ADMINISTRATIVE AGREEMENT

THIS ADMINISTRATIVE AGREEMENT ("Agreement") is entered into by and between

_____
(HOSPITAL NAME)
_____ (CITY) _____ (STATE) ("Hospital") and the Centers for Medicare & Medicaid Services ("CMS") of the United States Department of Health and Human Services. CMS and

_____
are individually referred to in this Agreement as a "Party" and jointly as "the Parties."

WHEREAS,

_____
has brought one or more administrative appeals (listed on Attachment A hereto) of a Medicare contractor's determination(s) that the Medicare program overpaid

_____
for certain inpatient services that the contractor found should have been billed as outpatient services based on patient status and medical necessity;

WHEREAS, the Parties desire to resolve this/these ongoing claims appeal(s), without the further expense and drain on resources required by continued administrative litigation, by entering into an Administrative Agreement relating to the underlying determinations and demands for repayment;

NOW THEREFORE,

_____
and CMS, intending to be legally bound, hereby enter into the following ADMINISTRATIVE AGREEMENT:

1. The parties agree that this Agreement is intended to resolve "eligible claims." For purposes of this agreement, "eligible claims" are defined as those meeting all elements of the following definition: 1) the claim was denied by any entity that conducted a review on behalf of CMS; 2) the claim was not for items or services furnished to a Medicare Part C enrollee; 3) the claim was denied based on an inappropriate setting determination, that is, on the basis that the service might have been reasonable and necessary, but treatment on an inpatient basis was not; 4) the first day of the admission was before October 1, 2013; 5) the Hospital timely appealed the denial; 6) as of the date of an executed Agreement submitted to CMS by the Hospital, the appeal decision was still pending at the MAC, QIC, ALJ, or DAB levels of review, or the Hospital had not yet exhausted its appeal rights at the MAC, QIC, ALJ, or DAB level; and 7) the Hospital did not receive payment for the service as a Part B claim.

2. CMS agrees to pay the Hospital the total sum listed on Attachment A, which represents sixty-eight (68) percent ('the percentage") of the net paid amount of each denied inpatient claim included in any appeal listed on Attachment A. "Net paid

amount" means the payment on the original inpatient claim net paid amount; it excludes the out-of-pocket obligations that are included in the "gross" or "allowable" amounts. This payment will be made in one payment (electronic funds transfer or otherwise) per hospital provider number or per owner or operator of multiple settling hospitals. In addition, CMS will refund to the Hospital all interest on any claim included in any appeal covered by this Agreement that CMS has collected from the Hospital as of the effective date of this Agreement as described in paragraph 17.

3. CMS will pay the agreed amount to the Hospital in accordance with this Agreement within sixty (60) days from the effective date of this Agreement as described in paragraph 17 herein. This payment represents payment in full by Medicare; no further interest or payments on disputed claims covered by this Agreement shall be made by Medicare, except that if CMS fails to make payment within the allotted sixty (60) days, CMS will pay interest to the Hospital for the period beginning on day sixty-one (61) through the date of payment. The interest rate shall be the Current Value of Funds Rate ("CVFR") as promulgated by the United States Department of the Treasury.

4. If the Hospital has not fully repaid the originally denied amount on a claim included in an appeal listed on Attachment A, the Hospital will receive for that claim payment of the percentage value applied less the outstanding overpayment balance. If the Hospital has not yet repaid any of the originally denied amount on a claim included in an appeal listed on Attachment A, or where the amount retained by the Hospital exceeds sixty-eight (68) percent of the net paid amount, the Hospital will owe CMS a refund for that claim. CMS will calculate the refund amount as the difference between the retained amount and sixty-eight (68) percent of the net paid amount. Any refund owed CMS will be subtracted from the total payment due under this Agreement or from future Medicare payments to the Hospital.

5. Receipt by CMS of an Agreement executed by the Hospital, along with the Hospital's proposed list of appeals to be resolved, will serve to stay all such appeals. Proceedings on all such appeals will remain stayed until either an Agreement is fully executed by both Parties or the Parties determine that they will not enter into an Agreement. Once fully executed by all Parties, this Agreement will serve as the Hospital's request to withdraw the appeals covered by this Agreement. CMS will provide copies of the executed Agreement to the appropriate administrative tribunals for the purpose of dismissing pending appeals that are being resolved in the Agreement. Such dismissals will be with prejudice except that the Hospital retains the right to reinstate its appeal if CMS fails to perform its obligations under the Agreement. In such a case, where the Hospital reinstates its appeal for some or all of the claims initially covered by the Agreement, CMS agrees that the requirements for good cause for late filing of an appeal request (described in 42 C.F.R. §§ 405.942(b), 405.962(b), 405.1014(b), and 405.1102(b)) will be deemed to be met. Similarly, the Hospital agrees to waive its rights to receive a timely decision on any pending appeal that is being resolved in this Agreement, including but not necessarily limited to rights under 42 C.F.R. §§ 405.950, 405.970, 405.1016, 405.1100, and 405.1132; except that for any appeal that is reinstated pursuant to this section the standard time limits for processing appeals issuing a determination or decision shall apply and begin with the date that the appeal is reinstated.

6. Upon receipt of an Agreement executed by the Hospital, CMS will determine whether the list of appeals furnished by the Hospital matches CMS's records at each level of the administrative appeals process. If so, CMS will execute the Agreement. If not, CMS and the Hospital will use their best efforts to work together to resolve promptly any discrepancies so that a match is achieved, at which time CMS will execute the Agreement.

7. The payment described in paragraph 2 shall be in full and final satisfaction of all of the Hospital's claims that are included in appeals of a Medicare contractor's determination(s) listed on Attachment A, including claims pending at any level of administrative review. The Hospital agrees it will not commence any further appeals or actions of any kind challenging the Medicare contractor's determination(s) regarding the claims included in the appeals listed on Attachment A; specifically, the Hospital will not attempt to rebill any of those services under Part B. Billing or rebilling of individual claims is not necessary for the Hospital to receive payment under this Agreement. CMS retains the right to recoup any duplicate or incorrect payments made for claims that were, but should not have been, included under this Agreement, including but not limited to payments that may have been made in the appeals process or secondary to Part B billing but also inadvertently included among the payment made under this Agreement.

8. The Hospital agrees that, as of the effective date of this Agreement as described in paragraph 17 herein, it will not seek additional payment from any Medicare beneficiary or collect any deductible or coinsurance amount regarding any claim resolved through this Agreement that is not subject to a repayment plan existing as of the effective date of this Agreement. The Hospital may retain any Medicare beneficiary deductible or coinsurance amounts already paid as of the effective date of this Agreement.

9. This Agreement does not constitute an admission of fact or law by the Parties and shall in no way affect the rights, duties, or obligations the parties may have with respect to other issues or claims not covered by this Agreement.

10. This Agreement resolves specific administrative and common law claims, and does not include a release of liability of any claims the United States may have under the False Claims Act, (31 U.S.C. section 3729 et seq.), the Civil Monetary Penalties Law, (42 U.S.C. section 1320a-7a), or the common law theories of payment by mistake, unjust enrichment, or fraud.

11. Hospital releases CMS from all liability arising from eligible claims that are resolved. CMS releases Hospital with respect to eligible claims which are resolved.

12. This Agreement shall be binding upon the Parties to it, their affiliated entities, successors and assigns.

13. Each Party shall bear its own costs and attorney fees.

14. The persons who have executed this Agreement below represent and warrant that they are fully authorized to sign this Agreement on behalf of the respective Parties.

15 The parties may execute this Agreement in one or more counterparts, each of which shall represent one and the same instrument.

16 This Agreement constitutes the complete agreement between the Parties. This Agreement may not be amended except by written consent of the Parties.

17 The effective date of this Agreement is the date of signature of the last signatory to the Agreement. The Parties' obligations under the Agreement become binding as of the effective date. Facsimiles of signatures shall constitute acceptable, binding signatures for purposes of this Agreement.

18 This Agreement is governed by the laws of the United States. Any dispute between the Parties under this Agreement shall be resolved by a federal court of competent jurisdiction.

_____ _____

(Signature) Date

_____

(Typed Name)

On behalf of

_____

(Hospital Name)

_____ _____

Gerald T. Walters Date

Senior Advisor to the Chief Financial Officer,
Office of Financial Management
Centers for Medicare & Medicaid Services