SETTLEMENT AGREEMENT

This Settlement Agreement ("Agreement") is entered into among the United States of America, acting through the United States Department of Justice and on behalf of the Office of Inspector General of the United States Department of Health and Human Services (HHS-OIG) (collectively, the "United States"), and Magnolia Diagnostics, LLC, Magnolia Health, LLC, John Bains, and Kelly Bains (collectively, the "Defendants") (hereafter collectively referred to as "the Parties"), through their authorized representatives.

RECITALS

A. Magnolia Diagnostics, LLC ("Magnolia") is a Texas limited liability corporation with its principal place of business in Dallas, Texas. Magnolia provided diagnostic and laboratory testing services, including respiratory pathogen panels ("RPs").

B. Magnolia Health, LLC ("Magnolia Health") is a Texas limited liability company wholly owned by John Bains and Kelly Bains. During the relevant period, Magnolia Health held a controlling interest in Magnolia Diagnostics.

C. John Bains resides in Austin, Texas. He co-founded Magnolia and served as its Chief Executive Officer.

D. Kelly Bains resides in Austin, Texas. She co-founded Magnolia and served as its President.

E. In early 2020, the novel coronavirus that causes COVID-19 spread rapidly throughout the United States, creating an urgent need for widespread diagnostic testing.

F. Older adults were particularly vulnerable to severe illness and death from COVID-19. Residents of assisted-living facilities, independent living facilities, and other senior living communities (collectively, "Senior Communities") faced heightened risks because of their age, underlying medical conditions, and communal living environments.

G. During 2020 and 2021, federal, state, and local authorities adopted policies and guidance designed to identify and control COVID-19 outbreaks in senior living communities. These measures included frequent COVID-19 testing of residents and staff, often on a facility-wide or community-wide basis.

H. Clinical laboratories played an important role in the national response to the COVID-19 pandemic by processing specimens and reporting diagnostic test results to health care providers and senior living communities. Timely reporting was particularly important because providers and facilities relied on test results to make treatment, isolation, and infection-control decisions.

I. RPs are molecular diagnostic tests that detect multiple respiratory pathogens from a single specimen. Depending on the panel, RPs may test for dozens of viral and bacterial organisms, including uncommon pathogens that generally are clinically relevant only for particular patients or under particular circumstances. Whether an RP is medically necessary depends on the beneficiary's symptoms, medical condition, and other individualized clinical circumstances that must be assessed by the beneficiary's treating provider. As relevant here, RPs were distinct from standalone COVID-19 tests and were reimbursed at a substantially higher rate.

Medicare reimburses clinical laboratory tests only when applicable coverage and payment requirements are satisfied. Among other requirements, laboratory tests must be ordered by an authorized treating physician or other practitioner, be reasonable and necessary for the diagnosis or treatment of illness or injury, and be used in the management of the beneficiary's specific medical condition.

K. Medicare's requirements concerning valid orders and medical necessity remained in effect during the COVID-19 public health emergency. Although certain regulatory

requirements were modified or waived to facilitate the emergency response, Medicare did not waive the requirement that laboratory tests be reasonable and necessary.

L. In June 2020, HHS-OIG notified the public that it had "program integrity concerns related to add-on tests in conjunction with COVID-19 testing, particularly fraudulent billing for associated respiratory pathogen panel (RPP) tests." The announcement noted that the relaxation of certain rules to allow for COVID-19 testing without an order from a treating provider created a risk that "unscrupulous actors" could have "more leeway for fraudulent billing of unnecessary add-on testing."

M. The United States contends that Defendants submitted or caused to be submitted claims for payment to the Medicare Program, Title XVIII of the Social Security Act, 4 U.S.C. §§ 1395-1395lll ("Medicare").

N. The United States contends that it has certain civil claims against Defendants arising from knowingly submitting or causing the submission of false claims for medically unnecessary RPs during the period from April 1, 2020 through September 30, 2021. Specifically, the United States contends that Defendants engaged in the following conduct (which is referred to below as the "Covered Conduct"):

> John Bains and Kelly Bains owned and operated Magnolia and, as demand for COVID-19 testing surged, devised a strategy to generate substantial revenue by including that testing in conjunction with Magnolia's more profitable RP.
>
> To carry out that strategy, Defendants implemented a protocol under which Magnolia offered COVID-19 testing to Senior Communities only as part of its broader RP, thus denying Senior Communities a standalone COVID- 9 testing option.

3. As John Bains told Magnolia's investors early in the pandemic, "[F]ederally insured patients will be required to have a full Respiratory Panel run in conjunction with the COVID-19 test." According to John Bains, this strategy positioned the company to make "a substantial amount of profit during this tumultuous period of time."

4. To implement the protocol, John Bains created two laboratory requisition forms: one for Senior Communities that included COVID-19 testing only as part of an RP, and another for all other clients that permitted standalone COVID-19 testing.

5. On the Senior Community requisition form, John Bains preselected RP+COVID-19 testing and associated diagnosis codes, thereby making those decisions the default for the purported ordering providers.

6. Defendants obtained provider signatures on those forms and then used them as blanket or standing orders authorizing RPs for all residents of a facility or across an entire chain of facilities.

7. Pursuant to those standing orders, Magnolia processed thousands of RPs on specimens collected by Senior Communities, typically during community-wide COVID-19 testing, and billed Medicare for those tests. The tests were not supported by requisition forms evidencing medical necessity determinations by treating providers. Magnolia instead relied on the purported community or chain-wide standing orders on which John Bains had preselected the testing and certain alleged symptoms.

8. Even when providers and Senior Communities requested or demanded COVID-19-only testing, questioned the panel's medical necessity or clinical value, or stated that they had not authorized the RPs, Defendants continued to perform RPs and bill Medicare for them. In certain instances, Magnolia performed RPs without any

provider authorization (even on a blanket or standing basis). In others, John Bains threatened to withhold COVID-19 testing from Senior Communities that asked not to receive RPs. In at least two instances, John Bains altered a provider-signed requisition form to expand the apparent scope of the provider's authorization beyond the facility identified on the original form. Magnolia then used those altered forms as standing orders to support RP testing for residents across multiple facilities that were not covered by the original form.

9. Magnolia also performed and billed Medicare for thousands of RPs that lacked clinical utility because the results were not reported in time to diagnose, treat, or manage the beneficiaries' conditions. Although Magnolia represented that RP results would be available within 24 to 48 hours, between at least July 2020 and February 2021, it froze and stored thousands of specimens, sometimes for weeks or months, before thawing and testing them. Magnolia thereby generated RP results and billed Medicare after those results could no longer inform timely treatment, isolation, or infection-control decisions.

Defendants knew, deliberately ignored, or recklessly disregarded that Medicare reimbursed clinical laboratory tests only if they were properly ordered by an authorized treating provider, were reasonable and necessary for the diagnosis or treatment of illness or injury, and were used to manage a beneficiary's specific medical condition.

Defendants certified their compliance with applicable Medicare requirements, and they received internal and external warnings that medical necessity and ordering requirements remained in effect during the COVID-19 public health emergency.

Defendants also received and reviewed a June 2020 HHS-OIG announcement that it had "program integrity concerns related to add-on tests in conjunction with COVID-19 testing, particularly fraudulent billing for associated respiratory pathogen panel (RPP) tests." John Bains also received direct outreach from Medicare's contractor, Novitas, warning him that RPs "must be medically reasonable and necessary for the Medicare beneficiary" and that "Medicare expects that the test ordered is in concordance with the illness of the beneficiary and administered in a healthcare setting commensurate with the severity of the illness." Nevertheless, Defendants continued to perform and bill Medicare for RPs under their RP+COVID-19 testing protocol.

3. Between April 1, 2020, and September 30, 2021, Defendants knowingly submitted or caused the submission of false and fraudulent claims to Medicare for medically unnecessary RPs.

O. This Settlement Agreement is neither an admission of liability by Defendants nor a concession by the United States that its claims are not well founded.

P. To avoid the delay, uncertainty, inconvenience, and expense of protracted litigation of the above claims, and in consideration of the mutual promises and obligations of this Settlement Agreement, the Parties agree and covenant as follows:

TERMS AND CONDITIONS

Defendants shall pay to the United States the sum of $19,211,78 ("Settlement Amount") and interest on the Settlement Amount at a rate of 4.5% per annum from July 17, 2026, of which $9,211,780 is restitution, no later than sixty (60) days after the Effective Date of this Agreement by electronic funds transfers pursuant to written instructions to be provided by the Civil Division of the United States Department of Justice.

Subject to the exceptions in Paragraph 3 (concerning reserved claims) below, and upon the United States' receipt of the Settlement Amount, plus interest due under Paragraph 1, the United States releases Defendants from any civil or administrative monetary claim the United States has for the Covered Conduct under the False Claims Act, 31 U.S.C. §§ 3729-3733; the Civil Monetary Penalties Law, 42 U.S.C. § 1320a-7a; the Program Fraud Civil Remedies Act, 31 U.S.C. §§ 3801-3812; or the common law theories of payment by mistake, unjust enrichment, and fraud.

3. Notwithstanding the release given in Paragraph 2 of this Agreement, or any other term of this Agreement, the following claims and rights of the United States are specifically reserved and are not released:

a. Any liability arising under Title 26, U.S. Code (Internal Revenue Code);

b. Any criminal liability;

c. Except as explicitly stated in this Agreement, any administrative liability or enforcement right, including mandatory exclusion from Federal health care programs;

d. Any liability to the United States (or its agencies) for any conduct other than the Covered Conduct;

e. Any liability based upon obligations created by this Agreement.

4. In compromise and settlement of the rights of HHS-OIG to exclude Defendants pursuant to 42 U.S.C. § 1320a-7(b)(7), based upon the Covered Conduct, Defendants agree to be excluded under this statutory provision from Medicare, Medicaid, and all other Federal health care programs, as defined in 42 U.S.C. § 1320a-7b(f), for a period of 7 years. The exclusion shall be effective upon the Effective Date of this Agreement. Such exclusion shall have national effect. Federal health care programs shall not pay anyone for items or services, including

administrative and management services, furnished, ordered, or prescribed by Defendants in any capacity while Defendants are excluded. This payment prohibition applies to Defendants and all other individuals and entities (including, for example, anyone who employs or contracts with Defendants, and any hospital or other provider where Defendants provides services). The exclusion applies regardless of who submits the claim or other request for payment. Violation of the conditions of the exclusion may result in criminal prosecution, the imposition of civil monetary penalties and assessments, and an additional period of exclusion. Defendants further agree to hold the Federal health care programs, and all federal beneficiaries and/or sponsors, harmless from any financial responsibility for items or services furnished, ordered, or prescribed to such beneficiaries or sponsors after the effective date of the exclusion. Defendants waive any further notice of the exclusion and agree not to contest such exclusion either administratively or in any state or federal court. Reinstatement to program participation is not automatic. If Defendants wish to be reinstated, Defendants must submit a written request for reinstatement to the HHS-OIG in accordance with the provisions of 42 C.F.R. §§ 1 3001-.3005. Such request may be made to the HHS-OIG no earlier than 90 days prior to the expiration of the 7-year period of exclusion. Reinstatement becomes effective upon application by Defendants, approval of the application by the HHS-OIG, and notice of reinstatement by the HHS-OIG. Obtaining another license, moving to another state, or obtaining a provider number from a Medicare contractor, a state agency, or a Federal health care program does not reinstate Defendants' eligibility to participate in these programs.

5. Defendants waive and shall not assert any defenses Defendants may have to any criminal prosecution or administrative action relating to the Covered Conduct that may be based in whole or in part on a contention that, under the Double Jeopardy Clause in the Fifth Amendment of the Constitution, or under the Excessive Fines Clause in the Eighth Amendment

of the Constitution, this Agreement bars a remedy sought in such criminal prosecution or administrative action.

6. Defendants fully and finally release the United States, its agencies, officers, agents, employees, and servants, from any claims (including attorney's fees, costs, and expenses of every kind and however denominated) that Defendants have asserted, could have asserted, or may assert in the future against the United States, and its agencies, officers, agents, employees, and servants related to the Covered Conduct and the United States' investigation and prosecution thereof.

7. The Settlement Amount shall not be decreased as a result of the denial of claims for payment now being withheld from payment by any Medicare contractor (*e.g.*, Medicare Administrative Contractor, fiscal intermediary, carrier) or any state payer, related to the Covered Conduct; and Defendants agree not to resubmit to any Medicare contractor or any state payer any previously denied claims related to the Covered Conduct, agrees not to appeal any such denials of claims, and agrees to withdraw any such pending appeals.

8. Defendants agree to the following:

a Unallowable Costs Defined: All costs (as defined in the Federal Acquisition Regulation, 48 C.F.R. § 31.205-47; and in Titles XVIII and XIX of the Social Security Act, 42 U.S.C. §§ 1395-1395lll and 1396-1396w-5; and the regulations and official program directives promulgated thereunder) incurred by or on behalf of Defendants, its present or former officers, directors, employees, shareholders, and agents in connection with:

(1) the matters covered by this Agreement;

(2) the United States' audit(s) and civil investigation(s) of the matters covered by this Agreement;

(3) Defendants' investigation, defense, and corrective actions undertaken in response to the United States' audit(s) and civil investigation(s) in connection with the matters covered by this Agreement (including attorneys' fees);

(4) the negotiation and performance of this Agreement; and

(5) the payment Defendants make to the United States pursuant to this Agreement.

are unallowable costs for government contracting purposes and under the Medicare Program (hereinafter referred to as Unallowable Costs).

b. Future Treatment of Unallowable Costs: Unallowable Costs shall be separately determined and accounted for by Defendants, and Defendants shall not charge such Unallowable Costs directly or indirectly to any contracts with the United States or any State Medicaid program, or seek payment for such Unallowable Costs through any cost report, cost statement, information statement, or payment request submitted by Defendants or any of its subsidiaries or affiliates to the Medicare Program.

c Treatment of Unallowable Costs Previously Submitted for Payment: Defendants further agree that within 90 days of the Effective Date of this Agreement it shall identify to applicable Medicare fiscal intermediaries, carriers, and/or contractors, any Unallowable Costs (as defined in this Paragraph) included in payments previously sought from the United States, or any State Medicaid program, including, but not limited to, payments sought in any cost reports, cost statements, information reports, or payment requests already submitted by Defendants or any of its subsidiaries or affiliates, and shall request, and agree, that such cost reports, cost statements, information reports, or payment requests, even if already settled, be adjusted to account for the effect of the inclusion of the unallowable costs. Defendants agree

that the United States, at a minimum, shall be entitled to recoup from Defendants any overpayment plus applicable interest and penalties as a result of the inclusion of such Unallowable Costs on previously-submitted cost reports, information reports, cost statements, or requests for payment.

Any payments due after the adjustments have been made shall be paid to the United States pursuant to the direction of the Department of Justice and/or the affected agencies. The United States reserves its rights to disagree with any calculations submitted by Defendants or any of its subsidiaries or affiliates on the effect of inclusion of Unallowable Costs (as defined in this paragraph) on Defendants' or any of its subsidiaries or affiliates' cost reports, cost statements, or information reports.

d. Nothing in this Agreement shall constitute a waiver of the rights of the United States to audit, examine, or re-examine Defendants' books and records to determine that no Unallowable Costs have been claimed in accordance with the provisions of this paragraph.

9. This Agreement is intended to be for the benefit of the Parties only. The Parties do not release any claims against any other person or entity, except to the extent provided for in Paragraph 10 (waiver for beneficiaries paragraph), below.

Defendants agree that it waives and shall not seek payment for any of the health care billings covered by this Agreement from any health care beneficiaries or their parents, sponsors, legally responsible individuals, or third party payors based upon the claims defined as Covered Conduct.

Each Party shall bear its own legal and other costs incurred in connection with this matter, including the preparation and performance of this Agreement.

Each Party and signatory to this Agreement represents that it freely and voluntarily enters into this Agreement without any degree of duress or compulsion.

3. This Agreement is governed by the laws of the United States. The exclusive venue for any dispute relating to this Agreement is the United States District Court for the Northern District of Texas. For purposes of construing this Agreement, this Agreement shall be deemed to have been drafted by all Parties to this Agreement and shall not, therefore, be construed against any Party for that reason in any subsequent dispute.

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

5. The undersigned counsel represent and warrant that they are fully authorized to execute this Agreement on behalf of the persons and entities indicated below.

6. This Agreement may be executed in counterparts, each of which constitutes an original and all of which constitute one and the same Agreement

7. This Agreement is binding on Defendants' successors, transferees, heirs, and assigns.

8. All Parties consent to the United States' disclosure of this Agreement, and information about this Agreement, to the public.

9. This Agreement is effective on the date of signature of the last signatory to the Agreement (Effective Date of this Agreement). Facsimiles and electronic transmissions of signatures shall constitute acceptable, binding signatures for purposes of this Agreement.

THE UNITED STATES OF AMERICA

DATED: 7/22/2026 BY: _____

Paul R. Perkins
Associate Deputy Attorney General
United States Department of Justice

DATED: 7/22/2026 BY: _____

Asha Natarajan
Trial Attorney, Civil Division
Commercial Litigation Branch
United States Department of Justice

DATED: 7/22/2026 BY: _____

Brian Stoltz
Assistant United States Attorney
Northern District of Texas

DATED: 7/17/2026 BY: _____

Susan E. Gillin
Assistant Inspector General for Legal Affairs
Office of Counsel to the Inspector General
Office of Inspector General
United States Department of Health and Human Services

MAGNOLIA DIAGNOSTICS, LLC - DEFENDANT

DATED: 7/17/2026 BY: _____
John Bains
Chief Executive Officer

DATED: 7/17/2026 BY: _____
Gene Besen
Counsel for Magnolia Diagnostics, LLC

MAGNOLIA HEALTH, LLC - DEFENDANT

DATED: 7/17/2026 BY: _____
ohn Bains
Chief Executive Officer

DATED: 7/17/2026 BY: _____
Gene Besen
Counsel for Magnolia Health, LLC

OHN BAINS – DEFENDANT

DATED: 7/17/2026 BY: _____
ohn Bains

DATED: 7/17/2026 BY: _____
Gene Besen
Counsel for John Bains

KELLY BAINS – DEFENDANT

DATED: 7/20/2026 BY: _____
Kelly Bains

DATED: 7/20/2026 BY: _____
Paul Monnin
Counsel for Kelly Bains