible for obtaining all consents and authorizations of patients, in accordance with HIPAA.

3. Use of Safeguards. The Blood Institute shall use appropriate safeguards to prevent the use or disclosure of the protected health information other than as provided for by this Agreement. If protected health information is transmitted, maintained or received electronically, the Blood Institute shall use administrative, technical and physical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of such information, including access controls, workstation security, integrity controls, data backup and storage and encryption.

4. Reporting. The Blood Institute shall promptly report to the Facility not later than 30 days after the Blood Institute becomes aware of (a) any acquisition, access, use or disclosure of protected health information not permitted by this Agreement or HIPAA, or (b) any other security incident related to protected health information of which the Blood Institute becomes aware (an "Incident") whether or not the Incident qualifies as a "reportable breach" under HIPAA. With respect to a reportable breach, the Blood Institute shall provide the following information to the Facility: (a) a brief description of the Incident; (b) a description of the nature and extent of protected health information involved in the Incident; (c) the individual who impermissibly used the protected health information; (d) a description of the Blood Institute's actions to mitigate the consequences of the Incident and to prevent further Incidents; and (e) if requested by the Facility, contact procedures for individuals to contact the Blood Institute for additional information. Except as directed by the Facility, the Blood Institute shall not directly report an Incident to the Secretary, the media, or any individual, and shall keep the matter strictly confidential. The parties shall take all necessary actions to promptly remedy the situation and to minimize any adverse consequences of such Incident.

5. Independent Contractor Status. The Blood Institute is performing services for the Facility as an independent contractor. Nothing in this Agreement shall be construed as creating an agency, partnership, employment or joint venture relationship between the Blood Institute and the Facility. Neither party may bind, or create any obligations on behalf of, the other party.

6. Obligation to Disclose Information. This Agreement does not impose any specific obligations on the Facility to disclose protected health information.

7. Binding Effect. This Agreement shall be binding upon the parties hereto and their respective legal representatives, successors and assigns.

8. Governing Law. This Agreement shall be governed by, and construed in accordance with, the laws of the State of Oklahoma.

9. Assignment. This Agreement may not be assigned by the Blood Institute, nor may the Blood Institute delegate its duties hereunder, without the express prior written consent of the Facility.

10. Amendments. This Agreement may not be amended except by an instrument in writing signed by the Facility and the Blood Institute.

11. Notices. Any and all notices, consents or other communications by one party intended for the other shall be deemed to have been properly given if in writing and personally delivered, transmitted by electronic means, or deposited in the United States, postpaid, to the addresses or numbers set forth below the signatures of the parties.

12. No Waiver. No waiver of a breach of any provision of this Agreement shall be construed to be a waiver of any breach of any other provision. No delay in acting with regard to any breach of any provision of this Agreement shall be construed as a waiver of such breach.

13. Entire Agreement. This Agreement constitutes the entire understanding and agreement of the parties with respect to its subject matter and cannot be changed or modified except by another agreement in writing signed by the parties.

EXECUTED as of the date written above.

FOR: THE FACILITY

_____
Signature

_____
Date

_____
Print Name

_____
Print Title

FOR: THE BLOOD INSTITUTE

_____
John Armitage, M.D., President and CEO

_____
Date

Exhibit B
Quality Standards

1. The Facility agrees that it will use only trained individuals to perform sample collections, patient consents and blood transfusions. The Facility further agrees to annually assess and document the competency of these individuals as required by federal law in 42 CFR 493.1235 and 42 CFR 493.1451.

   The Facility, through its employees, agents or consultants, agrees to be solely responsible for performing and documenting this quality requirement. Additionally, the Facility agrees to provide OBI with documentation of compliance, when requested by the Blood Institute

2. The Facility agrees to maintain a list of the employees, agents or consultants, identifiers or initials used by the Facility to track those responsible for collecting samples, consenting patients or performing transfusions. This list will contain the inclusive dates of employment.

   The Facility, through its employees, agents or consultants, agrees to be solely responsible for performing and documenting this quality requirement. Additionally, the Facility agrees to provide OBI with documentation of compliance, when requested by the Blood Institute

3. The Facility agrees that blood or blood products will only be stored in a validated storage device or container and that the device will be continuously monitored and equipped with an alarm system and to notify OBI of temperature excursions.

   The Facility, through its employees, agents or consultants, agrees to be solely responsible for performing and documenting this quality requirement. Additionally, the Facility agrees to provide Blood Institute with these records, when requested, to ensure that temperature excursions do not occur.

4. The Facility agrees to develop and administer transfusion consent forms that adequately describe risks associated with transfusions and to utilize the transfusion service physician or designee as a resource in identifying and describing the associated risks.

   The Facility, through its employees, agents or consultants, agrees to be solely responsible for performing and documenting this quality requirement. Additionally, the Facility agrees to provide OBI with documentation of compliance, when requested by the Blood Institute

FOR: THE FACILITY

_____
Signature

_____
Date

_____
Print Name

_____
Print Title

FOR: THE BLOOD INSTITUTE

_____
John Armitage, M.D.
President and CEO

_____
Date

Oklahoma Blood Institute

PRODUCT & SERVICES FEE SCHEDULE

Effective August 1, 2021 to July 31, 2022

2021-22

	1A.	Blood Products	Transfusion Services Fees
	16B	Leukoreduced Red Blood Cells (Prestorage)	$ 284.60
	20	Autologous Red Blood Cells (Prestorage Leukoreduced)	$ 284.60
*	24C	Autologous Red Blood Cells - Collected by Apheresis (2 Unit Prestorage Leukoreduced)	$ 566.20
	44	Cryoprecipitate - Whole Blood Derived (from 200 ml plasma)	$ 58.20
*	60	White Blood Cells - Collected by Apheresis	$ 1,238.10
	61	Leukoreduced Platelets - Collected by Apheresis (Full Dose> or = $3.0X10_{(11)}$)	$ 691.10
*	63	Leukoreduced Platelets - Collected by Apheresis (Partial Dose - (1.5 to 2.9 x $10_{(11)}$ Platelets)	$ 248.60
	40	AFFP (250 ± 25ml) x 2 Apheresis Derived	$ 190.10
	40-1	AFFP (250 ± 25ml) x 1 Apheresis Derived **Type AB**	$ 192.30
	40-2	AFFP (250 + 25ml) x 1 Apheresis Derived **non AB Type**	$ 57.00
	40PED	AFFP (100 ± 10ml) x 1 Apheresis Derived	$ 38.50
	42PED	FP-24 (Frozen < 24 hours) 1 x 100ml (100 ± 10 ml)	$ 38.50
	42	FFP-WBD 1 x 250ml (250 ± 25 ml) Whole Blood Derived	$ 57.00
	42HR	FP-24(Frozen < 24 hours) 1 x 250ml (250 ± 25ml)	$ 57.00
	50	Cryo Poor Plasma 1 x 250ml (250 + 25ml) Whole Blood Derived	$ 57.00
	1B.	**Blood Product Service Fees**	
	11	Red Blood Cells - Washing Fee	$ 156.00
	12	Red Blood Cells - Freezing and Deglycerolization Fee (Allogeneic & Autologous)	$ 394.40
*	14	CMV Negative Blood Product (Available Inventory)	$ 68.00
*	32	Volume Reduction Fee	$ 68.00
*	34	Platelet Washing Fee (plus plasma)	$ 203.30
	LVDS	Platelet Large Volume Delayed Sampling Fee - effective 8/1/2021 *Non-refundable on returned platelets*	$ 57.00
*	38	Hematocrit Adjustment	$ 98.80
*	37	Plasma Thawing - Per Product	$ 26.40
	98	Irradiation Procedure Fee	$ 57.00
	99	Each Additional Satellite Bag	$ 8.90
	97	Directed Donor Handling Fee	$ 60.50
	96	Autologous Donor Handling Fee	$ 60.50

*** Special Request/Requires OBI Physician Approval**

Autologous Products will be charged upon collection.

FDA License Number: 0766

Laboratory CLIA Registry: 37D0470358

Schedule 2.0

2. Laboratory Services - Clinical Laboratories

	Test / Service	2021-22 TS-F (300+ miles roundtrip)
01A	ABO-Rh	$ 62.60
02A	Direct Antiglobulin Test (Coombs Test) - single	$ 42.80
L03	Antibody Screen	$ 128.50
L04	Antibody Identification (includes ABO/Rh, antibody screen, comprehensive DAT, red cell panel, written consultation report, medical consultation as needed.)	$ 554.80
C05	**Transfusion Service Credit** for: Antibody Identification (includes ABO/Rh, antibody screen, comprehensive DAT, red cell panel, written consultation report, medical consultation as needed).	$ (412.90)
04A	Cold Agglutinin Low Temperature Screen	$ 247.20
04B	Antibody Elution and Red Cell Panel	$ 247.20
04E	Antibody Absorption and Red Cell Panel	$ 246.10
04F	Additional Red Cell Antibody Panel	$ 93.40
L07	Antibody Titer (per antibody)	$ 59.40
L19	Antibody Titer and Red Cell Panel	$ 529.40
L08	After-Hours Tech Call Fee: Surcharge per patient request	$ 243.90
RH2	C Antigen Type	$ 39.60
RH3	E Antigen Type	$ 36.20
RH4	c Antigen Type	$ 50.50
RH5	e Antigen Type	$ 50.50
RH8	Cw Antigen Type	$ 70.40
MS1	M Antigen Type	$ 100.00
MS2	N Antigen Type	$ 50.50
MS3	S Antigen Type	$ 100.00
MS4	s Antigen Type	$ 50.50
K1	K Antigen Type	$ 36.20
K2	k Antigen Type	$ 50.50
K3	Kpa Antigen Type	$ 70.40
FY1	Fya Antigen Type	$ 85.70
FY2	Fyb Antigen Type	$ 85.70
JK1	Jka Antigen Type	$ 85.70
JK2	Jkb Antigen Type	$ 85.70
LE1	Lea Antigen Type	$ 100.00
LE2	Leb Antigen Type	$ 100.00
P1	P1 Antigen Type	$ 100.00
AB4	A1 Type - Lectin A1 Type	$ 36.20
DI3	Wra Antigen Type	$ 70.40
OTH	Rare Antigen Type - Ag Types Requiring Rare Antisera or Genotyping	$ 70.40
L12	Compatibility Test (Allogeneic) per Unit - Immediate Spin	$ 100.00
12H	Autologous Compatibility (ABO/Rh per unit)	$ 60.50
12B	Compatibility Test (Allogeneic) per Unit - Full Crossmatch (AHG)	$ 132.90
L13	Pretreatment of Serum (eg. DTT, Rest, Plasma Neutralization, Urine Inhibition, Lewis Neutralization, P1 Neutralization)	$ 147.30

Nights (5 pm - 8 am)
Weekend (7 am Sat to 7 am Mon)

2. Laboratory Services - Clinical Laboratories (cont.)

	Test / Service	
L14	Pretreatment of RBCs (eg. DTT,CDP, EGA, Ficin, Density Gradient Separation, Neocytes)	$ 243.90
L15	Fetal Hemoglobin Stain (Kleihauer-Betke)	$ 246.10
15A	Fetal Hemoglobin Screen (rosette test)	$ 165.80
L17	Complete Red Blood Cells Phenotype	$ 477.80
L18	Cord Blood Workup (ABO/Rh, DAT, Ab elution and red cell panel, written consultation report, medical consultation as needed.).	$ 221.90
L30	Blood Component Preparation for each order to cover the preparation of the blood component for transport and transfusion.	$ 300.00
L31	Sample Resubmission Fee charged when a facility collects an improperly labeled sample for compatibility testing and requests another sample be picked up STAT from the facility.	$ 156.00
L32	Cancellation Fee charged when an order is cancelled once a driver is dispatched.	$ 49.50
L33	Non Routine Product Delivery Fee	$ 300.00
L35	Specimen Transportation Fee	$ 300.00
L36	Obstetrical Patient RhIg Workup (Post Delivery) Includes: ABO/Rh, Antibody Screen, Fetal Cell Screen.	$ 384.50
L37	Antigen Negative Multi-Unit Request - requests for greater than 10 units screened for a specific set of antigens. Add additional fee per unit.	$ 68.00
L85	Platelet Antibody Screen - Indirect	$ 163.70
L88	Platelet Antibodies - Crossmatch (per strip)	$ 163.70
L89	Hemoglobin S Screen (sickle cell)	$ 80.20
131	CD 34 Enumeration	$ 251.50
LC1	Technologist Written Consultation Report	-
LC2	Medical Written Consultation Report - Serological Problem	-
LC3	Compliance Consultation Fee/ Per Month/ Per Requested Activity	$ 193.30
RMT	RBC Phenotype by Molecular Testing	$ 376.90
EXT	Extraction of DNA for Red Cell Phenotype by Molecular Testing	$ 36.20
RHD	Partial D typing by molecular method	$ 376.90
RHC	RHCE variant typing by molecular method	$ 376.90

3. Disposable

YST	Y-Type Blood/Solution Set	$ 12.00
CST	Blood Component Recip Set	$ 5.60
TYP	Typenex Armbands	$ 28.60
SAL	0.9% NaCl, 500ml	$ 3.30
RED	Red Top Vacutainer Tubes X 100, 7 ml	$ 8.90
EDT7	EDTA Vacutainer Tubes X 100, 7ml	$ 8.90
EDT5	EDTA Vacutainer Tubes X 100, 5ml	$ 8.90

Your Blood Institute

To: Transfusion Service Facilities
From: Your Blood Institute, Client Relations and Contracting
Date: June 30, 2021
Subject: 2021-26 Hospital Agreement and Fee Schedule

An updated Agreement between your hospital and the Oklahoma Blood Institute, together with a 2021-22 Product & Services Fee Schedule, is enclosed. Both documents have an effective date of August 1, 2021. Please sign the Agreement and Business Associate Agreement (BAA) and return to OBI (scan/email to becky.heister@obi.org) by July 31, 2021. We will return a countersigned copy for your files.

We understand the budget pressures you are currently facing and we continue to work to control our portion of medical costs. Your Blood Institute is able to hold blood product, reference testing, and clinical services fee increases to 2% this year. This is in spite of the fact that we are facing increased collection and distribution costs as a result of the changing blood collection environment and significant increases in vendor costs to provide these services.

Some changes to the Agreement have been made to better serve hospitals and protect the blood supply:

- Transfusion Records (Paragraph 5). The OBI provided blood administration record, Bag Tag, documenting the transfusion does not need to be returned to OBI.
    - The Transfusion Service facility will be solely responsible for maintaining all documentation involved in the blood administration process to include, physician order, patient consent, vital signs, and transfusion reactions. This must be documented in the blood administration and/or transfusion reaction written process.

- Delivery and Storage (Paragraph 6). Temperature charts are no longer required to be sent to the OBI Reference Laboratory weekly.
    - The Transfusion Service facility must monitor and review on-site blood product storage device, have a written plan for alarm maintenance, and a corrective action plan for alarm activation.

- Peer Review (Paragraph 7). The following activities can be assessed by OBI's Transfusion Review Committee for Transfusion Service facilities that do not have a Transfusion Review Committee. A report can be provided upon request.
    - Transfusion audit of transfused products
    - Report of suspected transfusion reactions
    - Review of Crossmatch/Transfusion ratio reports
    - Review of Consignee Notifications

- Term (Paragraph 14). The term of the Agreement is for 5 years, and automatically renews year to year unless either party provides notice of termination at least 30 days before expiration.

Sylvan N. Goldman Center, 1001 N. Lincoln Blvd., Oklahoma City, OK 73104 • (405) 297-5700

- Transportation Fees (see Fee Schedule 2.0). Transfusion Service Clients will be charged the following fees for transportation required for specimen pickup and product delivery:
  - L35 – Specimen Transportation fee
    - Charged for all specimen pickups
    - Pre-determined price based on round trip mileage
  - L33 – Non Routine Product Delivery fee
    - Delivery of any product that is ordered ASAP or STAT
    - Pre-determined price based on round trip mileage
  - L30 – Component Prep fee
    - Charged when a blood administration record, bag tag, is attached to blood products for transfusion.
    - Also charged when red cells used for emergency release are prepared, bag tag attached, prior to transportation to the Transfusion Service facility.

- Credit/Return Policy (Paragraph 23/Schedule 23.0). This policy has been updated to include Large Volume Delayed Sampling (LVDS) for platelets. As previously communicated, in order to meet the new FDA requirements for platelets, OBI will begin distributing LVDS Platelets effective August 1, 2021. Despite many other centers no longer accepting platelet returns, we will continue to accept returns of platelet products, however the LVDS fee will be non-refundable.

Thank you for continuing to engage in this life-saving partnership with OBI. If you have comments, questions, or concerns about the blood supply, pricing, contracts or other topics in blood banking, please contact us. We welcome the opportunity to be of service.

Reference Laboratory Department

Barbara Ledford SBB (ASCP)	Executive Director, Reference Laboratory	Barbara.ledford@obi.org	(405)297-5711
Brandy Morrow MLS(ASCP)SBB	OKC IRL and Transfusion Services Manager	Brandy.morrow@obi.org	(405)297-5717
Afton Gilliland MSTM, MLS(ASCP)SBB	Special Projects Manager, Reference Laboratory	Afton.gilliland@obi.org	(405)297-5655
Elizabeth Hill MT(ASCP)SBB	Little Rock Reference Lab Manager	Elizabeth.hill@obi.org	(501)904-4599

Client Relations and Contracting Department

Randy Petty	Director, Client Relations and Contracting	Randy.Petty@obi.org	(405) 278-3118
Patti Barker	Regional Director, Client Relations and Contracting (Eastern OK & AR)	Patti.Barker@obi.org	(405) 313-9578
Lori Jeppesen	Manager, Client Relations and Contracting (Central/Western OK & TX)	Lori.Jeppesen@obi.org	(405) 227-1849
Becky Heister	Contracts Manager	Becky.Heister@obi.org	(405) 297-5560

Hospital Vendor Contract Summary Sheet

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

2. **Name of Contract: Participating Provider Agreement**

3. **Contract Parties: MCHA dba MRMC, Mangum Family Clinic and Oklahoma Complete Health, Inc.**

4. **Contract Type Services:** Insurance

5. **Impacted Hospital Departments: Rev Ops/Finance**

6. **Contract Summary:** Mangum Hospital, Hospital Based Providers, and the Clinic/RHC. This agreement includes the following products:

- Oklahoma Medicaid (SoonerSelect)
- Medicare Advantage (Wellcare)
- Commercial Exchange (Ambetter)

  - Oklahoma Medicaid:
    - Hospital IP/OP: Lesser of Allowable Charges or 100% of Medicaid Fee Schedule
    - Professional Services: Lesser of Allowable Charges or 100% of Medicaid Fee Schedule
    - Clinic/RHC: Typically, 100% of Medicaid FS but Payor has agreed to honor the current APM methodology using the most recent RHC - Medicare Encounter rate
  - Medicare Advantage:
    - Hospital IP/SWB/OP: 100% of Medicare Per Diem / 100% of Medicare Cost-to-Charge Ratio (Medicare/CAH rate letter)
    - Professional Services: Lesser of Allowable Charges or 100% of Medicare Fee Schedule
    - Clinic/RHC: 100% of Medicare Encounter rate
  - Commercial Exchange:
    - Hospital IP/OP: 165% of Medicare Per Diem / 145% of Medicare Cost-to-Charge Ratio
    - Professional Services: Lesser of Allowable Charges or 120% of Medicare Fee Schedule

- Clinic/RHC: 120% of Medicare Encounter rate

7. Cost: N/A

8. Prior Cost: N/A

9. Term: Two years, automatically renewable for one year

10. Termination Clause: 180 days notice

11. Other:

PARTICIPATING PROVIDER AGREEMENT

This Participating Provider Agreement (together with all Attachments and amendments, this "***Agreement***") is made and entered by and between Mangum City Hospital Authority dba Mangum Regional Medical Center and Mangum Family Clinic ("***Provider***") and Oklahoma Complete Health, Inc. ("***Health Plan***") (each a "***Party***" and collectively the "***Parties***"). This Agreement is effective as of the date designated by Health Plan on the signature page of this Agreement ("***Effective Date***").

WHEREAS, Provider desires to provide certain health care services to individuals in products offered by or available from or through a Company or Payor (as hereafter defined), and Provider desires to participate in such products as a Participating Provider (as defined herein), all as hereinafter set forth.

WHEREAS, Health Plan desires for Provider to provide such health care services to individuals in such products, and Health Plan desires to have Provider participate in certain of such products as a Participating Provider, all as hereinafter set forth.

NOW, THEREFORE, in consideration of the recitals and mutual promises herein stated, the Parties hereby agree to the provisions set forth below.

ARTICLE I - DEFINITIONS

When appearing with initial capital letters in this Agreement (including an Attachment(s)), the following quoted and underlined terms (and the plural thereof, when appropriate) have the meanings set forth below.

1.1. "Affiliate" means a person or entity directly or indirectly controlling, controlled by, or under common control with Health Plan.

1.2. "Attachment" means any document, including an addendum, schedule or exhibit, attached to this Agreement as of the Effective Date or that becomes attached pursuant to Section 2.2 or Section 8.7, all of which are incorporated herein by reference and may be amended from time to time as provided in this Agreement.

1.3. "Clean Claim" has, as to each particular Product, the meaning set forth in the applicable Product Attachment or, if no such definition exists, the Provider Manual.

1.4. "Company" means (collectively or individually, as appropriate in the context) Health Plan and/or one or more of its Affiliates, except those specifically excluded by Health Plan.

1.5. "Compensation Schedule" means at any given time the then effective schedule(s) of maximum rates applicable to a particular Product under which Provider and Contracted Providers will be compensated for the provision of Covered Services to Covered Persons. Such Compensation Schedule(s) will be set forth or described in one or more Attachments to this Agreement and may be included within a Product Attachment.

1.6. "Contracted Provider" means a physician, hospital, health care professional or any other provider of items or services that is employed by or has a contractual relationship with Provider and that provides Covered Services. The term "Contracted Provider" includes Provider for those Covered Services provided by Provider.

1.7. "Coverage Agreement" means any agreement, program or certificate entered into, issued or agreed to by Company or Payor, under which Company or Payor furnishes administrative services or other services in support of a health care program for an individual or group of individuals, and which may include access to one or more of Company's provider networks or vendor arrangements, except those excluded by Health Plan.

1.8. "Covered Person" means any individual entitled to receive Covered Services pursuant to the terms of a Coverage Agreement.

1.9. "Covered Services" means those services and items for which benefits are available and payable under the applicable Coverage Agreement and which are determined, if applicable, to be Medically Necessary under the applicable Coverage Agreement.

1.10. "Medically Necessary" or "Medical Necessity" shall have the meaning defined in the applicable Coverage Agreement or applicable Regulatory Requirements.

1.11. "Participating Provider" means, with respect to a particular Product, any physician, hospital, ancillary, or other health care provider that has contracted, directly or indirectly, with Health Plan to provide Covered Services to Covered Persons, that has been approved for participation by Company, and that is designated by Company as a "participating provider" in such Product.

1.12. "Payor" means the entity (including Company where applicable) that bears direct financial responsibility for paying from its own funds, without reimbursement from another entity, the cost of Covered Services rendered to Covered Persons under a Coverage Agreement and, if such entity is not Company, such entity contracts, directly or indirectly, with Company for the provision of certain administrative or other services with respect to such Coverage Agreement.

1.13. "Payor Contract" means the contract with a Payor, pursuant to which Company furnishes administrative services or other services in support of the Coverage Agreements entered into, issued or agreed to by a Payor, which services may include access to one or more of Company's provider networks or vendor arrangements, except those excluded by Health Plan. The term "Payor Contract" includes Company's or other Payor's contract with a governmental authority (also referred to herein as a "Governmental Contract") under which Company or Payor arranges for the provision of Covered Services to Covered Persons.

1.14. "Product" means any program or health benefit arrangement designated as a "product" by Health Plan (e.g., Health Plan Product, Medicaid Product, PPO Product, Payor-specific Product, etc.) that is now or hereafter offered by or available from or through Company (and includes the Coverage Agreements that access, or are issued or entered into in connection with such product, except those excluded by Health Plan).

1.15. "Product Attachment" means an Attachment setting forth requirements, terms and conditions specific or applicable to one or more Products, including certain provisions that must be included in a provider agreement under the Regulatory Requirements, which may be alternatives to, or in addition to, the requirements, terms and conditions set forth in this Agreement or the Provider Manual.

1.16. "Provider Manual" means the provider manual and any billing manuals, adopted by Company or Payor which include, without limitation, requirements relating to utilization management, quality management, grievances and appeals, and Product-specific, Payor-specific and State-specific requirements, as may be amended from time to time by Company or Payor.

1.17. "Regulatory Requirements" means all applicable federal and state statutes, regulations, regulatory guidance, judicial or administrative rulings, requirements of Governmental Contracts and standards and requirements of any accrediting or certifying organization, including, but not limited to, the requirements set forth in a Product Attachment.

1.18. "State" is defined as the state identified in the applicable Attachment.

ARTICLE II - PRODUCTS AND SERVICES

2.1. Contracted Providers. Provider shall, and shall cause each Contracted Provider, to comply with and abide by the agreements, representations, warranties, acknowledgements, certifications, terms and conditions of this Agreement (including the provisions of Schedule A that are applicable to Provider, a Contracted Provider, or their

services, and any other Attachments), and the Provider Manual, and fulfill all of the duties, responsibilities and obligations imposed on Provider and Contracted Providers under this Agreement (including each Attachment), and the Provider Manual.

2.2. Participation in Products. Subject to the other provisions of this Agreement, each Contracted Provider may be identified as a Participating Provider in each Product identified in a Product Attachment designated on Schedule B of this Agreement or added to this Agreement in accordance with Section 2.2 hereof.

2.2.1. Provider shall, at all times during the term of this Agreement, require each of its Contracted Providers to, subject to Company's approval, participate as Participating Providers in each Product identified in a Product Attachment that is designated on Schedule B to this Agreement or added to this Agreement in accordance with Section 2.2 hereof.

2.2.2. A Contracted Provider may only identify itself as a Participating Provider for those Products in which the Contracted Provider actually participates as provided in this Agreement. Provider acknowledges that Company or Payor may have, develop or contract to develop various Products or provider networks that have a variety of provider panels, program components and other requirements. No Company or Payor warrants or guarantees that any Contracted Provider: (i) will participate in all or a minimum number of provider panels, (ii) will be utilized by a minimum number of Covered Persons, or (iii) will indefinitely remain a Participating Provider or member of the provider panel for a particular network or Product.

2.2.3. Provider shall provide Health Plan with the information listed on Schedule C entitled "Information for Contracted Providers" for itself and the Contracted Providers as of the Effective Date. Provider shall provide Health Plan, from time to time or on a periodic basis as requested by Health Plan, with a complete and accurate list of Information for Contracted Providers and such other information as mutually agreed upon by the Parties and shall provide Health Plan with a list of modifications to such list at least 30 days prior to the effective date of such changes, when possible. Provider shall provide such lists in a manner and format mutually acceptable to the Parties.

2.2.4. Provider may add new providers to this Agreement as Contracted Providers. In such case, Provider shall provide written notice to Health Plan of the prospective addition(s), and shall use best efforts to provide such notice at least 60 days in advance of such addition. Provider shall maintain written agreements with each of its Contracted Providers (other than Provider) that require the Contracted Providers to comply with the terms and conditions of this Agreement and that address and comply with the Regulatory Requirements.

2.2.5. If Company desires to add one or more Contracted Providers to an additional Product, Company or Payor, as applicable, will provide advance written notice (electronic or paper) thereof to Provider, along with the applicable Product Attachment and the new Compensation Schedule, if any. The applicable Contracted Providers will not be designated as Participating Providers in such additional Product unless Provider or Contracted Provider opts into such additional Product by giving Company or Payor, as applicable, written notice of its decision to opt-in. Only those Contracted Providers with respect to whom or which such notice is provided shall be a Participating Provider in such additional Product on the terms and conditions set forth in this Agreement and the applicable Product Attachment.

2.3. Covered Services. Each Contracted Provider shall provide Covered Services described or referenced in the applicable Product Attachment(s) to Covered Persons in those Products in which the Contracted Provider is a Participating Provider, in accordance with this Agreement. Each Contracted Provider shall provide Covered Services to Covered Persons with the same degree of care and skill as customarily provided to patients who are not Covered Persons, within the scope of the Contracted Provider's license and in accordance with generally accepted standards of the Contracted Provider's practice and business and in accordance with the provisions of this Agreement, the Provider Manual, and Regulatory Requirements.

2.4. Provider Manual; Policies and Procedures. Provider and Contracted Providers shall at all times cooperate and comply with the requirements, policies, programs and procedures ("Policies") of Company and Payor, which may be described in the Provider Manual and include, but are not limited to, the following: credentialing criteria and requirements; notification requirements; medical management programs; claims and billing, quality assessment and improvement, utilization review and management, disease management, case management, on-site reviews, referral and prior authorization, and grievance and appeal procedures; coordination of benefits and third party liability policies; carve-out and third party vendor programs; and data reporting requirements. The failure to comply with such Policies could result in a denial or reduction of payment to the Provider or Contracted Provider or a denial or reduction of the Covered Person's benefits. Such Policies do not in any way affect or remove the obligation of Contracted Providers to render care. Health Plan shall make the Provider Manual available to Provider and Contracted Providers via one or more designated websites or alternative means. Upon Provider's reasonable request, Health Plan shall provide Provider with a copy of the Provider Manual. In the event of a material change to the Provider Manual, Health Plan will provide Provider with at least 30 days' advance written notice of such change. If Provider disputes the change, the Parties will meet in good faith to find a mutually beneficial solution, or either Party may exercise its rights in accordance with Section 7.2.1. Such notice may be given by Health Plan through a periodic provider newsletter, an update to the on-line Provider Manual, or any other written method (electronic or paper).

2.5. Credentialing Criteria. Provider and each Contracted Provider shall complete Company's and/or Payor's credentialing and/or recredentialing process as required by Company's and/or Payor's credentialing Policies and shall at all times during the term of this Agreement meet all of Company's and/or Payor's credentialing criteria. Provider and each Contracted Provider represents, warrants and agrees: (a) that it is currently, and for the duration of this Agreement shall remain: (i) in compliance with all applicable Regulatory Requirements, including licensing laws; (ii) if applicable, accredited by The Joint Commission or the American Osteopathic Association; and (iii) a Medicare participating provider under the federal Medicare program and a Medicaid participating provider under applicable federal and State laws; and (b) that all Contracted Providers and all employees and contractors thereof will perform their duties in accordance with all Regulatory Requirements, as well as applicable national, State and local standards of professional ethics and practice. No Contracted Provider shall provide Covered Services to Covered Persons or identify itself as a Participating Provider unless and until the Contracted Provider has been notified, in writing, by Company that such Contracted Provider has successfully completed Company's credentialing process.

2.6. Eligibility Determinations. Provider or Contracted Provider shall timely verify whether an individual seeking Covered Services is a Covered Person. Company or Payor, as applicable, will make available to Provider and Contracted Providers a method, whereby Provider and Contracted Providers can obtain, in a timely manner, general information about eligibility and coverage. Company or Payor, as applicable, does not guarantee that persons identified as Covered Persons are eligible for benefits or that all services or supplies are Covered Services. If Company, Payor or its delegate determines that an individual was not a Covered Person at the time services were rendered, such services shall not be eligible for payment under this Agreement. In addition, Company will use reasonable efforts to include or contractually require Payors to clearly display Company's name, logo or mailing address (or other identifier(s) designated from time to time by Company) on each membership card.

2.7. Referral and Preauthorization Procedures. Provider and Contracted Providers shall comply with referral and preauthorization procedures adopted by Company and or Payor, as applicable, prior to referring a Covered Person to any individual, institutional or ancillary health care provider. Unless otherwise expressly authorized in writing by Company or Payor, Provider and Contracted Providers shall refer Covered Persons only to Participating Providers to provide the Covered Service for which the Covered Person is referred. Except as required by applicable law, failure of Provider and Contracted Providers to follow such procedures may result in denial of payment for unauthorized treatment.

2.8. Treatment Decisions. No Company or Payor is liable for, nor will it exercise control over, the manner or method by which a Contracted Provider provides items or services under this Agreement. Provider and Contracted Providers understand that determinations of Company or Payor that certain items or services are not Covered Services or have not been provided or billed in accordance with the requirements of this Agreement or the Provider Manual are administrative decisions only. Such decisions do not absolve the Contracted Provider of its responsibility to

exercise independent judgment in treatment decisions relating to Covered Persons. Nothing in this Agreement (i) is intended to interfere with Contracted Provider's relationship with Covered Persons, or (ii) prohibits or restricts a Contracted Provider from disclosing to any Covered Person any information that the Contracted Provider deems appropriate regarding health care quality, medical treatment decisions or alternatives.

2.9. Carve-Out Vendors. Provider acknowledges that Company may, during the term of this Agreement, carve-out certain Covered Services from its general provider contracts, including this Agreement, for one or more Products as Company deems necessary or appropriate. Provider and Contracted Providers shall cooperate with and, when medically appropriate, utilize all third party vendors designated by Company for those Covered Services identified by Company from time to time for a particular Product.

2.10. Disparagement Prohibition. Provider, each Contracted Provider and the officers of Company shall not disparage the other during the term of this Agreement or in connection with any expiration, termination or non-renewal of this Agreement. Neither Provider nor Contracted Provider shall interfere with Company's direct or indirect contractual relationships including, but not limited to, those with Covered Persons or other Participating Providers. Nothing in this Agreement should be construed as limiting the ability of either Health Plan, Company, Provider or a Contracted Provider to inform Covered Persons that this Agreement has been terminated or otherwise expired or, with respect to Provider, to promote Provider to the general public or to post information regarding other health plans consistent with Provider's usual procedures, provided that no such promotion or advertisement is specifically directed at one or more Covered Persons. In addition, nothing in this provision should be construed as limiting Company's ability to use and disclose information and data obtained from or about Provider or Contracted Provider, including this Agreement, to the extent determined reasonably necessary or appropriate by Company in connection with its efforts to comply with Regulatory Requirements and to communicate with regulatory authorities.

2.11. Nondiscrimination. Provider and each Contracted Provider will provide Covered Services to Covered Persons without discrimination on account of race, sex, sexual orientation, age, color, religion, national origin, place of residence, health status, type of Payor, source of payment (e.g., Medicaid generally or a State-specific health care program), physical or mental disability or veteran status, and will ensure that its facilities are accessible as required by Title III of the Americans With Disabilities Act of 1991. Provider and Contracted Providers recognize that, as a governmental contractor, Company or Payor may be subject to various federal laws, executive orders and regulations regarding equal opportunity and affirmative action, which also may be applicable to subcontractors, and Provider and each Contracted Provider agree to comply with such requirements as described in any applicable Attachment.

2.12. Notice of Certain Events. Provider shall give written notice to Health Plan of: (i) any event of which notice must be given to a licensing or accreditation agency or board; (ii) any change in the status of Provider's or a Contracted Provider's license; (iii) termination, suspension, exclusion or voluntary withdrawal of Provider or a Contracted Provider from any state or federal health care program, including but not limited to Medicaid; or (iv) any settlements or judgments in connection with a lawsuit or claim filed or asserted against Provider or a Contracted Provider alleging professional malpractice involving a Covered Person. In any instance described in subsection (i)-(iii) above, Provider must notify Health Plan or Payor in writing within 10 days, and in any instance described in subsection (iv) above, Provider must notify Health Plan or Payor in writing within 30 days, from the date it first obtains knowledge of the pending of the same.

2.13. Use of Name. Provider and each Contracted Provider hereby authorizes each Company or Payor to use their respective names, telephone numbers, addresses, specialties, certifications, hospital affiliations (if any), and other descriptive characteristics of their facilities, practices and services for the purpose of identifying the Contracted Providers as "Participating Providers" in the applicable Products. Provider and Contracted Providers may only use the name of the applicable Company or Payor for purposes of identifying the Products in which they participate and may not use the registered trademark or service mark of Company or Payor without prior written consent.

2.14. Compliance with Regulatory Requirements. Provider, each Contracted Provider and Company agree to carry out their respective obligations under this Agreement and the Provider Manual in accordance with all

applicable Regulatory Requirements, including, but not limited to, the requirements of the Health Insurance Portability and Accountability Act, as amended, and any regulations promulgated thereunder. If, due to Provider's or Contracted Provider's noncompliance with applicable Regulatory Requirements or this Agreement, sanctions or penalties are imposed on Company, Company may, in its sole discretion, offset such amounts that are directly related to Provider's noncompliance against any amounts due Provider or Contracted Providers from Company or require Provider or the Contracted Provider to reimburse Company for such amounts. Company will provide a copy of the sanctions or penalties to Provider prior to any offsets.

2.15. Program Integrity Required Disclosures. Provider agrees to furnish to Health Plan complete and accurate information necessary to permit Company to comply with the collection of disclosures requirements specified in 42 C.F.R. Part 455 Subpart B or any other applicable State or federal requirements, within such time period as is necessary to permit Company to comply with such requirements. Such requirements include but are not limited to: (i) 42 C.F.R. §455.105, relating to (a) the ownership of any subcontractor with whom Provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request and (b) any significant business transaction between Provider and any wholly owned supplier or subcontractor during the 5 year period ending on the date of the request; (ii) 42 C.F.R. §455.104, relating to individuals or entities with an ownership or controlling interest in Provider; and (iii) 42 C.F.R. §455.106, relating to individuals with an ownership or controlling interest in Provider, or who are managing employees of Provider, who have been convicted of a crime.

ARTICLE III - CLAIMS SUBMISSION, PROCESSING, AND COMPENSATION

3.1. Claims or Encounter Data Submission. As provided in the Provider Manual and/or Policies, Contracted Providers shall timely submit to Payor or its delegate claims for payment for Covered Services rendered to Covered Persons within 180 days of the date Covered Services were rendered. Contracted Provider , if applicable, shall submit encounter data to Payor or its delegate in a timely fashion, which must contain statistical and descriptive medical and patient data and identifying information, if and as required in the Provider Manual. Payor or its delegate reserves the right to deny payment to the Contracted Provider if the Contracted Provider fails to submit claims for payment or encounter data in accordance with the Provider Manual and/or Policies.

3.2. Compensation. The compensation for Covered Services provided to a Covered Person ("Compensation Amount") will be the appropriate amount under the applicable Compensation Schedule in effect on the date of service for the Product in which the Covered Person participates. Subject to the terms of this Agreement and the Provider Manual, Provider and Contracted Providers shall accept the Compensation Amount as payment in full for the provision of Covered Services. Subject to the terms of this Agreement, Payor shall pay or arrange for payment of each Clean Claim received from a Contracted Provider for Covered Services provided to a Covered Person in accordance with the applicable Compensation Amount less any applicable copayments, cost-sharing or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement.

3.3. Financial Incentives. The Parties acknowledge and agree that nothing in this Agreement shall be construed to create any financial incentive for Provider or a Contracted Provider to withhold Covered Services.

3.4. Hold Harmless. Provider and each Contracted Provider agree that in no event, including but not limited to non-payment by a Payor, a Payor's insolvency, or breach of this Agreement, shall Provider or a Contracted Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Covered Person or person acting on the Covered Person's behalf, other than Payor, for Covered Services provided under this Agreement. This provision shall not prohibit collection of any applicable copayments, cost-sharing or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement. This provision survives termination or expiration of this Agreement for any reason, will be construed for the benefit of Covered Persons, and supersedes any oral or written agreement entered into between Provider or a Contracted Provider and a Covered Person.

3.5. Recovery Rights. Payor or its delegate will provide written or electronic notice to Provider before using an offset of amounts owed by Provider or a Contracted Provider to Payor or Company against amounts owed

by the Payor or Company to the Provider or Contracted Provider as a means to recover an overpayment or payment made in error. Payor or its delegate will not implement the offset if, within 30 days after the date of the notice, Provider refunds the overpayment or payment made in error, or initiates an appeal. The notice shall explain the reason and calculation of the overpayment or payment made in error. Appeals shall be made pursuant to procedures set forth in the Policies and/or Provider Manual. Provider and Contracted Providers agree that all recoupment and any offset rights under this Agreement will constitute rights of recoupment authorized under State or federal law and that such rights will not be subject to any requirement of prior or other approval from any court or other government authority that may now have or hereafter have jurisdiction over Provider or a Contracted Provider.

ARTICLE IV - RECORDS AND INSPECTIONS

4.1. Records. Each Contracted Provider shall maintain medical, financial and administrative records related to items or services provided to Covered Persons, including but not limited to a complete and accurate permanent medical record for each such Covered Person, in such form and detail as are required by applicable Regulatory Requirements and consistent with generally accepted medical standards.

4.2. Access. Provider and each Contracted Provider shall provide access to their respective books and records to each of the following, including any delegate or duly authorized agent thereof, subject to applicable Regulatory Requirements: (i) Company and Payor, during regular business hours and upon prior notice; (ii) appropriate State and federal authorities, to the extent such access is necessary to comply with Regulatory Requirements; and (iii) accreditation organizations. Provider and each Contracted Provider shall provide copies of such records at no expense to any of the foregoing that may make such request. Each Contracted Provider also shall obtain any authorization or consent that may be required from a Covered Person in order to release medical records and information to Company or Payor or any of their delegates. Provider and each Contracted Provider shall cooperate in and allow on-site inspections of its, his or her facilities and records by any Company, Payor, their delegates, any authorized government officials, and accreditation organizations. Provider and each Contracted Provider shall compile information necessary for the expeditious completion of such on-site inspection in a timely manner.

4.3. Record Transfer. Subject to applicable Regulatory Requirements, each Contracted Provider shall cooperate in the timely transfer of Covered Persons' medical records to any other health care provider, at no charge and when required.

ARTICLE V - INSURANCE AND INDEMNIFICATION

5.1. Insurance. During the term of this Agreement and for any applicable continuation period as set forth in Section 7.3 of this Agreement, Provider and/or each Contracted Provider shall maintain policies of general and professional liability insurance and other insurance necessary to insure Provider and such Contracted Provider, respectively; their respective employees; and any other person providing services hereunder on behalf of Provider or such Contracted Provider, as applicable, against any claim(s) of personal injuries or death alleged to have been caused or caused by their performance under this Agreement. Such insurance shall include, but not be limited to, any "tail" or prior acts coverage necessary to avoid any gap in coverage. Insurance shall be through a licensed carrier acceptable to Health Plan, and in a minimum amount of $1,000,000 per occurrence, and $3,000,000 in the aggregate unless a lesser amount is accepted by Health Plan or where State law mandates otherwise. Provider and/or each Contracted Provider will provide Health Plan with at least 10 days prior written notice of cancellation, non-renewal, lapse, or adverse material modification of such coverage. Upon Health Plan's request, Provider and each Contracted Provider will furnish Health Plan with evidence of such insurance.

5.2. Indemnification by Provider and Contracted Provider. Provider and each Contracted Provider shall indemnify and hold harmless (and at Health Plan's request defend) Company and Payor and all of their respective officers, directors, agents and employees from and against any and all third party claims for any loss, damages, liability, costs, or expenses (including reasonable attorney's fees) judgments or obligations arising from or relating

to any negligence, wrongful act or omission, or breach of this Agreement by Provider, a Contracted Provider, or any of their respective officers, directors, agents or employees.

5.3. Indemnification by Health Plan. Health Plan agrees to indemnify and hold harmless (and at Provider's request defend) Provider, Contracted Providers, and their officers, directors, agents and employees from and against any and all third -party claims for any loss, damages, liability, costs, or expenses (including reasonable attorney's fees), judgments, or obligations arising from or relating to any negligence, wrongful act or omission or breach of this Agreement by Company or its directors, officers, agents or employees.

ARTICLE VI - DISPUTE RESOLUTION

6.1. Informal Dispute Resolution. Any dispute between Provider and/or a Contracted Provider, as applicable (the "Provider Party"), and Health Plan and/or Company, as applicable (including any Company acting as Payor) (the "Administrator Party"), with respect to or involving the performance under, termination of, or interpretation of this Agreement, or any other claim or cause of action hereunder, whether sounding in tort, contract or under statute (a "Dispute") shall first be addressed by exhausting the applicable procedures in the Provider Manual pertaining to claims payment, credentialing, utilization management, or other programs. Health Plan shall complete these applicable procedures within 60 days after Provider notifies Health Plan of such claim reconsideration and/or claims Dispute. If at the conclusion of these applicable procedures, the matter is not resolved to satisfaction of the Provider Party and the Administrator Party, or if there are no applicable procedures in the Provider Manual, then the Provider Party and the Administrator Party shall engage in a period of good faith negotiations between their designated representatives who have authority to settle the Dispute, which negotiations may be initiated by either the Provider Party or the Administrator Party upon written request to the other Party, provided such request takes place within one year of the date on which the requesting party first had, or reasonably should have had, knowledge of the event(s) giving rise to the Dispute. If the matter has not been resolved within 60 days of such request, either the Provider Party or the Administrator Party may, as its sole and exclusive forum for the litigation of the Dispute or any part thereof, initiate arbitration pursuant to Section 6.2 below by providing written notice to the other party.

6.2. Arbitration. If either the Provider Party or the Administrator Party wishes to pursue the Dispute as provided in Section 6.1, such party shall submit it to binding arbitration conducted in accordance with the Commercial Arbitration Rules of the American Arbitration Association ("AAA"). In no event may any arbitration be initiated more than 1 year following, as applicable, the end of the 60 day negotiation period set forth in Section 6.1, or the date of notice of termination. Arbitration proceedings shall be conducted by an arbitrator chosen from the National Healthcare Panel at a mutually agreed upon location within the State. The arbitrator shall not award any punitive or exemplary damages of any kind, shall not vary or ignore the provisions of this Agreement, and shall be bound by controlling law. Any arbitration in which the total amount in controversy is less than $100,000 shall be conducted in a single hearing day. The Parties and the Contracted Providers, on behalf of themselves and those that they may now or hereafter represent, agree to and do hereby waive any right to pursue, on a class basis, any Dispute. Each of the Provider Party and the Administrator Party shall bear its own costs and attorneys' fees related to the arbitration except that the AAA's Administrative Fees, all Arbitrator Compensation and travel and other expenses, and all costs of any proof produced at the direct request of the arbitrator shall be borne equally by the applicable parties, and the arbitrator shall not have the authority to order otherwise. The existence of a Dispute or arbitration proceeding shall not in and of itself constitute cause for termination of this Agreement. Except as hereafter provided, during an arbitration proceeding, each of the Provider Party and the Administrator Party shall continue to perform its obligations under this Agreement pending the decision of the arbitrator. Nothing herein shall bar either the Provider Party or the Administrator Party from seeking emergency injunctive relief to preclude any actual or perceived breach of this Agreement, although such party shall be obligated to file and pursue arbitration at the earliest reasonable opportunity. Judgment on the award rendered may be entered in any court having jurisdiction thereof. Because of the confidential nature of this Agreement, the Provider and Administrator Parties further agree that in any action to compel arbitration or enforce any arbitration award, no party may file any part of this Agreement (including Attachments) in the court record, except this Section 6.2. Nothing contained in this Article VI shall limit a Party's right to terminate this Agreement with or without cause in accordance with Section 7.2.

ARTICLE VII - TERM AND TERMINATION

7.1. Term. This Agreement is effective as of the Health Plan Effective Date, and will remain in effect for an initial term ("Initial Term") of 2 year(s), after which it will automatically renew for successive terms of 1 year each (each a "Renewal Term"), unless this Agreement is sooner terminated as provided in this Agreement or either Party gives the other Party written notice of non-renewal of this Agreement not less than 120 days prior to the end of the then-current term. In addition, either Party may elect to not renew a Contracted Provider's participation as a Participating Provider in a particular Product for the next Renewal Term, by giving the other Party written notice of such non-renewal not less than 120 days prior to the, as applicable, last day of the Initial Term or applicable Renewal Term; in such event, Provider shall immediately notify the affected Contracted Provider of such non-renewal. Termination of any Contracted Provider's participation in a particular Product will not have the effect of terminating either this Agreement or the Contracted Provider's participation in any other Product in which the Contract Provider participates under this Agreement.

7.2. Termination. This Agreement, or the participation of Provider or a Contracted Provider as a Participating Provider in one or more Products, may be terminated or suspended as set forth below.

7.2.1. Upon Notice. This Agreement may be terminated by either Party giving the other Party at least 180 days prior written notice of such termination. The participation of any Contracted Provider as a Participating Provider in a Product may be terminated by either Party giving the other Party at least 180 days prior written notice of such termination; in such event, Provider shall immediately notify the affected Contracted Provider of such termination.

7.2.2. With Cause. This Agreement, or the participation of any Contracted Provider as a Participating Provider in one or more Products under this Agreement, may be terminated by either Party giving at least 90 days prior written notice of termination to the other Party if such other Party (or the applicable Contracted Provider) is in breach of any material term or condition of this Agreement and such other Party (or the Contracted Provider) fails to cure the breach within the 60 day period immediately following the giving of written notice of such breach. Any notice given pursuant to this Section 7.2.2 must describe the specific breach. In the case of a termination of a Contracted Provider, Provider shall immediately notify the affected Contracted Provider of such termination.

7.2.3. Suspension of Participation. Unless expressly prohibited by applicable Regulatory Requirements, Health Plan has the right to immediately suspend or terminate the participation of a Contracted Provider in any or all Products by giving written notice thereof to Provider when Health Plan determines that (i) based upon available information, the continued participation of the Contracted Provider appears to constitute an immediate threat or risk to the health, safety or welfare of Covered Persons, or (ii) the Contracted Provider's fraud, malfeasance or non-compliance with Regulatory Requirements is reasonably suspected. Provider shall immediately notify the affected Contracted Provider of such suspension. During such suspension, the Contracted Provider shall, as directed by Health Plan, discontinue the provision of all or a particular Covered Service to Covered Persons. During the term of any suspension, the Contracted Provider shall notify Covered Persons that his or her status as a Participating Provider has been suspended. Such suspension will continue until the Contracted Provider's participation is reinstated or terminated.

7.2.4. Insolvency. This Agreement may be terminated immediately by a Party giving written notice thereof to the other Party if the other Party is insolvent or has bankruptcy proceedings initiated against it.

7.2.5. Credentialing. The status of a Contracted Provider as a Participating Provider in one or more Products may be terminated immediately by Health Plan giving written notice thereof to Provider if the Contracted Provider fails to adhere to Health Plan's credentialing criteria, including, but not limited to, if the Contracted Provider (i) loses, relinquishes, or has materially affected its license to provide Covered Services in the State, (ii) fails to comply with the insurance requirements set forth in this Agreement; or (iii) is convicted of a criminal offense related to involvement in any state or federal health care program or has been terminated, suspended, barred, voluntarily

withdrawn as part of a settlement agreement, or otherwise excluded from any state or federal health care program. Provider shall immediately notify the affected Contracted Provider of such termination.

7.3. Effect of Termination. After the effective date of termination of this Agreement or a Contracted Provider's participation in a Product, this Agreement shall remain in effect for purposes of those obligations and rights arising prior to the effective date of termination. Upon such a termination, each affected Contracted Provider (including Provider, if applicable) shall (i) continue to provide Covered Services to Covered Persons in the applicable Product(s) during the longer of the 90 day period following the date of such termination or such other period as may be required under any Regulatory Requirements, and, if requested by Company, each affected Contracted Provider (including Provider, if applicable) shall continue to provide, as a Participating Provider, Covered Services to Covered Persons until such Covered Persons are assigned or transferred to another Participating Provider in the applicable Product(s), and (ii) continue to comply with and abide by all of the applicable terms and conditions of this Agreement, including, but not limited to, Section 3.4 (Hold Harmless) hereof, in connection with the provision of such Covered Services during such continuation period. During such continuation period, each affected Contracted Provider (including Provider, if applicable) will be compensated in accordance with this Agreement and shall accept such compensation as payment in full.

7.4. Survival of Obligations. All provisions hereof that by their nature are to be performed or complied with following the expiration or termination of this Agreement, including without limitation Sections 2.8, 2.10, 3.2, 3.4, 3.5, 4.2, 5.1, 5.2, 5.3, 6.2, 7.3, and 7.4 and Article VIII, survive the expiration or termination of this Agreement.

ARTICLE VIII - MISCELLANEOUS

8.1. Relationship of Parties. The relationship between or among Health Plan, Company, Provider, Payor and any Contracted Provider hereunder is that of independent contractors. None of the provisions of this Agreement will be construed as creating any agency, partnership, joint venture, employee-employer, or other relationship. References herein to the rights and obligations of any Company under this Agreement are references to the rights and obligations of each Company individually and not collectively. A Company is only responsible for performing its respective obligations hereunder with respect to a particular Product, Coverage Agreement, Payor Contract, Covered Service or Covered Person. A breach or default by an individual Company shall not constitute a breach or default by any other Company, including but not limited to Health Plan.

8.2. Conflicts Between Certain Documents. If there is any conflict between this Agreement and the Provider Manual, this Agreement will control. In the event of any conflict between this Agreement and any Product Attachment, the Product Attachment will control as to such Product.

8.3. Assignment. This Agreement is intended to secure the services of and be personal to Provider and may not be assigned, sublet, delegated, subcontracted or transferred by Provider without Health Plan's prior written consent. Health Plan shall have the right, exercisable in its sole discretion, to assign or transfer all or any portion of its rights or to delegate all or any portion of its interests under this Agreement or any Attachment to an Affiliate, successor of Health Plan, or purchaser of the assets or stock of Health Plan, or the line of business or business unit primarily responsible for carrying out Health Plan's obligations under this Agreement.

8.4. Headings. The headings of the sections of this Agreement are inserted merely for the purpose of convenience and do not limit, define, or extend the specific terms of the section so designated.

8.5. Governing Law. The interpretation of this Agreement and the rights and obligations of Health Plan, Company, Provider and any Contracted Providers hereunder will be governed by and construed in accordance with applicable federal and State laws.

8.6. Third Party Beneficiary. This Agreement is entered into by the Parties signing it for their benefit, as well as, in the case of Health Plan, the benefit of Company, and in the case of Provider, the benefit of each Contracted

Provider. Except as specifically provided in Section 3.4 hereof, no Covered Person or third party, other than Company, will be considered a third -party beneficiary of this Agreement.

8.7. Amendment. Except as otherwise provided in this Agreement, this Agreement may be amended only by written agreement of duly authorized representatives of the Parties.

8.7.1. Health Plan may amend this Agreement by giving Provider written notice of the amendment to the extent such amendment is deemed necessary or appropriate by Health Plan to comply with any Regulatory Requirements. Any such amendment will be deemed accepted by Provider upon the giving of such notice.

8.7.2. Health Plan may amend this Agreement by giving Provider written notice (electronic or paper) of the proposed amendment. All amendments must be in writing and counter executed by both Parties, unless Section 8.7.1. is applicable.

8.8. Entire Agreement. All prior or concurrent agreements, promises, negotiations or representations either oral or written, between Health Plan and Provider relating to a subject matter of this Agreement, which are not expressly set forth in this Agreement, are of no force or effect.

8.9. Severability. The invalidity or unenforceability of any terms or provisions hereof will in no way affect the validity or enforceability of any other terms or provisions.

8.10. Waiver. The waiver by either Party of the violation of any provision or obligation of this Agreement will not constitute the waiver of any subsequent violation of the same or other provision or obligation.

8.11. Notices. Except as otherwise provided in this Agreement, any notice required or permitted to be given hereunder is deemed to have been given when such written notice has been personally delivered or deposited in the United States mail, postage paid, or delivered in hard copy or electronically by a service that provides written receipt or acknowledgment of delivery, addressed as follows:

To Health Plan at:	To Provider at:
Attn: President	Attn: Dale Clayton
	Mangum City Hospital Authority dba Mangum Regional Medical Center and Mangum Family Clinic
Oklahoma Complete Health, Inc.	
7725 W. Reno Ave. [Suite 332]	PO Box 280
Oklahoma City, OK 73127	Mangum, OK 73554
	dale@cohesivehealthcare.net

or to such other address as such Party may designate in writing. Notwithstanding the previous paragraph, Health Plan may provide notices by electronic mail, through its provider newsletter or on its provider website.

8.12. Force Majeure. Neither Party shall be liable or deemed to be in default for any delay or failure to perform any act under this Agreement resulting, directly or indirectly, from acts of God, civil or military authority, acts of public enemy, war, accidents, fires, explosions, earthquake, flood, strikes or other work stoppages by either Party's employees, or any other similar cause beyond the reasonable control of such Party.

8.13. Proprietary Information. Each Party is prohibited from, and shall prohibit its Affiliates and Contracted Providers from, disclosing to a third party the substance of this Agreement, or any information of a confidential nature acquired from the other Party (or Affiliate or Contracted Provider thereof) during the course of this Agreement, except to agents of such Party as necessary for such Party's performance under this Agreement, or

as required by a Payor Contract or applicable Regulatory Requirements. Provider acknowledges and agrees that all information relating to Company's programs, policies, protocols and procedures is proprietary information and Provider shall not disclose such information to any person or entity without Health Plan's express written consent.

8.14. Authority. The individuals whose signatures are set forth below represent and warrant that they are duly empowered to execute this Agreement. Provider represents and warrants that it has all legal authority to contract on behalf of and to bind all Contracted Providers to the terms of the Agreement with Health Plan. Provider and each Contracted Provider acknowledges that references herein to the rights and obligations of any "Company" or a "Payor" under this Agreement are references to the rights and obligations of each Company and each Payor individually and not of the Companies or Payors collectively. Notwithstanding anything herein to the contrary, all such rights and obligations are individual and specific to each such Company and each such Payor and the reference to Company or Payor herein in no way imposes any cross-guarantees or joint responsibility or liability by, between or among such individual Companies or Payors. A breach or default by an individual Company or Payor shall not constitute a breach or default by any other Company or Payor, including but not limited to Health Plan.

THIS AGREEMENT CONTAINS A BINDING ARBITRATION PROVISION THAT MAY BE ENFORCED BY THE PARTIES.

IN WITNESS WHEREOF, the Parties hereto have executed this Agreement, including all Product Attachments noted on Schedule B, effective as of the date set forth beneath their respective signatures.

HEALTH PLAN:	**PROVIDER:**
Oklahoma Complete Health, Inc.	Mangum City Hospital Authority dba Mangum Regional Medical Center and Mangum Family Clinic (Legibly Print Name of Provider)
Authorized Signature:	Authorized Signature:
Print Name: Clayton Franklin	Print Name:
Title: President & CEO	Title:
Signature Date:	Signature Date:
ICM #: ICMProviderAgreement_164043	Tax Identification Number: 82-2087512
To be completed by Health Plan only: Effective Date:	National Provider Identifier: 1033635263 Medicare Number:

PARTICIPATING PROVIDER AGREEMENT

SCHEDULE A
CONTRACTED PROVIDER-SPECIFIC PROVISIONS

Provider and Contracted Providers shall comply with the applicable provisions of this Schedule A.

1. Hospitals. If Provider or a Contracted Provider is a hospital ("Hospital"), the following provisions apply.

1.1 24 Hour Coverage. Each Hospital shall be available to provide Covered Services to Covered Persons 24 hours per day, 7 days per week.

1.2 Emergency Care. Each Hospital shall provide Emergency Care (as hereafter defined) in accordance with Regulatory Requirements. "Emergency Care" (or derivative thereof) has, as to each particular Product, the meaning set forth in the applicable Coverage Agreement or Product Attachment. If there is no definition in such documents, "Emergency Care" means inpatient and/or outpatient Covered Services furnished by a qualified provider that are needed to evaluate or stabilize an Emergency Medical Condition. "Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.

1.3 Staff Privileges. Each Hospital shall assist in granting staff privileges or other appropriate access to Company's Participating Providers who are qualified medical or osteopathic physicians, provided they meet the reasonable standards of practice and credentialing standards established by the Hospital's medical staff and bylaws, rules, and regulations.

1.4 Discharge Planning. Each Hospital agrees to cooperate with Company's system for the coordinated discharge planning of Covered Persons, including the planning of any necessary continuing care.

1.5 Credentialing Criteria. Each Hospital shall: (a) currently, and for the duration of this Agreement, remain accredited by the Joint Commission or American Osteopathic Association, as applicable; and (b) ensure that all employees of Hospital perform their duties in accordance with all applicable local, State and federal licensing requirements and standards of professional ethics and practice.

1.6 National Committee for Quality Assurance ("NCQA") Accreditation of Health Plans Standards. Each Hospital agrees to: (i) cooperate with Quality Management and Improvement ("QI") activities; (ii) maintain the confidentiality of a Covered Persons information and records pursuant to the Agreement; and (iii) allow the Company to use Hospital's performance data.

2. Practitioners. If applicable, Provider or Contracted Provider is a physician or other health care practitioner (including physician extenders) ("Practitioner"), the following provisions apply.

2.1 Contracted Professional Qualifications. At all times during the term of this Agreement, Practitioner shall, as applicable, maintain medical staff membership and admitting privileges with at least one hospital that is a Participating Provider ("Participating Hospital") with respect to each Product in which the Practitioner participates. Upon Company's request, Practitioner shall furnish evidence of the foregoing to Company. If Practitioner does not have such admitting privileges, Provider or the Practitioner shall provide Company with a written statement from another Participating Provider who has such admitting privileges, in good standing, certifying that such individual agrees to assume responsibility for providing inpatient Covered Services to Covered Persons who are patients of the applicable Practitioner.

2.2 Acceptance of New Patients. To the extent that Practitioner is accepting new patients, such Practitioner must also accept new patients who are Covered Persons with respect to the Products in which such Practitioner participates. Practitioner shall notify Company in writing 45 days prior to such Practitioner's decision to no longer accept Covered Persons with respect to a particular Product. In no event will an established patient of any Practitioner be considered a new patient.

2.3 Preferred Drug List/Drug Formulary. If applicable to the Covered Person's coverage, Practitioners shall use commercially reasonable efforts, when medically appropriate under the circumstances, to comply with formulary or preferred drug list when prescribing medications for Covered Persons.

2.4 National Committee for Quality Assurance ("NCQA") Accreditation of Health Plans Standards. Each Practitioner agrees to: (i) cooperate with Quality Management and Improvement ("QI") activities; (ii) maintain the confidentiality of a Covered Persons information and records pursuant to the Agreement; and (iii) allow the Company to use Practitioner's performance data.

3. Ancillary Providers. If applicable, Provider or Contracted Provider is an ancillary provider (including but not limited to a home health agency, durable medical equipment provider, sleep center, pharmacy, ambulatory surgery center, nursing facility, laboratory or urgent care center) ("Ancillary Provider"), the following provisions apply.

3.1 Acceptance of New Patients. To the extent that Ancillary Provider is accepting new patients, such Ancillary Provider must also accept new patients who are Covered Persons with respect to the Products in which such Ancillary Provider participates. Ancillary Provider shall notify Company in writing 45 days prior to such Ancillary Provider's decision to no longer accept Covered Persons with respect to a particular Product. In no event will an established patient of any Ancillary Provider be considered a new patient.

3.2 National Committee for Quality Assurance ("NCQA") Accreditation of Health Plans Standards. Each ancillary provider agrees to: (i) cooperate with Quality Management and Improvement ("QI") activities; (ii) maintain the confidentiality of a Covered Persons information and records pursuant to the Agreement; and (iii) allow the Company to use ancillary provider's performance data.

4. FQHC. If applicable, Provider or a Contracted Provider is a federally qualified health center ("FQHC"), the following provision applies.

4.1 FQHC Insurance. To the extent FQHC's employees are deemed to be federal employees qualified for protection under the Federal Tort Claims Act ("FTCA") and Health Plan has been provided with documentation of such status issued by the U.S. Department of Health and Human Services (such status to be referred to as "FTCA Coverage"), Section 5.1 of this Agreement will not apply to those Contracted Providers with FTCA Coverage. FQHC shall provide evidence of such FTCA Coverage to Health Plan at any time upon request. FQHC shall promptly notify Health Plan if, any time during the term of this Agreement, any Contracted Provider is no longer eligible for, or if FQHC becomes aware of any fact or circumstance that would jeopardize, FTCA Coverage. Section 5.1 of this Agreement will apply to a Contracted Provider immediately upon such Contracted Provider's loss of FTCA Coverage for any reason.

5. Facility Providers. If applicable, Provider or a Contracted Provider is a facility (including but not limited to Clinic, FQHC, LTAC, Nursing Home, Rehab, Rural Health Clinic, Skilled Nursing) ("Facility Provider") the following provision applies.

5.1 National Committee for Quality Assurance ("NCQA") Accreditation of Health Plans Standards. Each facility agrees to: (i) cooperate with Quality Management and Improvement ("QI") activities; (ii) maintain the confidentiality of a Covered Persons information and records pursuant to the Agreement; and (iii) allow the Company to use facility's performance data.

6. Long Term Services and Supports ("LTSS") and Home and Community-Based Services ("HCBS") Providers. If applicable, Provider or a Contracted Provider is a provider of LTSS and/or HCBS services, the following provisions apply.

6.1 Definition. LTSS generally includes assistance with daily self-care activities (e.g., walking, toileting, bathing, and dressing) and activities that support an independent lifestyle (e.g., food preparation, transportation, and managing medications). The broad category of LTSS also includes care and service coordination for people who live in their own home, a residential setting, a nursing facility, or other institutional setting. Home and community-based services ("HCBS") are a subset of LTSS that functions outside of institutional care to maximize independence in the community.

6.2 HCBS Waiver Authorization. Provider shall not provide HCBS Covered Services to Covered Person without the required HCBS waiver authorization.

6.3 Conditions for Reimbursement. No payment shall be made to the Provider unless the Provider has strictly conformed to the policies and procedures of the HCBS Waiver Program, including but not limited to not providing HCBS Covered Services without prior authorization of Health Plan. For the purposes of this Exhibit, "HCBS Waiver Program" shall mean any special Medicaid program operated under a waiver approved by the Centers for Medicare and Medicaid Services which allows the provision of a special package of approved services to Covered Person.

6.4 Acknowledgement. Health Plan acknowledges that Provider is a provider of LTSS and is not necessarily a provider of medical or health care services. Nothing in this Agreement is intended to require Provider to provide medical or health care services that Provider does not routinely provide, but would not prohibit providers from offering these services, as appropriate.

6.5 Notification Requirements. Provider or the applicable Contracted Provider shall provide the following notifications to Health Plan, via written notice or via telephone contact at a number to be provided by Health Plan, within the following time frames:

6.5.1 Provider or the applicable Contracted Provider shall notify Health Plan of a Covered Person's visit to urgent care or the emergency department of any hospital, or of a Covered Person's hospitalization, within 24 hours of becoming aware of such visit or hospitalization.

6.5.2 Provider or the applicable Contracted Provider shall notify Health Plan of any change to the designated/assigned services being provided under a Covered Person's plan of care and/or service plan, within 24 hours of becoming aware of such change.

6.5.3 Provider or the applicable Contracted Provider shall notify Health Plan if a Covered Person misses an appointment with Provider, within 24 hours of becoming aware of such missed appointment.

6.5.4 Provider or the applicable Contracted Provider shall notify Health Plan of any change in a Covered Person's medical or behavioral health condition, within 24 hours of becoming aware of such change. (Examples of changes in condition are set forth in the Provider Manual.)

6.5.5 Provider or the applicable Contracted Provider shall notify Health Plan of any safety issue identified by Provider or Contracted Provider or its agent or subcontractor, within 24 hours of the identification of such safety issue. (Examples of safety issues are set forth in the Provider Manual.)

6.5.6 Provider or the applicable Contracted Provider shall notify Health Plan of any change in Provider's or Contracted Provider's key personnel, within 24 hours of such change.

6.6 Minimum Data Set. If Contracted Provider is a nursing facility, Provider or such Contracted Provider shall submit to Health Plan or its designee the Minimum Data Set as defined by CMS and required under federal law and Health Plan policy as it relates to all Covered Persons who are residents in Contracted Provider's facility. Such submission shall be via electronic mail, facsimile transmission, or other manner and format reasonably requested by Health Plan.

6.7 Quality Improvement Plan. Each Contracted Provider shall participate in Health Plan's LTSS quality improvement plan. Each Contracted Provider shall permit Health Plan to access such Contracted Providers' assessment and quality data upon reasonable advance notice, which may be given by electronic mail.

6.8 Electronic Visit Verification. If Contracted Provider provides in-home services, Contracted Provider shall comply with 21st Century Cures Act and Health Plan's electronic visit verification system requirements where applicable and accessible.

6.9 Criminal Background Checks. Provider shall conduct a criminal background check on each Contracted Provider prior to the commencement of services under this Agreement and as requested by Health Plan thereafter. Provider shall provide the results of such background checks to Health Plan and member, if self-directed, upon request. Provider agrees to immediately notify Health Plan of any criminal convictions of any Contracted or sub-contracted Provider. Provider shall pay any costs associated with such criminal background checks.

7. Person-Centered Planning, Care/Service Plan, and Services ("PCSP"). If applicable, Provider shall comply with all state and federal regulatory requirements related to person-centered planning, care/service plans, and services including, but not limited to:

7.1 Covered Persons shall lead the person-centered planning process and can elect to include, and/or consult with, any of their LTSS providers in the care/service plan development process.

7.2 The care/service plan must be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation through the mechanism required by state and federal requirements. Non-medical service providers (such as meals or assistive technology) can signify their agreement through this contract or written agreement in lieu of directly in the plan, if permitted by the Covered Persons.

7.3 LTSS Provider shall be aware of, respect, and adhere to a Covered Person's preferences for the delivery of services and supports.

7.4 LTSS Provider shall ensure services and supports are culturally appropriate, provided in plain language (where applicable), and accessible to Covered Persons and the person(s) supporting them who have disabilities and/or are limited English proficient.

7.5 Health Plan agrees to complete the care/service plan in a timely manner (within at least 120 days of enrollment or annually, or less if state requirements differ) and provide a copy to LTSS Provider(s) responsible for implementation.

PARTICIPATING PROVIDER AGREEMENT

SCHEDULE B
PRODUCT PARTICIPATION

Provider will be designated as a "Participating Provider" in the Product Attachments listed below as of the date of successful completion of credentialing in accordance with this Agreement.

List of Product Attachments:
Attachment A: Medicaid
Attachment B: Medicare
Attachment C: Commercial-Exchange
Attachment D: [Reserved]
Attachment E: [Reserved]

PARTICIPATING PROVIDER AGREEMENT

SCHEDULE C
INFORMATION FOR CONTRACTED PROVIDERS

Provider shall provide Health Plan with the information set forth below with respect to: (i) Provider; (ii) each Contracted Provider; and (iii) if applicable, each Contracted Provider's locations and/or professionals. To the extent Provider provides the name of any Contracted Provider to Health Plan hereunder, such entity and/or individual will be considered a Contracted Provider under this Agreement regardless of whether the complete list of information set forth below relating to such Contracted Provider is provided by Provider.

1. Name
2. Address
3. E-mail address
4. Telephone and facsimile numbers
5. Professional license numbers
6. Medicare/Medicaid ID numbers
7. Federal tax ID numbers
8. Completed W-9 form
9. National Provider Identifier (NPI) numbers
10. Provider Taxonomy Codes
11. Area of medical specialty
12. Age restrictions (if any)
13. Area hospitals with admitting privileges (where applicable)
14. Whether Providers are employed or subcontracted with Contracted Provider using the designation "E" for employed or "C" for subcontracted.
15. For a subcontracted Provider, whether its Providers are employed or contracted with the subcontracted Provider using the designation "E" for employed or "C" for contracted.
16. Office contact person
17. Office hours
18. Billing office
19. Billing office address
20. Billing office telephone and facsimile numbers
21. Billing office e-mail address
22. Billing office contact person
23. Ownership Disclosure Form, as required to comply with Regulatory Requirements and Governmental Contract

NOTE: For a complete listing of the information and additional documentation required, please refer to the enrollment application.

Attachment A: Medicaid

PRODUCT ATTACHMENT
OKLAHOMA MEDICAID PRODUCT (SOONERSELECT)
(INCLUDING REGULATORY REQUIREMENTS)

THIS PRODUCT ATTACHMENT (this "***Attachment***") is made and entered between Oklahoma Complete Health, Inc. ("Health Plan") and Mangum City Hospital Authority dba Mangum Regional Medical Center and Mangum Family Clinic ("***Provider***").

WHEREAS, Health Plan and Provider entered into that certain Participating 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;

WHEREAS, pursuant to the provisions of the Agreement, this Attachment is identified on Schedule B of the Agreement and, as such, the Contracted Providers will be designated and participate as "***Participating Providers***" in the Product described in this Attachment; and

WHEREAS, Health Plan has contracted with the Oklahoma Health Care Authority ("***OHCA***") to be a State Medicaid Care Management Organization to provide Covered Services to Covered Persons in the State's Medicaid program known as SoonerSelect, and such other programs (hereafter referred to as "Medicaid Product") as may be awarded to Health Plan by OHCA.

WHEREAS, the Agreement is modified or supplemented as hereafter provided.

NOW THEREFORE, in consideration of the recitals, the mutual promises herein stated, the parties hereby agree to the provisions set forth below.

1. Defined Terms. All capitalized terms not specifically defined in this Attachment will have the meanings given to such terms in the Agreement.

2. Product Participation.

2.1 SoonerSelect. This Attachment addresses the participation of Provider and the applicable Contracted Providers in the Medicaid Product. The Medicaid Product includes those programs and health benefit arrangements offered by Health Plan or other Company pursuant to a contract (the "***State Contract***") with the Oklahoma Health Care Authority, or any successor thereto, to provide specified services and goods to covered beneficiaries under the SoonerSelect programs (or additional, ancillary or successor State Medicaid programs thereto), and to meet certain performance standards while doing so. The Medicaid Product does not apply to any Coverage Agreements that are specifically covered by another Product Attachment to the Agreement. This Attachment applies only to the provision of health care services, supplies or accommodations (including Covered Services) to Covered Persons enrolled in the Medicaid Product.

Where Company is not the Payor, the rights and responsibilities assigned under this Attachment to Company, Payor, or "Company or Payor" shall be understood to apply to either Company or Payor as applicable under the circumstances and as determined by the terms of the Payor Contract, Regulatory Requirements and/or Company policies and procedures. The phrase "Company or Payor" is not intended to nor shall result in the expansion of any rights on the part of Provider or Contracted Providers or any liabilities on the part of Company or Payor. Nothing in this Attachment shall be construed as conferring any financial or legal liabilities of Payor under any Regulatory Requirements or the Payor Contract to Company or Health Plan. Nothing in this Attachment shall be construed as altering the terms of the Payor Contract, or in a manner that is inconsistent with Regulatory Requirements. The rights and responsibilities that arise under a Payor Contract (including a Governmental Contract)

and that are assigned under this Attachment to Health Plan are understood to be assigned to Company (and references to "Health Plan" will be understood to be references to Company) where Company is a party to the Payor Contract.

2.2 Participation. Unless otherwise specified in this Attachment, all Contracted Providers under the Agreement will participate in the Medicaid Product as "***Providers***," and will provide to Covered Persons enrolled in the Medicaid Product, upon the same terms and conditions contained in the Agreement, as supplemented or modified by this Attachment, those Covered Services that are provided by Contracted Providers pursuant to the Agreement. In providing such services, Provider shall, and shall cause Contracted Providers to, comply with and abide by the provisions of this Attachment and the Agreement (including the Provider Manual).

2.3 Attachment. This Attachment constitutes the Product Attachment for the Medicaid Product.

2.4 Construction. Except as expressly provided herein, the terms and conditions of the Agreement will remain unchanged and in full force and effect. In the event of a conflict between the provisions of the Agreement and the provisions of this Attachment, this Attachment will govern with respect to health care services, supplies or accommodations (including Covered Services) rendered to Covered Persons enrolled in the Medicaid Product. To the extent Provider or any Contracted Provider is unclear about its, his or her respective duties and obligations, Provider or the applicable Contracted Provider shall request clarification from the Company. To the extent any provision of this Attachment, or any provision of the Agreement as it relates to this Attachment, (including any exhibit, attachment, or other document referenced herein) is inconsistent with or contrary to any provision of the State Contract, the relevant provision of the State Contract shall have priority and control over the matter.

3. Term. This Attachment will become effective as of the Effective Date and will be coterminous with the Agreement unless a party or a Contracted Provider terminates the participation of the Contracted Provider in the Medicaid Product in accordance with the applicable provisions of the Agreement or this Attachment. Notwithstanding the above, Health Plan may immediately terminate this Attachment upon notice to Provider in the event that the State Contract is terminated or the SoonerSelect program (or any aspect thereof) is no longer authorized by law (i.e., has been vacated by a court of law, CMS has withdrawn federal authority for the program, or the program is the subject of a legislative repeal).

4. Governmental Contract/Regulatory Requirements. **Schedule A** to this Attachment, which is incorporated herein by this reference, sets forth the special provisions that are applicable to the Medicaid Product under the State Contract and the provisions that are required by the State Contract to be included in the Agreement with respect to the Medicaid Product. Schedule B to this Attachment, which is incorporated herein by this reference, sets forth the terms that are applicable to the Medicaid Product under State laws and regulations, and that are required under such laws and regulations to be included in the Agreement with respect to the Medicaid Product. To the extent that a Coverage Agreement is subject to the law cited in the **Schedule B**, such provision will apply to the rendering of Covered Services to a Covered Person with such Coverage Agreement. Provider shall expressly impose these terms and obligations, in writing, on each of its Contracted Providers, as such term is defined in the Agreement. Health Plan is and shall be a third -party beneficiary of any agreement between Provider and its Contracted Providers with the right to directly enforce these terms and condition upon Contracted Providers. Applicable State agencies have the right to modify, supplement, amend and add to the terms, conditions and obligations set forth in **Schedules A and B**, and Provider shall be bound by such changes

Attachment A: Medicaid

SCHEDULE A
GOVERNMENTAL CONTRACT REQUIREMENTS

This Schedule A sets forth the special provisions that are specific to the Oklahoma SoonerSelect Medicaid , SoonerSelect Children's Program and CHIP Product under the applicable State Contract.

1. Definitions. For purposes of this Attachment, the following terms have the meanings set forth below. Terms used in this Attachment and not defined below will have the same meaning set forth in the Agreement, or, if not defined there, in the State Contract (as defined below). Terms used in this Attachment that are not otherwise explicitly defined shall be understood to have the definition laid out 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.

1.1 "***Act***" means the Social Security Act.

1.2 **"*Adverse Benefit Determination*"** means, pursuant to 42 C.F.R. § 438.400(b):

a) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, health care setting, or effectiveness of a covered benefit;

b) The reduction, suspension, or termination of a previously authorized service;

c) The denial, in whole or in part, of payment for a service;

d) The failure to provide services in a timely manner, as defined by OHCA;

e) The failure of Company to act within the timeframes provided in 42 C.F.R. § 438.408(b)(1) and (b)(2) regarding the standard resolution of Grievances and Appeals;

f) For a resident of a Rural Area with only one MCO, the denial of a Covered Person's request to exercise his or her right, under 42 C.F.R. § 438.52(b)(2)(ii), to obtain services outside the network; or

g) The denial of a Covered Person's request to dispute a financial liability, including Cost Sharing, Copayments, premiums, deductibles, coinsurance and other Covered Person financial liabilities.

1.3 **"*Affiliate*"** means associated business concerns or individuals if, directly or indirectly: (1) either one controls or can control the other; or (2) a third party controls or can control both.

1.4 **"*American Indian/Alaska Native*"** or **"*AI/AN*"** means, pursuant to 42 C.F.R. § 438.14, any individual defined at 25 U.S.C. §§ 1603(13), 1603(28) or 1679(a) or who has been determined eligible as an Indian under 42 C.F.R. § 136.12. This means the individual:

a) Is a member of a Federally recognized Indian Tribe;

b) Resides in an urban center and meets one or more of the four criteria; o Is a member of an Indian Tribe, band or other organized group of Indians, including those tribes, bands or groups terminated since 1940 and those recognized now or in the future by the State in which they reside or who is a descendant, in the first or second degree, of any such member;

c) Is an Eskimo or Aleut or other Alaska Native; o Is considered by the Secretary of the Interior to be an Indian for any purpose; or o Is determined to be an Indian under regulations issued by the Secretary;

d) Is considered by the Secretary of the Interior to be an Indian for any purpose; or

e) Is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut or other Alaska Native.

1.5 **"*Appeal*"** means a review of an Adverse Benefit Determination by Company.

1.6 **"*Authorized Representative*"** means a competent adult who has the Covered Person's signed, written authorization to act on the Covered Person's behalf during the Grievance, Appeal, and State Fair Hearing process. The written authority to act shall specify any limits of the representation.

1.7 **'*Behavioral Health Services*"** means a wide range of diagnostic, therapeutic and rehabilitative services used in the treatment of mental illness, substance abuse and co-occurring disorders.

1.8 **"*Business Days*"** means Monday through Friday and is exclusive of weekends and State of Oklahoma holidays.

1.9 **"Calendar *Days*"** means all seven days of the week, including State of Oklahoma holidays.

1.10 **"*Care Manager*"** means Company's staff primarily responsible for delivering services to Covered Persons s in accordance with its OHCA-approved Risk Stratification Level Framework, and meets the qualifications specified in Section 1.8.4.3 of the State Contract.

1.11 **"*Care Plan*"** means a comprehensive set of actions and goals for the Covered Person developed by the Care Manager based on a Covered Person's unique needs. Company shall develop and implement Care Plans for all Covered Persons with a Special Health Care Need determined through the Comprehensive Assessment to need a course of treatment or regular care monitoring and in accordance with Section 1.8.3 of the State Contract.

1.12 **"*Children*"** means a child under age 19 determined eligible for SoonerCare under 42 C.F.R. § 435.118 or the state's Medicaid expansion CHIP.

1.13 **"*Clinical Practice Guidelines*"** means systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances. Company shall adopt Clinical Practice Guidelines in accordance with 42 C.F.R. § 438.236, ensuring they are based on valid and reliable clinical evidence or a consensus of Providers in the particular field; consider the needs of Covered Persons; are adopted in consultation with Participating Providers; and are reviewed and updated periodically as appropriate.

1.14 **"*Copayment*"** means a fixed amount that a Covered Person pays for a covered health care service when the Covered Person receives the service.

1.15 **"*Cost Sharing*"** means a State requirement that Covered Persons bear some of the cost of their care through mechanisms such as Copayments, deductibles and other similar charges.

1.16 **"*Covered Person*"** means an Eligible who is enrolled in Company's SoonerSelect plan.

1.17 **"*Covered Services*"** means all Medicaid services provided by Company in any setting, including but not limited to medical care, behavioral health care and pharmacy.

1.18 **"*Critical Incident*"** means any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety or well-being of a SoonerSelect program Company Enrollee. Critical Incidents include, but are not limited to, the following when the Covered Person is in the care of a behavioral health inpatient, residential or crisis stabilization unit, in accordance with OAC 317:305-95.39: Suicide death; non-suicide death; death-cause unknown; homicide; homicide attempt with significant medical intervention; suicide attempt with significant medical intervention; allegation of physical, sexual or verbal abuse or neglect; accidental injury with significant medical intervention; use of Restraints/Seclusion (Isolation); AWOL or absence from a mental health facility without permission; or treatment complications (medication errors and adverse medication reaction) requiring significant medical intervention.

1.19 **"*Days*"** means calendar days unless otherwise specified.

1.20 **"*Disenroll*"** means the removal of a Covered Person from participation in Company's MCO.

1.21 **"*Dual Eligible Individuals*"** means individuals eligible for both Medicaid and Medicare.

1.22 **"*Electronic Visit Verification (EVV) System*"** means an electronic system that documents the time that Providers begin and end the delivery of services to Covered Persons and the location of services. The EVV System shall comply with Section 12006 of the 21st Century Cures Act and associated CMS requirements.

1.23 **"*Eligible*"** means an individual who has SoonerCare coverage.

1.24 **"*Emergency Medical Condition*"** means a medical condition, including injury, manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the individual's health, or the health of an unborn child, in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organs or parts.

1.25 **"*Emergency Services*"** means Covered Services that are furnished by a Provider qualified to furnish such services and needed to evaluate, treat, or stabilize an Emergency Medical Condition.

1.26 **"*Encounter Data*"** means information relating to the receipt of any item(s) or service(s) by a Covered Person under this Attachment that is subject to the requirements of 42 C.F.R. §§ 438.242 and 438.818.

1.27 **"*Fraud*"** means intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or State law.

1.28 **"*Grievance*"** means a Covered Person expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a Provider or employee or failure to respect the Covered Person's rights regardless of whether remedial action is requested. A Grievance includes a Covered Person's right to dispute an extension of time proposed by Company to make an authorization decision.

1.29 **"*Grievance and Appeal System*"** means the processes that Company implements to handle Covered Person Grievances and Appeals of Adverse Benefit Determinations, as well as the processes to collect and track information about them.

1.30 **"*Indian Health Care Provider*"** *or* **"*IHCP*"** means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. § 1603).

1.31 **"*Indian Tribe*"** has the definition set forth in 25 U.S.C. § 1603.

1.32 **"*Limited English Proficiency*"** *or* **"*LEP*"** means Covered Persons who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may be Limited English Proficient (LEP) and may be eligible to receive language assistance for a particular type of service, benefit, or encounter.

1.33 **"*Managed Care Organization*"** *or* **"*MCO*"** means a health plan that has a contract with OHCA to participate in the SoonerSelect program and to deliver benefits and services to Covered Persons.

1.34 **"*Medically Necessary*"** means a standard for evaluating the appropriateness of services. Medical necessity, as established under OAC 317:30-3-1, is established through consideration of the following standards:

a) Services must be medical in nature and must be consistent with accepted health care practice standards and guidelines for the prevention, diagnosis or treatment of symptoms of illness, disease or disability;

b) Documentation submitted in order to request services or substantiate previously provided services must demonstrate through adequate objective medical records, evidence sufficient to justify the Covered Person's need for the service;

c) Treatment of the Covered Person's condition, disease or injury must be based on reasonable and predictable health outcomes;

d) Services must be necessary to alleviate a medical condition and must be required for reasons other than convenience for the Covered Person, family or medical provider;

e) Services must be delivered in the most cost-effective manner and most appropriate setting; and

f) Services must be appropriate for the Covered Person's age and health status and developed for the Covered Person to achieve, maintain or promote functional capacity or age appropriate growth and development.

Also aligning with federal standards, "Medically Necessary services" are no more restrictive than the State Medicaid program including Quantitative (QTL) and Non-Quantitative Treatment Limits (NQTL), as indicated in State statutes and regulations, the State Plan, and other State policies and procedures. Company shall cover Medically Necessary services related to the ability for a Covered Person to attain, maintain, or regain functional capacity.

1.35 **"*Non-Participating Provider*"** means a physician or other Provider who has not contracted with or is not employed by Company to deliver services under the SoonerSelect program.

1.36 **"*Non-Urgent Sick Visit*"** means medical care given for an acute onset of symptoms which is not emergent or urgent in nature. Examples of Non-Urgent Sick Visits include cold symptoms, sore throat and nasal congestion. Requires face-to-face medical attention within 72 hours of Covered Person notification of a non-urgent condition, as clinically indicated.

1.37 **"*Oklahoma Health Care Authority*"** *or* **"*OHCA*"** means the single state Agency for Medicaid in Oklahoma and the Agency with direct oversight of the SoonerSelect program.

1.38 **"*Overpayment*"** means any payment made to a Participating Provider by Company to which the Participating Provider is not entitled or any payment to Company by a state to which Company is not entitled to under Title XIX of the Act and under the SoonerSelect program.

1.39 **"*Participating Provider*"** means a physician or other Provider who has a contract with or is employed by Company to provide services to Covered Persons under the SoonerSelect program. This is the "Provider" in the Agreement between Company and the Participating Provider.

1.40 **"*Patient Centered Medical Home"* *or* *"PCMH*"** means primary care delivery system model that incorporates a managed care component with traditional fee-for-service and incentive payments for medical homes. For the purposes of this Attachment, the term "PCMH" shall be used instead of "primary care provider." PCMH Providers include the provider types listed in Section 1.12.4.1 of the State Contract.

1.41 **"*Pediatric*"** means relating to children from birth through age 21.

1.42 **"*Prior Authorization*"** means a requirement that a Covered Person obtain Company's approval before a requested medical service is provided or before services by a Non-Participating Provider are received. Prior Authorization is not a guarantee of claims payment; however, failure to obtain Prior Authorization may result in denial of the claim or reduction in payment of the claim.

1.43 **"*Protected Health Information*"** means information considered to be individually identifiable health information, as described in 45 C.F.R. § 160.103.

1.44 **"*Provider*"** means a provider that is either a Participating or a Non-Participating Provider.

1.45 **"*Provider-Preventable Conditions*"** means a condition occurring in any inpatient hospital setting, identified by the Secretary under Section 1886(d)(4)(D)(iv) of the Act for purposes of the Medicare program identified in the State Plan as described in Section 1886(d)(4)(D)(ii) and (iv) of the Act; other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients. Also includes a condition occurring in any health care setting that is identified in the State Plan, has been found by OHCA, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines; has a negative consequence for the Covered Person; is auditable; and includes, at a minimum, wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; and any surgical or other invasive procedure performed on the wrong patient.

1.46 **"*Rural Area*"** means a county with a population of less than 50,000 people.

1.47 **"*Secretary*"** means the Secretary of the U.S. Department of Health and Human Services.

1.48 **"*SoonerCare*"** means the Oklahoma Medicaid program.

1.49 **"*State*"** means, when not otherwise specified, a government entity or entities within the State of Oklahoma.

1.50 **"*State Contract*"** means the agreement between Company and OHCA whereby Company will provide Medicaid services to Covered Persons and be paid by OHCA as described in the terms therein, and which comprises the State Contract and any addenda, appendices, attachments or amendments thereto.

1.51 **"*State Plan*"** means the agreement between OHCA and CMS describing how Oklahoma administers its Medicaid and CHIP programs.

1.52 **"*State Fair Hearing*"** means the process set forth in Subpart E of 42 C.F.R. Part 431.

1.53 **"*Subcontractor*"** means an individual or entity that has a contract with Company that relates directly or indirectly to the performance of Company's obligations under the State Contract. Provider is not a Subcontractor by virtue of this Attachment.

1.54 **"*Telehealth*"** means the practice of health care delivery, diagnosis, consultation, evaluation and treatment, transfer of medical data or exchange of medical education information by means of a two-way, real-time interactive communication, not to exclude store and forward technologies, between a patient and a health care provider with access to and reviewing the patient's relevant clinical information prior to the telehealth visit. In accordance with Oklahoma law, including OAC 317:30-3-27 and 59 O.S. § 478, telehealth shall not include consultations provided by telephone audio-only communication, electronic mail, text message, instant messaging conversation, website questionnaire, nonsecure video conference, or facsimile transmission.

1.55 **"*Third Party Liability (TPL)*"** means all or part of the expenditures for a Covered Person's medical assistance furnished under the OHCA State Plan that may be the liability of a third party individual, entity or program.

1.56 **"*Urgent Care*"** means medical care provided for a condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse), such that a reasonably prudent layperson could expect that the absence of medical attention within 24 hours could result in:

a) Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

b) Serious impairment to bodily function; or

c) A serious dysfunction of any body organ or part.

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 Covered Persons under this Attachment. (Model Contract 1.12.2.1)

3. Conflict of Terms. If any requirement in the Agreement is determined by OHCA to conflict with the State Contract, such requirement shall be null and void and all other provisions of the Agreement shall remain in full force and effect. (Model Contract 1.12.2.1)

4. Approval of State Contract. Effectiveness of this Attachment 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, it, and this Attachment, will be considered null and void. (Model Contract 1.1.4)

5. Termination of this Attachment.

5.1 Availability of Records. In the event of termination of this Attachment 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 Attachment, and that the provision of such records shall be at no expense to OHCA. (Model Contract 1.12.2.2) Moreover, Provider shall cooperate with Company and OHCA to ensure that any Covered Person records and information are provided to Company to facilitate an orderly transition of all Covered Persons' care. (Model Contract 1.12.6.2.1)

5.2 Notice of Termination. Notwithstanding anything in the Agreement to the contrary, Health Plan and Provider may terminate this Attachment for cause upon thirty (30) days advance written notice to the other party, and without cause upon sixty (60) days advance written notice to the other party (Model Contract 1.12.6.1).

5.3 Immediate Termination. Notwithstanding anything in the Agreement to the contrary, this Attachment may be immediately terminated by Health Plan in the event of the following:

a) To protect the health and safety of Covered Persons;

b) Upon 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 Attachment;

d) Upon request of OHCA or, if OHCA determines termination is in the best interests of the State, upon direction of OHCA (Model Contract 1.12.2.2 and Model Contract 1.12.6.1); or

e) If Provider violates Section 1.24.1.7 of the State Contract (Model Contract 1.12.1.7).

f) DHS or OJA terminates or refuses to re-contract Provider.

6. 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. (Model Contract 1.12.2.2)

7. NPI. Providers rendering Covered Services, including Providers ordering or referring a covered service, must have an NPI, to the extent such Provider is not an atypical provider as defined by CMS. (Model Contract 1.12.2.2)

8. Enrollment in SoonerCare. Provider represents and warrants that it is now, and shall at all times during the term of this Attachment 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). (Model Contract 1.12.1.4.1 and 1.18.8) In accordance with 42 C.F.R. § 438.602(b)(2), Health Plan may execute this Attachment 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. (Model Contract 1.12.1.4.2)

9. 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. (Model Contract 1.12.2.2 and 1.12.3) and 42 C.F.R. § 438.214, 42 C.F.R. §§ 438.12(a)(2) and 438.214(b).

10. Covered Person Rights and Responsibilities. Provider shall abide by the Covered Person rights and responsibilities denoted in Section 1.11.5.2.4 of the State Contract and in Company's Enrollee Handbook. (Model Contract 1.12.2.2)

11. Display Notices of Covered Person 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. (Model Contract 1.12.2.2)

12. Physical Accessibility. Provider shall provide physical access, reasonable accommodations, and accessible equipment for Covered Persons with physical or mental disabilities, in accordance with 42 C.F.R. § 438.206(c)(3). (Model Contract 1.12.2.2)

13. Interpreter Presence. Provider shall accommodate the presence of interpreters and shall not suggest or require that Covered Persons with LEP, or who communicate through sign language, utilize friends or family as interpreters. (Model Contract 1.12.2.2 and 1.11.1.2).

14. Emergency Services. Emergency Services shall be rendered without the requirement of Prior Authorization. (Model Contract 1.12.2.2)

15. Confidentiality. Provider shall keep all Covered Person information confidential, as defined by State and federal laws, regulations and policy. (Model Contract 1.12.2.2)

16. Records.

16.1 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. Covered Persons and their representatives shall be given access to and can request copies of the Covered Persons' medical records to the extent and in the manner provided under State or federal law. (Model Contract 1.12.2.2)

16.2 Record Availability. Provider shall maintain all records related to services provided to Covered Persons for a ten year period (For minors, Provider shall retain all medical records during the period of minority, plus a minimum of ten years after the age of majority.) In addition, Providers shall make all Covered Persons' 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 Covered Persons' records. Covered Persons shall, at all times, have the right to request and receive copies of their medical records and to request they be amended. (Model Contract 1.12.2.2 and 1.10.9.1)

17. Professional Standards for Health Records. In accordance with 42 C.F.R. § 438.208(b)(5), Providers furnishing services to Covered Persons shall maintain and share Covered Persons' health records in accordance with professional standards. (Model Contract 1.12.2.2)

18. 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, DHS, and the Covered Person'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. Provider shall ensure that any serious incident that harms or potentially harms a Covered Person'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 Covered Persons and respond to any emergency needs of Covered Persons. 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, DHS, and the Covered Person'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. (Model Contract 1.10.10)

19. 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. (Model Contract 1.12.2.2)

20. 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 this Attachment. (Model Contract 1.12.2.2) 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. (Model Contract 1.18.1.4)

21. 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. (Model Contract 1.12.2.2)

22. Cost Sharing.

22.1 Covered Person Charges. When the Covered Service provided requires a Copayment, as allowed by Company, Provider may charge the Covered Person only the amount of the allowed Copayment, which may not exceed the Copayment 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 Covered Person, OHCA or the State. (Model Contract 1.12.2.2)

22.2 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 Covered Persons (Model Contract 1.17.2, and 1.15.3.4) nor for "Exempt Services" as defined in 42 C.F.R. 447.56 (Model Contract 1.17.3)

22.3 Cost Sharing – Payment Reduction. Company will reduce payment to a Provider by the amount of the Covered Person'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. (Model Contract 1.17.4)

22.4 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 Covered Person for the costs of Covered Services, except for any applicable Copayment amount allowed by OHCA. (Model Contract 1.14.1.3)

23. Third Party Liability. Provider shall identify Covered Person 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. (Model Contract 1.12.2.2)

24. Claims Submission and Payment. Provider shall promptly submit claims information needed to Company to make payment within six months of the Covered Service being provided to a Covered Person. (Model Contract 1.12.2.2) Except for those exceptions set forth in Section 1.14.4.2.1 of the Model Contract, resubmitted claims must be filed within an additional six months thereafter. (Model Contract 1.14.4.2.1)

25. Performance-based Provider Payments/Incentive Plans. Performance-based provider payment(s)/incentive plan(s) to which Provider is subject, if any, are set forth in the Compensation Schedule of the Agreement (Model Contract 1.12.2.2)

26. QM/QI Participation. Provider shall (i) participate in and cooperate with any internal and external 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. (Model Contract 1.12.2.2)

27. Data and Reporting. Provider shall timely submit of all reports, clinical information and Encounter Data required by Company and OHCA. (Model Contract 1.12.2.2)

28. Clinical Practice Guidelines. Provider and Contracted Providers shall exercise good faith efforts to adopt and utilize the Clinical Practice Guidelines adopted by Company. (Model Contract 1.7.4)

29. 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. (Model Contract 1.12.2.2)

30. 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 Covered Persons in a manner which will not result in discrimination against the Covered Person in order to provide or coordinate the provision of Covered Services, and shall not use discriminatory practices with regard to Covered Persons such as separate waiting rooms, separate appointment days or preference to private pay patients. (Model Contract 1.12.2.2)

31. Access and Cultural Competency. Provider shall take adequate steps to promote the delivery of services in a culturally competent manner to Covered Persons, including those with LEP and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity. (Model Contract 1.12.2.2)

32. 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 Covered Persons, 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 these timely access to care obligations. (Model Contract 1.12.1.2)

33. 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 Covered Persons and/or access to Covered Persons' Protected Health Information. 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 1.18.10 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 Attachment as provided under State and/or federal law. (Model Contract 1.12.2.2)

34. 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:

a) 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.

b) 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).

c) 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.

d) With respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act (ASFRA) of 1997.

e) With respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the Medicaid State Plan. (Model Contract 1.6.17)

35. Prohibited Affiliations and Exclusions. Provider acknowledges that Company, in accordance with 42 C.F.R. § 438.214(d)(1), 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), 438.808(b)(2) and § 1903(i)(2) of the Act; (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), 438.610(a) and § 1903(i)(2) of the Act; 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) 438.610(b) and 1903(i)(2) of the Act. 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 Federal Acquisition Regulation 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), 438.610(a) and § 1903(i)(2) of the Act; 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), 438.610(b), and § 1903(i)(2) of the Act. Provider warrants and represents to Company that it does not fall within any of the prohibited affiliations and exclusions described in this paragraph. (Model Contract 1.18.10) Health Plan may immediately terminate this Attachment 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 Section 1.18.10 of the State Contract. 1.14.2.3

36. Provider Right to Support Covered Person Grievance/Appeal. Company will take no punitive action against Provider in the event that Provider either requests an expedited resolution or supports a Covered Person's Appeal. (Model Contract 1.12.2.3)

37. Prohibited Payments. Company will suspend any payments to Provider for which the State determines there is a credible allegation of Fraud in accordance with Section 1.18.7 of the State Contract, entitled "Suspension of Payments for Credible Allegation of Fraud," and in accordance with 42 C.F.R. § 455.23. (Model Contract 1.14.2.2). 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:

a) Health- acquired conditions occurring in any inpatient hospital setting, identified as a health acquired condition by the Secretary of DHHS 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 Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients; and

b) Conditions meeting the following criteria:

- Is identified in the State Plan;
- 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;
- Has a negative consequence for the Covered Person;
- Is auditable; and
- Includes, at a minimum, wrong surgical or other invasive procedure performed on a patient, on the wrong body part or on the wrong patient. (Model Contract 1.14.2.4)

38. Provider Preventable Conditions - Reporting. Provider shall promptly report to Company all Provider Preventable Conditions associated with claims for payment or Covered Person treatments for which payment would otherwise be made. (Model Contract 1.21.2.12)

39. 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 a Covered Person 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 Covered Person (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 Covered Person to request a State Fair Hearing after receiving notice pursuant to 42 C.F.R. § 438.408 that the Adverse Benefit Determination is upheld. A Covered Person, 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 Covered Person is requesting an expedited resolution, a Covered Person'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 Covered Person with filing Grievances and Appeals including: provision of reasonable assistance to Covered Persons in (i) completing Grievance or Appeals forms; (ii) taking other procedural steps related to the Grievance or Appeal; (iii) making available Covered Person 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) (Model Contract 1.16.1.4) Covered Person has the right to request continuation of the benefits that Company seeks to reduce or terminate during an Appeal or State Fair Hearing filing, if filed within allowable timeframes, although the Covered Person may be liable for the cost of any continued benefits while the Appeal or State Fair Hearing is pending if the final decision upholds Company's determination that is adverse to the Covered Person. (Model Contract 1.16.1.2.1) Providers shall not be allowed to request continuation of benefits as an Authorized Representative of the Covered Person, as specified in 42 § 438.420(b)(5).

40. Overpayments to Providers. Provider shall utilize Company's established mechanism for reporting overpayments. Provider shall report overpayments within thirty (30) 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. (Model Contract 1.18.11.2 and 1.18.11.1)

41. Retroactive Dual Eligibility. Dual Eligible Individuals are excluded from SoonerSelect program enrollment. Covered Persons who become Dual Eligible Individuals will be Disenrolled as of their Medicare eligibility effective date. In the event that a Covered Person 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. (Model Contract 1.5.9)

42. Electronic Visit Verification ("***EVV***"). If Provider provides services subject to EVV, Provider shall participate in Company's EVV system. (Model Contract 1.19.1.1)

43. Encounter Data. Provider shall cooperate with and 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 Covered Persons. Provider shall submit Encounter Data and claims data in sufficient detail to support detailed utilization and tracking and financial reporting. (Model Contract 1.19.4.1 and 1.19.4.2)

44. 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 Attachment and upon Provider's request, of a paper copy of the Provider Manual(s).

45. Health Information Exchange ("***HIE***"). If Provider has a CMS-certified Electronic Health Records (EHR) system, Provider shall connect to the State HIE for the purpose of bi-directional health data exchange. If Provider does not have a certified EHR, Provider shall use the State HIE provider portal to query patient data for enhanced patient care, and shall sign a participation agreement with the State HIE and sign up for direct secure messaging services and portal access so that clinical information can be shared securely with other providers in Provider's community of care. Provider shall engage with the State HIE for the purpose of connecting its EHR system to the HIE to share Provider's patient electronic records. If Provider is a hospital, long term care facility or an emergency department, Provider shall send electronic patient event notifications of a patient's admission, discharge, and/or transfer ("***ADT***") to the state HIE. (Model Contract 1.19.4.4)

46. Compliance with Law.

46.1 Changes in Law/Interpretation of Laws. The Parties to this Attachment 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 Attachment 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 Attachment, the Parties shall be mutually bound by the amended requirements in effect at any given time following the Effective Date of this Attachment. The explicit inclusion of some statutory and regulatory duties in this Attachment shall not exclude other statutory or regulatory duties. All questions pertaining to the validity, interpretation and administration of this Attachment 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 Attachment is found to be in violation of State or federal statutes, that portion shall be stricken from this Attachment and the remainder of this Attachment and Agreement shall remain in full force and effect.

46.2 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:

- Title VI of the Civil Rights Act of 1964;
- The Age Discrimination Act of 1975;
- The Rehabilitation Act of 1973;
- Title IX of the Education Amendments of 1972 (regarding education programs and activities);
- The Americans with Disabilities Act of 1990 as amended;
- Section 1557 of the Patient Protection and Affordable Care Act (ACA);
- Healthcare Insurance Portability and Accountability Act, 42 U.S.C. 290dd-2;
- Mental Health Parity and Addiction Equity Act, 42 C.F.R. Part 2;

- Oklahoma Electronic Information Technology Accessibility (EITA) Act (Oklahoma 2004 HB 2197) regarding information technology accessibility standards for persons with disabilities;
- Oklahoma Medicaid False Claims Act, 63 O.S. §§ 5053 – 5054;
- Oklahoma Worker's Compensation Act, 85A O.S. §1 *et seq.*;
- 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;
- Title 317 of the Oklahoma Administrative Code ("OAC");
- 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
- Deceptive Trade Practices; Unfair Business Practices.

46.3 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; and/or (iv) have officers who have outstanding allegations of any Deceptive Trade Practice pending in any administrative hearing, litigation or other proceeding.

46.4 Covered Persons' 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 Covered Persons' rights, and shall ensure that its employees and Contracted Providers observe and protect those rights. (Model Contract 1.1.24)

47. Patient Centered Medical Homes ("*PCMHs*"). The following provisions shall apply if Provider is a PCMH. (Model Contract 1.12.2.4.1)

a) Provider shall deliver primary care services and follow-up care;

b) Provider shall utilize and practice evidence-based medicine and clinical decision supports;

c) Provider shall make referrals for specialty care and other covered services and, when applicable, work with Company to allow Covered Persons to directly access a specialist as appropriate for a Covered Person's condition and identified needs;

d) Provider shall maintain a current medical record for the Covered Person;

e) Provide shall use health information technology to support care delivery;

f) Provider shall provide care coordination in accordance with the Covered Person's Care Plan, as applicable based on Company's Risk Stratification Level Framework, and in cooperation with the Covered Person's Care Manager;

g) Provider shall insure coordination and continuity of care with Providers, including but not limited to specialists and behavioral health Providers;

h) Provider shall engage active participation by the Covered Person and the Covered Person's family, authorized representative or personal support, when appropriate, in health care decision-making, feedback and Care Plan development;

i) Provider shall provide access to medical care 24-hours per day, seven days a week, either directly or through coverage arrangements made with other Providers, clinics and/or local hospitals;

j) Provider shall 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

k) Provider shall participate in continuous quality improvement and voluntary performance measures established by Company and/or OHCA.

l) Provider shall maintain medical records documenting all referrals of Covered Persons.

m) Provider shall meet the following "Appointment Time" obligations for the applicable Provider-type category (Model Contract 1.12.4.1 and 1.12.4.2):

Service Category	Appointment Time
Adult PCMH Pediatric PCMH	• Not to exceed 30 days from date of the Covered Person's request for routine appointment. • Within 72 hours for Non-Urgent Sick Visits. • Within 24 hours for Urgent Care. • Each PCMH 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 Covered Person'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 Covered Person'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 benefit package. (Model Contract 1.12.4.3)

48. Behavioral Health Providers. The following provisions shall apply if Provider is a behavioral health provider.

a) Provider shall provide inpatient psychiatric services to Covered Persons and schedule the Covered Person for outpatient follow-up or continuing treatment prior to discharge from the inpatient setting with the outpatient treatment occurring within seven (7) Calendar Days from the date of discharge.

b) Provider shall complete the OHCA Customer Data Core (CDC) form located at http://www.odmhsas.org/picis/CDCPAForms/arc_CDCPA_Forms.htm as a condition of payment for services provided under the Model Contract;

c) Provider shall provide treatment to pregnant Covered Persons 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 Covered Person releases to share clinical information and Covered Person 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. (Model Contract 1.12.2.4.2)

e) Provider shall meet the following "Appointment Time" obligations (Model Contract 1.12.4.4):

Service Category	**Appointment Time**
Adult Mental Health Adult Substance Use Pediatric Mental Health Pediatric Substance Use	• Not to exceed 30 days from date of the Covered Person's request for routine appointment. • Within seven days of hospitalization. • Within 24 hours for Urgent Care.

f) If requested by the Covered Person 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. (Model Contract 1.12.4.4)

49. 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 Covered Persons. 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. (Model Contract 1.12.2.4.3)

Attachment A: Medicaid

SCHEDULE B
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 Covered Persons enrolled in or covered by this Product may be set forth in the Provider Manual or another Attachment. To the extent that a Coverage Agreement, or a Covered Person, 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 a Covered Person with such Coverage Agreement, or to such Covered Person, as applicable.

OK-1 Hold Harmless. In the event Payor fails to pay for Covered Services in accordance with the Agreement, a Covered Person 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 a Covered Person 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 ninety (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 ninety (90) days' advance written notice of such termination. Health Plan's rights to terminate the Agreement for cause upon less than ninety (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 Covered Persons confined on the date of insolvency in an inpatient facility, and for pregnant Covered Persons, until Covered Person's discharge from inpatient facilities, Covered Person'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 ninety (90) days from the date of notice for a Covered Person 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 Covered Persons 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 (6) 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, § 6993.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))

Attachment A: Medicaid

EXHIBIT 1
COMPENSATION SCHEDULE
FACILITY AND PROFESSIONAL SERVICES
RURAL HEALTH CLINIC

Mangum City Hospital Authority dba Mangum Regional Medical Center and Mangum Family Clinic

This compensation schedule ("Compensation Schedule") sets forth the maximum reimbursement amounts for Covered Services provided by Contracted Providers to Covered Persons enrolled in a Medicaid Product. Where the Contracted Provider's tax identification number ("TIN") has been designated by the Payor as subject to this Compensation Schedule, Payor shall pay or arrange for payment of a Clean Claim for Covered Services rendered by the Contracted Provider according to the terms of, and subject to the requirements set forth in, the Agreement and this Compensation Schedule. Payment under this Compensation Schedule shall consist of the Allowed Amount as set forth herein less all applicable Cost-Sharing Amounts. All capitalized terms used in this Compensation Schedule shall have the meanings set forth in the Agreement, the applicable Product Attachment, or the Definitions section set forth at the end of this Compensation Schedule.

Outpatient Services. The maximum compensation for facility and professional Covered Services rendered to a Covered Person shall be the "Allowed Amount." Except as otherwise provided in this Compensation Schedule, the Allowed Amount for facility and professional Covered Services is the lesser of: (i) Allowable Charges; or (ii) 100% of the Payor's Medicaid fee schedule. If Health Plan's payment obligation is secondary, Provider shall receive compensation as described above, less amounts paid by the primary payor and any applicable Cost-Sharing Amounts.

Health acknowledges the SoonerCare Reimbursement Notice, OHCA PRN 2019-09, updating RHC methodology effective July 1, 2019, RHCs have the option to be paid using an alternative payment methodology (APM) if the RHC elects. RHC services paid using the APM are reimbursed at the rate indicated on the facilities periodic rate notification letter from the Medicare Fiscal Intermediary. In order to receive this rate, a RHC must agree to the APM and forward a copy of the facilities' periodic rate notification letter for its most recent full cost reporting year from the fiscal intermediary to the Health Plan within 30 days of receipt. The APM rate a facility receives will not be less than prospective payment system (PPS). There is no retroactive cost settlement.

Health Plan agrees to comply with the updated RHC methodology and reimburse Provider according to the most current periodic rate notification letter for its most current cost reporting year received from CMS Fiscal Intermediary. Provider's failure to provide a copy of the rate notification letter within 30 days of receipt may result in a reduction in payments by Health Plan.

Outpatient Default. If there is no established payment amount on the Medicaid fee schedule for a Covered Service provided to a Covered Person, Payor may establish a payment amount to apply in determining the Allowed Amount. Until such time as Payor establishes such a payment amount, the maximum compensation shall be 50% of Allowable Charges.

Additional Provisions:

1. Code Change Updates. Payor utilizes nationally recognized coding structures (including, without limitation, revenue codes, CPT codes, HCPCS codes, ICD codes, national drug codes, ASA relative values, etc., or their successors) for basic coding and descriptions of the services rendered. Updates to billing-related codes shall become effective on the date ("Code Change Effective Date") that is the later of: (i) the first day of the month following sixty (60) days after publication by the governmental agency having authority over the applicable Product of such governmental agency's acceptance of such code updates, (ii) the effective date of such code updates as determined by such governmental agency or (iii) if a date is not established by such governmental agency or the applicable Product is not regulated by such governmental agency, the date that changes are made

to nationally recognized codes. Such updates may include changes to service groupings. Claims processed prior to the Code Change Effective Date shall not be reprocessed to reflect any such code updates.

2. Fee Change Updates. Updates to the fee schedule shall become effective on the effective date of such fee schedule updates, as determined by the Payor ("Fee Change Effective Date"). The date of implementation of any fee schedule updates, i.e. the date on which such fee change is first used for reimbursement ("Fee Change Implementation Date"), shall be the later of: (i) the first date on which Payor is reasonably able to implement the update in the claims payment system; or (ii) the Fee Change Effective Date. Claims processed prior to the Fee Change Implementation Date shall not be reprocessed to reflect any updates to such fee schedule, even if service was provided after the Fee Change Effective Date.

3. Encounter Updates. Updates to Contracted Provider-specific Encounter rates shall become effective ("Encounter Update Effective Date") as of the later of: (i) the first day of the month following thirty (30) days after Payor receives notification from Contracted Provider of such Encounter rate update as evidenced by the facilities' most current periodic rate modification letter from the Medicare Fiscal Intermediary; or (ii) the effective date of such code updates, as determined by the State. Claims processed prior to the Encounter Update Effective Date shall not be reprocessed to reflect any Encounter rate updates. Provider shall supply Health Plan their facilities' updated periodic rate modification letter within 30 days of receipt from CMS Fiscal Intermediary.

4. Primary Contact Billing. If Covered Person sees more than one health care professional during an encounter, the NPI billed on the CMS-1500 claim form, or its successor, should indicate the primary contact. The primary contact is defined as the health care professional who spends the greatest amount of time with the client during services.

5. Provider Type. Services must be provided by the appropriate provider type or specialty as defined in the Provider Manual. The Allowed Amount may be reduced based on the Contracted Provider's specialty, provider type, licensing/certifications or education as set forth in the Provider Manual.

6. Modifiers. Unless specifically indicated otherwise, fee amounts listed in the fee schedule represent global fees and may be subject to reductions based on appropriate Modifier (for example, professional and technical modifiers). As used in the previous sentence, "global fees" refers to services billed without a Modifier, for which the fee amount includes both the professional component and the technical component. Modifiers must be used as appropriate and be specific to primary contact, as applicable.

7. Claim Form - Professional. Contracted Provider when submitting outpatient or professional claims (billed on a CMS-1500 claim form, or its successor) spanning multiple dates of service: (i) is required to identify each date of service; and (ii) must contain modifiers as identified in the Provider Manual. Applicable modifiers should be placed in the first modifier field for claims payment.

8. Authorizations. Authorization requirements are as defined in this Agreement or in the Provider Manual. Service limits, unless specified in this Compensation Schedule, are as defined by the Provider Manual.

9. Level of Care. All reimbursement under this Compensation Schedule shall correspond to the level of care authorized by Payor.

10. Payment under this Compensation Schedule. Claims should be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative (CCI) Policy Manual, CCI table edits and other CMS guidelines). All payments under this Compensation Schedule are subject to the terms and conditions set forth in the Agreement, the Provider Manual, and any applicable billing manual and claims processing policies.

Definitions:

1. **Allowed Amount** means the amount designated in this Compensation Schedule as the maximum amount payable to a Contracted Provider for any particular Covered Service provided to any particular Covered Person, pursuant to this Agreement or its Attachments.

2. **Allowable Charges** means the Group's charges that qualify as Medically Necessary Covered Services and are eligible for reimbursement under the Plan.

3. **Cost-Sharing Amounts** means any amounts payable by a Covered Person, such as copayments, cost sharing, coinsurance, deductibles or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement, if applicable.

Attachment A: Medicaid

EXHIBIT 2
COMPENSATION SCHEDULE
PROFESSIONAL SERVICES

Mangum City Hospital Authority dba Mangum Regional Medical Center and Mangum Family Clinic

This compensation schedule ("Compensation Schedule") sets forth the maximum reimbursement amounts for Covered Services provided by Contracted Providers to Covered Persons enrolled in a Medicaid Product. Where the Contracted Provider's tax identification number ("TIN") has been designated by the Payor as subject to this Compensation Schedule, Payor shall pay or arrange for payment of a Clean Claim for Covered Services rendered by the Contracted Provider according to the terms of, and subject to the requirements set forth in, the Agreement and this Compensation Schedule. Payment under this Compensation Schedule shall consist of the Allowed Amount as set forth herein less all applicable Cost-Sharing Amounts. All capitalized terms used in this Compensation Schedule shall have the meanings set forth in the Agreement, the applicable Product Attachment, or the Definitions section set forth at the end of this Compensation Schedule.

The maximum compensation for professional Covered Services rendered to a Covered Person shall be the "Allowed Amount." Except as otherwise provided in this Compensation Schedule, the Allowed Amount for professional Covered Services is the lesser of: (i) Allowable Charges; or (ii) 100% of the Medicaid fee schedule.

Additional Provisions:

1. Code Change Updates. Payor utilizes nationally recognized coding structures (including, without limitation, revenue codes, CPT codes, HCPCS codes, ICD codes, national drug codes, ASA relative values, etc., or their successors) for basic coding and descriptions of the services rendered. Updates to billing-related codes shall become effective on the date ("Code Change Effective Date") that is the later of: (i) the first day of the month following sixty (60) days after publication by the governmental agency having authority over the applicable Product of such governmental agency's acceptance of such code updates, (ii) the effective date of such code updates as determined by such governmental agency or (iii) if a date is not established by such governmental agency or the applicable Product is not regulated by such governmental agency, the date that changes are made to nationally recognized codes. Such updates may include changes to service groupings. Claims processed prior to the Code Change Effective Date shall not be reprocessed to reflect any such code updates.

2. Fee Change Updates. Updates to the fee schedule shall become effective on the effective date of such fee schedule updates, as determined by the Payor ("Fee Change Effective Date"). The date of implementation of any fee schedule updates, i.e. the date on which such fee change is first used for reimbursement ("Fee Change Implementation Date"), shall be the later of: (i) the first date on which Payor is reasonably able to implement the update in the claims payment system; or (ii) the Fee Change Effective Date. Claims processed prior to the Fee Change Implementation Date shall not be reprocessed to reflect any updates to such fee schedule, even if service was provided after the Fee Change Effective Date.

3. Modifier. Unless specifically indicated otherwise, fee amounts listed in the fee schedule represent global fees and may be subject to reductions based on appropriate Modifier (for example, professional and technical modifiers). As used in the previous sentence, "global fees" refers to services billed without a Modifier, for which the fee amount includes both the professional component and the technical component. Any Cost-Sharing Amounts that the Covered Person is responsible to pay under the Coverage Agreement will be subtracted from the Allowed Amount in determining the amount to be paid.

4. Anesthesia Modifier Pricing Rules. The dollar amount that will be used in the calculation of time-based and non-time based anesthesia management fees in accordance with the anesthesia payment policy. Unless specifically

stated otherwise, the anesthesia conversion factor indicated is fixed and will not change. The anesthesia conversion factor is based on an anesthesia time unit value of 15 minutes.

5. Place of Service Pricing Rules. This fee schedule follows CMS guidelines for determining when services are priced at the facility or non-facility fee schedule (with the exception of services performed at Ambulatory Surgery Centers, POS 24, which will be priced at the facility fee schedule).

6. Payment under this Compensation Schedule. Claims should be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative (CCI) Policy Manual, CCI table edits and other CMS guidelines). All payments under this Compensation Schedule are subject to the terms and conditions set forth in the Agreement, the Provider Manual, and any applicable billing manual and claims processing policies.

Definitions:

1. **Allowed Amount** means the amount designated in this Compensation Schedule as the maximum amount payable to a Contracted Provider for any particular Covered Service provided to any particular Covered Person, pursuant to this Agreement or its Attachments.

2. **Allowable Charges** means a Contracted Provider's billed charges for services that qualify as Covered Services.

3. **Cost-Sharing Amounts** means any amounts payable by a Covered Person, such as copayments, cost-sharing, coinsurance, deductibles or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement, if applicable.

Attachment A: Medicaid

EXHIBIT 3
COMPENSATION SCHEDULE
CRITICAL ACCESS HOSPITAL SERVICES

Mangum City Hospital Authority dba Mangum Regional Medical Center and Mangum Family Clinic

This compensation schedule ("Compensation Schedule") sets forth the maximum reimbursement amounts for Covered Services provided by Contracted Providers to Covered Persons enrolled in a Medicaid Product. Where the Contracted Provider's tax identification number ("TIN") has been designated by the Payor as subject to this Compensation Schedule, Payor shall pay or arrange for payment of a Clean Claim for Covered Services rendered by the Contracted Provider according to the terms of, and subject to the requirements set forth in, the Agreement and this Compensation Schedule. Payment under this Compensation Schedule shall consist of the Allowed Amount as set forth herein less all applicable Cost-Sharing Amounts. All capitalized terms used in this Compensation Schedule shall have the meanings set forth in the Agreement, the applicable Product Attachment, or the Definitions section set forth at the end of this Compensation Schedule.

Inpatient Services. The maximum compensation for Covered Services rendered to a Covered Person during an inpatient stay shall be the "Allowed Amount" as set forth below. Except as otherwise provided in this Compensation Schedule, the Allowed Amount for inpatient Covered Services is the lesser of: (i) Allowable Charges; or (ii) 100% of the Medicaid fee schedule. Such payment shall be inclusive of all services rendered.

Outpatient Services. The maximum compensation for outpatient Covered Services is the "Allowed Amount" as set forth below. Except as otherwise provided in this Compensation Schedule, the Allowed Amount for outpatient Covered Services is the lesser of (i) Allowable Charges; or (ii) 100% of the Medicaid fee schedule. Such payment shall be inclusive of all services rendered.

Additional Provisions:

1. Cost-to-Charge Ratio. Payment for outpatient services as indicated above shall constitute the final payment from Payor to Contracted Provider. No reconciliation or settlement of the Contracted Provider's Cost-to-Charge Ratio shall occur at year-end.

2. Critical Access Hospital Status. In the event Contracted Provider no longer meets the current criteria set forth by CMS for being designated as a Critical Access Hospital ("CAH") or is no longer designated by CMS as a CAH, Contracted Provider shall immediately notify Payor in writing of the failure to meet criteria or loss of designation, and as a result, effective as of the date Contracted Provider ceases to hold such designation or such later date as specified by Payor in its sole discretion, the rates and payment methodology of the terms of this Compensation Schedule shall not apply to Covered Services rendered by Contracted Provider to Covered Persons. Upon notice to Payor of Contracted Provider's loss of CAH status, the Parties shall negotiate in good faith for a period of sixty (60) days for the purpose of agreeing upon non-CAH Contracted Provider rates.

3. Application of 72-Hour Rule. Payments made to any Contracted Provider for inpatient Covered Services shall constitute payment for all such Contracted Provider's charges relating to a Covered Person's pre-admission testing and procedures occurring within seventy-two (72) hours prior to an admission, including, but not limited to, charges for laboratory services, pathology services, radiology services, and medical/surgical supplies. If the admitting hospital is a CAH, the payment window policy does not apply. However, if the admitting hospital is a short stay acute hospital paid under the inpatient prospective payment system (IPPS) and the wholly owned or wholly operated outpatient entity is a CAH, the outpatient CAH services are subject to the payment window. The CAH services are also subject to the payment window if the admitting hospital is a psychiatric hospital, inpatient rehabilitation hospital, long-term care hospital, children's hospital, or cancer hospital.

4. Admissions for Same or Related Diagnoses. Inpatient admissions for the same or a related diagnoses occurring within thirty (30) days following a discharge in connection with a previous admission shall be considered part of the previous admission and are not separately reimbursable.

5. Hospital-Acquired Conditions and Provider Preventable Conditions. Payment to a Contracted Provider under this Compensation Schedule shall comply with state and federal laws requiring reduction of payment or non-payment to a Contracted Provider for "Hospital-Acquired Conditions" and for "Provider Preventable Conditions" as such terms (or the reasonable equivalents thereof) are defined under applicable state and federal laws.

6. Never Events. Each Contracted Provider shall use best efforts to comply with applicable state and federal reporting or other requirements relating to Never Events and/or Serious Adverse Events, as the applicable term is defined by the National Quality Forum or by state or federal law. Contracted Providers shall not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Payor, Company or Covered Person for any charges associated with Never Events and/or Serious Adverse Events. To the extent a Contracted Provider receives any payment in connection with a Never Event or Serious Adverse Event, the Contracted Provider shall promptly refund such amount.

7. Provider-Based Billing. Provider-Based Billing (as defined herein) will not be reimbursed under this Compensation Schedule as they are included as part of the compensation for professional fees under this Agreement. Neither the Payor nor Covered Person shall be responsible for such Provider-Based Billing. "Provider-Based Billing" are amounts charged by a clinic or facility as a technical component, or for overhead, in connection with professional services rendered in a clinic or facility, and include but are not limited services billed using Revenue Codes 0510-0519.

8. Code Change Updates. Payor utilizes nationally recognized coding structures (including, without limitation, revenue codes, CPT codes, HCPCS codes, ICD codes, national drug codes, ASA relative values, etc., or their successors) for basic coding and descriptions of the services rendered. Updates to billing-related codes shall become effective on the date ("Code Change Effective Date") that is the later of: (i) the first day of the month following sixty (60) days after publication by the governmental agency having authority over the applicable Product of such governmental agency's acceptance of such code updates, (ii) the effective date of such code updates as determined by such governmental agency or (iii) if a date is not established by such governmental agency or the applicable Product is not regulated by such governmental agency, the date that changes are made to nationally recognized codes. Such updates may include changes to service groupings. Claims processed prior to the Code Change Effective Date shall not be reprocessed to reflect any such code updates.

9. Fee Change Updates. Updates to the fee schedule shall become effective on the effective date of such fee schedule updates, as determined by the Payor ("Fee Change Effective Date"). The date of implementation of any fee schedule updates, i.e. the date on which such fee change is first used for reimbursement ("Fee Change Implementation Date"), shall be the later of: (i) the first date on which Payor is reasonably able to implement the update in the claims payment system; or (ii) the Fee Change Effective Date. Claims processed prior to the Fee Change Implementation Date shall not be reprocessed to reflect any updates to such fee schedule, even if service was provided after the Fee Change Effective Date.

10. Encounter Payment. Encounter is defined as the same treatment for the same diagnosis in the same treatment setting without being discharged, released, or transferred within the same 48 hour period.

11. Payment under this Compensation Schedule. Claims should be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative (CCI) Policy Manual, CCI table edits and other CMS guidelines). All payments under this Compensation Schedule are subject to the terms and conditions set forth in the Agreement, the Provider Manual, and any applicable billing manual and claims processing policies.

Definitions:

1. **Allowed Amounts** means the amount designated in this Compensation Schedule as the maximum amount payable to a Contracted Provider for any particular Covered Service provided to any particular Covered Person, pursuant to this Agreement or its Attachments.

2. **Allowable Charges** means a Contracted Provider's billed charges for services that qualify as Covered Services.

3. **Cost-Sharing Amounts** means any amounts payable by a Covered Person, such as copayments, cost-sharing, coinsurance, deductibles or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement, if applicable

4. **Cost-to-Charge Ratio** or **CCR** means the Contracted Provider-specific cost-to-charge ratios as defined by CMS that are applied to the Allowed Amount.

5. **Per Diem** means a pricing method (i) that, for an inpatient stay, is based on each "Inpatient Day" of an inpatient stay and includes all Covered Services provided to a Covered Person during the inpatient stay, and (ii) that, for outpatient or intermediate services, includes all Covered Services provided to a Covered Person for one calendar day of service. For purposes hereof, an "Inpatient Day" means a calendar day when a Covered Person receives Covered Services as a registered bed patient; to qualify as an Inpatient Day, the Covered Person must be present at the midnight census.

Attachment B: Medicare

MEDICARE PRODUCT ATTACHMENT
(INCLUDING REGULATORY REQUIREMENTS AND COMPENSATION SCHEDULE)

THIS PRODUCT ATTACHMENT (this "***Product Attachment***") is made and entered into as of the Effective Date of the Agreement by and between Oklahoma Complete Health, Inc. ("***Health Plan***") and Mangum City Hospital Authority dba Mangum Regional Medical Center and Mangum Family Clinic ("***Provider***").

WHEREAS, Health Plan and Provider entered into that certain provider agreement, including all Attachments, 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; and

WHEREAS, pursuant to the provisions of the Agreement, this Attachment is identified on Schedule B of the Agreement and, as such, the Contracted Providers will be designated and participate as "Participating Providers" in the Product described in this Attachment; and

WHEREAS, the Agreement is modified or supplemented as hereafter provided.

NOW THEREFORE, in consideration of the recitals, the mutual promises herein stated, the parties hereby agree to the provisions set forth below.

1. Defined Terms. All capitalized terms not specifically defined in this Attachment will have the meanings given to such terms in the Agreement.

2. Product Participation.

2.1 Medicare Product. This Attachment addresses the participation of Provider and the applicable Contracted Providers in the following Product: Medicare Product (which is sometimes referred to in this Attachment as this *"**Product**"*). The term "***Medicare Product***" refers to those programs and health benefit arrangements offered by Health Plan or another Company in connection with one or more of the following Medicare product types that is administered, sponsored or regulated by the federal government (or any agency, department or division thereof) on its own or jointly with a State that administers or regulates such program or plan (each a "Medicare Product Type"): a non-Dual Eligible Special Needs Plan Medicare Advantage plan ("***MA Plan***"); a Medicare Advantage prescription drug plan ("***MA-PD Plan***"); a Dual Eligible Special Needs Plan ("***DSNP Plan***"); a Capitated Financial Alignment Demonstration ("***MMP Plan***") plan or program (e.g., a plan or program adopted or established under the Affordable Care Act of 2010, to test new service delivery and payment models for people dually eligible for Medicare and Medicaid, including any regulations or CMS pronouncements and any future Attachments); or other Medicare Product Types. The Medicare Product includes those Coverage Agreements entered into, issued or agreed to by a Payor under which a Company furnishes administrative services or other services in support of a Medicare Product. The Medicare Product does not apply to any Coverage Agreements that are specifically covered by another Product Attachment to the Agreement. This Attachment applies only to the provision of health care services, supplies or accommodations (including Covered Services) to Covered Persons enrolled in the Medicare Product. Provider acknowledges that it will participate in each Medicare Product Type for which a Compensation Schedule(s) is attached to this Medicare Product Attachment.

2.2 Participation. Except as otherwise specified in this Attachment, all Contracted Providers under the Agreement will participate in the Medicare Product as "Participating Providers," and will provide to Covered Persons enrolled in the Medicare Product, upon the same terms and conditions contained in the Agreement, as supplemented or modified by this Attachment, those Covered Services that are provided by Contracted Providers pursuant to the Agreement. In providing such services, Provider shall, and shall cause Contracted Providers to, comply with and abide by the provisions of this Attachment and the Agreement (including the Provider Manual).

Provider acknowledges that all or certain of Health Plan's duties with respect to the Medicare Product may be delegated to a Company, a Payor or their delegates. Neither Health Plan, Company nor any Payor warrants or guarantees that any Contracted Provider: (i) will participate in all or a minimum number of provider panels and/or Medicare Product Types, (ii) will be utilized by a minimum number of Covered Persons, or (iii) will indefinitely remain a Participating Provider or member of the provider panel for a particular network or Medicare Product Type.

2.3 Attachment. This Attachment constitutes the Product Attachment and Compensation Schedule(s) for the Medicare Product.

2.4 Construction. Except as expressly provided herein, the terms and conditions of the Agreement will remain unchanged and in full force and effect. In the event of a conflict between the provisions of the Agreement and the provisions of this Attachment, this Attachment will govern with respect to health care services, supplies or accommodations (including Covered Services) rendered to Covered Persons enrolled in the Medicare Product. To the extent Provider or any Contracted Provider is unclear about its, his or her respective duties and obligations, Provider or the applicable Contracted Provider shall request clarification from the Company.

3. Term. This Attachment will become effective as of the Effective Date, and will be coterminous with the Agreement unless a party or a Contracted Provider terminates the participation of the Contracted Provider in the Medicare Product in accordance with the applicable provisions of the Agreement or this Attachment.

4. CMS Regulatory Requirements. Schedule A to this Attachment, which is incorporated herein by this reference, sets forth the special provisions that are applicable to the Medicare Product under a Governmental Contract.

5. Compensation Schedule. This Section sets forth or describes the Compensation Schedule(s) applicable to the various Medicare Product Types.

5.1 Schedule. The Compensation Schedule for the Medicare Product at any given time is the lesser of (i) the Allowable Charges for the particular Covered Service, or (ii) the appropriate amount for such Covered Service under the Company's fee schedule in effect on the date of service for the Medicare Product. Upon Provider's reasonable written request from time to time the Company will provide Provider with a representative sample of the fees then in effect under the Company's fee schedule applicable to the Medicare Product.

5.2 Other Terms and Conditions. Except as modified or supplemented by this Attachment, the compensation hereunder for the provision of Covered Services by Contracted Providers to Covered Persons enrolled in the Medicare Product is subject to all of the other provisions in the Agreement (including the Provider Manual) that affect or relate to compensation for Covered Services provided to Covered Persons.

Attachment B: Medicare

SCHEDULE A
CMS REGULATORY REQUIREMENTS

This Schedule sets forth required provisions that are applicable to all Medicare Product Types under this Medicare Product Attachment.

1. **DEFINITIONS**. The following terms shall be defined as set forth below as used in this Medicare Product Attachment. Capitalized terms not otherwise defined in this Schedule shall be defined as set forth in the Agreement or elsewhere in the Medicare Product Attachment.

1.1 ***Capitated Financial Alignment Demonstration Program*** means the program, created by Congress in the Affordable Care Act of 2010, to test new service delivery and payment models for people dually eligible for Medicare and Medicaid, including any regulations or CMS pronouncements and any future Attachments.

1.2 ***Clean Claim*** means a claim that has no defect, impropriety, lack of any required substantiating documentation – including the substantiating documentation needed to meet the requirements for encounter data – or particular circumstance requiring special treatment that prevents timely payment; and a claim that otherwise conforms to the Clean Claim requirements under original Medicare.

1.3 ***CMS*** means Centers for Medicare and Medicaid Services.

1.4 ***CMS Contract*** means the contract between Health Plan or a Payor and CMS, or among Health Plan or a Payor, CMS and the State, that governs the terms of Health Plan's or Payor's participation in a Medicare Plan.

1.5 ***Completion of Audit*** means completion of audit by HHS, the Government Accountability Office, or their designees of a Medicare Advantage Organization, First Tier, Downstream or Related Entity.

1.6 ***Covered Persons*** means those individuals who are enrolled in a Medicare Plan.

1.7 ***Covered Services*** means those services which are covered under a Medicare Plan.

1.8 ***Downstream Entity*** means any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit, below the level of the arrangement between Health Plan and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

1.9 ***First Tier Entity*** means any party that enters into a written arrangement, acceptable to CMS, with Health Plan to provide administrative services or health care services for a Medicare eligible individual under a Medicare Plan.

1.10 ***HHS*** means the United States Department of Health and Human Services.

1.11 ***Medicare Advantage Program*** means the program created by Congress in the Medicare Modernization Act of 2003 to replace the Medicare+Choice Program established under Part C of Title XVIII of the Social Security Act, including any regulations or CMS pronouncements and any future Attachments.

1.12 ***Preclusion List*** means the CMS-compiled list of individuals and entities that -

a. Meet all of the following requirements: (i) The individual or entity is currently revoked from Medicare under 42 § 424.535. (ii) The individual or entity is currently under a reenrollment bar under 42 § 424.535(c). (iii) CMS determines that the underlying conduct that led to the revocation is detrimental to the best interests of the

Medicare program. In making this determination under (iii), CMS considers the following factors: (A) The seriousness of the conduct underlying the individual's or entity's revocation. (B) The degree to which the individual's or entity's conduct could affect the integrity of the Medicare program. (C) Any other evidence that CMS deems relevant to its determination; or

b. Meet both of the following requirements: (i) The individual or entity has engaged in behavior for which CMS could have revoked the individual or entity to the extent applicable had they been enrolled in Medicare. (ii) CMS determines that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare program. In making this determination under (ii), CMS considers the following factors: (A) The seriousness of the conduct involved. (B) The degree to which the individual's or entity's conduct could affect the integrity of the Medicare program; and (C) Any other evidence that CMS deems relevant to its determination. *42 C.F.R. § 422.2*

1.13 ***Related Entity*** means any entity that is related to Health Plan by common ownership or control and (1) performs some of Health Plan's management functions under contract or delegation; (2) furnishes services to Covered Persons under an oral or written agreement; or (3) leases real property or sells materials to Health Plan at a cost of more than $2,500 during a contract period.

1.14 ***State*** means one or more applicable state governmental agencies of the State of Oklahoma, unless otherwise defined in an Attachment for the purposes of that Attachment.

2. **COVERED SERVICES**. Provider shall furnish Covered Services to Covered Persons as set forth in the Agreement and this Medicare Product Attachment.

3. **SUBCONTRACTOR OBLIGATIONS**. To the extent that Provider engages any other person (excluding an employee) or entity to perform services in connection with a Medicare Product, including any Downstream or Related Entity, Provider agrees that such engagement shall be set forth in a written agreement that requires such other person or entity to assume the same obligations that Provider assumes under this Medicare Product Attachment.

4. **GOVERNMENT RIGHT TO INSPECT**.

4.1 Provider agrees that HHS, the Comptroller General or their designees have the right to audit evaluate, collect and inspect any books, contracts, computer or other electronic systems, including medical records and documentation of Provider relating to the CMS Contract through ten (10) years from the termination date of this Medicare Product Attachment or from the date of Completion of Audit, whichever is later. *42 C.F.R. §§ 422.504 (i)(2)(i) and (ii), 423.505(i)(2)(i) and (iv).*

4.2 Provider agrees that HHS, the Comptroller General, or their designees have the right to audit, evaluate, collect, and inspect any records under Section 4.1 of this Medicare Product Attachment directly from Provider or any other First Tier, Downstream or Related Entity. For records subject to review under this Section 4.2, except in exceptional circumstances, CMS will provide notification to Health Plan that a direct request for information has been initiated. *42 C.F.R. §§ 422.504(i)(2)(ii) and (iii), 423.505(i)(2)(ii) and (iii).*

5. **PRIVACY, CONFIDENTIALITY AND ACCURACY OF ENROLLEE RECORDS**. Provider shall comply with all privacy, confidentiality and accuracy requirements with respect to Covered Person record accuracy requirements, including: (1) abiding by all federal and State laws regarding the confidentiality and disclosure of medical records or other health and enrollment information; (2) safeguarding the privacy of any information that identifies a particular Covered Person and, as applicable, having procedures that specify (i) for what purposes the information is used within the organization; and (ii) to whom and for what purposes it discloses the information outside the organization; (3) ensuring that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoena; (4) maintaining the records and information in an accurate and timely manner; and (5) ensuring timely access by Covered Persons to the records and information that pertains to them. *42 C.F.R. §§422.504(a)(13). 422.118 and 423.136*

6. **HOLD HARMLESS**.

6.1 Provider hereby agrees that Covered Persons shall not be held liable for payment of any fees that are the legal obligation of Payor. *42 C.F.R. §§422.504(i)(3)(i), 422.504(g)(1)(i), 423.505(i)(3)(i) and 423.505(g)(1)(i).*

6.2 With respect to MA Plans and MA-PD Plans, Provider hereby acknowledges and agrees that for Covered Persons eligible for both Medicare and Medicaid, such Covered Persons shall not be held liable for Medicare Part A and Part B cost-sharing when the State is responsible for paying such amounts. With respect to Medicare-Medicaid Plans, Provider hereby acknowledges and agrees that Covered Persons eligible for both Medicare and Medicaid shall not be held liable for Medicare Part A and Part B cost-sharing; in addition, Medicare Parts A and B services must be provided at zero cost-sharing as part of the integrated package of benefits. *42 C.F.R. §§422.504(g)(1)(iii); March 29, 2012 CMS Issued Guidance*

With respect to all Medicare Plans, Provider will be informed of Medicare and Medicaid benefits and rules for Covered Persons eligible for Medicare and Medicaid. If Provider contracts with Contracted Providers to provide Covered Services to Covered Persons, Provider will inform Contracted Providers of Medicare and Medicaid benefits and rules for Covered Persons eligible for Medicare and Medicaid. Provider may not impose, and must prohibit any Downstream Entities from imposing, cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the Covered Person under title XIX if such Covered Person were not enrolled with Health Plan or Payor. Provider shall accept payment from Payor as payment in full, or bill the appropriate State source. *42 C.F.R. §§422.504(i)(3)(i) and 422.504(g)(1)(iii)*

7. **COMPLIANCE WITH CMS CONTRACT**. Provider shall perform its obligations under this Medicare Product Attachment in a manner consistent with and in compliance with Health Plan's and Payor's contractual obligations under the CMS Contract. *42 C.F.R. §§422.504(i)(3)(iii), 423.505(i)(3)(iii).*

8. **PROMPT PAYMENT**. Payor shall pay, or arrange to pay, Provider for Covered Services rendered to Covered Persons in accordance with Compensation Schedule Exhibit(s) to this Medicare Product Attachment. Any Clean Claim shall be paid within 30 days of receipt by Health Plan, Payor or (if Provider contracts with Downstream Entities) Provider, as applicable, as designated by Provider or such Downstream Entity, as applicable. *42 C.F.R. §422.520(b)(1) and (2)*

9. **EFFECT OF PRECLUSION LIST**. Provider acknowledges and agrees that Payor may not pay, directly or indirectly, on any basis, for items or services furnished to a Covered Person by any individual or entity that is excluded by the HHS Office of the Inspector General or is included on the Preclusion List. Provider acknowledges and agrees that, after the expiration of the 60-day period specified in 42 C.F.R. § 422.222: (i) Provider will no longer be eligible for payment from Payor and will be prohibited from pursuing payment from the Covered Person as stipulated by the terms of the contract between CMS and the Payor per 42 C.F.R. § 422.504(g)(1)(iv); and (ii) Provider will hold financial liability for services, items, and drugs that are furnished, ordered, or prescribed after this 60-day period, at which point Provider will have already received notification of the preclusion. *42 C.F.R. §§422.224; 422.504(g)(1)(v)*

10. **COMPLIANCE WITH FEDERAL AND STATE LAWS**. Health Plan, Provider, Payor, and any Downstream or Related Entity shall comply with all applicable laws including Medicare laws, regulations and CMS and/or State instructions. *42 C.F.R. §§422.504(i)(4)(v), 423.505(i)(4)(iv)*

11. **DELEGATION OF DUTIES**. In the event that Health Plan delegates to Provider any function or responsibility imposed pursuant to the CMS Contract, such delegation shall be subject to the applicable requirements set forth in 42 C.F.R. §§ 422.504(i)(4) and 423.505(i), as they may be amended over time. Any delegation by Provider of functions or responsibilities imposed pursuant to this Medicare Product Attachment shall be subject to the prior written approval of Health Plan or Payor and shall also be subject to the requirements set forth in 42 C.F.R. §§ 422.504(i)(4) and (5) and 423.505(i), as they may be amended over time.

11.1 Provider's delegated activities and reporting responsibilities, if any, are specified in the Agreement or applicable attachment to the Agreement (e.g., Delegated Credentialing Agreement, Delegated Services Agreement, Statement of Work, or other scope of services attachment). If such attachment is not executed, no administrative functions shall be deemed as delegated.

11.2 CMS, Health Plan and Payor reserve the right to revoke the delegation activities and reporting requirements or to specify other remedies in instances where CMS, Health Plan or Payor determine that such parties have not performed satisfactorily.

11.3 Health Plan or Payor will monitor the performance of the parties on an ongoing basis.

11.4 As specified in the attached Delegated Credentialing Agreement or Delegated Services Agreement to this Agreement, the credentials of medical professionals affiliated with Provider will be either reviewed by Health Plan, or the credentialing process will be reviewed and approved by Health Plan and Health Plan must audit the credentialing process on an ongoing basis.

11.5 If Health Plan or Payor delegates the selection of providers, contractors, or subcontractors, Health Plan or Payor retains the right to approve, suspend, or terminate any such arrangement. *42 C.F.R. §§ 422.504(i)(4) and (5), and 423.505(i).*

12. **NON-DISCRIMINATION BASED ON HEALTH OR OTHER STATUS**. Provider shall not deny, limit, or condition coverage or the furnishing of health care services or benefits to Covered Persons based on any factor related to health status, including, but not limited to, medical condition (including mental as well as physical illness), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), race, ethnicity, national origin, religion, sex, age, sexual orientation, source of payment and mental or physical disability. *42 C.F.R. §422.110(a)*

13. **SERVICE AVAILABILITY**. Provider shall ensure that its hours of operation are convenient to Covered Persons and do not discriminate against Covered Persons; and that Covered Services are available twenty-four (24) hours a day, seven (7) days a week, when medically necessary. *42 C.F.R. §422.112(a)(7).*

14. **CULTURAL COMPETENCE**. Provider must provide all services in a culturally competent manner to all Covered Persons, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds. *42 C.F.R. §422.112(a)(8).*

15. **FOLLOW-UP CARE**. Provider shall ensure that Covered Persons are informed of specific health care needs that require follow-up and receive, as appropriate, training in self-care and other measures they may take to promote their own health. *42 C.F.R. §422.112(b)(5).*

16. **ADVANCE DIRECTIVES**. Provider shall comply with Health Plan's and Payor's policies and procedures concerning advance directives. *42 C.F.R. §422.128(b)(1)(ii)(E).*

17. **PROFESSIONALLY RECOGNIZED STANDARDS OF CARE**. Provider agrees to provide Covered Services under the Agreement to Medicare beneficiaries in a manner consistent with professionally recognized standards of health care. *42 C.F.R. §422.504(a)(3)(iii).*

18. **CONTINUATION OF BENEFITS**. Provider shall provide Covered Services as provided in the Agreement and this Medicare Product Attachment: (a) for all Covered Persons, for the duration of the contract period for which CMS payments have been made; and (b) for Covered Persons who are hospitalized on the date the CMS Contract terminates, or, in the event of an insolvency, through discharge. This continuation of benefits provision shall survive termination of this Medicare Product Attachment. *42 C.F.R. §§422.504(g)(2)(i); 422.504(g)(2)(ii); 422.504(g)(3)*

19. **PHYSICIAN INCENTIVE ARRANGEMENTS**. If Provider is a physician or physician group, neither Payor nor Health Plan shall make any specific payment, directly or indirectly, to Provider as an inducement to reduce or limit medically necessary services furnished to any particular Covered Person. Indirect payments may include offerings of monetary value (such as stock options or waivers of debt) measured in the present or future. Provider agrees that, if Health Plan or Payor has a physician incentive plan that places Provider at substantial financial risk (as determined under 42 C.F.R § 422.208(d)) for services that Provider does not furnish itself, Provider shall obtain and maintain either aggregate or per-patient stop-loss protection in accordance with the requirements at 42 C.F.R. § 422.208(f). *42 C.F.R. §422.208.*

20. **INFORMATION DISCLOSURES TO CMS**. Provider shall cooperate with Health Plan and Payor in providing any information to CMS deemed necessary by CMS for the administration or evaluation of the Medicare program. *42 C.F.R. §422.504(f)(2).*

21. **NOTICE OF PROVIDER TERMINATIONS**. Health Plan shall make a good faith effort to provide written notice of a termination of a contracted provider at least 30 calendar days before the termination effective date to all Covered Persons who are patients seen on a regular basis by the provider whose contract is terminating, irrespective of whether the termination was for cause or without cause. If Provider is a primary care professional, all Covered Persons who are patients of that primary care professional must be notified. *42 C.F.R. §422.111(e).*

22. **RISK ADJUSTMENT DATA**. Provider shall provide to Health Plan risk adjustment data as required by CMS. *42 C.F.R. §§ 422.310(d)(3), (4)*. Upon Health Plan's or CMS's request, Provider shall submit a sample of medical records for the validation of risk adjustment data, as required by CMS. Provider acknowledges that penalties may apply for submission of false data. Provider certifies based on best knowledge, information and belief that the data it submits under 42 C.F.R. § 422.310 are accurate, complete and truthful. *42 C.F.R. §§ 422.310(e) and 422.504(l)(3).*

23. **COMPLIANCE WITH HEALTH PLAN POLICIES AND PROCEDURES**. Provider shall comply with Health Plan's and Payor's policies and procedures. In addition, if Provider is a physician or physician group, Provider shall, or shall require the physician members of the group to, upon Health Plan's request, consult with Health Plan regarding Health Plan's medical policy, quality improvement programs and medical management procedures and ensure that the following standards are met: (a) practice guidelines and utilization management guidelines (i) are based on reasonable medical evidence or a consensus of health care professionals in the particular field; (ii) consider the needs of the enrolled population; (iii) are developed in consultation with contracting physicians; and (iv) are reviewed and updated periodically; (b) the guidelines are communicated to providers and, as appropriate, to Covered Persons; and (c) decisions with respect to utilization management, Covered Person education, coverage of services, and other areas in which the guidelines apply are consistent with the guidelines. *42 C.F.R. §422.202(b)*. Provider shall comply with Health Plan's quality assurance and performance improvement programs. *42 C.F.R.§422.504(a)(5).*

24. **WRITTEN NOTICE FOR REASON FOR SUSPENSION AND TERMINATION**. In the event Health Plan suspends or terminates this Medicare Product Attachment with respect to Provider or any physicians employed or contracted with Provider, Health Plan shall give Provider or such physician written notice of the following: (a) the reasons for the action, including, if relevant, the standards and profiling data used to evaluate the affected physician, and the numbers and mix of physicians needed by Health Plan, and (b) the affected physician's right to appeal the action and the process and timing for requesting a hearing. *42 C.F.R. §422.202(d)(1)*

25. **NOTICE OF WITHOUT CAUSE TERMINATION**. Health Plan and Provider must provide a minimum of sixty (60) days written notice, or such longer period specified in this Agreement, to each other before terminating this Medicare Product Attachment without cause. *42 C.F.R. §422.202(d)(4)*.

26. **COMPLIANCE WITH FEDERAL LAWS AND REGULATIONS**. Health Plan and Provider agree to comply with (a) federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of federal criminal law, the False Claims Act (31 U.S.C. 3729 et. seq.), and

the anti-kickback statute (section 1128B(b)) of the Act); and (b) HIPAA administrative simplification rules at 45 CFR parts 160, 162, and 164. *42 C.F.R. §422.504(h)(1).*

27. **FEDERAL FUNDS**. Provider acknowledges that payments Provider receives from Health Plan or Payor to pursuant to this Medicare Product Attachment are, in whole or part, from Federal funds. Therefore, Provider and any of its Downstream or Related Entities are subject to certain laws that are applicable to individuals and entities receiving Federal funds, which may include but is not limited to, Title VI of the Civil Rights Act of 1964 as implemented by 45 C.F.R. Part 84; the Age Discrimination Act of 1975 as implemented by 45 C.F.R. Part 91; the Americans with Disabilities Act; the Rehabilitation Act of 1973 and any other regulations applicable to recipients of Federal Funds. *Medicare Managed Care Manual, Ch. 11 § 120.*

28. **EXCLUDED PERSONS/PROGRAM INTEGRITY**. Provider warrants to Health Plan and each Payor that it is not excluded and shall not employ or contract for the provision of health care, utilization review, medical social work, or any administrative services pursuant to this Agreement with any individual or entity (hereafter, "person") whom Provider knows or reasonably should have known is excluded from participation in the Medicare and Medicaid program under Section 1128 or 1128A of the Social Security Act. Provider hereby certifies that no such excluded person currently is employed by or under contract with Provider. Provider shall review the Office of Inspector List of Excluded Individuals and Entities and the System for Award Management exclusion list and verify on a monthly basis or as often as required by CMS guidelines, that the persons it employs or contracts for the provision of such services pursuant to this Agreement are in good standing. Provider shall promptly disclose to Health Plan and Payor any exclusion, or other event that makes a Provider employee or Downstream or Related Entity ineligible to perform work related to Medicare or Medicaid. *42 C.F.R. § 422.752(a)(8)*. Provider shall promptly notify Health Plan and Payor in writing in the event that Provider is criminally convicted or has a civil judgment entered against Provider for fraudulent activities or is sanctioned under any Federal program involving the provision of health care or prescription drug services. Provider agrees to be bound by the provisions set forth at 2 C.F.R. Part 376.

29. **COMPLIANCE WITH GRIEVANCE AND APPEALS REQUIREMENTS**. Provider shall cooperate and comply with all applicable State, federal Health Plan and Payor requirements regarding Covered Persons grievances and appeals, as well as enrollment and disenrollment determinations, including the obligation to provide information (including medical records and other pertinent information) to Health Plan and Payor within the time frame required by regulation or, if not so required, reasonably requested for such purpose.

30. **OFFSHORE SUBCONTRACTORS**. In addition to the applicable requirements of Section 11 of this Medicare Product Attachment, Provider shall disclose to Health Plan in writing, 30 days prior to signing an offshore contract, all offshore contractor information and an attestation for each such offshore contractor, in a format required or permitted by CMS. *CMS Health Plan Management System Memos 7/23/2007, 9/20/2007, and 8/26/2008.*

31. **SCOPE AND CONFLICTS**. Nothing in this Medicare Product Attachment shall be held to vary, alter, waive or extend any of the terms, conditions, agreements or limitations of the Agreement, including the Provider Manual, except as stated in this Medicare Product Attachment. In the event of any conflict between this Medicare Product Attachment and any provision of the Agreement, the provisions of this Medicare Product Attachment shall govern. In the event that any provision of this Medicare Product Attachment conflicts with the provisions of any statute or regulation applicable to Health Plan, the provisions of the statute or regulation shall have full force and effect unless such statute or regulation is preempted by federal law.

32. **TERMINATION**. This Medicare Product Attachment shall terminate upon the termination of the Agreement and under the same terms and conditions specified in the Agreement. This Medicare Product Attachment may be further terminated by Health Plan immediately upon written notice to Provider if a CMS Contract is terminated, or if Provider is listed on the GSA List or SAM as excluded or is otherwise suspended or excluded from participation in Medicare or Medicaid or is listed on the Preclusion List.

Attachment B: Medicare

EXHIBIT 1
COMPENSATION SCHEDULE
MA PLAN/MA-PD PLAN/DSNP PLAN
FACILITY AND PROFESSIONAL SERVICES
RURAL HEALTH CLINIC

Mangum City Hospital Authority dba Mangum Regional Medical Center and Mangum Family Clinic

This compensation schedule ("Compensation Schedule") sets forth the maximum reimbursement amounts for Covered Services provided by Contracted Providers to Covered Persons enrolled in a Medicare Product. Where the Contracted Provider's tax identification number ("TIN") has been designated by the Payor as subject to this Compensation Schedule, Payor shall pay or arrange for payment of a Clean Claim for Covered Services rendered by the Contracted Provider according to the terms of, and subject to the requirements set forth in, the Agreement and this Compensation Schedule. Payment under this Compensation Schedule shall consist of the Allowed Amount as set forth herein less all applicable Cost-Sharing Amounts. All capitalized terms used in this Compensation Schedule shall have the meanings set forth in the Agreement, the applicable Product Attachment, or the Definitions section set forth at the end of this Compensation Schedule.

Outpatient Services. The maximum compensation for facility and professional Covered Services rendered to a Covered Person shall be the "Allowed Amount." Except as otherwise provided in this Compensation Schedule, the Allowed Amount for facility and professional Covered Services is 100% of the Medicare encounter rate in effect on the date of service. If Health Plan's payment obligation is secondary, Provider shall receive compensation as described above, less amounts paid by the primary payor and any applicable Cost-Sharing Amounts.

Additional Provisions:

1. Code Change Updates. Payor utilizes nationally recognized coding structures (including, without limitation, revenue codes, CPT codes, HCPCS codes, ICD codes, national drug codes, ASA relative values, etc., or their successors) for basic coding and descriptions of the services rendered. Updates to billing-related codes shall become effective on the date ("Code Change Effective Date") that is the later of: (i) the first day of the month following sixty (60) days after publication by the governmental agency having authority over the applicable Product of such governmental agency's acceptance of such code updates, (ii) the effective date of such code updates as determined by such governmental agency or (iii) if a date is not established by such governmental agency or the applicable Product is not regulated by such governmental agency, the date that changes are made to nationally recognized codes. Such updates may include changes to service groupings. Claims processed prior to the Code Change Effective Date shall not be reprocessed to reflect any such code updates.

2. Fee Change Updates. Updates to the fee schedule shall become effective on the effective date of such fee schedule updates, as determined by the Payor ("Fee Change Effective Date"). The date of implementation of any fee schedule updates, i.e. the date on which such fee change is first used for reimbursement ("Fee Change Implementation Date"), shall be the later of: (i) the first date on which Payor is reasonably able to implement the update in the claims payment system; or (ii) the Fee Change Effective Date. Claims processed prior to the Fee Change Implementation Date shall not be reprocessed to reflect any updates to such fee schedule, even if service was provided after the Fee Change Effective Date.

3. Primary Contact Billing. If Covered Person sees more than one health care professional during an encounter, the NPI billed on the CMS-1500 claim form, or its successor, should indicate the primary contact. The primary contact is defined as the health care professional who spends the greatest amount of time with the client during services.

4. Provider Type. Services must be provided by the appropriate provider type or specialty as defined in the Provider Manual. The Allowed Amount may be reduced based on the Contracted Provider's specialty, provider type, licensing/certifications or education as set forth in the Provider Manual.

5. Modifiers. Unless specifically indicated otherwise, fee amounts listed in the fee schedule represent global fees and may be subject to reductions based on appropriate Modifier (for example, professional and technical modifiers). As used in the previous sentence, "global fees" refers to services billed without a Modifier, for which the fee amount includes both the professional component and the technical component. Modifiers must be used as appropriate and be specific to primary contact, as applicable.

6. Authorizations. Authorization requirements are as defined in this Agreement or in the Provider Manual. Service limits, unless specified in this Compensation Schedule, are as defined by the Provider Manual.

7. Level of Care. All reimbursement under this Compensation Schedule shall correspond to the level of care authorized by Payor.

8. Payment under this Compensation Schedule. Claims should be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative (CCI) Policy Manual, CCI table edits and other CMS guidelines). All payments under this Compensation Schedule are subject to the terms and conditions set forth in the Agreement, the Provider Manual, and any applicable billing manual and claims processing policies.

Definitions:

1. **Allowable Charges** means a Contracted Provider's billed charges for services that qualify as Covered Services.

2. **Allowed Amount** means the amount designated in this Compensation Schedule as the maximum amount payable to a Contracted Provider for any particular Covered Service provided to any particular Covered Person, pursuant to this Agreement or its Attachments.

3. **Cost-Sharing Amounts** means any amounts payable by a Covered Person, such as copayments, cost sharing, coinsurance, deductibles or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement, if applicable.

4. **Encounter** means a face-to-face encounter between a Contracted Provider's patient and a health care professional for services that qualify to be paid as a PPS encounter.

Attachment B: Medicare

EXHIBIT 2
COMPENSATION SCHEDULE
MA PLAN/MA-PD PLAN/DSNP PLAN
PROFESSIONAL SERVICES

Mangum City Hospital Authority dba Mangum Regional Medical Center and Mangum Family Clinic

This compensation schedule ("Compensation Schedule") sets forth the maximum reimbursement amounts for Covered Services provided by Contracted Providers to Covered Persons enrolled in a Medicare Product. Where the Contracted Provider's tax identification number ("TIN") has been designated by the Payor as subject to this Compensation Schedule, Payor shall pay or arrange for payment of a Clean Claim for Covered Services rendered by the Contracted Provider according to the terms of, and subject to the requirements set forth in, the Agreement and this Compensation Schedule. Payment under this Compensation Schedule shall consist of the Allowed Amount as set forth herein less all applicable Cost-Sharing Amounts. All capitalized terms used in this Compensation Schedule shall have the meanings set forth in the Agreement, the applicable Product Attachment, or the Definitions section set forth at the end of this Compensation Schedule.

The maximum compensation for professional Covered Services rendered to a Covered Person shall be the "Allowed Amount." Except as otherwise provided in this Compensation Schedule, the Allowed Amount for professional Covered Services is the lesser of: (i) Allowable Charges; or (ii) 100% of the Medicare fee schedule in effect on the date of service.

Additional Provisions:

1. Code Change Updates. Payor utilizes nationally recognized coding structures (including, without limitation, revenue codes, CPT codes, HCPCS codes, ICD codes, national drug codes, ASA relative values, etc., or their successors) for basic coding and descriptions of the services rendered. Updates to billing-related codes shall become effective on the date ("Code Change Effective Date") that is the later of: (i) the first day of the month following sixty (60) days after publication by the governmental agency having authority over the applicable Product of such governmental agency's acceptance of such code updates, (ii) the effective date of such code updates as determined by such governmental agency or (iii) if a date is not established by such governmental agency or the applicable Product is not regulated by such governmental agency, the date that changes are made to nationally recognized codes. Such updates may include changes to service groupings. Claims processed prior to the Code Change Effective Date shall not be reprocessed to reflect any such code updates.

2. Fee Change Updates. Updates to the fee schedule shall become effective on the effective date of such fee schedule updates, as determined by the Payor ("Fee Change Effective Date"). The date of implementation of any fee schedule updates, i.e. the date on which such fee change is first used for reimbursement ("Fee Change Implementation Date"), shall be the later of: (i) the first date on which Payor is reasonably able to implement the update in the claims payment system; or (ii) the Fee Change Effective Date. Claims processed prior to the Fee Change Implementation Date shall not be reprocessed to reflect any updates to such fee schedule, even if service was provided after the Fee Change Effective Date.

3. Provider Type. Services must be provided by the appropriate provider type or specialty as defined in the Provider Manual. The Allowed Amount may be reduced based on the Contracted Provider's specialty, provider type, licensing/certifications or education as set forth in the Provider Manual.

4. Modifier. Unless specifically indicated otherwise, fee amounts listed in the fee schedule represent global fees and may be subject to reductions based on appropriate Modifier (for example, professional and technical modifiers). As used in the previous sentence, "global fees" refers to services billed without a Modifier, for which

the fee amount includes both the professional component and the technical component. Any Cost-Sharing Amounts that the Covered Person is responsible to pay under the Coverage Agreement will be subtracted from the Allowed Amount in determining the amount to be paid.

5. Anesthesia Modifier Pricing Rules. The dollar amount that will be used in the calculation of time-based and non-time based anesthesia management fees in accordance with the anesthesia payment policy. Unless specifically stated otherwise, the anesthesia conversion factor indicated is fixed and will not change. The anesthesia conversion factor is based on an anesthesia time unit value of 15 minutes.

6. Place of Service Pricing Rules. This fee schedule follows CMS guidelines for determining when services are priced at the facility or non-facility fee schedule (with the exception of services performed at Ambulatory Surgery Centers, POS 24, which will be priced at the facility fee schedule).

7. Payment under this Compensation Schedule. Claims should be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative (CCI) Policy Manual, CCI table edits and other CMS guidelines). All payments under this Compensation Schedule are subject to the terms and conditions set forth in the Agreement, the Provider Manual, and any applicable billing manual and claims processing policies.

Definitions:

1. **Allowable Charges** means a Contracted Provider's billed charges for services that qualify as Covered Services.

2. **Allowed Amount** means the amount designated in this Compensation Schedule as the maximum amount payable to a Contracted Provider for any particular Covered Service provided to any particular Covered Person, pursuant to this Agreement or its Attachments.

3. **Cost-Sharing Amounts** means any amounts payable by a Covered Person, such as copayments, cost-sharing, coinsurance, deductibles or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement, if applicable.

Attachment B: Medicare

EXHIBIT 3
COMPENSATION SCHEDULE
MA PLAN/MA-PD PLAN/DSNP PLAN
CRITICAL ACCESS HOSPITAL SERVICES

Mangum City Hospital Authority dba Mangum Regional Medical Center and Mangum Family Clinic

This compensation schedule ("Compensation Schedule") sets forth the maximum reimbursement amounts for Covered Services provided by Contracted Providers to Covered Persons enrolled in a Medicare Product. Where the Contracted Provider's tax identification number ("TIN") has been designated by the Payor as subject to this Compensation Schedule, Payor shall pay or arrange for payment of a Clean Claim for Covered Services rendered by the Contracted Provider according to the terms of, and subject to the requirements set forth in, the Agreement and this Compensation Schedule. Payment under this Compensation Schedule shall consist of the Allowed Amount as set forth herein less all applicable Cost-Sharing Amounts. All capitalized terms used in this Compensation Schedule shall have the meanings set forth in the Agreement, the applicable Product Attachment, or the Definitions section set forth at the end of this Compensation Schedule.

Inpatient Services. The maximum compensation for inpatient critical access hospital Covered Services rendered to a Covered Person shall be the "Allowed Amount." Except as otherwise provided in this Compensation Schedule, the Allowed Amount for inpatient critical access hospital Covered Services is 100% of the Medicare Per Diem in effect on the date of service. Such payment shall be inclusive of all services rendered.

Swing-bed. The maximum compensation for inpatient swing-bed Covered Services rendered to a Covered Person shall be the "Allowed Amount." Except as otherwise provided in this Compensation Schedule, the Allowed Amount for inpatient swing-bed Covered Services is 100% of the Medicare Per Diem in effect on the date of service. Such payment shall be inclusive of all services rendered.

Outpatient Services. The maximum compensation for outpatient critical access hospital Covered Services rendered to a Covered Person shall be the "Allowed Amount." Except as otherwise provided in this Compensation Schedule, the Allowed Amount for outpatient critical access hospital Covered Services is 100% of the Medicare Cost-to-Charge Ratio in effect on the date of service. Such payment shall be inclusive of all services rendered.

Additional Provisions:

1. Cost-to-Charge Ratio. Payment for outpatient services as indicated above shall constitute the final payment from Payor to Contracted Provider. No reconciliation or settlement of the Contracted Provider's Cost-to-Charge Ratio shall occur at year-end.

2. Critical Access Hospital Status. In the event Contracted Provider no longer meets the current criteria set forth by CMS for being designated as a Critical Access Hospital ("CAH") or is no longer designated by CMS as a CAH, Contracted Provider shall immediately notify Payor in writing of the failure to meet criteria or loss of designation, and as a result, effective as of the date Contracted Provider ceases to hold such designation or such later date as specified by Payor in its sole discretion, the rates and payment methodology of the terms of this Compensation Schedule shall not apply to Covered Services rendered by Contracted Provider to Covered Persons. Upon notice to Payor of Contracted Provider's loss of CAH status, the Parties shall negotiate in good faith for a period of sixty (60) days for the purpose of agreeing upon non-CAH Contracted Provider rates.

3. Admissions for Same or Related Diagnoses. Inpatient admissions for the same or a related diagnoses occurring within thirty (30) days following a discharge in connection with a previous admission shall be considered part of the previous admission and are not separately reimbursable.

4. Hospital-Acquired Conditions and Provider Preventable Conditions. Payment to a Contracted Provider under this Compensation Schedule shall comply with state and federal laws requiring reduction of payment or non-payment to a Contracted Provider for "Hospital-Acquired Conditions" and for "Provider Preventable Conditions" as such terms (or the reasonable equivalents thereof) are defined under applicable state and federal laws.

5. Never Events. Each Contracted Provider shall use best efforts to comply with applicable state and federal reporting or other requirements relating to Never Events and/or Serious Adverse Events, as the applicable term is defined by the National Quality Forum or by state or federal law. Contracted Providers shall not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Payor, Company or Covered Person for any charges associated with Never Events and/or Serious Adverse Events. To the extent a Contracted Provider receives any payment in connection with a Never Event or Serious Adverse Event, the Contracted Provider shall promptly refund such amount.

6. Code Change Updates. Payor utilizes nationally recognized coding structures (including, without limitation, revenue codes, CPT codes, HCPCS codes, ICD codes, national drug codes, ASA relative values, etc., or their successors) for basic coding and descriptions of the services rendered. Updates to billing-related codes shall become effective on the date ("Code Change Effective Date") that is the later of: (i) the first day of the month following sixty (60) days after publication by the governmental agency having authority over the applicable Product of such governmental agency's acceptance of such code updates, (ii) the effective date of such code updates as determined by such governmental agency or (iii) if a date is not established by such governmental agency or the applicable Product is not regulated by such governmental agency, the date that changes are made to nationally recognized codes. Such updates may include changes to service groupings. Claims processed prior to the Code Change Effective Date shall not be reprocessed to reflect any such code updates.

7. Fee Change Updates. Updates to the fee schedule shall become effective on the effective date of such fee schedule updates, as determined by the Payor ("Fee Change Effective Date"). The date of implementation of any fee schedule updates, i.e. the date on which such fee change is first used for reimbursement ("Fee Change Implementation Date"), shall be the later of: (i) the first date on which Payor is reasonably able to implement the update in the claims payment system; or (ii) the Fee Change Effective Date. Claims processed prior to the Fee Change Implementation Date shall not be reprocessed to reflect any updates to such fee schedule, even if service was provided after the Fee Change Effective Date.

8. Payment under this Compensation Schedule. Claims should be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative (CCI) Policy Manual, CCI table edits and other CMS guidelines). All payments under this Compensation Schedule are subject to the terms and conditions set forth in the Agreement, the Provider Manual, and any applicable billing manual and claims processing policies.

Definitions:

1. **Allowable Charges** means a Contracted Provider's billed charges for services that qualify as Covered Services.

2. **Allowed Amounts** means the amount designated in this Compensation Schedule as the maximum amount payable to a Contracted Provider for any particular Covered Service provided to any particular Covered Person, pursuant to this Agreement or its Attachments.

3. **Cost-Sharing Amounts** means any amounts payable by a Covered Person, such as copayments, cost-sharing, coinsurance, deductibles or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement, if applicable

4. **Cost-to-Charge Ratio** or **CCR** means the Contracted Provider-specific cost-to-charge ratios as defined by CMS that are applied to the Allowed Amount.

5. **Per Diem** means a pricing method (i) that, for an inpatient stay, is based on each "Inpatient Day" of an inpatient stay and includes all Covered Services provided to a Covered Person during the inpatient stay, and (ii) that, for outpatient or intermediate services, includes all Covered Services provided to a Covered Person for one calendar day of service. For purposes hereof, an "Inpatient Day" means a calendar day when a Covered Person receives Covered Services as a registered bed patient; to qualify as an Inpatient Day, the Covered Person must be present at the midnight census.

Attachment C: Commercial-Exchange

PRODUCT ATTACHMENT
(INCLUDING REGULATORY REQUIREMENTS AND COMPENSATION SCHEDULE)

THIS PRODUCT ATTACHMENT (this "***Product Attachment***") is made and entered between Oklahoma Complete Health, Inc. ("Health Plan") and Provider.

WHEREAS, Health Plan and Provider entered into that certain Participating 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 or other Downstream Entities participate in certain Products offered by or available from or through a Company; and

WHEREAS, pursuant to the provisions of the Agreement, this Product Attachment is identified on Schedule B of the Agreement and, as such, the Contracted Providers will be designated and participate as Participating Providers in the Product described in this Product Attachment, and will be considered to be and will be governed under this Product Attachment as Downstream Entities as defined in this Product Attachment; and

WHEREAS, the Agreement is modified or supplemented as hereafter provided.

NOW THEREFORE, in consideration of the recitals, the mutual promises herein stated, the parties hereby agree to the provisions set forth below.

1. Defined Terms. For purposes of the Commercial-Exchange Product, the following terms have the meanings set forth below. All capitalized terms not specifically defined in this Product Attachment will have the meanings given to such terms in the Agreement.

1.1. "***Commercial-Exchange Product***" refers to those programs and health benefit arrangements offered by a Company that provide incentives to Covered Persons to utilize the services of certain contracted providers. The Commercial-Exchange Product includes those Coverage Agreements entered into, issued or agreed to by a Payor under which a Company furnishes administrative services or other services in support of a health care program for an individual or group of individuals, which may include access to one or more of the Company's provider networks or vendor arrangements, and which may be provided in connection with a state or governmental-sponsored, health insurance exchange, except those excluded by Health Plan. The Commercial-Exchange Product does not apply to any Coverage Agreements that are specifically covered by another Product Attachment to the Agreement.

1.2. "***Delegated Entity***" means any party, including an agent or broker, that enters into an agreement with Health Plan to provide administrative services or health care services to qualified individuals, qualified employers or qualified employees and their dependents (as such terms are defined in 45 C.F.R. §156.20).

1.3. "***Downstream Entity***" means any party, including an agent or broker, that enters into an agreement with a Delegated Entity or with another Downstream Entity for purposes of providing administrative or health care services related to the agreement between the Delegated Entity and Health Plan. The term "Downstream Entity" is intended to reach the entity that directly provides administrative services or health care services to qualified individuals, qualified employers, or qualified employees and their dependents (as such terms are defined in 45 C.F.R. §156.20).

1.4. "***Emergency***" or "***Emergency Care***" has the meaning set forth in the Covered Person's Coverage Agreement.

1.5. "***Emergency Medical Condition***" has the meaning set forth in the Covered Person's Coverage Agreement.

1.6. "***State***" means the State of Oklahoma, or such other state to the extent that a Coverage Agreement or Covered Person is subject to such other state's law.

2. Commercial-Exchange Product. This Product Attachment constitutes the "Commercial-Exchange Product Attachment" and is incorporated into the Agreement between Provider and Health Plan. It supplements the Agreement by setting forth specific terms and conditions that apply to the Commercial-Exchange Product with respect to which a Participating Provider has agreed to participate, and with which a Participating Provider must comply in order to maintain such participation. This Product Attachment applies with respect to the provision of health care services, supplies or accommodations (including Covered Services) to Covered Persons enrolled in or covered by a Commercial-Exchange Product.

3. Participation. Except as otherwise provided in this Product Attachment or the Agreement, all Contracted Providers under the Agreement will participate as Participating Providers in this Commercial-Exchange Product, and will provide to Covered Persons enrolled in or covered by a Commercial-Exchange Product, upon the same terms and conditions contained in the Agreement, as supplemented or modified by this Product Attachment, those Covered Services that are provided by Contracted Providers pursuant to the Agreement. In providing such services, Provider shall, and shall cause Contracted Providers, to comply with and abide by the provisions of this Product Attachment and the Agreement (including the Provider Manual).

4. Attachments. This Product Attachment includes, at Schedule A, the Regulatory Requirements with which Participating Providers are required to comply based on State laws governing the applicable Coverage Agreement or Covered Person, and the Compensation Schedule(s) for the Commercial-Exchange Product, each of which are incorporated herein by reference.

5. Construction. This Product Attachment supplements and forms a part of the Agreement. Except as otherwise provided herein or in the terms of the Agreement, the terms and conditions of the Agreement will remain unchanged and in full force and effect as a result of this Product Attachment. In the event of a conflict between the provisions of the Agreement and the provisions of this Product Attachment, this Product Attachment will govern with respect to health care services, supplies or accommodations (including Covered Services) rendered to Covered Persons enrolled in or covered by a Commercial-Exchange Product. To the extent Provider or any Contracted Provider is unclear about its, his or her respective duties and obligations, Provider or the applicable Contracted Provider shall request clarification from the Company.

6. Term. This Product Attachment will become effective as of the Effective Date, and will be coterminous with the Agreement unless a Party terminates the participation of the Contracted Provider in this Commercial-Exchange Product in accordance with the applicable provisions of the Agreement or this Product Attachment.

7. Federal Requirements. The following requirements apply to Delegated and Downstream Entities under this Commercial-Exchange Product Attachment, which includes but is not limited to Provider and all Contracted Providers.

7.1. Provider's delegated activities and reporting responsibilities, if any, are specified in the Agreement or applicable attachment to the Agreement (e.g., Delegated Credentialing Agreement, Delegated Services Agreement, Statement or Work, or other scope of services attachment) attached to this Agreement. If such attachment is not executed, no administrative functions shall be deemed as delegated.

7.2. CMS, Health Plan and Payor reserve the right to revoke the delegation activities and reporting requirements or to specify other remedies in instances where CMS, Health Plan or the Payor determine that Provider or any Downstream Entity has not performed satisfactorily.

7.3. Provider and all Downstream Entities must comply with all applicable laws and regulations relating to the standards specified under 45 CFR §156.340(a);

7.4. Provider and all Downstream Entities must permit access by the Secretary and OIG or their designees in connection with their right to evaluate through audit, inspection or other means, to the Provider's or Downstream Entities' books, contracts, computers, or any other electronic systems including medical records and documentation, relating to Health Plan's obligations in accordance with federal standards under 45 CFR §156.340(a) until ten (10) years from the termination date of this Product Attachment.

8. Other Terms and Conditions. Except as modified or supplemented by this Product Attachment, the compensation hereunder for the provision of Covered Services by Contracted Providers to Covered Persons enrolled in or covered by the Commercial-Exchange Product is subject to all of the other provisions in the Agreement (including the Provider Manual) that affect or relate to compensation for Covered Services provided to Covered Persons.

Attachment C: Commercial-Exchange

SCHEDULE A
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 Commercial-Exchange Product. Any additional Regulatory Requirements that may apply to the Coverage Agreements or Covered Persons enrolled in or covered by this Product may be set forth in the Provider Manual or another Attachment. To the extent that a Coverage Agreement, or a Covered Person, 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 a Covered Person with such Coverage Agreement, or to such Covered Person, as applicable.

OK-1 Hold Harmless. In the event Payor fails to pay for Covered Services in accordance with the Agreement, a Covered Person 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 a Covered Person 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 ninety (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 ninety (90) days' advance written notice of such termination. Health Plan's rights to terminate the Agreement for cause upon less than ninety (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 Covered Persons confined on the date of insolvency in an inpatient facility, and for pregnant Covered Persons, until Covered Person's discharge from inpatient facilities, Covered Person'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 ninety (90) days from the date of notice for a Covered Person 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 Covered Persons 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 (6) 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, § 6993.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))

Attachment C: Commercial-Exchange

EXHIBIT 1
COMPENSATION SCHEDULE
FACILITY AND PROFESSIONAL SERVICES
RURAL HEALTH CLINIC

Mangum City Hospital Authority dba Mangum Regional Medical Center and Mangum Family Clinic

This compensation schedule ("Compensation Schedule") sets forth the maximum reimbursement amounts for Covered Services provided by Contracted Providers to Covered Persons enrolled in a Commercial-Exchange Product. Where the Contracted Provider's tax identification number ("TIN") has been designated by the Payor as subject to this Compensation Schedule, Payor shall pay or arrange for payment of a Clean Claim for Covered Services rendered by the Contracted Provider according to the terms of, and subject to the requirements set forth in, the Agreement and this Compensation Schedule. Payment under this Compensation Schedule shall consist of the Allowed Amount as set forth herein less all applicable Cost-Sharing Amounts. All capitalized terms used in this Compensation Schedule shall have the meanings set forth in the Agreement, the applicable Product Attachment, or the Definitions section set forth at the end of this Compensation Schedule.

Outpatient Services. The maximum compensation for facility and professional Covered Services rendered to a Covered Person shall be the "Allowed Amount." Except as otherwise provided in this Compensation Schedule, the Allowed Amount for facility and professional Covered Services is 120% of the Medicare encounter rate in effect on the date of service. If Health Plan's payment obligation is secondary, Provider shall receive compensation as described above, less amounts paid by the primary payor and any applicable Cost-Sharing Amounts.

Additional Provisions:

1. Code Change Updates. Payor utilizes nationally recognized coding structures (including, without limitation, revenue codes, CPT codes, HCPCS codes, ICD codes, national drug codes, ASA relative values, etc., or their successors) for basic coding and descriptions of the services rendered. Updates to billing-related codes shall become effective on the date ("Code Change Effective Date") that is the later of: (i) the first day of the month following sixty (60) days after publication by the governmental agency having authority over the applicable Product of such governmental agency's acceptance of such code updates, (ii) the effective date of such code updates as determined by such governmental agency or (iii) if a date is not established by such governmental agency or the applicable Product is not regulated by such governmental agency, the date that changes are made to nationally recognized codes. Such updates may include changes to service groupings. Claims processed prior to the Code Change Effective Date shall not be reprocessed to reflect any such code updates.

2. Fee Change Updates. Updates to the fee schedule shall become effective on the effective date of such fee schedule updates, as determined by the Payor ("Fee Change Effective Date"). The date of implementation of any fee schedule updates, i.e. the date on which such fee change is first used for reimbursement ("Fee Change Implementation Date"), shall be the later of: (i) the first date on which Payor is reasonably able to implement the update in the claims payment system; or (ii) the Fee Change Effective Date. Claims processed prior to the Fee Change Implementation Date shall not be reprocessed to reflect any updates to such fee schedule, even if service was provided after the Fee Change Effective Date.

3. Fee Sources. In the event CMS contains no published fee amount, alternate (or "gap fill") fee sources may be used to supply the fee basis amount for deriving fee amount (the "Alternative Fee Source Amount"). Health Plan will utilize such Alternative Fee Source Amount until such time that CMS publishes its own RBRVS value. At such time in the future as CMS publishes its own RBRVS value for that CPT/HCPCS code, Payor will use the CMS fee amount for that code and no longer use the Alternate Fee Source Amount. If CMS has no published fee amount or a gap fill fee source is not available for a Covered Service provided to a Covered Person, Payor

may establish a payment amount to apply in determining the Allowed Amount. Until such time as Payor establishes such a payment amount, the maximum compensation shall be 50% of Allowable Charges.

4. Encounter Updates. Updates to Contracted Provider-specific Encounter rates shall become effective ("Encounter Update Effective Date") as of the later of: (i) the first day of the month following thirty (30) days after Payor receives notification from Contracted Provider of such Encounter rate updates; or (ii) the effective date of such code updates, as determined by the State. Claims processed prior to the Encounter Update Effective Date shall not be reprocessed to reflect any Encounter rate updates.

5. Primary Contact Billing. If Covered Person sees more than one health care professional during an encounter, the NPI billed on the CMS-1500 claim form, or its successor, should indicate the primary contact. The primary contact is defined as the health care professional who spends the greatest amount of time with the client during services.

6. Provider Type. Services must be provided by the appropriate provider type or specialty as defined in the Provider Manual. The Allowed Amount may be reduced based on the Contracted Provider's specialty, provider type, licensing/certifications or education as set forth in the Provider Manual.

7. Modifiers. Unless specifically indicated otherwise, fee amounts listed in the fee schedule represent global fees and may be subject to reductions based on appropriate Modifier (for example, professional and technical modifiers). As used in the previous sentence, "global fees" refers to services billed without a Modifier, for which the fee amount includes both the professional component and the technical component. Modifiers must be used as appropriate and be specific to primary contact, as applicable.

8. Authorizations. Authorization requirements are as defined in this Agreement or in the Provider Manual. Service limits, unless specified in this Compensation Schedule, are as defined by the Provider Manual.

9. Level of Care. All reimbursement under this Compensation Schedule shall correspond to the level of care authorized by Payor.

10. Payment under this Compensation Schedule. Claims should be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative (CCI) Policy Manual, CCI table edits and other CMS guidelines). All payments under this Compensation Schedule are subject to the terms and conditions set forth in the Agreement, the Provider Manual, and any applicable billing manual and claims processing policies.

Definitions:

1. **Allowable Charges** means a Contracted Provider's billed charges for services that qualify as Covered Services.

2. **Allowed Amount** means the amount designated in this Compensation Schedule as the maximum amount payable to a Contracted Provider for any particular Covered Service provided to any particular Covered Person, pursuant to this Agreement or its Attachments.

3. **Cost-Sharing Amounts** means any amounts payable by a Covered Person, such as copayments, cost sharing, coinsurance, deductibles or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement, if applicable.

Attachment C: Commercial-Exchange

EXHIBIT 2
COMPENSATION SCHEDULE
PROFESSIONAL SERVICES

Mangum City Hospital Authority dba Mangum Regional Medical Center and Mangum Family Clinic

This compensation schedule ("Compensation Schedule") sets forth the maximum reimbursement amounts for Covered Services provided by Contracted Providers to Covered Persons enrolled in a Commercial-Exchange Product. Where the Contracted Provider's tax identification number ("TIN") has been designated by the Payor as subject to this Compensation Schedule, Payor shall pay or arrange for payment of a Clean Claim for Covered Services rendered by the Contracted Provider according to the terms of, and subject to the requirements set forth in, the Agreement and this Compensation Schedule. Payment under this Compensation Schedule shall consist of the Allowed Amount as set forth herein less all applicable Cost-Sharing Amounts. All capitalized terms used in this Compensation Schedule shall have the meanings set forth in the Agreement, the applicable Product Attachment, or the Definitions section set forth at the end of this Compensation Schedule.

The maximum compensation for professional Covered Services rendered to a Covered Person shall be the "Allowed Amount." Except as otherwise provided in this Compensation Schedule, the Allowed Amount for professional Covered Services is the lesser of: (i) Allowable Charges; or (ii) 120% of the Medicare fee schedule in effect on the date of service.

Additional Provisions:

1. Code Change Updates. Payor utilizes nationally recognized coding structures (including, without limitation, revenue codes, CPT codes, HCPCS codes, ICD codes, national drug codes, ASA relative values, etc., or their successors) for basic coding and descriptions of the services rendered. Updates to billing-related codes shall become effective on the date ("Code Change Effective Date") that is the later of: (i) the first day of the month following sixty (60) days after publication by the governmental agency having authority over the applicable Product of such governmental agency's acceptance of such code updates, (ii) the effective date of such code updates as determined by such governmental agency or (iii) if a date is not established by such governmental agency or the applicable Product is not regulated by such governmental agency, the date that changes are made to nationally recognized codes. Such updates may include changes to service groupings. Claims processed prior to the Code Change Effective Date shall not be reprocessed to reflect any such code updates.

2. Fee Change Updates. Updates to the fee schedule shall become effective on the effective date of such fee schedule updates, as determined by the Payor ("Fee Change Effective Date"). The date of implementation of any fee schedule updates, i.e. the date on which such fee change is first used for reimbursement ("Fee Change Implementation Date"), shall be the later of: (i) the first date on which Payor is reasonably able to implement the update in the claims payment system; or (ii) the Fee Change Effective Date. Claims processed prior to the Fee Change Implementation Date shall not be reprocessed to reflect any updates to such fee schedule, even if service was provided after the Fee Change Effective Date.

3. Fee Sources. In the event CMS contains no published fee amount, alternate (or "gap fill") fee sources may be used to supply the fee basis amount for deriving fee amount (the "Alternative Fee Source Amount"). Health Plan

will utilize such Alternative Fee Source Amount until such time that CMS publishes its own RBRVS value. At such time in the future as CMS publishes its own RBRVS value for that CPT/HCPCS code, Payor will use the CMS fee amount for that code and no longer use the Alternate Fee Source Amount. If CMS has no published fee amount or a gap fill fee source is not available for a Covered Service provided to a Covered Person, Payor may establish a payment amount to apply in determining the Allowed Amount. Until such time as Payor establishes such a payment amount, the maximum compensation shall be 50% of Allowable Charges.

4. Modifier. Unless specifically indicated otherwise, fee amounts listed in the fee schedule represent global fees and may be subject to reductions based on appropriate Modifier (for example, professional and technical modifiers). As used in the previous sentence, "global fees" refers to services billed without a Modifier, for which the fee amount includes both the professional component and the technical component. Any Cost-Sharing Amounts that the Covered Person is responsible to pay under the Coverage Agreement will be subtracted from the Allowed Amount in determining the amount to be paid.

5. Anesthesia Modifier Pricing Rules. The dollar amount that will be used in the calculation of time-based and non-time based anesthesia management fees in accordance with the anesthesia payment policy. Unless specifically stated otherwise, the anesthesia conversion factor indicated is fixed and will not change. The anesthesia conversion factor is based on an anesthesia time unit value of 15 minutes.

6. Place of Service Pricing Rules. This fee schedule follows CMS guidelines for determining when services are priced at the facility or non-facility fee schedule (with the exception of services performed at Ambulatory Surgery Centers, POS 24, which will be priced at the facility fee schedule).

7. Payment under this Compensation Schedule. Claims should be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative (CCI) Policy Manual, CCI table edits and other CMS guidelines). All payments under this Compensation Schedule are subject to the terms and conditions set forth in the Agreement, the Provider Manual, and any applicable billing manual and claims processing policies.

Definitions:

1. **Allowable Charges** means a Contracted Provider's billed charges for services that qualify as Covered Services.

2. **Allowed Amount** means the amount designated in this Compensation Schedule as the maximum amount payable to a Contracted Provider for any particular Covered Service provided to any particular Covered Person, pursuant to this Agreement or its Attachments.

3. **Cost-Sharing Amounts** means any amounts payable by a Covered Person, such as copayments, cost-sharing, coinsurance, deductibles or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement, if applicable.

Attachment C: Commercial-Exchange

EXHIBIT 3
COMPENSATION SCHEDULE
CRITICAL ACCESS HOSPITAL SERVICES

Mangum City Hospital Authority dba Mangum Regional Medical Center and Mangum Family Clinic

This compensation schedule ("Compensation Schedule") sets forth the maximum reimbursement amounts for Covered Services provided by Contracted Providers to Covered Persons enrolled in a Commercial-Exchange Product. Where the Contracted Provider's tax identification number ("TIN") has been designated by the Payor as subject to this Compensation Schedule, Payor shall pay or arrange for payment of a Clean Claim for Covered Services rendered by the Contracted Provider according to the terms of, and subject to the requirements set forth in, the Agreement and this Compensation Schedule. Payment under this Compensation Schedule shall consist of the Allowed Amount as set forth herein less all applicable Cost-Sharing Amounts. All capitalized terms used in this Compensation Schedule shall have the meanings set forth in the Agreement, the applicable Product Attachment, or the Definitions section set forth at the end of this Compensation Schedule.

Inpatient Services. The maximum compensation for inpatient critical access hospital Covered Services rendered to a Covered Person shall be the "Allowed Amount." Except as otherwise provided in this Compensation Schedule, the Allowed Amount for inpatient critical access hospital Covered Services is 165% of the Medicare Per Diem. Such payment shall be inclusive of all services rendered.

Outpatient Services. The maximum compensation for outpatient critical access hospital Covered Services rendered to a Covered Person shall be the "Allowed Amount." Except as otherwise provided in this Compensation Schedule the Allowed Amount for outpatient critical access hospital Covered Services is 145% of the Medicare Cost-to-Charge Ratio. Such payment shall be inclusive of all services rendered.

Additional Provisions:

1. Disproportionate Share Hospital ("DSH"), Direct Graduate Medical Education ("GME"), Indirect Medical Education ("IME") or any other "add-on." Notwithstanding anything to the contrary contained herein, in no event will the Contracted Rate, Allowable Charges or any other cost calculations hereunder include DSH, GME, IME or any other "add-on" for any inpatient admission.

2. Cost-to-Charge Ratio. Payment for outpatient services as indicated above shall constitute the final payment from Payor to Contracted Provider. No reconciliation or settlement of the Contracted Provider's Cost-to-Charge Ratio shall occur at year-end.

3. Critical Access Hospital Status. In the event Contracted Provider no longer meets the current criteria set forth by CMS for being designated as a Critical Access Hospital ("CAH") or is no longer designated by CMS as a CAH, Contracted Provider shall immediately notify Payor in writing of the failure to meet criteria or loss of designation, and as a result, effective as of the date Contracted Provider ceases to hold such designation or such later date as specified by Payor in its sole discretion, the rates and payment methodology of the terms of this Compensation Schedule shall not apply to Covered Services rendered by Contracted Provider to Covered Persons. Upon notice to Payor of Contracted Provider's loss of CAH status, the Parties shall negotiate in good faith for a period of sixty (60) days for the purpose of agreeing upon non-CAH Contracted Provider rates.

4. Admissions for Same or Related Diagnoses. Inpatient admissions for the same or a related diagnoses occurring within thirty (30) days following a discharge in connection with a previous admission shall be considered part of the previous admission and are not separately reimbursable.

5. Hospital-Acquired Conditions and Provider Preventable Conditions. Payment to a Contracted Provider under this Compensation Schedule shall comply with state and federal laws requiring reduction of payment or non-payment to a Contracted Provider for "Hospital-Acquired Conditions" and for "Provider Preventable Conditions" as such terms (or the reasonable equivalents thereof) are defined under applicable state and federal laws.

6. Never Events. Each Contracted Provider shall use best efforts to comply with applicable state and federal reporting or other requirements relating to Never Events and/or Serious Adverse Events, as the applicable term is defined by the National Quality Forum or by state or federal law. Contracted Providers shall not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Payor, Company or Covered Person for any charges associated with Never Events and/or Serious Adverse Events. To the extent a Contracted Provider receives any payment in connection with a Never Event or Serious Adverse Event, the Contracted Provider shall promptly refund such amount.

7. Provider-Based Billing. Provider-Based Billing (as defined herein) will not be reimbursed under this Compensation Schedule as they are included as part of the compensation for professional fees under this Agreement. Neither the Payor nor Covered Person shall be responsible for such Provider-Based Billing. "Provider-Based Billing" are amounts charged by a clinic or facility as a technical component, or for overhead, in connection with professional services rendered in a clinic or facility, and include but are not limited services billed using Revenue Codes 0510-0519.

8. Code Change Updates. Payor utilizes nationally recognized coding structures (including, without limitation, revenue codes, CPT codes, HCPCS codes, ICD codes, national drug codes, ASA relative values, etc., or their successors) for basic coding and descriptions of the services rendered. Updates to billing-related codes shall become effective on the date ("Code Change Effective Date") that is the later of: (i) the first day of the month following sixty (60) days after publication by the governmental agency having authority over the applicable Product of such governmental agency's acceptance of such code updates, (ii) the effective date of such code updates as determined by such governmental agency or (iii) if a date is not established by such governmental agency or the applicable Product is not regulated by such governmental agency, the date that changes are made to nationally recognized codes. Such updates may include changes to service groupings. Claims processed prior to the Code Change Effective Date shall not be reprocessed to reflect any such code updates.

9. Fee Change Updates. Updates to the fee schedule shall become effective on the effective date of such fee schedule updates, as determined by the Payor ("Fee Change Effective Date"). The date of implementation of any fee schedule updates, i.e. the date on which such fee change is first used for reimbursement ("Fee Change Implementation Date"), shall be the later of: (i) the first date on which Payor is reasonably able to implement the update in the claims payment system; or (ii) the Fee Change Effective Date. Claims processed prior to the Fee Change Implementation Date shall not be reprocessed to reflect any updates to such fee schedule, even if service was provided after the Fee Change Effective Date.

10. Fee Sources. In the event CMS contains no published fee amount, alternate (or "gap fill") fee sources may be used to supply the fee basis amount for deriving fee amount (the "Alternative Fee Source Amount"). Health Plan will utilize such Alternative Fee Source Amount until such time that CMS publishes its own RBRVS value. At such time in the future as CMS publishes its own RBRVS value for that CPT/HCPCS code, Payor will use the CMS fee amount for that code and no longer use the Alternate Fee Source Amount. If CMS has no published fee amount or a gap fill fee source is not available for a Covered Service provided to a Covered Person, Payor may establish a payment amount to apply in determining the Allowed Amount. Until such time as Payor establishes such a payment amount, the maximum compensation shall be 50% of Allowable Charges.

11. Encounter Payment. Encounter is defined as the same treatment for the same diagnosis in the same treatment setting without being discharged, released, or transferred within the same 48 hour period.

12. Payment under this Compensation Schedule. Claims should be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative (CCI) Policy Manual, CCI table edits and other CMS guidelines). All payments under this Compensation Schedule are subject to the terms and conditions set forth in the Agreement, the Provider Manual, and any applicable billing manual and claims processing policies.

Definitions:

1. **Allowable** Charges means a Contracted Provider's billed charges for services that qualify as Covered Services.

2. **Allowed Amounts** means the amount designated in this Compensation Schedule as the maximum amount payable to a Contracted Provider for any particular Covered Service provided to any particular Covered Person, pursuant to this Agreement or its Attachments.

3. **Cost-Sharing Amounts** means any amounts payable by a Covered Person, such as copayments, cost-sharing, coinsurance, deductibles or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement, if applicable

4. **Cost-to-Charge Ratio** or **CCR** means the Contracted Provider-specific cost-to-charge ratios as defined by CMS that are applied to the Allowed Amount.

5. **Per Diem** means a pricing method (i) that, for an inpatient stay, is based on each "Inpatient Day" of an inpatient stay and includes all Covered Services provided to a Covered Person during the inpatient stay, and (ii) that, for outpatient or intermediate services, includes all Covered Services provided to a Covered Person for one calendar day of service. For purposes hereof, an "Inpatient Day" means a calendar day when a Covered Person receives Covered Services as a registered bed patient; to qualify as an Inpatient Day, the Covered Person must be present at the midnight census.

Hospital Vendor Contract Summary Sheet

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

2. **Name of Contract: Service Agreement (Addendum)**

3. **Contract Parties: Stericycle and MRMC**

4. **Contract Type Services: Hazardous Pharmaceuticals Disposal**

5. **Impacted Hospital Departments: Pharmacy**

6. **Contract Summary: Stericycle is the only company in Oklahoma licensed to dispose of hazardous pharmaceuticals now required by the EPA. Stericycle currently provides disposal services for our regulated medical biohazardous waste.**

7. **Cost: $215/month**

8. **Prior Cost: $0**

9. **Term: 60 months**

10. **Termination Clause: 30 days prior to renewal**

11. **Other:**

Account/Site #
Generator ID#:

Service Agreement
Effective Date 7-1-2022 between Stericycle, Inc and Mangum Regional

Service Address

Customer/Company Name:	Mangum Regional
Address 1:	1 Wickersham Drive
Address 2:	
City/State/Zip:	Mangum, OK 73554
Phone #:	(800) 942-2904
Fax:	
E-Mail:	astearns@chmcok.com

Billing Address

Address 1:	1 Wickersham Drive
Address 2:	
City/State/Zip:	Mangum, OK 73554
Phone #:	
Fax:	
E-Mail:	astearns@chmcok.com

Services Included checked below (Reference Attachment "Service Descriptions" for details)	Allotted Annual Containers	Allotted Annual Stops	Additional Stop Charge	Additional Container / Over Weight / Envelope Charge	Monthly Service Fee
☐ Biohazardous Regulated Medical Waste Disposal	-	-	-	-	$0.00
☐ Stericycle Reusable Sharps Program (Only available with purchase of "Biohazardous Regulated Medical Waste Disposal" services)	-		-	-	$0.00
	-		-	-	
	-		-	-	
	-		-	-	
☐ Fixer / Developer - Photo Processing Disposal Service	0	-	-	-	$0.00
☐ Pathological / Trace Chemotherapy Disposal Service	0	-	-	-	$0.00
☑ Pharmaceutical Waste Disposal Hazardous Drug Disposal Service (HDDS)	5	2	$700	$200.00	$215.00
☐ CsRx Controlled Substance Waste Service (Only available with purchase of "HDDS" services)	0	-	-	0	$0.00
☐ HIPAA Steri-Safe	-	-	-	-	$0.00

	Container Type (WA Only)	*Price per Container	Price per Stop	Min. Cont. per Pickup	Scheduled Frequency	***No Waste Fee	**Minimum Pickup Fee
☑ Biohazardous Regulated Medical Waste Disposal - Transactional		$75.00	$150.00	1	On Call (up to 2)	$225.00	$225.00

** Price per Box:* ***WA only*** *= Based on WUTC Tariff pricing*
*** Minimum Pickup Fee:* ***WA only*** *= $10.00 minimum monthly fee.* ***Transactional*** *= (min. 1 container(es) agreed to by customer + stop charge)*
****No Waste Fee:* ***WA only*** *= $25.00* ***Transactional*** *=* ***Minimum Pickup Fee***

Total Monthly Service Fee: $215.00

Billing Schedule: Monthly

Includes All Fees (Additional taxes May Apply)

Monthly Service Fee Total: $215.00

Minimum Pickup Fee Total: $225.00

During the first 12 months of the Agreement, Stericycle will not increase the above fees.

Thereafter, fees will not increase by more than 7.00% annually.

Service Guarantee: Stericycle guarantees to deliver the highest quality service at all times. Any complaints about the quality of service which have not been resolved in the normal course of business should be communicated to Stericycle by written notice to the Account Care department at the address listed below. If Stericycle fails to resolve any material service complaint within thirty (30) days, the customer may terminate this Agreement provided all equipment is paid for at the then current replacement values or returned to Stericycle in good and usable condition.

IN WITNESS WHEREOF, this Agreement has been duly executed on the day, month and year written below.

**The offer will expire* 6-29-2022

Stericycle:

Contracting Entity: **Stericycle, Inc.**
Name: Maggie Walton
Title:
Date:
Signature:

Customer:

Customer/Company Name: **Mangum Regional**
Name: Alex Stearns
Title:
Date:
Signature:

By signing above I acknowledge that I am the Customer's authorized officer or agent and that I have the authority to bind Customer to this Agreement. Customer agrees to be bound by these terms and conditions and comply with Stericycle's Waste Acceptance Policy, both of which are integral parts of this Agreement.

Office Use Only: Code#:HZ215.00.S0.00

TERMS AND CONDITIONS

Stericycle, Inc., a Delaware corporation, with offices at 2355 Waukegan Rd., Bannockburn, IL 60015 (collectively, "Stericycle"), and Mangum Regional with offices at 1 Wickersham Drive,Mangum,OK,73554 ("Customer"), hereby enter into and agree as provided in this Services Agreement (the "Agreement") dated as of the 1 day of July, 2022 (the "Effective Date).

1. **Services.** (a) Stericycle will provide Customer the services set forth on page 1 of this Agreement (the "Services") which are incorporated herein and made a part of this Agreement. (b) The current version of the Stericycle Waste Acceptance Policy ("WAP") is attached. Stericycle may periodically update the WAP. Customer shall comply with the WAP applicable to the Services. (c) Customer shall be liable for and shall indemnify, defend and hold harmless Stericycle from and against all demands, claims, actions, losses, damages, and expenses, including reasonable attorney fees, resulting from any Non-Conforming Waste (as defined in the WAP) or Customer's failure to properly store, package, label, or segregate RMW. (d) During the Term, Stericycle shall be the exclusive provider of the Services to Customer at all of its locations, and Customer shall use no other regulated medical waste ("RMW") disposal service, method or service provider, whether at the service location(s) set forth herein or at any other current or future location(s) of Customer. (e) Stericycle may bill additional charges for each non-compliant container (including overweight containers; containers holding Non-Conforming Waste; and containers where the waste is improperly segregated or packaged) provided by Customer.

2. **Term of this Agreement.** (a) The initial term of this Agreement (the "Initial Term") will begin on the Effective Date set forth above and continue for 60 months. This Agreement will automatically renew for successive terms of the same duration (each, an "Extension Term"), unless either party gives the other party at least 60 days' written notice, prior to the renewal date, of its request to terminate this Agreement. The Initial Term and each Extension Term, if any, are collectively referred to as the "Term ".(b) Upon the expiration or termination of this Agreement, Customer shall pay Stericycle all amounts due for services and products provided prior to the expiration or termination (and any other amounts due to Stericycle, which may include a final pickup fee). (c) Stericycle shall have the right to retrieve its Equipment (defined below) from Customer wherever located.

3. **Pricing.** Customer shall pay to Stericycle the service fees and surcharges as set forth on page 1 (collectively "Service Fees"). Stericycle reserves the right, in its sole discretion, to increase the amount of each Service Fee or adjust or add a surcharge from time to time. Stericycle will provide notice of any new surcharges to Customer, which notice may be included on an invoice. Notwithstanding any provision to the contrary, for Customers with transactional pricing models, Customer shall pay the No Waste Charge if Customer declines or cancels a scheduled service or if Customer's location is closed during a scheduled service. Customer shall pay the Minimum Pickup Charge for service where the total container and stop fees are less than the Minimum Pickup Charge. For Customers with subscription-based pricing models, for services rendered beyond the stated quantities, the total charge will increase based on the amount of units serviced at the applicable additional container rate, extra material unit rate or the current Stericycle standard list price. Customer agrees to pay ancillary charges according to the then-current Schedule of Ancillary Charges at www.stericycle.com ("Schedule"), which is incorporated by reference as if fully set forth herein and is subject to change from time to time in Stericycle's discretion.

4. **Payment Terms.** (a) Customer shall pay in full each Stericycle invoice within 30 days of the date of such invoice by ACH or other agreed upon means. Any invoiced amounts not received by Stericycle within that timeframe will be subject to a late fee of 1.5% per month (or the maximum amount allowed by law). Customer shall reimburse Stericycle for all costs that it incurs in collecting overdue amounts from Customer. Stericycle may, with notice, suspend services until any overdue amounts (plus interest charges and collection fees, if any) are paid. Customer shall also pay all taxes imposed by any governmental authority with respect to the purchase of any services and products hereunder, including all sales, use, excise, occupation, franchise and similar taxes and tax-like fees and charges (but excluding all taxes on Stericycle's net income). Stericycle will cooperate with Customer to determine the applicability of exemption certificates, if any, that Customer provides in a timely manner to Stericycle. (b) Stericycle shall submit invoices to Customer in accordance with Stericycle's standard billing process. Stericycle shall not be required to adopt Customer's billing process or to use Customer's preferred billing portal. If Stericycle agrees to depart from its standard billing process (which is entirely within Stericycle's discretion), such agreement may be made provided that: (i) Customer agrees to pay a billing surcharge; (ii) Customer reimburses Stericycle for all fees or other costs payable for the use of Customer's portal; and/or (iii) Customer agrees to any other reasonable requirements of Stericycle related to the use of non-standard billing processes.

5. **Early Termination.** In the event that Customer terminates this Agreement prior to the expiration of the Term other than as set forth in Section 6 Customer shall promptly pay Stericycle (a) all unpaid invoices and any late charges thereon; and (b) an amount equal to 50% of Customer's average monthly charge multiplied by the number of months (including any partial months) remaining until the expiration date of the Term.

6. **Default and Early Termination for Cause.** Either party may immediately terminate this Agreement, in whole or in part, upon written notice to the other party if the other party breaches any material provision of this Agreement and fails to cure such breach within thirty (30) days following receipt of written notice of such breach. Documented service or performance deficiencies by Stericycle or nonpayment by Customer of amounts rightfully owed to Stericycle or Customer's failure to comply with Stericycle polices related to the Services shall constitute a material breach.

7. **Limitation of Liability**. In no event shall either party be liable for any indirect, exemplary, punitive, special, incidental or consequential damages, or lost profits, lost revenue, lost business opportunities or the cost of substitute items or services under or in connection with this Agreement.

8. **Compliance Materials; Confidentiality**. To the extent that Stericycle provides Customer with electronic or printed materials ("Compliance Materials "), it provides these subject to a limited license to Customer to use Compliance Materials for its own, non- commercial use. Stericycle may revoke this license at any time. Customer may not copy or distribute Compliance Materials or use or republish Compliance Materials for or to any third party or audience. Customer agrees to return all Compliance Materials to Stericycle at Customer's expense at the expiration or termination of this Agreement. Stericycle may charge Customer a fee for failure to return Compliance Materials. Customer agrees to not disclose to any third parties Stericycle pricing, policies and procedures. Customer agrees to not disclose to any third parties Stericycle pricing, policies and procedures. Stericycle will keep confidential all Customer confidential information provided to Stericycle in connection with this Agreement and will use the same solely for the purposes provided in this Agreement. As used herein, "confidential information" means any information provided to Stericycle in confidence that relates to Customer's property, business and/or affairs, other than (i) information that is or has become publicly available due to disclosure by Customer or by a third party having a legal right to make such disclosure and (ii) information previously known to Stericycle free of any obligation to keep it confidential prior to receipt of the same from Customer.

9. **Compliance with Laws and Policies.** Each party shall comply with all laws, rules and regulations applicable to its performance hereunder, including anti-corruption and economic and trade sanctions laws. Stericycle and Customer shall keep adequate books, records and documentation as required by applicable laws, rules, and regulations pertaining to storage or handling of RMW and the Services hereunder.

10. **Excuse of Performance.** Neither party will be responsible if its performance of any act(s) required hereunder (other than the payment of any amounts due) is interrupted or delayed due to any reason beyond its reasonable control.

11. **Equipment**. Customer shall have the care, custody and control of any containers and other equipment owned by Stericycle and placed at Customer's premises ("Equipment") and accepts responsibility and liability for the Equipment and its contents. Any damage or loss to such Equipment, other than normal wear and tear, will be charged to Customer at full replacement value.

12. **Waste Brokers**. Stericycle reserves the right to deal solely with the Customer and not with any third party agents of the Customer for all purposes relating to this Agreement. Customer represents and warrants to Stericycle that it is the medical waste generator and is acting for its own account and not through a broker or agent. Stericycle shall be entitled to terminate this agreement and seek all available legal remedies, including but not limited to liquidated damages, in the amount set forth herein for Customer's breach of this representation and warranty.

13. **Miscellaneous**. (a)This Agreement constitutes the entire agreement between the parties relating to the subject matter of this Agreement and supersedes any prior agreements and arrangements between the parties. (b) This Agreement may be modified only by a written amendment signed by an authorized representative of each party. (c) This Agreement shall be binding upon and inure to the benefit of the parties hereto and their respective successors and permitted assigns, legal representatives and heirs; provided, however, that Customer may not assign its rights or delegate its obligations under this Agreement without the prior written consent of Stericycle. (d) Stericycle's relationship with Customer is that of an independent contractor, and nothing in this Agreement shall be construed to designate Stericycle as an employee, agent or partner of or a joint venture with Customer. (e) Any dispute arising in connection with or relating to this Agreement or between the parties ("Disputes") that the parties are unable to resolve informally, such as via discussion and negotiation between the parties, shall solely and exclusively be resolved by binding and final arbitration before the American Arbitration

Association ("AAA"), conducted pursuant to the Federal Arbitration Act (as the parties acknowledge that the services provided involve interstate commerce). All Disputes will be determined on an individual basis (and not as a class member or in any purported class or representative capacity, considered unique as to its facts, and shall not be consolidated in any arbitration or other proceeding with any claim or controversy of any other party, and the arbitrator or trier of fact shall not preside over any form of representative or class proceeding. The exclusive jurisdiction and forum for resolution of any Dispute shall be by arbitration, which shall take place in the state where Customer is located at the closest AAA office. (f) The failure of either party to insist upon the performance of any provision hereof, or to exercise any right granted under any provision hereof, will not be construed as waiving that provision or any other provision, and the provision will continue in full force and effect. (g) No term or condition contained in a Customer purchase order or any other invoice acknowledgment shall be binding upon Stericycle unless agreed to by Stericycle in writing. (h) Each provision of this Agreement must be interpreted in a way that is valid under applicable law. If any provision is held invalid, the rest of the Agreement will remain in full force and effect. (i) The failure of either party to insist upon the performance of any provision hereof, or to exercise any right granted under any provision hereof, will not be construed as waiving that provision or any other provision, and the provision will continue in full force and effect. All waivers must be in writing and signed by the party waiving its rights (j) Except as otherwise set forth herein, this Agreement shall be governed by and construed in accordance with the laws of the State of Illinois, without regard to the conflict of law provisions.

Regulated Medical Waste Service

Regulated Medical Waste Acceptance Policy

Stericycle policy requires compliance with all applicable regulations regarding the collection, transportation and treatment of regulated medical waste. Federal Department of Transportation (DOT) regulations require the generator of regulated medical waste to certify that the packaging and documentation of transported regulated medical waste complies with DOT regulations regarding waste classification, packaging, labeling and shipping documentation. To ensure that neither Stericycle nor the generator of regulated medical waste violates applicable regulations, it is imperative that all parties understand the rules regarding proper identification, classification, segregation and packaging of regulated medical waste. The purpose of this policy is to summarize the minimum requirements for preparing your medical waste for collection, transportation and treatment. Additional facility or state-specific waste acceptance policies may apply based on permit specifications. Please contact your local representative for further information or email customercare@stericycle.com.

REGULATED MEDICAL WASTE

Stericycle accepts medical waste generated in a broad range of medical, diagnostic, therapeutic and research activities. The term "medical waste" includes biohazardous, biomedical, infectious or regulated medical waste as defined under federal, state or local laws, rules, regulations and guidelines. Except as defined by specific state regulations, this **excludes** RCRA hazardous waste pharmaceuticals, all DEA scheduled drugs including *controlled substances, bulk chemotherapy, waste containing mercury or other heavy metals, batteries of any type, cauterizers, non-infectious dental waste, chemicals such as solvents, reagents, corrosives or ignitable materials classified as hazardous waste under Federal and/or state-specific EPA Regulations. In addition, Stericycle **cannot accept** bulk liquids, radioactive materials, or complete human remains (including heads, full torsos and fetuses). Stericycle **cannot accept** these excluded materials packaged as regulated medical waste. All lab wastes or materials which contain or have the potential to contain infectious substances arising from those agents listed under 42 CFR Part 73 (HHS), 7 CFR Part 331 (USDA-Plant Protection and Quarantine), and 9 CFR Part 121 (USDA-Veterinary Services) are strictly prohibited from medical waste by federal law and must be pretreated prior to disposal. Separate protocol and packaging requirements may apply for the disposal of non-hazardous pharmaceuticals. Hazardous waste transportation services may be offered in certain geographical locations, under separate contract. Please contact your local representative for details and packaging specifications.

**Un-dispensed from DEA Registrant*

WASTE SEGREGATION AND PACKAGING

The generator is solely responsible for properly segregating, packaging and labeling of regulated medical waste. Proper segregation and packaging reduces the potential for accidental release of the contents and exposure to employees and the general public. DOT regulations (49 CFR 173.197) require that all packages of regulated medical waste be prepared for transport in containers that meet all of the following requirements: rigid, leak resistant, impervious to moisture, of sufficient strength to prevent tearing or bursting under normal conditions of use and handling, sealed to prevent leakage during transport and puncture resistant for sharps. All regulated medical waste must be accompanied by a properly completed shipping document (See 49 CFR 172.202).

MANAGEMENT OF NON-CONFORMING WASTE

As required by regulation and company policy, Stericycle employees may refuse containers that are non-conforming because of their contents or are improperly packaged, leaking, damaged or likely to create a risk of exposure to employees or the general public. Any waste found to be non-conforming to this Waste Acceptance Policy identified in route to, or at a Stericycle location, may be returned to the generator for proper packaging and disposal, or may be rerouted for appropriate destruction; this may include improperly marked regulated medical waste which should have been identified for incineration (i.e. pathological, chemotherapy or non-hazardous pharmaceuticals). Proper segregation and packaging is essential to ensure compliant and safe handling, collection, transportation and treatment of regulated medical waste.

STERICYCLE REGULATED MEDICAL WASTE ACCEPTANCE POLICY CHECKLIST

ACCEPTED REGULATED MEDICAL WASTE

- Sharps - Means any object contaminated with a pathogen or that may become contaminated with a pathogen through handling or during transportation and also capable of cutting or penetrating skin or a packaging material. Sharps includes needles, syringes, scalpels, broken glass, culture slides, culture dishes, broken capillary tubes, broken rigid plastic and exposed ends of dental wires.
- Regulated Medical Waste or Clinical Waste or Biomedical Waste - Means a waste or reusable material derived from the medical treatment of an animal or human, which includes diagnosis and immunization, or from biomedical research, which includes the production and testing of biological products.

ACCEPTED REGULATED MEDICAL WASTE WHICH MUST BE IDENTIFIED AND SEGREGATED FOR INCINERATION

- Trace Chemotherapy Contaminated Waste: RCRA Empty drug vials, syringes and needles, spill kits, IV tubing and bags, contaminated gloves and gowns and related materials as defined in applicable laws, rules, regulations or guidelines.
- Pathological Waste: Human or animal body parts, organs, tissues and surgical specimens (decanted of formaldehyde, formalin or other preservatives as required per hazardous waste rules).
- Non-RCRA Pharmaceuticals: Must be characterized and certified as non-RCRA hazardous material by the generator. Excludes all DEA scheduled drugs, including controlled substances.*
- **California Only -** Solidified Suction Canisters: Suction canisters that have been injected with solidifier materials to control liquids or suction canisters made of high heat resistant plastics such as polysulfone.

OTHER REGULATED MEDICAL WASTES **NOT** ACCEPTED AS REGULATED MEDICAL WASTE BY STERICYCLE

- Untreated Category A Infectious Substances
- Complete Human Remains (including heads, full torsos and fetuses)
- Bulk Chemotherapy Waste
- Mercury-Containing Dental Waste: Non-contact and contact amalgam and products, chairside traps, amalgam sludge or vacuum pump filters, extracted teeth with mercury fillings and empty amalgam capsules
- Mercury Containing Material or Devices: Any mercury thermometers, sphygmomanometers, lab or medical devices
- RCRA Hazardous Pharmaceutical Waste and all DEA Federal and state controlled substances*
- Chemicals: Formaldehyde, formalin, acids, alcohol, waste oil, solvents, reagents, fixer developer, fluorescein
- Compressed Gas Cylinders, Canisters, Inhalers and Aerosol Cans
- Hazardous or Universal Waste: Any other waste determined by Federal or State EPA regulations including but not limited to batteries, bulbs, heavy metals, etc.
- Radioactive Waste: Any container with a radioactivity level that exceeds regulatory or permitted limits; lead-containing materials

**Consult Stericycle Representative for specific requirements*

Additional waste acceptance policies may apply based on state or permit specific requirements. Hazardous waste transportation services may be offered in certain geographical locations, under separate contract. Please refer to your local Stericycle Representative for additional information and options for possible hazardous waste handling. For additional information on container and labeling requirements contact our Stericycle Customer Service Department at customercare@stericycle.com.

We protect what matters.

Stericycle®

Stericycle®

SERVICE DESCRIPTIONS

Biohazardous Regulated Medical Waste Disposal

- Safe, compliant collection, transport and treatment of regulated medical waste.
- Access to DOT and biohazardous training on MyStericycle.com, our convenient online customer portal.

RELATED SERVICES:

Secure pick-up of Fixer/Developer – Photo Processing Disposal Service

- Treatment and disposal of x-ray fixer/developer containing silver or hydroquinone.
- This service is available in CA and parts of CT, MA, NH, RI, VT, NJ and NY.

Secure pick-up of Pathological/Trace Chemotherapy Disposal Service

- Treatment and disposal of infectious waste or discarded items that have been contaminated by trace amounts of chemotherapeutic, cytotropic or antineoplastic pharmaceuticals.

Regulated Medical Waste – Transactional

- Containers, manifests, collection, transport, treatment and disposal of all regulated medical waste (except non-conforming waste) on an on-call basis.

Stericycle Reusable Sharps Program

- Our Sharps Management Service utilizes reusable sharps containers to streamline the collection and disposal of sharps in your facility. A Stericycle driver will pick up your packaged, full sharps containers and provide clean ones for continued use.
- Each reusable container can be utilized up to 600 times. Our service reduces plastic going into landfills and helps avoid utilizing natural resources to create new containers.
- Easy-to-use container design allows for single-handed disposal of sharps. The container base is transparent making it easy to see the fill line and prevent overfilling to reduce needlestick injuries.

Steri•Safe℠ OSHA Compliance Solutions

- Award-winning bloodborne pathogens training*, available online in English and Spanish. Our Online Training Center provides tracking and reporting.
- Simple, automated Safety Plan Builder to help you stay compliant and access to over 10 million Safety Data Sheets to easily create a customized online binder.
- Preferred level services include annual on-site training, mock OSHA inspection and a dedicated Healthcare Compliance Educator. We also provide a No Fine. No Fail. OSHA Guarantee.
- Enjoy a 10% discount on Healthcare Products.

Steri•Safe℠ HIPAA Compliance Solutions

- Critical training including HIPAA privacy, security and social media.
- Easy-to-use HIPAA privacy and security risk assessments.
- Preferred level services include annual on-site HIPAA privacy and security gap analysis and trainings.

**2016 Bronze Telly Award for our bloodborne pathogens training in the category of Non-Broadcast Productions – Health and Wellness.*

We protect what matters.

Pharmaceutical Waste Disposal

Drug Disposal Service

- Treatment and disposal of non-hazardous pharmaceutical waste. This includes pharmaceutical and over-the-counter drug products that do not fall under the definition of hazardous pharmaceutical waste.
- Environmentally-friendly solutions to protect your communities and waterways.

Hazardous Drug Disposal Service

- Treatment and disposal of pharmaceuticals that either exhibit characteristics that make them a hazardous waste or that are specifically listed as a hazardous waste by EPA or state authorities.
- We provide you with a Pharmaceutical Waste Identification Checklist.

Seal&Send℠ Controlled Substance Envelopes

– Seal&Send controlled substance mailback envelopes are for use only by patients/end-users; 50 envelopes per location annually.

CsRx® Controlled Substance Waste Service

– This solution is designed to help small hospitals and non-acute care facilities prevent diversion when disposing of controlled substances in the form of tablets, capsules, liquids and patches.

– Mitigates the risk of diversion when disposing of controlled substance waste in your facilities.

– This solution provides peace of mind that your controlled substance waste will be processed with total security and compliance.

Certificate Of Completion

Envelope Id: D9855570FDF24F5D9BF44E414201E17A
Status: Sent
Subject: Stericycle Document(s) for your Signature on Mangum Regional
Source Envelope:
Document Pages: 6
Signatures: 0
Certificate Pages: 4
Initials: 0
AutoNav: Enabled
EnvelopeId Stamping: Enabled
Time Zone: (UTC-06:00) Central Time (US & Canada)

Envelope Originator:
Maggie Walton
2355 Waukegan Road
Bannockburn, IL 60062
maggie.walton@stericycle.com
IP Address: 13.110.78.8

Record Tracking

Status: Original
6/22/2022 1:34:15 PM
Holder: Maggie Walton
maggie.walton@stericycle.com
Location: DocuSign

Signer Events	Signature	Timestamp
Alex Stearns astearns@chmcok.com Security Level: Email, Account Authentication (None) **Electronic Record and Signature Disclosure:** Accepted: 6/22/2022 1:39:27 PM ID: 1f7fc457-8558-4c87-ac9c-530be87040c9		Sent: 6/22/2022 1:34:58 PM Viewed: 6/22/2022 1:39:27 PM
Maggie Walton maggie.walton@stericycle.com Security Level: Email, Account Authentication (None) **Electronic Record and Signature Disclosure:** Not Offered via DocuSign		

In Person Signer Events	Signature	Timestamp

Editor Delivery Events	Status	Timestamp

Agent Delivery Events	Status	Timestamp

Intermediary Delivery Events	Status	Timestamp

Certified Delivery Events	Status	Timestamp

Carbon Copy Events	Status	Timestamp

Witness Events	Signature	Timestamp

Notary Events	Signature	Timestamp

Envelope Summary Events	Status	Timestamps
Envelope Sent	Hashed/Encrypted	6/22/2022 1:34:58 PM

Payment Events	Status	Timestamps

Electronic Record and Signature Disclosure

CONSUMER DISCLOSURE

From time to time, Stericycle Inc. (we, us or Company) may be required by law to provide to you certain written notices or disclosures. Described below are the terms and conditions for providing to you such notices and disclosures electronically through the DocuSign, Inc. (DocuSign) electronic signing system. Please read the information below carefully and thoroughly, and if you can access this information electronically to your satisfaction and agree to these terms and conditions, please confirm your agreement by clicking the 'I agree' button at the bottom of this document.

Getting paper copies

At any time, you may request from us a paper copy of any record provided or made available electronically to you by us. You will have the ability to download and print documents we send to you through the DocuSign system during and immediately after signing session and, if you elect to create a DocuSign signer account, you may access them for a limited period of time (usually 30 days) after such documents are first sent to you. After such time, if you wish for us to send you paper copies of any such documents from our office to you, you will be charged a $0.00 per-page fee. You may request delivery of such paper copies from us by following the procedure described below.

Withdrawing your consent

If you decide to receive notices and disclosures from us electronically, you may at any time change your mind and tell us that thereafter you want to receive required notices and disclosures only in paper format. How you must inform us of your decision to receive future notices and disclosure in paper format and withdraw your consent to receive notices and disclosures electronically is described below.

Consequences of changing your mind

If you elect to receive required notices and disclosures only in paper format, it will slow the speed at which we can complete certain steps in transactions with you and delivering services to you because we will need first to send the required notices or disclosures to you in paper format, and then wait until we receive back from you your acknowledgment of your receipt of such paper notices or disclosures. To indicate to us that you are changing your mind, you must withdraw your consent using the DocuSign 'Withdraw Consent' form on the signing page of a DocuSign envelope instead of signing it. This will indicate to us that you have withdrawn your consent to receive required notices and disclosures electronically from us and you will no longer be able to use the DocuSign system to receive required notices and consents electronically from us or to sign electronically documents from us.

All notices and disclosures will be sent to you electronically

Unless you tell us otherwise in accordance with the procedures described herein, we will provide electronically to you through the DocuSign system all required notices, disclosures, authorizations, acknowledgements, and other documents that are required to be provided or made available to you during the course of our relationship with you. To reduce the chance of you inadvertently not receiving any notice or disclosure, we prefer to provide all of the required notices and disclosures to you by the same method and to the same address that you have given us. Thus, you can receive all the disclosures and notices electronically or in paper format through the paper mail delivery system. If you do not agree with this process, please let us know as described below. Please also see the paragraph immediately above that describes the consequences of your electing not to receive delivery of the notices and disclosures

electronically from us.

How to contact Stericycle Inc.:

You may contact us to let us know of your changes as to how we may contact you electronically, to request paper copies of certain information from us, and to withdraw your prior consent to receive notices and disclosures electronically as follows:

To contact us by email send messages to: customercare@stericycle.com

To advise Stericycle Inc. of your new e-mail address

To let us know of a change in your e-mail address where we should send notices and disclosures electronically to you, you must send an email message to us at customercare@stericycle.com and in the body of such request you must state: your previous e-mail address, your new e-mail address. We do not require any other information from you to change your email address..

In addition, you must notify DocuSign, Inc. to arrange for your new email address to be reflected in your DocuSign account by following the process for changing e-mail in the DocuSign system.

To request paper copies from Stericycle Inc.

To request delivery from us of paper copies of the notices and disclosures previously provided by us to you electronically, you must send us an e-mail to customercare@stericycle.com and in the body of such request you must state your e-mail address, full name, US Postal address, and telephone number. We will bill you for any fees at that time, if any.

To withdraw your consent with Stericycle Inc.

To inform us that you no longer want to receive future notices and disclosures in electronic format you may:

i. decline to sign a document from within your DocuSign session, and on the subsequent page, select the check-box indicating you wish to withdraw your consent, or you may;

ii. send us an e-mail to customercare@stericycle.com and in the body of such request you must state your e-mail, full name, US Postal Address, and telephone number. We do not need any other information from you to withdraw consent.. The consequences of your withdrawing consent for online documents will be that transactions may take a longer time to process..

Required hardware and software

Operating Systems:	Windows® 2000, Windows® XP, Windows Vista®; Mac OS® X
Browsers:	Final release versions of Internet Explorer® 6.0 or above (Windows only); Mozilla Firefox 2.0 or above (Windows and Mac); Safari™ 3.0 or above (Mac only)
PDF Reader:	Acrobat® or similar software may be required to view and print PDF files
Screen Resolution:	800 x 600 minimum
Enabled Security Settings:	Allow per session cookies

** These minimum requirements are subject to change. If these requirements change, you will be asked to re-accept the disclosure. Pre-release (e.g. beta) versions of operating systems and browsers are not supported.

Acknowledging your access and consent to receive materials electronically

To confirm to us that you can access this information electronically, which will be similar to other electronic notices and disclosures that we will provide to you, please verify that you were able to read this electronic disclosure and that you also were able to print on paper or electronically save this page for your future reference and access or that you were able to e-mail this disclosure and consent to an address where you will be able to print on paper or save it for your future reference and access. Further, if you consent to receiving notices and disclosures exclusively in electronic format on the terms and conditions described above, please let us know by clicking the 'I agree' button below.
By checking the 'I agree' box, I confirm that:

- I can access and read this Electronic CONSENT TO ELECTRONIC RECEIPT OF ELECTRONIC CONSUMER DISCLOSURES document; and

- I can print on paper the disclosure or save or send the disclosure to a place where I can print it, for future reference and access; and

- Until or unless I notify Stericycle Inc. as described above, I consent to receive from exclusively through electronic means all notices, disclosures, authorizations, acknowledgements, and other documents that are required to be provided or made available to me by Stericycle Inc. during the course of my relationship with you.

LEASE AGREEMENT

THIS LEASE AGREEMENT, dated as of the _____ day of_ _____, 2022, is made by and between the City of Mangum, Oklahoma, a municipal corporation (the "Lessor") and the Mangum City Hospital Authority, an Oklahoma public trust, doing business as Mangum Regional Medical Center (the "Lessee").

W I T N E S S E T H:

WHEREAS, the City of Mangum, Oklahoma, is a municipal corporation organized and existing under the laws of the State of Oklahoma; and

WHEREAS, the Mangum City Hospital Authority is an Oklahoma public trust with the City of Mangum, Oklahoma as beneficiary thereof; and

WHEREAS, the City of Mangum recognizes the need for the availability of quality health care services for the health, safety and welfare of the City's citizens and residents of the surrounding area; and

WHEREAS, the Mangum City Hospital Authority currently provides such health care services through the operation of the Mangum Regional Medical Center, and now requires additional facilities to adequately provide such health care services.

NOW, THEREFORE, in consideration of the respective representations and agreements contained herein, the parties hereto agree as follows:

SECTION 1. Demise of the Leased Premises. The Lessor hereby agrees to demise, let, lease and rent to the Lessee, and the Lessee does hereby agree to lease and rent from the Lessor, for the term covered herein, all of the Lessor's right, title and interest to the real property described in Exhibit "A" attached hereto and made a part hereof (hereinafter, the "Leased Premises").

SECTION 2. Lease Term. The initial term of this Lease shall be for a period of one (1) year, beginning on July 1,, 2022 and expiring on June 30,, 2023. Thereafter, this agreement will automatically renewed successive twelve (12) month periods (the "Lease Term") if neither party moves to terminate this agreement within 90 days of any renewal term. Regardless of lease term, this agreement will terminate in the event the Lessee ceases operating the Mangum Regional Medical Center.

SECTION 3. Rent. The Lessor acknowledges and values the significant services the Lessee provides to the Lessor's citizens in the operation of the Mangum Regional Medical Center. The Lessor believes the services are necessary for the public welfare and the Lessor cannot perform the services on its own accord. Therefore, the rent to be paid by Lessee to Lessor shall be $1.00 and other goods and services described in this lease, including maintenance of the leased, for the initial term and also for each successive annual renewal term throughout the Lease Term, said sum being recognized by the City as a reasonable amount in consideration for the public benefits to be derived from Lessee's provision of health care services in connection with its occupancy of the Leased Premises. However, both parties acknowledge that neither party may obligate funds and revenue beyond one fiscal year. Therefore, this contract may be terminated at the conclusion of any fiscal year, without cause, if funding is not available for subsequent fiscal years. In no way does this agreement obligate or require either party to appropriate any funds or revenue beyond the current fiscal year to satisfy any expressed or implied future obligation that may otherwise arise under this agreement.

SECTION 4. Possession. Lessor shall give possession of the Leased Premises to Lessee upon the execution of this Lease Agreement. By taking possession of the Leased Premises, the Lessee will be deemed to have accepted the Leased Premises as suitable for the purposes for which the same are leased.

SECTION 5. Use. The Lessee hereby represents that the Leased Premises will be used by the Lessee as an annex to the Mangum Regional Medical Center for outpatient services, administrative offices, and such other uses appropriate to the operation of a hospital. Further, the Lessee may not use the premises for any other purpose without the express written consent of the Lessor. The Lessee will maintain the Leased Premises in a clean and healthful condition and comply with all requirements of any governmental authority having jurisdiction of the Leased Premises. Upon the termination of this Lease Agreement, the Lessee will deliver up the Leased Premises to the Lessor in the condition which existed on the date of possession, ordinary wear and tear, permitted alterations and additions and insured casualty loss excepted.

SECTION 6. Utilities. The Lessee shall be and remain throughout the Lease Term liable for the payment of all electrical, natural gas, telephone, internet, cable, satellite and any other municipal

utility charges incurred or used in connection with the Leased Premises, and shall place said utilities and services in Lessee's name.

SECTION 7. Lessee's Insurance and Taxes. During the Lease Term of this Lease, or any extension thereof:

(a) Lessee agrees to purchase or pay the premium for commercial general liability insurance covering the Leased Premises in amounts deemed sufficient to Lessor.

(b) Lessee shall maintain insurance for all contents to be contained in or about the Leased Premises in sufficient amounts, and Lessor shall in no manner be liable for damage to such contents, whether owned by Lessee or otherwise.

(c) Lessee shall pay all taxes levied and assessed against personal property used in its business and located on the Leased Premises.

(d) Lessee shall pay in full and discharge all real property ad valorem, special assessment and any other taxes, if any, levied or assessed against the Leased Premises or any part thereof.

SECTION 8. Lessor's Insurance. During the Lease Term of this Lease, or any extension thereof:

(a) Lessor agrees that it will keep in force fire and extended coverage insurance in sufficient amounts, protecting the buildings and structures located on the Leased Premises against damage by fire, wind, storm or other casualty, the premium for which shall be reimbursed by the Lessee to the Lessor.

SECTION 9. Alterations. The Lessee may make minor alterations to the Leased Premises without the prior written consent of the Lessor if such alterations are to further a hospital-related purpose, including the placement of signs on the building, decorations, additions, or other improvements. Any major construction alterations, including, but not limited to, alterations of the current floor plan, the removal of any permanent wall, the installation of anything inside any wall, including electrically or plumbing, or any other alteration that will permanently alter the current floor plan and use of the building, must be pre-authorized by the City in writing. All alterations to the Leased Premises will be performed at the Lessee's expense. Fixtures

installed by the Lessee during the term of this Lease Agreement shall become the property of the Lessor and may not be removed at any time, except upon written consent of the Lessor. All alterations must be built in accordance with all relevant building codes, regulations, or guidelines and does not otherwise interrupt or interfere with services currently provided at the Mangum Regional Medical Center.

SECTION 10. Lessee's Maintenance and Repairs. Lessee shall, at its sole cost and expense, keep the Leased Premises in good, clean and habitable condition. It is understood and agreed that Lessee's responsibilities shall include routine maintenance and repairs pertaining to the Leased Premises, including the repair and/or replacement of all lighting, heating, air conditioning, plumbing and other electrical and mechanical equipment; replacement of cracked or broken windows and glass, and all damage caused by any break-ins or attempted break-ins to the Leased Premises. The Lessee shall further keep and maintain the exterior of the Leased Premises and the parking lot and landscaping in good condition and repair.

SECTION 11. Indemnity. To the extent not caused by the willful conduct or gross negligence of the Lessor, the Lessor will not be liable to the Lessee or the Lessee's agents, employees, invitees or to any person claiming through the Lessee for any injury to person, loss or damage to property or the Lessee's business, occasioned by the acts or omissions of the Lessor, its agents, employees or contractors, or by any other cause whatsoever, including personal injuries to any employees or agents of the Lessee or of any person employed by an independent contractor retained by the Lessee. Further, the Lessor will not be liable for and the Lessee agrees to indemnify and hold the Lessor harmless from all costs incurred in connection with loss of life, bodily or personal injury or property damage arising out of any occurrence on the Leased Premises or the occupancy by the Lessee of the Leased Premises or any part thereof, or occasioned wholly or in part by any action or omission of the Lessee, its agents, employees or invitees. If the Lessor is, without fault on the Lessor's part, made a party to any action commenced by or against the Lessee, the Lessee agrees to protect and hold the Lessor harmless therefrom and to pay all loss, expenses and the reasonable attorney's fees of the Lessor incurred in connection therewith.

SECTION 12. Default. If any default is made in the performance of or compliance with any term or condition hereof, this Lease, at the option of Lessor, shall terminate and be forfeited, and Lessor may re-enter and take possession of the Leased Premises.

SECTION 13. Notices. Each notice, demand, request and other communication required or permitted hereunder shall be in writing and shall be deemed to be delivered if delivered by either Party to the other and shall be effective: (i) ten days after having been deposited in the United States mail, registered or certified mail, postage prepaid, return receipt requested; or (ii) upon delivery to recipient if delivered by personal service, Federal Express or other overnight delivery service. Such Notice shall be addressed to the party for whom intended, as follows:

If to Lessor: City of Mangum
c/o Mayor
201 N. Oklahoma Ave.
Mangum, OK 73554

If to Lessee: Mangum City Hospital Authority
c/o Chairman of Trustees
201 N. Oklahoma Ave.
Mangum, OK 73554

Either party hereto may from time to time by notice to the other party designate a different address which shall be substituted for the one above specified.

SECTION 14. Cumulative Rights. The rights granted to the Lessor in this Lease Agreement are cumulative of every other right or remedy which the Lessor might otherwise have at law or in equity and the exercise of one or more rights or remedies will not prejudice the concurrent or subsequent exercise of other rights or remedies.

SECTION 15. Entire Agreement. The parties agrees that there are no representations, understandings, stipulations, agreements or promises pertaining to this Lease Agreement or the Leased Premises which are not incorporated herein. This Lease Agreement shall not be altered, waived, amended or extended, except by a written agreement signed by the Lessor and the Lessee.

SECTION 16. Severability. If any clause or provision of this Lease Agreement is illegal, invalid or unenforceable under any present or future law, the remainder of this Lease Agreement will not be affected thereby. It is the intention of the parties that is any provision is held to be illegal, invalid or unenforceable, there will be added in lieu thereof a provision as similar in terms to such provision as is possible and be legal, valid and enforceable.

SECTION 17. Binding Effect. The provisions of this Lease Agreement will be binding on and inure to the benefit of the Lessor and the Lessee and their respective successors and permitted assigns.

SECTION 18. Governing Law. This Lease Agreement will be construed and enforced according to the laws of the State of Oklahoma. All claims, disputes and other matters in question arising out of or relating to this Lease Agreement, or the breach thereof, will be decided by proceedings instituted and litigated in the District Court of Greer County, State of Oklahoma.

Section 19. Relationship of the Parties. The Lessor and the Lessee are entering into this agreement solely to ensure continued hospital-related services in the City of Mangum. Both parties agree and acknowledge that they are not partners or joint venturers and will, for all purposes be considered independent contractors in the fulfillment of their contractual responsibilities stated in this agreement. In this respect, neither party may bind the other or otherwise incur an obligation on behalf of the other.

Section 20. No Third Party Beneficiaries. There are no intended third party beneficiaries under this Agreement, and no third party has any rights or make any claim, it being intended that solely the parties to this agreement has any right to make any claim or enforce any terms stated in this agreement.

IN WITNESS WHEREOF, this Lease Agreement has been executed and delivered by the parties hereto, as of the date first above written.

[This Space Intentionally Left Blank]

LESSOR:

CITY OF MANGUM, OKLAHOMA

By: _____
Mayor

LESSEE:

MANGUM CITY HOSPITAL AUTHORITY dba Mangum Regional Medical Center

By: _____
Chairman

EXHIBIT "A"

DESCRIPTION OF LEASED PREMISES

The Leased Premises shall consist of the following real property situated in Greer County, Oklahoma, more fully described as follows:

The property and building commonly known as the David L. Caley Memorial Medical Annex

Street Address: 2 Wickersham Drive, Mangum, Oklahoma

Hospital Vendor Contract Summary Sheet

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

2. Name of Contract: Interface Performance Expectations

3. Contract Parties: CPSI-Evident and MCHA dba MRMC/MFC.

4. Contract Type Services: E-clinical Works Digital Interface

5. Impacted Hospital Departments: Clinic, Lab and Radiology

6. Contract Summary: This agreement defines a digital interface that enables information to be transferred between CPSI-Evident and ECW.

7. Cost: N/A

8. Prior Cost: N/A

9. Term: N/A

10. Termination Clause: N/A

11. Other: