

Site Investigation for Suppliers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)

SUPPLIER INFORMATION

Supplier Type:

Supplier Number: 0223970001

Supplier Name: PNEU MED INC

National Provider Identifier(NPI): 1720021868

Authorized Representative: STEPHANIE DIANE
GLINES

Telephone Number: 8006362704

Address: 3475 E AMAZON DR

City/State/Zip Code: Eugene, OR 97405

Reason for Visit: Revalidation

VISIT DATES

Date of First Visit

12/05/2023



Time of First Visit

02:15 PM

Date of Second Visit

12/06/2023



Time of Second Visit

01:00 PM

FACILITY INFORMATION

1. Type of Facility

Storefront

☐ Yes

☒ No

Suite-Mall/Plaza

☐ Yes

☒ No

Suite-Office Building

☒ Yes

☐ No

Private Residence

☐ Yes

☒ No

Warehouse (Only)

- ☐ Yes
☒ No

Office-Warehouse Attached

- ☐ Yes
☒ No

Other

- ☐ Yes
☒ No

If "Other", Please Describe

Attach Photo

- ☒ Yes
☐ No

Photo Upload



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Longitude: -123.0797026
Date: 12/05/2023 02:10 PM PST

a. What is the approximate size of the facility?

7,700 sq ft

b. Is access to facility restricted (gated community, call box, etc)?

- ☐ Yes
☒ No

c. Are there customers or signs of business activity during the inspection?

- ☒ Yes
☐ No

d. Is this facility normally visited by beneficiaries?

- ☒ Yes
☐ No

e. If a home based business, are all local zoning requirements met?

- ☐ Yes
☐ No
☒ N/A

2. Is the facility accessible to the disabled?

- ☒ Yes
☐ No

If "No", how does the supplier accommodate disabled persons?

Attach Photo

- ☒ Yes
☐ No

Photo Upload



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Longitude: -123.0796739
Date: 12/05/2023 02:16 PM PST

3. Is there a permanent, visible sign with the supplier's business name posted on the facility?

- ☒ Yes
☐ No

Attach Photo

- ☒ Yes
☐ No

Photo Upload



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Longitude: -123.0797026
Date: 12/05/2023 02:11 PM PST

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938- 0749. The time required to complete this information collection is estimated to average 30 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244- 1850.

4. Are hours of operation posted?

- ☒ Yes
☐ No

Attach Photo

- ☒ Yes
☐ No

Photo Upload



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Longitude: -123.079669
Date: 12/05/2023 02:14 PM PST

Open 24/7 (Open 24 hours a day, 7 days a week)

OR

☐ Yes

☒ No

By Appointment Only (no fixed days or hours)

AND/OR

☐ Yes

☒ No

Please list hours of operation below

Monday

8:00 AM to 5:00 PM

Tuesday

8:00 AM to 5:00 PM

Wednesday

8:00 AM to 5:00 PM

Thursday

8:00 AM to 5:00 PM

Friday

8:00 AM to 5:00 PM

Saturday

Closed

Sunday

Closed

Total Hours

45

5. Was the site visit completed? If unable to conduct site visit for any reason (supplier not operational or inspection refused), please explain in the Additional Comments section at the end of this form.

- ☒ Yes
☐ No

INTERVIEW OF INDIVIDUAL(S) PRESENT

6. Individual(s) Interviewed

- ☐ Owner
☐ President
☒ Manager
☐ Administrator
☐ Other

Owner's Last Name

Owner's First Name

President's Last Name

President's First Name

Manager's Last Name

Manager's First Name

Administrator's Last Name

Administrator's First Name

If "Other", Please Describe

Additional Information

7. The supplier must provide a list of all owners and management with day-to-day control, including name and title.

Attach Copy

- ☐ Yes
☒ No

8. Does the supplier have other locations that service Medicare beneficiaries? If additional space is needed, please use the Additional Comments section at the end of this form.

- ☐ Yes
☒ No

If "Yes", please supply the following items:

Business Name

Address

City

State

Zip Code

PTAN

9. Does the owner or any relatives own(ed) any other medical entities? If additional space is needed, please use the Additional Comments section at the end of this form.

- ☐ Yes
☒ No

If "Yes", please supply the following items:

Owner's Last Name

Owner's First Name

Relationship

Business Name

Address

City

State

Zip Code

10. Does the supplier share office space with other DME suppliers or other medical businesses?

- ☐ Yes
☒ No

If "Yes", please supply the following items:

Business Name

Type of Business

Owner's Last Name

Owner's First Name

Attach Photo

- ☐ Yes
☒ No

Do the co-located businesses share any of the following items?

a. Entrances

- ☐ Yes
☐ No

b. Office personnel/ownership

- ☐ Yes
☐ No

c. EIN

- ☐ Yes
☐ No

d. Telephone

- ☐ Yes
☐ No

e. Inventory

- ☐ Yes
☐ No

If "Yes" to any of the above, please describe and attach photos.

RECORDS & TELEPHONE

11. Are the patient records maintained (check all that apply)

at this location?

- ☒ Yes
☐ No

at an off-site storage facility?

- ☐ Yes
☒ No

electronically?

- ☒ Yes
☐ No

a) Do these records include physician ordering/referral documentation?

- ☒ Yes
☐ No

b) Do these records include beneficiary communications, such as questions received from beneficiaries and progress notes?

- ☒ Yes
☐ No

c) Do these records include documentation of delivery?

- ☒ Yes
☐ No

d) Do these records include documentation of maintenance, repairs, or exchanges?

- ☒ Yes
☐ No

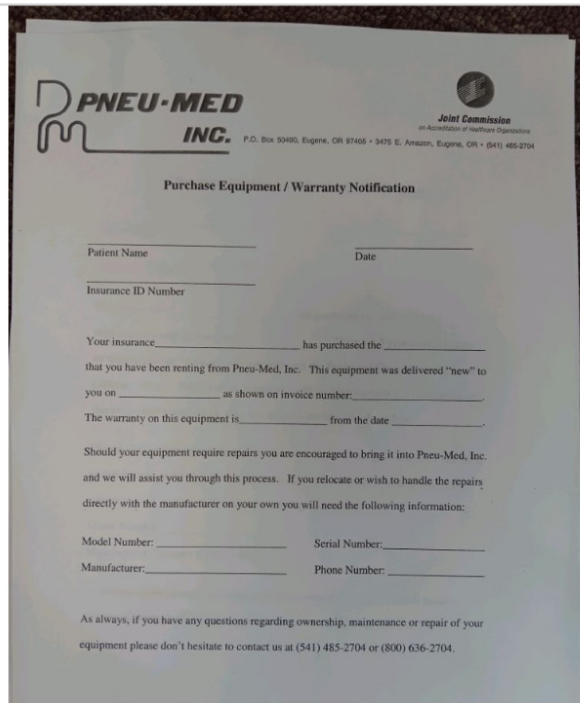
e) Do these records include proof the supplier provided equipment warranty?

- ☒ Yes
☐ No

Attach Photo

- ☒ Yes
☐ No

Photo Upload



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Date: 12/05/2023 02:23 PM PST

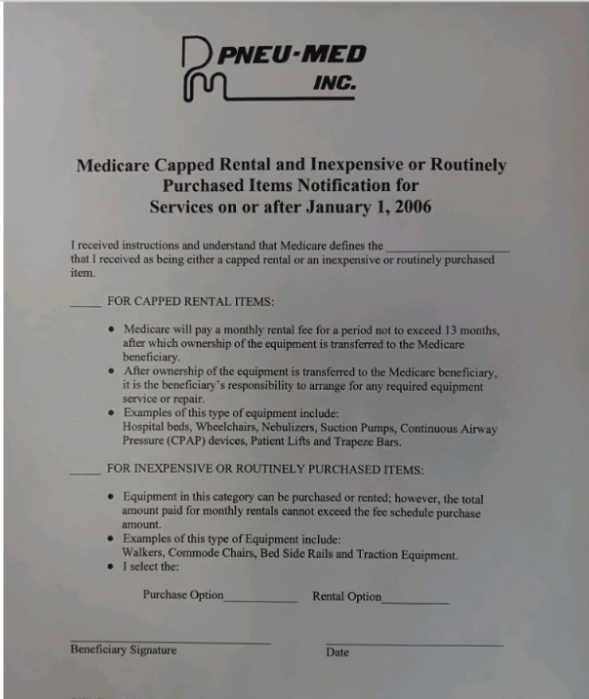
f) Do these records include proof the supplier advises beneficiaries that they may either rent or purchase inexpensive or routinely purchased equipment, and of the capped rental policy?

- ☒ Yes
☐ No

Attach Photo

- ☒ Yes
☐ No

Photo Upload



PNEU-MED INC.

Medicare Capped Rental and Inexpensive or Routinely Purchased Items Notification for Services on or after January 1, 2006

I received instructions and understand that Medicare defines the _____ that I received as being either a capped rental or an inexpensive or routinely purchased item.

____ FOR CAPPED RENTAL ITEMS:

- Medicare will pay a monthly rental fee for a period not to exceed 13 months, after which ownership of the equipment is transferred to the Medicare beneficiary.
- After ownership of the equipment is transferred to the Medicare beneficiary, it is the beneficiary's responsibility to arrange for any required equipment service or repair.
- Examples of this type of equipment include:
Hospital beds, Wheelchairs, Nebulizers, Suction Pumps, Continuous Airway Pressure (CPAP) devices, Patient Lifts and Trapeze Bars.

____ FOR INEXPENSIVE OR ROUTINELY PURCHASED ITEMS:

- Equipment in this category can be purchased or rented; however, the total amount paid for monthly rentals cannot exceed the fee schedule purchase amount.
- Examples of this type of Equipment include:
Walkers, Commode Chairs, Bed Side Rails and Traction Equipment.
- I select the:
Purchase Option _____ Rental Option _____

Beneficiary Signature _____ Date _____

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Date: 12/05/2023 02:25 PM PST

g) Do these records include proof the supplier provides beneficiaries with written information and instructions on how to use Medicare covered items safely and effectively?

- ☒ Yes
- ☐ No

If "No" to any of the above, please explain

Attach Photo

- ☒ Yes
- ☐ No

Photo Upload

Oxygen: Training Certification

Patient Name: _____ Telephone: _____
Address: _____ Physician: _____
Person Receiving Orientation: _____ Respiratory Diagnosis: _____
Equipment Set up: ☐ O2 Concentrator ☐ Compressed Gas Portable ☐ Liquid O2 Rx/LPM: _____

GOAL: Patient / Client will demonstrate an understanding of the safe operation of the prescribed Medical Oxygen Equipment.

Use and Safety Information:

- Explain safety precautions, safe storage, transportation and potential hazards of Oxygen, particularly No smoking in the presence of oxygen and the dangers to self and others. Post NO SMOKING Sign.
- Explain the importance of following the physician's prescription – Oxygen is a legal drug.
- Explain the potential tripping hazards of extension tubing and the availability of darker tubing.
- Explain how to fill and attach the humidifier if using as well as the need for distilled water.
- Demonstrate how to turn on the equipment and to set or change the liter flow.
- Demonstrate how to change the oxygen regulator from cylinder to cylinder and check for leaks.
- Explain the frequency of changing the nasal cannula/extension tubing.
- Explain proper placement of the concentrator as well as the hazards of using extension cords.
- Explain the meaning of the concentrator alarm and simple troubleshooting techniques.
- Explain approximate supply times at the patient's ordered liter flow.
- Explain the importance of the backup oxygen system.
- Explain the hazards of cold gas to the skin and eyes if using liquid oxygen as well as how to fill the portable system. Explain slow venting of gas through the relief systems is Normal and expected.
- Provide the Oxygen Set up book with the supplier standards as well as the phone number to call for problems that may arise during and after business hours. Point out sections in the set up book.
- Have the patient/caregiver demonstrate understanding by reverse demonstration.

Functional Limitations/Restrictions: ☐ Mobility aide: _____
Y N Y N Y N Y N Y N
Environment: ☐ Space ☐ Electrical ☐ Access ☐ Clean ☐ Smoke detector-test

Patient Safety: ☐ Fall Hx ☐ Fear of Falling ☐ Tripping Hazards (i.e. throw rugs)
☐ No Assist ☐ One person Assist ☐ Two person Assist

Smokers in the Home: ☐ Yes, install OxySafe Valve ☐ Fire Evacuation Plan

Comments: _____

Patient is in Facility – they have their own Oxygen Safety Procedures, Instruction declined: YES

Signature of Person Receiving the Instructions: _____ Date: _____

Latitude: 44.0192061
Longitude: -123.0794545
Date: 12/05/2023 02:26 PM PST

12. Does the supplier have a written complaint policy/procedure established and document for logging complaints?

- ☒ Yes
☐ No

If "Yes", please attach a copy of their complaint policy and complaint log.

- ☒ Yes
☐ No

Complaint Policy Photo Upload

Pneu-Med, Inc.

JCAHO Standard:
Effective: 10/14/1994

Revised: 06/06/2019
Reviewed: 06/06/2019
Approved: S.G.

Subject: Complaint Policy

Policy Statement: To provide a system to allow patients, their families or caregivers, referral sources, employees or affected community members to voice concerns/problems regarding a specific aspect of the services provided by Pneu-Med, Inc. in a safe and non-threatening manner with a documented follow up.

Policy Procedure:

1. A complaint as defined for this policy is an ongoing concern or problem that has been unable to find resolution through normal processes.
2. There are two ways that an individual/entity can express an initial concern/problem:
 - A. They may call Pneu-Med, Inc and speak with the office staff or a manager at their request who will attempt to resolve the issue, or
 - B. They may speak with their driver/therapist who will fill out the designated problem/needs section at the bottom of the invoice or assessment form.
3. If the employee handling the complaint/problem can resolve the situation no further action is required. If the employee can't resolve the problem, it will be referred to the appropriate manager (i.e. clinical or operations) for resolution. Additionally, if the employee's resolution is unsatisfactory the manager will resolve the problem/need appropriately and explain to the employee why their resolution was unsatisfactory.
4. If the problem would put the patient at risk or violate the physician's order, the physician will be notified immediately.
5. If the situation requires additional information the manager may wish to contact the affected party for clarification or more detail necessary to resolve the problem. The patient or parties involved will be notified of the final resolution within 72 hours. The report of client need form will be completed at the conclusion of the situation and scanned into the patient's chart as well as filed in the complaint log.
6. Any problems not able to be resolved through this process will be referred to the Grievance Review Policy.

Latitude: 44.0191772
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Date: 12/05/2023 02:28 PM PST

Complaint Log Photo Upload

JCAHO Standard: RI.2.210

Report of Client: Need | | Problem | |

Client Name: _____ HCN: _____
Address: _____ Intake Date: _____
Phone: _____

1. Nature of client's need or problem _____

2. What corrective action have you taken to resolve the problem or meet the need?
☐ Provide additional education & reinstruction ☐ Provide additional equipment
☐ Other: _____

Comments: _____

3. Do you feel this issue requires further action: ☐ YES ☐ NO
If yes, explain: _____

Copy of Disposition requested? ☐ YES ☐ NO
Prepared by: _____ Resolution Date: _____
Reviewed by: _____
☐ Administration _____
☐ Respiratory Therapy _____
☐ Operations _____

4. Additional Action /Comments: _____

Latitude: 44.0191772
Longitude: -123.0794633
Date: 12/05/2023 02:28 PM PST

13. Does the supplier have a business phone number (other than a cellular phone) listed in a local telephone directory under the business name?

- ☒ Yes
☐ No

Please list the phone number

(541) 485-2704

a) How was the phone number verified (check all that apply)?

White/Yellow Pages

- ☒ Yes
☐ No

Directory Assistance

- ☒ Yes
☐ No

b) Was there telephone activity during the site inspection?

- ☒ Yes
☐ No

LICENSING/CERTIFICATION

14. Are the supplier's business, customers, and employees covered by comprehensive liability insurance? (Obtain current certificate of insurance with NSC as the certificate holder.)

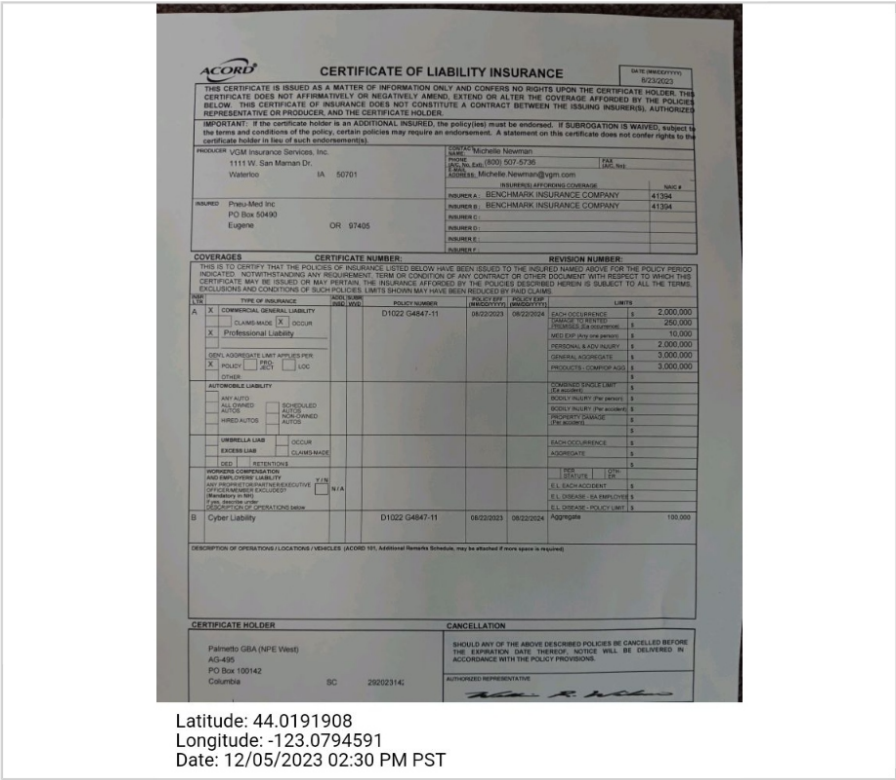
- ☒ Yes
☐ No

If "No", please describe

Attach Photo

- ☒ Yes
☐ No

Photo Upload



15. Does the supplier have valid state and federal licenses applicable to their business?

If “No”, please describe

- ☒ Yes
- ☐ No

Attach Photo

- ☒ Yes
- ☐ No

Photo Upload



16. Does the supplier provide custom fitted or fabricated Orthotic and Prosthetic items?

- ☐ Yes
☒ No

If "Yes", what are the name(s) and qualifications of those providing this service?

Attach Photo

- ☐ Yes
☒ No

a) Does the supplier fabricate items onsite?

- ☐ Yes
☒ No

If "No", does the supplier contract with other companies for the purchase of items necessary to fill orders?

- ☐ Yes
☒ No

If "Yes", please identify the company:

Company Name

Street Address

City

State

Zip Code

Telephone #

17. Does the supplier provide diabetic footwear?

- ☐ Yes
☒ No

If "Yes", what are the name(s) and qualifications of those providing this service?

Attach Photo

- ☐ Yes
☒ No

18. Does the supplier provide oxygen or oxygen related equipment?

- ☒ Yes
☐ No

If "Yes", what are the name(s) and qualifications of those providing this service?

There are two staff members certified as Respiratory Therapists, Tammy Werth and Stuart Nurre.

Attach Photo

- ☒ Yes
☐ No

Photo Upload

Oregon Health Authority/Health Licensing Office - License Confirmation

Board: RT
Respiratory Therapist and Polysomnographic

License Type: P
P - Respiratory Therapist - Permanent

License Number: 10111986

License Issued: 6/30/2006 Method: Application

Licensee Name: WERTH, TAMMY S

City/State/Zip: SPRINGFIELD, OR 97477

License Status: Active

License Active through: 06/30/24

Unresolved Disciplinary Action:

"Disciplinary Action" codes indicate an outstanding "Compliance" issue against this license. This means that a final order has been issued following the due process of law, but the license holder has not yet completed the payment of fines or other sanctions. "Active" status indicates the license is in good standing. Closed cases where no civil penalty was involved or closed cases where the civil penalty was paid are not shown. All final disciplinary orders on HLO licenses may be obtained through a public records request to the agency. If you have additional questions regarding a particular license record, call HLO Enforcement at (503) 379-8667 ext. 4310 or email hlo.info@state.or.us (mailto:hlo.info@state.or.us?subject=Compliance%20issues&body=Please%20enter%20your%20question%20or%20request).

The information on this Web Site is provided for your convenience. If you have any questions or cannot find the license information that you are seeking, please contact the Health Licensing Office - 1430 Tandem Ave. NE, Suite 180, Salem, OR 97301, Ph:(503) 379-8667.

Latitude: 44.0191649
Longitude: -123.0795437
Date: 12/06/2023 01:18 PM PST

INVENTORY

19. Does the supplier have inventory stored on site?

- ☒ Yes
☐ No

Attach Photo

- ☒ Yes
☐ No

Briefly provide description of inventory present

The pictured inventory includes CPAP machines, masks, oxygen, beds, wheelchairs, commodes and walkers.

Photo Upload



Latitude: 44.019151
Longitude: -123.0794526
Date: 12/05/2023 02:43 PM PST

20. Does the inventory present support the supplier's billing history?

- ☐ Yes
☒ No

N/A (No billing history)

Yes

a) If "No", please obtain invoices and/or contracts to verify the purchase of DME supplies.

- ☒ N/A
☐ Attach Photo

Vendor Name

Street Address

City

State

Zip Code

Telephone #

b) Does the supplier maintain an off-site storage facility?

- ☐ Yes
☒ No

If "Yes", please provide

Street Address

City

State

Zip Code

c) Does the supplier accept other types of health insurance?

- ☒ Yes
☐ No

If "Yes", please list

This supplier also accepts Aetna, Blue Cross, and Providence health insurances.

21. Does the supplier rent Durable Medical Equipment?

- ☒ Yes
☐ No

a) If "Yes", does the supplier directly service, maintain or replace DME items it rents to beneficiaries?

- ☒ Yes
☐ No

b) Do they have a service contract with another supplier?

- ☐ Yes
☒ No

If "Yes", please identify the company

- ☐ Yes
☐ No

Company Name

Street Address

City

State

Zip Code

Telephone #

If "No" to any of the above, please provide an explanation:

The supplier directly services Durable Medical Equipment and does not have a contract with any service provider.

Attach Photo

- ☐ Yes
☒ No

CONTACT WITH BENEFICIARY

22. Is a copy of the current Supplier Standards provided to all Medicare patients?

- ☒ Yes
☐ No

23. Does the supplier directly solicit (or utilize any third-party vendors to solicit) beneficiary referrals via telephone?

- ☐ Yes
☒ No

If "Yes" to third-party vendor, list company name(s).

If "No", please describe what methods the supplier uses to obtain new customers?

Notes

The supplier relies on word-of-mouth referrals from physicians and hospitals.

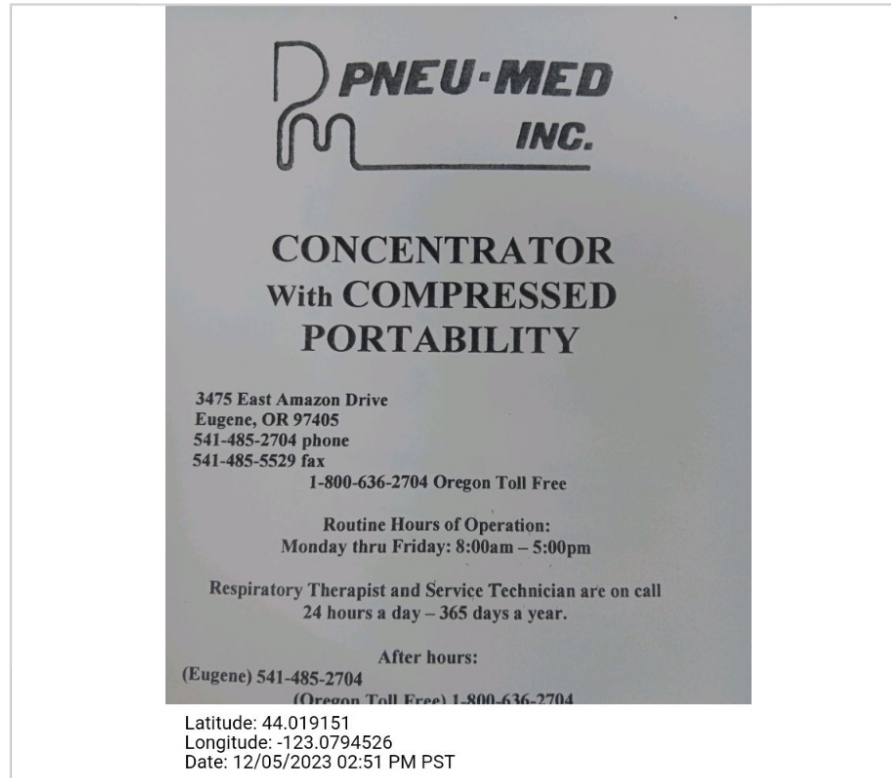
24. Does the supplier furnish contact information to beneficiaries at the time of delivery? Example: an equipment sticker label listing the supplier's name and telephone number

- ☒ Yes
☐ No

Attach Photo

- ☒ Yes
☐ No

Photo Upload



25. Does the supplier accept returns of substandard (less than full quality for the particular item) or unsuitable items (inappropriate for the beneficiary at the time it was fitted and rented or sold) from beneficiaries?

- ☒ Yes
- ☐ No

If "No", explain the reasons why

SIGNATURE AND DECLARATION

Additional Comments

First visit 12/5/2023 - Photos reviewed for clarity and accuracy. Second visit 12/6/2023 -A second visit was needed for more photos and clarifications. All photos checked for accuracy and quality.

I prepared this document, which is the report of my inspection of the noted facility pursuant to their enrollment in the Medicare program. This report is a true and accurate account of the events that occurred and transpired on the dates described therein. I am capable and willing to testify as a witness at a hearing about the content of this report. The foregoing information is based on my personal knowledge or is information provided to me in my official capacity. I declare under penalty of perjury that this information is true and correct to the best of my knowledge and belief.

Executed This On

12/06/2023



Signature of Declarant



Printed Name

Leah Geocaris

Date of Inspection

12/06/2023





Latitude: 44.0190159
Longitude: -123.0797236
Date: 12/06/2023 01:07 PM PST

If Applicable, 2nd Visit Exterior View



Latitude: 44.0190159
Longitude: -123.0797236
Date: 12/06/2023 01:04 PM PST

If Applicable, 2nd Visit Front Entrance View

Licensee Details

Demographic Information

Name: INDUSTRIAL SOURCE

Address Information

Line 1: 3500 COMMERCIAL AVE
Line 2:
Line 3:
Line 4: SPRINGFIELD OR 97478

License Information

Type: Manufacturer
Lic #: M-0001602
Status: Active
Issued: 1/13/2004
Expiration Date: 9/30/2024
Last Renewed: 7/18/2023
Small Business?

Prerequisite Information

Relationship/Name	Dates	License Details
No Specialty Information		

Discipline Information

No Discipline Information

Board Orders

No Available Board Orders

Latitude: 44.0191908
Longitude: -123.0794591
Date: 12/05/2023 02:32 PM PST

15. Oregon state pharmacy license

Oregon Health Authority/Health Licensing Office - License Confirmation

Board RT
License Type Respiratory Therapist and Polysomnographic
License Number P
License Issued P - Respiratory Therapist - Permanent
License Number 000655
License Issued 7/20/1992
Method
Licensee Name NURRE, STUART C
City/State/Zip EUGENE, OR 97405
License Status Active
License Active through 03/31/24
Unresolved Disciplinary Action None

"Disciplinary Action" codes indicate an outstanding "Compliance" issue against this license. This means that a final order has been issued following the due process of law, but the license holder has not yet completed the payment of fines or other sanctions. "Active" status indicates the license is in good standing. Closed cases where no civil penalty was involved or closed cases where the civil penalty was paid are not shown. All final disciplinary orders on HLO licensees may be obtained through a public records request to the agency. If you have additional questions regarding a particular license record, call HLO Enforcement at (503) 378-8667 ext. 4310 or email hlo.info@state.or.us (mailto:hlo.info@state.or.us?subject=Compliance%20Issues&body=Please%20Enter%20your%20question%20or%20request)

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Latitude: 44.0191908
Longitude: -123.0794591
Date: 12/05/2023 02:34 PM PST

15. Registered respiratory therapist license 1



Latitude: 44.019151
Longitude: -123.0794526
Date: 12/05/2023 02:44 PM PST

19 CPAP masks



Latitude: 44.0190159
Longitude: -123.0797236
Date: 12/06/2023 01:06 PM PST

Address



Latitude: 44.0191465
Longitude: -123.0795196
Date: 12/06/2023 01:23 PM PST

Beds



Latitude: 44.0191895
Longitude: -123.079482
Date: 12/06/2023 01:15 PM PST

Commode seat



Latitude: 44.0191895
Longitude: -123.079482
Date: 12/06/2023 01:15 PM PST

Oxygen

VGM Insurance Services, Inc.
PO Box 1328
Waterloo, IA 50704
Telephone: 866-497-0472

Insurance SERVICES

Medicare Surety Bond Receipt

To: Pneu-Med, Inc.
Payment Date: 5/24/2023 6:53:26 PM
Payment Method: Credit Card: Mastercard ...6170
Reference: 3261903

Description: Surety Bond Renewal Payment

Medicare Bonds:
Your bond is continuous and remains active until either cancelled or non-renewed. You will not receive a new bond each term. When renewal payments are made, you will be given a confirmation receipt showing that your bond is still active. We recommend printing the receipts and filing them with your bond in a safe, accessible place.

Item	Amount
Renewal Premium for Pneu-Med, Inc., Eugene; NPI Number: 1720021868; Effective 7/2/2023 - 7/2/2024; Bond Number: 1045652	\$495.00
Subtotal:	\$495.00
Handling:	\$0.00
Payment Processing Fee:	\$14.85
Grand Total:	\$509.85

If you have any questions concerning this Receipt, call VGM Insurance Services at 800-362-3362 or email bondinfo@vgm.com.

THANK YOU FOR YOUR BUSINESS!

Latitude: 44.0192144
Longitude: -123.0794603
Date: 12/05/2023 02:54 PM PST

Surety Bond

LEXON INSURANCE COMPANY
SURETY BOND
SUPPLIERS OF DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND SUPPLIES
MEDICARE PROGRAM

PRINCIPAL: Pneu-Med, Inc. **BONDNUMBER:** 1045652
ADDRESS: 3475 E Amazon Eugene, OR 97405
NPI #: 1720021868 **TIN:** 93-0707791 **NSC/PTAN#:** 0223970001

KNOW ALL PERSONS BY THESE PRESENTS, that subject to the terms, conditions and limitations of this bond, **Pneu-Med, Inc.**, 3475 E Amazon Eugene, OR 97405, as Principal, and Lexon Insurance Company, 10002 Shelbyville Rd. Suite 100 Louisville, KY 40223, a corporation organized and existing under the laws of Texas, as Surety, are held and firmly bound unto the Centers for Medicare & Medicaid Services ("CMS"), an agency of the United States Department of Health and Human Services ("CMS"), as Obligor, in the Penal Sum of Fifty Thousand Dollars (\$50,000.00) for the payment of which Principal and Surety bind themselves, their heirs, executors, administrators and assigns, jointly and severally, by these presents.

WHEREAS, Principal is enrolled in or is seeking to be enrolled in the Medicare program as a supplier of durable medical equipment, prosthetics, orthotics and supplies ("DMEPOS"); and

WHEREAS, pursuant to Section 4312(a) of the Balanced Budget Act of 1997 (Pub.L. 105-33) and 42 CFR § 424.57, the Principal is required to provide a surety bond as a condition of participation in the Medicare program, and this bond is provided in compliance with the supplier's obligations as set forth in those authorities.

NOW THEREFORE, the condition of this Bond is that if the Principal shall pay the Obligor any unpaid claims, civil money penalties and assessments (as such terms are defined by 42 CFR § 424.57(a)) then this Bond shall be null and void, otherwise to remain in full force and effect, subject, however, to the following:

1. Principal and Surety are liable under this Bond for only the amount of any unpaid claim, civil money penalty or assessment imposed by CMS or the Office of Inspector General, plus accrued interest, for which the Principal is responsible and for which, subject to Paragraph 7, the Obligor first demands payment from the Surety during the term of this Bond; provided, however, that any claim under this Bond must be related to overpayments or other events that occurred on or after March 3, 2009.
2. Surety agrees to pay a claim within 30 days of receiving written notice of the claim and sufficient evidence (as such term is defined by 42 CFR § 424.57 (a)) to establish Surety's liability under this Bond.
3. CMS is the sole Obligor of this Bond, and no action may be brought on it by, or for the use or benefit of, any person or entity other than CMS or its contractors.
4. Regardless of the number of years this Bond is in effect, the number of premiums paid, or the number of claims made, the Surety's aggregate liability shall not be more than the penal sum of this Bond.
5. Subject to Paragraph 7, the Surety's liability under this Bond shall terminate and the Surety shall have no further liability upon the effective date of cancellation or expiration of this Bond by the Surety or Principal in accordance with Paragraph 6 of this Bond.
6. The Surety or Principal may cancel this Bond by providing written notice of such cancellation to the Obligor. Cancellation or expiration shall be effective 30 days after notice of cancellation is sent to the Obligor's contractor, the National Supplier Clearinghouse, provided such notice is actually received.
7. In the event this Bond is cancelled or expires, and the Principal fails to submit a new bond to the Obligor, the Surety remains liable for unpaid claims, civil money penalties or assessments that were imposed or assessed by CMS or the Office of Inspector General during the 2 years following the effective date of cancellation or expiration of this Bond.

This Bond is effective October 02, 2009

In witness whereof, the undersigned Principal and Surety have set their hands and seals on this 29 day of September, 2009

Principal: Pneu-Med, Inc. Signature: Sharon L. Pyke
Company Name Print Name Sharon L. Pyke
Title: CEO

Latitude: 44.0192144
Longitude: -123.0794603
Date: 12/05/2023 02:55 PM PST

Surety bond pg 2

POWER OF ATTORNEY **LX - 038488**

Lexon Insurance Company

KNOW ALL MEN BY THESE PRESENTS, that **LEXON INSURANCE COMPANY**, a Texas Corporation, with its principal office in Louisville, Kentucky, does hereby constitute and appoint: **John Spragle, Warren Freeman, Janean Craig**, *****

Nicole Jensen *****

its true and lawful Attorney(s)-in-Fact to make, execute, seal and deliver for, and on its behalf as surety, any and all bonds, undertakings or other writings obligatory in nature of a bond.

This authority is made under and by the authority of a resolution which was passed by the Board of Directors of **LEXON INSURANCE COMPANY** on the 1st day of July, 2003 as follows:

Resolved, that the President of the Company is hereby authorized to appoint and empower any representative of the Company or other person or persons as Attorney-In-Fact to execute on behalf of the Company any bonds, undertakings, policies, contracts of indemnity dollars, which the Company might execute through its duly elected officers, and affix the seal of the Company thereto. Any said execution of such documents by an Attorney-In-Fact shall be as binding upon the Company as if they had been duly executed and acknowledged by the regularly elected officers of the Company. Any Attorney-In-Fact, so appointed, may be removed for good cause and the authority so granted may be revoked as specified in the Power of Attorney.

Resolved, that the signature of the President and the seal of the Company may be affixed by facsimile on any power of attorney granted, and the signature of the Vice President, and the seal of the Company may be affixed by facsimile to any certificate of any such power and any such power or certificate bearing such facsimile signature and seal shall be valid and binding on the Company. Any such power so executed and sealed and certificate so executed and sealed shall, with respect to any bond of undertaking to which it is attached, continue to be valid and binding on the Company.

IN WITNESS THEREOF, **LEXON INSURANCE COMPANY** has caused this instrument to be signed by its President, and its Corporate Seal to be affixed this 2nd day of July, 2003.

LEXON INSURANCE COMPANY

BY: David E. Campbell
David E. Campbell
President

ACKNOWLEDGEMENT

On this 2nd day of July, 2003, before me, personally came David E. Campbell to me known, who being duly sworn, did depose and say that he is the President of **LEXON INSURANCE COMPANY**, the corporation described in and which executed the above instrument; that he executed said instrument on behalf of the corporation by authority of his office under the By-laws of said corporation.

"OFFICIAL SEAL"
MAUREEN K. AYE
Notary Public, State of Illinois
My Commission Expires 09/21/13

Maureen K. Aye
Maureen K. Aye
Notary Public

CERTIFICATE

I, the undersigned, Secretary of **LEXON INSURANCE COMPANY**, a Texas Insurance Company, DO HEREBY CERTIFY that the original Power of Attorney of which the foregoing is a true and correct copy, is in full force and effect and has not been revoked and the resolutions as set forth are now in force.

Signed and Sealed at Lombard, Illinois this 28th Day of Sept, 2003.

Donald D. Buchanan
Donald D. Buchanan
Secretary

Latitude: 44.0192144
Longitude: -123.0794603
Date: 12/05/2023 02:54 PM PST

Surety bond pg1



Latitude: 44.0192034
Longitude: -123.0794797
Date: 12/06/2023 01:14 PM PST

Walkers



Latitude: 44.0191465
Longitude: -123.0795196
Date: 12/06/2023 01:23 PM PST

Wheelchait