


John T. Mather Memorial Hospital

POLICY AND PROCEDURE

SUBJECT: CODE OF CONDUCT AND COMPLIANCE MANUAL	Policy # C-31
	Effective Date: 05/14/14
DEPARTMENT: ADMINISTRATION	Page: 1 of 36
Approved By: 	Revised Date: 09/16/11; 12/10; 01/08; 10/06; 04/03; 07/02; 02/00; 04/97
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This Code of Conduct and Compliance Manual ("Manual") sets forth the policies and procedures that together constitute the Hospital's Compliance Program. All directors, employees, agents, suppliers and members of the voluntary staff of the Hospital are required to understand and comply with this Manual.

OVERVIEW

I. INTRODUCTION

A. General. The John T. Mather Memorial Hospital (the "Hospital") is committed to integrity as the fundamental guiding principle for its employees and others who act on its behalf, and has prepared this Manual to reaffirm this commitment. This Manual sets forth standards of conduct that all personnel employed by or associated with the Hospital are expected to follow. The Manual is designed to be a guide and resource to help all personnel ensure that their behavior is in compliance with all laws and regulations that affect all of their business dealings. The Manual also describes the procedures that will be followed in enforcing these standards and ensuring that the Hospital stays in compliance with all applicable laws. The willingness of each of us to raise ethical and legal concerns is essential. Ultimately, the responsibility for ethical behavior rests with each of us in the exercise of our independent judgment.

All personnel will be expected to read and understand this Manual and to review it as necessary in order to be alert to situations which could create a conflict of interest or otherwise be contrary to the established policies of the Hospital. All personnel must, upon receiving a copy of this Manual, sign and date an Acknowledgment of Receipt and return that Acknowledgment to the Compliance Officer.

B. The Importance of the Compliance Program. The implementation of an effective Compliance Program is important for several reasons.

First and foremost, it is essential that we ensure that we are operating pursuant to the highest ethical standards and in conformity with all applicable legal rules. This is not only the right thing to do, but is also important for our continuing reputation for honesty and integrity in all of our business and medical dealings with others. That reputation had been achieved and maintained through the integrity of our officers and employees, and it is one of our greatest assets; our success depends in large measure on the trust patients, government regulators, and the public places in us. A Compliance Program will help ensure that we are living up to this reputation and continue to deserve that trust.

Moreover, compliance with state and federal rules and regulations is essential because of our potential civil or even criminal liability if we were found to have violated the applicable legal standards. A governmental inquiry can result in very high financial exposure and damage to our reputation for honesty and integrity. Prevention is certainly the wiser business plan, and that is what our Compliance Program is designed to accomplish.

To be effective, however, a Compliance program must be a real part of an institution's culture, mission, and values. As a result, an institution must demonstrate that it is both committed to, and actually exercises, due diligence in seeking to prevent and detect violations of law.

To be considered effective, federal guidelines require that: (i) a Compliance Program must establish clear standards; (ii) the Program must be administered by a designated Compliance Officer; (iii) all positions involving significant discretionary decisions making must be filled by honest employees; (iv) there must be periodic employee training; (v) there must be continuous monitoring (i.e., audits) of the institution's billing and business systems; (vi) the Program must provide for an enforcement mechanism to deal with violations of the established standards; and (vii) the Program must respond effectively to such violations. Our Compliance Program is designed to satisfy all of these requirements.

C. Questions and Concerns. Even the most carefully constructed Compliance Program cannot cover every situation that our personnel might face. As a result, if you are unsure of what a proper course of conduct might be in a specific situation, or believe that the standards of conduct set forth in this Manual may have been violated, then you are urged to contact the Hospital's Compliance Officer or his designee at the number of address below. The Compliance Officer, who has been appointed by the Board of Directors, is the Senior Vice President of Administration, Kevin J. Murray. The Compliance Officer, in coordination with our Legal Counsel, is responsible for implementation of the Hospital's Corporate Compliance Plan, including the Code of Conduct. The Compliance Officer will work with others in the Hospital, as necessary, with respect to elements of implementation, including training and enforcement of this Code of Conduct. Any employee who has a question regarding the applicability or interpretation of the Code of Conduct should direct the question to the Compliance Officer at the following address and telephone number (which is available 24 hours per day via voice mail):

Kevin J. Murray, Corporate Compliance Officer
Senior Vice President of Administration
John T. Mather Memorial Hospital
75 North Country Road
Port Jefferson, NY 11777
Email: kmurray@matherhospital.org
Telephone (631) 476-2816

Mr. Murray may also be contacted via the dedicated Corporate Compliance hotline number:
(631) 686-7900

Employees may also contact the following individual with comments, questions or concerns regarding the Code of Conduct, or to report potential compliance problems:

Leo Sternlicht, Chairman
Corporate Compliance Committee
9 Rosita Lane
Port Jefferson, NY 11777
Email: lsternlicht@juno.com
Telephone (631) 642-2133

Any individual who has a question regarding the application or interpretation of the Code of Conduct should contact Mr. Murray or Mr. Sternlicht. All reported compliance issues will be investigated. You may raise the issue anonymously if you wish. There is a strict policy prohibiting retaliation against or intimidation of anyone who raises or reports a compliance issue in good faith.

STANDARDS OF CONDUCT

II. GENERAL PRINCIPLES.

A. The Hospital expects each employee to recognize and avoid activities and relationships that involve or might appear to involve conflicts of interest, and behavior that may cause embarrassment to the Hospital or compromise its integrity.

The following principles are intended to guide employees in recognizing these situations:

- The Hospital and its employees will abide by the letter and spirit of all applicable laws and regulations and will act in such a manner that the full disclosure of all facts related to any activity will reflect favorably upon the Hospital.
- The Hospital and its employees will adhere to the highest ethical standards of conduct in all business activities and will act in a manner that enhances the Hospital's standing as a vigorous and ethical contributor within the community.
- All personnel and affiliated practitioners will comply with the privacy and security requirements of the HIPAA regulations.
- The Hospital will deal fairly and honestly with those who are affected by our actions and treat them as we would expect them to treat us if the situation were reversed.
- The Hospital will undertake only those activities that will withstand public scrutiny and not pursue any course of action, which involves a violation of the law or these principles.
- The Hospital will promote relationships based on mutual trust and respect and provide an environment in which individuals may question a practice without fear of adverse consequences.
- No employee shall violate or authorize another employee to violate any Federal or State law. Any supervisor who fails to detect a subordinate's violation of the law shall be subject to disciplinary action.
- Each of us will abide by the Hospital's Conflict of Interest Policy, will disclose any potential conflict of interest we may have regarding our responsibilities to the Hospital's Compliance Officer and will remove the conflict as required.

We would expect outside colleagues, e.g. vendors, consultants and others whose actions could be attributed to the Hospital, to adhere to the same standards in their dealings with us and with others on our behalf.

B. Governance. The Board of Directors is responsible for overseeing the operation of the Compliance Program and ensuring that processes are in place so that the Hospital can operate in compliance with all federal and state laws, rules and regulations. The Board will maintain a direct reporting relationship with the Compliance Officer and receive appropriate reports from the Compliance Officer and senior management as to the operation of the Compliance Program, identification of potential issues, and the formulation of annual work plans.

C. Quality of Care. The Hospital is fully committed to providing the highest quality of patient care in accordance with all applicable laws, rules and regulations. Quality of care includes, but is not limited to, access to care, meeting recognized standards of care, preventing and addressing deficiencies in patient care, honoring patients' rights, and ensuring staff are qualified to provide patient care. As part of this commitment, the Hospital will ensure that necessary quality assurance systems are in place and functioning effectively.

D. Credentialing. The Hospital complies with all federal and state laws, rules and regulations governing the credentialing process. The Hospital has processes in place for the on-going and continuous credentialing, competency and licensure reviews of clinical and non-clinical staff. Complying

with credentialing requirements is a necessary component of the Hospital's commitment to providing appropriate quality of care to its patients.

E. Mandatory Reporting. The Hospital is committed to complying with all federal and state mandatory reporting laws, rules and regulations. To this end, the Hospital will ensure that all mandated adverse incidents are timely reported, and will monitor the Hospital's compliance with such requirements

III. STANDARDS RELATING TO QUALITY OF CARE

A. Generally. The Hospital is committed to providing the highest quality of care and services to our patients in accordance with all applicable laws, rules and regulations. As part of this commitment, we will ensure that necessary quality assurance systems and related functions are in place and proceed effectively, that quality-related data is collected and reported as required, and that the Hospital is engaged in continuous, pro-active quality improvement processes to address gaps in the current system and identify other areas for improvement.

1. Hospital personnel will honor the dignity and privacy of each of our patients and will treat them with consideration, courtesy and respect.
2. Hospital personnel will provide appropriate and timely care to all patients without regard to race, religion, age, gender, national origin, sexual orientation, disability or military status and without regard to the patient's insurance coverage.
3. The Hospital will provide reasonable accommodations and modifications for patients with disabilities.
4. The Hospital will protect and promote the rights of every patient, including, but not limited to, the patient's right to respect, privacy, a dignified existence, self-determination, and the right to participate in all decisions about their own care, treatment and discharge.
5. When a patient presents with an emergency medical condition, Hospital personnel will provide that patient with a screening examination and stabilization of any emergency condition in accordance with applicable laws, rules and regulations, regardless of the patient's ability to pay.
6. Patients will be transferred only after they have been medically stabilized and an appropriate transfer has been arranged.
7. The Hospital will ensure that patient care that conforms to acceptable clinical and safety standards.
8. The Hospital will ensure that patients are properly evaluated and treated by a qualified practitioner.
9. The Hospital will maintain complete and thorough records of patient information to fulfill the requirements set forth in our policies, accreditation standards and applicable laws and regulations.
10. The Hospital will support and promote a continuous quality and performance improvement program throughout the Hospital.
11. The Hospital will continuously strive toward a culture of patient safety and provide quality medical care to its patients.

B. Credentialing. The Hospital will ensure appropriate processes are in place for the on-going and continuous credentialing of clinical and non-clinical staff, including processes to ensure that such individuals are appropriately licensed, not excluded from participation in Medicare or Medicaid or otherwise sanctioned by any regulatory agency and are eligible and have the experience and expertise necessary to perform their duties. The Hospital's Medical Staff Office has policies and procedures in place for the ongoing and continuous credentialing and competency reviews of clinical and non-clinical staff.

As part of the Compliance Program, the Hospital's Compliance Officer, or other designated person, will communicate regularly with staff in the Medical Staff Office who are responsible for overseeing the

credentialing process. The Compliance Officer will validate that appropriate credentialing processes are in place and functioning effectively. In addition, the Compliance Officer will conduct periodic reviews to ensure that the Hospital complies with all federal and state laws, rules and regulations governing the credentialing process.

C. Licensure and Competency Requirements. The Hospital will screen all employed and/or contracted physicians and other providers who are reasonably expected to interact with patients or members of the public at the Hospital to ensure that they have not been sanctioned by any regulatory agency and are eligible to perform their designated responsibilities. In accordance with Hospital policies, the Hospital will routinely monitor such personnel to ensure that their licenses/registrations/certifications are current and that they are not included on the Federal Department of Health and Human Services' Office of Inspector General ("OIG") or New York State Office of Medicaid Inspector General's ("OMIG") list of excluded individuals, or the General Services Administration's ("GSA's") list of parties excluded from Federal programs. Such exclusion checks shall be performed and documented on a monthly basis.

The Hospital will not submit any claim for payment to any payor for services provided by a physician or other practitioner who it knows or has reason to know is not appropriately licensed or otherwise excluded from participation in any Federal or state health care program.

D. Mandatory Reporting. The Hospital will ensure that all incidents and events that are required to be reported under federal and state mandatory reporting laws, rules and regulations are reported in a timely manner.

As part of the Compliance Program, the Hospital's Compliance Officer, or other designated person, will communicate regularly with staff who are responsible for overseeing the reporting process. The Compliance Officer or his designee will validate that appropriate systems are in place for identifying and reporting incidents that require reporting. Personnel will be made aware of the types of matters that are required to be reported specific to their job functions and how they should be reported. In addition, all personnel of the Hospital, including physicians and Board members, will be made aware of the type of compliance-related issues or concerns that should be reported to the Compliance Officer, who shall determine whether such issues are required to be disclosed to the OIG and/or OMIG. Lastly, the Compliance Officer will conduct periodic reviews to monitor the Hospital's compliance with such requirements in connection with, but not limited to, the following:

1. The New York State Department of Health New York Patient Occurrence Reporting and Tracking System ("NYPORTS").
2. The Federal Drug Administration.
3. Elder abuse.
4. Child abuse.
5. State and local authorities for domestic violence, assaults and other reportable crimes.
6. National Practitioners Data Bank and/or New York State licensing board for misconduct and other events.

E. Medications. Many of the Hospital's employees have responsibility for or access to medications, controlled substances, and other regulated pharmaceuticals such as hypodermic needles. The Hospital is legally responsible for the proper distribution and handling of these pharmaceutical products. Federal, state and local laws covering medications and controlled substances are intended to maintain the integrity of our national drug distribution system and protect consumers by assuring that medications are safe and properly labeled.

These laws include prohibitions against diversion of any medications or controlled substances, in any amount for any reason to an unauthorized individual or entity. The distribution of an adulterated,

misbranded, mislabeled, expired or diverted pharmaceutical is a violation of federal and state law for which severe criminal penalties may be imposed on individual violators as well as on the Hospital.

It is the Hospital's policy that all employees be both diligent and vigilant in carrying out their obligations to handle and dispense the Hospital's medications and controlled substances in accordance with all applicable laws, regulations and Hospital procedures. These Hospital procedures and policies are available in written form from the Pharmacy Department, the Nursing Department and the Medical Board. Every professional employee, whether physician, nurse, pharmacist or any other licensed individual authorized to prescribe, dispense, or handle medications or controlled substances, is expected to maintain the highest professional standards in safeguarding pharmaceuticals of all kinds and in preventing unauthorized access to them. This includes adherence to laws and regulations governing procedures, for securing scheduled controlled substances and for their return or destruction.

No medications or controlled substance may be sold, transferred or otherwise distributed unless authorized by a written Hospital policy or the appropriate Hospital individual charged with such responsibility. Nonprofit hospitals, including this Hospital, are permitted by a specific exception to the federal anti-trust and price discrimination laws to purchase medications at a specially discounted price, if certain conditions are met. However, the medications dispensed by the Hospital pharmacy are restricted by law to the Hospital's "own use" as defined by law. In general, the exemption permits dispensing these medications to hospital employees, volunteers and staff physicians for their personal use or for the use of their dependents, but not to others such as non-dependents, subject to compliance with applicable legal requirements. Medications may also be dispensed to outpatients, as prescribed, to continue the care initiated by the Hospital.

Any violation of any law or of any Hospital policy involving prescription drugs, controlled substances or other pharmaceuticals may constitute grounds for dismissal. Each employee is expected to protect the integrity of the Hospital by safeguarding the drugs entrusted to us for appropriate institutional medical use. If you become aware of any potential lapses in security, or any actual infringement of any law, policy or regulation relating to drugs, you must advise your supervisor and the Compliance Officer immediately.

IV. STANDARDS RELATING TO CODING, BILLING AND PROVIDING SERVICES

A. Medical Necessity for Services and Tests. The Hospital will submit claims to Medicare or Medicaid (or any other federally funded health care program) only for services that were medically necessary or that otherwise constituted a covered service. Medical necessity will be determined individually for each service or test provided or ordered by the responsible practitioner. A medically necessary service or test is defined as one that is reasonable and necessary for the diagnosis or treatment of an illness, injury, or to improve the functioning of a malformed body member. 42 U.S.C. 1395y(a). The government will generally only pay for services and tests that are medically necessary and will deny payments for those that are not necessary, such as routine physicals, many screening tests, or tests conducted for research purposes.

B. Billing-Generally. Only those medical services to patients that are consistent with acceptable standards of medical care may be billed. The Hospital only bills for the actual services rendered, and only when those services were consistent with accepted standards of medical care. The billing for such services must comply with all applicable rules and regulations governing correct documentation, coding and billing.

1. **Adequate Documentation.** Billing must always be based on adequate documentation of the medical justification for the service provided and for the bill submitted, and this medical documentation must comport with all applicable regulations. A bill may not be submitted to a payor if the

documentation of the nature or scope of the service is unclear or if it is otherwise unclear what the appropriate code is.

2. **Correct Coding and Grouping.** In addition, DRG, APC, CPT-4, HCPCS and ICD-9-CM or ICD-10 codes (or any succeeding ICD coding number, as applicable) should never be selected only on the basis of whether the given code or group guarantees payment. Billing may never be based on a “default” to a particular code. Rather, only those codes that correspond to the service rendered and documented should be selected.

It is also strict policy that no personnel associated with the Hospital knowingly engage in any form of upcoding of any services in violation of any law, rule, or regulation. All federal and state regulations governing billing procedures will be meticulously followed. The Hospital does not provide financial incentives to physicians, providers, employees, or outsiders to upcode claims.

3. **Accurate and Truthful Billing.** All billing must be accurate and truthful, and no personnel should ever misrepresent charges to, or on behalf of, a patient or third-party payor. The Hospital bills only for those services that were actually and appropriately rendered. False statements or intentional omissions of material information by any personnel to a government agency or other payor will not be tolerated. Deliberate misstatements to government agencies or other payors will expose the personnel involved to termination and criminal penalties. Therefore, all personnel are expected to adhere to the Hospital’s policy entitled “Compliance with Federal and State False Claims Acts,” as set forth in Section XVII (C) below.

All personnel, moreover, must avoid not only intentional misstatements, but reckless ones as well. It is, of course, illegal to intentionally falsify billing documents submitted to the government or private insurance companies. It is also illegal, however, to supply false information with either a deliberate ignorance or a reckless disregard of its falsity or truth. Thus, if personnel have any question as to the truth or accuracy of the documentation for billing purposes, or if there is material information that is missing, the bill for the services in question must be held until the uncertainties are resolved. Anything less can result in over billing and is strictly prohibited.

V. STANDARDS RELATED TO HOSPITAL BILLING

A. **Correct Coding.** All federal and state regulations governing billing procedures will be meticulously followed, and all personnel responsible for billing will be trained in the appropriate rules governing billing, coding, and documentation as it relates to their job function.

If the documentation in the medical record is unclear, then billing personnel – whether employees of the Hospital or employees of an outside billing service – must request clarification or additional information from the physician or provider of services. This includes when the appropriate code or diagnosis is unclear. Billing personnel cannot create coding or diagnostic information based on their own interaction with the patient, from information provided from an earlier date of service, or based on what they might conclude is the probable or most likely diagnosis.

B. **Billing for Hospital Inpatient, Outpatient and Ambulatory Surgery Services.** It is the Hospital’s policy that medical records for inpatient services, Ambulatory Surgery, and outpatient services will be coded as accurately and correctly as possible. All coding will be based upon the appropriate documentation in the medical record and upon the appropriate and most current coding guidelines, as set forth in the Health Information Management Department’s internal coding procedures and guidelines, the Coding Clinic, the CPT-4, ICD-9 or ICD-10 code (or any succeeding ICD coding number, as applicable) and APC guidelines, and any relevant coding bulletins and updates received by the Hospital.

C. Training and Coding Updates. All coders will be fully trained in how to read, review and appropriately code medical records. All new coders will be given continual feedback as to their performance and the accuracy of their coding.

On a periodic basis, all coders will also attend training sessions, seminars, and workshops provided by organizations outside the Hospital on proper coding practices, on the governing rules and regulations, on recent developments in the coding guidelines, and on other appropriate subject matters. Coding staff who attend the training sessions will in turn provide training to all applicable coding staff, in conjunction with the Coding Supervisor or Director of Health Information Management.

All coders will also be informed of all updates and modifications to the Coding Clinic, all other relevant coding guidelines, and will be kept abreast of all bulletins and other relevant communications from the state and federal government on documentation, coding, and billing requirements. The Director of the Health Information Management or Coding Supervisor will be responsible for reviewing both the yearly revisions to the Coding Clinic and the CPT-4 guidelines, as well as all incoming bulletins and communications. The Director will ensure that the Department's internal coding guidelines and coding policies and procedures are revised or updated accordingly; and, in conjunction with the Director of HIM or Coding Supervisor, the Director will then distribute all updates to all relevant staff and conduct training sessions at staff meetings, or on a more formal basis, to improve coding accuracy and to ensure that all personnel understand any changes in the documentation, coding and billing requirements.

D. Billing Rules for Hospital Lab and Other Hospital Out-Patient Diagnostic Testing. As part of the Compliance Program, separate compliance protocols have been issued for the clinical laboratory and those departments of the Hospital that bill for outpatient testing. These protocols contain standards of conduct and compliance procedures. A few of the key standards of conduct set forth in these protocols are as follows:

1. ***Bill Only for Tests that Were Actually Ordered and Conducted.*** The Hospital will bill only for tests that were ordered by a practitioner and actually conducted. If a test is ordered, but is not performed for any reason, then no bill for the test may be submitted to any third-party payor. Tests should be performed only when there is a clear order from the patient's practitioner and there is no reason to believe that the test is not medically necessary.

2. ***Medical Necessity for Tests.*** Although it is ultimately the ordering practitioner's responsibility to determine whether a test is medically necessary or not, we should not submit claims to Medicare or Medicaid (or any other federally funded health care program) that we have reason to believe are not, in fact, medically necessary. All of our ordering procedures - from requisition design to our interactions with the ordering practitioner - must be designed to encourage ordering practitioner's or other health care providers to order only medically necessary tests for which reimbursement will be sought from the government.

3. ***Submitting Claims for the Purpose of Receiving a Denial.*** Denials may sometimes be required in order for a patient to seek reimbursement from a secondary insurer. In instances where a claim is being submitted to Medicare for this purpose, billing personnel must indicate on the claim that it is being submitted for the purpose of receiving a denial in order to bill a secondary insurer, and will use appropriate modifiers, as required by Medicare. If a carrier pays such a claim even though the service is non-covered and the Hospital did not intend for payment to be made, the amount paid must be immediately refunded with an explanation that the service is not covered.

VI. STANDARDS RELATING TO EMERGENCY TREATMENT

A. Medical Screening. The Hospital will provide an appropriate medical screening examination to each person who comes to a dedicated emergency department of the Hospital with any medical condition, and to any person on Hospital property who exhibits a condition which a prudent layperson would believe may be an emergency medical condition, to determine whether the individual has an emergency medical condition. The Hospital will provide an appropriate medical screening examination to determine whether or not an individual requesting such an examination has an emergency medical condition. The screening process will be conducted in a non-discriminatory manner, and will not provide a different level of care based on the patient's payment status, race, sex, national origin, or other suspect classification. Nor will the screening examination or stabilizing treatment be delayed by inquiring about the patient's ability to pay for care. Rather, based on the patient's presenting symptoms, the screening examination will be reasonably calculated to determine in a timely manner whether an emergency medical condition actually exists.

B. Admission, Transfer or Discharge. If the examination reveals that an emergency medical condition does exist, the patient will be given treatment to stabilize that condition or will be transferred to another hospital. Such a transfer will occur only if the patient requests the transfer or the medical benefits to be expected from the transfer outweigh the risks associated with the transfer, and if the transfer is otherwise made in an appropriate manner as required by federal law. If admission to the Hospital is necessary, the patient will be admitted unless the treatment required by the patient is outside the scope of services offered by the Hospital, the patient refuses admission, or the patient requests transfer to another facility. In such instances, the patient will either be discharged or transferred, as appropriate, but only after the patient's emergency medical condition has been stabilized.

VII. OTHER BILLING PRACTICES

In addition to complying with federal and state documentation and coding practices, the Hospital will also provide and bill for services in compliance with federal and state rules concerning such matters as waiver of coinsurance, billing Medicare patients for non-covered services, providing professional courtesy to other physicians or providers, and collecting appropriate information concerning primary and secondary insurance.

A. Waiver of Coinsurance. It is illegal to offer remuneration - defined to include a waiver of coinsurance and deductible amounts - to a patient to induce that patient to order an item or service for which payment may be made under Medicare or Medicaid. A waiver is appropriate only if the patient has a documented financial need. As a result, the Hospital will not waive any patient's coinsurance unless the patient has an actual financial need and that need is documented in an appropriate record. Otherwise, all patients will be billed pursuant to normal procedures for the coinsurance; the coinsurance will then be written off to bad debt only if the normal procedures have failed to result in collection of the coinsurance.

B. Professional Courtesy. Providing professional courtesy discounts to other physicians or their families or patients are not prohibited if they are provided only as a true "courtesy" on an occasional or limited basis, without regard to the physician's referral of patients to the provider or other business between the parties. The practice of providing such discounts is problematic, however, if they are provided, even in part, in consideration of a physician's referrals or to induce future referrals.

In compliance with these general rules, the Hospital has a Board approved policy and procedure for "Professional Courtesy Discounts for Members of the Medical Staff". Pursuant to this policy the hospital will offer professional courtesy discounts only as a true courtesy and never as an inducement or reward for referrals. If the professional courtesy involves any whole or partial waiver of any coinsurance obligation, the Hospital will provide the insurer with written notification of that reduction. The courtesy

will not include the waiver of any Medicare co-insurance or deductible amounts, unless there has been a good faith showing of financial need and that need has been appropriately documented. This policy applies to any physician on the medical staff and their immediate family members. The "immediate family" of a physician includes his or her legally married spouse or dependent children until the age 19 (age 23, if full-time student).

C. Waivers from Patients. If, in an outpatient setting, an employed practitioner deems it clinically appropriate to order a test or perform a service that Medicare may find to be medically unnecessary and thus not reimbursable, the patient should complete and sign a Medicare "Advance Beneficiary Notice." This notice informs the patient that the test may not be covered by Medicare and that he or she thus may be liable for paying for the test. In cases in which medically unnecessary tests are performed for a Medicare patient, the patient generally may not be billed for the service without such a Notice having been completed.

D. Collecting Insurance Information. Medicare requires that all providers must bill other primary payors before billing Medicare and must maintain a system that is reasonably designed to identify payors other than Medicare, so that incorrect billing and Medicare overpayments can be prevented. As a result, the Hospital has instituted such procedures, for both inpatients and outpatients, in compliance with applicable Medicare rules, and will make appropriate efforts as to all patients to determine who the primary or secondary payors are and to bill accordingly.

E. Retention of Records. All billing records that demonstrate the Hospital's right to receive payment from third-party payors, and all medical and other records that disclose the nature and extent of services furnished and the medical necessity for those services, will be retained according to the Hospital's record retention requirements.

F. Compliance with Licensure and Competency Requirements. All physicians and other providers employed by the Hospital will be properly licensed pursuant to applicable state requirements, and the Hospital will take steps on a regular basis to ensure each compliance with state requirements and basic competency. The Hospital will not submit any bill to a third party payor for services provided by a physician or other provider who is not properly licensed.

VIII. STANDARDS RELATING TO BUSINESS PRACTICES

A. Business Practices. The Hospital will forego any business transaction or opportunity that can only be obtained by improper and illegal means, and will not make any unethical or illegal payments to anyone to induce the use of our services.

1. **Business Transactions.** Business transactions and joint ventures with other health care providers will be aimed at enhancing the quality or continuity of care provided to patients. Financial investments in such transactions and ventures, and any return on investments, will be based on the bona fide financial value of the investment and its positive impact on the Hospital's ability to deliver medical services. Such investments will not be based on an intent to induce or reward referrals to or from another provider.

In the course of the Hospital's business practices, personnel must deal with a variety of individuals, companies, organizations, and governmental agencies. In those dealings, all personnel must never make any misrepresentations, dishonest statements, or statements intended to mislead or misinform. If it appears that anything you have said has been misunderstood, correct it promptly.

2. **Business Records.** In addition, management must ensure that all business records are accurate and truthful, with no material omissions; that the assets and liabilities of the Hospital are

accounted for properly in compliance with all tax and financial reporting requirements, and that no false records are made. Similarly, all reports submitted to governmental agencies, insurance carriers, or other entities will be accurately and honestly made.

3. **Cost Report.** Finally, the institutional cost report will be prepared in compliance with all applicable state and federal regulations. Costs will be claimed when based on appropriate and accurate documentation; unallowable costs will not be claimed for reimbursement; and all costs will be properly allocated to the appropriate cost centers based on verifiable information and data.

B. Purchasing and Competitive Bidding Policy. All purchasing decisions must be made with the purpose of obtaining the highest quality product or service for the Hospital or its patients at the most reasonable price. No purchasing decision may be made based on any consideration that any employee, officer or board member - or any family member or friend of any of them - will benefit by the transaction. Rather, the sole criteria behind all purchasing decisions must be only the best interests of the Hospital (see also the section below on Conflict of Interest Rules). Nor can any service or item be purchased in return for a referral of patients from another or with a view towards inducing another to refer patients (See also the rules governing Marketing Activities and Patient Referrals set forth below).

In purchasing items or contracting for services, the Hospital's competitive bidding and pricing rules must be followed.

C. Payments and Gifts. No personnel will engage, either directly or indirectly, in any corrupt business practice, including bribery, kickbacks or payoffs, intended to influence or reward favorable decisions of any patient, physician, government representative, contractor, vendor, or any other person in a position to benefit the Hospital or the employee in any way.

1. **Giving Payments or Gifts.** No personnel will make or offer to make any payment or provide any other thing of value to another person with the understanding or intention that such payment is to be used for an unlawful or improper purpose. Cash gifts to physicians or other referral sources are strictly prohibited. Gifts of even nominal value may not be offered to any governmental official. Such gifts can be misinterpreted as an attempt to improperly influence the official and are absolutely prohibited.

2. **Accepting Payments or Gifts.** It is prohibited for any personnel to accept gifts, gratuities, loans, or other favors with a fair market value in excess of \$75 from any vendor, contractor, individual, or concern that does (or is seeking to do) business with, or is a competitor of, the Hospital. Gifts or gratuities of any value are also prohibited under circumstances from which it could be inferred that the gift was meant to induce the personnel to act in an official capacity for his or her own benefit, and not solely for the benefit of the Hospital. Gifts of cash or cash equivalents are strictly prohibited.

Personnel, as they may be authorized, may provide or receive ordinary and reasonable business or social entertainment consistent with acceptable industry standards. Such business or social entertainment cannot be provided or received for the purpose of influencing the business behavior of the recipient. Any business or social entertainment received, inconsistent with industry standards, under circumstances from which it could be inferred that judgment or actions on behalf of the Hospital was improperly influenced, must be reported to the Compliance Officer.

If personnel are in doubt as to whether a gift, gratuity, business entertainment or social entertainment falls within the proper application of this manual and whether disclosure is required in a specific instance, they should err on the side of disclosure and immediately make all the facts known to the Compliance Officer.

Any questions regarding whether or not an item or situation falls within the scope of this policy must be raised immediately with your supervisor or the Compliance Officer.

D. Grants. From time to time, Hospital personnel and departments receive grants from government agencies, private industry, and various philanthropies to conduct research or other projects in association with the Hospital. While the receipt of such money is to be encouraged in appropriate cases, the receipt and use of grants must be subject to adequate safeguards to ensure that an appearance of impropriety, or actual impropriety, is not created.

The receipt and use of all grant money at the Hospital must be pre-approved by senior management. As part of this pre-approval process, the appropriateness of the proposed research or project will be reviewed, and a system of tracking the use and allocation of the grant money will be put into place. This system will ensure that the money is being used in conformity with the requirements of the grant and in a manner consistent with the policies of the Hospital, the needs of its patients, and the scope of the personnel's employment with the Hospital.

The receipt, or continued receipt, of the grant money must occur under conditions which do not create an appearance that the judgment of Hospital personnel will be adversely affected, so as to place their own interest, or that of an outside concern, above that of the Hospital and its patients. Grant money should not be accepted in return for the promise or expectation that the Hospital or any of its personnel will purchase specific services or supplies from a particular company. The Hospital does not accept remuneration as an inducement to purchase any services or items and even the appearance that remuneration is being accepted for that purpose must be assiduously avoided.

If a grant is provided in order to test, develop, or use equipment or supplies from a particular manufacture or supplier, then the terms and conditions of that grant will be subjected to close scrutiny during the pre-approval process. In addition, any subsequent purchase of such equipment or supplies must also be subjected to close review to ensure that the judgment of the Hospital personnel involved with the grant has not been compromised and that the purchase is otherwise in the best interest of the Hospital and its patients. In such instances, those personnel directly involved in the receipt and use of the grant money will take no part in the final determination as to the proposed purchase.

E. Credit Balances. On a periodic, regular basis, the Hospital will generate reports of the status of any credit balances of refunds owing to Medicare, other third-party payors and self-pay patients. Such refunds will then be made to the appropriate payor in a timely and reasonable manner.

IX. STANDARDS RELATING TO REFERRALS

A. Compliance with Federal and State Anti-Referral Law. The Hospital does not pay incentives to any personnel based upon the number of persons admitted for treatment or the value of services provided. Nor does the Hospital pay physicians, or anyone else, either directly or indirectly, for patient referrals. The decision to refer patients is a separate and independent clinical decision made by the referring physician or health care provider. Federal and state law make it unlawful to pay any individual on the basis of the value or volume of referral of patients. This includes the giving of any form of remuneration, including virtually anything of value, in return for a referral.

The Hospital also does not accept any form of remuneration in return for referring our patients to other health care providers. Rather, in discharging patients and referring them to other providers, it is the Hospital's policy: (i) that such referrals will be based on the patient's documented medical need for the referred service and the ability of the referred provider to meet that need; and (ii) that the patient's freedom to choose the provider is at all times respected and honored.

The federal and state Anti-Kickback statutes make it a crime to give or receive any remuneration (which is broadly defined to include money, goods, and services) in exchange for a referral or as an inducement to provide health care services paid for by Medicare or Medicaid. The physician self-referral laws (the

“Stark” laws) forbid referrals between physicians and health care entities which have certain prohibited financial relationships. Under the Stark laws, a physician cannot refer patients to entities furnishing “designated health services,” which are payable under Medicare or Medicaid, if the physician or his or her immediate family members have a financial interest in that entity. A prohibited financial relationship includes both an ownership or investment interest and any compensation arrangement.

B. Relationships with Other Healthcare Providers. In compliance with these laws, all contracts, leases, and other financial relationships with other healthcare medical providers who have a referral relationship with the Hospital will be based on the fair market value of the services or items being provided or exchanged, and not on the basis of the volume or value of referrals of Medicare or Medicaid business between the parties.

The Hospital will not engage in any practice that violates the anti-referral laws or tend to create an appearance of illegality or impropriety, including but not limited to:

1. **Free Services.** Providing free services or items to, or accepting such services or items from, another provider with whom there is a referral relationship;
2. **Above Fair Market Value.** Paying or charging excessive amounts above fair market value to another provider for the provision of equipment, space or personnel services;
3. **Below Fair Market Value.** Paying or charging amounts below fair market value to another provider for the provision of equipment, space or personnel services;
4. **Joint Ventures.** Entering into joint ventures with other providers or facilities for which applicable Safe Harbors or Exceptions under the anti-referral laws do not apply, or pursuant to which benefits are conferred on one party in a manner that could be interpreted as an inducement to refer.

Thus, for instance, the Hospital will not provide: excessive payments for medical directorships; free services to physicians who otherwise have a financial relationship with the Hospital; free or below market rents or fees for administrative services; interest-free loans; or excessive payment for intangible assets in a physician practice acquisition.

All contracts, leases, and other financial relationships with providers with whom the Hospital has a referral relationship will be reviewed to ensure compliance with the federal and state Anti-Kickback and Stark Laws, and compliance with any applicable Safe Harbor or Exception under those laws.

C. Marketing Activities. All marketing activities and advertising by personnel must be based on the merits of the services provided and not on any promise, express or implied, of remuneration for referrals.

In addition, all marketing activities and advertising must be truthful and not misleading, and must be supported by evidence to substantiate any claims made. In this regard, the Hospital’s best advertisements are the quality of the medical services we provide, including clinical diagnostic testing. No personnel should disparage the service or business of a competitor through the use of false or misleading representations.

X. GOVERNMENT INQUIRIES

A. Speaking with Government Agents. Personnel may speak voluntarily with government agents, and the Hospital will not attempt to obstruct any government inquiry or prevent any Hospital personnel from speaking with government agents, should the personnel desire to do so. It is

recommended to all personnel, however, that before speaking with government agents, they contact their supervisor, the Compliance Officer or his designee first.

B. Responding to Subpoenas and Requests for Documents. In no event, however, may any personnel respond to a request to disclose documents that are the property of the Hospital without first speaking with their supervisor and receiving approval from Administration. As a general matter, any personnel who receive a governmental request for information, a subpoena, or any other inquiry or legal document regarding the Hospital's business should notify his or her supervisor and request specific direction from Administration as to a response before attempting to make a reply. The Hospital's policy for receipt of subpoenas should be adhered to and the Compliance Officer must be notified of any request received from government agencies dealing with compliance issues. The Compliance Officer will notify legal counsel.

C. Accurate and Complete Responses. If a response is given to a request for information from government regulatory agencies, the response must be accurate and complete. It is the Hospital's policy to comply with the law and to cooperate with reasonable demands made during the course of a legitimate governmental investigation or inquiry.

D. No Destruction of Records or Evidence. No Hospital personnel are to destroy, alter or change any Hospital records in response to a request for such records. Such action will subject the personnel to immediate discharge and possible criminal prosecution.

XI. SCOPE AND APPLICATION OF STANDARDS TO PERSONNEL AND OTHERS

A. Personnel Covered. The Hospital Compliance Program, including the standards set forth in this Code of Conduct and the Compliance Procedures set forth in this Manual, apply to all personnel employed by or associated with the Hospital.

B. Other Compliance Protocols. In addition to the Code of Conduct and Compliance Procedures set forth in this Manual, certain of the Hospital's departments may, from time to time, adopt department-specific compliance policies and procedures. These additional policies and procedures, to the extent adopted, will become an integral part of the Compliance Program and will be designed to compliment the procedures and standards set forth in this Manual.

C. Compliance Responsibilities.

1. ***Responsibility of the Board.*** The Hospital's Board of Directors is responsible for overseeing the operation of the Compliance Program and ensuring that processes are in place so that the Hospital can operate in compliance with all federal and state laws, rules and regulations. The Board maintains a direct reporting relationship with the Compliance Officer and receives appropriate reports from the Compliance Officer and senior management as to the operation of the Compliance Program, identification of potential issues, and the formulation of annual work plans based on appropriate risk assessments. All Board members will receive periodic training, either on an informal or formal basis, as to basic compliance principles (including a review of the fraud and abuse laws and regulations), the Board's responsibilities and the specific risk areas that need to be addressed by the Compliance Program.

2. ***Responsibility of All Employees.*** All employees are expected to comply and be familiar with all federal and state laws, rules, and regulations that govern their job at the Hospital. All employees are also expected to comply with this Code of Conduct, compliance standards and procedures set forth in this Manual, and any applicable compliance standards and policies maintained by their respective departments. Employees must, upon new hire and annual orientation, sign and date an acknowledgement

that they received a copy of the Code of Conduct and Compliance Manual and training on the Compliance Program and false claims acts.

3. ***Responsibilities of Department Heads, Supervisors and Managers.*** All department heads, supervisors and managers have the responsibility to help create and maintain a work environment in which ethical concerns can be raised and openly discussed. They are also responsible to ensure that the personnel they supervise understand the importance of this Code of Conduct and the Compliance Program; that these personnel are aware of its provisions and of the procedures for reporting suspected unlawful activity (set forth in the next Part of this Manual); and that all personnel are protected from retaliation and intimidation if they come forward with information about suspected wrongdoing.

4. ***Responsibilities of Contractors and Other Providers.*** All persons and entities with which the Hospital contracts will receive a copy of the Hospital's Code of Conduct and Compliance Program Summary and will be asked to cooperate with the Hospital's Compliance Program. This includes individual physicians, physician groups, vendors, contractors, and other healthcare providers.

D. Raise Compliance Issues. If any personnel believe that this Code of Conduct or any applicable legal rules were or may have been violated - or has a question about a compliance issue - they should raise their concern with their supervisor, with the Hospital's Compliance Officer or his designee.

E. Review of These Compliance Policies and Procedures. All personnel will be expected to read and understand this Compliance Manual, or a summary of it and to review it periodically. The Compliance Officer, through the Human Resources Department, will ensure that it is distributed to all appropriate personnel and that new personnel receive a copy along with a training session.

COMPLIANCE POLICIES & PROCEDURES

This section of the Manual summarizes the rules under which the Compliance Program will operate. To be effective, a Compliance Program must provide for the following: continued reporting of issues or possible violations of the Code of Conduct to the Compliance Officer or her/his designee; enforcement of the Code through the promulgation of disciplinary procedures; continued, periodic reviews and self-audits of our business practices; and implementation of modifications in the Compliance Program, as necessary, to prevent future violations. Rules and procedures as to each of these topics are set forth below.

XII. COMPLIANCE PERSONNEL

A. Compliance Officer. A Compliance Officer, Kevin J. Murray, has been appointed to run the day-to-day operations of the Compliance Program and will be assisted, as necessary, by outside compliance counsel. The Compliance Officer is responsible for ensuring that compliance issues are properly addressed as they arise and that appropriate compliance assurance reviews, audits, and inquiries are conducted.

The Compliance Officer will have the authority to review all documents and other information that are relevant to compliance activities including, but not limited to, patient records, billing records, records concerning marketing efforts, and records of arrangements with other parties. The Compliance Officer should also be informed of, and have access to, all information concerning any overpayments made to the institution and all pertinent audits, reviews, or investigations by any state or federal governmental agency.

The Compliance Officer will report directly on compliance matters to the President/CEO and to the Corporate Compliance & Audit Committee of the Board of Directors, and will work with the Hospital's Compliance Committee.

B. Coding Supervisor. A Coding Supervisor has been appointed who will work with the Compliance Officer. The Coding Supervisor will work primarily with coding, documentation and billing issues and will conduct regular Compliance Assurance Reviews.

C. Hospital Compliance Committee. A Hospital Compliance Committee composed of Senior Management, Administration, Management and Supervisory Staff has also been formed. This Committee works with the Compliance Officer and Coding Supervisor and is responsible for ensuring the hospital adheres to the standards set forth in the Compliance Program, and assists the Compliance staff in reviewing compliance issues and implementing appropriate corrective action.

D. Corporate Compliance & Audit Committee of the Board of Directors. A Corporate Compliance & Audit Committee, composed of at least three (3) members of the Board of Directors, has also been formed. This Committee receives reports from the Compliance Officer and Hospital Compliance Committee, oversees the operation of the Compliance Program and ensures that the Board of Directors is kept informed concerning the operation of the Program, all as more fully set forth in the Corporate Compliance & Audit Committee Charter.

E. Reporting. The Compliance Officer will report directly to the President and Chief Executive Officer of the Hospital, and on a periodic basis, will report to the Hospital's Board of Directors. The Compliance Officer will also attend all meetings of the Corporate Compliance & Audit Committee, and make an annual report to such committee as required by the Corporate Compliance & Audit Committee Charter. The Compliance Officer will keep all such parties informed about: the compliance efforts that have taken place; specific compliance issues; and any changes to the Compliance Program that can be made to improve compliance.

F. Modification and Revision of Compliance Procedures and this Manual. On a periodic basis, the Compliance Officer will review and evaluate the effectiveness of the operation of the Compliance Program, as set forth in this Manual. Based on such reviews, the Compliance Officer will then recommend to the Compliance Committee of the Board of Directors appropriate modifications of, or revisions to, the compliance procedures or this Manual.

XIII. RISK ASSESSMENT AND ANNUAL WORK PLAN

A. Risk Assessment. The Hospital has a process in place to conduct periodic assessments of the compliance risks that potentially face the Hospital. This process requires the Compliance Officer, or other designated person, to conduct compliance assurance monitoring (reviews/audits) of potential compliance risk areas. Risks identified during the risk assessment process will be incorporated into the annual work plan for the following year.

B. Annual Work Plan. The Compliance Officer, with the assistance of compliance personnel and the Hospital Compliance Committee, will produce an annual work plan to the Compliance Committee of the Board of Directors that addresses the changing government priorities and the Hospital's operations, as well as any compliance issues identified through the Hospital's risk assessment process and routine compliance assurance monitoring and audits conducted during the prior year.

XIV. REPORTING COMPLIANCE ISSUES

A. Reporting and Complaint Procedures. All personnel should raise any question they might have about potentially unethical or illegal conduct with the Compliance Officer or the Coding Supervisor. Moreover, even if personnel merely have a general question about the propriety of conduct, they should still reach out to the Compliance Officer or her/his designee for guidance. Obviously, it is

preferable that questions about a potentially troublesome issue be raised before the issue becomes a legal problem.

B. Confidential Reporting of Compliance Issues. A "Compliance Hotline" has also been set up, and may be reached at (631) 686-7900. This Hotline is composed of a dedicated voice-mail telephone line monitored by the Compliance Officer. In addition to raising questions directly with the Compliance Officer or his designee, all personnel may leave a message with the Compliance Officer's voicemail to report possible violations, ask questions, or raise compliance concerns. Compliance issues and concerns may also be reported to Leo Sternlicht, Chairman of the Board Compliance Committee, at (631) 642-2133.

A report or question may be raised anonymously, if personnel choose, and will be held in the strictest confidence possible, consistent with the need to investigate any allegations of wrongdoing. To the extent possible, the Compliance Officer and his designee will not disclose the identity of anyone who reports a suspected violation of law or who participates in an investigation. All personnel should be aware, however, that the Compliance Officer and compliance counsel are obligated to act in the best interests of the Hospital and do not act as the personal representative or lawyer for employees.

C. Retaliation and Intimidation is Prohibited. Retaliation and intimidation in any form against an individual who in good faith reports possible unethical or illegal conduct is strictly prohibited and is itself a serious violation of the Code of Conduct. In addition to the Hospital's policy against retaliation and intimidation, federal law grants individuals who report certain conduct (i.e., submission of intentionally false claims for reimbursement from the Government) certain protections. These protections are spelled out in the Hospital's policy entitled "Compliance with Federal and State False Claims Acts." Acts of retaliation or intimidation should be reported to the Compliance Officer immediately and will be disciplined appropriately.

XV. INVESTIGATIONS, CORRECTIVE ACTION AND DISCIPLINE

A. Investigation. Upon receiving a report of possible unethical or illegal conduct, or of a pattern of possible improper billing, the Compliance Officer or Coding Supervisor will bring such report to the attention of senior management, the Compliance Committee of the Board of Directors and/or will contact compliance counsel.

The Compliance Officer will then work under the supervision and direction of outside compliance counsel, as necessary, to conduct an investigation and take all necessary and appropriate actions. All personnel are expected to cooperate in such investigations.

The objective of such an inquiry will be to determine whether, first, a compliance issue exists or there has been a violation of the Code of Conduct or applicable legal rules. If an issue or violation does exist, then the inquiry will attempt to determine its cause, so that appropriate and effective corrective action can be instituted.

In addition, for reports that include possibly improper billing or related issues, the investigation may also include selecting for review a small, random sampling of bills, along with the supporting medical documentation. Only bills that have not been submitted for payment and are being processed within the institution will be selected. If the review of these bills warrants, the sample will be expanded to additional bills that have not been submitted for payment, so that the extent of any problem can be more accurately assessed.

During these reviews, any bills that appear to be improper or inadequate will be held and not submitted for payment until all questions regarding them have been resolved. If it is determined at the conclusion of

the inquiry that any bills were submitted in error to the government or any other payor, any payments received will be refunded.

B. Corrective Action and Responses to Suspected Violations. Whenever a compliance problem or billing error is uncovered, regardless of the source, the Compliance Officer will ensure that appropriate and effective corrective action is implemented. Such problems might include, for instance, evidence that the Hospital is billing for services or procedures that were not performed or ordered, instances of double billing, use of improper codes, or suspect financial relationships with physicians or providers who refer patients to the Hospital. In discharging this responsibility, the Compliance Officer will work in consultation with senior management, the Department Chairperson, and compliance counsel, among others, as appropriate.

Any corrective action and response implemented must be designed to ensure that the violation or problem does not reoccur (or reduce the likelihood that it will reoccur) and be based on an analysis of the root cause of the problem. In addition, the corrective action plan should include, whenever applicable, a review of the effectiveness of the corrective action following its implementation. If such a review establishes that the corrective action plan has not been effective, then additional or new corrective actions must be implemented. Corrective actions may include, but are not limited to, the following:

1. Informing and discussing with the offending physician, billing personnel, or other staff members both the violation and how it should be avoided in the future;
2. Providing remedial education (formal or informal) to ensure that they understand the applicable rules and regulations;
3. Conducting a follow-up review to ensure that the problem is not recurring;
4. Having personnel go through a cycle or cycles of remedial education and focused audits;
5. Imposing discipline, as set forth below;
6. Suspending all billing of the services provided by a physician or provider, as set forth below;
7. Refunding any past payments that resulted from improper bills; and
8. Voluntarily disclosing to an appropriate governmental agency.

If it appears that a larger, systemic problem may exist, then possible modification or improvement of the Hospital's compliance or billing practices will be considered. Such action might include, for instance, creating new procedures, or modifying existing procedures, so as to ensure that similar errors will not reoccur in the future. Possible changes or additions to procedures will be reviewed with senior management and - if necessary - with the Board of Directors.

Other corrective actions that may be considered might also include working with a specific department to formulate new or revised policies or procedures for that department, and conducting formal or informal training on specific issues for an entire department.

C. Corrective Action and Discipline Following Compliance Assurance Reviews. Should a Compliance Assurance Review of the medical records prepared by a physician or provider identify non-compliance in the manner in which that person documented, coded, or billed for any service, the physician or provider will be required, as necessary, to attend remedial training sessions and be subject to a follow-up focused review. If the results of the follow-up focused review demonstrate that the physician's or provider's documentation, coding, or billing practices are still not in compliance with applicable rules, regulations, or laws, discipline will be imposed. In addition, the physician's or provider's conduct will be considered as part of his or her performance appraisal, and will directly affect compensation or promotion decisions. For voluntary physicians, conduct will be a consideration in decisions relative to compensation, promotion and staff appointment. In appropriate cases, disciplinary action will be imposed on the physician, as set forth below.

D. Suspension of Billing. If, following an internal review, a physician or provider has refused or is unable to correct identified documentation, coding or billing errors; and if these errors present the risk that improper claims will be submitted to governmental and other third-party payors, the matter will be referred to senior management, who will authorize the suspension of billing for services provided by that physician or provider. If the errors at issue relate only to billing for a particular service, billing for only that specific service will be suspended.

Any suspension of billing will remain in place until the Compliance Officer obtains adequate assurances that the physician's or provider's deficient practices have been corrected and that the risk of continued submission of improper claims has been eliminated.

E. Discipline. All personnel and physicians are expected to adhere to this Code of Conduct and applicable departmental compliance protocols. If the responses to violations instituted by the Compliance Officer, as outlined above, are inadequate to correct a pattern of non-compliance, and if the Compliance Officer concludes, after an appropriate investigation, that the Code has been violated, then appropriate discipline, including discharge or termination of privileges, may be imposed. Disciplinary action shall be taken and will be fairly and firmly enforced as appropriate for:

1. Authorizing or participating in actions that violate federal and/or state laws and regulations, the Code of Conduct, compliance standards or applicable departmental compliance protocols;
2. Failing to report a violation, or suspected violation, of federal and/or state laws and regulations, the Code of Conduct, compliance standards or applicable departmental compliance protocols;
3. Encouraging, directing, facilitating or permitting either actively or passively non-compliant behavior;
4. Failing to detect and report a compliance violation by a violator's supervisor(s), if such failure reflects inadequate supervision or lack of oversight;
5. Refusing to cooperate in the investigation of a potential violation; and
6. Retaliating against, or intimidating, an individual for reporting a compliance violation.

The severity of the disciplinary action, which will be determined by the President/CEO of the Hospital, upon the recommendation of the Compliance Officer, will depend on a variety of factors, including, but not limited to: (1) the severity of the violation; (2) whether the violation was committed intentionally, recklessly, negligently or accidentally; (3) whether the individual has committed any other violations in the past; (4) whether the individual self-reported his or her misconduct; and (5) whether (and the extent to which) the individual cooperated with the Compliance Officer in connection with the investigation of the misconduct.

The President/CEO may also refer the matter to the Medical Board for corrective action and discipline pursuant to the By Laws of the Hospital. In recommending discipline of a non-physician employee, the Compliance Officer will refer the matter to the appropriate senior management, Human Resources and the employee's supervisor for disciplinary action.

F. Compliance Assurance Monitoring and Training.

In addition to the responsibilities set forth above, the Compliance Officer and the Compliance Committee will also be responsible for continued monitoring of compliance with this Manual and all applicable federal and state rules, laws, and regulations.

1. Compliance Assurance Reviews. On a periodic basis, the Compliance Officer and Committee will ensure that reviews of coding, billing, and business practices are conducted. These reviews may include, but not be limited to, the following:

(a) Chart and Billing Reviews. The Compliance Officer or his designee (including the Coding Supervisor, as appropriate) will conduct periodic chart reviews of a small sample of medical

records, and corresponding billing documents, to test the adequacy of documentation and coding of services being billed by the Hospital, including the documentation and coding of physician services, outpatient testing or procedures, clinic services, or other Hospital services. Claims for both in-patient, outpatient and physician office services will be reviewed where possible.

The reviewer will examine the medical record and the relevant billing documents, and check both the adequacy of the documentation and the appropriateness of the billing code(s) selected. Such reviews will also include checking such items as: the presence of a signed note in the medical record; an appropriate diagnosis code; proper use of modifiers and site of service designation; proper completion of charge documents; that the services billed correspond to the services rendered; and that, for diagnostic tests, a proper, signed order is in the file.

If the review uncovers billing, coding, or documentation errors, the Compliance Officer (working with the Compliance Committee) will determine the scope of the problem, expanding the scope of the review as necessary and appropriate, and ensure that appropriate corrective action is undertaken.

(b) ***Review of Billing Denials and Client Complaints.*** Periodic reviews will also be performed of denials from Medicare, Medicaid, and other third-party payors in order to determine whether any patterns of improper billing exist that need correction. In addition, billing complaints from patients will also be tracked to determine whether such complaints reflect the existence of possible patterns of improper billing or other compliance issues.

(c) ***Response to Third Party Audits.*** Following resolution of audits by third-party payors, the results of the audit will be reviewed to determine if those results reflect any systemic deficiency or problem in the Hospital's compliance with state or federal rules, regulations, or laws. If such a problem is identified, appropriate corrective action, as outlined above, will be taken.

(d) ***Review of Compliance Issues.*** Periodically, the Compliance Officer will review reports received of suspected violations of the Code of Conduct to determine if there are any patterns of violations that might indicate broader compliance issues.

(e) ***Review of Exclusion Lists.*** The Compliance Officer and Compliance Committee will review the results of monthly checks of the OIG's, OMIG's and General Services Administration's exclusion lists in order to make sure that all current and potential employees have not been excluded from participation in federal health care programs.

(f) ***Business Reviews.*** Periodically, the Compliance Officer will spot check the Hospital's business practices to insure compliance with applicable laws, rules and regulations. Such checks might include a review of the Hospital's credit balance, the Hospital's practice of waiving co-payments or providing professional courtesy, and the fair market value of leases, equipment rental agreements, or personal service contracts with other providers.

(g) ***Purchasing Review.*** Periodically, the Compliance Officer will review the Hospital's competitive bidding practices and, for vendors not subject to the competitive bidding procedures, a review of the quoted prices of other, similarly situated vendors for the same or similar goods or services.

(h) ***Departmental Reviews.*** The Compliance Officer will also ensure that the compliance reviews specified in the various departmental compliance policies and procedures are conducted on an annual or periodic basis.

(i) ***Responses to Reviews.*** If any of these reviews indicate that possible compliance issues might exist, the Compliance Officer will inform, the appropriate department head, senior management and counsel, as appropriate. A determination will then be made whether further investigation is required and whether the Hospital's practices need to be modified or improved in any way to ensure continuing compliance with applicable federal and state laws and regulations.

2. ***Tracking New Developments.*** On a continuing basis, the Compliance Officer and the Compliance Committee will ensure that all new regulatory or legal requirements issued by the federal or state government are reviewed by appropriate personnel. This includes the following:

(a) reviewing all new rules governing the documentation, coding and billing of services provided by the Hospital;

(b) receiving and reviewing all Medicare bulletins, Medicaid updates, annual updates to the Current Procedural Terminology (CPT), or other relevant announcements;

- (c) communicating with the appropriate professional society as to recent initiatives or developments that might affect the Hospital, or new practices that might assist the Hospital in complying with rules and regulations that specifically apply to its areas of practice; and
- (d) reviewing all new Special Fraud Alerts issued by the Office of the Inspector General.

Based on any relevant new developments, the Compliance Officer, in conjunction with the Compliance Committee, will review existing policies and procedures to ensure that the Hospital is in compliance with the requirements of federal and state law. If necessary, the Compliance Officer and the Compliance Committee will then work to ensure that appropriate corrective action is taken.

3. **Training.** The Compliance Officer is responsible for ensuring that this Compliance Manual or a summary of it is distributed to all personnel and providers. The Compliance Officer is also responsible for overseeing Human Resources' distribution of the Code of Conduct and Compliance Procedures to all newly hired personnel. Human Resources Department will maintain in the personnel files each employee's signed acknowledgement form including all newly hired personnel.

In addition, the Compliance Officer will develop a schedule of occasional training on compliance issues, as necessary, for new and existing personnel and providers. The Compliance Officer will maintain a record of all personnel who have attended such training. Finally, the Compliance Officer will be responsible for any remedial training that is required as part of the Compliance Program.

XVI. HIPAA

As a central part of the HIPAA Compliance Program, this Code of Conduct sets forth the standards of conduct that all personnel are expected to follow. Everyone should adhere both to the spirit and the language of the Code in order to avoid any conduct that could reasonably be expected to violate HIPAA or give the appearance of violating HIPAA.

A. **Mission and Values:** The Hospital is committed to providing patients with quality health care, in a confidential and private manner in accordance with the wishes of its patients and the requirements of the law. These standards apply to the Hospital's interactions with its patients; other health care providers; consultants; government entities to whom the Hospital reports; public and private third party payors (e.g. managed care companies and HMOs); and any other persons and entities with whom the Hospital interacts. In this regard, all personnel and affiliated practitioners must act in compliance with all applicable legal rules and regulations.

In short, the Hospital does not and will not tolerate any form of unlawful behavior by anyone associated with the Hospital. We expect and require all personnel and affiliated practitioners to maintain the confidentiality and security of our patient health information in accordance with HIPAA standards. To ensure that these expectations are met, this HIPAA Compliance Program has become an integral part of the Hospital's corporate mission and business operations.

B. General Standards:

1. **Compliance with Law and Hospital Policies.** All personnel and affiliated practitioners are expected to comply specifically with all of the requirements of HIPAA regarding the privacy and security of health information. If personnel and affiliated practitioners are unsure whether an action involving health information complies with HIPAA, then they should first check with their supervisor or the Hospital's Privacy or Security Officer.

In addition, all personnel and affiliated practitioners must comply with the applicable policies and procedures of the Hospital. Strict compliance with these legal and compliance standards is a condition of employment and/or affiliation with the Hospital, and a violation of any of these standards of conduct will result in discipline being imposed, including termination of your employment or clinical privileges, if necessary.

2. Cooperation with the Compliance Program. Because of the importance of the HIPAA Compliance Program, we require that each of you cooperate fully with this effort. The HIPAA Compliance Program will work effectively only if everyone works together to ensure its success. Therefore, Hospital personnel and affiliated practitioners must understand what is required under the law and this Compliance Program, and work to ensure that these standards are being followed. In particular, all personnel and affiliated practitioners must cooperate with all inquiries concerning the use, disclosure, transfer, security, release, sharing utilization, examination, access to, or analysis of an individual's protected health information and actively work to correct any improper practices that are identified. Furthermore, it is imperative that all personnel and affiliated practitioners report suspected HIPAA violations to the Privacy Officer or Security Officer or other appropriate high-level officers or administrators of the Hospital. Ignoring suspected HIPAA violations may subject you to disciplinary proceedings by the Hospital.

3. Retaliation and Intimidation. The Hospital expressly forbids any intimidation, threats, coercion, discrimination or retaliation against individuals who report in good faith suspected HIPAA violations or exercise their rights to health information as provided for by HIPAA.

C. Scope and Application of Standards to Personnel and Others

1. Personnel Covered. The HIPAA Compliance Program, including the standards set forth in this Code of Conduct, applies to all personnel employed by or associated with the Hospital (including health care practitioners with clinical privileges) and all of its affiliated companies. Each of these entities is fully committed to following the mandates of the Hospital's HIPAA Compliance Program, and working with the Hospital to ensure mutual compliance with all applicable rules, regulations, laws and Hospital policies and procedures. As a result, this Code of Conduct applies to the health care practitioners and personnel of all affiliated entities in the same manner that it applies to the Hospital's own personnel and affiliated practitioners.

2. Contractors and Other Providers. To the extent practicable, all persons and entities with which the Hospital contracts will be asked to cooperate with the Hospital's HIPAA Compliance Program. If persons or entities electronically exchange health information with the Hospital or receive or disclose protected health information on behalf of the Hospital, then such entities will be required to enter into business associate contracts with the Hospital as required by law. This requirement will apply to, among others, various physicians, physician groups, vendors, and contractors with whom the Hospital exchanges health information. These persons and entities will be encouraged to adopt their own HIPAA Compliance Programs when appropriate.

The Privacy Officer for the Hospital is Kevin Murray, Senior Vice-President, Administration. If you are concerned about any privacy issues, please call extension 4216 to schedule an appointment or telephone him at (631) 476-2816.

The HIPAA Security Officer for the Hospital is Thomas Heiman, Vice-President for Information Services & CIO. You may contact him at extension 4234, or at (631) 476-2710.

XVII. CONDUCTING THE HOSPITAL'S BUSINESS

The Hospital's activities involve thousands of transactions each day. Obviously, we must have strict rules to guard against fraud or dishonesty and guidelines for addressing possible problems that may arise.

If you detect or suspect any behavior which you believe is or may be improper or inconsistent with the guidelines contained in this Code of Conduct or the law on the part of any employee or agent of the Hospital or any person with whom the Hospital deals, you should report it immediately to your supervisor, or department manager and the compliance officer, so that the appropriate investigation is initiated.

If evidence of a violation of this Code of Conduct is established, any involved employee or agent is subject to a disciplinary process including termination. Any such evidence will be reviewed by the Compliance Officer, the Administrator (President) and where appropriate, the Legal Advisor.

Referral by the Hospital for criminal prosecution will be made when appropriate after review by our Legal Advisors.

A. Proper Use of the Hospital's Assets

All managers should establish appropriate internal accounting controls over all areas of their responsibility to ensure the safeguarding of the Hospital's assets and the accuracy of financial records and reports. These established accounting practices and procedures must be followed to assure the complete and accurate recording of all transactions. All employees, within their areas of responsibility, are expected to adhere to these established controls.

If you become aware of any improper use of Hospital assets, you should report the matter immediately to the Compliance Officer.

To be certain the Hospital's policies on proper use of resources are carried out, you are expected to observe the following long-standing rules:

- Make outside payments only with a draft or check or through other properly documented sources i.e., petty cash. No payment on behalf of the Hospital should be approved or made without adequate supporting documentation or with the intention or understanding that any part is to be used in any way other than described in the supporting documents.
- Do not establish any undisclosed or unrecorded corporate account, fund or asset for any purpose.
- Obtain proper authorization before opening any new account with an outside agency, such as a bank or financial institution (not vendors).
- Do not use any account for a misleading purpose or to conceal the existence or use of any corporate resource.
- Record every payment to and every transaction with an outside party on the Hospital's books promptly, accurately and through normal financial reporting channels. If you are involved in or accountable for any such transaction, you are expected to make sure a prompt and accurate accounting is made.

You are also expected to select the Hospital's business partners solely on their merits, in the best interest of the Hospital, and without regard to non-business-related considerations.

Anything that would constitute improper or questionable behavior on the part of an employee is also unacceptable if engaged in through a third party, such as a spouse, other family member, friend or any other person or entity with whom the employee is closely identified or in which he or she has any significant ownership or financial interest or position.

B. Trade Practices/Antitrust

Antitrust laws are designed to preserve and foster fair and honest competition within the free enterprise system. To accomplish this goal, the language of these laws is deliberately broad, prohibiting such activities as “unfair methods of competition” and agreements “in restraint of trade.” Such language gives enforcement agencies the right to examine many different business activities to judge the effect on competition.

The Hospital’s policy requires full compliance with all antitrust laws. No employee, under any circumstances, has the authority to approve a violation of the law.

Penalties for antitrust violations are severe for the Hospital and for the individual. They include the following: (i) imprisonment for individuals (ii) substantial fines against the Hospital and against the individual for each criminal offense (iii) payment of treble (triple) damages plus attorneys’ fees and litigation costs, to firms or individuals injured by the violation, and (iv) injunctions or consent decrees prohibiting certain activities. Consent decrees can seriously limit a company’s future freedom to engage in business activity and can be applied across a broader scope than was involved in the original alleged violation.

The greatest danger for violations of antitrust laws rests in contacts with competitors. Antitrust laws make illegal any agreement or understanding, expressed or implied, written or oral, with competitors which restricts competition or interferes with the ability of the free market system to function properly. In the eyes of the law, good intentions, customer benefits or consumer benefits do not justify or excuse violations. For the Hospital, a “competitor” may be another hospital (with the exception of St. Charles Hospital)* or, depending on the circumstances, any other health care provider.

You should not have any discussions or other communications with competitors about the allocation of either patients, geographic areas, or services; discussions with competitors regarding the circumstances under which business will be conducted with suppliers, insurance companies, patients or customers (including boycotts); or conversations about marketing efforts. However, joint purchasing through the Hospital Council or similar organization is permitted. Further, you should avoid discussions with competitors regarding the future business plans of the Hospital or any other competitors. Finally, you should not have any discussions with competitors regarding prices, discounts, or reimbursement or salary levels.

** A Joint Venture Agreement was entered into with St. Charles Hospital in April 1996, which permits the two Hospitals to act as one.*

Under Hospital policy, participation in surveys among competitors regarding information on salaries, fees, etc., is permissible only if (1) the survey is managed by a non-competitor third party; (2) the information provided by survey participants is based on data more than three months old; (3) at least five hospitals participate in the survey; and (4) the information provided is not identifiable. Two competitors should not share this information directly between themselves even if the information is available through public sources.

One activity of particular sensitivity in the area of antitrust laws is participation in professional and trade associations. The Hospital encourages such participation and the antitrust laws recognize the legitimate function of these associations. Essentially, however, these associations are comprised of individuals and organizations which compete with one another. Thus, the collective action of members of such associations is not immune from the application of the antitrust laws, and all activities of Hospital personnel undertaken in connection with these associations are subject to the standards discussed above. You can, of course, discuss proposed legislation or regulations concerning sensitive matters if it is for the purpose of developing the association’s position. But if you are at an association meeting where

participants stray into areas of discussion that seem to be improper, try to stop such discussion. If you cannot change the course of discussion, threaten to leave the meeting to emphasize how serious you are. If the course of discussion is still not changed, leave the meeting.

C. Compliance with Applicable Federal and State False Claims Acts: Overview of the Laws Regarding False Claims And Whistleblower Protections

1. Compliance with Applicable Federal and State False Claims Laws

It is the Hospital's policy that all personnel (including employees, management, physicians, consultants and other agents) shall comply with all applicable Federal and New York State false claims laws and regulations. The Hospital has instituted various procedures to ensure compliance with these laws and to assist us in preventing fraud, waste and abuse in Federal and State health care programs. As part of the Hospital's Compliance Program, personnel shall receive training on these laws, which are summarized below, and should consult with the Compliance Officer (who may confer with the Hospital's legal counsel, as needed) if they have questions about the application of these laws to their job.

THE FEDERAL LAW

1. The Federal False Claims Act and Administrative Remedies (31 USC §§3729-3733; 31 USC Chapter §§3801 – 812)

The False Claims Act ("FCA") provides, in pertinent part, that:

(1) any person who (A) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval; (B) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim; (C) conspires to commit [the above violations]; . . . or (D) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government,

* * *

is liable to the United States Government for a civil penalty of not less than \$5,000 and not more than \$10,000,^[1] plus 3 times the amount of damages which the Government sustains because of the act of that person

For purposes of this section:

(1) the terms "knowing" and "knowingly" (A) mean that a person, with respect to information-- (i) has actual knowledge of the information; (ii) acts in deliberate ignorance of the truth or falsity of the information; or (iii) acts in reckless disregard of the truth or falsity of the information; and (B) require no proof of specific intent to defraud; and

(2) the term "claim" (A) means any request or demand, whether under a contract or otherwise, for money or property and whether or not the United States has title to the money or property, that-- (i) is presented to an officer, employee, or agent of the United States; or (ii) is made to a contractor, grantee, or other recipient, if the money or property is to be spent or used on the Government's behalf or to advance a Government program or interest, and if the United States Government (I) provides or has provided any portion of the money or property requested or demanded; or (II) will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded; and

(3) the term “obligation” means an established duty, whether or not fixed, arising from an express or implied contractual, grantor-grantee, or licensor-licensee relationship, from a fee-based or similar relationship, from statute or regulation, or from the retention of any overpayment; and

(4) the term “material” means having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property.

¹¹ Although the statutory provisions of the FCA authorizes a range of penalties of from between \$5,000 and \$10,000, those amounts have been adjusted for inflation and increased by regulation to not less than \$5,500 and not more than \$11,000. 28 CFR §85.3(a)(9).

31 U.S.C. § 3729

While the FCA imposes liability only when the claimant acts “knowingly,” it does not require that the person submitting the claim have actual knowledge that the claim is false. A person who acts in reckless disregard or in deliberate ignorance of the truth or falsity of the information, also can be found liable under the Act.

In sum, the FCA imposes liability on any person who submits a claim to the federal government or a contractor of the federal government that he or she knows (or should know) is false. An example may be a physician who submits a bill to Medicare for medical services she knows she has not provided. The FCA also imposes liability on an individual who may knowingly submit a false record in order to obtain payment from the government. An example of this may include a government contractor who submits records that he knows (or should know) are false and that indicate compliance with certain contractual or regulatory requirements. The third area of liability includes those instances in which someone may obtain money from the federal government to which he may not be entitled, and then uses false statements or records in order to retain the money. An example of this so-called “reverse false claim” may include a healthcare facility that obtains interim payments from Medicare throughout the year, and then knowingly files a false cost report at the end of the year in order to avoid making a refund to the Medicare program.

In addition to its substantive provisions, the FCA provides that private parties may bring an action on behalf of the United States. These private parties, known as “qui tam relators,” may share in a percentage of the proceeds from an FCA action or settlement.

Section 3730(d)(1) of the FCA provides, with some exceptions, that a qui tam relator, when the government has intervened in the lawsuit, shall receive at least 15 percent but not more than 25 percent of the proceeds of the FCA action depending upon the extent to which the relator substantially contributed to the prosecution of the action. When the government does not intervene, Section 3730(d)(2) provides that the relator shall receive an amount that the court decides is reasonable and shall be not less than 25 percent and not more than 30 percent.

2. The Program Fraud Civil Remedies Act (“PFCRA”)

This statute allows for administrative recoveries by federal agencies. If a person submits a claim that the person knows is false or contains false information, or omits material information, then the agency receiving the claim may impose a penalty of up to \$5,000 for each claim. The agency may also recover twice the amount of the claim.

Unlike the False Claims Act, a violation of this law occurs when a false claim is submitted, not when it is paid. Also unlike the False Claims Act, the determination of whether a claim is false, and the imposition of fines and penalties is made by the administrative agency, not by prosecution in the federal court system.

NEW YORK STATE LAWS – CIVIL AND ADMINISTRATIVE

New York's false claims laws fall into two categories: civil and administrative; and criminal laws. Some apply to recipient false claims and some apply to provider false claims, and while most are specific to healthcare or Medicaid, some of the "common law" crimes apply to areas of interaction with the government.

1. False Claims Act (State Finance Law, §§187-194)

The NY False Claims Act closely tracks the federal False Claims Act. It imposes penalties and fines on individuals and entities that file false or fraudulent claims for payment from any state or local government, including health care programs such as Medicaid. The penalty for filing a false claim is \$6,000 - \$12,000 per claim and the recoverable damages are between two and three times the value of the amount falsely received. In addition, the false claim filer may have to pay the government's legal fees.

The Act allows private individuals to file lawsuits in state court, just as if they were state or local government parties. If the suit eventually concludes with payments back to the government, the person who started the case can recover 25-30% of the proceeds if the government did not participate in the suit of 15-25% if the government did participate in the suit.

2. Social Services Law §145-b and c -- False Statements

It is a violation to knowingly obtain or attempt to obtain payment for items or services furnished under any Social Services program, including Medicaid, by use of a false statement, deliberate concealment or other fraudulent scheme or device. The State or the local Social Services district may recover three times the amount incorrectly paid. In addition, the Department of Health may impose a civil penalty of up to \$2,000 per violation. If repeat violations occur within 5 years, a penalty up to \$7,500 per violation may be imposed if they involve more serious violations of Medicaid rules, billing for services not rendered or providing excessive services.

If any person applies for or receives public assistance, including Medicaid, by intentionally making a false or misleading statement, or intending to do so, the person's, the person's family's needs are not taken into account for 6 months if a first offense, 12 months if a second (or once if benefits received are over \$3,900) and five years for 4 or more offenses.

NEW YORK STATE LAWS - CRIMINAL

1. Social Services Law §145 -- Penalties

Any person who submits false statements or deliberately conceals material information in order to receive public assistance, including Medicaid, is guilty of a misdemeanor.

2. Social Services Law § 366-b -- Penalties for Fraudulent Practices

Any person who obtains or attempts to obtain, for himself or others, medical assistance by means of a false statement, concealment of material facts, impersonation or other fraudulent means is guilty of a Class A misdemeanor.

Any person who, with intent to defraud, presents for payment and false or fraudulent claim for furnishing services, knowingly submits false information to obtain greater Medicaid compensation or knowingly submits false information in order to obtain authorization to provide items or services is guilty of a Class A misdemeanor.

3. Penal Law Article 155, Larceny

The crime of larceny applies to a person who, with intent to deprive another of his property, obtains, takes or withholds the property by means of trick, embezzlement, false pretense, false promise, including a scheme to defraud, or other similar behavior. It has been applied to Medicaid fraud cases. Depending on the degree, penalties can range from \$1,000 to \$1 million.

4. Penal Law Article 175, False Written Statements

Four crimes in this Article relate to filing false information or claims and have been applied in Medicaid fraud prosecutions:

(a) Falsifying business records involves entering false information, omitting material information or altering an enterprise's business records with the intent to defraud. It is a Class A misdemeanor.

(b) Falsifying business records in the first degree includes the elements of the §175.05 offense and includes the intent to commit another crime or conceal its commission. It is a Class E felony.

(c) Offering a false instrument for filing in the second degree involves presenting a written instrument (including a claim for payment) to a public office knowing that it contains false information. It is a Class A misdemeanor.

(d) Offering a false instrument for filing in the first degree includes the elements of the second degree offense and must include an intent to defraud the state or a political subdivision. It is a Class E felony.

5. Penal Law Article 176 -- Insurance Fraud

The crime of insurance fraud Applies to claims for insurance payment, including Medicaid or other health insurance and contains six crimes. Depending on the degree, the crimes range from misdemeanors to felonies.

6. Penal Law Article 177 -- Health Care Fraud

The crime of health care fraud applies to claims for health insurance payment, including Medicaid, and contains five crimes. The degree of the crime is dependent upon the amount that is collected as a result of the crime. Depending on the degree, the crimes range from misdemeanors to felonies.

WHISTLEBLOWER PROTECTION

Federal False Claims Act (31 U.S.C. §3730[h])

The FCA provides protection to any employee, contractor, or agent who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of their employment as a result of their lawful acts in furtherance of other efforts to stop violations of the FCA. Remedies include reinstatement with comparable seniority as the employee, contractor, or agent would have had but for the discrimination, two times the amount of any back pay, interest on any back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees.

NY False Claim Act (State Finance Law §191)

The New York State False Claim Act also provides protection to *qui tam* relators who are discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of their employment as a result of their furtherance of an action under the Act. Remedies include reinstatement with comparable seniority as the *qui tam* relator would have had but for the discrimination, two times the amount of any back pay, interest on any back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees.

New York Labor Law §740

An employer may not take any retaliatory action against, or intimidate, an employee if the employee discloses information about the employer's policies, practices or activities to a regulatory, law enforcement or other similar agency or public official. Protected disclosures are those that assert that the employer is in violation of a law that creates a substantial and specific danger to the public health and safety or which constitutes health care fraud under Penal Law §177 (knowingly filing, with intent to defraud, a claim for payment that intentionally has false information or omissions). The employee's disclosure is protected only if the employee first brought up the matter with a supervisor and gave the employer a reasonable opportunity to correct the alleged violation. If an employer intimidates or takes a retaliatory action against the employee, the employee may sue in state court for reinstatement to the same, or an equivalent position, any lost back wages and benefits and attorneys' fees. If the employer is a health provider and the court finds that the employer's intimidation or retaliatory action was in bad faith, it may impose a civil penalty of \$10,000 on the employer.

New York Labor Law §741

A health care employer may not take any retaliatory action against an employee if the employee discloses certain information about the employer's policies, practices or activities to a regulatory, law enforcement or other similar agency or public official. Protected disclosures are those that assert that, in good faith, the employee believes constitute improper quality of patient care. The employee's disclosure is protected only if the employee first brought up the matter with a supervisor and gave the employer a reasonable opportunity to correct the alleged violation, unless the danger is imminent to the public or patient and the employee believes in good faith that reporting to a supervisor would not result in corrective action. If an employer takes a retaliatory action against the employee, the employee may sue in state court for reinstatement to the same, or an equivalent position, any lost back wages and benefits and attorneys' fees. If the employer is a health provider and the court finds that the employer's retaliatory action was in bad faith, it may impose a civil penalty of \$10,000 on the employer.

D. Tax

The Hospital and some of its affiliates are charities, exempt from taxation by the federal, state, and local governments. In order to maintain this exemption, which is critical to the Hospital's survival, the Hospital must operate for the benefit of the community and must avoid what the tax law calls "private inurement" and "private benefit." All nonexempt individuals or entities must pay fair market value for use of Hospital services or property. Violation of the tax law can give rise to criminal penalties as well. Questions on tax issues should be referred to the Compliance Officer.

Care must also be taken that the Hospital's sales tax exemption is used only for legitimate Hospital activities. Personal items should not be purchased through the Hospital even if the Hospital is reimbursed by the employee (except for products purchased through the Dietary Department or used equipment which the Hospital offers to sell). The Hospital will collect the appropriate sales tax on dietary products.

All appropriate taxes must be withheld from employees' wages, and the use of a purchase order to compensate individuals must be limited to true independent contractors and first cleared by Human Resources or Administration.

The Hospital has issued tax exempt bonds which are secured by mortgages covering much of its property. These bonds contain restriction on the use of this property and on other Hospital activities which, if violated, could jeopardize the Hospital's ability to borrow money in the future. Questions on these issues should be referred to the Vice President of Finance.

E. Fund Raising

As a charity, the Hospital relies heavily on contributions from donors to support its many activities. Employees are encouraged to support this fund raising effort, but are required to coordinate all activities with the Development Department. Monies or other items received on behalf of the Hospital as gifts should be immediately deposited in Hospital accounts vis a vis the Charitable Giving Department/to the Finance Department.

Charitable contributions from vendors to the Hospital may raise issues implicating federal and state anti-kickback laws (see above). Care should be taken when soliciting or receiving such contributions that the contributor not be lead to believe, either directly or indirectly, that the contribution will affect the Hospital's professional judgment regarding the goods or services it purchases, recommends, or provides to its patients. All such contributions must be handled through the Charitable Giving Department and accepted on behalf of the Hospital by the Charitable Giving Department or Administration.

F. Immigration

Federal law prohibits employers from hiring employees who are not legally authorized to work in this country. Unless an employee is a U.S. citizen or has a "green card" or visa which authorizes him or her to work in the position in question, the Hospital may be subject to civil or criminal penalties if he or she is placed on the payroll. All prospective employees must present appropriate documentation of their citizenship status to the Human Resources Department. Whenever possible, this should be done well in advance of the employee's first day of work to avoid hardship or embarrassment. Questions on immigration issues should be referred to the Human Resources Department.

G. Certificate of Need/Licensure

State law requires the Hospital under certain circumstances to obtain the prior approval of the Department of Health before purchasing major medical equipment, changing the services it provides or making other significant capital expenditures. Questions regarding the Certificate of Need law should be referred to the Vice President of Planning or Administration.

The Hospital is licensed by the State of New York and accredited by The Joint Commission. These two agencies have numerous requirements that determine the manner in which the Hospital delivers its services. Each employee is expected to be familiar with the regulations governing his or her area, to stay abreast of new developments, and to alert his or her supervisor to possible non-compliance. Questions regarding regulatory requirements should be referred to your department manager.

H. Environment, Health, and Safety

In the course of the Hospital's operations, hazardous materials and infectious wastes may be used or generated. The Hospital is financially and legally responsible for the proper handling and disposal of these materials. Environmental responsibility is also an important component of our duty to the public and our good reputation.

It is essential that everyone at the Hospital who deals with hazardous materials and infectious waste complies with environmental laws and regulations, and follows the environmental safety procedures explained in the Hospital's programs and existing manuals. Employees are also expected to ensure that the Hospital:

- complies with all laws and regulations governing the handling, storage and use of hazardous materials, other pollutants and infectious wastes;
- complies with its permits that allow it to safely discharge pollutants into the air, sewage systems, water pollution control facilities, or onto or into land;
- hires only reputable licensed services to transport and dispose of hazardous and polluted materials and infectious wastes; and accurately maintains the records required by the environmental laws and regulations, including those that require precise description of the amount, concentration, and make-up of hazardous materials or other regulated pollutants and infectious wastes that are used, stored, discharged or generated; and the time, place of origin, destination and transporter of hazardous materials, and discharge of pollutants. These records should be destroyed only pursuant to Hospital policy.

No one at the Hospital may participate in concealing improper discharge or disposal of hazardous materials, pollutants or infectious wastes. Any employee who has reason to believe that there have been violations of this or any other aspect of the Hospital's environmental compliance procedures should report it immediately to the Compliance Officer, who will in turn notify appropriate government agencies as required by law. Before proceeding to act on any instruction of questionable propriety, or to take any environment-related action about which they are unsure, employees are expected to discuss their questions with Administration or the Compliance Officer.

Both federal and state laws regarding the promotion of occupational safety and avoidance of job related hazards are designed to ensure that each of us works in a safe environment. Due regard and attention should be paid to those laws and regulations. Each of us plays a valuable role in providing the services of the Hospital. Without a safe and non-hazardous environment in which to work, none of us can achieve the goals of community service to which we strive. Should you notice a potential or actual infringement of the laws and rules regarding occupational safety, you must advise your supervisor or the Compliance Officer.

XVIII. POLITICAL PARTICIPATION

A. Generally

Participation in the political process is one of every American's most basic rights. Federal and state laws, however, limit the nature and extent of individual and organizational political participation. For example, both federal and state law prohibit not for profit organizations from contributing to political candidates or officeholders.

Federal law states that no one can be reimbursed for personal political contributions. Personal compensation will not be altered in any way under any circumstances to reflect such contributions.

The Hospital encourages employees to participate in the American political process if they so desire. They may make personal political contributions or communicate their personal beliefs to elected officials.

It is important, however, to distinguish between personal and organizational political activities. As a responsible citizen, the Hospital will occasionally speak out on issues of importance to it. Senior

management is responsible for developing the Hospital's position on relevant legislative and regulatory issues.

Unless you are specifically requested by the Hospital to represent it before legislative or other governmental bodies, be sure you clearly label any personal communication with legislators as your own beliefs. Hospital stationary, or hospital titles should not be used when writing a personal communication to a legislator. If you are contacted by legislators or regulators regarding the Hospital's position on public issues, you should refer them to the Department of Public Affairs.

B. Lobbying

Certain management personnel may periodically be called upon by the Hospital to make contact with members of city, county, state or federal legislative bodies and other officials to set forth and advocate for the Hospital's positions on issues. These persons are expected to abide by all applicable laws at all times. Any person who attempts to influence any legislative, executive or other governmental action, official or employee on behalf of the Hospital may be required to register as a lobbyist and file certain reports concerning his or her activities. There are also registration and reporting requirements as well as explicit limitations on lobbying that apply to the Hospital. In addition, some laws provide rules of conduct for lobbyists. Federal law prohibits giving anything of value to any federal public official or person selected to be a public official in order to influence a decision by such official. In order to avoid any ambiguity in such matters, the Hospital prohibits the giving of gifts, meals or gratuities to federal officials without prior authorization, as discussed above. Similarly, although New York State law permits gifts, including meals up to \$75 to be offered or made to state executive or legislative officers or employees, in order to avoid the appearance of impropriety with respect to lobbying, it is the Hospital's policy that no gifts, meals or gratuities be given to any government personnel without prior authorization from Administration. To assure that these laws and policies are fully complied with, no employee should/will engage in lobbying without authorization from the Administration.

The Hospital also periodically engages lobbyists or lobbying firms to help promote its interests, and has established internal controls to assure that all activities are legal. Written authorization must be obtained from the President prior to engaging any lobbyist, outside legal counsel or consultant to lobby for or otherwise promote the Hospital's interests on any legislative, regulatory or other governmental issue. The following evidence must be submitted along with the proper request for authorization to justify the engagement:

- The purpose for the engagement and the nature and extent of services to be performed.
- The basis for selecting the proposed individual, firm or company.
- The agreed-upon fee and the means by which the fee was determined to be reasonable and appropriate for the services to be performed.

All requests for reimbursement of expenses incurred by a lobbyist must be accompanied by a specific expense reporting form completed and signed by that lobbyist.

XIX. DOING BUSINESS WITH THE GOVERNMENT

A. Medicare and Medicaid Requirements

The Hospital participates heavily in Medicare and Medicaid. Both programs are governed by complicated laws and regulations which impose strict requirements on providers that are significantly different from and more extensive than those encountered in non-government commercial contracts. For example, Medicare and Medicaid have very complicated payment guidelines that identify not only the circumstances under which, but also how much, those programs will reimburse the Hospital for goods and

services rendered to patients covered under those programs. These guidelines are oftentimes different than directives received from other third party payors. Violation of Medicare and Medicaid laws and regulations can result in criminal sanctions being imposed not only on the persons actually involved but also the organization on whose behalf those persons act. Moreover, if the Hospital were found to be involved, it would be precluded from participating entirely in the Medicare and Medicaid programs. It is essential, therefore, that there be strict compliance with all Medicare and Medicaid laws and regulations while providing services under these government programs.

B. Hiring of Former Government Employees

Very specific rules exist to eliminate even the appearance of a conflict of interest by former government employees who upon termination of their government service seek employment with those who do business with the government. You should obtain clearance from the Human Resources Department prior to discussing the employment or possible retention as a consultant of any current or former government employee.

Both the Hospital and any employee or consultant who was a former government employee must comply with all applicable rules while working on the Hospital's behalf.

C. No Gifts, Meals or Gratuities for Government Personnel

You may not provide or pay for meals, refreshments, travel or lodging expenses for government employees. Very strict guidelines prohibit any type of gratuity, with very few exceptions, (NY State law permits gifts, including meals up to \$75 to be offered to or made to State Executive or Legislative officers or employees) and your strict compliance is required. Unlike in other circumstances, the laws regarding this issue could be violated if anything of value is given to a government employee even if there is no intent to influence an official action or decision. Therefore, no employee should entertain a public official without authorization from Administration.

XX. AVOIDING CONFLICTS OF INTEREST

The Hospital expects its employees to serve the Hospital faithfully. You should avoid situations in which a conflict of interest, or the appearance of a conflict, could arise. For more complete guidance as to the Hospital's policy on these types of issues, please refer to the Conflict of Interest policy.

XXI. USE OF HOSPITAL INFORMATION

A. Safeguarding the Privacy of Our Patients

Our professions require that we gather a great deal of personal information about individuals. Therefore, we must carefully avoid any unwarranted invasion of the individual's right to privacy. This applies to information about our patients and our employees.

For this reason, and to assure the accuracy of the information we retain, the following guidelines apply:

- To protect individuals against misuse of information identifiable to them, limit access to that information, except to the extent permitted by Hospital policy.
- Use only legitimate means to collect the information and, whenever practical, obtain it directly from the individual concerned.

- Special confidentiality rules apply to patients in psychiatric; drug and alcohol treatment programs as well as disclosure regarding a patient's HIV status. When release of any information with respect to patients with these illnesses is contemplated, these rules must be adhered to carefully.

Any employee or agent of the Hospital who engages in unauthorized access or disclosure of information in violation of the privacy rights of our patients or others may be subject to immediate termination in addition to possible civil or criminal sanctions. Any person who becomes aware of such unauthorized access or disclosure should report it immediately.

B. Confidentiality of Hospital Information

One of the Hospital's most valuable assets is its body of confidential information. The widespread use of computer terminals and computer systems has caused this information to be accessible to many employees. Failure to protect this information can lead to the loss of highly confidential data that may place the Hospital legally at risk. Because of this risk of harm to the Hospital, its employees and patients, no employee may, without the written consent of the Hospital during the term of employment or thereafter, use for the benefit of such employee or others or disclose to others any confidential information obtained during the course of employment.

Confidential information includes the Hospital's methods, processes, techniques, computer software, equipment, service marks, copyrights, research data, clinical and pharmacological data, marketing and sales information, personnel data, patient lists, financial data, plans and all other know-how and trade secrets which are in the possession of the Hospital and which have not been published or disclosed to the general public.

As an employee, you are responsible and accountable for the integrity and protection of business information and must take steps to protect information that has been entrusted to you. For example, you must not make inappropriate modification of information or destroy or disclose information except as authorized. Documents containing sensitive data, including information concerning patients, should be handled carefully during work hours and must be properly secured at the end of the business day. Particular attention must be paid to the security of data stored on the computer system. If you observe individuals whom you do not recognize using terminals in your area, immediately report this to your supervisor or to the Security Department.

C. Information Owned by Others

Like the Hospital, other organizations have intellectual property they want to protect. So do individuals. Also like the Hospital, these other parties are sometimes willing to disclose their confidential information for a particular purpose. If you are on the receiving end of another party's confidential information, you must proceed with caution to prevent any accusations that you or the Hospital misappropriated or misused the information.

To avoid the risk of you or the Hospital being accused of misappropriating or misusing someone's confidential or restricted information, there are certain steps you should take before receiving such information. The receipt of confidential or restricted information whether oral, visual or written must not take place until the terms of its use have been formally agreed to by the Hospital and the other party. That means a written agreement approved by our Legal Advisors. Furthermore, unless otherwise delegated, establishing such an agreement for the receipt of confidential or restricted information of another party will require the prior written approval of the appropriate Hospital officer. Once another party's confidential or restricted information is properly in your hands, you must not use, copy, distribute or disclose that information unless you do so in accordance with the terms of the agreement.

Special care should be taken in acquiring software programs from others. As intellectual property, software programs are protected by copyright laws and may also be protected by patent, trade secret laws or as confidential information. Such software includes computer programs, databases and related documentation owned by the party with whom you are dealing or by another party. Before you accept software or sign a license agreement, you must follow established Hospital procedures. The terms and conditions of such license agreements -- such as provisions not to copy or distribute programs -- must be strictly followed. Also, if you acquire software for your personally-owned equipment, you should not copy any part of such software program in any work you do for the Hospital, or place such software on any Hospital-owned computer system. This provision does not apply to "Freeware" software or "Shareware" software applications.

In any case, do not take the status of information for granted. If you have information in your possession that you believe may be confidential to a third party or may have restrictions placed on its use, you should consult with Administration or Information Services.

D. Records Retention/Destruction

The Hospital is required by law to maintain certain types of medical and business records, usually for a specified period of time. Failure to retain these documents for this minimum period could subject the Hospital to penalties and fines, cause the loss of rights, obstruct justice, place the Hospital in contempt of court, or put the Hospital at a serious disadvantage in litigation. Accordingly, the Hospital has established controls to assure retention for required periods and timely destruction of retrievable records such as hard copies and records on computers, electronic systems, microfiche and microfilm. Even if a document is retained for the minimum period, legal liability could still result if a document is destroyed before its scheduled destruction date.

You are expected to comply fully with the records retention and destruction schedule for the department in which you work. If you believe that documents should be saved beyond the applicable retention period, consult your supervisor, a department manager or Administration or a vice-president.

It is likewise critical to the successful accomplishment of the Hospital's goals that its records be fully and accurately completed and maintained consistently with proper business practices. Many of the Hospital records serve as a basis for treatment decisions for its patients, as documentation of goods and services rendered for billing purposes and as a record of historical courses of treatment. Each of these functions serves an indispensable role in enabling the Hospital to fulfill its obligations to its patients, the medical and nursing staff and the various payors for goods and services. Consequently, the proper and timely creation of fully accurate and complete records is a duty of each member of the Hospital.

XXII. HUMAN RESOURCES

The Hospital recognizes that its greatest strength lies in the talent and ability of its employees. While specific human resources programs and policies may differ somewhat by department, these goals have been established to guide the Hospital's activities in employee relations. It is the Hospital's on-going policy:

- To provide equal opportunity for employment and advancement on the basis of ability and aptitude without regard to race, color, creed, age, sex or sexual orientation, disability or national origin, except where age, sex or physical status is a bona fide occupational qualification.
- To protect the health and safety of employees in their work environment.
- To compensate employees equitably, and to provide competitive benefits within the framework of prevailing practices.

The Human Resources Department has prepared an extensive manual of policies designed to implement the above-stated goals of the Hospital. Familiarity with and adherence to the Hospital's Human Resources policy is a responsibility of each employee.

XXIII. INDIVIDUAL JUDGMENT

The foregoing guidelines are to help all of us better understand what we believe to be in the best interest of our employees, patients, those with whom we do business and the public at large. Ultimately, however, you are left to depend on your own individual judgment in deciding on the correct course of action.

As you contemplate a particular situation, consideration of the following factors may help you arrive at a satisfactory answer:

- Is my action consistent with Hospital practices?
- Could my action give the appearance of impropriety?
- Will the action bring discredit to myself, to any employee or to the Hospital if disclosed fully to the public?
- Can I defend my action to my supervisor, other employees and to the general public?
- Does my action meet my personal code of behavior?
- Does my action conform to the spirit of this Code of Conduct?

Remember always to use good judgment and common sense. This Code of Conduct is intended to reflect the collective good judgment and common sense of all of us. Whenever you see a situation where this purpose does not appear to be served by the Code of Conduct, you have the responsibility to bring your concern to the attention of the Compliance Officer.