HOSPITAL ABATEMENT DISTRIBUTION CLAIM FORM

HOSPITAL ABATEMENT DISTRIBUTION CLAIM FORM DEADLINE: September 30, 2022

Please read these instructions carefully before filling out this Hospital Abatement Distribution Claim Form, including Exhibit A as applicable (this "Claim Form"). Capitalized terms used herein, and not otherwise defined, shall have the meanings ascribed to them in the *Fourth Amended Joint Plan of Reorganization (With Technical Modifications) of Mallinckrodt and Its Debtor Affiliates Under Chapter 11 of the Bankruptcy Code [D.I. 6510]* (as modified, amended or supplemented from time to time, the "Plan") or the Hospital Trust Distribution Procedures (as modified, amended or supplemented from time to time, the "Hospital TDP") dated July 20, 2021 [Docket No. 3232-2].

The Holder of a Hospital Opioid Claim is described in the Plan as the Hospital Opioid Claimant (the "Claimant") and is required to complete and submit this Claim Form in order to be eligible to receive Hospital Abatement Distributions from the Hospital Trust. A Hospital Opioid Claim is an Opioid Claim for an eligible Acute Care hospital defined as: (i) a non-federal acute care hospital, as defined by CMS, or (ii) a non-federal hospital or hospital district that is required by law to provide inpatient acute care and/or fund the provision of inpatient acute care.

The submission of this completed Claim Form by the Hospital Abatement Distribution Claim Form Deadline set forth above is a prerequisite to eligibility for a Hospital Abatement Distribution, but does not guarantee that a Holder of a Hospital Opioid Claim will be deemed eligible for a Hospital Abatement Distribution. If a Holder of a Hospital Opioid Claim is deemed eligible by the Trustee pursuant to the Hospital TDP to receive Hospital Abatement Distributions, the information provided in this Claim Form will be used to determine each such Hospital Authorized Recipient's Hospital Abatement Distribution from the Hospital Trust (as defined in the Plan, the "Hospital Trust"). Holders of Hospital Opioid Claims may redact information on this Claim Form, or any attached documents, as they deem necessary. A Holder of a Hospital Opioid Claim shall only attach *copies* of any documents that support a claim, and shall not submit original documents; **documents submitted may be destroyed after scanning and will not be returned to the Holder of a Hospital Opioid Claim**. A person who files a fraudulent claim on behalf of a Holder of a Hospital Opioid Claim may, at a minimum, be fined up to $500,000.00, imprisoned for up to 5 years, or both in accordance with 18 U.S.C. §§ 152,157. Holders of Hospital Opioid Claims shall provide the information requested that is, to the best of their knowledge, current and valid as of the date this Claim Form is completed and delivered to the Trustee by such a Holder of a Hospital Opioid Claim**.**

Please provide the following information to the Trustee by delivering this completed Claim Form by secure file transfer protocol (“SFTP”) as provided at www.mlnkhospitalsettlement.com prior to the Claim Form Deadline set forth on page 1 of this Claim Form.

Failure to submit a completed copy of this Claim Form and Requisite Claims Data (as described in Exhibit A #20 herein) by the Claim Form Deadline set forth on page 1 of this Claim Form may disqualify you from receiving a Hospital Abatement Distribution. Additionally, failure to complete any portion of this Claim Form may result in a reduced Hospital Abatement Distribution or disqualification from receiving a Hospital Abatement Distribution.

I. Claimant Information

Please provide the information in Section I for the Claimant.

A. Name of Operating Entity:			
B. Address:	Street Address Line 1		
	Street Address Line 2		
	City	State	Zip
C. Federal Employer Identification Number:	____ – ________		
D. Claimant Number: If you received a Claimant Number after you completed your Registration Form, check the box and provide that four-digit Claimant Number.	☐ ____		

II. Contact Information

Please provide the information in Section II where notices and Hospital Abatement Distribution(s) should be sent.

A. Contact Name:			
B. Contact Title:			
C. Address:	Street Address Line 1		
	Street Address Line 2		
	City	State	Zip
D. Phone:	(________) – ________ – ______________		
E. Email:			
F. By filling out this Claim Form, you are deemed to consent to receipt of notice by email.			

Please provide the information below for the Claimant.

1. Are you a named Plaintiff in any active cause of action against opioids manufacturers, distributors, or pharmacies? ___ Yes ___ No
   a. If yes, please provide whether the active cause of action is filed (check one below):
      i. in the MDL: ___
      ii. in state court: ___
   b. If yes, attach a copy of the most recently filed Complaint.

2. Unless a filed Complaint is attached to this Claim Form, describe below the opioid problem that has impacted each of the Acute Care hospitals/facilities listed on Exhibit A to this Claim Form, and include with particularity, data reflecting overdoses and deaths from overdoses in your respective service area(s) for the period of time ranging from January 1, 2009 through October 20, 2020.

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3. To qualify for Hospital Abatement Distributions from the Hospital Trust, a Claimant must certify that:
    a. It adheres to the standard of care for the emergency department, hospital wards and/or outpatient clinics at the time of any prospective evaluation, diagnosis, and treatment of OUD, including with respect to the applicable standard of care for the treatment of addiction, acute withdrawal and treatment for OUD with medication assisted treatment, AND
    b. It provides discharge planning and post-discharge care coordination for patients with OUD, including information for appropriate OUD treatment services.

   Does the Claimant and/or each of the Acute Care hospitals/facilities listed on Exhibit A to this Claim Form satisfy a. above?
   ___ Yes ___No;

   Does the Claimant and/or each of the hospitals/facilities listed on Exhibit A to this Claim Form satisfy b. above?
   ___ Yes ___No.

4. Please execute and submit a Business Associate and Confidentiality Agreement ("BAA") to Legier & Company, *apac*, attached as Exhibit B to this Claim Form, and return with this Claim Form for each Acute Care hospital/facility listed on Exhibit A. This BAA is not subject to revision or update.

5. Funds received from the Hospital Trust may only be used for specific abatement purposes as set forth in Section 7 of the Hospital TDP. If the Claimant on whose behalf this claim has been prepared is allocated a Hospital Abatement Distribution from the Hospital Trust, as a condition of receiving the funds, then it will use the funds for one or more specific uses as listed below.

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6. Please complete Exhibit A to this Claim Form for EACH Acute Care hospital/facility owned and/or operated by the above Claimant in Section I for which a claim is filed.

7. Please complete the W-9 (that is available for download at www.mlnkhospitalsettlement.com) for each Claimant and return the W-9 with this Claim Form.

I certify that I am authorized to sign this Claim Form and I understand that an authorized signature on this Claim Form serves as an acknowledgement that I have a reasonable belief that the information is true and correct.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Your typed signature and submission of this Claim Form will have the same force and effect as if you signed the Claim Form on paper, which you may do alternatively.

Signature: ____

Executed on date: (MM/DD/YYYY) _____________________________

Print the name of the person who is completing and signing this Claim Form.

Name (First, Middle, Last): ____

Title: ____

Hospital: ____

Address: ____

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Contact phone: (________) – ________ – _____________

Email: ____

HOSPITAL ABATEMENT DISTRIBUTION CLAIM FORM – EXHIBIT A

HOSPITAL ABATEMENT DISTRIBUTION CLAIM FORM DEADLINE: September 30, 2022

I. Claimant Information

Please provide the information in Section I below for the Claimant, which should be the same information provided in Section I of the Claim Form.

A. Name of Operating Entity:	
B. Federal Employer Identification Number:	____ – ________
C. Claimant Number: If you received a Claimant Number after you completed your Registration Form, check the box and provide that four-digit Claimant Number.	☐ ____

II. Hospital/Facility Information

Please provide the following information for the Acute Care hospital/facility owned and/or operated by the above referenced Claimant in Section I above for which a claim is filed. If there is more than one such Acute Care hospital/facility, please complete a separate Exhibit A for EACH Acute Care hospital/facility for which a claim is being filed.

A. Name of Hospital/Facility:			
B. Address:	Street Address Line 1		
	Street Address Line 2		
	City	State	Zip
C. Duration of Ownership:	Date Acquired/Opened	Date Sold/Closed	
D. Number of Staffed Beds:[1]			

[1] *The number of beds reported from a hospital's most recent Medicare cost report (W/S S-3, Part I, line 7 column 2). Cost report instructions define staffed beds as, "the number of beds available for use by patients at the end of the cost reporting period. A bed means an adult bed, pediatric bed, birthing room, or newborn bed maintained in a patient care area for lodging patients in acute, long term, or domiciliary areas of the hospital. Beds in labor room, birthing room, post anesthesia, postoperative recovery rooms, outpatient areas, emergency rooms, ancillary departments,*

E. Claim Number: If you received a Claim Number after you completed your Registration Form, provide that seven-digit Claim Number.	_______

1. Has the Acute Care hospital/facility listed above, as of the date of this Claim Form Exhibit A, provided to the Ad Hoc Group of Hospitals or its agent, substantially all of the Requisite Claims Data relating thereto (as described in #20 herein) to the best of your knowledge?
   ___ Yes ___ No

2. Is the Acute Care hospital/facility listed above listed on the national registry of hospitals maintained by the American Hospital Directory®, as in effect on the Effective Date, and it (a) a non-federal acute care hospital, as defined by CMS, or (b) a non-federal hospital or hospital district that is required by law to provide inpatient acute care and/or fund the provision of inpatient acute care?
   __ Yes __ No

3. Service Area. Please list below the counties that the above-described Acute Care hospital/facility serves that represents at least 75% of the total annual admissions of its hospital/facility in 2021, the population of those counties and the percentage of the total population of those counties served by the hospital/facility. Attach any supporting documents that deemed to be helpful.

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nurses' and other staff residences, and other such areas which are regularly maintained and utilized for only a portion of the stay of patients (primarily for special procedures or not for inpatient lodging) are not termed a bed for these purposes."

4. For the Acute Care hospital/facility listed above, please provide the payor mix (% of payor payments to total of all payor payments) as follows:

    a. % Medicare _______%
    b. % Medicaid _______%
    c. % TRICARE _______%
    d. % Commercial, e.g., Blue Cross Blue Shield, other non-governmental payors _______%
    e. % Self-pay _______%
    f. % All Other Payors _______%
    g. Describe the name of each payor that comprises "All Other Payors" ____ ____

5. Please provide the amounts of funding, if any, received by the Acute Care hospital/facility listed above for the period of January 1, 2009 through October 20, 2020 in each of the following areas:

    a. Grants $____
    b. Taxing authorities $____
    c. Health-care authorities$ ____
    d. State funded programs for indigent care $______________________________
    e. "Disproportionate Share"[2] $______________________________________
    f. Foundations/charities $____
    g. Others $____

[2] *Disproportionate Share Hospitals serve a significantly disproportionate number of low-income patients and receive payments from the Centers for Medicaid and Medicare Services to cover the costs of providing care to uninsured patients.*

6. List and describe with particularity, all Hospital Authorized Abatement Purposes instituted at the Acute Care hospital/facility listed above that are intended to treat, reduce, abate and prevent opioid addiction. Include in the description below the year(s) such program(s) began; whether they presently remain operational; and, the prospective end date for the program(s), if any. In addition, please provide the extent that any funding received, as described in No. 5 above, was used to pay for the abatement programs described herein.

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7. Prescribing practices:

   a. Did the Acute Care hospital/facility listed above, prescribe the following opioids: (i) Brand Name Medications: OxyContin®, Hysingla ER®, Butrans®, Dilaudid®, Ryzolt, MS Contin®, MSIR®, Palladone®, DHC Plus®, OxyIR®, or OxyFast®; and (ii) the following Generic Medications: oxycodone extended-release tablets, buprenorphine transdermal system, hydromorphone immediate-release tablets, hydromorphone oral solution, tramadol extended release tablets, morphine extended-release tablets, oxycodone immediate-release tablets, oxycodone and acetaminophen tablets (generic to Percocet®), hydrocodone and acetaminophen tablets (generic to Vicodin® or Norco)?___ Yes ___No.

   b. Did the Acute Care hospital/facility listed above provide pain management care in a pain management clinic during the period of January 1, 2009 through October 20, 2020? ___ Yes ___No.
   If yes, please provide the dates for which each of the pain management clinics were in operation.

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8. Is the Acute Care hospital/facility listed above a "safety net" hospital as defined in the CARES ACT?[3] ___ Yes ___No.

    a. If yes, please provide proof of such designation.

9. Is the Acute Care hospital/facility listed above a tertiary referral center? (A hospital provides tertiary healthcare if it provides "*care of a highly technical and specialized nature, in a medical center, usually one affiliated with a university, for patients with unusually severe, complex, or uncommon health problems.*" See Flegel, Ken, Tertiary Hospitals Must Provide General Care (March 3, 2015), Nat'l Ctr. for Biotechnology Information, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4347764).
   ___ Yes ___No.

10. Does the Acute Care hospital/facility listed above perform screening brief intervention referral to treatment ("SBIRT") in the emergency department? _____ Yes _____ No.

11. Does the Acute Care hospital/facility listed above equip emergency departments to treat acute withdrawal and initiate treatment for OUD with medications, including buprenorphine, suboxone, and subutex, etc.? ___Yes ___ No.

12. Does the Acute Care hospital/facility listed above make discharge planning and post-discharge care coordination mandatory for patients with OUD? ___Yes ___No.

13. Does the Acute Care hospital/facility listed above provide bridge programs to encourage access to treatment for patients with OUD? ___ Yes ___ No.

14. Does the Acute Care hospital/facility listed above participate in community efforts to provide OUD treatment to others in the community, such as those in jails, or other detention facilities? ___ Yes ___ No.

15. Does the Acute Care hospital/facility listed above provide transportation to OUD treatment facilities? __Yes ___No.

16. Does the Acute Care hospital/facility listed above implement needle exchange in the hospital or an adjacent clinic and/or provide on-site medication-assisted treatment ("MAT") services? ___Yes ___No.

17. Does the Acute Care hospital/facility listed above use telemedicine, telehealth, and/or teleconsulting to support treatment and to support "spoke" entities? ___Yes ___No.

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[3] *A "safety net" hospital has (a) a Medicare Disproportionate Patient Percentage (DPP) of 20.2% or greater; (b) annual uncompensated care (UCC) of at least $25,000 per bed; and (c) profit margin of 3.0% or less.*

18. Does the Acute Care hospital/facility listed above perform heart valve replacements?
___ Yes ___ No.

    a. If yes, please provide the percentage of all heart valve replacements performed that are secondary to opioid addiction. __________%

19. Does the Acute Care hospital/facility listed above have a Neonatal Intensive Care Unit ("NICU") that treats babies with Neonatal Abstinence Syndrome ("NAS")?
___ Yes ___ No.

    a. If yes, does the hospital/facility have a dedicated NAS NICU? ___ Yes ___ No

    b. If yes, does the hospital/facility provide obstetric and perinatal services to treat mothers with OUD? ____Yes ___ No

20. For all inpatient and outpatient discharges during the period January 1, 2009 through October 20, 2020, from the Acute Care hospital/facility listed above, please provide to the SFTP the following data in CSV (Comma Delimited) Electronic File or Pipe Delimited Electronic Text File to be used in connection with the calculation of financial damages. **An example of the data formatting is set forth in Exhibit C**. **This data should be in a separate CSV (Comma Delimited) Electronic File or Pipe Delimited Electronic Text File for each Hospital Opioid Claim**. Physician office visits and non-acute care visits should **NOT** be included in data provided.

    For the CSV (Comma Delimited) Electronic File or Pipe Delimited Electronic Text File, please include in the file name the name of the Hospital Opioid Claim, City and State where located and Date Range of Data Provided, for example, PhoenixGeneral-Phoenix-AZ-Jan09-Dec12.csv. If more than one file is provided due to size limitations, each file name will be the same with only the date range of the data provided changing for example, PhoenixGeneral-Phoenix-AZ-Jan13-Dec20.csv

    It is important to note, and as further described below, that the following data for each visit/discharge will need to be repeated on each row corresponding to each different ICD diagnosis code (except for ICD diagnosis code, ICD diagnosis code description and ICD diagnosis code priority). The data for the ICD diagnosis codes, ICD diagnosis code descriptions and ICD diagnosis code priorities for each visit/discharge will therefore be unique to each row. For example, if a visit has 18 ICD diagnosis codes, there would be 18 rows/lines for that visit/discharge with each line containing a different ICD diagnosis code, ICD diagnosis code description and ICD diagnosis code priority. For all other data fields, such as Patient Medical Record Number, Date of Discharge, etc., this data will be the same, and thus repeated, on all 18 rows/lines for that visit/discharge.

    To the extent the hospital/facility listed above utilizes a coding system for any columns/data fields, please provide an index to explain the contents of any column/data

field to the SFTP provided by the Trustee. For example, the Patient Type data provided includes a 1, 2, or 3 and these respective contents are 1=Inpatient, 2=Outpatient, 3=Emergency.

Please also ensure that all columns/data fields that may contain commas are updated so that such columns/data fields are placed in quotations when populating the CSV (Comma Delimited) Electronic File or Pipe Delimited Electronic Text File. The columns/data fields that often contain commas include, but are not limited to, Attending Physician Name, DRG and ICD Diagnosis Code Descriptions.

Once the CSV (Comma Delimited) Electronic File or Pipe Delimited Electronic Text File is prepared, **please review the data VERY CAREFULLY** to confirm the data in each column contains the applicable data for that respective column's data field description. For example, payment amounts (Total Payments) should not be shown in the DRG Code column/data field, ICD Diagnosis Code column/data field should not be blank or designated null for a patient visit without an explanation, etc. This will require, that in conducting your review that you "reality test" your data before submission to ensure that it does not contain obvious errors and inconsistencies. **After submission of the Registration Form, each Claimant will be provided a SFTP by the Trustee to upload an executed BAA (as described in #4 of the Claim Form), and then upload this Requisite Claims Data to the SFTP.**

Requisite Claims Data		
Column	**Data Fields**	**Definitions and Clarifications**
a.	**Name**	Name of hospital/facility for which data is provided.
b.	**Address**	Address of hospital/facility for which data is provided.
c.	**City**	City of hospital/facility for which data is provided.
d.	**State**	State of hospital/facility for which data is provided.
e.	**Zip**	Zip of hospital/facility for which data is provided.
f.	**CMS Certification Number**	Center for Medicare & Medicaid Services Certification Number – Formerly known as the Medicare Provider Number. This should be a six-digit Medicare certification number for which the data is provided.

g.	**Patient Medical Record #**	
h.	**Patient Account #**	
i.	**Payor Financial Class Description**	e.g., Blue Cross, Medicaid, Self Pay, etc.
j.	**Patient Type**	e.g., Inpatient or Outpatient. Hospital related clinics or physician office visits should NOT be included in data provided.
k.	**Custom Patient Type**	e.g., Inpatient Psych, Outpatient Single Visit, Surgery, Lab, etc. Hospital related clinics or physician office visits should NOT be included in data provided.
l.	**Date of Admission**	
m.	**Date of Discharge**	
n.	**Length of Stay (days)**	
o.	**Admission Type Description**	e.g., Emergency, Reservation, Reference Lab, etc.
p.	**Discharge Disposition Description**	e.g., Discharge Home, Nursing Home, Expired, etc.
q.	**Patient Date of Birth**	
r.	**Patient Age at Discharge**	
s.	**Patient Gender**	
t.	**Patient Race**	
u.	**Patient City**	
v.	**Patient State**	
w.	**Patient Zip Code**	

x.	**Attending Physician Name**	
y.	**Total Charges**	
z.	**Total Payments**	Total Payments should only contain actual payments received (e.g., insurance/self-pay). It should NOT include adjustments, bad debt, write-offs or contractual adjustments.
aa.	**DRG Code**	Diagnosis Related Group (DRG) code for each inpatient visit/discharge.
ab.	**DRG Code Description**	DRG Code description for the above DRG Code.
ac.	**All ICD Diagnosis Code**	All International Classification of Disease (ICD) diagnosis codes (ICD-9 or ICD-10, as applicable) associated with each patient visit/discharge. Note: In most instances there should be multiple ICD codes for a patient visit/discharge. Each of these ICD Diagnosis Codes related to each patient's visit should NOT be listed in multiple columns but rather each ICD Code should be listed in the same single column with each ICD Code shown on separate rows within the same single column. See Exhibit C.
ad.	**ICD Diagnosis Code Descriptions**	ICD Diagnosis Code descriptions for the above ICD Diagnosis Codes.
ae.	**ICD Diagnosis Code Priority**	Indicate whether each ICD Diagnosis Code is a Primary, Secondary, Tertiary, etc. diagnosis. These categories must be expressed in terms of a numerical code such as 1=Primary, 2=Secondary, 3=Tertiary, etc.
af.	**Mom's MRN - If applicable**	This field pertains only to Hospital Opioid Claims that deliver newborn babies or have a neonatal unit. If this visit/charge is for a birth mother, then this field should be blank as it would be the same MRN as the patient reported in #g above. However, if this visit/charge pertains to a baby, then this field should contain the mother's MRN so that there can be a mother/baby link associated therewith.

ag.	**Baby's MRN - If applicable**	This field pertains only to Hospital Opioid Claims that deliver newborn babies or have a neonatal unit. If this visit/charge is for a baby, then this field should be blank as it would be the same MRN as the patient reported in #g above. However, if this visit/charge pertains to a birth mother, then this field should contain the Baby's MRN so that there can be a mother/baby link associated therewith.

I certify that I am authorized to sign this Claim Form Exhibit A and I understand that an authorized signature on this Claim Form Exhibit A serves as an acknowledgement that I have a reasonable belief that the information is true and correct.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Your typed signature and submission of this Claim Form will have the same force and effect as if you signed the Claim Form on paper, which you may do alternatively.

Signature: ____

Executed on date: (MM/DD/YYYY) ________________________________

Print the name of the person who is completing and signing this Claim Form Exhibit A.

Name (First, Middle, Last): ____

Title: ____

Hospital: ____

Address: ____

____

Contact phone: (________) – ________ – ______________

Email: ____

Exhibit B

BUSINESS ASSOCIATE AND CONFIDENTIALITY AGREEMENT

This Business Associate and Confidentiality Agreement (the "BAA") is made effective the ___ day of ____________, 2022, by and between ____________________________________, hereinafter referred to as "Covered Entity," and **Legier & Company.** ***apac***, hereinafter referred to as "Business Associate" (individually, a "Party" and collectively, the "Parties").

WITNESSETH:

WHEREAS**,** Covered Entity is a creditor with an economic interest in both various opioid litigation and bankruptcy matters ("Litigation Matters"), and has engaged legal counsel to represent its interest therein; and

WHEREAS, Business Associate is a nationally recognized forensic accounting firm that has been engaged by various attorneys in the Litigation Matters to provide litigation consulting services in connection with these matters, such litigation consulting to include the preparation of damage claims ("Services"); and

WHEREAS, pursuant to the preparation of damage claims, Business Associate must process various financial data from Covered Entity that may include, Protected Health Information ("PHI") and/or Electronic Protected Health Information ("ePHI") as defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") (Public Law 104-191) enacted on August 21, 1996, as has been amended thereto ("Data Aggregation"); and

WHEREAS, Business Associate has agreed to provide its Services on behalf of Covered Entity; and

WHEREAS, the Parties now wish to enter into this BAA to ensure compliance with the Privacy and Security Rules of The Health Insurance Portability and Accountability Act of 1996 ("HIPAA Privacy and Security Rules") (45 C.F.R. Parts 160 and 164); and

WHEREAS, the Health Information Technology for Economic and Clinical Health ("HITECH") Act of the American Recovery and Reinvestment Act of 2009, Pub. L. 111-5, modified the HIPAA Privacy and Security Rules (hereinafter, all references to the "HIPAA Privacy and Security Rules" include all amendments thereto set forth in the HITECH Act and any accompanying regulations); and

WHEREAS, Business Associate and Covered Entity wish to comply with the HIPAA Privacy and Security Rules, and Business Associate wishes to honor its obligations as a Business Associate to Covered Entity.

THEREFORE, in consideration of the Parties' new or continuing obligations, and for other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the Parties agree to the provisions of this BAA.

Except as otherwise defined herein, any and all capitalized terms in this BAA shall have the definitions set forth in the HIPAA Privacy and Security Rules. In the event of an inconsistency between the provisions of this BAA and mandatory provisions of the HIPAA Privacy and Security Rules, the HIPAA Privacy and Security Rules in effect at the time shall control. Where provisions of this BAA are different than those mandated by the HIPAA Privacy and Security Rules, but are nonetheless permitted by the HIPAA Privacy and Security Rules, the provisions of this BAA shall control.

Exhibit B

I. PERMITTED USES AND DISCLOSURES BY BUSINESS ASSOCIATE

a. Business Associate may use or disclose PHI to perform the Services hereunder and any other functions, activities, or services for, or on behalf of, Covered Entity as described in this BAA or as otherwise requested by the Covered Entity, provided that such use or disclosure would not violate the HIPAA Privacy and Security Rules if done by Covered Entity.

b. Business Associate may use PHI in its possession for its proper management and administration and to fulfill any present or future legal responsibilities of Business Associate, provided that such uses are permitted under state and federal confidentiality laws.

c. Business Associate may disclose PHI in its possession to third parties for the purposes of its proper management and administration or to fulfill any present or future legal responsibilities of Business Associate, provided that:

1. the disclosures are required by law; or

2. Business Associate obtains reasonable assurances from the third parties to whom the PHI is disclosed that the information will remain confidential and be used or further disclosed as described under this BAA or as required by law or for the purpose for which it was disclosed to the third party, and that such third parties will notify Business Associate of any instances of which they are aware in which the confidentiality of the information has been breached.

II. OBLIGATIONS AND ACTIVITIES OF BUSINESS ASSOCIATE

a. Business Associate agrees not to use or further disclose PHI other than as permitted or required by this BAA or as required by law.

b. Business Associate agrees to use appropriate safeguards, and to comply, where applicable, with 45 C.F.R. Part 164, Subpart C with respect to ePHI, to prevent use or disclosure of PHI other than as provided for by this BAA. Specifically, Business Associate will:

1. implement the administrative, physical, and technical safeguards set forth in 45 C.F.R. §§ 164.308, 164.310, and 164.312 that reasonably and appropriately protect the confidentiality, integrity, and availability of any PHI that it creates, receives, maintains, or transmits on behalf of Covered Entity, and, in accordance with 45 C.F.R. § 164.316, implement and maintain reasonable and appropriate policies and procedures to enable it to comply with the requirements outlined in 45 C.F.R. §§ 164.308, 164.310, and 164.312; and

2. report to Covered Entity any Security Incident that does not rise to the level of a Breach of Unsecured Protected Health Information ("Breach"), and any use or disclosure of PHI that is not provided for by this BAA but that does not rise to the level of a Breach, of which Business Associate becomes aware. The report shall be made as soon as practical, and in any event within twenty (20) days of Business Associate's discovery of the Security Incident or the impermissible use or disclosure.

c. Business Associate shall, during the term of this BAA, at its sole cost and expense obtain and maintain insurance coverage against improper access, uses, and disclosures of Covered Entity's data and PHI by Business Associate, in at least the minimum amount deemed appropriate by Business Associate's insurance carrier based on the Services to be provided under this BAA. Business Associate shall provide a certificate as evidence of such insurance coverage upon written request of Covered Entity.

Exhibit B

d. Business Associate shall require each subcontractor that creates, receives, maintains, or transmits PHI on its behalf to enter into a business associate agreement containing the same restrictions on access, use, and disclosure of PHI as those applicable to Business Associate under this BAA. Furthermore, to the extent that Business Associate provides ePHI to a subcontractor, Business Associate shall require such subcontractor to comply with all applicable provisions of 45 C.F.R. Part 164, Subpart C.

e. Business Associate agrees to comply with any requests for restrictions on certain disclosures of PHI to which Covered Entity has agreed in accordance with 45 C.F.R. § 164.522 of which Business Associate has been notified by Covered Entity.

f. If Business Associate maintains a designated record set on behalf of Covered Entity, at the request of Covered Entity and in a reasonable time and manner, Business Associate agrees to make available PHI required for Covered Entity to respond to an individual's request for access to his or her PHI in accordance with 45 C.F.R. § 164.524. If Business Associate maintains PHI in an electronic designated record set, it agrees to make such PHI available electronically to Covered Entity or, upon Covered Entity's specific request, to the individual requesting it.

g. If Business Associate maintains a designated record set on behalf of Covered Entity, at the request of Covered Entity and in a reasonable time and manner, Business Associate agrees to make available PHI required for amendment by Covered Entity in accordance with the requirements of 45 C.F.R. § 164.526.

h. Business Associate agrees to document any disclosures of PHI, and to make PHI available for purposes of accounting of disclosures, as required by 45 C.F.R. § 164.528.

i. If Business Associate is to carry out one or more of Covered Entity's obligations under 45 C.F.R. Part 164, Subpart E, Business Associate shall comply with the requirements of Subpart E that apply to Covered Entity in the performance of such obligation(s).

j. Business Associate agrees that it will make its internal practices, books, and records relating to the use and disclosure of PHI received from, or created or received by Business Associate on behalf of, Covered Entity, available to the Secretary, in a time and manner designated by the Secretary, to enable the Secretary to determine Business Associate's or Covered Entity's compliance with the HIPAA Privacy and Security Rules. Business Associate also shall cooperate with the Secretary and, upon the Secretary's request, pursuant to 45 C.F.R. § 160.310, shall disclose PHI to the Secretary to enable the Secretary to investigate and review Business Associate's or Covered Entity's compliance with the HIPAA Privacy and Security Rules.

k. Unless authorized in this BAA, Business Associate shall not:

1. use PHI for marketing or fundraising;

2. use PHI to create a limited data set or to de-identify the information;

3. use PHI to provide data aggregation services relating to the health care operations of Covered Entity other than the data aggregation services being provided in connection with the Services being performed by Business Associate under this Agreement; or

4. use or disclose PHI in exchange for remuneration of any kind, whether directly or indirectly, financial or non-financial, other than such remuneration as Business Associate receives from Covered Entity in exchange for Business Associate's provision of the Services specified in this BAA.

III. BUSINESS ASSOCIATE'S MITIGATION AND BREACH NOTIFICATION OBLIGATIONS

a. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this BAA.

b. Following the discovery of a Breach, Business Associate shall notify Covered Entity of such Breach without unreasonable delay and in no case later than five (5) calendar days after discovery of the Breach, and shall assist in Covered Entity's Breach analysis process, including risk assessment, if requested. A Breach shall be treated as discovered by Business Associate as of the first day on which such Breach is known to Business Associate or, through the exercise of reasonable diligence, would have been known to Business Associate. The Breach notification shall be provided to Covered Entity in the manner specified in 45 C.F.R. § 164.410(c) and shall include the information set forth therein to the extent known. If, following the Breach notification, Business Associate learns additional details about the Breach, Business Associate shall notify Covered Entity promptly as such information becomes available. Covered Entity shall determine whether Business Associate or Covered Entity will be responsible for providing notification of any Breach to affected individuals, the media, the Secretary, and/or any other parties required to be notified under the HIPAA Privacy and Security Rules or other applicable law. If Covered Entity determines that Business Associate will be responsible for providing such notification, Business Associate may not carry out notification until Covered Entity approves the proposed notices in writing.

c. Business Associate shall bear all of Covered Entity's costs of any Breach and resultant notifications, if applicable, when the Breach arises from Business Associate's willful misconduct, violation of law, or violation of this BAA.

IV. OBLIGATIONS OF COVERED ENTITY

a. Upon request of Business Associate, Covered Entity shall provide Business Associate with the notice of privacy practices that Covered Entity produces in accordance with 45 C.F.R. § 164.520.

b. Covered Entity shall provide Business Associate with any changes in, or revocation of, permission by an individual to use or disclose PHI, if such changes or revocation could reasonably be expected to affect Business Associate's permitted or required uses and disclosures.

c. Covered Entity shall notify Business Associate of any restriction on the use or disclosure of PHI to which Covered Entity has agreed in accordance with 45 C.F.R. § 164.522, and Covered Entity shall inform Business Associate of the termination of any such restriction, and the effect that such termination shall have, if any, upon Business Associate's use and disclosure of such PHI.

V. TERM AND TERMINATION

a. Term. This BAA shall be effective as of the date first written above, and shall terminate upon the later of the following events: (i) in accordance with Section V.c. below, when all of the PHI provided by Covered Entity to Business Associate or created or received by Business Associate on behalf of Covered Entity is returned to Covered Entity or destroyed (and a certificate of destruction is provided)

or, if such return or destruction is infeasible, or by order of Court, when protections are extended to such information;

b. Termination. Upon either Party's knowledge of a material breach by the other Party of its obligations under this BAA, the non-breaching Party shall, notify the breaching Party, and the breaching Party shall have thirty (30) calendar days from receipt of that notice to cure the breach or end the violation. If the breaching Party fails to take reasonable steps to effect such a cure within such time period, the non-breaching Party may terminate this BAA without penalty.

Where either Party has knowledge of a material breach by the other Party and determines that cure is infeasible, prior notice is not required and the non-breaching Party shall terminate this BAA without penalty.

c. Effect of Termination.

1. Except as provided in paragraph 2 of this subsection c., upon termination of this BAA or upon request of Covered Entity, whichever occurs first, Business Associate shall within ten (10) days return or destroy all PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to PHI that is in the possession of subcontractors of Business Associate. Neither Business Associate nor its subcontractors shall retain copies of the PHI except as required by law.

2. In the event that Business Associate determines that returning or destroying the PHI is infeasible, Business Associate shall provide within ten (10) days to Covered Entity notification of the conditions that make return or destruction infeasible. Upon mutual agreement of the Parties that return or destruction of PHI is infeasible, Business Associate, and its applicable subcontractors, shall extend the protections of this BAA to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate and its applicable subcontractors maintain such PHI.

VI. MISCELLANEOUS

a. Indemnification. Each Party shall indemnify and hold the other harmless from and against all claims, liabilities, judgments, fines, assessments, penalties, awards, or other expenses, of any kind or nature whatsoever, including, without limitations, attorneys' fees, expert witness fees, and costs of investigation, litigation or dispute resolution, relating to or arising out of any breach of this BAA, or any Breach, by that Party or its subcontractors or agents.

b. No Rights in Third Parties. Except as expressly stated herein or in the HIPAA Privacy and Security Rules, the Parties to this BAA do not intend to create any rights in any third parties.

c. Survival. The obligations of Business Associate under Section V.c. above shall survive the expiration, termination, or cancellation of this BAA, and/or the business relationship of the Parties, and shall continue to bind Business Associate, its agents, employees, contractors, successors, and assigns as set forth herein. Furthermore, the Parties' indemnification obligations pursuant to Section VI.a. of this BAA shall survive the expiration, termination, or cancellation of this BAA, and/or the business relationship of the Parties and any such underlying agreements between the Parties, and shall continue to bind the Parties, their agents, employees, contractors, successors, and assigns as set forth herein.

d. Amendment. The Parties agree that this BAA will only be modified or be amended to conform to any changes in the HIPAA Privacy and Security Rules and the Health Insurance Portability and

Accountability ACT as are necessary for each party to comply with the current requirements of such. In those instances where an amendment to this BAA is required by law, the Parties shall negotiate in good faith to amend the terms of this BAA within sixty (60) days of the effective date of the law or final rule requiring the amendment. If, following such period of good faith negotiations, the Parties cannot agree upon an amendment to implement the requirements of said law or final rule, then either Party may terminate this BAA and any underlying agreements as may exist between the Parties upon ten (10) days written notice to the other Party. Except as provided above, this BAA may be amended or modified only in a writing signed by the Parties. This BAA shall not otherwise be modified or amended at the request of Covered Entity.

e. Assignment. Neither Party may assign its respective rights and obligations under this BAA without the prior written consent of the other Party.

f. Independent Contractor. None of the provisions of this BAA are intended to create, nor will they be deemed to create, any relationship between the Parties other than that of independent parties contracting with each other solely for the purposes of effecting the provisions of this BAA and any other agreements between the Parties evidencing their business relationship. Nothing in this BAA creates or is intended to create an agency relationship.

g. Governing Law. To the extent this BAA is not governed exclusively by the HIPAA Privacy and Security Rules or other provisions of federal statutory or regulatory law, it will be governed by and construed in accordance with the laws of the state of Louisiana.

h. No Waiver. No change, waiver, or discharge of any liability or obligation hereunder on any one or more occasions shall be deemed a waiver of performance of any continuing or other obligation, or shall prohibit enforcement of any obligation, on any other occasion.

i. Interpretation. Any ambiguity of this BAA shall be resolved in favor of a meaning that permits Covered Entity and Business Associate to comply with the HIPAA Privacy and Security Rules.

j. Severability. In the event that any provision of this BAA is held by a court of competent jurisdiction to be invalid or unenforceable, the remainder of the provisions of this BAA will remain in full force and effect.

k. Notice. Any notification required in this BAA shall be made in writing to the representative of the other Party who signed this BAA or the person currently serving in that representative's position with the other Party.

l. Certain Provisions Not Effective in Certain Circumstances. The provisions of this BAA relating to the HIPAA Security Rule shall not apply to Business Associate if Business Associate does not receive, create, maintain, or transmit any ePHI from or on behalf of Covered Entity.

m. Entire Agreement. This BAA constitutes the entire understanding of the Parties with respect to the subject matter hereof and supersedes all prior agreements, oral or written. In the event of any inconsistency between this BAA and any other agreement between the Parties concerning the use and disclosure of PHI and the Parties' obligations with respect thereto, the terms of this BAA shall control.

n. Counterparts. This BAA may be executed in one or more counterparts, each of which shall be deemed an original but all of which together shall constitute one and the same BAA.

Exhibit B

o. Foreign Entities. In performing the functions, activities or services for, or on behalf of Covered Entity, Business Associate and its affiliates shall not, and shall not permit any of its subcontractors, to transmit or make available any PHI to any entity or individual outside the United States without the prior written consent of Covered Entity's Privacy and Security Officer.

IN WITNESS WHEREOF, the Parties have executed this BAA as of the day and year written above. Your typed signature and submission of this BAA will have the same force and effect as if you signed the BAA on paper, which you may do alternatively.

Covered Entity:	**Business Associate: Legier & Company, *apac***
By:____________________________________	By:____________________________________
Name: __________________________________	Name: __________________________________
Title:__________________________________	Title: __________________________________

HOSPITAL ABATEMENT DISTRIBUTION CLAIM FORM
EXHIBIT C

	A	B	C	D	E	F	G	H	I	J	K
1	**Hospital Name**	**Hospital Address**	**Hospital City**	**Hospital State**	**Hospital Zip**	**CMS Certification Number**	**Patient Medical Record #**	**Patient Account #**	**Payor Financial Class Description**	**Patient Type**	**Custom Patient Type**
2	ABC Hospital	123 Main Street	Shelbyville	US State	12345	123456	101	A12345	Blue Cross	Inpatient	Lab
3	ABC Hospital	123 Main Street	Shelbyville	US State	12345	123456	101	A12345	Blue Cross	Inpatient	Lab
4	ABC Hospital	123 Main Street	Shelbyville	US State	12345	123456	101	A12345	Blue Cross	Inpatient	Lab
5	ABC Hospital	123 Main Street	Shelbyville	US State	12345	123456	101	A12346	Blue Cross	Outpatient	OB
6	ABC Hospital	123 Main Street	Shelbyville	US State	12345	123456	101	A12346	Blue Cross	Outpatient	OB
7	ABC Hospital	123 Main Street	Shelbyville	US State	12345	123456	999	A12399	Blue Cross	Outpatient	Nursery
8	ABC Hospital	123 Main Street	Shelbyville	US State	12345	123456	102	A12356	Medicare	Inpatient	Lab
9	ABC Hospital	123 Main Street	Shelbyville	US State	12345	123456	102	A12356	Medicare	Inpatient	Lab
10	ABC Hospital	123 Main Street	Shelbyville	US State	12345	123456	103	A12367	Champus	Inpatient	Lab
11	ABC Hospital	123 Main Street	Shelbyville	US State	12345	123456	103	A12367	Champus	Inpatient	Lab
12	ABC Hospital	123 Main Street	Shelbyville	US State	12345	123456	103	A12367	Champus	Inpatient	Lab
13	ABC Hospital	123 Main Street	Shelbyville	US State	12345	123456	103	A12367	Champus	Inpatient	Lab
14	ABC Hospital	123 Main Street	Shelbyville	US State	12345	123456	103	A12367	Champus	Inpatient	Lab
15	ABC Hospital	123 Main Street	Shelbyville	US State	12345	123456	103	A12368	Champus	Emergency	ER
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HOSPITAL ABATEMENT DISTRIBUTION CLAIM FORM

EXHIBIT C

	L	M	N	O	P	Q	R	S
1	**Date of Admission**	**Date of Discharge**	**Length of Stay**	**Admission Type Description**	**Discharge Disposition Description**	**Patient Date of Birth**	**Patient Age**	**Patient Gender**
2	5/6/2016	5/8/2016	2	Transfer	Discharge Home	4/1/1980	36	Female
3	5/6/2016	5/8/2016	2	Transfer	Discharge Home	4/1/1980	36	Female
4	5/6/2016	5/8/2016	2	Transfer	Discharge Home	4/1/1980	36	Female
5	2/28/2017	3/1/2017	1	O/P Observation	Discharge Home	4/1/1980	36	Female
6	2/28/2017	3/1/2017	1	O/P Observation	Discharge Home	4/1/1980	36	Female
7	2/28/2017	2/28/2017	1	O/P Observation	Discharge Home	2/28/2017	0	Female
8	4/15/2016	4/18/2016	3	Transfer	Discharge Home	1/1/1955	61	Male
9	4/15/2016	4/18/2016	3	Transfer	Discharge Home	1/1/1955	61	Male
10	12/7/2016	12/10/2016	3	Reservation	Home w/ Health Serv	2/1/1975	41	Female
11	12/7/2016	12/10/2016	3	Reservation	Home w/ Health Serv	2/1/1975	41	Female
12	12/7/2016	12/10/2016	3	Reservation	Home w/ Health Serv	2/1/1975	41	Female
13	12/7/2016	12/10/2016	3	Reservation	Home w/ Health Serv	2/1/1975	41	Female
14	12/7/2016	12/10/2016	3	Reservation	Home w/ Health Serv	2/1/1975	41	Female
15	7/4/2017	7/4/2017	1	Emergency	Discharge Home	2/1/1975	42	Female
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There is only one column for ICD Code. Therefore, each patient stay must be replicated as many times as necessary to provide all of the ICD Codes associated with the stay. For example, a patient stay with five ICD Codes would be listed in five rows (e.g., the 12/10/2016 stay of patient 103).

HOSPITAL ABATEMENT DISTRIBUTION CLAIM FORM

EXHIBIT C

	T	U	V	W	X	Y	Z	AA	AB	AC
1	Patient Race	Patient City	Patient State	Patient Zip Code	Attending Physician Name	Total Charges	Total Payments	DRG Code	DRG Code Description	ICD Diagnosis Code
2	African American	Shelbyville	US State	12345	Smith, Jane	$1,000.00	$350.00	181	Respiratory Neoplasms w CC	B974
3	African American	Shelbyville	US State	12345	Smith, Jane	$1,000.00	$350.00	181	Respiratory Neoplasms w CC	B998
4	African American	Shelbyville	US State	12345	Smith, Jane	$1,000.00	$350.00	181	Respiratory Neoplasms w CC	F1110
5	African American	Shelbyville	US State	12345	Doe, John	$500.00	$125.00			G459
6	African American	Shelbyville	US State	12345	Doe, John	$500.00	$125.00			A419
7	African American	Shelbyville	US State	12345	Doe, John	$600.00	$125.00	795	Normal Newborn	L22
8	Caucasian	Shelbyville	US State	12345	Smith, Jane	$2,000.00	$725.00	603	Cellulitis w/o MCC	Z431
9	Caucasian	Shelbyville	US State	12345	Smith, Jane	$2,000.00	$725.00	603	Cellulitis w/o MCC	T148
10	African American	Springfield	US State	12367	Smith, Jane	$5,000.00	$1,500.00	539	Osteomyelitis w MCC	E861
11	African American	Springfield	US State	12367	Smith, Jane	$5,000.00	$1,500.00	539	Osteomyelitis w MCC	J209
12	African American	Springfield	US State	12367	Smith, Jane	$5,000.00	$1,500.00	539	Osteomyelitis w MCC	Z041
13	African American	Springfield	US State	12367	Smith, Jane	$5,000.00	$1,500.00	539	Osteomyelitis w MCC	T1491
14	African American	Springfield	US State	12367	Smith, Jane	$5,000.00	$1,500.00	539	Osteomyelitis w MCC	N179
15	African American	Springfield	US State	12367	Doe, John	$1,000.00	$200.00			F1199
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There is only one column for ICD Code. Therefore, each patient stay must be replicated as many times as necessary to provide all of the ICD Codes associated with the stay. For example, a patient stay with five ICD Codes would be listed in five rows (e.g., the 12/10/2016 stay of patient 103).

HOSPITAL ABATEMENT DISTRIBUTION CLAIM FORM

EXHIBIT C

	AD	AE	AF	AG
1	**ICD Diagnosis Code Description**	**ICD Diagnosis Code Priority**	**Mom's Medical Record #**	**Baby's Medical Record #**
2	Respiratory syncytial virus as the cause of diseases classified elsewhere	1		999
3	Other infectious disease	3		999
4	Opioid Abuse - Uncomplicated	2		999
5	Transient Cerebral Ischemic Attack - Unspecified	2		999
6	Sepsis - Unspecified Organism	1		999
7	Diaper Dermatitis	1	101	
8	Encounter For Attention To Gastrostomy	1		
9	Other Injury Of Unspecified Body Region	2		
10	Hypovolemia	1		
11	Acute Bronchitis - Unspecified	2		
12	Encounter for examination and observation following transport accident	3		
13	Suicide attempt	4		
14	Acute Kidney Failure - Unspecified	5		
15	Opioid Use - Unspecified With Unspecified Opioid-Induced Disorder	1		
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The last two fields will only be populated where a facility has a neonatal unit and delivers babies. These two fields link the mother's record to the baby's medical record number (MRN) and vice versa. For example, if Patient 101 is a mother, the baby's MRN would be shown in column AG and column AF would be blank since the record relates to the mother. If the patient is the baby, then the mother's MRN would be shown in column AF and column AG would be blank since the records relates to the baby.