CORPORATE COMPLIANCE PLAN

DREW MEMORIAL HOSPITAL

First Amended and Substituted Statement of Policy and Compliance Plan

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DREW MEMORIAL HOSPITAL
CORPORATE COMPLIANCE PLAN

I. Overview of the Compliance Plan

A. Compliance Commitment- Value Statement

Drew Memorial Hospital is committed to compliance with all laws and regulations that apply to it. This applies to all employees and agents.

B. Purpose of the Compliance Plan

DMH's Compliance Plan has been adopted to reaffirm our commitment to conducting our business in full compliance with applicable statutes, regulations, and other Federal and State health care program requirements. This program provides a framework for structuring a comprehensive range of compliance activities that are designed to avoid legal and compliance problems in the first instance, to effectively address compliance concerns, investigations, or allegations as they arise, and to remedy any instances of noncompliance.

C. Legal Basis

The DMH Compliance Program has been developed in accordance with applicable law, rules and regulations. It utilizes guidance from Federal and state authorities, including the OIG Guidance for Hospitals and the OIG Supplemental Guidance for Hospitals, along with the CMS Conditions of Participation. This plan and program can be expanded at any time to encompass additional areas of regulatory compliance to which DMH is subject.

D. 7 Core Elements

The Compliance Plan reflects DMH's good faith effort and due diligence to identify and reduce risk, improve internal controls, and establish standards to which the entire organization shall adhere. The following core elements are adopted into the Compliance Plan:

1. Designation of a Compliance Officer (“CCO”) and Compliance Committee charged with operating and monitoring the compliance program.

2. Development and maintenance of a Compliance Plan, Policies, and Procedures, including Standards of Conduct, and identifying specific areas of risk.

3. Develop and maintain open lines of Communication for reporting of concerns and complaints related to Compliance Violations, without fear of retaliation or retribution.

4. Provision of appropriate Training and Education, done on a regular basis and as needed, for all DMH employees, directors, officers, and Medical Staff members.

5. Internal Monitoring and Auditing Plans and Reports, systems, and protocols to evaluate DMH's compliance with laws, rules and regulations, compliance standards, and other Federal and state health care program requirements.

6. Investigating, Responding to and preventing detected deficiencies or other identified or reported compliance problems, including establishing appropriate and coordinated corrective action measures.

7. Enforcement of Disciplinary Standards and appropriate hiring criteria to deal with compliance breaches and employees who have violated laws.

E. Scope

These Compliance standards shall apply to all employees, directors, medical staff, and agents affiliated with DMH. It is the responsibility of all those listed to be familiar with and comply with all requirements of the Compliance Program that pertain to their respective areas of responsibility, recognize and avoid actions and relationships that might violate those requirements, and seek guidance in situations raising legal or ethical concerns.

F. Limitations

The Compliance Plan is not intended to summarize all laws and regulations applicable to DMH. It is a framework for compliance. This Compliance Plan will be updated periodically to assure that DMH's directors, officers, managers, supervisors, employees, medical staff, and agents are kept informed of the most current legal and compliance developments in the health care industry.

II. Written Standards

A core principle of this Compliance Plan is the development, distribution, and implementation of written standards that address principal risk areas and reflect DMH's commitment to promote compliance with all applicable legal duties and to foster and assure ethical conduct. Written standards shall consist of the Code of Conduct and Ethical Behavior, as well as Policies and Procedures, that reflect our values and expectations regarding the behavior of employees, directors, medical staff, and agents. These written Standards also explain the operation of the Compliance Program, clarify and establish internal standards for compliance with laws and regulation, and help employees, directors, medical staff and agents understand the consequences of noncompliance to both DMH and to the individual.

A. Code of Conduct and Ethical Behavior

The Code of Conduct and Ethical Behavior is intended to serve as a guide to provide standards by which employees, directors, medical staff, and agents will conduct themselves to protect and promote organization-wide integrity and to enhance DMH's ability to achieve its mission. The Code of Conduct is designed to assist all employees, directors, medical staff, and agents in carrying out daily activities within the appropriate ethical and legal standards. This is not, however, a substitute for each person's own internal senses of fairness, honesty, and integrity. Each person must utilize their own good judgment, along with the principles outlined in the Code, to maintain DMH's value of integrity.

The Code of Conduct is intended to be easily understood. In many cases, the subjects discussed in the code are complex and additional guidance may be needed to provide adequate direction. The Code of Conduct is designed to be supplemented by the Compliance Program and a comprehensive set of compliance policies and procedures.

The Code of Conduct defines how DMH operates internally and conducts business with respect to the following:

1. Commitment to patients and families;

2. Commitment to legal and regulatory compliance efforts;

3. Expectation that employees, directors, medical staff, and agents remain free of conflicts of interest in the performance of their responsibilities and services to DMH[1];

4. Commitment to satisfy the payment conditions required by the payers with which DMH transacts business, including the Federal and State Health Care Programs;

5. Commitment to monitor and structure our relationship with physicians and other providers in ways that are legal and ethical;

6. Commitment to a diverse workforce free of harassment or discrimination;

7. Commitment to safeguard the privacy and security of all personal health information.

[1] With regard to conflicts of interest, the Board of Directors and key officers in administration are required, each year, to submit a conflict of interest statement concerning possible conflicts of interest. The Hospital also has a separate Conflict of Interest Policy which is incorporated herein by reference.

B. Policies and Procedures

The Compliance Plan requires the establishment, distribution, and maintenance of sound policies and procedures that govern the operation of the compliance effort and address our principal legal areas of risk.

Policies directly relating to the operation of the Compliance Plan shall address critical issues, such as the following:

1. The duties of the CCO, the duties of the Corporate Compliance Committee, and the duties of any subcommittees or task forces created by the Compliance Committee;

2. Compliance education and training, both initial and ongoing;

3. The specifics of operation of a disclosure program;

4. Disciplinary Standards and action to be used against those who are found to have violated the Compliance Program standards;

5. Screening mechanisms for new employees, including protocols for querying the lists of Excluded Persons and Entities to identify those who may have been sanctioned by Federal Health Care Programs;

6. Effective auditing and monitoring programs;

7. Investigating and responding to complaints and potential compliance problems;

8. Department specific compliance policies;

9. Implementing Corrective Action Plans in instances of noncompliance.

There are certain areas of heightened risk that have been identified throughout the health care industry, including the investigative and audit functions of the OIG. To ensure the effectiveness of DMH's Compliance Program, it is important for policies and procedures to address these risk areas. These policies and procedures must be easily available to all directors, employees, medical staff, and agents, and revised on a regular basis.

III. Chief Compliance Officer and Compliance Committee

The CCO provides leadership and oversight of the ongoing development and implementation of the compliance program. DMH also has established a Compliance Committee to advise and provide support to the CCO in this effort. In this regard, the CCO shall have access to the Hospital Board and shall regularly attend Board meetings.

A. Chief Compliance Officer

While compliance is everyone's responsibility, the CCO is the focal point of the Compliance Program, and is held accountable for all Compliance efforts at DMH. The CCO may delegate authority and responsibility for certain aspects of the Compliance Program as needed and as appropriate.

The presence of the CCO does not diminish or alter the independent duty of any employee, director, medical staff member, or agent to abide by the Compliance Program. Department Directors, Managers, and Supervisors are responsible for monitoring and promoting compliant behavior among those they supervise.

Other duties of the CCO include:

1. Periodically accessing DMH's Compliance Risk exposure and the development of action plans to assure that the Compliance Program responds to identified risk areas.

2. Formulating and ensuring the distribution of the Code of Conduct.

3. Overseeing the establishment, distribution, and maintenance of the policies and procedures necessary to support the Compliance Program.

4. Ensuring that effective systems are established to prevent employment of individuals or contracting with individuals, agents, or vendors who are excluded individuals or entities, or entities who are otherwise determined to have engaged in illegal activities.

5. Ensuring that compliance training and education programs are effective to familiarize all employees, directors, medical staff, and agents with the components of the Compliance Program, the Code of Conduct, and other compliance policies.

6. Updating and refreshing education and training information through mandatory periodic training that addresses compliance issues related to specific departments, groups of employees or medical staff.

7. Coordinating internal audit endeavors to assess the effectiveness of DMH's internal controls and to detect significant violations of legal and ethical standards.

8. Maintaining a well-publicized disclosure for reporting of potential Compliance Program violations without fear of retaliation and promoting effective lines of communication for employees, directors, medical staff, and agents to pose informal compliance questions.

9. Maintain a record of compliance-related complaints and allegations and the disposition of each case, including any associated disciplinary actions and remedial actions pursued by DMH.

10. Conducting investigations, or authorizing outside investigations, in consultation with legal counsel, of potential violations of laws, regulations, or other Federal Healthcare program requirements, or instances of unethical behavior, which would jeopardize DMH's reputation or financial stability.

11. Evaluating, determining, and implementing the most appropriate remedy to correct an incident of noncompliance, once detected, and develop and implement strategies for identifying and preventing future incidents.

12. Reporting, in consultation with legal counsel, any compliance matter requiring external reporting or disclosure.

13. Making quarterly reports on compliance developments to the CEO and to the Board.

14. Serving as Chairperson of the Compliance Committee.

15. Maintaining a good working relationship with key operational areas relevant to the effective implementation of the Compliance Program, including Accounting, Financial Services, Health Information, and Patient Financial Services.

16. Providing guidance and interpretation to the Board, CEO, and other officers, in consultation with legal counsel if necessary, on matters related to the Compliance Program.

17. Preparing, at least annually, a report describing the compliance activities and actions undertaken during the preceding year, the compliance priorities for the next year, and any recommendations for changes to the Compliance Program. This report may require input from legal counsel or auditors.

18. Reviewing and updating this Compliance Plan at least annually, and as required by events, such as changes in the law, or discovered flaws in the Program.

To carry out the responsibilities of this Compliance Officer role, the CCO has complete authority to review all documents or other information related to compliance activities, including, but not limited to:

1. Patient Records

2. Billing Records

3. Records concerning Marketing Activities

4. Records concerning DMH's arrangements with employees, directors, medical staff, and agents, including personnel files and credential files.

5. Contracts, and obligations that may implicate applicable laws, such as anti- kickback, physician self‑referral or other statutory or regulatory requirements.

6. Audit record's, internal or external.

B. Compliance Committee

The Compliance Committee shall be responsible for providing support to the CCO in the creation, implementation, and operation of the Compliance Program. The Compliance Committee is critically important to establishing accountability, credibility, and the structure of the Compliance Program. The Compliance Committee shall generally meet quarterly pursuant to a written agenda; provided, however that the Compliance Committee may meet more often as required.

The Compliance Committee shall include representatives of the following:

1. Human Resources

2. Nursing

3. Accounting

4. Health Information

5. Patient Financial Services and Registration

6. Financial Services

7. CEO

8. Information Services and Security

9. Home Health Services

The Compliance Committee may choose to invite other employees to meetings if additional expertise is needed in a matter under discussion.

The Compliance Committee will support the CCO in furthering the objectives of the Compliance Program by:

1. Developing a corporate structure to promote compliance of organizational functions;

2. Analyzing the legal requirements with which the hospital must comply, and the specific risk areas;

3. Updating and providing revisions to the Code of Conduct

4. Developing effective training programs

5. Recommending and supervising, in consultation with the specific departments, the development of internal controls and systems to achieve the standards set forth in the Code of Conduct and in DMH policies and procedures.

6. Determining the appropriate strategy to promote adherence to the Compliance Program Standards.

7. Developing a system to solicit, evaluate, and respond to complaints and problems.

8. Creating and implementing effective methods for the proactive identification of potential compliance programs throughout the organization.

9. Assessing the effectiveness of the Compliance Program

10. Furnishing recommendations to the CEO regarding reports to be furnished to the CEO, the Board, or external third parties.

11. Reviewing and providing comments on the annual audit plan.

The Compliance Committee may also address other compliance functions as the Compliance Program develops throughout the year.

The Compliance Committee shall create ad hoc sub-committees and task forces as necessary to perform specialized functions, such as conducting an investigation into reported noncompliance, in an efficient and effective manner. Moreover, the Compliance Committee may form smaller subcommittees for the purpose of discussing highly sensitive or confidential matters most appropriately discussed in a smaller setting.

C. Outside Consultants

The CCO is authorized .to rely on outside consultants to provide legal, financial, billing, clinical and other assistance as needed. The CCO is authorized to seek advice from legal counsel on an as needed basis. The CCO shall consult with either the CEO

or CFO before engaging other outside consultants.

IV. Areas of Sensitivity/Fraud and Abuse Risk Areas

All employees are to be made aware of the basic legal requirements that apply to his or her job responsibilities. The Compliance Officer, or any appropriate supervisor, must be consulted as to questions whether a particular action is a violation.

We have identified the following areas as particularly susceptible. Some of these areas relate to all Drew Memorial Hospital employees, and others relate only to those who work in certain specialized fields.

A. Honesty and Fairness, non-Discrimination, non-Harassment:

Drew Memorial Hospital is engaged in varied business relations with other organizations and individuals, and is the seller and buyers of goods and services. Many of you are therefore called upon in the course of your duties to represent Drew Memorial in dealing with these outside organizations. Regardless of the identity of the individuals or organizations you deal with, you should always adhere to the following standards:

1. Never make misrepresentations or dishonest statements or statements intended to mislead or misinform. If it appears that anything you have said has been misunderstood, correct it promptly. Efforts must be made to document corrective action in appropriate circumstances.

2. Respond accurately, completely and promptly to all requests for information from government regulatory agencies. Immediately alert your supervisor of any such requests.

3. Never use Drew Memorial Hospital's size or success to intimidate or threaten another organization. Although you may cite legitimate advantages of doing business with Drew Memorial Hospital, you must be careful not to engage in any activity that could be construed as coercive or threatening.

4. Never disparage a competitor, its products or services. Rather, stress in a fair and accurate manner the advantages of Drew Memorial Hospital's Services.

5. Although it is permissible for an employee to attend a legitimate business meal or hospitality session at a vendor trade show or seminar, the delivery or receipt of substantial gifts is prohibited. Gifts of appreciation such as flowers and candy from patients or visitors may be received when given to the entire department. Consult your supervisor if you are ever offered a gift.

6. No one may offer any gifts or gratuities to any government official, unless the gift is given entirely in the context of personal friendship and cannot possibly

be considered as part of an attempt to influence official behavior, and does not otherwise create an appearance of impropriety.

B. Submission of Accurate Claims and Information

1. Coding

Accurate and Complete records drive the Coding function. Coding drives the billing function. Among other things, policy and procedure must address:

A. "Up coding" to more complex procedures than were actually performed to obtain greater payment than that which is applicable for the items or services actually provided:
B. "Unbundling" or splitting a code for combined services into individual component codes to maximize reimbursement.
C. Falsely indicating that a particular health care professional attended a procedure, or that services were otherwise rendered in a manner they were not.

2. Billing - Billing for Hospital Services

The Hospital and its staff provide a wide range of services to patients and the community. Because of our mission, some of these services are provided at no charge, or reduced rates. In most cases, however billing statements are provided to the patient or a third party payer responsible for payment. It is imperative that the statements accurately reflect the services actually provided, who performed the service, and the precise charges for those services, as well as all other pertinent data relating to the patient.

The integrity and accuracy of claims submitted to Federal health Care Programs and a commercial payer for reimbursement is of utmost importance. Among other things, policies should address the following risk areas:

A. Billing separately for outpatient services within 72 hours prior to an inpatient admission;

B. Billing for a patient discharge that accurately should be billed as a patient transfer;

C. Claiming reimbursement for services that have not been rendered;

D. Filing duplicate claims for the same service;

E. Billing for a length of stay beyond what is medically necessary;

F. Billing for services or items that are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve certain functions;

G. Billing excessive charges.

Accordingly, all heath care professionals who provide billing information and all employees who perform technical or clerical task in connection with preparing or submitting billing statements are required to become familiar with and strictly adhere to claims procedures. Each employee must use his or her best efforts to prevent and, where appropriate, report errors, improprieties or suspicious circumstances in billing that could violate applicable laws and regulations.

Hospital employees and agents who prepare or submit claims should be alert for these and other errors. It is important to remember that outside consultants only advise the Hospital. The final decision on billing questions rests with the Hospital. If you have knowledge of any billing errors or improprieties, or if you suspect that an individual's conduct with regard to billing is inconsistent with the Hospital's billing rules, this information must be reported to your supervisor or to the Compliance Officer.

3. False Claims Act

It is of course fundamental that no one acting on behalf of the Hospital would intentionally falsify a claim. Such conduct is a crime, is never in the best interest of the Hospital and will result in severe sanctions. Negligently prepared bills cause significant administrative problems as well as tarnish the Hospital's reputation for professionalism. Billing errors as well as billing improprieties of any kind may expose the Hospital to civil or criminal liability. Medicare, Medicaid and other payers may only be billed for medically necessary services that are properly documented. Under the Medicare and Medicaid programs, an erroneous bill could, in certain circumstances, be deemed to be a "false claim." The Hospital has adopted a “False Claims Act Policy” which is incorporated herein by reference. This Policy is included in the Hospital’s Employee Handbook.

4. Complete and Accurate Records

Accurate records play a vital role in assuring the maintenance of high ethical standards. Accordingly, all of Drew Memorial's transactions and services must be recorded accurately, completely, and timely. Never make false or artificial entries in any of Drew Memorials’ records. Never understate, or overstate, reports of services or costs, or alter any documents used to support those reports.

5. Chargemaster Maintenance

Chargemaster maintenance is done routinely through a contracted company and under the responsibility of the Business Office Director. Input is given by all departments involved in charging, including Lab, Radiology, Nursing Directors, and others involved in the charging function.

6. ABN Utilization

Advance Beneficiary Notices are required if a patient presents for care that may not be covered by applicable insurance under their diagnosis.

C. The Referral Statutes

1. Stark

Patient referrals are important to the delivery of appropriate health care services. Patients are admitted, or referred, to the Hospital by their physicians. Patients leaving the Hospital may be referred to other facilities, such as skilled nursing or rehabilitation facilities. Patients may also need durable medical equipment, home care, pharmaceuticals, oxygen, and may be referred to qualified suppliers of these items and services. The Hospital's policy is that patients, or their legal representatives, are free to select their health care providers and suppliers subject to the requirements of their health insurance plans. The choice of a hospital, a diagnostic facility, or a supplier should be made by the patient, with guidance from his or her physician as to which providers are qualified and medically appropriate.

Physicians and other health care providers may have financial relationships with the Hospital or its affiliates. These relationships may include compensation for administrative or management services, income guarantees, loans of certain types, or free or subsidized administrative services. In some cases, a physician may have invested as a part owner in a piece of diagnostic equipment or a health care facility.

A federal law known as the "Stark law" applies to any physician who has, or whose immediate family member has, a "financial relationship" with an entity such as the Hospital, and prohibits referrals by that physician to the Hospital for the provision of certain designated health services reimbursed by Medicare and Medicaid, If a financial relationship exists, referrals are prohibited unless a specific exception is met. The Hospital requires that each financial relationship with a referring physician or his or her family member fit within one of the exceptions to the Stark law. Although responsibility for evaluating financial relationships with physicians lies with the CEO and the CCO, the manager of each department, administration, and the payroll department are expected to monitor financial relationships and report any irregularities to the Compliance Officer.

The Stark law applies to the following types of services:

1. clinical laboratory
2. physical therapy
3. occupational therapy
4. radiology (including MRI, CT, ultrasound, and mammography)
5. durable medical equipment
6. parenteral and enteral nutrients equipment and supplies
7. prosthetics and orthotics
8. home health services
9. outpatient prescription drugs
10. inpatient and outpatient hospital services
11. radiation therapy services and supplies.

Penalties for violating the Stark law include (i) no Medicare or Medicaid payment for the service referred illegally; (ii) a refund to the beneficiary of any amounts collected; (iii) fines and penalties levied on both the physician and the entity for each service referred illegally, plus additional fines based on the amounts billed; and (iv) exclusion from the Medicare or Medicaid programs.

2. Anti-Kickback

The federal and state anti-kickback laws are broadly written to prohibit the Hospital and its representatives from knowingly and willfully offering, paying, asking, or receiving any money or other benefit, directly or indirectly, in return for any referral or recommendation of any healthcare item or service which may be reimbursed by a government payor. The anti-kickback laws must be considered whenever something of value is given or received by the Hospital or its representatives or affiliates, that is in any way connected to patient services. This is particularly true when the arrangement could result in over-utilization of services or a reduction in patient choice. Even if only one purpose of a payment scheme is to influence referrals, and otherwise it appears to be a legitimate, appropriate business arrangement, the payment may be unlawful.

There are many transactions that may violate the anti-kickback rules. For example, no one acting on behalf of the Hospital may offer gifts, loans, rebates, services, or payment of any kind to a physician who refers patients to the Hospital, or to a patient, without consulting the Compliance Officer. The Compliance Officer should review any discounts offered to the Hospital by suppliers and vendors, as well as discounts offered by the Hospital to insurance companies or other third party payors. Patient deductibles and co-payments may not be waived without the prior authorization of the CEO and CFO. Rentals of space and equipment must be at fair market value, without regard to the volume or value of referrals that may be received by the Hospital in connection with the space or equipment. In many cases, fair market value should be determined through an independent appraisal.

Any questions about these agreements should be directed to the Compliance Officer. Joint ventures with physicians or other health care providers, or investment in other health care entities, must be reviewed by the Compliance Officer.

The U.S. Department of Health and Human Services has described a number of payment practices that will not be subject to criminal prosecution under the anti- kickback laws. These so-called "safe harbors" are intended to help providers protect against abusive payment practices while permitting legitimate ones. If an arrangement fits within a safe harbor it will not create a risk of criminal penalties and exclusion from the Medicare and Medicare programs. However, the failure to satisfy every element of a safe harbor does not in itself make an arrangement illegal. Analysis of a payment practice under the anti-kickback laws and the safe harbors is complex, and depends upon the specific facts and circumstance of each case. Employees should not make unilateral judgments on the availability of a safe harbor for a payment practice, investment, discount, or other

arrangement. These situations must be brought to the attention of the Compliance Officer for review with legal counsel.

Violation of the anti-kickback laws is a felony, punishable by a $25,000 fine or imprisonment for up to five years, or both. Violation of the law could also mean that the Hospital and/or a physician is excluded from participating in the Medicare and Medicaid programs for up to five years.

D. Relationships with Physicians and other Referral Sources

1. Compensation Arrangements with Physicians

Care is taken that all compensation arrangements with physicians are in writing, reviewed by counsel, and are not in violation of Stark, Anti-Kickback, or IRS rulings. All physician contracts should be reviewed by the Compliance Officer and legal counsel, to avoid violation of any IRS requirements, or other prohibited activity.

2. Physician Recruitment

The recruitment and retention of physicians require special care to comply with Hospital policy and applicable law. Physician recruitment has implications under the anti-kickback laws, the Stark law, and the IRS rules governing the Hospital's tax-exempt status. Each recruitment package or commitment should be in writing, consistent with guidelines established with the Hospital. The Compliance Officer, who may request legal counsel review and approval, should review new or unique recruitment arrangements. Support should be of limited duration. The physician cannot be required to refer patients to the Hospital, and the amount of compensation or support cannot be related to the volume or value of referrals. Income guarantees present special issues and should be reviewed to hospital counsel on a case-by-case basis.

3. Physician Office Practices

To improve the delivery of health care services, the Hospital may, from time to time, acquire physician practices, or manage physician practices. These arrangements require special care to comply with applicable law because they have implications under the anti-kickback laws, the Stark law, and the IRS rules governing the Hospital's tax-exempt status.

4. Other Referral Relationships

DMH does not, and must avoid the appearance of, paying for referrals or of being paid for referrals. Toward this goal, the hospital must follow applicable law in allowing patients free choice and informed decision-making opportunities in selecting referral for DME, Nursing Home placement, Home Health service selection, and any other referral for services.

E. EMTALA

Operation of the emergency department is an integral part of the Hospital's service to the community under its charitable mission. The emergency department is known as a place where any sick or injured person may come for care regardless of his or her ability to pay. The federal government has enacted an "anti-dumping" law to ensure that emergent patients are not transferred from a hospital emergency room to another facility unless it is medically appropriate.

Prompt and effective delivery of emergency care may not be delayed in order to determine a patient's insurance or financial status. Each patient who presents at the emergency department must receive an appropriate medical screening examination. Patients with emergency medical conditions, and patients in active labor, must be cared for in the Hospital's emergency department until their condition has stabilized, except in certain limited circumstances.

Any employee who believes that an emergency patient has been transferred improperly must report the incident to the Compliance Officer. No employee will be penalized for reporting a suspected violation of the patient transfer law. If an employee or professional staff member believes that an emergency patient has been transferred to the Hospital improperly, the suspected violation must be reported to the Compliance Officer and to proper authorities within 72 hours of its occurrence. The name and address of any on-call physician who refuses or fails to appear within a reasonable time to provide necessary stabilizing treatment of an emergency medical condition or active labor is to be reported immediately to the Compliance Officer, or the Administrator or Administrator on Call.

In addition to the Hospital's medical records, the emergency department will maintain an on-call duty roster and a log documenting each individual who comes to the emergency department seeking assistance. The log must document whether the patient refused treatment or was refused treatment, transferred, was admitted and treated, stabilized and transferred, or discharged. When a patient or a patient's legal representative requests a transfer or refuses a transfer, the informed consent or refusal must be documented in writing. If there are questions about the records required under the patient transfer law, the Compliance Officer will answer them or refer them to counsel.

The federal "anti-dumping" law is enforced through significant civil monetary penalties and through damages in private civil actions. A physician, including an on-call physician, who is responsible for the examination, treatment, or transfer of an emergency patient and who negligently violates the law may also be fined. If the violation is gross and flagrant or repeated, the physician may be excluded from participation in the Medicare and Medicaid programs.

F. HIPAA Security and Privacy; Records Generally

1. Privacy

Hospital employees and health care professionals possess sensitive, privileged information about patients and their care. Patients properly expect that this information will be kept confidential. The Hospital takes very seriously any violation of a patient's confidentiality and is committed to protecting the privacy and security of the health information of our patients and residents as required by the Health Insurance and Portability and Accountability Act and its regulations (HIPAA). Discussing a patient's medical condition, or providing any information about patients, with or to anyone other than Hospital personnel who need the information, and other authorized persons, will have serious consequences for an employee. Employees may not discuss patients outside the Hospital or with their families.

Medical records are strictly confidential, which means that they may not be released except with the authorization of the patient or as deemed appropriate under HIPAA and state law. Special protections apply to mental health records, records of drug and alcohol abuse treatment, and records relating to HIV infection. Medical records should not be physically removed from the Hospital, altered, or destroyed. All documents ready for disposal containing protected health information are deposited in a secure box and are destroyed by shredding by an outside vendor.

Employees who have access to medical records must preserve the confidentiality and integrity of the records, and no employee is permitted access to the medical record of any patient without a legitimate, Hospital-related reason for so doing. Any unauthorized release of or access to medical records must be reported to a supervisor or to the Compliance Officer.

2. Security of Data and Information

Security refers primarily to the Electronic Record which may contain patient's private health information or billing information and to the electronic transmission of health information.

This includes:

a. Computer Records
b. Faxes
c. Telephones
d. Mobile Communication Devices
e. Smart Phones
f. E-Mail
g. Cameras
h. Videos

Special policies and procedures govern how electronic information can be stored, shared, encrypted, and secured. All employees who have access to this information must be mindful of the security policies, receive regular training, and agree to not share passwords, leave information pulled up on computer screens, and avoid other potential breaches of data security. All such breaches must be reported immediately to the HIPAA Security Officer, the Director of Information Technology.

3. Litigation Hold

If the hospital or any of its officers or directors are named in a suit, an immediate hold is placed on any and all communications, internal or external, having to do with the topic of the suit. This prevents the destruction of any email, or other forms of electronic information from being destroyed to prevent discovery. The hospital intends to remain open and transparent in its dealing with others and all employees, officers, and directors, must refrain from disparaging or inappropriate remarks in email or on any electronic device.

4. Document Retention and Destruction

The space available for the storage of Hospital documents is limited and expensive. It is therefore important that all employees regularly discard unnecessary papers such as duplicates and drafts. On the other hand, there are legal requirements that certain records be retained for specific periods of time as dictated in the Hospital's Record Retention Policy. If you are unsure about the need to keep particular documents or the procedures for disposal, consult the head of your department.

5. Confidentiality

No employee may use for personal gain or the gain of others, confidential non-public information that may come to him or her from any source connected in any way with the Hospital. Such information could concern, for example, patient medical or financial information. Each employee must sign a confidentiality statement when hired. If you have questions regarding the Hospital's confidentiality policy, consult your supervisor.

G. Waste Disposal

A hospital produces waste of various types. The Hospital is committed to safe and responsible disposal of biomedical waste and other waste products. Compliance with applicable federal and state environmental regulations requires ongoing monitoring and care. The Hospital uses a medical waste tracking system, biohazard labels, and biohazard containers for the disposal of infectious or physically dangerous medical or biological waste. Failure to follow the system could result in significant penalties to the Hospital.

Employees who come into contact with biological waste should be familiar with the Hospital's medical waste policy and procedures, and should report any deviations from the policy to their supervisor or the Compliance Officer.

The Hospital complies with the Clean Air Act, the Clean Water Act, the Resource Conservation and Recovery Act, and other federal and state laws and regulations governing the incineration, treatment, storage, disposal, and discharge of Hospital waste. If an employee suspects noncompliance or violation of any of these requirements, the circumstances should be reported to a supervisor or to the Compliance Officer. Spills and releases of hazardous materials must be reported immediately, so that necessary reports can be made and cleanup can be initiated.

The Hospital supports ongoing legal and technical review to identify and correct environmental problems. The Hospital will initiate environmental assessments and compliance audits as appropriate. Failure to prevent, report, or correct environmental problems can result in significant criminal and civil penalties.

H. Controlled Substances

The Hospital, through its pharmacy, is registered to compound and dispense narcotics and other controlled substances. Improper use of these substances is illegal and extremely dangerous.

The Hospital requires that its employees comply with the terms of the Hospital's controlled substances registration and with federal and state laws regulating controlled substances. Under Hospital policy, access to controlled substances is limited to persons who are properly licensed and who have express authority to handle them.

No health care practitioner may dispense controlled substances except in conformity with state and federal laws and the terms of the practitioner's license. Employees should carefully follow record keeping procedures established by their departments and the pharmacy.

Unauthorized manufacture, distribution, use, or possession of controlled substances by Hospital employees is strictly prohibited, and will be prosecuted to the full extent of the law. Any employee who knows of unauthorized handling of controlled substances is to provide the information immediately to his or her supervisor or the Compliance Officer.

Federal law may impose significant sentences and fines if the Hospital or its employee is convicted or liable under federal or state law of unlawfully manufacturing, distributing, prescribing, or dispensing a controlled substance, and the Hospital and any employee can be excluded from the Medicare and Medicaid programs.

I. Purchasing, Selling, Marketing, and Anti-Trust

Purchasing and Selling Goods and Services

In dealing with other organizations that are doing business with Drew Memorial Hospital, employees are expected to be sensitive to potential unlawful behavior, such as delivery or receipt of kickbacks.

To list everything that may constitute an improper inducement under the anti-kickback laws would not be possible. But one thing is clear: the Hospital must avoid either offering or receiving improper inducement. Care must be taken in structuring relationships with persons not employed by the hospital so as not to create a situation where the Hospital appears to be offering an improper inducement to those who may be in a position to refer or influence the referral of patients to the Hospital.

Compliance with Antitrust Laws

Compliance with government laws to ensure that the market for goods and services operates competitively and efficiently is essential. Violations of the antitrust laws can lead not only to substantial civil liability, but are often deemed to be criminal acts that can result in felony convictions.

The following are examples of activities that are prohibited under the antitrust laws:

1. Agreements with competitors, such as to control or fix prices or conditions of sale;
2. Agreements with competitors to allocate products, markets or territories;
3. Agreements with competitors to boycott certain customers or suppliers; and
4. Agreements with competitors to refrain from the sale or marketing of, or limit the supply of particular products or services.

Penalties for antitrust violations are substantial. Significant criminal fines and imprisonment may result. In addition, actions giving rise to antitrust violations may violate other federal criminal statutes, such as mail fraud or wire fraud, under which substantial fines and even longer prison sentences can be imposed. Antitrust violations also create civil liability. Private individuals or companies may bring actions to enjoin antitrust violations and to recover damages for injuries caused by violations. If successful, private claimants are entitled to receive three times the amount of damages suffered, plus attorneys' fees. Moreover, if the antitrust violation was a conspiracy, each member of that conspiracy may be liable for the entire damage caused by the conspiracy.

J. Federally Funded Grants

The Hospital from time to time receives various federal grants such as grant funding from the National Institutes of Health and other organizations. Federal regulations impose duties and obligations upon the recipients of federal grants. As a recipient institution, the Hospital expects its personnel to abide by all applicable federal regulations, including but not limited to regulations relating to accurate reporting and appropriate expenditure of grant funds. Questions relating to matters concerning federal grants should be directed to the Chief Financial Officer to ensure that all regulations are observed.

K. Relationships with Accrediting Agencies, Medicare, Medicaid

The Hospital participates in the Medicare and Medicaid programs also known as Title XVIII and XIX of the Social Security Act. Both programs are governed by complicated laws and regulations which impose strict requirements on providers that are significantly different from and more extensive than those encountered in non-government commercial contracts. For example, Medicare and Medicaid have very complex payment guidelines that identify not only the circumstances under which, but also how much, those programs will reimburse the Hospital for goods and services rendered to patients covered under those programs. These guidelines are oftentimes different than directives, received from other third party payers.

L. Civil Rights and Anti-Discrimination

The Hospital and its affiliates are committed to a policy of nondiscrimination and equal opportunity for all qualified applicants and employees, without regard to race, color, sex, religion, age, national origin, ancestry, disability, or sexual orientation. Our policy of non-discrimination extends to the care of patients.

If an employee feels he or she or any patient has been discriminated against or harassed on the basis of his or her race, color, sex, or other protected category, he or she should contact the Human Resource manager so that an investigation may be initiated in accordance with Hospital policies and procedures. A patient who feels he or she has been the subject of unlawful discrimination or harassment is encouraged to contact the hospital Administrator who will refer the matter to the appropriate Hospital personnel for investigation.

M. Political Activities and Contributions

The Hospital believes that our democratic form of government benefits from citizens who are politically active. For this reason, the Hospital encourages each of its employees to participate in civic and political activities in his or her own way. The Hospital's direct political activities are, however, limited by law. The Hospital may not contribute any money, or lend the use of vehicles, equipment, or facilities, to candidates for federal, state, or local office. Nor may the Hospital make contributions to political action committees that make contributions to candidates for federal, state, or local office. The Hospital may not require any employees or professional staff members to make any such contribution. Finally, the Hospital cannot reimburse its employees or professional staff members for any money they contribute to federal, state, or local candidates or campaigns. Consistent with its charitable purpose, the Hospital does not carry on "propaganda" or attempt to "influence legislation," as these acts are defined under the Internal Revenue Code. The Hospital and its representatives may not participate in or intervene in any political campaign for or against any candidate.

N. Fundraising

In furtherance of its charitable purposes, the Hospital conducts fundraising activities through its Foundation. The Hospital complies with registration, record keeping, and reporting requirements with respect to its fundraising activities. Hospital policy requires that all solicitation of charitable contributions for the Hospital or its affiliates must be done under the supervision of the Foundation. The Hospital does not authorize any employee or other individual to use the Hospital's name in any fundraising activities not approved or supervised by the Foundation.

It is illegal for any employee or representative of the Hospital to make any false, deceptive, or misleading statement in connection with a solicitation of funds or a sale of goods or services to benefit the Hospital. It is against Hospital policy to use any sponsor or endorsement in connection with fundraising activities unless the sponsor or endorsement has been verified by the Foundation. If the Hospital or its employees violate the law on charitable donations, the Hospital could lose its ability to raise funds.

O. Payments, Discounts, and Gifts

The Hospital participates in the Medicare program, a federal program which provides health insurance to the aged and disabled, and the Medicaid program, a federal/state program which provides health care coverage to low income persons. Federal law makes it illegal for the Hospital to provide or accept "remuneration" in exchange for referrals of patients covered by Medicare or Medicaid. The law also bars the payment or receipt of such remuneration in return for directly purchasing, leasing, ordering, or recommending the purchase, lease, or ordering of any goods, facilities, services, or items covered under the benefits of Medicare or Medicaid. The so-called "fraud and abuse" or "anti-kickback" laws are designed to prevent fraud in the Medicare and Medicaid programs and abuse of the public funds supporting the programs. The Hospital is committed to carefully observing the anti-kickback rules and avoiding any practice that may be interpreted as abusive. Employees in the finance department, purchasing and facilities departments, laboratory, pharmacy, medical staff, administration, and any department entering into personal service contracts are expected to be vigilant in identifying potential anti-kickback violations and bringing them to the attention of the Compliance Officer.

P. Tax-Exempt Organizations

As a non-profit hospital serving charitable purposes, the Hospital holds federal tax- exemptstatus. That is, the Hospital is exempt from paying federal income tax on most of its revenue. The Hospital also may accept tax-deductible charitable contributions from members of the community. Loss of exempt status would result in penalties, interest, and significant cost.

In order to qualify for tax exemption, the Hospital must be operated exclusively for charitable purposes. The Hospital must provide a community benefit, such as the promotion of health and the operation of an emergency department open to all. None of

its earnings may inure to the benefit of any private individual. Any such "private inurement" could cause the Hospital to lose its tax-exempt status. If an employee is aware of payments by the Hospital to a private individual or organization that may be unrelated to the Hospital's mission or in excess of fair market value, these circumstances should be disclosed to the employee's supervisor or to the Compliance Officer.

Because the Hospital is dedicated to its charitable purposes, all contracts and agreements must be negotiated at arm length. Compensation provided to health professionals for recruitment, retention, employment, and personal services must be reasonable in the context of the services provided and the need for them. Reasonableness must be analyzed based on overall compensation and benefits. Areas of particular concern are below-market rents, compensation tied to Hospital or department revenues, income guarantees (especially where there is no obligation to repay), below-market loans, and loan guarantees. Any compensation arrangement involving one of these benefits must be reported to the Compliance Officer.

Any income derived from activities unrelated to the Hospital's charitable purposes should be reported and appropriate tax paid. Failure to report accurate compensation information may constitute fraud and could result in criminal prosecution as well as loss of exempt status for the Hospital.

Q. Independent Contractors & Vendors

The Hospital purchases goods and services from many consultants, independent contractors, and vendors. The Hospital's policy is that all contractors and vendors who provide items or services to the Hospital must comply with all applicable laws and Hospital policies. Each consultant, vendor, contractor, or other agent furnishing items or services worth at least $20,000 per year shall be informed of the Hospital's Compliance Program Policy and shall provide a written certification indicating awareness of and willingness to comply with the Hospital's Compliance Program Policy Manual. Contractors should bring any questions or concerns about Hospital practice or their own operations to the Compliance Officer.

Hospital employees who work with consultants, contractors, and vendors or who process their invoices should be aware that the Hospital's compliance policies apply to those outside companies as well. Employees are encouraged to monitor carefully the activities of contractors in their areas. Any irregularities, questions, or concerns on those matters should be directed to the Compliance Officer.

R. Physician Services

Hospital credentialing and peer review activities also may carry antitrust implications. Because of the special training and experience of physicians, other physicians may best evaluate their skills. It is appropriate for physicians to review the work of their peers. Because the physicians reviewing a particular physician may, by virtue of their medical specialties, be the physician's competitors, special care must be taken to ensure that free

and open competition is maintained. As a result, credentialing, peer review and physician discipline at the Hospital are conducted only through properly constituted committees. Physicians participating in these activities are expected to use objective medical judgment.

If any Hospital employee is involved in negotiating a contract of employment or a personal service contract with a physician or other health care provider, it is important to review with care any non-competition provisions incorporated in the agreement. The appropriate geographic scope and duration of a non-competition agreement may vary from case to case. Questions about the appropriateness of a non-competition provision should be directed to the Compliance Officer for review with legal counsel.

S. Unfair or Deceptive Practices

The Hospital is committed to complying with other federal and state laws governing market competition and trade practices. Federal law, particularly the Federal Trade Commission Act, prohibits the use of "unfair or deceptive acts and practices," including the distribution of labeling, advertising, and marketing materials that are false or misleading. Hospital employees responsible for preparing and distributing such materials must be familiar with these laws. Questions about specific materials should be directed to the Compliance Officer before distribution.

T. OIG Work Plan

The Compliance Officer and Compliance Committee shall review, each year, the OIG Work Plan, which has historically been published in or around October and discusses areas of concern and increased scrutiny for the federal Office of the Inspector General, or OIG. The Compliance Officer and Compliance Committee shall react accordingly and implement auditing and monitoring policies and initiatives and/or policies and procedures to facilitate with identified areas of risk for the Hospital.

There are several other areas of sensitivity which the Hospital has addressed through policies and procedures. Concerns regarding these laws and others are addressed through various departments including Human Resources and Quality management. If you have questions regarding these areas, you should consult the head of your department.

V. Education, Training, and Communication

To promote compliance with applicable legal requirements and to assure that the standards set forth in this Compliance Program are maintained, Drew Memorial Hospital is committed to conducting education and training programs for employees (including officers), directors, medical staff and, as applicable, agents at least annually, but more often if there is a change in law, regulation or policy that affect the Compliance Program, or if specific issues arise and the CCO feels there is a need for additional training.

The CCO, working with Drew Memorial Hospital staff and management, shall be responsible for the proper coordination and supervision of the education and training

process. The CCO shall develop a general compliance and training program that is designed to provide an overview of Compliance Program activities and requirements and emphasizes the areas that generate the greatest compliance risks for Drew Memorial Hospital.

In addition to a general compliance training program, Drew Memorial Hospital will also sponsor more detailed, job-specific compliance training programs designed for certain employees, including officers, managers, medical staff and, as applicable, certain agents, to help them effectively perform their job duties, and comply with the various specific legal and ethical issues that general training may not cover.

The combined general and specific compliance training programs are intended to provide each Drew Memorial Hospital employee with an appropriate level of information and instruction regarding the Compliance Program, applicable legal requirements, ethical standards, and appropriate procedures to fulfill the objectives of the Compliance Program. Both general and specific compliance training programs shall include distribution of the Code of Conduct and policies and procedures relevant to the various departments, facilities and committees.

Each new employee orientation will, at a minimum, include general compliance training. New employees may also receive specific training based on their job- function.

Compliance education and training sessions shall be conducted by qualified personnel, which may include the CCO, or other trained Drew Memorial Hospital personnel. Seminars may also be conducted by consultants or vendors competent to provide educational programs. The CCO is authorized to require that certain employees, medical staff, and as applicable agents, attend, at Drew Memorial Hospital's expense, publicly available seminars covering relevant areas of law.

Education and training programs should be updated to consider results from audits and investigations, feedback from previous training and education programs, trends in hotline reports, and changes in State or Federal Health Care Program requirements. As new developments or concerns arise, the CCO may require additional training for some or all employees.

Attendance at and completion of the education and training programs should be mandatory for all employees (including officers), directors and medical staff with regards to general training, and selected employees and agents with regard to specific training. Attendance shall also be a factor in each employee's performance evaluation. Failure to attend and complete compliance training will be grounds for disciplinary action, which may include termination of employment.

The CCO shall be responsible for seeking feedback from employees, medical staff and agents attending training and education sessions, and developing and implementing a system for retaining records of employee training, including attendance logs, certifications, and material distributed at training sessions.

VI. Communication and Reporting

The successful implementation of the Compliance Program requires an open line of communication between Drew Memorial hospital employees, directors, medical staff and agents and the compliance office. All employees, directors, medical staff and agents are encouraged to communicate their compliance concerns to, as applicable, their direct supervisors or the CCO to enable Drew Memorial Hospital to identify possible Compliance Program violations early, and more immediately initiate investigations, determine the materiality of employee, director, medical staff member or agent has made a report, the complainant has a continuing obligation to update the report as new information becomes known to the complainant.

To ensure a viable disclosure program, the following steps shall be incorporated:

1. Creation of an environment within which employees, directors, medical staff and agents feel comfortable reporting concerns, questions and instance of improper conduct without fear of retaliation.

2. Provision of a mechanism for confidential or anonymous reporting for employees, directors, medical staff and agents who are uncomfortable reporting concerns to their supervisor, manager, or the CCO. This reporting may be accomplished through the use of the Drew Memorial Hospital Hotline which can be accessed 24 hours a day, 7 days a week, by dialing 1-877-472-2110.

3. Publicizing the Drew Memorial Hospital Hotline in a manner in which all employees, directors, medical staff and agents may know of its existence.

4. Tracking, documentation and oversight mechanisms to ensure that reports of suspected noncompliance are fully and promptly investigated and addressed. In the case of the Drew Memorial Hospital Hotline, a log of the calls received should be maintained by the CCO.

5. Mechanisms to ensure that the CEO, the Board, and relevant senior management are properly and regularly apprised of, and can take appropriate action on, compliance issues identified in investigations that result from reports of noncompliance. Such action many include the development or updating of related policies and procedures and training content.

Although Drew Memorial Hospital shall always strive to maintain the confidentiality of a complainant's identity, regardless of whether the compliant is reported through the Hotline of the complainant's supervisor, the complainant should be made aware that his or her identity may have to be revealed in certain circumstances, such as scenarios involving governmental enforcement authorities, or when it is necessary to further the internal investigation. Nevertheless, no complainant shall be retaliated against unless the complainant is responsible for the noncompliance.

VII. Disciplinary Standards, Hiring, and Enforcement

Compliance with Compliance Program standards and all applicable laws and regulations is a condition of employment or association with Drew Memorial Hospital and Drew Memorial Hospital will pursue appropriate disciplinary action to enforce compliance.

A. Disciplinary Standards

Drew Memorial Hospital shall develop, implement and maintain a mechanism of accountability and discipline for individuals who violate any law or regulation, or any of the Compliance Program standards, in the course of their employment or association with Drew Memorial Hospital. Examples of actions or omissions that will subject an employee, medical staff member and certain agents to disciplinary action include, but are not limited to:

1. A violation of law or any of the Compliance Program standards;

2. Failure to report a suspected or actual violation of law or the Compliance Program, or failure to cooperate fully in an internal investigation of alleged noncompliance;

3. Lack of attention or diligence on the part of supervisory personnel that directly or indirectly leads to a violation of law or the Compliance Program;

4. Direct or indirect retaliation against an employee who reports through any means a violation or possible violation of law or the Compliance Program; or

5. Deliberately making a false report of violation of law or any of the Compliance Program standards.

Possible disciplinary action may include, but shall not be limited to, counseling, warning, suspension, demotion, reduction in pay, revocation of privileges, termination of employment, and failure to renew agreements, depending on the degree of severity of noncompliance. Disciplinary action will be pursued on a fair and equitable basis, and employees at all levels of Drew Memorial Hospital shall be subject to the same disciplinary action for the commission of similar offenses, including officers. The Human Resources Department will serve as the appropriate body to ensure that the imposed discipline is proportionate and administered fairly and consistently in compliance with Drew Memorial Hospital policies and procedures.

B. Hiring Criteria

No individual who has engaged in illegal or unethical behavior and/or has been convicted of health care-related crimes shall occupy positions with Drew Memorial Hospital that involve the exercise of discretionary authority. No individual or company currently excluded from participation in federal or state healthcare programs will be employed or contracted with. Notwithstanding the foregoing, in the event that there exists a

significant community need for a particular physician service, Drew Memorial Hospital, in its discretion, may contract with or employ a physician who is or has been excluded from participation in one or more federal or state healthcare programs, in order to satisfy the identified community need. Drew Memorial Hospital will only undertake such an arrangement after careful consideration of all of the facts and circumstances relating to the proposed relationship. This course of action shall not be routine and shall only apply to physicians.

Accordingly, any applicant for an employment position with Drew Memorial Hospital, and any agent seeking to provide services to or for Drew Memorial Hospital, will be required to disclose whether the individual, or entity, has ever been convicted of a crime, including crimes related to health care or has ever been sanctioned by a Federal health Care Program. In addition, Drew Memorial Hospital will reasonably inquire into the status of each prospective employee and agent by, at a minimum, pursuing the following steps:

1. Conducting background checks of employees and agents to ensure that no history of engaging in illegal or unethical behavior exists;

2. Conducting periodic reviews of the GSA's List of Parties Excluded from Federal Programs available at www.arnet.gov and the OIG's List of Excluded Individuals and Entities at http://oig.hhs.gov/fraud/exclusions.html; and

3. Conducting periodic reviews of the national Practitioner Data Bank for physicians and other health care practitioners.

Except in very limited circumstances as described herein, Drew Memorial Hospital shall not knowingly employ or contract with Excluded Individuals and Entities. Accordingly, Drew Memorial Hospital has implemented procedures to terminate employees, or its relationship with Agents who have been convicted or excluded from participation in Federal Health Programs. Except in very limited circumstances as described herein, Drew Memorial Hospital will not allow a clinician, physician or billing representative to perform in those capacities if such person or entity has ever been excluded from participation in any State or Federal Health Care Program.

Drew Memorial Hospital will not discriminate with respect to race, color, religion, sex, national origin, age, sexual orientation, disability, or any other basis prohibited by Federal, state, or local laws in any aspect of its employment or hiring practices. Drew Memorial Hospital will not tolerate harassment of its employees or agents by other employees or agents. Examples of harassment that are explicitly prohibited include words or actions that are sexual in nature, as well as words or actions based on race, color, religion, national origin, age, sexual orientation, presence of a disability or other basis protected by Federal, state, and local laws.

VIII. Auditing and Monitoring

Drew Memorial Hospital will facilitate organizational compliance by conducting a variety of active auditing and monitoring functions designed to test and confirm compliance with legal requirements and with the Compliance Program standards. Auditing and monitoring functions are critical in identifying areas in which Compliance Program's effectiveness with regard to the functions instrumental to its operation, such as the education and training programs, billing compliance, employee screening, and the appropriateness of disciplinary actions.

Regular audits shall be set forth in an audit plan to be reviewed by the Compliance Committee or a subcommittee thereof, with input from the CCO as necessary. The audit plan shall be re-evaluated annually to ensure that it addresses the proper areas of concern, which may be based on the prior years' audit findings, or risk areas identified as part of an annual risk assessment. In addition, the audit plan shall include an assessment of billings systems, in addition to claims accuracy, in an effort to identify the origin of billing errors.

Individuals who conduct the compliance audit will be independent from the area audited. Persons conducting compliance audits will have a general awareness of applicable federal and state health care laws and Federal Health Care Program requirements, and will confer with the CCO for specific guidance concerning legal requirements as needed. Audits will target diverse levels of Drew Memorial Hospitals operations, including external relationships with third-party contractors, specifically those with substantive exposure to government enforcement actions, potential kickback arrangements, physician self-referrals, billing, coding, claim development and submissions, cost reporting, and marketing endeavors. Further, and as warranted, audits will be repeated on a periodic basis to measure Drew Memorial Hospital’s current level of compliance as the Compliance Program matures.

Compliance audits may take one or more of the following forms:

A. A *baseline audit* is an initial audit in a series of identical audits, and provides a basis against which the progress of future audits is compared. Assessment of organizational risk levels can be determined through baseline audits.

B. *Prospective audits* occur before billing, and may require Drew Memorial Hospital to correct discovered errors before submitting a bill.

C. *Retrospective audits* occur after billing, and may require Drew Memorial Hospital to correct discovered errors by re-billing or self-disclosing to a Federal, state, or private health care program

D. *Special audits* are performed at the direction of the CCO, in consultation with the CEO, in response to events such as internal or external investigations.

E. Post-compliance reviews are audits performed following the correction of a compliance issue to determine the effectiveness of the remedial effort.

F. A *risk assessment* is a broad based audit that may be used to identify the effectiveness of and opportunities for improvement in the Compliance Program.

The CCO, with input from Drew Memorial Hospital's Compliance Committee as necessary, will establish procedures to supplement such audits, which may include:

- Interviews conducted with personnel involved in management, operations and other related activities, to be conducted by the CCO, or a designee of the CCO;

- Reviews, at least annually, to determine the efficiency of the Compliance Program, (e.g. the effectiveness of education and training programs); and

- Reviews of billing documentation, including clinical documentation, in support of a claim.

Drew Memorial Hospital's compliance monitoring activities will be carried out by and within each department or product line. The CCO will communicate to each department and product line the level of monitoring activities necessary to detect and prevent violations Compliance Program requirements. Monitoring activities should provide Drew Memorial Hospital with the opportunity to correct any noncompliance before it creates significant risk to Drew Memorial Hospital. Monitoring activities may also be initiated by departments and product lines when no specific problems have been identified to confirm and document ongoing compliance.

Compliance reports created by an auditing or ongoing monitoring process, including reports of noncompliance, should be reported to, and maintained by, the CCO and shared with the Compliance Committee, or a sub-committee thereof, the CEO and the Board as dictated by Drew Memorial Hospital policy. The CCO will report compliance matters to the Board on a quarterly basis and as the CCO, determines is necessary.

IX. Investigation and Prevention (Corrective Action)

Detected but uncorrected violations of law or the Compliance Program standards can seriously endanger the mission, reputation and legal status of Drew Memorial Hospital. Consequently, Drew Memorial Hospital will establish mechanisms that make possible prompt response to situations where conduct inconsistent with legal requirements or Compliance Program standards is reported, suspected or confirmed.

When an instance of potential noncompliance is reported, suspected or confirmed, the CCO should consult with the CEO and coordinate with representatives from the relevant functional areas, which may include the Audit Services Department or Patient Financial Services, to pursue the following steps:

A. Promptly halt the underlying activity and halt or mitigate where possible, any ongoing harm caused by the suspected noncompliance.

B. Fairly and expediently investigate, according to Drew Memorial Hospital policy and procedure, to determine the existence, scope and seriousness of the noncompliance, and to identify the conduct of proves that caused the noncompliance.

C. Respond with appropriate action to correct the confirmed noncompliance.

D. Implement preventative measure to avoid similar instances of noncompliance in the future.

E. Perform periodic reviews of the identified problem areas to ensure that the implemented preventative measure have effectively eliminated the cause of the noncompliance.

If an investigation uncovers credible evidence of noncompliance, and, after a reasonable inquiry, the CCO has reason to believe that the noncompliance may violate any criminal, state or regulation, the matter will be immediately reported to the CEO for advice regarding Drew Memorial Hospital's reporting obligations. After consulting with the CEO, the CCO will report such matters to the Board. The CCO will maintain appropriate protocol to ensure that steps are pursued to secure or prevent the destruction of documents or other evidence relevant to the investigation. The CCO, CEO, and Board shall be responsible for directing appropriate corrective action to be taken, which may include re-billing for services improperly billed and disclosure to applicable payers, including federal and state health programs.

X. Response to Investigations

State and federal agencies have broad legal authority to investigate the Hospital and review its records. The Hospital will comply with subpoenas and cooperate with governmental investigations to the full extent required by law. The Compliance Officer is responsible for coordinating the Hospital's response to investigations and the release of any information.

If a department, an employee, or a professional staff member receives an investigative demand, subpoena, or search warrant involving the Hospital, it should be brought immediately to the Compliance Officer. Do not release or copy any documents without authorization from the Compliance Officer or Hospital counsel. If an investigator, agent, or government auditor comes to the Hospital, contact the Compliance Officer immediately. In the Compliance Officer's absence, contact the Hospital's Chief Executive Officer or a member of Executive Administration. Ask the investigator to wait until the Compliance Officer or his designee arrives before reviewing any documents or conducting any interviews. The Compliance Officer, his designee, or Hospital counsel is

responsible for assisting with any interviews, and the Hospital will provide counsel to employees, where appropriate.

If a professional staff member receives an investigative demand at his or her private office and the investigation may involve the Hospital, the staff member is asked to notify the Compliance Officer immediately.

Hospital employees are not permitted to alter, remove, or destroy documents or records of the Hospital in violation of any Records Retention Policy. This includes paper, tape, and computer records.

Subject to coordination by the Compliance Officer, the Hospital and its employees will disclose information required by government officials, supply payment information, provide information on subcontractors, and grant authorized federal and state authorities with immediate access to the Hospital and its personnel. Failure to comply with these requirements could mean that the Hospital will be excluded from participating in the Medicare and Medicaid programs.

Subcontractors of the Hospital who provide items or services in connection with the Medicare and/or Medicaid programs are required to comply with the Hospital's policies on responding to investigations. Subcontractors must immediately furnish the Compliance Officer, Hospital counsel, or authorized government officials with information required in an investigation.

XI. Resources for Compliance

The Hospital operates in a highly regulated industry, and must monitor compliance with a great variety of highly complex regulatory schemes. The Hospital needs the cooperation of employees and professional staff members in complying with these regulations and bringing lapses or violations to light. The Hospital's continued ability to operate and serve the community depends upon each employee's help in regulatory compliance. Some of the regulatory programs which employees may deal with in the course of their duties include the following:

1. Arkansas hospital licensure
2. CMS accreditation
3. Medicare certification and conditions of participation
4. Controlled substance registration
5. Pharmacy licensure and registration
6. Clinical laboratory regulation-CLIA and FDA Occupational Safety and Health regulation Building, safety, food service and fire codes
7. Health Insurance Portability and Accountability Act (HIPAA)

The Compliance Officer can provide employees with more information on these rules, and can direct questions or concerns to the proper person.

XII. Acknowledgement and Certification

Employee, Director, Medical Staff and Agent Acknowledgement Process

All Drew Memorial Hospital employees, directors, medical staff and agents will receive these Compliance Program standards and other information necessary to assure compliance with these standards. All new employees, medical staff and agents will receive a copy the Compliance Program standards within 2 weeks after beginning employment or association with Drew Memorial Hospital. Within 4 weeks after receiving the Compliance Program Manual, each employee, directors, medical staff member and agent must sign and return the acknowledgement Form reprinted at the end of this Manual, which states that the employee, directors, medical staff member and agent has read and understands the provisions of the Manual. If any employee or agent is unable to read this document, it will be explained to such person verbally. Each employee, directors, medical staff member and agent will be required to review these Compliance Program standards and sign and return a new Acknowledgement Form periodically and as updates occur. All employees, directors, medical staff and agents are encouraged to ask questions or comment on the components of the standards. All Acknowledgements and Certification Forms must be submitted to the CCO and the CCO will be responsible for tracking appropriate completion of all Acknowledgements and Certifications.

[Certification page follows.]

EMPLOYEE ACKNOWLEDGEMENT AND CERTIFICATION

I hereby certify that I have received and read the DMH Compliance Plan, and I understand that compliance with the requirements set forth in the Compliance Plan is a condition of my continued employment. I understand that it is my responsibility to read, understand, and seek guidance, should I require clarification, with regard to these standards. I also understand that I may be subject to disciplinary action, up to and including termination, for violating these standards or failing to report violations of these standards.

Print Name: _____

Signed: _____

Department: _____

Date: _____

Please retain a copy for your records and return your original signed acknowledgement form to:

Chief Compliance Officer
Drew Memorial Hospital
778 Scogin Drive
Monticello, AR 71655