

STANDARD POLICY AND/OR PROCEDURE

TITLE: ORGANIZATIONAL CODE OF CONDUCT
(This policy replaces Policy #48.6H "Ethics in Marketing and Advertising", Policy #40.896H "Organizational Ethics Statement", Policy #50.13D "Code of Ethics", & Policy #40.139D "Code of Conduct")

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DISTRIBUTION OF COPIES: All Departments, Medical Staff

STATEMENT OF PURPOSE: Princeton Community Hospital ("PCH") has adopted a Corporate Compliance Program Plan (the "Plan") to ensure that we operate in full compliance with applicable laws. In addition, PCH has adopted this Organizational Code of Conduct (the "Code"), which sets forth our basic principles of exhibiting organizational behavior that is honest, forthright, responsible, and uncompromised. The Code applies to all business operations and personnel. Non-personnel, such as agents and independent contractors, *e.g.*, sales agents or external advisors and consultants, should also be directed to conduct themselves in a manner consistent with the Code when they are acting on behalf of PCH.

RATIONALE: This policy pertains to all employees, medical staff and allied health professionals who enjoy professional, staff privileges, and all vendors, suppliers, and other organizations or individuals who contractually provide products or services for PCH patients, as applicable. Principles that guide our daily practice will display the consideration of the moral and ethical values of the organization. We will strive to maintain excellent relations with our customers, and the community. The Plan and this Code are not intended to and shall not be deemed or construed to provide any rights, contractual or otherwise, to any personnel or third parties.

AUTHORITY/RESPONSIBILITY: The Hospital CEO and the Board of Directors (the "Board") shall have ultimate authority and responsibility for the implementation of a viable Compliance Program. The Compliance Officer, under the direction of the CEO shall have authority and responsibility for compliance with governmental laws and regulations,

including taking all necessary and required actions to verify accurate billing for patient services; to direct repayment; and to report misconduct to enforcement authorities. Each manager or supervisor is responsible for ensuring that the personnel within their supervision are acting ethically and in compliance with applicable law and the Code. All personnel are responsible for acquiring sufficient knowledge to recognize potential compliance issues applicable to their duties and for appropriately seeking advice regarding such issues.

TEXT: One of PCH's strongest assets is our reputation for integrity and honesty. Consistent with PCH principles and the Plan, all personnel shall act in compliance with the requirements of applicable federal and state laws and this Code in order to conduct business and operations in a sound ethical manner. Achieving business results by illegal acts or unethical conduct is strictly prohibited.

PROCEDURE:

1. **Marketing:** The purpose of advertising at PCH is to communicate to the public only those services or educational programs which are available within the scope of services at our facility or by those who are affiliated with our hospital. At no time will statements be permitted in advertisements that would mislead the customer.

Advertising may be accomplished through use of newspaper, website, printed materials (brochures, pamphlets, and posters), radio or television. All advertising information will be cleared through the Marketing and Public Relations Department to assure the appropriateness of the information, as well as compliance with copyright and trademark infringement laws.

Marketing and Advertising materials will (as appropriate):

- Accurately represent and address the care, treatment, and services that the hospital provides directly or by contractual agreement, with the primary objective of public or patient information and education.
- Protect and preserve patient confidentiality, using patient information or photographs only with the patient's or legal guardian's written consent.
- Demonstrate honesty and accuracy in description of hospital services and staff credentials.
- Avoid exaggerated or misleading claims or projection of outcomes.
- Encourage utilization of services as appropriate and in the best interest of the patient.

- Avoid disparaging references to individuals, organizations, or competing health systems.
 - Remain in compliance with laws governing copyright or trademark infringement. Articles, quotes, photographs or artwork written, compiled or created by external sources will not be used without appropriate written permission or subscription rights.
 - Communicate hospital ownership or other business relationships with off-site services to which patients may be referred.
 - Include a statement of non-discriminatory practice.
2. **Admission:** Admission to the hospital will not be denied based on the patient's ability to pay for services received. If a patient is unable to make payment, the hospital will assist the patient in setting a payment schedule, applying for Medicaid, or making application for other available financial resources as deemed appropriate. PCH will admit and treat patients without regard to age, race, color, national origin, religion, creed, sex or handicap.
 3. **Transfer:** All patients treated in the hospital will receive one level of care, which will be the most appropriate care provided within the scope of services available at this hospital. If it is determined that the patient needs services not available at this hospital, arrangements will be made to an appropriate facility which provides those services. Transfer to another facility may also occur at the request of the patient, or family if the patient is incapacitated or unconscious. Prior to the transfer, consent will be obtained from the patient or surrogate decision maker. The hospital transfer policy will be followed in all cases.
 4. **Discharge:** The hospital makes decisions regarding the provision of ongoing care, treatment, services or the discharge of a patient based on assessed needs of the patient. The patient and/or family shall be involved in these decisions. For any post-discharge arrangements coordinated by PCH, the patient/legal representative will be informed regarding any service and financial relationship PCH may have with those entities owned and operated by PCH staff.
 5. **Billing:** An itemized statement will be provided when requested by the patient and/or authorized responsible party. There is no charge for this service. The bill will include charges only for those services and care provided during the time frame of service. Explanation of the itemized statement will be provided by patient accounts representatives in the Business Office upon patient or payer request. Any questions or complaints about patient bills will be responded to promptly. If unable to be addressed to patient satisfaction/understanding of bill, the conflict will be referred to the Supervisor of the Business Office for resolution & tracking. Personnel shall be completely honest in all dealings with government agencies and representatives. No

misrepresentations shall be made, and no false bills or requests for payment or other documents shall be submitted to government agencies or representatives. Personnel certifying the correctness of records submitted to government agencies, including bills or requests for payment, shall have knowledge that the information is accurate and complete before giving such certification. The cost report will be prepared in compliance with all applicable regulations and accurately reflect the cost structure of the hospital. Billing and cost reporting will be subject to internal and external audit to ensure that errors are corrected in a timely fashion.

6. **Conflict of Interest:** Prior to finalization on any contractual agreement which includes the provision of patient services, Administration on behalf of the Board will review the contract to ensure that there is no professional, ownership, contractual, or other relationship conflict of interest. Each Board member signs a Conflict of Interest statement upon their appointment to the Board that they do not have a personal or financial conflict of interest.

Each person shall avoid actual, potential or the appearances of conflicts of interest in those situations in which a person has the potential to direct or influence a decision to his/her own gain. Any persons having an investment, financial interest, or compensation relationship, direct or indirect, with any supplier, client or competitor, shall make prompt disclosure to the hospital and seek evaluation for participation in the transaction. Information about the relationship between the use of, care, treatment, services and financial incentives are available to all patients, staff, licensed independent practitioners and contractual providers when requested. Personnel shall not engage in any financial, business, or other activity which competes with the hospital's business which may interfere or appear to interfere with the performance of their duties or that involve the use of PCH property, facilities, or resources, except to the extent consistent with the conflict of interest policies.

Patient Care Conflicts: The patient's legal surrogate's right to informed participation in decisions involving the patient's health care and the right to consent to treatment or refuse treatment will be respected in all cases. In the event that conflict exists among those with equal authority to consent to treatment or refuse treatment, all measures will be taken to achieve conflict resolution and shall in any event be resolved in accordance with legal requirements. The policy regarding informed consent should be followed in reviewing and evaluating the needs and wishes of patients and their family or legal surrogate. This policy outlines the person(s) generally in possession of authority for making medical decisions for the patient, including the authority of the patient who is a competent adult to make medical decisions for himself/herself. In the event that conflict exists among those with equal authority to make medical decisions for the patient, the hospital staff should remain neutral in recognition of the principle that informed consent is a process that involves the physician and the patient and/or family or legal surrogate.

However, the following steps should be taken to assist the decision-making

process and resolve conflict.

- A. Initially, the Physician /Department Director /Nursing Supervisor may answer any questions regarding day-to-day care of the patient and explain any medical terms the family or legal surrogate does not understand. Questions regarding physician orders, results of tests, and care should be referred to the attending physician.
- B. A care conference with the attending physician, nursing personnel and family/legal surrogate may be arranged to discuss any misunderstandings/questions and assure that the family/legal surrogate understand all aspects of care. Involvement of the Clinical Ethics Program may be implemented in accordance with the Clinical Ethics Program policy.

7. **Relationship to Other Healthcare Providers, Educational Institutions, and Payers:** As required or permitted by law, the hospital will engage in contractual arrangements and transfer agreements with other healthcare providers, as well as educational institutions, and payers. The contracts will define the responsibilities of each party. Conflicts of interest will be addressed at the time of the initial contract and upon contract renewal as addressed above.

No part of the compensation set forth in any hospital agreement with other health care providers shall be in any way contingent upon or based upon either referring patients to the hospital by any party to the agreement or the utilization of any hospital services by any party to the agreement. In all agreements the hospital shall assure that consideration payable under any Agreement was negotiated at arm's length with the parties involved and represents, to the extent reasonably ascertainable, reasonable consideration and fair market value for the services to be provided under the agreement.

The hospital will not refuse care, treatment or services to a patient, regardless of his or her ability to pay or contractual arrangement with a medical insurance carrier. It will be the patient's decision whether to receive care at PCH based on his or her medical insurance coverage or other contractual arrangements.

8. **Patient Responsibility** The safety of healthcare delivery is enhanced when patients, as appropriate to their condition, are partners in the health care process and exhibit reasonable and responsible behavior to help facilitate the safe delivery of care, treatment, and services.

Therefore, a patient has the right to expect:

- Reasonable access to care
- Care that is safe, professional, courteous, considerate and respectful of one's pastoral, spiritual, cultural, psychosocial needs, as well as one's personal dignity, beliefs, values and privacy.

- A plan of care adapted to the specific needs and limitations of the patient.
- To be informed about treatment, including positive, as well as adverse outcomes of care in language the patient can understand and to participate in decisions regarding one's care, including any restricted communication access (*i.e.* mail, phones, etc).
- To participate (or, if not possible, for the patient's legal representative(s) to participate), in ethical questions that arise in the course of the patient's care, including issues of conflict resolution, withholding resuscitative services, forgoing or withdrawal of life sustaining treatment, and participation in investigational studies or clinical trials.
- Security and personal privacy and confidentiality of information in accordance with state and federal law .
- To designate a decision maker in case one is incapable of understanding a proposed treatment or procedure or is unable to communicate one's wishes regarding care.
- To be informed regarding the internal patient grievance process, as well as being informed of the local and state regulatory agencies to which complaints can be filed.
- Have complaints or concerns addressed timely and confidentially without fear of reprisal from any member of the hospital staff.
- Access to protective services as needed. The Case Management Department staff assists with this process. On admission the patient/surrogate is provided with names/addresses/phone numbers in the patient/family handbook directing them to state advocacy groups for reporting adult/child abuse/neglect, domestic violence, sexual assault, or institutional abuse/neglect, Lost or stolen property. (See "Assessing Protective Services: Abuse/Neglect" Policy).
- To be educated about these responsibilities initially upon admission and as needed thereafter.

In exchange, healthcare professionals have the right to expect that the patient will:

- Follow the plan of care prescribed by the physician, nurses or other members of the health care team, and agreed upon with the patient as a participant in that decision.
- Be an active participant in the health care plan by providing accurate name, demographic and medical information about all matters pertaining to the health care of the patient, to include information about the symptoms, reason for visit, past illnesses and hospitalizations, medications which include nonprescription medications and herbal agents, and other matters of care.
- Be reasonable in demands and expectations of the health care team.
- Respect the privacy of roommates and maintain confidentiality of any medical information about roommates or other patients.
- Be considerate of other patients and encourage visitors to be considerate,

particularly with regard to noise and number of visitors.

- Speak up, ask questions, and notify the physician or nurse if the patient does not know what to do or does not understand the diagnosis, treatment, prognosis or outcomes.
- Accept the consequences associated with refusal of the prescribed medical care plan.
- Recognize that health care providers are deserving of respect and consideration and be responsible in requests of them.
- Abide by the rules and safety regulations as they apply to each patient.
- Be prompt in the provision of information necessary for insurance processing of bills and accept the financial obligation associated with care.
- Advise the physician/department director/nursing supervisor or administrator of any dissatisfaction the patient may have in regard to the care given or hospital services.

9. **Business Relations:** Consistent with the Plan, in all business dealings, including but not limited to transactions with vendors and suppliers, all PCH personnel are expected to do the following:

- Strive to conduct all business with honesty, fairness, integrity, and loyalty to the organization and the profession.
- Decline all gifts or gratuities and not enter into any transactions that would result in personal benefit.
- Exercise reasonable business judgment to obtain the maximum value for each dollar of expenditure.
- Treat with discretion all information obtained in confidence
- Strive for standardization to reduce cost and further the development of products and methods that emphasize high quality, safety, and effectiveness of care.
- Comply with applicable antitrust laws. There shall be no discussions or agreements with competitors regarding price or other terms for product sales, prices paid to suppliers or providers, dividing up customers or geographic markets, or joint action to boycott or coerce certain customers, suppliers, or providers.

10. **Confidentiality:** Consistent with the Plan and other privacy policies of PCH, health care professionals should not use or disclose a patient's protected health information without the patient's authorization except as otherwise required or permitted by law. Consistent with PCH's policies, patients shall be given PCH's Notice of Privacy Practices at the time of the first visit and be informed about what information is

recorded, how it is used, who will have access to the information and what these practices may mean to the patient. All health care professionals shall exercise reasonable discretion in discussing any patient's condition or actions with another health care provider in the presence of, or in the hearing of, persons not on the health care team. All personnel shall maintain the confidentiality of the organization's confidential proprietary and/or trade secret information, including but not limited to information relating to the organization's vendors, suppliers, providers, and customers. PCH personnel shall only use such information as authorized by PCH management for the lawful business purposes of PCH. Personnel shall not seek to improperly obtain or to misuse confidential information about the hospital's competitors.

11. **Accounting:** All business transactions shall be carried out in accordance with management's general or specific directives. All financial records shall be kept in accordance with generally accepted accounting standards or other applicable standards. All transactions, payments, receipts, accounts, and assets shall be completely and accurately recorded. No payment shall be approved or made with the intention or understanding that it will be used for any purpose other than that described in the supporting documentation for the payment. All information recorded and submitted to other persons must not be used to mislead those who receive the information or to conceal anything that is improper. Financial records shall be created, maintained, retained, or destroyed in accordance with PCH's records management policies.

12. **Integrity.** The Plan and this Code protect the integrity of clinical decision making, regardless of how the hospital compensates or shares financial risks with its leaders, managers, clinical staff and licensed independent practitioners. To avoid compromising quality of care, clinical decisions, including tests, treatments, and other interventions, are based on the individual healthcare needs of each patient. If required by law, PCH will disclose information about its financial relationships or risk sharing arrangements. Policies and procedures and information about the relationship between the use or care, treatment, and services, and financial incentives as they relate to either referring to or using services are available to all patients, staff, licensed independent practitioners, and contracted providers, when requested. PCH expects the following from its personnel, agents and independent contractors:
 - Present a professional attitude at all times and avoid disruptive and inappropriate behaviors, *e.g.*, profanity or raising one's voice in anger.
 - Ensure that the work environment is free of discrimination or harassment due to age, race, gender, color, religion, national origin, disability, sexual orientation, or covered veteran status. Any form of sexual harassment, including the creation of a hostile working environment, is completely prohibited.

- Follow safe work practices and comply with all applicable safety standards and health regulations.
- Present a neat, clean, professional personal attire appearance at all times, following the approved hospital dress expectations.
- Display courtesy and respect for all customers, including patients, families, colleagues, visitors, vendors and co-workers.
- Work harmoniously together while fulfilling all requirements defined by the organization.
- Refrain from discussing concerns regarding another employee's performance/actions in the presence of PCH patients or with someone other than a member of PCH's management level staff.
- PCH expects and requires that the Plan and this Code be followed at all times and shall take such action as PCH deems necessary to enforce such policies up to and including disciplinary action.

APPROVED BY:

Thomas S. Lilly, President PCH Board of Directors **Date**

Wayne Griffith, Chief Executive Officer **Date**

Rosa Moody, Compliance Officer **Date**

Princeton Community Hospital Association, Inc.
Corporate Compliance Program
Compliance Plan

2.47H

1. General Policy

It is the policy of Princeton Community Hospital Association, Inc. (the "Hospital") to provide services in compliance with all state and federal laws governing its operations, and consistent with the required standards of business and professional ethics. This plan is a solemn commitment to our patients, to our community, to those government agencies that regulate the Hospital, and to ourselves. In order to ensure that the Hospital's compliance policies are consistently applied, the Hospital has established a legal and regulatory Corporate Compliance Program (the "Program"). The Program is directed by a Corporate Compliance Committee (the "Compliance Committee") and a Compliance Officer, who are charged with reviewing our compliance policies and specific compliance situations that may arise, among other things.

All Hospital employees, as well as those professionals who enjoy professional staff membership of the Hospital, must carry out their duties for the Hospital in accordance with this policy and the Program. Vendors of the Hospital shall be required to adhere to certain Hospital policies and procedures, as applicable. Any violation of applicable law, or deviation from appropriate ethical standards, will subject an employee or independent professional to appropriate disciplinary action as set forth in the employee handbook and medical staff bylaws, and which may include oral or written warning, disciplinary probation, suspension, reduction in salary, demotion, dismissal from employment or revocation of privileges. These disciplinary actions also may apply to an employee's supervisor (or a department manager) who directs or approves the employee's improper actions, or is aware of those actions but does not act appropriately to correct them or enforce these requirements, or who otherwise fails to exercise appropriate supervision.

This Corporate Compliance Program Policy Manual (this "Manual") includes statements of the Hospital's policy in a number of specific areas. All employees and professional staff members must comply with these and other applicable policies, which,

in part, define the scope of Hospital employment and professional staff membership. The Hospital has a variety of additional policies and procedures further addressing subjects covered in this Manual and other subjects related to compliance, to which reference is also made. Conduct that does not comply with statements in compliance policies and this Manual is not authorized by the Hospital, is outside the scope of Hospital employment and professional staff membership, and may subject employees and professional staff members to disciplinary action. If a question arises as to whether any action complies with Hospital policies or applicable law, an employee or professional staff member should present that question to that employee's supervisor, or, if appropriate, directly to the Hospital's Compliance Officer, or to a member of the Compliance Committee. All employees and professional staff members should review this Manual and other Program materials from time to time to make sure that these policies guide their actions when acting on behalf of the Hospital.

If, at any time, any employee or professional staff member becomes aware of any apparent violation of the Hospital's corporate compliance policies, he or she must report it. Reports may be made verbally or in writing to the employee's supervisor or to the Compliance Officer. Reports may be made on an anonymous basis to the Compliance Officer. All persons making such reports are assured that such reports are treated as confidential to the fullest extent allowed by law; such reports will otherwise be shared only on a bona fide need-to-know basis or as required by law. The Hospital will take no adverse action against persons making such reports, whether or not the report ultimately proves to be well-founded, unless such person was involved in the violation. If an employee or professional staff member does not report conduct violating the Hospital's policies, that employee or professional staff member may be subject to appropriate disciplinary action, up to and including termination of employment or revocation of privileges.

The laws discussed in this Manual and other Program materials are complex and many of the concepts are developed in case-by-case determinations. In addition, this Manual deals only generally with some of the more important legal principles. Their mention is not intended to minimize the importance of other applicable laws, professional standards, or ethical principles, which may or may not be covered in other Hospital policies

and Program materials. Consequently, any employee or professional staff member who is in doubt as to the propriety of a course of action must promptly communicate with his or her supervisor, or with the Compliance Officer, as applicable, before taking action.

2. **Payments, Discounts, Gifts, etc.**

The Hospital participates in the Medicare program, a federal program which provides health insurance to the aged and disabled, the Medicaid program, a federal/state program which provides health care coverage to low income persons, and other federal health care programs. Federal law makes it illegal for the Hospital to provide, offer or accept "remuneration" in exchange for referrals of patients or other business covered by Medicare, Medicaid or other federal health care programs. The law also bars the payment or receipt of such remuneration in return for purchasing, leasing, ordering, arranging for or recommending the purchase, lease, or ordering of any goods, facilities, services, or items covered under the benefits of Medicare, Medicaid or other federal health care programs. In West Virginia, similar state statutes apply prohibitions to Medicaid and other state programs. (See Section 2 (c) hereafter.)

The so-called "fraud and abuse" or "anti-kickback" laws are designed to prevent fraud in the Medicare, Medicaid and other federal health care 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 or illegal. Employees in the billing and 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 any potential anti-kickback violations and bringing them to the attention of the Compliance Officer.

(a) **Anti-Kickback Laws**

The 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 obtaining or rewarding favorable treatment in connection with the award of a government contract or government business. The anti-kickback laws must be considered whenever something of value is given, offered or received by the Hospital or its representatives or affiliates, that is in any way connected

to patient services or business. This is particularly true when the arrangement could result in inappropriate or over-utilization of services, increased costs, interference with clinical decision making, patient safety or quality of care concerns, or a reduction in patient choice. Even if only one purpose of a payment scheme is to influence referrals or other business, 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 payments 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 Chief Financial Officer ("CFO ") and in accordance with Hospital policies and legal requirements. Except in limited recruitment situations, 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 or other business generated. Fair market value should be determined through an independent appraisal or other independent sources.

Agreements for professional services, management services, and consulting services must be in writing, have at least a one-year term except as otherwise authorized by the Hospital Chief Executive Officer ("CEO"), or the Compliance Officer, and must specify the compensation in advance. Payment based on a percentage of revenue should be avoided in many circumstances. 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, absent unusual circumstances. 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 should not create a risk of criminal penalties and exclusion from the Medicare and Medicaid programs. However, the failure to satisfy every element of a safe harbor does not in and of 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.

(b) Entertainment and Gifts

The Hospital recognizes that business dealings may include a shared meal or other similar social occasion, which may be proper business expenses and activities. More extensive entertainment, however, only rarely will be consistent with Hospital policy and should be reviewed and approved in advance by the Compliance Officer. Hospital employees may not receive any gift under circumstances that could be construed as an improper attempt to influence the Hospital's or an employee's decisions or actions. When an employee receives a gift that violates this policy, the gift should be returned to the donor and reported to the Compliance Officer. Gifts may be received by Hospital employees when they are of such limited value that they could not reasonably be perceived by anyone as an attempt to affect the judgment of the recipient. For example, token promotional gratuities from suppliers, such as advertising novelties (e.g., key chains) marked with the donor's name, are not prohibited under this policy, nor are gifts of value under \$25.00. Notwithstanding the foregoing, gifts to physicians and immediate family members of physicians may be barred altogether under the "Stark" laws. (See Section 4 hereafter.)

Whenever an employee is not sure whether a gift is prohibited by this policy, the gift must be reported to the Compliance Officer upon its receipt.

(c) State Fraud, Anti-kickback and False Claim Laws

Under West Virginia law, it is illegal for a person to knowingly make or cause to be made a false statement or false representation of any material fact in the application for medical assistance under the medical programs of the West Virginia Division of Human Services (which includes the Medicaid program). It is also illegal to knowingly make or cause to be made a false statement or false representation of any material fact necessary to determine the rights of any other person to medical assistance under these programs, or to knowingly and intentionally conceal or fail to disclose any fact with the intent to obtain medical assistance under these programs to which any person is not entitled. Violations are a felony and, upon conviction, a person can be confined in the penitentiary not less than one nor more than ten years or can be fined not to exceed \$10,000 or both fined and imprisoned.

It is also illegal for any person to solicit, offer or receive any remuneration, including any kickback, rebate or bribe, directly or indirectly, with the intent of causing an expenditure of monies out of the West Virginia Human Services Medical Services Fund (which includes Medicaid funds) which is not authorized by applicable laws or rules and regulations. Further, it is illegal for a person to make or present or cause to be made or presented a claim under the medical programs of the West Virginia Division of Human Services (which, again, includes the Medicaid program) knowing the claim is false, fraudulent or fictitious or for any person to enter into an agreement, combination or conspiracy to obtain or aid another in obtaining the payment or allowance of a false, fraudulent or fictitious claim. Violations of these provisions are also a felony and, upon conviction, a person can be confined in the penitentiary for not less than one nor more than ten years or can be fined not to exceed \$10,000, or both fined and imprisoned.

In addition to the criminal penalties, any person who willfully, by means of a false statement or representation, or by concealment of any material fact, or by other fraudulent scheme, devise or artifice, obtains or attempts to obtain benefits or payments or allowances under these medical programs of the West Virginia Division of Human Services to which such person is not entitled, or in a greater amount than that to which such a person is entitled, will be liable for three times the amount of the benefits, payments or allowances to which such person was not entitled, and will be liable for the payment of

reasonable attorney fees and all other fees and costs of litigation.

These remedies and penalties provided above are in addition to and not in lieu of those penalties and remedies provided elsewhere by law.

(d) Hiring of Excluded Persons

Federal law imposes substantial penalties on health care providers or suppliers who hire individuals or entities excluded from participating in federal health care programs, including Medicare and Medicaid. Excluded individuals or entities must not be hired in violation of this requirement, and an appropriate inquiry, including a query of the U.S. Department of Health and Human Services Office of Inspector General's ("OIG") List of Excluded Individuals/Entities, must be made prior to hiring or contracting with any individual or entity. The OIG's website listing of excluded individuals/entities must be accessed and queried prior to hiring or contracting with an individual or entity at www.hhs.gov/oig or such other website address as provided by the OIG.

(e) Prohibition on Payments to Reduce or Limit Services.

Federal law also imposes civil money penalties for payments, direct or indirect, by a hospital to induce a physician to limit or reduce services to Medicare or Medicaid beneficiaries under the physician's direct care. No payments may be in violation of this requirement.

3. **Billing and Claims**

When claiming payment for Hospital or professional services, the Hospital has an obligation to its patients, third party payors, and the state and federal governments to exercise diligence, care, and integrity. The right to bill the Medicare and Medicaid programs, conferred through the award of a provider or supplier number and/or agreement, carries a responsibility that may not be abused. The Hospital is committed to maintaining the accuracy of every claim it processes and submits. Many people, throughout the Hospital, have responsibility for entering charges and procedure codes. Each of these individuals is expected to monitor compliance with applicable billing rules and requirements for all payors, whether Medicare, Medicaid, insurers or otherwise. The Hospital maintains a charge master for various procedures for billing and coding purposes, which shall be updated at least annually and more frequently where required or necessary.

Any false, inaccurate, or questionable claims should be reported immediately to a supervisor or to the Compliance Officer.

False billing is a serious offense. For example, Medicare and Medicaid rules prohibit knowingly and willfully making or causing to be made any false statement or representation of a material fact in an application for benefits or payment. In the context of false claims, "knowingly" includes acting in deliberate ignorance or reckless disregard of the truth or falsity of a claim. It is also unlawful to conceal or fail to disclose the occurrence of an event affecting the right to payment with the intent to secure payment that is not due.

Examples of false claims include:

- * Claiming reimbursement for services that have not been rendered,
- * Filing duplicate claims,
- * "Upcoding" to more complex procedures than were actually performed or DRG manipulation,
- * Including inappropriate or inaccurate costs on Hospital cost reports,
- * Falsely indicating that a particular health care professional attended a procedure or that services were otherwise rendered in a manner they were not,
- * Billing for a length of stay beyond what is medically necessary,
- * Billing for services for items that are not medically necessary,
- * Failing to provide medically necessary services or items,
- * Billing excessive charges,
- * Billing for outpatient services rendered in connection with inpatient stays,
- * Unbundling,
- * Billing for discharge rather than transfer,
- * Failure to comply with requirements to bill for training and residency services such as supervision and record keeping requirements.

Other risk areas include inaccurate or incorrect coding (including outpatient procedure coding), billing for services not covered, insufficient documentation, admissions and discharges (e.g., not following "same-day" rules), supplemental payments like, for example, abuse of outlier payments or improper claims for incorrectly designated

“provider-based” entities, and use of information technology that cannot accommodate new billing and payment requirements. Hospital employees and agents who prepare or submit claims should be alert for these and other errors. In addition, bad debts should be reported to and expense claimed from Medicare, and credit balances reported to Medicare, only in accordance with Hospital policies and legal requirements. (See, for example, Medicare Bad Debt Policy and Credit Balance Return Policy.) It is important to remember that outside consultants only advise the Hospital. The final decision on Hospital billing questions rests with the Hospital.

In compliance with federal law, the Hospital does not permit charging for any Medicaid service at a rate higher than approved by the state or accepting any payment as a precondition of admitting a Medicaid patient to the Hospital.

The Hospital carefully follows the Medicare rules on assignment and reassignment of billing rights, which strictly limit the circumstances under which someone other than the provider of the service may bill Medicare for the service. If there is any question whether the Hospital may bill for a particular service, either on behalf of a physician or on its own behalf, the question should be directed to the Compliance Officer for review. Hospital employees should not submit claims for other entities or claims prepared by other entities, including outside consultants, without approval from the Compliance Officer. Special care should be taken in reviewing these claims, and Hospital personnel should request documentation from outside entities if necessary to verify the accuracy of the claims.

A provider or supplier who violates the false claims rules is guilty of a felony, and may be subject to fines of up to \$25,000 per offense, imprisonment for up to five years, or both. Other persons guilty of false claims may face fines of up to \$10,000 per offense, imprisonment for up to one year, or both. In addition to the criminal penalties, the Federal False Claims Act permits substantial civil monetary penalties against any person who submits false claims. The Act provides a penalty of triple damages as well as fines up to \$11,000 for each false claim submitted. The person (as well as the Hospital) may be excluded from participating in the Medicare and Medicaid programs. In addition, under the federal anti-kickback laws, violations of the assignment and reassignment rules are misdemeanors carrying fines of up to \$2,000 and imprisonment of up to six months, or

both, as well as other penalties.

Numerous other federal laws prohibit false statements or inadequate disclosure to the government and mandate exclusion from the Medicare and Medicaid programs. For instance, neither the Hospital nor its agents are permitted to make, or induce others to make, false statements in connection with the Hospital's Medicare certification. Persons doing so are guilty of a felony and may be subject to fines of up to \$25,000 and imprisonment for up to five years. The Hospital or individual health care providers will be excluded from the Medicare and Medicaid programs for at least five years if convicted of Medicare- or Medicaid-related crime or any crime relating to patient abuse. Medicare and Medicaid exclusion may result if the Hospital or a provider is convicted of fraud, theft, embezzlement, or other financial misconduct in connection with any government-financed program.

It is illegal to make any false statement to the federal government, including statements on Medicare or Medicaid claim forms. It is illegal to use the U.S. mail in a scheme to defraud the government. Any agreement between two or more people to submit false claims may be prosecuted as a conspiracy to defraud the government. In addition, see Section 2 (c) for state law limitations, requirements and penalties in connection with billing and claims.

The Hospital promotes full compliance with each of the relevant laws by maintaining a strict policy of ethics, integrity, and accuracy in all its financial dealings. Each employee and professional, including outside consultants, who is involved in submitting charges, preparing claims, billing, and documenting services is expected to maintain the highest standards of personal, professional, and institutional responsibility.

4. **Patient Referrals**

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, where appropriate, compensation for administrative, management or professional services, space and equipment leases, 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 or other such entity for the provision of certain designated health services reimbursed by Medicare. A financial relationship may be in the form of an ownership interest (including equity, debt or other means) or in the form of a compensation arrangement, and may be direct or indirect. A physician under the Stark law includes doctors of medicine and osteopathy, dentists and dental surgeons, podiatrists, optometrists and chiropractors. If a financial relationship exists, referrals are prohibited and the entity may not bill for the items or services 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 and their family members lies with the Compliance Officer in conjunction with the CEO and/or CFO,

the head of each department, the medical staff 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:

- * clinical laboratory
- * physical therapy
- * occupational therapy and speech-language pathology
- * radiology and certain other imaging services
- * durable medical equipment and supplies, parenteral and enteral nutrients equipment and supplies
- * prosthetics and orthotics and devices and supplies
- * home health services
- * outpatient prescription drugs
- * inpatient and outpatient hospital services
- * radiation therapy services and supplies.

The exceptions under the Stark law are complex, and several general rules must be followed. Both leases for physician office space, equipment and personal services contracts with physicians must be in writing for at least one year terms (with some limited exceptions as to service contracts), and signed by the parties. Any premises leased must be specified, must be exclusively used by the lessee when being rented (and not shared with others at the same time) and must not exceed the space reasonably needed for the physician's legitimate purposes. Rental charges must be set in advance, at fair market value without regard to the volume or value of referrals by the physician or other business generated. A lease must be commercially reasonable even if no referrals were made between the parties. Similarly, a personal services contract must specify all the services or incorporate other arrangements directly or indirectly to be provided by the physician to the Hospital, which must be reasonable and necessary for legitimate purposes. Compensation paid to physicians must also be set in advance at fair market value, be unrelated to the volume or value of referrals or business otherwise generated, and be commercially reasonable. Contract services may not involve the counseling or promotion of an illegal business

arrangement. Physician recruitment arrangements must meet very detailed requirements outlined in the Stark regulations and must be approved in advance by the CEO. Physician incentive plans, which may include volume-based compensation, will be acceptable if certain requirements are met. Other exceptions exist, which have technical requirements, and must be reviewed by the Compliance Officer or the Hospital CEO or Director of Business Development/Physician Liaison and, where necessary, legal counsel.

Physicians purchasing clinical laboratory services or other items or services from the Hospital must pay fair market value. An arrangement whereby the Hospital bills for a group practice may be acceptable if it was in place prior to December 19, 1989, and meets certain other requirements. A pathologist, radiologist, or radiation oncologist may provide Hospital laboratory, pathology, diagnostic radiology, or radiation oncology services on his own order or on a consultation request from another physician.

Penalties for violating the Stark law include (i) no Medicare payment for the service referred illegally; (ii) a refund to the beneficiary of any amounts collected; (iii) fines of up to \$15,000 levied on both the physician and the entity for each service referred illegally, plus additional fines based on the amounts billed; (iv) civil monetary penalties of up to \$100,000 plus other assessments; and (v) exclusion from the Medicare or Medicaid programs.

In addition, although West Virginia does not have a separate self-referral statute, state licensing statutes and regulations for various practitioners include provisions that limit or may be implicated by referrals to entities with which a practitioner has a financial relationship. For example, West Virginia licensing statutes for medical doctors require the disclosure, in writing, to a patient of any proprietary interest the physician may have in a clinical laboratory or pharmacy before referring a patient to such laboratory or pharmacy. Penalties for violations of licensing requirements may include, among other sanctions, denial or suspension of a license and civil fines.

5. **Physician Recruitment**

The recruitment of physicians requires special care to comply with Hospital policy and applicable law. Physician recruitment has implications under the anti-kickback laws, the Stark law, and the Internal Revenue Service (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. New or unique recruitment arrangements must be reviewed by the Compliance Officer, the CEO and require legal counsel review and approval. In general, support provided to a new physician, in an identified needed specialty, is most likely to be acceptable if it is provided in order to persuade the physician to relocate to the geographic service area served by the Hospital from outside that area in order to become a member of the professional staff, or, in certain circumstances, if it is provided to a new physician completing his or her training, and the support is reasonable. Support should be of limited duration. The physician cannot be required to refer patients or other business to the Hospital and may not be precluded from joining the medical staff of any other facility, and the amount of compensation or support cannot be related to the volume or value of referrals or business otherwise generated. Income guarantees present special issues and the form of agreement should be reviewed by the Compliance Officer, the CEO and legal counsel on a case-by-case basis.

6. **Physician Practice Acquisition**

To improve the delivery of health care services, the Hospital may, from time to time, acquire physician practices. These acquisitions 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.

(a) Anti-Kickback Laws

As discussed above, federal law makes it illegal for the Hospital to provide or accept "remuneration" in exchange for referrals of patients covered by Medicare, Medicaid, or any other federal health care program. Acquisitions of physician practices may implicate the anti-kickback laws because they may constitute illegal payments to induce the referral of Medicare or Medicaid patients or other business.

Generally, acquisitions will comply with federal law when the amounts paid by the Hospital reflect the fair market value of the acquired practice, and not include installment payments (with very limited exceptions) and do not reflect future referrals to the Hospital or ancillary services or items. Fair market value should be determined through an independent appraisal. Payments in excess of fair market value may violate the

anti-kickback laws, particularly when there is an ongoing relationship between the Hospital and the acquired practice. Several specific types of payment are subject to scrutiny:

- * payment for good will
- * payment for value of ongoing business unit
- * payment for covenants not to compete
- * payment for exclusive dealing agreements
- * payment for patient lists
- * payment for patient records.

The "safe harbor" protections discussed above may also apply to particular acquisitions. Employees should not, however, make unilateral judgments on the availability of a safe harbor. These situations must be brought to the attention of the Compliance Officer for review with legal counsel. Any questions should be directed to the Compliance Officer, and any proposed acquisition of a physician practice must be reviewed by the Compliance Officer or the CEO or the Director of Business Development/Physician Liaison.

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 physicians are excluded from participating in the Medicare and Medicaid programs for up to five years, as well as be subject to other penalties.

(See section 2(c) for West Virginia State law penalties and prohibited practices.)

(b) Stark Law

Physician practice acquisitions also implicate the Stark law discussed earlier. Because the law is particularly complex, all transactions must be reviewed by the Compliance Officer, the CEO and legal counsel to ensure compliance.

(c) IRS Scrutiny

The IRS retains authority to audit the activities of tax-exempt organizations. In particular, the IRS may revoke the Hospital's tax-exempt status if payments for the acquisition of practices are deemed "excessive." While current, independent appraisals are important, equally important are the rationale and support for the reasonableness of the assumptions on which the valuation is based and the demonstration that and how the acquisition furthers an exempt purpose of the Hospital. Any questions should be directed

to the Compliance Officer or the CEO for review with legal counsel.

7. **Patient Transfers**

Operation of the emergency department is an integral part of the Hospital's services to the community under its charitable mission. The Hospital 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 patients are given appropriate medical screening and unstabilized patients are not transferred from a hospital or another covered 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 or otherwise comes to the Hospital must receive an appropriate medical screening examination using any resources routinely available to the emergency department including ancillary services. A patient outside the formal Emergency Department but otherwise on the Hospital's property or in a Hospital-owned and operated ambulance (if any) is considered to have come to the Hospital emergency department. Patients with emergency medical conditions, and patients in active labor, must be cared for until their condition has stabilized within the responsibilities of the staff and facilities of the Hospital, or appropriate transfer is made. An emergency may include psychiatric disturbance, symptoms of substance abuse, or contractions experienced by pregnant women.

If necessary, the patient may be transferred to another hospital that is qualified to care for the patient, has space available, and has agreed to accept the transfer. Before transfer, Hospital staff shall provide the medical treatment which minimizes the risks to the patient's health and, in the case of a woman in labor, the health of the unborn child. A physician must sign a certification that the medical benefits reasonably expected from treatment at another medical facility outweigh the risks to the patient (and, if appropriate, the unborn child). No physician will be penalized for refusing to authorize the transfer of an individual with an emergency condition that has not been stabilized. The transfer must be performed by qualified personnel and transportation equipment, including life support measures during transfer if medically appropriate. A copy of the patient's record, including

complete records of the emergency department encounter and any other records that are available, must be sent to the receiving hospital.

The "anti-dumping" law carries reporting obligations. 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 has reason to believe 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 as promptly as reasonably possible. 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.

In addition to the Hospital's medical records, the emergency department will maintain an on-call duty roster and a central log documenting each individual who comes to the emergency department or Hospital 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.

Off campus Hospital facilities have certain anti-dumping obligations, which vary depending on whether the facilities are operated as a department of the Hospital or not. The federal "anti-dumping" law is enforced through civil monetary penalties and through damages in private civil actions. If a hospital with 100 beds or more violates the statute, it can be fined up to \$50,000 for each violation. 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 be fined up to \$50,000 for each violation. If the violation is gross and flagrant or repeated, the physician may be excluded from participation in the Medicare and Medicaid programs.

8. **Market Competition**

The Hospital is committed to complying with all state and federal antitrust laws. The purpose of the antitrust laws is to preserve the competitive free enterprise system. The antitrust laws in the United States are founded on the belief that the public interest is best served by vigorous competition, free from collusive agreements among competitors on price or service terms. The antitrust laws help preserve the country's economic, political, and social institutions; they apply fully to health care services provided by hospitals and physicians, and the Hospital is firmly committed to the philosophy underlying those laws.

While the antitrust laws clearly prohibit most agreements to fix prices, divide markets, and boycott competitors — which are addressed below — they also proscribe conduct that is found to restrain competition unreasonably. This can include, depending on the facts and circumstances involved, certain attempts to tie or bundle services together, certain exclusionary activities, and certain agreements that have the effect of harming a competitor or unlawfully raising prices. Any questions that might arise should be addressed to the Compliance Officer.

(a) Discussion With Competitors

Hospital policy requires that the rates it charges for Hospital care and related items and services, and the terms of its third party payor contracts, must be determined solely by the Hospital and may be subject to State Health Care Authority review. Independently determining prices and terms, the Hospital may take into account all relevant factors, including costs, market conditions, widely used reimbursement schedules, and prevailing competitive prices, to the extent these can be determined in the marketplace. There can be, however, no oral or written understanding with any competitor concerning prices, pricing policies, pricing formulas, bids, or bid formulas, or concerning discounts, credit arrangements, or related terms of sale or service. To avoid the possibility of misunderstanding or misinterpretation, it is the Hospital policy to prohibit any consultation or discussion with competitors relating to prices or terms which the Hospital or any competitor charges or intends to charge. Joint ventures, group purchasing arrangements and affiliations that may require pricing discussions must be individually reviewed for antitrust compliance. Discussions with competitors concerning rationalization of markets,

down-sizing, or elimination of duplication ordinarily implicate market division and must be avoided.

Hospitals are often asked to share information concerning employee compensation. It is Hospital policy to prohibit the sharing with competing hospitals of current information or future plans regarding individual salaries or salary levels. The Hospital may participate in and receive the results of general surveys by industry, media or industry data gathering organizations, but these must conform to the guidelines for participation in surveys provided under trade associations in (b) below.

Similarly, Hospital policy prohibits consultation or discussion with competitors with respect to its services, selection of markets, territories, bids, or customers. Any agreement or understanding with a competitor to divide markets is prohibited. This includes an agreement allocating shares of a market among competitors, dividing territories, dividing product lines or customers.

(b) Trade Associations

The Hospital and its health care providers are involved in a number of trade and professional associations. These organizations promote quality patient care by allowing the Hospital and providers to learn new skills, develop policies and, where appropriate, speak with one voice on public issues. However, it is not always appropriate to share business information with trade associations and their members. Sharing information is appropriate if it is used to better inform consumers or to promote efficiency and competition.

The Hospital may participate in surveys of price, cost, and wage information if the survey is conducted by a third party on a regular basis as part of its data gathering efforts and not in connection with a given hospital and involves at least five comparably sized hospitals. Any price, cost, or wage information released by the Hospital must be at least three months old. If an employee is asked to provide a trade association with information about the Hospital's charges, costs, salaries, or other business matters, he or she should consult the Compliance Officer. Joint purchasing through a trade association is probably acceptable, but any joint purchasing plan should be reviewed in advance by the Compliance Officer. If an employee or professional staff member has any question or concern about an activity of a trade association, he or she may ask the Compliance Officer to seek

guidance from counsel.

(c) Boycotts

Hospital policy prohibits any agreement with competitors to boycott or refuse to deal with a particular person or persons, such as a vendor, payor, or other provider. These agreements need not be written to be illegal; any understanding reached with a competitor (directly or indirectly) on such matters is prohibited. All negotiations by Hospital agents and employees must be conducted in good faith. Exclusive arrangements with payors, vendors, and providers must be approved by a Hospital officer or by the Compliance officer based on an analysis of the relevant market.

(d) Physician Services

Hospital credentialing and peer review activities also may carry antitrust implications. Because of the special training and experience of physicians, their skills may be best evaluated by other physicians. 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 must exercise objective medical judgment.

If any Hospital employee is involved in negotiating a contract of employment or a personal services 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 Hospital CEO or the Compliance Officer for review with legal counsel.

(e) Use of Hospital's Market Position

The Hospital is one of the key providers of health care in the area. As such, it may, with respect to certain limited services (and depending on the circumstances), have what is considered in the law to be "market power." To the extent the Hospital may have a dominant or controlling position with respect to any particular service or group of services,

it is the policy of the Hospital to avoid any use of its market power in any one area to improperly extend its power in any other area. In particular, it is the policy of the Hospital not to use its market position to exclude competitors or attempt to increase its market power through improper means, as opposed to competition. Decisions as to selection of providers and any choices as to use of hospital facilities, or cooperation with other health care providers, should always be made on the basis of health care concerns and maximizing efficiency. If any doubt arises as to whether a particular decision will amount to an unfair exclusion of a provider or group of providers or unfair use of the Hospital's existing position in the market, then the matter should be referred to the Compliance Officer for review with legal counsel. Contracts with third party payors (including PPOs, HMOs and similar arrangements) are an area in which antitrust considerations play a significant part. In general, contracts with such payors must be entered into independently and the terms must not be discussed with or influenced by the position of other health care providers. Any contracts with payors under which the Hospital is to be the exclusive provider (whether the contract is explicit on the point or whether that provision is an implied term) for one or more services for a given area, should be scrutinized to determine whether any improper market foreclosure is occurring. Any such assessment is highly fact dependent on the particular services at issue, and the Hospital's market share regarding those services. Also highly pertinent is the market share of the payor. Antitrust rules preclude the Hospital from unfairly or improperly excluding other providers from a large share of the potential purchasers of health care services. When any doubt arises in regard to any such contracts, they should be discussed with the Compliance Officer.

Additionally, as noted above, joint negotiations with payors by multiple health care providers should never be undertaken without the explicit determination that the joint action is permissible. In general, it is not permissible for multiple parties to agree in advance on the terms they will offer for their services to a third party buyer. Because of this, any proposals for the Hospital to join joint ventures, or other organizations that are composed of health care providers who intend to compete in the provision of services to the community, must be scrutinized carefully. Such ventures can be pro-competitive but only if they are properly structured. In general there must be a degree of integration and

risk or, alternatively, the venture or other organizational form selected by the health care providers must be very limited in its services (e.g., acting simply as a “messenger”). Because of the fact-intensive nature of determining whether the antitrust laws are met in those circumstances, and the complexity of the legal issues, the Compliance Officer should be consulted before any negotiations regarding such entities are undertaken.

(f) Penalties

Penalties for antitrust violations are substantial. Individuals and corporations can be fined \$350,000 and \$10,000,000 respectively, for each antitrust violation, and individuals can be sentenced for up to three years in prison for each offense. 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.

(g) Robinson-Patman Act

This Act limits the provision and sale of pharmaceuticals, supplies, durable medical equipment and other items obtained by the Hospital with the Hospital’s nonprofit discount, because of the Hospital’s competitive advantage relating to its tax-exempt status. This act does not prohibit the Hospital’s “own use” of pharmaceuticals or other items, e.g., use for or provision to Hospital patients, employees or dependent immediate family members of employees. The “own use” rule excludes transfers to other related for-profit entities. Transfers to related not-for-profit entities may be allowed if the entity will not re-sell the items, but instead will make use of them in compliance with the “own use” rule.

(h) Unfair or Deceptive Practices

In addition to the antitrust laws, the Hospital is committed to complying with other federal and state laws governing market competition. 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 or legal counsel before distribution.

Sanctions under this law usually take the form of “cease and desist” orders and may include civil penalties.

Under state law, there is no general prohibition on deceptive practices, although any such acts might constitute fraud or misrepresentation. Manifestly, the Hospital’s goal and policy is to avoid any deceptive acts of any kind.

In addition, state law declares to be “unfair” any sale of goods below cost if the sale is intended to unfairly divert business from another competitor or will have the probable effect of injuring competitors or destroying competition. Under state antitrust law, a similar rule would apply to the sales of services. Generally, a sale is not unlawful if it is intended to meet competition or if the price established is not below the average variable cost of providing the service.

9. Tax-Exempt Organizations

As a non-profit hospital serving charitable purposes, the Hospital holds federal tax-exempt status. 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 other costs.

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 certain private parties (“insiders”), including individuals. Any such “private inurement” could cause the Hospital to lose its tax-exempt

status. In addition to the inurement proscription, a private party, including an individual, may not receive more than an incidental benefit from Hospital assets, measured against the community benefit provided by the Hospital in the given activity. Further, as such, the Hospital cannot participate or intervene in any political campaign on behalf of a candidate for public office and any lobbying activities are extremely limited and subject to complex rules.

Because the Hospital is dedicated to its charitable purposes, all contracts and agreements must be negotiated at arms length. Compensation provided to health professionals for recruitment, 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 CEO or the Compliance Officer. 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.

In addition, intermediate sanctions can be imposed when an exempt organization has an "excess benefit transaction" with a "disqualified person." Excess benefit transactions include non-fair market value or unreasonable transactions. In addition, any transaction involving the sharing of the revenue must be approved by the CEO or the Compliance Officer. The term disqualified persons could include certain physicians on staff in certain circumstances and does include directors and trustees, certain officers, certain family members, and others, including, and, possibly, managers depending on the facts and circumstances. The penalties are imposed personally upon the recipient of the excess benefit (up to 200% of the excess benefit) and organization managers (up to \$10,000 per transaction), and not the organization. Organization managers include officers, directors, trustees and others having similar powers or responsibilities, including those who regularly exercise general authority to make administrative or policy decisions on behalf of the

organization and in certain circumstances may include committee members.

Any income derived from activities unrelated to the Hospital's charitable purposes shall 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. Income to third parties from arrangements with the Hospital must be reported as appropriate to the Internal Revenue Service.

10. **Tax-Exempt Bonds**

Because the Hospital's tax-exempt bonds (the "Bonds") may be publicly traded securities, certain activities of the Hospital may be subject to certain provisions of the federal securities laws. These laws govern the dissemination or use of information about the affairs of the Hospital or its affiliates. Federal securities laws also address the dissemination or use of information which might be of interest to persons considering the purchase or sale of the Bonds.

(a) Continuing Disclosure

The Securities and Exchange Commission ("SEC") requires continuing disclosure on municipal securities transactions by relevant parties. The Hospital is committed to carrying out any continuing contractual disclosure obligations involving health care revenue bond transactions, and shall make appropriate annual disclosures and all necessary periodic or material disclosures in a timely manner.

(b) Insider Trading

It is generally illegal for any person, either personally or on behalf of others, (i) to buy or sell securities such as the Bonds while in possession of material nonpublic information, or (ii) to communicate (to "tip") material nonpublic information to another person who trades in the Bonds on the basis of the information or who in turn passes the information on to someone who trades. All employees, trustees, and professional staff members must comply with these "insider trading" restrictions.

Penalties for violating the insider trading rules include civil fines of up to three times the profit gained or loss avoided by the trading, criminal fines of up to \$1,000,000, and imprisonment for up to 10 years. There can also be civil liability to those damaged by the trading. An employer whose employee violates the insider trading prohibitions may be

liable for a civil fine of up to the greater of \$1,000,000 or three times the profit gained or loss avoided as a result of the employee's insider trading violation.

All information that an investor might consider important in deciding whether to buy, sell or hold securities is considered "material." Examples of some types of material information are:

- * financial and operating results for the month, quarter or year
- * financial forecasts, including proposed or approved budgets
- * utilization statistics such as occupancy rates, payor mix, number of discharges and ambulatory visits, etc.
- * awarding or loss of major research funding
- * possible mergers, acquisitions, joint ventures and other purchases and sales of companies and investments in companies
- * obtaining or losing important contracts
- * major personnel or medical staff changes
- * major litigation developments.

Information that is likely to affect the price of securities is almost always material.

Information is considered to be nonpublic unless it has been effectively disclosed to the public, for example by a press release. The information must not only be publicly disclosed, but there must also be adequate time for the market as a whole to digest the information. All information about the Hospital or its business plans is potentially "insider" information until publicly disclosed or made available by the Hospital. Thus, Hospital employees may not disclose it to others, such as relatives, friends, or business or social acquaintances, who do not need to know it for legitimate business reasons.

When an employee (or a member of the professional staff or trustee) knows material nonpublic information about the Hospital, he or she is prohibited from these activities:

- * trading in the Bonds for his or her own account or for the account of another (including any trust of which the employee, member of the professional staff, or director is a trustee, or any other entity that buys or sells securities, such as a mutual fund)
- * having anyone else trade for the employee

- * disclosing the information to anyone else who then trades or in turn “tips” another person who trades.

Neither the employee nor anyone acting on the employee’s behalf, nor anyone who learns the information from the employee, may trade for as long as the information continues to be material and nonpublic.

If an employee, member of the professional staff, or trustee is considering buying or selling the Bonds and has a question as to whether the transaction might involve the improper use of material nonpublic information, that individual should obtain specific prior approval from the Compliance Officer. Consultation with the individual’s own attorney is also strongly encouraged.

All of us should remember that outsiders may be listening to us or watching us and may be able to pick up information they should not have. We should not, for example, discuss the Hospital’s affairs in places where we can be overheard or assessed by others — and we should be careful about how we handle and dispose of sensitive papers. Any questions or concerns about disclosure of nonpublic information should be brought to the Compliance Officer.

(c) Private Use and Other Bond Limitations.

The Hospital is the beneficiary of tax-exempt bonds. As such, there are limitations on the use of bond-financed property, even if these tax-exempt bonds are not publicly traded. The failure to comply with the rules relating to tax-exempt bonds could cause these bonds to become subject to income tax. The IRS interprets the use of bond-financed property broadly and includes certain management agreements and other arrangements whereby the benefit of ownership may be transferred. In order to comply with IRS guidelines, there are limitations as to contracts involving the use of bond-financed property on the nature of compensation, the length of the term, and the overlap of control between the Hospital and the user of bond-financed property. Moreover, arrangements involving sharing of net profits are generally prohibited by these rules. All agreements with respect to bond-financed property should be reviewed by the Compliance Officer, the CEO or CFO or legal counsel in advance.

11. **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 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 criminal and civil penalties as high as \$50,000 per day per violation, imprisonment for up to two years, or both. Even merely negligent violations can result in imprisonment and substantial fines if they pose a serious threat to human health.

12. **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 recordkeeping 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 sentences of up to twenty years in prison and fines of up to \$1,000,000. If the Hospital or its employee is convicted under federal or state law of unlawfully manufacturing, distributing, prescribing, or dispensing a controlled substance, the Hospital can be excluded from Medicare and Medicaid programs.

The penalties for violations of the West Virginia Uniform Controlled Substances Act and other state drug and narcotics requirements vary significantly. For example, except as allowed under this Act, the unlawful manufacture, delivery, or possession with the intent to manufacture or deliver a controlled substance classified in Schedule I or II and which is a narcotic drug is a felony.

As another example, it is illegal for any person to knowingly or intentionally possess a controlled substance unless it is obtained directly from, or pursuant to, a valid prescription or order of a practitioner in the course of the practitioner's profession, except as otherwise authorized by this Act. A person who violates this provision is guilty of a misdemeanor. Penalties under the West Virginia Uniform Controlled Substances Act are in addition to, and not in lieu of, any civil or administrative penalty or sanction otherwise authorized by law.

To protect the interests of our employees and patients, we are committed to an alcohol and drug-free work environment. All employees must report for work free of the influence of alcohol and illegal drugs. Reporting to work under the influence of any illegal drug or alcohol; having an illegal drug in an employee's system; or using, possessing, or selling illegal drugs while on Hospital work time or property may result in immediate termination. We may use drug testing as a means of enforcing this policy. It is also recognized individuals may be taking prescription or over the counter drugs, which could

impair judgment or other skills required in job performance. Employees with questions about the effect of such medication on their performance or who observe an individual who appears to be impaired in the performance of his or her job must immediately consult with their supervisor.

13. **Confidentiality**

Hospital employees and health care professionals possess sensitive, confidential or 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. Discussing a patient's medical condition, or providing any information about patients, to anyone other than Hospital personnel who need the information about patients and other authorized persons, will have serious consequences for an employee. Employees should not discuss patients outside the Hospital or with their families.

The Hospital is the owner of the medical record which documents a patient's condition and the services received by the patient at the Hospital, although patients and their authorized representatives or agents have the right to access medical information subject to certain limitations. Medical records are strictly confidential, which means that they may not be disclosed except with the consent and/or authorization of the patient or in other limited circumstances in accordance with state and federal law. Special protections apply to mental health records, records of drug and alcohol abuse treatment, records relating to HIV testing or infection and records relating to prenatal care of minors, and certain other treatments or interventions. Medical records should not be physically removed from the Hospital, altered, or destroyed. Employees who have access to medical records must take precautions to preserve their confidentiality and integrity, 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 should be immediately reported to a supervisor.

In addition, federal law and regulations are in place to protect the privacy and security of patient information, including in electronic format. This law, known as HIPAA, imposes sweeping federal requirements as to the use and disclosure of this patient

information, and codifies and grants new rights to patients as to their health information. Under these privacy and confidentiality regulations, the Hospital will need to make a good faith effort to have each patient sign an acknowledgment of receipt of a notice of privacy rights and practices, which the Hospital must prepare, provide to patients and also post. The Hospital will also need to obtain a specific authorization for non-routine uses or disclosures of health information with limited exceptions like required reporting of abuse and neglect. Except for disclosures for treatment and other limited purposes, authorized disclosures must be limited to the minimum information necessary. In addition, the Hospital will have to account to patients for most disclosures of health information and require various "business associates" with whom the Hospital contracts to agree, in writing, to abide by these requirements. Other rights are granted as to the use and disclosure of this patient information, and codifies and grants new rights to patients as to the privacy of their medical information, and other obligations are imposed on the Hospital under HIPAA and the privacy and confidentiality regulations. The security rule specifies a series of administrative, technical and physician security procedures for the Hospital so as to protect confidentiality of their electronic health information. The penalties for violations include civil money penalties ranging up to \$25,000, and criminal penalties (both fines and imprisonment) for knowing violations and other actions. The privacy and confidentiality regulations apply to all HIPAA also requires the Hospital to enter into detailed "business associate" contracts with service providers who need access to health information whether in paper, oral or electronic form, and in the event of conflict or overlap with the state law, the stronger privacy protection controls. Confer with the Compliance Officer on any questions you have about HIPAA. See the following policies as to HIPAA.

The West Virginia Computer Crime and Abuse Act is designed to punish and deter computer crime. It has extensive provisions prohibiting unauthorized access to data networks or computers and any use of computers or computer information as part of a scheme to defraud or obtain money. Criminal penalties include fines up to \$10,000 and sentences of up to 10 years in jail. Generally, any access by an unauthorized person to another data network is prohibited, and any effort to alter or destroy data in a network, absent express authorization, is prohibited. Furthermore, the statute prohibits access to

state-maintained databases without authorization and provides that no one may obtain access through the state computers to information the state holds, but is required to keep confidential. Additionally, the statute prohibits access to confidential information such as salary, credit or personal information related to individuals even if the information is kept in a private network, if the access occurs without authorization. The law provides for a penalty of up to 6 months in jail for violation of that provision. Finally, the law also prohibits the unauthorized disclosure of passwords or access codes or other security information about a computer system.

In compliance with the law, the Hospital prohibits unauthorized access to its computer system, either directly or by network or telephone. An individual who does not have a legitimate password will be held to know that access is unauthorized. The Hospital prohibits the destruction or corruption of electronically stored or processed data. Persons who violate these rules will be prosecuted to the full extent of the law.

14. **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, marital status, or other protected category. Our policy of non-discrimination extends to the care of patients. Discrimination may also violate state and/or federal anti-discrimination laws and trigger substantial civil penalties.

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 their supervisor or the Human Resources Director 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 Vice President of Patient Care Services or the Patient Advocate who will refer the matter to the appropriate Hospital personnel for investigation.

The Hospital is also strongly committed to complying with other federal and state laws governing employment. These laws include:

- * the Americans with Disabilities Act

- * the Employee Retiree Income Security Act
- * the Occupational Safety and Health Act
- * the Labor Management Relations Act
- * the Age Discrimination in Employment Act
- * the Fair Labor Standards Act
- * the Immigration Reform and Control Act
- * the West Virginia Human Rights Act

The Compliance Officer and the personnel in human resources can provide employees with information on these laws and can direct questions to the proper person.

15. **Political 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. Corporations may not make any contributions – whether direct or indirect – to candidates for federal or state office. Thus, the Hospital may not generally contribute any money, or lend the use of vehicles, equipment, or facilities, to candidates for federal or state office, nor may the Hospital make contributions to political action committees that make contributions to candidates for federal or state office. The Hospital may not require any employees or professional staff members to make any such contributions. Finally, the Hospital cannot reimburse its employees or professional staff members for any money they contribute to federal or state candidates or campaigns.

Violation of federal election laws carries potential criminal penalties of up to one year in jail and a fine of \$25,000 or three times the amount of the illegal contribution, whichever is greater. Civil penalties also may be assessed. Violation of state law carries a potential criminal penalty of a fine of up to \$5,000.

In addition to the foregoing limitations, consistent with its charitable purpose and tax-exempt status as noted above, the Hospital cannot and does not carry on substantial "propaganda" or attempt to "influence legislation," as these acts are defined under the Internal Revenue Code, and neither the Hospital nor its representatives may participate in

or intervene in any political campaign for or against any candidate.

16. **Purchasing**

Purchasing decisions must be made in accordance with applicable Hospital policies and with legal requirements, including those applicable to the Hospital through its relationship with the City of Princeton. In addition, the prohibitions discussed in Section 2 of this Manual entitled "Payments, Discounts, and Gifts," apply to purchasing decisions made on behalf of the Hospital. Purchasing decisions must in all instances be made free from any conflicts of interest that could affect the outcome. See Section 18. The Hospital is committed to a fair and objective procurement system which results in the acquisition of quality goods and services for the Hospital at a fair price.

17. **Fund-Raising**

In the furtherance of its charitable purposes, the Hospital may conduct fund-raising activities. In addition, the Princeton Community Hospital Foundation, Inc. (the "Foundation") and the Auxiliary of the Hospital, consisting of volunteers, may promote and advance the welfare of the Hospital through, among other things, approved fund-raising. To the extent activities of the Hospital are not exempt, the Hospital complies with, and the Foundation and Auxiliary must comply with, the West Virginia Solicitation of Charitable Funds Act registration, record-keeping and retention, and reporting requirements. This Act also imposes requirements on the manner in which funds are raised. The Compliance Officer or the CEO must be consulted for specific requirements in this regard, or in the event of use of professional fund-raising counsel or a professional solicitor. Hospital policy requires that all charitable contributions to the Hospital be done under the supervision of the CEO. The Hospital does not authorize any employee or other individual to use the Hospital's name in any fund raising activities that are not approved or supervised by the CEO and, with respect to the Foundation. Moreover, all Hospital fund raising activities should be coordinated with the CEO.

It is illegal for any employee or representative of the Hospital or the Foundation 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 fund-raising activities unless the

sponsor or endorsement has been verified and approved by the CEO.

If the Hospital or its employees or the Foundation or Auxiliary violate the law on charitable donations, the Hospital could lose its ability to raise funds. In addition, penalties exist as set forth in the following paragraphs.

In addition to penalties of up to \$500.00 for failure to file in a timely manner, a person who willfully and knowingly violates any of these requirements, or who willingly and knowingly gives false or incorrect information to the West Virginia Secretary of State, is guilty of a misdemeanor, and upon conviction, will be fined in an amount of not less than \$100 nor more than \$500 for the first conviction, or imprisoned in the county jail for not more than six months, or both fined and imprisoned, and for the second and any subsequent offense, will be fined not less than \$500 nor more than \$1,000, or imprisoned for not more than one year, or both fined and imprisoned.

Moreover, state officials may bring an action to enjoin any violations and to seek such other relief as the Court deems appropriate.

Further, any charitable organization that willfully and knowingly violates these prohibitions by employing any device, scheme, artifice, false representation or promise with the intent to defraud or obtain money or other property is guilty of a misdemeanor and, upon conviction for the first offense, can be fined not less than \$100 nor more than \$500, or can be confined in the county jail not more than six months, or can be both fined and imprisoned, and for the second and any subsequent offense, can be fined not less than \$500 nor more than \$1,000, or confined to the county jail not more than one year, or be both fined and imprisoned.

In addition, if the court finds that any contributions are readily returnable to the original contributors, it may order the money to be placed in the custody and control of the general receiver who shall be responsible for proper disbursement to such contributors, or, if not possible, it may order the money to be placed in the custody and control of a receiver pursuant to other provisions of law.

In addition to the foregoing, any person who suffers injury or damages as a result of any violations may bring a civil action against the charitable organization and may recover damages sustained, costs incurred and reasonable attorney fees. Punitive

damages may also be awarded for intentional violations, and the West Virginia Attorney General or the West Virginia Secretary of State, or any person entitled to bring an action, may institute a class action for recovery of damages.

If the Court finds that intentional violations have occurred, the state may also recover attorney fees and a civil penalty not exceeding three times the amount collected in the civil action.

18. **Conflicts of Interest**

Hospital employees should avoid all potential conflicts of interest. Adherence to this policy ensures that the Hospital's employees act with total objectivity in carrying out their duties for the Hospital. See also, Conflicts of Interest policy and procedure.

To this end, Hospital employees may not be employed by, act as a consultant to, or have an independent business relationship with any of the Hospital's service providers, competitors, or third party payors, except in accordance with Hospital policies. Nor may employees invest in any payor, provider, supplier, or competitor (other than through mutual funds or through holdings of less than 0.5 percent of the outstanding shares of publicly traded securities) unless they first obtain written permission from the Compliance Officer.

Employees should not have other outside employment or business interests that place them in the position of (i) appearing to represent the Hospital, (ii) providing goods or services substantially similar to those the Hospital provides or is considering making available, or (iii) lessening their efficiency, productivity, or dedication to the Hospital in performing their everyday duties.

Employees may not use Hospital assets for personal benefit or personal business purposes. Employees may not have an interest in or speculate in products or real estate the value of which may be affected by the Hospital's business. Employees may not divulge or use the Hospital's confidential information – such as financial data, payor information, computer programs, and patient information – for their own personal or business purposes.

Any personal or business activities by an employee that may raise concerns along these lines must be reviewed with, and approved in advance, by the employee's immediate supervisor or the Compliance Officer.

In order for the Hospital to comply with requirements of the Medicare program, every

employee must notify the Director of Human Resources or the Compliance Officer if he or she was at any time during the year preceding his or her employment with the Hospital employed by the Medicare intermediary or carrier. An employee's failure to make this disclosure at the time of employment could cause the Hospital to lose its right to participate in Medicare.

Because the Hospital participates in state programs such as Medicaid, current and potential Hospital employees must inform the Director of Human Resources or the Compliance Officer if they are or have previously been employed on a full-time or part-time basis by the State of West Virginia, any county or municipal government body (such as the City of Princeton) or any political subdivision thereof.

The state ethics law prohibits a public employee from obtaining or seeking employment from a person (including a corporation) who had a matter on which the employee or a subordinate has taken regulatory action within the past 12 months, or currently has a matter before the agency in which the employee or a subordinate is working.

The term "seeking employment" is defined to include responding to an unsolicited offer of employment as well as any direct or indirect contact with a potential employer regulated by the agency, and "employment" includes work as an independent contractor.

The law imposes criminal penalties against a public employee who violates these restrictions, but also permits the employee to seek an exemption from the West Virginia Ethics Commission if he or she would be adversely affected. The Ethics Commission may grant exemptions on a case-by-case basis. In practice, the Ethics Commission may grant an exemption if the employee can show that the employee's employment prospects are limited without the ability to contact a regulated party.

Regulations issued under the law provide that no regulated person should offer employment to a full time employee or official of the regulating agency during their employment with the agency. The Hospital should not offer employment to a public employee whose agency regulates the Hospital, unless the public employee has been granted an exemption by the Ethics Commission.

19. **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 legal requirements and Hospital policies. Each consultant, vendor, contractor, or other agent furnishing items or services worth at least \$25,000 per year shall be given a copy of the Hospital's Compliance Program Policy and shall provide a written certification that it is aware of and will 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 the 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.

20. **Regulation**

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. While the regulatory schemes may not carry criminal penalties, they control the licenses and certifications that allow the Hospital to deliver care to its patients. 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:

- * West Virginia Department of Health (Hospital Licensure)
- * Joint Commission accreditation
- * Medicare certification and conditions of participation
- * Certificate of Need
- * Controlled substance registration
- * Pharmacy licensure and registration

- * Clinical laboratory licensure and regulation
- * Labor relations requirements
- * Occupational Safety and Health regulation
- * Building, safety, food service and fire codes
- * Securities regulation
- * State rate regulation

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

21. **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 or the CEO. Do not release or copy any documents without authorization from the Compliance Officer, the CEO or Hospital counsel. If an investigator, agent, or government auditor comes to the Hospital, contact the Compliance Officer or the CEO immediately. In the Compliance Officer's or the CEO's absence, contact the Hospital's on duty Nursing Supervisor or the Assistant Vice President of Quality Services. Ask the investigator to wait until the Compliance Officer or his or her designee arrives before reviewing any documents or conducting any interviews. Until the arrival or earlier approval of the Compliance Officer or other person noted above, as appropriate, no department, employee or professional staff member shall remove, alter or destroy any documents and otherwise despoil any evidence except in compliance with the Hospital's document or record retention/retrieval practices or policies, as applicable, with shall be in compliance with the federal Sarbanes-Oxley bill which makes it a crime to destroy or alter records during a federal investigation and other legal requirements. The Compliance Officer, the CEO or the Hospital counsel is responsible for assisting with any

interviews, and the Hospital will provide counsel to employees, where appropriate. If Hospital employees are approached by government investigators and agents, the employee has the right to insist on being interviewed only at the Hospital, during business hours or with counsel present.

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 Office or the CEO immediately.

Hospital employees are not permitted to alter, remove, or destroy documents or records of the Hospital, except in accordance with the Hospital's document or record retention/retrieval practices or policies, as applicable. This includes paper, tape, and computer records.

Subject to coordination by the Compliance Officer or the CEO and applicable legal requirements, 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. Moreover, the Sarbanes-Oxley Act grants whistleblower protection to persons giving law enforcement officials truthful information relating to federal offenses.

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, the CEO, Hospital counsel, or authorized government officials with information required in an investigation.

The provisions of this Section are not intended to apply to subpoenas and requests for records in standard professional liability cases and other routine requests or proceedings.

22. **Federally Funded Grants**

The Hospital may, from time to time, receive various federal grants such as grant funding from the National Institutes of Health. 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 grant agreements and federal laws and regulations, including regulations relating to accurate reporting and appropriate expenditure of grant funds. Questions relating to matters concerning federal grants should be directed to the Compliance Officer to ensure that all regulations are observed.

23. **Scientific Integrity**

The Hospital may also receive federal funds and grants to conduct scientific research and must, therefore, comply with the federal regulations imposed upon the recipients of those funds. These regulations generally prohibit "misconduct in science," which includes intentional fabrication, falsification, or plagiarism in proposing, conducting, or reporting research. Honest errors or differences in interpretations of data are not considered violations.

These so-called "misconduct regulations" are designed to prevent dishonesty and fraud in federally funded research programs. The Hospital is committed to complying with the regulations and avoiding any practice that may be interpreted as misconduct. Employees in the laboratory, medical staff and administration, and any department receiving federal funds to conduct research must be vigilant in identifying violations of these regulations and reporting them to the Compliance Officer.

The federal regulations provide procedures for a thorough and confidential internal inquiry and investigation of any allegation. Because evaluating these claims is complex and depends upon the specific facts and circumstances of each case, the Hospital shall appoint an inquiry team consisting of legal counsel and at least two scientists experienced in the particular scientific field to determine whether a violation may have occurred. If further investigation is recommended, the Hospital is required to notify the Office of Research Integrity of the Department of Health and Human Services, which monitors such investigations and is authorized by law to conduct its own review of the allegations.

Violation of these federal regulations could result in the Hospital's and/or scientist's

exclusion from eligibility for federal grants and contracts generally up to three years. Federal law also provides criminal sanctions for making false written or oral statements to the Office of Research Integrity during the course of an investigation.

EMPLOYEE CERTIFICATION AND AGREEMENT OF COMPLIANCE

I certify that I have received and read Princeton Community Hospital Association, Inc.'s "Corporate Compliance Program Compliance Plan" (the "Plan") and fully understand the requirements set forth in that document. I confirm that I have discussed the Plan and Compliance Program of the Hospital with my Department Manager. I agree specifically to act in accordance with and be bound by the policies set forth in the Plan and other applicable policies, and understand that I will be subject to disciplinary action, including termination, for violating the Compliance Plan of the Hospital, the Plan, or those other policies, or any laws, rules or other requirements, or for failing to report violations thereof.

Signed: _____

Date: _____

SUBCONTRACTOR CERTIFICATION AND AGREEMENT OF COMPLIANCE

I hereby certify that I am a duly authorized officer of the independent contractor named below ("Contractor"). On behalf of Contractor and its officers, directors, employees, and agents, I certify that I have received and read the "Corporate Compliance Program Compliance Plan" of Princeton Community Hospital Association, Inc. (the "Hospital"), and fully understand the requirements set forth in that document. I certify that Contractor shall act in full accordance with all rules and policies of the Hospital. These rules and policies include the Hospital's commitment to comply with all applicable federal and state laws and regulations, and the Hospital's commitment to conduct its business in compliance with the highest ethical standards.

To this end, Contractor expressly agrees that the Hospital's "Corporate Compliance Program Compliance Plan" and other Hospital policies shall be incorporated within and made a part of Contractor's agreement with the Hospital and shall survive termination of that agreement for any reason. Any failure of Contractor to comply with the rules and policies set forth in the Hospital's Corporate Compliance Program Compliance Plan, or other Hospital policies, or to report violations of these rules and policies, may result in immediate termination by the Hospital of its agreement with Contractor, notwithstanding anything in agreement to the contrary.

Name of Contractor: _____

Representative: _____

Signed: _____

Date: _____

STANDARD POLICY AND/OR PROCEDURE

TITLE: Federal and State False Claims Statutes Policy

ORIG. EFF. DATE: 7/26/08

REV. EFF. DATE:

REVISED DATE(S):

REVIEWED DATE(S):

DISTRIBUTION OF COPIES: All Departments

STATEMENT OF PURPOSE:

The purpose of this policy is to educate Princeton Community Hospital ("PCH") officers, directors, employees and management, as well as vendors, independent contractors and agents, as applicable, of the rights, obligations and remedies for false claims and statements established under certain state and federal laws. In particular, this policy is implemented to abide by the requirements of Section 6032 of the Deficit Reduction Act of 2005 and to implement and enforce PCH policies and procedures to detect and prevent fraud, waste, and abuse with respect to payments to PCH from state and federal health care programs and to provide protections for those who report actual or suspected wrongdoing.

This policy applies and shall be distributed to all officers, directors, employees and management of PCH, as well as to vendors, independent contractors and agents, as applicable.

STATEMENT OF POLICY:

One of the primary purposes of false claims laws is to combat fraud and abuse in government health care programs. False claims laws do this by making it possible for the government to bring civil actions to recover damages and penalties when healthcare providers submit false claims. These laws often permit qui tam suits as well, which are lawsuits brought by lay people, typically employees or former employees of healthcare facilities that submit false claims.

There is a federal False Claims Act, and there are also West Virginia laws that address fraud and abuse of the West Virginia Medicaid program. Under the federal False Claims Act, any person or entity that knowingly submits a false or fraudulent claim for payment of United States Government funds is liable for significant penalties and fines. Defined broadly, the term “knowingly” means actual knowledge of the information, acts and deliberate ignorance of the truth or falsity of the information, or acts and reckless disregard of the truth or falsity of the information. Specific intent to defraud is not required. Common examples of potential false claims include knowingly billing Medicare or Medicaid for services that were not rendered, billing for services that were not medically necessary, submitting inaccurate or misleading claims for actual services provided such as upcoding, miscoding to obtain reimbursement for non-covered services, or making false statements to obtain payment for products or services. Any person found guilty of violating the False Claims Act is subject to civil penalties of not less than \$5,500 and not more than \$11,000 per violation plus three times the amount of actual damages which the government sustains due to the violation, as well as the cost of any civil action brought to recover such penalties or damages. Generally, the federal False Claims Act applies to any federally funded program. The False Claims Act applies, for example, to claims submitted by healthcare providers to Medicare or Medicaid.

One of the unique aspects of the federal False Claims Act is the “qui tam” provision, commonly referred to as the “whistleblower” provision. This allows a private person with knowledge of a false claim to bring a civil action on behalf of the United States Government. The purpose of bringing the qui tam suit is to recover the funds paid by the Government as a result of the false claims. Sometimes the United States Government decides to join the qui tam suit. If the suit is ultimately successful, the whistleblower that initially brought the suit may be awarded a percentage of the funds recovered. Because the Government assumes responsibility for all of the expenses associated with a suit when it joins a false claims action, the percentage is lower when the Government joins a qui tam claim. However, regardless of whether the Government participates in the lawsuit, the court may reduce the whistleblower’s share of the proceeds if the court finds that the whistleblower planned and initiated the false claims violation. Further, if the whistleblower is convicted of criminal conduct related to his role in the preparation or submission of the false claims, the whistleblower will be dismissed from the civil action without receiving any portion of the proceeds.

The federal False Claims Act also contains a provision that protects a whistleblower from retaliation by his employer. This applies to any employee who is discharged, demoted, suspended, threatened, harassed, or discriminated against in his employment as a result of the employee’s lawful acts in furtherance of a false claims action. The whistleblower may bring an action in the appropriate federal district court and is entitled to reinstatement with the same seniority status, two times the amount of back pay, interest on the back pay, and compensation for any special damages as a result of the discrimination, such as litigation costs and reasonable attorneys fees.

A similar federal law is the Program Fraud Civil Remedies Act of 1986 (the “PFCRA”). It

provides administrative remedies for knowingly submitting false claims and statements. A false claim or statement includes submitting a claim or making a written statement that is for services that were not provided, or that asserts a material fact that is false, or that omits a material fact. A violation of the PFCRA results in a maximum civil penalty of \$5,000 per claim plus an assessment of up to twice the amount of each false or fraudulent claim.

West Virginia has not adopted false claims statutes that contain qui tam or whistleblower provisions that are similar to those found in the federal False Claims Act. However, West Virginia has adopted a generally applicable Medicaid fraud control statute that makes it unlawful for a person to make or present a claim that is known to be false, fraudulent or fictitious, or from conspiring with another to obtain or to aid another in obtaining a payment or allowance known to be false, fraudulent or fictitious under state medical programs such as Medicaid. A person found guilty of engaging in such conduct may be convicted of a felony and sent to prison for a period of not less than one year nor more than ten years and be fined up to \$10,000. In addition to criminal penalties, civil remedies can be levied against such person in an amount that equals three times the amount of any benefits, payments or allowances that were made, as well as the reasonable costs of attorney fees and fees and costs of litigation.

PROCEDURE:

PCH takes issues regarding false claims and fraud and abuse seriously. PCH encourages all officers, directors, employees and management, as well as vendors, independent contractors and agents, as applicable, to be aware of the laws regarding fraud and abuse and false claims and to identify and resolve any issues immediately. Staff members are encouraged to report matters involving fraud, abuse, or false claims to the hospital's Compliance Officer through one of the confidential communication methods listed below:

Outsourced Compliance Hotline: (866) 846-9857

Internet Reporting: www.tnwinc.com/webreport

Standard Mail: Compliance Officer

P.O. Box 1369

Princeton, WV 24740

Interdepartmental Mail: Compliance Officer Mailbox

If a matter involves potential criminal conduct, the Compliance Officer shall confer with legal counsel in determining an appropriate course of action. The Compliance Officer shall maintain the confidentiality or anonymity of any PCH staff or other person making a report of fraud and abuse to the fullest extent practicable or permitted by law.

A report made to someone other than the Compliance Officer shall be immediately forwarded to the Compliance Officer. No supervisor or manager shall take any action against an employee who has made a report in accordance with this policy or who is suspected of making a report in accordance with this policy. It is the responsibility of the Compliance Officer to oversee fraud and abuse investigations and to react promptly to any reports made. Based on the results of an investigation, the Compliance Officer shall be

responsible for determining when an incident must be reported to an appropriate law enforcement agency. The Compliance Officer shall be responsible for implementing appropriate methods for identifying fraud and abuse and for responding promptly to all potential violations. Further, the Compliance Officer and CEO shall be responsible for taking corrective action and to implement systematic changes to prevent further violations.

PCH shall implement safeguards to monitor and ensure the accuracy of claims and to prevent the possibility of entering into transactions or relationships with employees, vendors, independent contractors, agents and providers that are or have been debarred or excluded from participating in Medicare, Medicaid or other federally funded programs.

All officers, directors, employee and management, as well as vendors, independent contractors and agents, as applicable, should be aware of related PCH policies regarding detection and prevention of health care fraud and abuse. These policies and procedures can be accessed via Outlook e-mail under Public Folders, Policies and Procedures.

PCH responsibilities include, but are not limited to:

- Ensuring that all officers, directors, employees and management, as well as vendors, independent contractors and agents, as applicable, are provided with this policy.
- Implementing a Corporate Compliance Program Policy Plan (the "Plan") to address ethical issues and the need to adhere to all federal and state laws governing health care.
- Making revisions to this policy as necessary to comply with changes in the law. Changes must be documented and implemented.
- Educating all new employees on the Plan, including the contents of this policy, during new employee orientation.
- Annual computer based training on the Plan via the Healthstream Education System.

PCH shall cooperate with federal and state agencies in the conduct of any fraud and abuse investigation. Any PCH staff found to have violated a state or federal fraud and abuse law shall be subject to disciplinary action up to and including termination. No person shall be retaliated against or discriminated against in any way for reporting in good faith a violation or potential violation of state and federal fraud and abuse laws, filing a complaint under the False Claims Act, or participating in a False Claims Act investigation or litigation. Any person found to have engaged in retaliation or discrimination against a person for engaging in the conduct described above shall be subject to disciplinary action up to and including termination.

REFERENCES:

W. Va. Code Ann. § 9-7-1, *et seq.*

31 U.S.C. §§ 3801-3812

31 U.S.C. §§ 3729-3733

Deficit Reduction Act of 2005, Sections 6031, 6032

APPROVED BY:

Thomas S. Lilly, President PCH Board of Directors

Date

Wayne Griffith, Chief Executive Officer

Date

Rosa Moody, Compliance Officer

Date