

Fill in this information to identify the case:

Debtor 1 Tehum Care Services, Inc.

Debtor 2 Corizon Health, Inc.
 (Spouse, if filing)

United States Bankruptcy Court for the: Southern District of Texas

Case number 4:23-bk-90086

Official Form 410
Proof of Claim

04/22

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Do not use this form to make a request for payment of an administrative expense. Make such a request according to 11 U.S.C. § 503.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies of any documents that support the claim, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, judgments, mortgages, and security agreements. Do not send original documents; they may be destroyed after scanning. If the documents are not available, explain in an attachment.

A person who files a fraudulent claim could be fined up to \$500,000, imprisoned for up to 5 years, or both. 18 U.S.C. §§ 152, 157, and 3571.

Fill in all the information about the claim as of the date the case was filed. That date is on the notice of bankruptcy (Form 309) that you received.

Part 1: Identify the Claim

1. **Who is the current creditor?** Bay Hospital, Inc.
 Name of the current creditor (the person or entity to be paid for this claim)

Other names the creditor used with the debtor Gulf Coast Regional Medical Center; HCA Florida Gulf Coast Hospital

2. **Has this claim been acquired from someone else?** No
 Yes. From whom? _____

3. **Where should notices and payments to the creditor be sent?**

Federal Rule of Bankruptcy Procedure (FRBP) 2002(g)	Where should notices to the creditor be sent?	Where should payments to the creditor be sent? (if different)
	<u>Bay Hospital, Inc. c/o James Bowen</u>	<u>Bay Hospital, Inc. c/o Jon Rose</u>
	Name	Name
	<u>1906 West End Ave.</u>	<u>One Park Plaza, I-2W</u>
	Number Street	Number Street
	<u>Nashville TN 37203</u>	<u>Nashville TN 37203</u>
City State ZIP Code	City State ZIP Code	
Contact phone <u>615-320-3700</u>	Contact phone <u>615-344-1213</u>	
Contact email <u>jbowen@rjfirm.com</u>	Contact email <u>Jonathan.Rose@HCAHealthcare.com</u>	
Uniform claim identifier for electronic payments in chapter 13 (if you use one): _____		

4. **Does this claim amend one already filed?** No
 Yes. Claim number on court claims registry (if known) _____ Filed on _____
 MM / DD / YYYY

5. **Do you know if anyone else has filed a proof of claim for this claim?** No
 Yes. Who made the earlier filing? _____



Part 2: Give Information About the Claim as of the Date the Case Was Filed

6. Do you have any number you use to identify the debtor? No
 Yes. Last 4 digits of the debtor's account or any number you use to identify the debtor: _____

7. How much is the claim? \$ 2,189.82. Does this amount include interest or other charges?
 No
 Yes. Attach statement itemizing interest, fees, expenses, or other charges required by Bankruptcy Rule 3001(c)(2)(A).

8. What is the basis of the claim? Examples: Goods sold, money loaned, lease, services performed, personal injury or wrongful death, or credit card.
 Attach redacted copies of any documents supporting the claim required by Bankruptcy Rule 3001(c).
 Limit disclosing information that is entitled to privacy, such as health care information.
Health care services provided

9. Is all or part of the claim secured? No
 Yes. The claim is secured by a lien on property.
Nature of property:
 Real estate. If the claim is secured by the debtor's principal residence, file a *Mortgage Proof of Claim Attachment* (Official Form 410-A) with this *Proof of Claim*.
 Motor vehicle
 Other. Describe: _____
Basis for perfection: _____
 Attach redacted copies of documents, if any, that show evidence of perfection of a security interest (for example, a mortgage, lien, certificate of title, financing statement, or other document that shows the lien has been filed or recorded.)
Value of property: \$ _____
Amount of the claim that is secured: \$ _____
Amount of the claim that is unsecured: \$ _____ (The sum of the secured and unsecured amounts should match the amount in line 7.)
Amount necessary to cure any default as of the date of the petition: \$ _____
Annual Interest Rate (when case was filed) _____%
 Fixed
 Variable

10. Is this claim based on a lease? No
 Yes. Amount necessary to cure any default as of the date of the petition. \$ _____

11. Is this claim subject to a right of setoff? No
 Yes. Identify the property: _____

12. Is all or part of the claim entitled to priority under 11 U.S.C. § 507(a)? No

A claim may be partly priority and partly nonpriority. For example, in some categories, the law limits the amount entitled to priority.

Yes. Check one:

<input type="checkbox"/> Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).	Amount entitled to priority \$ _____
<input type="checkbox"/> Up to \$3,350* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use. 11 U.S.C. § 507(a)(7).	\$ _____
<input type="checkbox"/> Wages, salaries, or commissions (up to \$15,150*) earned within 180 days before the bankruptcy petition is filed or the debtor's business ends, whichever is earlier. 11 U.S.C. § 507(a)(4).	\$ _____
<input type="checkbox"/> Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8).	\$ _____
<input type="checkbox"/> Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(5).	\$ _____
<input type="checkbox"/> Other. Specify subsection of 11 U.S.C. § 507(a)() that applies.	\$ _____

* Amounts are subject to adjustment on 4/01/25 and every 3 years after that for cases begun on or after the date of adjustment.

Part 3: Sign Below

The person completing this proof of claim must sign and date it. FRBP 9011(b).

If you file this claim electronically, FRBP 5005(a)(2) authorizes courts to establish local rules specifying what a signature is.

A person who files a fraudulent claim could be fined up to \$500,000, imprisoned for up to 5 years, or both. 18 U.S.C. §§ 152, 157, and 3571.

Check the appropriate box:

I am the creditor.

I am the creditor's attorney or authorized agent.

I am the trustee, or the debtor, or their authorized agent. Bankruptcy Rule 3004.

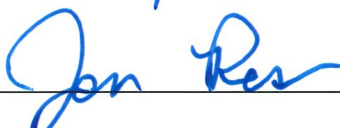
I am a guarantor, surety, endorser, or other codebtor. Bankruptcy Rule 3005.

I understand that an authorized signature on this *Proof of Claim* serves as an acknowledgment that when calculating the amount of the claim, the creditor gave the debtor credit for any payments received toward the debt.

I have examined the information in this *Proof of Claim* and have a reasonable belief that the information is true and correct.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on date 6/22/2023
MM / DD / YYYY



Signature

Print the name of the person who is completing and signing this claim:

Name	<u>Jon</u>	<u>Rose</u>
	First name	Last name
Title	<u>Senior Litigation Counsel</u>	
Company	<u>Bay Hospital, Inc.</u>	
	Identify the corporate servicer as the company if the authorized agent is a servicer.	
Address	<u>One Park Plaza, I-2W</u>	
	Number	Street
	<u>Nashville</u>	<u>TN</u>
	City	State
		<u>37203</u>
		ZIP Code
Contact phone	<u>615-344-1213</u>	Email <u>Jonathan.Rose@HCAHealthcare.com</u>

EXHIBIT A

KING & SPALDING

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January 23, 2018

VIA CERTIFIED MAIL, RETURN RECEIPT

Ms. Jennifer Finger
Assistant General Counsel
Corizon
103 Powell Court
Brentwood, TN 37027

Re: Corizon's Continuing Contract Breaches

Dear Ms. Finger:

We have been retained by the hospitals identified in the spreadsheet attached to this letter (collectively, the "Hospitals") in connection with the underpaid accounts for services provided by to inmates in Florida under contract with Corizon. The Hospitals have thus far identified underpayments associated with at least 102 accounts through July 2017 totaling more than \$985,000. The Hospitals reserve the right to update the detail of accounts as additional charges are found to have been underpaid.

The accounts detailed in the attached spreadsheet have been improperly underpaid by Corizon, for what appear to be varying reasons, which appear to include: (1) failure to pay at the correct contracted rates; (2) improperly denying charges for medically necessary services; (3) wrongfully "bundling" certain charges that were properly billed by the Hospitals; and (4) inappropriately downcoding inpatient days to lower levels of care than the appropriate level.

None of these payment practices are permissible under the contracts between the parties. The contracts with Corizon expressly state that inpatient stays for these accounts are to be billed at a set percentage of the Hospitals' billed charges and/or at Medicare rates. The contracts do not provide for Corizon to unilaterally and without justification downcode, bundle or disallow charges on the Hospitals' bills where payment is based on charges, or to reduce the level of care where accounts are based on Medicare.

The parties' course of performance confirms that Corizon's audits and resulting underpayments on these accounts are improper and constitute breaches of the relevant contracts. For many years prior to Corizon's retention of Equian to conduct the unauthorized audits, Corizon consistently paid the amounts

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Ms. Jennifer Finger
January 23, 2019
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billed without any unilateral “bundling,” downcoding or disallowing of properly billed charges, or level of care reductions. Equian’s practices are at odds with the parties’ long course of performance and is strong evidence against the changes caused by Equian’s work.

Equian’s audits also appear to be misapplying some unspecified “CMS/Medicare guidelines.” The Hospitals disagree with the contention that they have billed in any way contrary to CMS/Medicare guidelines. The Hospitals follow any CMS/Medicare billing guidelines that might apply to these claims, and further, bill in accordance with industry charging practices and billing standards. Of course, the fact that Equian has not specified what particular CMS/Medicare guidelines it purports to be applying to downcode these claims impedes the ability to further address what Equian has gotten wrong. But the Hospitals are confident that their billing is fully compliant and that Equian is in error.

The Hospitals hereby demand that Corizon immediately cure these breaches by paying in full the amounts owed as reflected on the attached spreadsheet. If the Hospitals do not receive full payment within thirty (30) days of your receipt of this letter – i.e., by February 22, 2018 – and absent you and I working out some alternative schedule based on a foreseeable method of resolving this matter, the Hospitals will assume that they have no choice but to begin formal legal proceedings against Corizon to enforce the contracts. If that becomes needed the Hospitals reserve their rights to pursue any and all remedies available at law.

Please feel free to call me to discuss at my direct number 213-443-4335.

Very truly yours,



David J. Tassa

Attachment

cc: Glenn E. Solomon

	A	B	C	D	E	F	G	H	I
1	Facility Name	Pat Name	Pat Num	DOB	Admit Date	Discharge Date	Subscriber Number	Final Bill Date	Total Due
2	LAWNWOOD REGIONAL MEDICAL CENTER							7/8/2017	\$37,517.68
3	LAWNWOOD REGIONAL MEDICAL CENTER							5/12/2017	\$18,167.66
4	LAWNWOOD REGIONAL MEDICAL CENTER							3/17/2017	\$4,999.16
5	LAWNWOOD REGIONAL MEDICAL CENTER							7/15/2017	\$2,713.11
6	NORTH FLORIDA REGIONAL MEDICAL CENTER							11/20/2016	\$4,960.88
7	LAWNWOOD REGIONAL MEDICAL CENTER							11/7/2016	\$3,714.75
8	ST. LUCIE MEDICAL CENTER							11/23/2016	\$56,890.08
9	LAWNWOOD REGIONAL MEDICAL CENTER							4/11/2017	\$23,868.98
10	LAWNWOOD REGIONAL MEDICAL CENTER							8/16/2016	\$9,883.25
11	NORTH FLORIDA REGIONAL MEDICAL CENTER							8/8/2016	\$6,370.63
12	LAWNWOOD REGIONAL MEDICAL CENTER							8/1/2016	\$8,861.16
13	LAWNWOOD REGIONAL MEDICAL CENTER							7/2/2016	\$6,360.67
14	LAWNWOOD REGIONAL MEDICAL CENTER							6/27/2016	\$2,332.52
15	LAWNWOOD REGIONAL MEDICAL CENTER							6/21/2016	\$6,345.22
16	LAWNWOOD REGIONAL MEDICAL CENTER							6/23/2016	\$9,876.75
17	MEMORIAL HOSPITAL JACKSONVILLE							5/18/2017	\$72,778.07
18	LAWNWOOD REGIONAL MEDICAL CENTER							5/10/2016	\$4,550.61
19	MEMORIAL HOSPITAL JACKSONVILLE							5/7/2016	\$7,398.44
20	OCALA REGIONAL MEDICAL CENTER							5/7/2016	\$3,676.63
21	LAWNWOOD REGIONAL MEDICAL CENTER							5/3/2016	\$10,348.32
22	MEMORIAL HOSPITAL JACKSONVILLE							4/28/2016	\$5,036.39
23	LAWNWOOD REGIONAL MEDICAL CENTER							4/18/2016	\$18,715.06
24	MEMORIAL HOSPITAL JACKSONVILLE							4/17/2016	\$2,216.79
25	CAPITAL REGIONAL MEDICAL CENTER							4/13/2016	\$2,472.33
26	LAWNWOOD REGIONAL MEDICAL CENTER							4/10/2016	\$7,224.42
27	NORTH FLORIDA REGIONAL MEDICAL CENTER							4/5/2016	\$3,195.98
28	MEMORIAL HOSPITAL JACKSONVILLE							3/28/2016	\$7,116.97
29	MEMORIAL HOSPITAL JACKSONVILLE							3/18/2016	\$7,606.14
30	MEMORIAL HOSPITAL JACKSONVILLE							3/10/2016	\$5,423.05
31	MEMORIAL HOSPITAL JACKSONVILLE							3/2/2016	\$4,442.64
32	MEMORIAL HOSPITAL JACKSONVILLE							3/4/2016	\$4,031.98

	A	B	C	D	E	F	G	H	I
1	Facility Name	Pat Name	Pat Num	DOB	Admit Date	Discharge Date	Subscriber Number	Final Bill Date	Total Due
33	MEMORIAL HOSPITAL JACKSONVILLE							3/1/2016	\$24,314.97
34	MEMORIAL HOSPITAL JACKSONVILLE							2/22/2016	\$2,124.60
35	MEMORIAL HOSPITAL JACKSONVILLE							2/21/2016	\$4,986.14
36	MEMORIAL HOSPITAL JACKSONVILLE							2/19/2016	\$4,995.02
37	LAWNWOOD REGIONAL MEDICAL CENTER							5/11/2017	\$4,377.02
38	MEMORIAL HOSPITAL JACKSONVILLE							4/26/2017	\$2,575.36
39	LAWNWOOD REGIONAL MEDICAL CENTER							1/30/2016	\$7,482.61
40	MEMORIAL HOSPITAL JACKSONVILLE							1/25/2016	\$2,636.65
41	MEMORIAL HOSPITAL JACKSONVILLE							1/26/2016	\$6,080.14
42	MEMORIAL HOSPITAL JACKSONVILLE							1/15/2016	\$3,146.32
43	MEMORIAL HOSPITAL JACKSONVILLE							1/15/2016	\$8,376.36
44	MEMORIAL HOSPITAL JACKSONVILLE							1/4/2016	\$5,690.87
45	MEMORIAL HOSPITAL JACKSONVILLE							12/22/2015	\$4,536.15
46	MEMORIAL HOSPITAL JACKSONVILLE							12/15/2015	\$7,414.21
47	MEMORIAL HOSPITAL JACKSONVILLE							12/15/2015	\$16,006.76
48	MEMORIAL HOSPITAL JACKSONVILLE							12/21/2015	\$8,073.32
49	MEMORIAL HOSPITAL JACKSONVILLE							12/4/2015	\$13,159.46
50	MEMORIAL HOSPITAL JACKSONVILLE							11/28/2015	\$4,250.04
51	MEMORIAL HOSPITAL JACKSONVILLE							11/20/2015	\$6,193.44
52	MEMORIAL HOSPITAL JACKSONVILLE							11/19/2015	\$6,864.50
53	MEMORIAL HOSPITAL JACKSONVILLE							11/17/2015	\$2,275.52
54	MEMORIAL HOSPITAL JACKSONVILLE							11/4/2015	\$4,259.45
55	MEMORIAL HOSPITAL JACKSONVILLE							10/31/2015	\$11,393.72
56	MEMORIAL HOSPITAL JACKSONVILLE							10/24/2015	\$8,273.61
57	MEMORIAL HOSPITAL JACKSONVILLE							10/24/2015	\$6,436.43
58	MEMORIAL HOSPITAL JACKSONVILLE							10/20/2015	\$6,022.73
59	MEMORIAL HOSPITAL JACKSONVILLE							10/17/2015	\$6,404.21
60	MEMORIAL HOSPITAL JACKSONVILLE							10/9/2015	\$9,216.76
61	MEMORIAL HOSPITAL JACKSONVILLE							10/9/2015	\$5,064.20
62	LAWNWOOD REGIONAL MEDICAL CENTER							10/8/2015	\$4,534.34
63	MEMORIAL HOSPITAL JACKSONVILLE							10/13/2015	\$4,145.25

	A	B	C	D	E	F	G	H	I
1	Facility Name	Pat Name	Pat Num	DOB	Admit Date	Discharge Date	Subscriber Number	Final Bill Date	Total Due
64	MEMORIAL HOSPITAL JACKSONVILLE							10/6/2015	\$5,381.26
65	MEMORIAL HOSPITAL JACKSONVILLE							10/4/2015	\$10,095.64
66	MEMORIAL HOSPITAL JACKSONVILLE							10/2/2015	\$3,751.90
67	MEMORIAL HOSPITAL JACKSONVILLE							10/12/2015	\$11,978.85
68	MEMORIAL HOSPITAL JACKSONVILLE							9/29/2015	\$10,201.86
69	LAWNWOOD REGIONAL MEDICAL CENTER							9/25/2015	\$2,639.08
70	MEMORIAL HOSPITAL JACKSONVILLE							9/24/2015	\$4,325.51
71	LAWNWOOD REGIONAL MEDICAL CENTER							9/19/2015	\$4,652.29
72	MEMORIAL HOSPITAL JACKSONVILLE							9/15/2015	\$5,859.43
73	MEMORIAL HOSPITAL JACKSONVILLE							9/15/2015	\$9,262.12
74	LAWNWOOD REGIONAL MEDICAL CENTER							9/1/2015	\$7,777.50
75	MEMORIAL HOSPITAL JACKSONVILLE							8/18/2015	\$7,871.85
76	LAWNWOOD REGIONAL MEDICAL CENTER							8/13/2015	\$59,301.51
77	MEMORIAL HOSPITAL JACKSONVILLE							7/29/2015	\$6,276.26
78	LAWNWOOD REGIONAL MEDICAL CENTER							7/28/2015	\$39,585.34
79	MEMORIAL HOSPITAL JACKSONVILLE							6/4/2015	\$4,453.27
80	MEMORIAL HOSPITAL JACKSONVILLE							5/28/2015	\$15,498.12
81	MEMORIAL HOSPITAL JACKSONVILLE							5/27/2015	\$3,733.39
82	MEMORIAL HOSPITAL JACKSONVILLE							5/26/2015	\$11,499.82
83	MEMORIAL HOSPITAL JACKSONVILLE							5/22/2015	\$4,358.99
84	MEMORIAL HOSPITAL JACKSONVILLE							6/1/2015	\$8,029.04
85	MEMORIAL HOSPITAL JACKSONVILLE							5/21/2015	\$9,170.24
86	MEMORIAL HOSPITAL JACKSONVILLE							5/22/2015	\$14,327.07
87	MEMORIAL HOSPITAL JACKSONVILLE							5/5/2015	\$3,746.13
88	MEMORIAL HOSPITAL JACKSONVILLE							4/23/2015	\$4,552.54
89	MEMORIAL HOSPITAL JACKSONVILLE							4/17/2015	\$4,104.64
90	MEMORIAL HOSPITAL JACKSONVILLE							4/15/2015	\$6,297.84
91	MEMORIAL HOSPITAL JACKSONVILLE							4/14/2015	\$3,224.49
92	MEMORIAL HOSPITAL JACKSONVILLE							4/9/2015	\$8,807.04
93	MEMORIAL HOSPITAL JACKSONVILLE							4/28/2015	\$5,752.95
94	MEMORIAL HOSPITAL JACKSONVILLE							3/22/2015	\$12,180.83

	A	B	C	D	E	F	G	H	I	
1	Facility Name	Pat Name	Pat Num	DOB	Admit Date	Discharge Date	Subscriber Number	Final Bill Date	Total Due	
95	MEMORIAL HOSPITAL JACKSONVILLE								2/19/2015	\$2,733.75
96	NORTH FLORIDA REGIONAL MEDICAL CENTER								2/17/2015	\$48,857.22
97	LAWNWOOD REGIONAL MEDICAL CENTER								2/16/2015	\$3,772.59
98	LAWNWOOD REGIONAL MEDICAL CENTER								2/5/2015	\$20,959.90
99	MEMORIAL HOSPITAL JACKSONVILLE								2/4/2015	\$4,932.84
100	GULF COAST REGIONAL MEDICAL CENTER								1/16/2015	\$2,189.82
101	MEMORIAL HOSPITAL JACKSONVILLE								1/7/2015	\$5,509.79
102	LAWNWOOD REGIONAL MEDICAL CENTER								11/11/2014	\$4,906.55
103	MEMORIAL HOSPITAL JACKSONVILLE								10/11/2014	\$2,039.87
104										\$985,005.61

EXHIBIT B

HOSPITAL SERVICES AGREEMENT

Between

Corizon, Inc.

And

South Atlantic Division, Inc.

This Agreement is made and entered into this 13th day of October, 2013 (the "Effective Date"), by and between Corizon, Inc., a Missouri corporation with principal offices located at 105 Westpark Drive, Suite 200, Brentwood, TN, 37027, acting for itself or on behalf of any/all/other affiliated prisons listed on Exhibit I hereto made a part hereof (hereinafter collectively referred to as "Corizon") and South Atlantic Division, Inc. as disclosed agent for each individual hospital listed in Exhibit II (each individually a "Hospital"). Notwithstanding anything to the contrary, all rights, responsibilities and obligations are individual and specific to such hospitals and the all-inclusive reference to "Hospital" herein in no way imposes any cross-guarantees or joint responsibility by and amongst such individual hospitals or the disclosed agent authorized to enter into this Agreement on their behalf. This Agreement shall apply only to inmates from the prisons listed in Exhibit I hereto.

WITNESSETH:

WHEREAS, Corizon has a contract to provide or arrange for the provision of Health Care Services to certain inmates and detainees under the control of Florida Department of Corrections (hereinafter referred to as "Client"). In certain circumstances, it is necessary for Corizon to utilize hospital services for its Patients for both inpatient and outpatient care; and

WHEREAS, Hospital is a licensed hospital facility in the State of Florida, which is capable and willing to provide Health Care Services to the prison/jail community; and

WHEREAS, Corizon desires to engage Hospital and Hospital desires to contract with Corizon to provide Health Care Services to inmates and detainees in the custody of the Client, as specified and on the terms and conditions set forth herein.

NOW THEREFORE, for and in consideration of the mutual covenants and promises as are hereinafter set forth and other good and valuable consideration, the sufficiency of which is hereby acknowledged by the parties, Corizon and Hospital hereby agree as follows:



SECTION 1
Definitions

1.1 **Intentionally Omitted**

1.2 **Corizon/Client Contract** means the agreement entered into between Corizon and the Client whereby Corizon has agreed to provide or arrange for the provision of Health Care Services to the inmates and detainees in the custody of the Client.

1.3 **Corizon-Contracted Physician or Provider** means a physician or other midlevel provider contracted or employed by Corizon to provide medical services to Patients.

1.4 **Corizon's Medical Director** means the physician designated as the Corizon Medical Director for the correctional facility or facilities served under the Corizon/Client Contract.

1.5 **Completed Claim** means a timely claim submitted on an industry standard claim form (CMS-1500 or UB-04), for reimbursement of Health Care Services which contains at least the following information:

- 1) Patient (Inmate) name and Department of Correction or Booking Identification number (Inmate Number).
- 2) Name and Address of Correctional Facility from which the inmate was transported.
- 3) Patient Date of Birth.
- 4) Date(s) of Service.
- 5) Hospital Name, Address, Phone number, and Tax Identification number.
- 6) ICD-9 Diagnostic and Surgical Procedure codes and descriptions.
- 7) Current industry standard procedure coding (UB-04 Revenue Codes, DRG, HCPCS and CPT codes as appropriate) and descriptions.
- 8) Detailed billing of charges and units.

1.6 **Health Care Services** means the hospital and other related services, including both inpatient and outpatient care, provided to a Patient by Hospital which are Medically Necessary and are requested by (i) the HSA; (ii) the Medical Director or a Corizon-Contracted Physician or Provider; or (iii) a physician with privileges at Hospital or another health care professional at Hospital furnishing services under supervision of such a physician. The term Health Care Services shall also include all services that constitute Emergency Services.

1.7 **Health Services Administrator (HSA)** means the Corizon employee responsible for managing the medical program for the correctional facility or facilities served under the Corizon/Client Contract.

1.8 **Emergency Medical Condition** means a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in placing the health of the Patient in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.



1.9 **Emergency Services** means those Health Care Services which are Medically Necessary and provided for the treatment of an Emergency Medical Condition.

1.10 **Medically Necessary** describes those services which are: (a) appropriate for the treatment of the Patient's medical condition; (b) provided for the diagnosis or care and treatment of the Patient's medical condition; (c) in accordance with the applicable standards of good medical practice; and (d) not elective or cosmetic or primarily for the convenience of the Patient, the Hospital or any medical provider. In addition, any Health Care Service ordered by the HSA; the Medical Director or a Corizon-Contracted Physician or Provider; a physician with privileges at Hospital who is treating a Patient, or any other health care professional who is supervised by such a physician treating the Patient; and any Health Care Service reasonably arising out of or related thereto, shall be deemed to be Medically Necessary for purposes of this Agreement.

1.11 **Patient** means those correctional facility inmate patients or detainees in the custody of the Client for whom Corizon has contracted to provide or arrange for the provision of Health Care Services pursuant to the Corizon/Client Contract.

1.12 **Primary Payor** Entity that has the initial obligation to pay a claim for Health Care Services for Patient.

1.13 **Secondary Payor** Entity that pays second on a claim for Health Care Services for Patient and their payment is only to the extent that payment has not been made by Primary Payor.

SECTION 2 Hospital's Rights and Obligations

2.1 **General Engagement.** Corizon hereby engages Hospital to provide Health Care Services to Patients and Hospital hereby accepts such engagement according to the terms and conditions of this Agreement. Patient transfer travel arrangements will be made by Corizon only after approval of the provision of Health Care Services by Corizon's HSA, who will coordinate the provision of Health Care Services and the implicated security requirements with the appropriate agency officials.

2.2 **Time and Place of Services.** Hospital agrees to provide and/or make available Health Care Services at Hospital's usual and customary site for rendering services and in accordance with Hospital's usual and customary schedule for rendering services. If Hospital decides voluntarily to limit, or discontinue any of the services that it offers, it will provide Corizon with written notice of such action at least sixty (60) days prior to such limitation, or discontinuation. If Hospital must involuntarily limit or discontinue any services, it will provide Corizon with written notice immediately upon learning of such limitation or discontinuation.

2.3 **Qualifications.** Hospital represents that Hospital possesses a current and unrestricted license to operate as a hospital in the State of Florida. Hospital also represents that Hospital possesses current and unrestricted controlled substance certification. Hospital shall maintain all federal, state and local licenses, certifications and permits, without material restriction, which are



required to provide Health Care Services according to the laws and jurisdiction in which Health Care Services are provided, and shall comply with all applicable statutes and regulations. Hospital shall also require that all health care professionals employed by or under contract with Hospital to render Health Care Services possess and maintain any required licenses and permits without material restrictions. Hospital shall provide Corizon with written documentation of Hospital's current JCAHO accreditation upon request. Hospital's failure to meet or maintain all the required qualifications described in this Section may result in immediate termination of this Agreement after reasonable opportunity to cure, if curable.

2.4 **Discharge Summaries and Itemized Statements.** Hospital shall provide to Corizon a narrative discharge summary and operative report for all Patients receiving inpatient care and a summary discharge statement for all Patients receiving outpatient services at Hospital.

Corizon will receive an itemized bill for each such Patient, whether the services provided are inpatient or outpatient in nature, or both. Upon at least 10 business days' prior written notice, and during the term of this Agreement, Corizon shall be entitled to audit any medical and billing records related to a Patient necessary to insure that services billed to Corizon were rendered in accordance with the invoice presented.

2.5 **Utilization Review.** Hospital specifically agrees to use reasonable efforts to cooperate with the utilization review program, included as Attachment 1, implemented by Corizon on behalf of the Client. The Hospital will assist with physician communications regarding each case. Subject to Hospital's policies regarding concurrent review and the other terms of this Agreement, Hospital will permit Corizon to review Patient hospital stays during and after hospitalization and will provide Corizon with access to Patient medical information useful in ascertaining the Medical Necessity of particular procedures and the length of time of particular stays. Upon at least 15 business days' prior written notice, Hospital will make available for review by Corizon utilization review personnel medical and billing records maintained by the Hospital regarding a particular admission of a Patient during the term of this Agreement. Subject to Hospital's policies regarding utilization review by third parties, the Hospital's Medical Records Department will honor Corizon's utilization review personnel's requests for records.

2.6 **Intentionally Omitted.**

2.7 **Quality Assurance.** Hospital shall ensure the application of a quality assurance process that utilizes appropriate quality of care standards. Hospital will also ensure that appropriate quality assurance review activity, including subsequent action taken by the Hospital, will occur for quality of care issues referred by Corizon.

2.8 **Compliance with Applicable Law.** Hospital agrees that all Health Care Services provided by or through Hospital pursuant to this Agreement, and documentation thereof, will be in compliance with applicable law and certification or licensure requirements.

2.9 **Security.** Corizon and the Client shall be responsible for the security of Patients being treated on either an inpatient or outpatient basis at Hospital. Corizon has the ability to bind the Client to the terms of this provision. Neither Corizon nor Hospital shall be responsible for



providing such security, but both are required to adhere to security regulations established by the Client or its designee.

2.10 **Staff Privileges.** Hospital hereby agrees that Corizon's Medical Director shall be considered for staff privileges at Hospital during the term of this Agreement. Approval for staff privileges shall be determined by the guidelines set by the medical staff by-laws of the Hospital.

2.11 **Employment Eligibility.** Hospital shall utilize the U.S. Department of Homeland Security's E-Verify system to verify employment eligibility of all persons employed by Hospital during the contract term by Corizon to perform work or provide services pursuant to this Agreement with the Client.

SECTION 3 Compensation of Hospital

3.1 **Reimbursement for Services.** For any Patient admitted or brought to Hospital for either inpatient or outpatient Health Care Services by or at the direction of Corizon, the Corizon Regional or Site Medical Director or a Corizon-Contracted Physician or Provider, the following reimbursements shall apply. Corizon agrees that the presentation of a Patient at Hospital shall be construed to constitute a pre-authorization by Corizon to furnish Emergency Services to a Patient, however this does not relieve Hospital of the responsibility of notification and of authorization request for Health Care Services other than Emergency Services. If the Patient's attending physician at Hospital orders an inpatient admission of the Patient, Hospital shall notify Corizon at the time of admission. Authorization for continued stay shall be in accordance with Section II, Attachment 1, Utilization Review.

3.1.1 **Inpatient Care.** Corizon shall reimburse Hospital for Health Care Services according to the rates listed in Exhibit II.

3.1.1.1 When Corizon is the Primary Payor, the payment from Corizon as specified in Exhibit II shall be accepted by Hospital as payment in full for all authorized Health Care Services.

3.1.1.2 Notwithstanding the above, Corizon will be considered Secondary Payor to all other possible payors.

3.1.1.3 Verification of available benefits will be documented prior to payment by Corizon to the extent known by Corizon. Corizon will coordinate payment up to 100% of what is owed under this Agreement with any other insurance carrier, provided, however, that in no case shall Corizon be responsible for payments beyond its coverage limits.

3.1.1.4 Corizon is only responsible for payments of Health Care Services provided to Patients as defined by this Agreement. If the Patient is released from custody of the Client while hospitalized, then Corizon will cooperate to determine the availability of third party reimbursement. If third party reimbursement is not available, Corizon will be responsible for payment for Health Care Services provided to Patients through the date of discharge. Cooperation will include Corizon notifying the



Hospital of the inmate's release or impending release from Client's custody. Corizon will cooperate with Hospital in providing information which will allow the Hospital to seek reimbursement from other parties once the Patient is no longer an inmate.

3.1.2 **Outpatient Care.**

All outpatient services including emergency, ancillary, diagnostic or outpatient surgery rendered by Hospital on behalf of a Patient under the care of Corizon will be reimbursed according to the rates listed in Exhibit II.

3.2 **Hospital Acquired Conditions.** The Parties hereby agree that reimbursement for conditions acquired while Patient is being treated at Hospital ("Hospital Acquired Condition" or "HAC" as defined in Attachment 2 to this Agreement) will be governed by the terms set forth in Attachment 2, Hospital Acquired Conditions and Preventable Surgical Events.

3.3 **Patient-Inflicted Injuries While at Hospital.** Corizon shall pay Hospital for any Health Care Services rendered to a Patient necessitated by self-inflicted injuries or other actions taken by the Patient to harm himself or herself while such Patient was an inpatient or outpatient at Hospital unless Hospital has failed to follow its security protocols and procedures.

3.4 **Claims Submission.**

3.4.1 Completed Claims should be sent to the following address:

Corizon
PO Box 981639
El Paso, TX 79998

To inquire about the status of claims submitted, please call Corizon at 888-865-2910.

Corizon will also accept the electronic filing of UB-04 forms. When submitting UB-04 forms via an electronic format, Hospital should use the Corizon payer identification number 43160.

3.4.2 Hospital will submit Completed Claims to Corizon within ninety (90) days of date of service rendered to the Patient or Corizon will have no obligation to pay; provided, however, this 90 day time frame shall be extended for another reasonable time if the failure of the Hospital to submit the Completed Claim was due to Hospital not having knowledge of alternate payment sources.

3.4.3 Hospital will use the most current procedural (CPT) and HCPCS codes on all forms. Hospital will abide by all AMA/CPT code billing standards, rules and regulations that are applicable (including inclusive procedure codes, prospective payment system OPPS and/or automated payment classification APC).



3.4.4 Guidelines for billing and coverage for services not specifically detailed within this Agreement will be governed by the most current version of the Centers for Medicare and Medicaid Service's guidelines for the Medicare Program.

3.4.5 Corizon shall pay Completed Claims, or give Hospital notice of denial, for services provided under this Agreement within forty-five (45) days after receipt of the Completed Claim by Corizon.

3.5 **Claim Audits.** Hospital acknowledges and agrees that all Hospital claims contractually paid at a percentage of charges may be reviewed by a nurse analyst and/or claims auditor. In this process, detailed charges are reviewed for improper, inappropriate or erroneous billings. The review process may also include a verification of diagnosis codes in relation to the performed procedures. Corizon may request Hospital to provide appropriate documentation to substantiate questioned charges and all itemized services may be analyzed for payment on an individual basis according to the type and location of service being provided; provided, however, Corizon shall not conduct any Medical Necessity reviews for inpatient admissions or outpatient services for which an authorization was given (or which are deemed given pursuant to this Agreement) or which were concurrently reviewed by Corizon. For any particular claims found to be overpaid, Corizon shall notify Hospital of such alleged overpayments. Without Hospital's written consent in each instance, Corizon shall not have the right to offset or setoff from amounts it owes Hospital amounts Corizon allegedly overpaid Hospital.

3.6 **Appeal Process.** In the event that a dispute arises concerning the resolution of a Completed Claim, Hospital may appeal by submitting the dispute to Corizon in writing, with supporting documentation, within forty five (45) calendar days following Corizon's response or denial of the Completed Claim. Corizon shall provide a reply within forty five (45) days and the Hospital shall initiate appropriate action with Corizon, if any, within forty five (45) days following receipt of Corizon's response. If Hospital fails to dispute in writing Corizon's handling of a Completed Claim within forty five (45) calendar days following receipt of Corizon's response, then such claim may be considered waived and Corizon shall not be obligated to make any payment or adjustment thereafter.

3.7 **Right of Recovery.** Hospital will not seek reimbursement from the Patient or from the Client without Corizon's written consent.



SECTION 4
Term and Termination

4.1 **Term.** The term of this Agreement will commence on the Effective Date and will continue in effect for five (5) years ("Initial Term") and shall automatically renew for recurring one (1) year terms thereafter.

4.2 **Termination.** In addition, this Agreement may be terminated as follows:

4.2.1 **Termination without Cause.** Either party may terminate this Agreement, without cause by giving the other party written notice of termination, not less than ninety (90) days prior to termination date. In addition, any Hospital that is a party to this Agreement can terminate this Agreement without cause as to itself, without terminating this Agreement as a whole, by providing notice to Corizon in the manner set forth herein.

4.2.2 **Termination for Cause.** Corizon may terminate this Agreement for cause if the Hospital's breach of a material provision of this Agreement has not been cured within thirty (30) days after written notice of the breach from Corizon; provided, however, if not all Hospitals that are a party to this Agreement have breached a material provision of this Agreement, Corizon shall terminate only such Hospitals that have failed to cure the material breach, and not any other Hospital that is a party to this Agreement. Similarly, Hospital may terminate this Agreement for cause if Corizon's breach of a material provision of this Agreement has not been cured within thirty (30) days after written notice of the breach from Hospital; provided, however, a particular Hospital may terminate its participation under this Agreement for cause, without terminating this Agreement as a whole, in the manner provided for herein.

4.2.3 **Immediate Termination by Corizon.** Corizon may immediately terminate this Agreement upon the occurrence of any of the following events:

4.2.3.1 Hospital's failure to maintain required insurance as provided in this Agreement; or

4.2.3.2 Hospital's inability to meet its obligations pursuant to this Agreement due to financial insolvency, bankruptcy, or lack of capacity to provide Health Care Services; or

4.2.3.3 Hospital is found guilty of a criminal offense; or

4.2.3.4 Hospital is found liable by a court of law for gross misconduct in providing care to Patients under this Agreement.

Notwithstanding the foregoing, if not all Hospitals that are parties to this Agreement have engaged in actions that give rise to immediate termination,



Corizon shall terminate only such Hospitals whose actions give rise to immediate termination, and not any other Hospital that is a party to this Agreement.

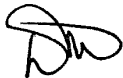
4.2.4 **Immediate Termination by Hospital.** Hospital may immediately terminate this Agreement as a whole upon the occurrence of any of the following events:

- 4.2.4.1 Hospital may terminate this Agreement (i) on the filing by Corizon of a voluntary petition in bankruptcy or for reorganization under any bankruptcy law, or a petition for the appointment of a receiver of all or any substantial portion of the assets of Corizon, or any voluntary or involuntary steps to dissolve Corizon unless such steps to dissolve are promptly reversed or voided; (ii) upon the consent by Corizon to an order for relief under the federal bankruptcy laws or the failure to vacate such an order for relief within ninety (90) days from and after the date of entry thereof; (iii) upon the entry of an order, judgment, or decree adjudging Corizon as bankrupt or insolvent or which appoints or provides for the taking of possession by a receiver, trustee, liquidator, or similar official for any of the property of Corizon and any such order, judgment, or decree continuing unstayed and in effect for a period of ninety (90) days; or
- 4.2.4.2 Corizon is found guilty of a criminal offense.
- 4.2.4.3 Corizon loses its contract with the Florida Department of Corrections

4.3 **Services Subsequent to Termination.** Following termination of this Agreement, Hospital shall continue to provide Health Care Services to any Patient who is at the time of the termination under active treatment, and either the patient is discharged or treatment responsibility is assumed by another provider. Corizon shall pay Hospital for such Health Care Services as is set forth in Exhibit II as long as the Patient remains the responsibility of Corizon. This provision shall survive the termination or expiration of this Agreement for any reason.

SECTION 5 Insurance

5.1 **Insurance.** At all times during the term of this Agreement and any renewals hereof, Hospital shall maintain or cause to be maintained adequate professional liability insurance policies or self-insurance with limits of not less than one million dollars (\$1,000,000) per occurrence and three million dollars (\$3,000,000) in annual aggregate. In addition, Hospital agrees to procure and maintain, at its sole expense, such comprehensive general and/or umbrella liability insurance as Hospital shall reasonably deem necessary to cover its potential general



liability risk exposure. Hospital shall require all health care professionals employed by or under contract with Hospital to procure or maintain the same limits of professional liability insurance as set forth above, unless such professionals are covered under Hospital's insurance policy.

The insurance obtained pursuant to this Section, including any Continuing Coverage, will cover all employees, physicians and agents of Hospital who provide Health Care Services to Patients, against any and all claims, actions, judgments, liabilities, losses, damages, costs, and obligations (including attorney's fees) which are attributable to or which arise, directly or indirectly, out of any act or omission by Hospital and/or its employees, physicians, or agents.

5.2 **Certifications.** Hospital shall, within ten (10) days after execution of this Agreement and on an annual basis thereafter, provide to Corizon certificates issued by an insurance carrier or its agent or other evidence of insurance as required under this Agreement. Hospital shall provide Corizon with at least thirty (30) days prior written notice of any modification, cancellation, or non-renewal of such policies.

SECTION 6 Relationship of the Parties

6.1 **Relationship of the Parties.** The relationship of Hospital to Corizon is that of independent contractor. Nothing contained herein shall create an employer-employee, principal-agent, or partnership relationship between Corizon and Hospital or between Corizon and any employee, agent, or physicians of Hospital. Corizon shall not exercise control or direction over the manner in which Hospital or any employee, agent, or physician of Hospital renders services. Nothing contained herein shall interfere with the hospital-patient relationship between Hospital and any patient, including the Patients under this Agreement, or with Hospital's legal or ethical obligation to provide the proper standard of care to Patients.

6.2 **Confidential Information.** Each of Hospital and Corizon agrees not to disclose or in any way use, or allow any other person to disclose or use, confidential information of or concerning the other without the other party's prior express written consent. Confidential information includes, but is not limited to, legal or claim data, financial data, methods of operation, policies and procedures. Neither party shall copy or remove the other's documents for its own use or for the use of others, nor shall any party make use of or allow or assist any other person or company to make use of the other party's procedures or programs, except as authorized under this Agreement. Neither Hospital nor Corizon shall disclose, or allow others to disclose, the terms of this Agreement, except, as it is necessary to perform this Agreement or to obtain accounting, legal or tax advice from its professional advisors. This Section shall survive termination of this Agreement.

6.3 **Non-Exclusivity.** This Agreement is a non-exclusive arrangement. Hospital may participate in other affiliations and render such other services as Hospital determines. Hospital acknowledges that Corizon may contract with other health care providers, including hospitals, for the purpose of fulfilling its obligations pursuant to the Corizon/Client Contract.



6.4 **Medical Records.** Hospital agrees to prepare comprehensive medical records for each Patient to whom Hospital provides Health Care Services. Each such medical record shall contain sufficient information to identify the Patient, establish a diagnosis and medical classification, support the diagnosis, identify and justify the treatment, and document the results of such treatment. Medical records prepared by Hospital during the term of this Agreement will be kept confidential by Hospital and shall be maintained in accordance with applicable state and federal laws governing confidentiality. Hospital will allow Corizon and its health care professional's access to such medical records without cost to Corizon. To the extent Corizon requires Hospital to make copies of Patient medical records; Corizon shall pay Hospital for such copies the maximum amounts set forth in Chapter 395, Florida Statutes. This Section shall survive termination of this Agreement.

SECTION 7 Construction of Agreement

7.1 **Assignment.** The Parties to this Agreement may not assign, sell or transfer any of their rights or responsibilities under this Agreement without the prior written consent of the other party; provided however, that Corizon may transfer its rights or interest or delegate its obligations under this Agreement to Corizon's affiliated entity, Corizon Health, Inc. A change in control of more than 33% of the ownership or control of a party shall be deemed an assignment for purposes of this Agreement.

7.2 **Amendments.** This Agreement may be amended only by written agreement signed by the parties hereto.

7.3 **Section Headings.** The headings of sections in this Agreement are for reference only and shall not affect the meaning of this Agreement.

7.4 **Entire Agreement.** This Agreement, inclusive of any and all amendments, attachments and exhibits incorporated herein by reference, constitutes the entire understanding and agreement between the parties with regard to the subject matter hereof. No other prior or contemporaneous promise, obligation, statement or understanding between the parties, whether written or oral, shall be valid or binding.

7.5 **Binding Effect.** This Agreement shall be binding upon and inure to the benefit of each party hereto, and their successors and permitted assigns. No party may assign this Agreement, except as specifically provided otherwise herein.

7.6 **No Third Party Beneficiary Rights.** No patient, nor the Client, nor any other third party shall have any third party beneficiary rights hereunder.

7.7 **Non-Waiver.** Failure to insist upon strict compliance with any of the terms or conditions of this Agreement shall not be deemed to be a waiver in the event of any future breach of any term or condition hereunder.



7.8 **Severability.** Should any provision (or part thereof) of this Agreement be held to be invalid and/or unenforceable, the remaining provisions shall remain in full force and effect.

7.9 **Notices.** Any notice required hereunder shall be sent by registered or certified mail (return receipt requested), personal delivery, overnight commercial carrier, or other guaranteed delivery. The notice shall be effective as of the date of delivery if the notice is personally delivered, or the date of receipt or refusal to accept delivery if the notice is forwarded by other means. Unless otherwise specified, notices shall be sent to:

Corizon

Corizon
105 Westpark Drive, Suite 200
Brentwood, TN 37027
Attn: Therese Brumfield, Vice President Provider Operations

With a courtesy copy to the Attn: General Counsel

Hospital

South Atlantic Division, Inc.
900 Island Park Drive, Suite 202-A
Charleston, SC 29492
Attn: Teresa Finch

With a copy to:

HCA
One Park Plaza, Building 1
Nashville, TN 37203
Attn: General Counsel

7.10 **Non-Discrimination.** Hospital shall not discriminate on the basis of race, color, sex, religion, national origin, ethnic group, age or disability.

7.11 **Multiple Counterparts.** This Agreement may be executed in multiple counterparts, each of which shall be deemed to be an original and all of which taken together shall constitute a single instrument.

7.12 **Name, Symbol and Service Mark.** During the term of this Agreement, each party shall have the right to use the other's name solely to make public reference to Hospital as a contracted provider for Corizon and Client. Hospital and Corizon shall not otherwise use each other's name, symbol or service mark without prior written approval.

7.13 **Applicable Law.** For conflict of law purposes, the laws of the State of Florida shall apply in interpreting the terms of this Agreement.



IN WITNESS WHEREOF, the parties have executed this Agreement effective as of that Commencement Date first above written.

Corizon, Inc.

South Atlantic Division, Inc.

John Dallas
Signature

[Signature]
Signature

John Dallas
Printed Name

Teresa Finch Jimmie Thomas
Printed Name

Vice President, Operations
Title

Vice President
Title

Date: 12-17-13

Date: 12-18-13

M. Therese Brumfield
Signature

M. Therese Brumfield
Printed Name

Vice President, Provider Operations
Title

Date: 12/17/13

CONTRACT NOT VALID WITHOUT SIGNATURES
Hospital Services Agreement
Revised: 12/8/08; 8/09; 3/10; 5/10; 6/10, 8/10, 06/11

[Signature]

EXHIBIT I

Prisons Subject to this Agreement:

Description	Street Address	City & State	Zip Code	Phone Number
APALACHEE WEST UNIT	52 West Unit Drive	Sneads, Florida	32460-4165	(850) 718-0577
APALACHEE EAST UNIT	35 Apalachee Drive	Sneads, Florida	32460-4166	(850) 718-0688
JACKSON C.I.	5563 10th Street	Malone, Florida	32445-3144	(850) 569-5260
CALHOUN C.I.	19562 SE Institution Dr.	Blountstown, Florida	32424-5156	(850) 237-6500
CENTURY C.I.	400 Tedder Road	Century, Florida	32535-3659	(850) 256-2600
HOLMES C.I.	3142 Thomas Drive	Bonifay, Florida	32425-0190	(850) 547-8700
WALTON C.I.	691 Institution Road	De Funiak Springs, Florida	32433-1831	(850) 951-1300
GULF C.I.	500 Ike Steele Road	Wewahitchka, Florida	32465-0010	(850) 639-1000
NWFRC MAIN UNIT.	4455 Sam Mitchell Drive	Chipley, Florida	32428-3597	(850) 773-6100
FRANKLIN C.I.	1760 Highway 67 North	Carrabelle, Florida	32322	(850) 697-1100
OKALOOSA C.I.	3189 Colonel Greg Malloy Road	Crestview, Florida	32539-6708	(850) 682-0931
WAKULLA C.I.	110 Melaleuca Drive	Crawfordville, Florida	32327-4963	(850) 410-1895
SANTA ROSA C.I.	5850 East Milton Road	Milton, Florida	32583-7914	(850) 983-5800
LIBERTY C.I.	11064 N.W. Dempsey Barron Road	Bristol, Florida	32321-9711	(850) 643-9400
WAKULLA ANNEX	110 Melaleuca Drive	Crawfordville, Florida	32327-4963	(850) 487-4341
NWFRC ANNEX.	4455 Sam Mitchell Drive	Chipley, Florida	32428-3597	(850) 773-6500
SANTA ROSA ANNEX	5850 East Milton Road	Milton, Florida	32583-7914	(850) 981-7602
QUINCY ANNEX	2225 Pat Thomas Parkway	Quincy, Florida	32351	(850) 627-5400
COLUMBIA C.I.	216 S.E. Corrections Way	Lake City, FL	32025-2013	(386) 754-7600
FLORIDA STATE PRISON	7819 N.W. 228th Street	Raiford, Florida	32026-1000	(904) 368-2500

FSP WEST UNIT	7819 N.W. 228th Street	Raiford, Florida	32026-3000	(904) 368-2500
R.M.C. WEST UNIT	8183 SW 152nd Loop	Lake Butler, Florida	32054-0628	(386) 496-6002
R.M.C. MAIN UNIT (W/O HOSPITAL)	7765 S. CR 231	Lake Butler, Florida	32054-0628	(386) 496-6000
CROSS CITY C.I.	568 N.E. 255th Street	Cross City, Florida	32628	(352) 498-4444
MAYO C.I.	8784 US Highway 27 West	Mayo, Florida	32066-3458	(386) 294-4500
UNION C.I.	7819 N.W. 228th Street	Raiford, Florida	32026-4000	(386) 431-2000
HAMILTON C.I.	10650 S.W. 46th Street	Jasper, Florida	32052-1360	(386) 792-5151
MADISON C.I.	382 Southwest MCI Way	Madison, Florida	32340	(850) 973-5300
TAYLOR C.I.	8501 Hampton Springs Road	Perry, Florida	32348-8747	(850) 838-4000
TAYLOR ANNEX	8501 Hampton Springs Road	Perry, Florida	32348	(850) 838-4002
SUWANNEE C.I.	5964 U.S. Highway 90	Live Oak, Florida	32060	(386) 963-6201
HAMILTON ANNEX	10650 S.W. 46th Street	Jasper, Florida	32052-1360	(386) 792-5151
COLUMBIA ANNEX	216 S.E. Corrections Way	Lake City, FL	32025-2013	(386) 466-3000
LAWTEY C.I.	22298 NE County Road 200B	Lawtey, Florida	32058	(904) 782-2000
BAKER C.I.	20706 U.S. Highway 90 West	Sanderson, Florida	32087-2359	(386) 719-4500
LANCASTER C.I.	3449 S.W. State Road 26	Trenton, Florida	32693-5641	(352) 463-4100
R.M.C. HOSPITAL	7765 S. CR 231	Lake Butler, Florida	32054-0628	(386) 496-6000
TOMOKA C.I.	3950 Tiger Bay Road	Daytona Beach, Florida	32124-1098	(386) 323-1070
PUTNAM C.I.	128 Yelvington Road	East Palatka, Florida	32131-2100	(386) 326-6800
MARION C.I.	3269 NW 105th Street	Lowell, Florida	32663-0158	(352) 401-6400
SUMTER C.I.	9544 County Road 476B	Bushnell, Florida	33513-0667	352) 569-6100
LAKE C.I.	19225 U.S. Highway 27	Clermont, Florida	34715-9025	(352) 394-6146

LOWELL C.I.	11120 NW Gainesville Rd.	Ocala, Florida	34482-1479	(352) 401-5301
CFRC MAIN	7000 H C Kelley Rd	Orlando, FL	32831-2518	(407) 207-7777
CFRC EAST	7000 H C Kelley Rd.	Orlando, FL	32831-2518	(407) 207-7777
CFRC SOUTH	7000 H C Kelley Rd	Orlando, FL	32831-2518	(407) 207-7777
HERNANDO C.I.	16415 Spring Hill Drive	Brooksville, Florida	34604-8167	(352) 754-6715
AVON PARK C.I.	P.O. Box 1100 County Road 64 East	Avon Park, Florida	33826-1100	(863) 453-3174
LOWELL RECEPTION CENTER	3700 NW 111th Place	Ocala, Florida	34482-1479	352-840-8000
ZEPHYRHILLS C.I.	2739 Gall Boulevard	Zephyrhills, Florida	33541-9701	(813) 782-5521
POLK C.I.	10800 Evans Road	Polk City, Florida	33868-6925	(863) 984-2273

**EXHIBIT II
HOSPITAL LISTING AND COMPENSATION**

Memorial Health Care Group Inc. d/b/a Memorial Hospital Jacksonville
3625 University Blvd.
Jacksonville, FL 32216
Tax: 59-3283127
NPI: 1447206438
Medicare 10-0179
Medicaid 0101931-00
Phone: (904) 399-6111
Billing Address: Memorial Hospital Jacksonville
P.O. Box 406368, Atlanta, GA 30384-6368

Rates of Reimbursement for Hospital Listing. – See Attached



ATTACHMENT 1

UTILIZATION REVIEW

SECTION I. GENERAL INFORMATION

Corizon's Utilization Review Program (hereinafter "Corizon UR") utilizes nationally accepted clinical guidelines to determine justification of admission and necessity of services. Continued stay is based upon severity of illness, necessity of service and level of care provided by the Hospital.

The Hospital Utilization Review Department (hereinafter referred to as "Hospital UR") is requested to assist Corizon UR in obtaining current clinical information on all hospitalized Patients who are in the Facility.

Corizon UR may request the medical record (selected portions or its entirety) upon discharge of the patient from the Hospital to perform retrospective review or quality assurance reviews as needed; provided, however, all services performed as a result of or arising out of an order from a Corizon-Contracted Physician or Provider, the HSA or the Medical Director, or the physician at a Hospital furnishing services to a Patient, shall be deemed authorized and Medically Necessary, except as otherwise expressly otherwise provided in this Agreement or this Attachment.. Requests for Patient medical records shall be in writing to the Medical Records Department. Separate written consent of the Patient is not necessary when Corizon is the primary payor of the claim.

All Patient information received by the Hospital, and likewise by Corizon, will remain privileged and confidential. Information will not be disclosed to unauthorized parties.

SECTION II. ADMISSION AND CONTINUED STAY REVIEWS

Except in Emergencies, Corizon shall notify Hospital in advance of the presentation of a Patient to Hospital for inpatient or outpatient services. Corizon shall provide Hospital with an authorization number for all elective/planned admissions prior to the admission; emergency admissions will not be given an authorization number, and none is required. Hospital may obtain verification of authorization numbers from Corizon UR for elective/planned admissions during normal working hours (Monday through Friday 8:30 a.m. - 6:00 p.m.) by calling (800) 729-0069. During non-business hours admissions may be reported by Fax to (615) 376-1165.

Authorization of an admission of a Patient by Corizon guarantees coverage, eligibility, and payment for Health Care Services provided during the admission. Further, Corizon shall pay for all Emergency Services rendered by Hospital to a Patient who presents to Hospital without the need for any authorization. Determination by Corizon UR that false, misleading, or incomplete information was provided at the time of initial authorization of service, may result in a denial of payment.



Corizon UR will contact the Hospital UR to request review during the Hospital UR Office's normal working hours. Corizon may provide a dedicated utilization reviewer to Hospital to be located on Hospital's premises Monday – Friday. Reviews are requested at a minimum upon admission to the facility, with continued stay reviews on Mondays, Wednesdays and Fridays. Periods between reviews may be more or less frequent if the patient's condition indicates such and both the Corizon UR Representative and the Hospital's UR Representative are in agreement. Authorization for continued stay will be given to the Hospital's UR Representative by the Corizon UR Representative for the period of time for which the service was provided and reported. Authorization for continued stay is not given in advance unless the patient's condition warrants less frequent reviews. If clinical information provided does not meet the criteria for continued Hospital stay, Hospital UR will be notified by Corizon UR of the potential for denial of payment. An opportunity for the attending physician or Hospital UR to provide further information is then given. If it is determined that Patient will be discharged, Corizon will give notice to Hospital and will ensure secure transportation under custody of Corizon personnel or Corizon's designee. A Corizon physician advisor is available Monday - Friday 8:30 a.m. - 6:00 p.m. at (800) 729-0069 for discussion of the case.

SECTION III. DENIALS AND RECONSIDERATION

The Corizon Utilization Review Department will notify the Hospital UR Department when the decision to issue a denial for authorization of services consistent with this Agreement. Such notification shall be by telephone followed by written letter indicating the reason(s) for denial. Denials may be issued only for circumstances within the Hospital's control, including HACs. Discharge from Hospital shall be dependent on the order of Patient's attending physician.

The Hospital may request reconsideration for denied authorization of services. Written request for reconsideration must be made within forty five (45) days of the dated letter of authorization denial and should include supportive documents for reconsideration such as Physician Progress Notes, Lab and X-ray Results, Nursing Notes, Medication Records, etc. Reconsideration requests should be forwarded to the following address:

Corizon Appeals
105 Westpark Drive, Suite 200
Brentwood, TN 37027

A determination by the Appeals committee of Corizon will be issued in writing to the Hospital within forty-five (45) days of request for reconsideration. No determination shall affect the rights of Hospital pursuant to this Agreement.



SECTION IV. COVERAGE ISSUES

All non-emergency services not related to or arising out of the Patient's primary diagnosis must be authorized in advance by the Corizon UR Department Representative.

Corizon does not provide payment for services for the following:

- * Sterilizations/Tubal Ligations
- * Non-authorized Elective Surgical Procedures
- * Cosmetic Surgery
- * Infertility Studies
- * Organ Transplants

SECTION V. EXPIRATION OF SENTENCE

The Corizon UR Department will notify the Hospital by telephone, followed by written confirmation, of all Patient inmates released from custody of the Client. Corizon will continue to pay for services being rendered by Hospital to a Patient who, when admitted, was in Client's custody, but who while hospitalized, was released from such custody, until such Patient's discharge.

SECTION VI. OUTPATIENT SERVICES

Corizon provides precertification of all non-emergent outpatient services. Except for Emergency Services, which can be furnished without pre-authorization, elective services which are provided without pre-authorization shall be clinically audited for necessity and justification prior to payment. Services which have been granted an authorization shall not be subject to Medical Necessity reviews. Corizon UR Department will work with the outpatient clinic areas to provide verification of authorized services during normal working hours specified above.

SECTION VII. QUALITY ASSURANCE

Hospital shall ensure the application of a quality assurance process that utilizes appropriate quality of care standards. Hospital will also ensure that appropriate quality assurance review activity, including subsequent action taken by the Hospital, will occur for quality of care issues referred by Corizon. Subject to any applicable privileges, Hospital shall make available for review and examination by Corizon's Medical Director or his or her designee, upon request, documentation regarding the Hospital's quality assurance activities as they may reasonably relate to Health Care Services rendered to Patients hereunder.

Upon at least 15 business days' prior written request, Corizon may request Patient medical records for QA purposes.



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EXHIBIT II

Memorial Hospital Jacksonville

Hospital shall be paid the contract rates set forth in this attachment. All Physician Services are EXCLUDED from the below rate structures.


Corizon - DOC INMATES FINAL

Line	INPATIENT	Criteria	Rate	Legend	Criteria	Rate	Legend	Criteria	Rate	Legend	Criteria	Rate	Legend	Criteria	Rate	Legend	Department of Corrections Inmates	Rev Code(s)	CPT CODES
		Rates 10/13 /13			Rates 10/1/14			Rates 10/1/15			Rates 10/1/16			Rates 10/1/17			Footnotes		
1	All Inpatient Services																		
2	Catastrophic:- First dollar																		
3	Threshold																		

HCA Initials: 

Plan Initials: _____

Memorial Hospital Jacksonville																			
Hospital shall be paid the contract rates set forth in this attachment. All Physician Services are EXCLUDED from the below rate structures.																			
Corizon - DOC INMATES FINAL																			
		Criteria	Rate	Legend	Criteria	Rate	Legend	Criteria	Rate	Legend	Criteria	Rate	Legend	Criteria	Rate	Legend	Department of Corrections Inmates	Rev Code(s)	CPT CODES
4	Payment Basis	[REDACTED]																	

HCA Initials: 
 Plan Initials: _____

Memorial Hospital Jacksonville

Hospital shall be paid the contract rates set forth in this attachment. All Physician Services are EXCLUDED from the below rate structures.

Corizon - DOC INMATES FINAL

		Criteria	Rate	Legend	Criteria	Rate	Legend	Criteria	Rate	Legend	Criteria	Rate	Legend	Criteria	Rate	Legend	Department of Corrections Inmates	Rev Code(s)	CPT CODES	
5	OUTPATIENT																			Footnotes
6	Outpatient Catastrophic Threshold																			
7	Payment Basis																			
8	PTCA/Angioplasty/EP Studies																			


Confidential HCA 005563

HCA Initials: *DA*

Plan Initials: _____

Memorial Hospital Jacksonville																				
Hospital shall be paid the contract rates set forth in this attachment. All Physician Services are EXCLUDED from the below rate structures.																				
Corizon - DOC INMATES FINAL																				
		Criteria	Rate	Legend	Criteria	Rate	Legend	Criteria	Rate	Legend	Criteria	Rate	Legend	Criteria	Rate	Legend	Department of Corrections Inmates	Rev Code(s)	CPT CODES	
9	Lithotripsy																			
10	Cardiac Cath																			
11	Surgery																			

Confidential HCA 005564

HCA Initials: 
 Plan Initials: _____


Memorial Hospital Jacksonville

Hospital shall be paid the contract rates set forth in this attachment. All Physician Services are EXCLUDED from the below rate structures.

Corizon - DOC INMATES FINAL

		Criteria	Rate	Legend	Criteria	Rate	Legend	Criteria	Rate	Legend	Criteria	Rate	Legend	Criteria	Rate	Legend	Department of Corrections Inmates	Rev Code(s)	CPT CODES
		a		d	a		d	a		d	a		d						
12	Observation (entire case)																		
13	Emergency Room (entire case)																		

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HCA Initials: 
 Plan Initials: _____

Memorial Hospital Jacksonville

Hospital shall be paid the contract rates set forth in this attachment. All Physician Services are EXCLUDED from the below rate structures.

Corizon - DOC INMATES FINAL

		Criteria	Rate	Legend	Criteria	Rate	Legend	Criteria	Rate	Legend	Criteria	Rate	Legend	Criteria	Rate	Legend	Department of Corrections Inmates	Rev Code(s)	CPT CODES
		a		d	a		d	a		d	a		d	a		d			
14	Outpatient Diagnostic CT Scan (Per Procedure)																		
15	Outpatient Diagnostic MRI (Per Procedure)																		
16	All Other Outpatient																		

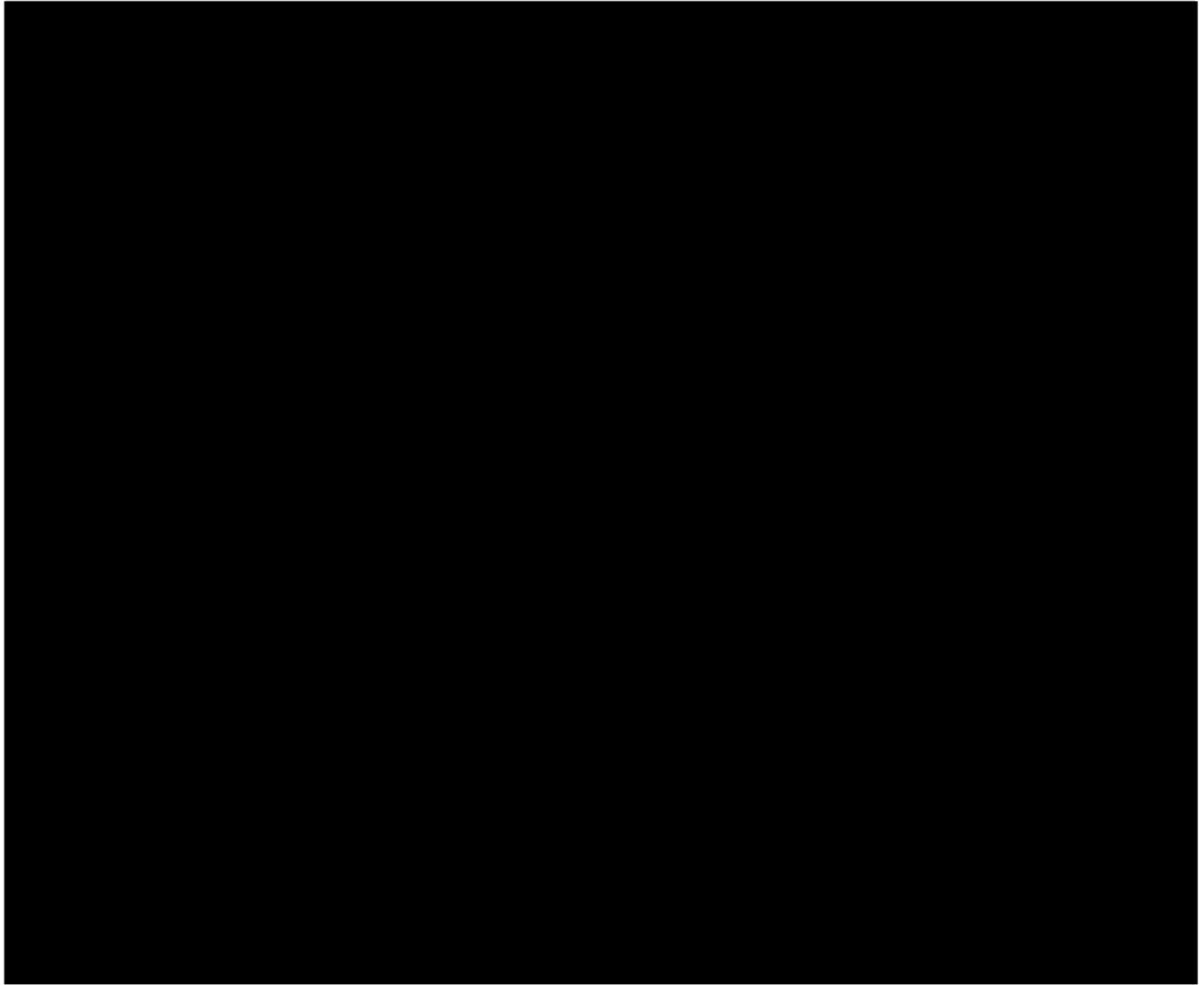
BC = Billed Charges
 FF - Flat Fee or Case Rate
 Outpatient Hierarchy above determines the payment

Confidential HCA 005566

HCA Initials: 

Plan Initials: _____

Exhibit II Price Protection



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