EXHIBIT "I"
to Third Amended Complaint

U.S. ex rel. Williams v. Health Management Associates, Inc., Tenet Healthcare Corporation and Hispanic Medical Management d/b/a Clinica de la Mama, et al.

DEPARTMENT OF COMMUNITY HEALTH
DIVISION OF MEDICAL ASSISTANCE

STATEMENT OF PARTICIPATION

THIS STATEMENT OF PARTICIPATION between the State of Georgia, Department of Community Health, Division of Medical Assistance (the "Department") and the undersigned Provider becomes effective on the date of enrollment indicated by the Department.

WHEREAS, the Department is charged with the administration of the Georgia State Plan for Medical Assistance (the "Medicaid program") in accordance with the requirements of Title XIX of the Social Security Act of 1935, as amended, and O.C.G.A. § 49-4-1 *et seq.*, and seeks to enroll qualified health care providers ("Providers") to render services to eligible Medicaid recipients;

WHEREAS, Provider affirms that all prerequisites, certification and/or licensure requirements and other necessary qualifications have been met in Provider's area(s) of specialty as required by law in the State of Georgia to render health care services to patients; and,

WHEREAS, Provider desires to enroll in the Medicaid program to render Covered Services to eligible Medicaid recipients under certain category(ies) of service, and seeks reimbursement for rendering such services.

NOW THEREFORE, in consideration of the mutual covenants and promises contained herein and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties agree to the terms and conditions named herein as follows:

1. THE DEPARTMENT'S OBLIGATIONS

A. Legal Compliance. The Department shall adhere to all applicable provisions of federal and state laws and regulations, Rules of the Department, and all of the Department's Policies and Procedures manuals governing the Medicaid program, and any amendments thereto (collectively, the "Department's requirements").

B. Reimbursement to Providers. The Department shall reimburse Provider for claims that are submitted in compliance with the Department's requirements, and in such amounts allowed under the Medicaid program as administered by the Department.

C. Modifications to Department's Policies and Procedures. The Department shall notify Provider of modifications to the provisions contained in the Policies and Procedures manual(s) for the category(ies) of service in which the Provider is enrolled by disseminating such notices to the address(es) at which Provider is then registered with the Department. Public notice of significant changes in the Department's methods and standards for setting payment rates for Covered Services will be given in accordance with the Rules governing the Department.

2. PROVIDER'S OBLIGATIONS

A. Legal Compliance. Provider shall comply with all of the Department's requirements applicable to the category(ies) of service in which Provider participates under this Statement of Participation, including Part I, Part II and the applicable Part III manuals. The term "Provider" shall include those persons or entities performing services under the supervision or other direction of Provider, and all acts or omissions of such persons or entities shall be attributed to Provider.

B. Provider Enrollment and Continued Participation. Provider shall comply with the Department's requirements to enroll and continue participating as a Provider in the Medicaid program, including but not limited to completion of all enrollment forms, cooperation with site audits, and the following:

1. Certification of Provider Information. Provider certifies that all statements and information furnished to the Department for enrollment and continued participation are true and complete, and recognizes that the Department will rely on such information to evaluate Provider's participation under the Medicaid program. Provider shall give the Department written updates to information previously submitted, and advance notice of changes when required by the Department in this Statement of Participation and the Department's requirements.

2. Disclosure.

   A. Business Transactions. Within thirty-five (35) days of a request, Provider shall submit to the U.S. Department of Health and Human Services or the Department full and complete information about (a) the ownership of any subcontractor with whom Provider has had business transactions totaling more than $25,000 during the twelve (12) month period ending on the date of the request; and (b) any significant business transactions between Provider and any wholly owned supplier or subcontractor during the five (5) year period ending on the date of the request. Failure to disclose information as requested will result in denial of reimbursement from the date after which the information is due until the day before it is supplied.

   B. General Disclosure. Provider authorizes the Department to request, copy, access, use and share Provider's records and other information as may be necessary for the Department to determine the appropriateness of Provider's participation in or termination from the Medicaid program, subject to any applicable state or federal laws which may deem such records or parts of such records privileged or confidential. Provider's records and information may be requested from or exchanged with any source, including but not limited to the Composite State Board of Medical Examiners, any federal or state governmental agency, accreditation agency, licensing agency, regulatory body, certifying agency, or any other person or entity, subject to any applicable state or federal law limiting the distribution of such information. Provider's authorization to request, copy, access, use and share records and other information includes but is not limited to disclosure of ownership or control interests, and of any criminal offenses related to any federal or state health care program. This disclosure provision shall exclude sanctions against Provider that are protected by private order of the issuing board or agency.

3. License/Certification. Provider shall possess and maintain in good standing and without restriction valid professional, occupational, facility or other license and/or certification that is necessary for rendering Covered Services in the selected category(ies) of service, and as required by the Department. Provider shall provide the Department with written copies of licenses and/or certifications upon request. Except where disclosure is protected by private order of the issuing board or agency, Provider shall inform the Department promptly in writing of any restriction or adverse action against Provider's license and/or certification.

4. Hold Harmless. Provider releases from liability and holds harmless the Department, its agents, and any and all individuals and entities who, in good faith, furnish or release information for any acts performed and statements made or released in connection with the evaluation of Provider under the Medicaid program including the services rendered by Provider, and other matters pertinent to Provider's status and duties in connection with this Statement of Participation. This provision shall survive termination or expiration of this Statement of Participation for any reason.

   A. Claims Submission; Certification of Claims. Provider shall submit claims for Covered Services rendered to eligible Medicaid recipients in the form and format designated by the Department. For each claim submitted by or on behalf of Provider, Provider shall certify each claim for truth, accuracy and completeness, and shall be responsible for research and correction of all billing discrepancies without cost to the Department. This provision shall survive termination or expiration of this Statement of Participation for any reason.

   B. Recipient Records. Provider shall maintain in an orderly manner and ensure the confidentiality of all original source documents, medical records, identifying recipient

data, and any copies thereof, as may be necessary to fully substantiate the nature and extent of all services provided. Records shall be retained for a minimum of five (5) years from the date of service, or longer as required by state or federal law. Upon request by the Department, its agent, and any authorized agency including but not limited to the U.S. Department of Health and Human Services, the Comptroller General, the State Auditor, State Attorney General's Office or office of any Georgia District Attorney and their authorized representatives, Provider shall disclose and provide legible copies to the requestor, or permit the requestor to copy, without cost, all Medicaid-related documents, records or data. This provision shall apply to all records regardless of the enrollment status of Provider, subject to any applicable state or federal laws that may deem such records or parts of such records privileged or confidential. Provider's failure to abide by this provision may constitute grounds for disallowance of all applicable charges, recoupment of corresponding payments, and/or termination of Provider's participation. This provision shall survive termination or expiration of this Statement of Participation for any reason.

C. Covered Services. Provider shall render Covered Services, as defined in the Department's Policies and Procedures manuals, to eligible Medicaid recipients that are medically necessary as defined by the Department, within the parameters permitted by Provider's license or certification, and within the category(ies) of service indicated in the Provider Enrollment documents. By submitting claims for reimbursement, Provider certifies that Covered Services were rendered in the amount, duration, scope and frequency indicated on the claims. Provider shall not discriminate against any recipient on the basis of race, color, national origin, religion, sex, marital status, age, disability, health status, or source of payment.

D. Reimbursement for Covered Services. Reimbursement for Covered Services performed shall be made in a form and format designated by the Department. Payment shall be made in conformity with the provisions of the Medicaid program, applicable federal and state laws, rules and regulations promulgated by the U.S. Department of Health and Human Services and the State of Georgia, and the Department's Policies and Procedures manuals in effect on the date the service was rendered. Such reimbursement shall constitute payment in full for Covered Services rendered, and Provider shall not bill, accept or seek payment from eligible Medicaid recipients, except for applicable co-payments, co-insurance or deductibles required by the Department. Without cost to the Department or its agents, Provider agrees to cooperate with refund and recoupment efforts to the Department, and shall assist in recovering any amounts for which a third party may be liable. Provider agrees that the Department shall not reimburse any claim, or portion thereof, for services rendered prior to the effective date of enrollment indicated by the Department or for which federal financial participation is not available.

Provider acknowledges that payment of claims submitted by or on behalf of Provider will be from federal and state funds, and the Department may withhold, recoup or recover payments as a result of Provider's failure to abide by the Department's requirements. This provision shall survive termination or expiration of this Statement of Participation for any reason.

E. Prohibition on Reassignment. Provider acknowledges and agrees that the payee or billing service designated by Provider to receive payments or to process claims is not an individual or organization, such as a collection agency or service bureau, that advances money based on future Medicaid payments (accounts receivable) due to Provider after agreeing to sell, transfer or assign such rights to payment to the individual or organization for an added fee or a percentage of the accounts receivable. Furthermore, payment to the payee or billing service for services rendered shall be related to the cost of processing, and shall not be based on the payments due to Provider or based upon the percentage of claims processed.

F. Indemnification. Provider shall indemnify and hold harmless the Department and its agents from all causes of action, claims, suits, judgments, or damages, including court costs and attorneys' fees, arising out of the misconduct, negligence or omissions of Provider in the course of participating in the Medicaid program, including but not limited

to the provision of services to an eligible Medicaid recipient or a person believed to be a recipient. If and to the extent such damage or loss (including costs and expenses) is covered by any funds established and maintained by the State of Georgia, Provider agrees to reimburse the funds for such monies paid out by such funds. This provision shall survive termination or expiration of this Statement of Participation for any reason.

3. **TERM; TERMINATION**

A. Term. Unless otherwise renewed and subject to the Department's requirements for continued participation, this Statement of Participation shall expire automatically at 11:59 p.m. on June 30 of each year. The Department, in its sole discretion, has the option to renew this Agreement for an additional fiscal year, and if exercised, the Department shall issue written notice to Provider prior to the end of the then-current fiscal year. The Department has the right to terminate this Agreement at any time with or without cause under applicable laws, rules or regulations.

B. Termination by Provider. Unless otherwise authorized by the Department or by law, Provider shall give ten (10) days prior written notice to the Department of voluntary termination.

C. Termination under Other Programs. The Department may terminate and take other action against Provider under the Medicaid program when adverse action is taken against Provider under any other plan or program, including but not limited to exclusions from or licensure restrictions or conditions by other federal or state authorities, plans or programs. The Department shall issue written notice of termination to Provider to be effective on the date indicated therein. The Department also may notify other state and federal authorities, plans or programs of Provider's enrollment status in the Medicaid program, including other plans or programs within the Department. Termination under the Medicaid program may result in Provider's termination under other federal and state plans or programs.

D. Termination for Unavailability of Funds. Notwithstanding any other provision hereof, in the event that funds are no longer appropriated for the Department, Division of Medical Assistance by the General Assembly of the State of Georgia or from the Congress of the United States of America, or in the event that the sum of all obligations of the Department incurred pursuant to the Medicaid program equals or exceeds the balance of such sources available to the Department for "Medical Assistance Benefits" for the fiscal year in which this Statement of Participation is effective less one hundred dollars ($100.00), then this Statement of Participation shall terminate immediately without further obligation to or by the Department. The certification by the Commissioner of the Department of the occurrence of either of the events stated above shall be conclusive. The Department will attempt to provide Provider with ten (10) days notice of the possible occurrence of events described in this provision.

4. **GENERAL PROVISIONS**

A. Notice. All mailed notices shall be issued to the Provider's address on record with the Department as of the date of such notice.

B. Waiver of Breach. Waiver of breach of any provision of this Statement of Participation shall not be deemed a waiver of any other breach of the same or different provision of this Statement of Participation.

C. Conflict of Interest. The parties certify that the provisions of O.C.G.A. § 45-10-20 *et seq.*, as amended, and 41 U.S.C. § 423 regarding conflicts of interest have not and will not be violated in any respect.

D. Headings. The headings of sections and provisions contained herein are for reference purposes only and shall not affect in any way the meaning or interpretation of this Statement of Participation.

E. Governing Law. This Statement of Participation shall be governed by and construed in accordance with the laws of the State of Georgia.

F. Assignment. Provider may not assign any right or obligation under this Agreement without the prior written consent of the Department.

G. Amendments. Except as otherwise specifically provided herein, amendments or modifications to this Statement of Participation shall be in writing and signed by each party.

H. Provider-Patient Relationship. Nothing in this Statement of Participation shall be construed to interfere with or in any way alter any Provider-patient relationship or interfere with the obligations of Provider to exercise independent medical judgment in rendering health care services to patients or in governing the level of care of a patient.

I. Independent Relationship. This Statement of Participation establishes the means and terms of reimbursement between the Department and Provider, but does not prescribe the conduct of any medical or other professional practice. No provision in this Statement of Participation is intended to create or shall be deemed or construed to create any relationship between the Department and Provider other than that of independent entities contracting with each other solely for the purpose of effecting the provisions of this Statement of Participation. Neither the Department nor Provider is or shall be considered an employer, employee, agent, partner or joint venture of the other.

J. Binding Authority. Each party acknowledges that it has the full power and authority to enter into and perform this Statement of Participation and the person signing on behalf of each party has been properly authorized and empowered to enter into this Statement of Participation.

K. Entire Agreement. This Statement of Participation, together with the Department's Policies and Procedures manuals, all enrollment documents, and any amendments thereto, shall constitute the entire agreement between the parties with respect to the subject matter contained herein, and shall supersede all previous communications, representations, or agreements, either verbal or written, between the parties.

IN WITNESS WHEREOF, Provider executes this Statement of Participation in person, or as an authorized party on behalf of an entity. to become effective on the date indicated by the Department.

Accepted and authorized on this 19th day of January, in the year 2004

Monroe HMA Inc d/b/a Walton Regional Medical Center ("Provider")
(Printed Name of Enrolling Provider)

Provider's Signature: _____

Alan George, Executive Director
(Printed name and title of Authorized Agent (for non-individual practitioners only)

Authorized Agent's Signature: _____

DEPARTMENT OF COMMUNITY HEALTH
DIVISION OF MEDICAL ASSISTANCE (the "Department")

Accepted and authorized on this _____ day of _____, in the year _____

BY: _____
DIRECTOR, DIVISION OF MEDICAL ASSISTANCE

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