COMPLIANCE PLAN

OF

SALINA REGIONAL HEALTH CENTER, INC.

2022

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ARTICLE 1

GENERAL OBJECTIVES

1.1 ***General Statement of Purpose of Compliance Plan.*** In adopting this Compliance Plan it is the objective of Salina Regional Health Center, Inc. ("SRHC") to provide a framework for dedicating resources of the institution toward an effective program to prevent and detect violations of federal and state law in the conduct of its operations. Salina Regional Health Center has as its core objective that its operations be conducted honestly, fairly, and with the highest integrity by its employees, trustees, volunteers, and medical staff. This Compliance Plan is adopted as part of the Salina Regional Health Center Peer Review and Risk Management program and, as such, is privileged pursuant to K.S.A 65-4914 *et seq.*, and K.S.A. 65-4921 *et seq.,* as amended from time to time and pursuant to the applicable provisions of federal law. In adopting and implementing this plan, the Board of Trustees intends that all persons participating shall have the greatest immunity possible under federal or state law from any claims arising out of their good faith participation in any duties required under this Compliance Plan. Moreover, this Compliance Plan is intended to assist employees, officers, trustees, medical staff and volunteers with compliance with the law. It is not intended to create any higher legal duty than the law requires and it shall not be admissible in any court for any purpose, other than to show that it is the policy of the Health Center to try to prevent and detect violations of federal and state law in the conduct of its operations. It is understood that the implementation of this Compliance Plan will occur over the course of months and years and will be a continually evolving process.

1.2 ***General Elements of Compliance Plan.*** This Compliance Plan will generally be composed of the following seven elements:

1.2.1 ***Code of Ethical Conduct, Policies and Guidelines.*** Establish a Code of Ethical Conduct and compliance policies and guidelines reasonably capable of reducing the prospect of wrongful conduct and to require, where appropriate, specific departments to create and adopt policies and procedures consistent with such compliance policies and guidelines;

1.2.2 ***Compliance Officer and Multidisciplinary Compliance Committee.*** Appoint a Compliance Officer with overall responsibility to oversee compliance with such standards and procedures. Establish a multidisciplinary committee that includes representatives of SRHC subsidiary organizations and the medical staff. This committee should meet at least quarterly to review compliance issues within the organization and assist the Compliance Officer with determining that appropriate responses to compliance issues as they arise;

1.2.3 ***Education and Training.*** Develop and implement regular, effective education and training programs for all affected covered persons.

1.2.4 ***Communication Systems.*** Maintain a process, such as a hotline, to receive complaints; and publicize a reporting system whereby covered persons can report perceived wrongful conduct by others within the organization without fear of retribution;

1.2.5 ***Monitoring and Auditing Systems.*** Take reasonable steps to achieve compliance by utilizing monitoring and auditing systems,

1.2.6 ***Disciplinary Mechanisms.*** Consistently enforce its standards through appropriate disciplinary mechanisms;

1.2.7 ***Response and Prevention of Recurrence.*** Take responsible steps to respond appropriately to non-compliance after detection and to prevent recurrence, which may require modifications to the compliance program.

1.3 ***Benefits of Compliance Plan.*** In adopting this compliance plan, the Board of Trustees seeks to obtain the following benefits:

1.3.1 To demonstrate to covered persons and the community at large the Health Center's strong commitment to honest and responsible corporate conduct;

1.3.2 To provide covered persons and contractors with adequate guidance concerning requirements to comply with fraud and abuse laws;

1.3.3 To identify and prevent criminal and unethical conduct;

1.3.4 To improve the quality of patient care;

1.3.5 To create a centralized source for information on health care statutes, regulations and other program directives related to fraud and abuse;

1.3.6 To provide a mechanism that encourages the reporting and prevention of problems;

1.3.7 To prevent the inappropriate use of protected health information.

1.4 ***Definitions.*** As used in this Compliance Plan the following definitions shall apply:

1.4.1 "***Salina Regional Health Center", "the Health Center" or "SRHC".*** As used in this Compliance Plan the terms "Salina Regional Health Center", "the Health Center" or "SRHC" mean Salina Regional Health Center, Inc.

and each of its divisions, subsidiaries and operating or business units, including affiliated hospitals. It does not apply to joint ventures in which Salina Regional Health Center does not have more than a 50% ownership interest because those organizations will have their own compliance plans.

1.4.2 ***"Covered Person".*** The term "covered person" as used in this Compliance Plan includes "officers," "trustees," "employees," "medical staff appointees," and "volunteers" of Salina Regional Health Center or any of its divisions, subsidiaries, operating or business units.

1.5 ***Distribution.*** This Compliance Plan shall be posted on the SRHC Intranet site so that it is accessible to the Administrative Staff, Department Directors, Supervisors, and other covered persons of SRHC. At least once each year such persons shall be tested on how to access the compliance plan and on its basic elements. All new covered persons shall be advised during orientation of the existence of the plan, of its general contents and how it is accessed. It shall also be included in the Trustee's Manual of the Board of Trustees and copies distributed to the Board of Trustees for inclusion in their manual any time it is updated. Any subsidiary, vendor, or contractor or general public may access the Compliance Plan through the srhc.com website. Any covered person requesting a hard copy of the Compliance Plan shall be given one within a reasonable time following a request.

ARTICLE 2

ORGANIZATIONAL COMPLIANCE STRUCTURE

2.1 ***Designation of Compliance Officer.*** The Board of Trustees shall appoint a Compliance Officer. No officer of the Health Center who has the responsibility for signing the Cost Report filed with the Centers for Medicare & Medicaid Services ("CMS") should be designated as the compliance officer. The Compliance Officer has the authority to review all documents and other information that are relevant to compliance activities, including, but not limited to, patient records, billing records, and records concerning the marketing efforts of the Health Center and the Health Center's contracts with other parties, including employees, professionals on staff, independent contractors, suppliers, agents, and physicians. Such officer shall have the following functions:

2.1.1 ***Oversight and Monitoring.*** The Compliance Officer will oversee and monitor the implementation of the Compliance Program.

2.1.2 ***Reporting.*** The Compliance Officer shall report regularly to the Health Center's Board of Trustees, its Chief Executive Officer, and its Compliance Committee on the progress of the Compliance Plan, and assist such entities and persons in establishing methods to improve the Health Center's efficiency and quality of services and to reduce the Health Center's vulnerability to fraud, abuse and waste;

2.1.3 ***Revisions in Program.*** The Compliance Officer shall assist in revising the compliance program to reflect the changes in the Health Center and the laws, policies, and procedures of government and private payors;

2.1.4 ***Educational Programs.*** The Compliance Officer shall develop, coordinate, and participate in a multifaceted educational and training program that focuses on the elements of the compliance program, so that covered persons and management are knowledgeable of, and comply with, pertinent federal and state standards;

2.1.5 ***Distribute Information to Vendors.*** The Compliance Officer or his or her designee shall distribute pertinent information to vendors and suppliers of the Health Center about its compliance program and requirements that may exist for such entities;

2.1.6 ***Personnel Issues.*** The Compliance Officer shall work with the Health Center Human Resources Department and other appropriate departments so that the National Practitioner Data Bank and System for Award Management's Excluded Parties List System are checked with respect to employees, medical staff, hospice volunteers, and independent contractors;

2.1.7 ***Financial Management.*** The Compliance Officer will assist with the Health Center financial management team in coordinating internal compliance review and monitoring activities, including annual or periodic reviews of departments;

2.1.8 ***Coordinate Investigations.*** The Compliance Officer will coordinate the investigation into matters related to compliance, and shall have the flexibility to design and coordinate internal investigations (e.g., responding to reports of problems or suspected violations) and any resulting corrective action with all hospital departments, providers and sub-providers, covered persons, and, if appropriate, independent contractors.

2.1.9 ***Development of Policies and Procedures.*** The Compliance Officer will assist appropriate departments with the development of policies and procedures and will encourage covered persons to report suspected fraud and other improprieties without fear of retaliation.

2.2 ***Compliance Committee.*** The Chief Executive Officer of the Health Center shall appoint a multidisciplinary Compliance Committee to advise and assist the Compliance Officer with the implementation of the compliance program. The committee shall include individuals having varying responsibilities within the Health Center and may include representatives of accounting, human resources, patient accounts and financial services, materials management, risk management, medical records, nursing, social work, laboratory, the active medical staff and any other division, subsidiary, operating or business units of SRHC. The functions of the committee shall include:

2.2.1 ***Identification of Risks.*** Assisting with the identification or risks that need monitoring for legal compliance and the legal requirements for compliance;

2.2.2 ***Assess Existing Policies.*** Assess existing policies and procedures that address identified areas of risk and determine whether they should be incorporated into the compliance program;

2.2.3 ***Coordinate Compliance Efforts Among Departments.*** Work with appropriate hospital departments to develop standards of conduct and policies and procedures to promote compliance with the Health Center's program;

2.2.4 ***Internal Systems and Controls.*** Recommend and monitor, in conjunction with the relevant departments, the development of internal systems and controls to carry out the Health Center's standards, policies and procedures as part of its daily operations;

2.2.5 ***Develop Strategies to Promote Compliance.*** Determine appropriate strategies to promote compliance with the program and the detection of any potential violations, such as through hotlines and other fraud reporting mechanisms;

2.2.6 ***Complaint Procedure.*** Develop a system to solicit, evaluate and respond to complaints and problems.

2.3 ***Education and Training Programs.*** The Compliance Officer and Compliance Committee shall develop an effective and ongoing education and training program for covered persons. Such personnel should be required to attend training in applicable federal and state statutes, regulations and guidelines and in corporate ethics. An essential element of such a training and education program will be to educate such personnel about the compliance program and the procedural steps being undertaken to assure compliance within the Health Center. Training instructors may come from inside or outside of the Health Center. New covered persons should be especially targeted for such programs. Training and education programs should be appropriately documented including the maintenance of attendance logs and materials distributed at each training session.

2.4 ***Communication Systems.*** The Compliance Officer and Compliance Committee shall develop and implement an effective system through which there is an open line of communication by which Health Center personnel may communicate with them. Such communication systems shall focus on the following objectives:

2.4.1 ***Written Confidentiality and Non-Retaliation Policies.*** The communication system shall contain written confidentiality and non-retaliation policies that are distributed to all covered persons to encourage communication and the reporting of incidents of potential fraud and misconduct.

2.4.2 ***Independent Reporting Channels.*** The communication system shall have several independent reporting paths for any covered person to report potential fraud, waste and abuse so that such reports cannot be diverted by supervisors or other personnel.

2.4.3 ***Feedback System.*** The communication system should include a procedure by which Health Center personnel may seek clarification from the compliance officer or members of the Compliance Committee in the event of any confusion or question regarding a policy or procedure. Questions and answers should be documented, dated and shared with interested persons.

2.4.4 ***Hotline.*** The Compliance Officer and Compliance Committee will develop a hotline that will allow persons to anonymously report violations of compliance policies, regulations and statutes. Serious violations should be documented and promptly investigated to determine their veracity. A log should be maintained that records such calls, including the nature of the investigation and its results.

2.5 ***Auditing and Monitoring.*** The Health Center, under the direction of the Compliance Officer and Compliance Committee, shall conduct regular and ongoing compliance audits or monitoring by external and internal auditors who have expertise in federal and state health care statutes, regulations and federal health care program requirements. The audits should focus on the hospital's programs or divisions, including external relationships with third-party contractors, specifically those with substantive exposure to government enforcement actions. Among other things these audits should focus on the Health Center's compliance with laws governing kickback arrangements, physician self-referral prohibitions, CPT/HCPCS ICD 10 coding, claim development and submission, reimbursement, cost reporting and marketing. Reports of the results of such audits and monitoring should be shared with the Health Center's senior management and the Compliance Committee.

2.6 ***Regular Reports to Board of Trustees.*** The Compliance Officer and Compliance Committee shall regularly report its activities to the Board of Trustees of the Health Center. Such reports may be in the form of minutes of the Compliance Committee.

ARTICLE 3

PRINCIPLES OF ETHICAL CONDUCT

3.1 ***Purpose.*** The Board of Trustees of Salina Regional Health Center provides standards by which covered persons of the Health Center will conduct themselves in order to protect and promote organization-wide integrity and to enhance its ability to achieve the organization's mission. All covered persons are responsible to ensure that their behavior and activity is consistent with the Principles of Ethical Conduct.

3.2 ***Definitions.*** The following definitions shall apply to the Principles of Ethical Conduct.

3.2.1 ***Principles***. The statements of *Principles* that **are stated in bold print and** capitalized articulate the policy of the organization.

3.2.2 ***Standards***. The *standards* that follow the statements of *principle* are intended to provide additional guidance to persons functioning in managerial or administrative capacities. The Principles set forth shall be communicated via the Code of Ethical Conduct periodically to all covered persons.

3.2.3 "***Salina Regional Health Center", "the Health Center" or "SRHC".*** As used in these Principles of Ethical Conduct, the terms "Salina Regional Health Center", "the Health Center", or "SRHC" mean Salina Regional Health Center, Inc. and each of its divisions, subsidiaries and operating or business units, including affiliated hospitals. It does not apply to joint ventures in which Salina Regional Health Center does not have more than a 50% ownership interest because those organizations will have their own Principles of Ethical Conduct.

3.2.4 ***"Covered Person".*** The term "covered person" as used in this Compliance Plan and Code of Ethical Conduct includes "officers," "trustees," "employees," "medical staff appointees," and "volunteers" of Salina Regional Health Center or any of its divisions, subsidiaries, or operating or business units.

3.3 ***Distribution of Code of Ethical Conduct.*** The Code of Ethical Conduct shall be continually updated on the Intranet. Annually employees will sign an acknowledgement at the time of their performance evaluation. All new covered persons shall be provided with a copy of the Code of Ethical Conduct at the time of orientation. All covered persons are responsible to ensure that their behavior and activity is consistent with the Code of Ethical Conduct.

3.4 ***Legal Compliance.*** The following principles and standards apply to the requirement that the Health Center comply with the law.

3.4.1 ***Statement of Principle—Legal Compliance***

SALINA REGIONAL HEALTH CENTER WILL STRIVE TO ENSURE ALL ACTIVITY BY OR ON BEHALF OF THE ORGANIZATION IS IN COMPLIANCE WITH APPLICABLE LAWS.

3.4.2 ***Standards for Legal Compliance***. The following Standards are intended to provide guidance to covered persons to assist them in their obligation to comply with applicable laws. These standards are neither exclusive nor complete. Where examples of potential violations are given, they are not intended to be all inclusive but simply illustrations of issues that could arise. Covered persons are required to comply with all applicable laws, whether or not specifically addressed in this Plan. If questions regarding the existence of, interpretation or application of any law arise, they should be directed to the Compliance Officer or the Compliance Committee or the Health Center legal counsel.

3.4.2.1 ***False Claims and Fraud and Abuse***. The Health Center expects its covered persons to refrain from conduct that may violate the fraud and abuse laws. These laws prohibit certain conduct, including, but not limited to: (1) direct, indirect or disguised payments in exchange for the referral of patients; (2) the submission of false, fraudulent or misleading claims to any government entity or third party payor, including claims for services not rendered, claims which characterize the service differently than the service actually rendered, or claims which do not otherwise comply with applicable program or contractual requirements; and (3) making false representations to any person or entity in order to gain or retain participation in a program or to obtain payment for any service. (For additional guidance, please refer to the Health Center Fraud and Abuse Compliance Policy under Article IV that follows and, if applicable, your compliance policies and procedures).

3.4.2.2 ***Antitrust Compliance.*** All covered persons must comply with applicable antitrust and similar laws that regulate competition. Examples of conduct prohibited by the laws include (1) agreements to fix prices, bid rigging, collusion (including price sharing) with competitors; (2) boycotts, certain exclusive dealing and price discrimination agreements; and (3) unfair trade practices including bribery, misappropriation of trade secrets, deception, intimidation and similar unfair practices. Covered persons are expected to seek advice from the Health Center's legal counsel when confronted with business decisions involving a risk of violation of the antitrust laws.

3.4.2.3 ***Tax Compliance.*** As a nonprofit entity, the Health Center has a legal and ethical obligation to act in compliance with applicable laws, to engage in activities in furtherance of its charitable purpose, and to ensure

that its resources are used in a manner which furthers the public good rather than the private or personal interests of any individual. Consequently, the Health Center and its covered persons will avoid compensation arrangements in excess of fair market value, will accurately report payments to appropriate taxing authorities, and will file all tax and information returns in a manner consistent with applicable laws.

3.4.2.4 ***Lobbying/Political Activity***. The Health Center expects each of its covered persons to refrain from engaging in activity that may jeopardize the tax exempt status of the organization, including a variety of lobbying and political activities. This means that no individual may make any agreement to contribute any money, property, or services of any officer or covered person at the Health Center's expense to any political candidate, party, organization, committee or individual in violation of any applicable law. Covered persons may personally participate in and contribute to political organizations or campaigns, but they must do so as individuals, not as representatives of the Health Center, and they must use their own funds. Where its experience may be helpful, the Health Center may publicly offer recommendations concerning legislation or regulations being considered. In addition, it may analyze and take public positions on issues that have a relationship to the operations of the Health Center when the Health Center's experience contributes to the understanding of such issues. Salina Regional Health Center has many contacts and dealings with governmental bodies and officials. All such contacts and transactions shall be conducted in an honest and ethical manner. Any attempt to influence the decision-making process of governmental bodies or officials by an improper offer of any benefit is absolutely prohibited. Any requests or demands by any governmental representative for any improper benefit should be immediately reported to the Health Center's legal counsel.

3.4.2.5 ***Environmental***. It is the policy of Salina Regional Health Center to manage and operate its business in the manner that respects our environment and conserves natural resources. The Health Center covered persons will strive to utilize resources appropriately and efficiently, to recycle where possible, and otherwise dispose of all waste in accordance with applicable laws and regulations, and to work cooperatively with the appropriate authorities to remedy any environmental contamination for which the Health Center may be responsible.

3.4.2.6 ***Discrimination.*** The Health Center believes that the fair and equitable treatment of covered persons, patients and other persons is important to fulfilling its vision and goals. It is a policy of the Health Center to treat patients without regard to race, color, religion, sex, sexual orientation, gender identity, ethnic origin, age or disability of such person, or any other classification prohibited by law. It is a policy of the Health Center to recruit, hire, train, promote, assign, transfer, lay off, recall and

terminate employees based on their own ability, achievement, experience and conduct without regard to race, color, religion, sex, ethnic origin, age or disability, or any other classification prohibited by law. No form of harassment or discrimination on the basis of sex, sexual orientation, gender identity, race, color, disability, age, religion or ethnic origin or disability or any other classification prohibited by law will be permitted. Each allegation of harassment or discrimination will be promptly investigated in accordance with applicable human resource policies.

3.5 ***Business Ethics.*** The following principles and standards apply to the business ethics and integrity of the Health Center.

3.5.1 ***Statement of Principle—Business Ethics***

IN FURTHERANCE OF SALINA REGIONAL HEALTH CENTER'S COMMITMENT TO THE HIGHEST STANDARDS OF BUSINESS ETHICS AND INTEGRITY, COVERED PERSONS WILL ACCURATELY AND HONESTLY REPRESENT SALINA REGIONAL HEALTH CENTER AND WILL NOT ENGAGE IN ANY ACTIVITY OR SCHEME INTENDED TO DEFRAUD ANYONE OF MONEY, PROPERTY OR HONEST SERVICES.

3.5.2 ***Standards for Business Ethics***. The Standards set forth below are designed to provide guidance to ensure that the Health Center's business activities reflect the high standards of business ethics and integrity. Covered persons' conduct not specifically addressed by these standards must be consistent with this principle.

3.5.2.1 ***Honest Communication.*** The Health Center requires candor and honesty from individuals in the performance of their responsibilities and in communication with our attorneys and auditors. No covered person shall make false or misleading verbal or written statements to any patient, person or entity doing business with the Health Center about other patients, persons or entities doing business or competing with the Health Center, or about the products or services of the Health Center or its competitors.

3.5.2.2 ***Misappropriation of Proprietary Information.*** The Health Center covered persons shall not misappropriate confidential or proprietary information belonging to another person or entity nor utilize any publication, document, computer program, information or product in violation of a third party's interest in such product. All Health Center

covered persons are responsible to ensure they do not improperly copy for their own use documents or computer programs in violation of applicable copyright laws or licensing agreements. Covered persons shall not utilize confidential business information obtained from competitors, including customer lists, price lists, contracts or other information in violation of a covenant not to compete, prior employment agreements, or in any other manner likely to provide an unfair competitive advantage to the Health Center.

3.5.2.3 ***False Claims and Fraud and Abuse.*** See paragraph 3.4.2.1 above.

3.6 ***Confidentiality*****.** The following principles and standards apply to the requirement that the Health Center and its covered persons maintain confidentiality.

3.6.1 ***Statement of Principle—Confidentiality.***

HEALTH CENTER COVERED PERSONS SHALL MAINTAIN THE CONFIDENTIALITY OF PATIENT AND OTHER CONFIDENTIAL INFORMATION IN ACCORDANCE WITH APPLICABLE LEGAL AND ETHICAL STANDARDS.

3.6.2 ***Standards for Confidentiality.*** The Health Center and its covered persons are in possession of and have access to a broad variety of confidential, sensitive and proprietary information, the inappropriate release of which could be injurious to individuals, the Health Center's business partners and the Health Center itself. Every Health Center covered person has an obligation to actively protect and safeguard confidential, sensitive and proprietary information in a manner designed to prevent the unauthorized disclosure of information.

3.6.2.1 ***Patient/Member Information***. All Health Center covered persons have an obligation to conduct themselves in accordance with the principle of maintaining the confidentiality of patient and member information in accordance with all applicable laws and regulations. Covered persons shall refrain from revealing any personal or confidential information concerning patients or members unless supported by legitimate business or patient care purposes. If questions arise regarding an obligation to maintain the confidentiality of information or the appropriateness of releasing information, covered persons should seek guidance from management, Privacy Officer or the Health Center's legal counsel.

3.6.2.2 ***Proprietary Information.*** All information, ideas and intellectual property assets of the Health Center are important to organizational success. Information pertaining to the Health Center's

competitive position or business strategies, payment and reimbursement information, and information relating to negotiations with covered persons or third parties should be protected and shared only with covered persons having a need to know such information in order to perform their job responsibilities. Covered persons should exercise care to ensure that intellectual property rights, including patents, trademarks, copyrights and software are carefully maintained and managed to preserve and protect their value.

3.6.2.3 ***Personnel Actions/Decisions.*** Salary, benefit and other personal information relating to covered persons shall be treated as confidential. Personnel files, payroll information, disciplinary matters and similar information shall be maintained in a manner designed to ensure confidentiality in accordance with applicable laws. Covered persons will exercise due care to prevent the release or sharing of information beyond those persons who may need such information to fulfill their job function.

3.7 ***Conflicts of Interest.*** The following principles and standards apply to the requirement that the Health Center and its covered persons avoid conflicts of interest.

3.7.1 ***Statement of Principle—Conflicts of Interest.***

TRUSTEES, OFFICERS, COMMITTEE MEMBERS AND COVERED PERSONS OWE A DUTY OF UNDIVIDED AND UNQUALIFIED LOYALTY TO THE ORGANIZATION. PERSONS HOLDING SUCH POSITIONS MAY NOT USE THEIR POSITIONS TO PROFIT PERSONALLY OR TO ASSIST OTHERS IN PROFITING IN ANY WAY AT THE EXPENSE OF THE ORGANIZATION. (PLEASE REFER TO THE HEALTH CENTER CONFLICTS OF INTEREST POLICY FOR FURTHER GUIDANCE.)

3.7.2 ***Standards for Conflicts of Interest.*** All covered persons are expected to regulate their activities so as to avoid actual impropriety and/or the appearance of impropriety which might arise from the influence of those activities on business decisions of the Health Center, or from disclosure or private use of business affairs or plans of the Health Center.

3.7.2.1 ***Outside Financial Interests.*** While not all inclusive, the following will serve as a guide to the types of activities by a covered person, or household members of such person, which might cause conflicts of interest:

1. ***Ownership or Employment by Outside Concerns.*** Ownership in or employment by any outside concern that does business with the Health Center may cause conflicts of interest. This does not apply to stock or other investments held in a publicly held corporation, *provided* the value of the stock or other investments does not exceed 5% of the corporation's stock. The Health Center may, following a review of the relevant facts, permit ownership interests which exceed these amounts if management concludes such ownership interests will not adversely impact the Health Center's business interest or the judgment of the covered person.

2. ***Conduct of Business not on Behalf of Health Center.*** Conduct of any business not on behalf of the Health Center, with any vendor, supplier, contractor, or agency, or any of their officers by covered persons may cause conflicts of interest to occur.

3. ***Representation of Health Center in which Personal Interest Exists.*** Representation of the Health Center by a covered person in any transaction in which he or she or a household member has a substantial personal interest is a conflict of interest.

4. ***Disclosure of Inside Information.*** Disclosure or use of confidential, special or inside information of or about the Health Center, particularly for personal profit or advantage of the covered person or a household member is a conflict of interest.

5. ***Competing With the Health Center.*** Competition with the Health Center by a covered person, directly or indirectly, in the purchase, sale or ownership of property or property rights or interests, or business investment opportunities may result in a conflict of interest.

3.7.2.2 ***Services for Competitors/Vendors.*** No covered person shall perform work or render services for any competitor of the Health Center or for any organization with which the Health Center does business or which seeks to do business with the Health Center outside of the normal course of his/her employment with the Health Center without the approval of the Chief Executive Officer of the Health Center or the person's supervisor. Nor shall any such covered person be a director, officer, or consultant of such an organization, nor permit his/her name to be used in any fashion that would tend to indicate a business connection with such organization.

3.7.2.3 ***Participation on Boards of Trustees/Directors.*** Care should be taken by all covered persons to avoid conflicts of interest that may arise by reason of service on another Board of Trustees/Directors of an

organization doing business with the Health Center. In this regard, the following practices should be followed:

1. ***Supervisory Approval.*** A covered person must obtain approval from his/her supervisor prior to serving as a member of the Board of Trustees/Directors of any organization whose interests may conflict with those of the Health Center.

2. ***Exemption for Civic Duties.*** A covered person who is asked or seeks to serve on the Board of Trustees/Directors of any organization whose interest would not impact the Health Center (for example, civic, non-governmental, charitable, fraternal and so forth), will not be required to obtain such approval.

3. ***Fees for Service.*** All fees/compensation (other than reimbursement for expenses arising from Board participation) that are received for Board services provided during normal work time shall be paid directly to the Health Center unless otherwise agreed by the Health Center in writing.

4. ***Disclosure.*** An officer or trustee must disclose all Board of Trustees/Directors activities in the annual Conflict of Interest disclosure statement.

5. ***Right of Prohibition.*** The Health Center retains the right to prohibit membership on any Board of Trustees/Directors where such membership might conflict with best interests of the Health Center.

6. ***Questions.*** Questions regarding whether or not Board participation might present a conflict of interest should be discussed with a covered person's supervisor.

3.7.2.4 ***Honoraria.*** Covered persons are, with the permission of their supervisor, encouraged to participate as faculty and speakers at educational programs and functions.

3.8 ***Business Relationships*****.** The following principles and standards apply to the business relationships of the Health Center.

3.8.1 ***Statement of Principle—Business Relationships.***

BUSINESS TRANSACTIONS WITH VENDORS, CONTRACTORS AND OTHER THIRD PARTIES SHALL BE TRANSACTED FREE FROM OFFERS OR SOLICITATION OF

GIFTS AND FAVORS OR OTHER IMPROPER INDUCEMENTS IN EXCHANGE FOR INFLUENCE OR ASSISTANCE IN A TRANSACTION.

3.8.2 ***Standards for Business Relationships.*** The Standards set forth below are intended to guide covered persons in determining the appropriateness of the listed activities or behaviors within the context of the Health Center business relationships, including relationships with vendors, providers, contractors, third party payors and government entities. It is the intent of the Health Center that this policy be construed broadly to avoid even the appearance of improper activity. If there is any doubt or concern about whether specific conduct or activities are ethical or otherwise appropriate, you should contact legal counsel.

3.8.2.1 ***Gifts and Gratuities.*** It is the Health Center's desire at all times to preserve and protect its reputation and to avoid the appearance of impropriety. The following are guidelines for compliance in this area.

1. ***"Nominal Value".*** The Health Center has made no attempt to define "nominal" as a specific dollar value. Rather, the Health Center expects its covered persons to exercise good judgment and discretion in accepting gifts in accordance with the guidelines that follow. Covered persons are expected to consult with their supervisor or the compliance officer if they have any questions about the amount of any gift or gratuity.

2. ***Gifts from Patients or Their Family.*** Covered persons are prohibited from *soliciting* tips, personal gratuities or gifts from patients and/or their families and from accepting monetary tips or gratuities. Covered persons may accept gifts of a nominal value from patients and/or their families if they can be shared with their co-workers. If a patient or another individual wishes to present a monetary gift to SRHC, he/she should be referred to the Salina Regional Health Foundation.

3. ***Gifts Influencing Decision-making.*** Covered persons shall not accept gifts, favors, services, entertainment or other things of value to the extent that decision-making or actions affecting the Health Center might be influenced. Similarly, the offer or giving of money, services or other things of value with the expectation of influencing the judgment or decision making process of any purchaser, supplier, customer, government official or other person by the Health Center is absolutely prohibited. Any such conduct must be reported immediately to the Compliance Officer.

4. ***Gifts From Existing Vendors*.** Covered persons may retain gifts from vendors that have a nominal value. If a covered person has any concern whether a gift should be accepted, the employee should consult with his/her supervisor. To the extent possible, these gifts should be shared with employees' co-workers. Covered persons shall not accept excessive gifts, meals, expensive entertainment or other offers of goods or services which have more than a nominal value nor may they solicit gifts from vendors, suppliers, contractors or other persons.

5. ***Vendor Sponsored Entertainment.*** At a vendor's invitation, an individual may accept meals or refreshments at the vendor's expense. Occasional attendance at a local theater or sporting event, or similar entertainment at vendor expense may also be accepted. In most circumstances, a regular business representative of the vendor should be in attendance with the covered person.

6. ***Additional Policies***. Nothing in this policy shall prohibit a business unit or supervisor from establishing stricter rules relating to the acceptance of gifts, gratuities or other things of value from vendors.

3.8.2.2 ***Workshops, seminars and training sessions.*** Attendance at local, vendor sponsored workshops, seminars and training sessions is permitted. Attendance, at vendor expense, at out of town seminars, workshops and training sessions is permitted only with the approval of a covered person's supervisor.

3.8.2.3 ***Contracting.*** Covered persons may not utilize "insider" information for any business activity conducted by or on behalf of the Health Center. All business relations with contractors must be conducted at arm's length, both in fact and in appearance and in compliance with the Health Center policies and procedures. Covered persons must disclose personal relationships and business activities with contractor personnel that may be construed by an impartial observer as influencing the covered persons' performance of duties. Covered persons have a responsibility to obtain clarification from management employees on questionable issues that may arise and to comply, where applicable, with the Health Center's conflict of interest policy.

3.8.2.4 ***Business Inducements.*** The Health Center's covered persons shall not seek to gain any advantage through the improper use of payments, business courtesies or other inducements. Offering, giving, soliciting or receiving any form of bribe or other improper payment is prohibited.

3.9 ***Protection of Assets.*** The following principles and standards apply to the protection of assets of the Health Center.

3.9.1 ***Statement of Principle—Protection of Assets.***

ALL COVERED PERSONS WILL STRIVE TO PRESERVE AND PROTECT THE CORPORATION'S ASSETS BY MAKING PRUDENT AND EFFECTIVE USE OF THE HEALTH CENTER RESOURCES AND PROPERLY AND ACCURATELY REPORTING ITS FINANCIAL CONDITION.

3.9.2 ***Standards for Protection of Assets.*** The Standards set forth below are intended to guide covered persons by articulating the Health Center's expectations as they relate to activities or behaviors which may impact the Health Center's financial health or which reflect a reasonable and appropriate use of the assets of a nonprofit entity.

3.9.2.1 ***Internal Controls.*** The Health Center has established control standards and procedures to ensure that assets are protected and properly used and that financial records and reports are accurate and reliable. All covered persons of the Health Center share the responsibility for maintaining and complying with required internal controls.

3.9.2.2 ***Financial Reporting***. All financial reports, accounting records, research reports, expense accounts, time sheets and other documents must accurately and clearly represent the relevant facts or the true nature of a transaction. Improper or fraudulent accounting, documentation or financial reporting is contrary to the policy of the Health Center and may be in violation of applicable laws.

3.9.2.3 ***Travel and Entertainment.*** Travel and entertainment expenses should be consistent with the covered person's job responsibility and the organization's needs and resources. It is the Health Center's policy that a covered person should not suffer a financial loss nor a financial gain as a result of business travel and entertainment. Covered persons are expected to exercise reasonable judgment in the use of the Health Center's assets and to spend the organization's assets as carefully as they would spend their own. Covered persons must also comply with the Health Center policies relating to travel and entertainment expense.

3.9.2.4 ***Personal Use of Corporate Assets.*** All covered persons are expected to refrain from converting assets of the organization to personal

use. All property and business of the organization shall be conducted in the manner designed to further the Health Center's interest rather than the personal interest of an individual covered person. Covered persons are prohibited from the unauthorized use or taking of the Health Center's equipment, supplies, materials or services. Prior to engaging in any activity on company time which will result in remuneration to the covered person or the use of the Health Center's equipment, supplies, materials or services for personal or non-work related purposes, covered persons shall obtain the approval of the appropriate business unit or other management of the Health Center.

3.10 ***Administration and Application of the Principles.*** The Health Center expects each person to abide by the Principles and Standards set forth herein and to conduct the business and affairs of the Health Center in a manner consistent with the general statement of principles set forth herein.

3.10.1 ***Failure to Comply*.** Failure to abide by these Principles and Standards or the guidelines for behavior which they represent may lead to disciplinary action. For alleged violations, the Health Center will weigh relevant facts and circumstances, including, but not limited to, the extent to which the behavior was contrary to the express language or general intent of the Principles and Standards, the egregiousness of the behavior, the covered person's history with the organization and other factors that the Health Center deems relevant. Discipline for failure to abide by the Compliance Plan or the Code of Ethical Conduct may, in the Health Center's discretion, range from oral correction to termination.

3.10.2 ***No Contract Rights*.** Nothing in this Code of Ethical Conduct is intended to nor shall be construed as providing any additional employment or contract rights to covered persons or other persons.

3.10.3 ***Changes in Code of Ethical Conduct.*** While the Health Center will generally attempt to communicate changes concurrent with or prior to the implementation of such changes, the Health Center reserves the right to modify, amend or alter the Code of Ethical Conduct without notice to any person or employee.

ARTICLE 4

SUBSTANTIVE LAWS FOR COMPLIANCE

4.1 ***Preamble*.** There are certain substantive areas of the law that merit particular coverage in the Compliance Plan because they contain criminal and/or civil penalties. As such, the Federal Sentencing Guidelines reward the adoption of an effective compliance program by reducing the imposed sanctions. It is the objective of this Article 4 to focus particular attention on those areas of the law that are particularly applicable to the Health Center and to which the Federal Sentencing Guidelines may apply. For each

such identified area there will be a statement of intent, a statement of policy, an application of the policy, and compliance guidelines. It should be understood that simply because these areas of the law are identified, does not mean that the Health Center is focused on complying with just these laws. Rather, it is the intention of the Health Center to fully comply with all laws that apply to its operations.

4.2 ***False Claims Acts.*** The Federal False Claims Act 31 U.S.C. §3729, *et.seq.* imposes civil liability on any person or entity who: 1) knowingly files a false or fraudulent claim for payments to Medicare, Medicaid or other federally funded health care program; 2) knowingly uses a false record or statement to obtain payment on a false or fraudulent claim from Medicare, Medicaid or other federally funded health care program; or 3) conspires to defraud Medicare, Medicaid or other federally funded health care program by attempting to have a false or fraudulent claim paid. Similarly, the false claims provisions under the Social Security Act, 42 U.S.C. §1320a-7b makes it a federal crime to knowingly and willfully make or cause to be made any false statement or representation of material fact in any claim for benefits or payments under a federal healthcare program, including Medicare or Medicaid. In combination, these laws subject providers knowingly making false claims to criminal fines and penalties, civil penalties and exclusion from the Medicare or Medicaid programs. These laws are collectively referred to herein as "the False Claims Acts".

4.2.1 ***Statement of Intent.*** It is the intent of the Health Center to consistently and fully comply with all laws and regulations pertaining to the delivery of and billing for services which apply to the Health Center on account of its participation in Medicare, Medicaid and other government programs and other private payors.

4.2.2 ***Statement of Policy.*** The Health Center expects its covered persons to refrain from conduct that may violate the False Claims Acts. These laws prohibit (1) direct, indirect or disguised payments in exchange for the referral of patients; (2) the submission of false, fraudulent or misleading claims to any government entity or third party payor, including claims for services not rendered, claims which characterize the service differently than the service actually rendered, or claims which do not otherwise comply with applicable program or contractual requirements; and (3) making false representations to any person or entity in order to gain or retain participation in a program or to obtain payment for any service.

4.2.3 ***Application of Policy.*** It is the responsibility of all covered persons that submissions for reimbursement to Medicare, Medicaid, and other government payors for services rendered by the Health Center and any of its subsidiaries, divisions and contractors be accurate and free of violations of the law. In addition, this policy is intended to apply to business arrangements with physicians, vendors, hospitals and other persons which may be impacted by federal or state laws relating to fraud and abuse. Individuals within SRHC, Inc. who observe activities or behavior that may violate the law in some manner and who report their observations

either to management or to governmental agencies are provided protections under the law.

4.2.4 ***Compliance Guidelines.*** By adhering to the following guidelines, the chances of violating the False Claims Acts can be decreased. These guidelines, however, should not be viewed as providing an answer for all situations. Whenever a question arises concerning the propriety of a certain course of conduct, guidance should be sought from appropriate accounting representatives within the Health Center, the Health Center's Compliance Officer, the Compliance Committee or legal counsel. Generally, covered persons should comply with the following guidelines:

4.2.4.1 ***Billing for Items or Services Not Actually Rendered.*** No patient or his or her payor should be billed for services that are not actually rendered or performed.

4.2.4.2 ***Providing Medically Unnecessary Services.*** Claims should not be submitted to a patient or his or her payor ***that*** seek reimbursement for a service that is not warranted by the patient's current or documented medical condition. Exception: If patient has signed an advanced beneficiary notice prior to the medically unnecessary service it is allowed to bill the patient individually.

4.2.4.3 ***Upcoding and DRG Creep.*** Billing codes and the assignment of DRG's should accurately reflect the service provided to the patient. Billing codes or DRG codes should not be used that provide for a higher payment rate than the billing code that actually reflects the service furnished to the patient.

4.2.4.4 ***Outpatient Services Rendered in Connection with Inpatient Stays.*** Claims should not be submitted for non-physician outpatient services that are included in inpatient payment under the Prospective Payment System. Non-physician outpatient services provided within 72 hours of in-patient admission to the hospital are subject to this prohibition.

4.2.4.5 ***Duplicate Billings.*** Duplicate billings should be avoided. This occurs when ***more*** than ***one*** claim is submitted to more than one primary payor at the same time.

4.2.4.6 ***False Cost Reports.*** False cost reports should not be submitted. Statistics, financial data, and payor information should be accurate and supported by auditable documentation. Expenses and allocations should be accurately reported in the proper cost centers. Care should be taken through the use of professional auditors that cost reports are accurate.

4.2.4.7 ***Unbundling.*** Bills should not be submitted piecemeal or in fragmented fashion to maximize the reimbursement for various tests or procedures that are required to be billed together at a reduced cost.

4.2.4.8 ***Billing for Discharge in Lieu of Transfer.*** When the Health Center transfers a patient to another Prospective Payment System hospital, the Health Center should charge Medicare only the per diem amount. The receiving Hospital may charge the full DRG.

4.2.4.9 ***Refund of Credit Balances.*** Credit balances should be fully refunded on a timely basis.

4.2.4.10 ***Falsely Billing Physician Services.*** Claims for physician services should not be presented if the person providing the service is not a physician.

4.2.4.11 ***Conversion of Payments.*** The knowing and willful conversion (stealing) of a payment intended for the use of another person is a crime and should be avoided.

4.3 ***Fraud and Abuse Laws.*** For the purposes of this section, the phrase "fraud and abuse laws" generally refers to those laws that prohibit: (1) the payment of kickbacks or other forms of remuneration in exchange for referrals of patient or business reimbursed by a federal healthcare program (e.g. the Anti-Kickback Statute, 42 U.S.C. §1320a-7b(b)); or (2) Physicians from making referrals for certain services to entities with which they have a prohibited financial relationship (e.g. the Stark Laws, 42 U.S.C. §1395nn). The Anti-Kickback Statute provides criminal penalties and prohibitions from participation in the government payment programs for violations and applies to all federally funded health care programs. The Stark Laws provide civil penalties against physicians that violate the law and it applies to Medicare and Medicaid payments.

4.3.1 ***Statement of Intent.*** It is the intent of the Health Center to consistently and fully comply with the fraud and abuse laws and to avoid prohibited remuneration in exchange for referrals and violations of the physician self-referral laws, where applicable.

4.3.2 ***Statement of Policy.*** The Health Center expects its covered persons to refrain from conduct that may violate the fraud and abuse laws. These laws prohibit (1) direct, indirect or disguised payments in exchange for the referral of patients; (2) participating in prohibited situations in which physicians refer to an entity in which such a physician or his or her family has a direct or indirect ownership interest. It is noted that there are certain applicable "safe harbors" or exceptions that the law prescribes and such transactions may be permissible if they meet one or more of these safe harbors.

4.3.3 ***Application of Policy.*** It is the responsibility of all covered persons to not engage in transactions in which there is prohibited compensation paid for referrals to the Health Center or in which physicians make prohibited referrals to entities in which they have an ownership interest.

4.3.4 ***Compliance Guidelines.*** By adhering to the following guidelines, the chances of violating the Anti-kickback laws can be decreased. Whenever a question arises concerning the propriety of a certain course of conduct, it is expected that the Health Center's Compliance Officer or legal counsel will be consulted. Generally, covered persons should comply with the following guidelines:

4.3.4.1 ***Advice of Counsel.*** No transaction potentially involving the fraud and abuse laws shall be entered into by the Health Center without the written advice of competent legal counsel citing specific authority that will support the legality of the transaction.

4.3.4.2 ***OIG Advisory Opinions.*** In any transaction where the fraud and abuse laws apply, the Health Center shall seek the advice of counsel on whether to request an advisory opinion from the Office of the Inspector General of CMS or other such governmental office issuing such opinions before entering into the transaction.

4.4 ***Emergency Service "Anti-Dumping" Law.*** The Emergency Medical Treatment and Active Labor Act ("EMTALA") was enacted in 1986 (42 U.S.C. §1395dd). The statute is intended to protect the uninsured and indigent from denial of emergency care which include both care and active labor. EMTALA prohibits "patient dumping," the transfer of an unstable patient or the refusal to provide emergency care based on the patient's inability to pay or on other grounds unrelated to the patient's need for emergency services (e.g. a busy ED or no contract with the patient's insurer). Under this law, anyone coming to the Health Center seeking emergency services must undergo a Medical Screening Examination to determine whether such person is in an "emergency medical condition" or "active labor". If the Medical Screening Examination reveals that the patient has an emergency medical condition, the Health Center must stabilize the patient if it has the capability of doing so, or it must transfer the patient to an appropriate facility equipped to stabilize the patient. Under this law hospitals and physicians alike may be subject to Civil Monetary Penalties and exclusion from the Medicare and State healthcare programs.

4.4.1 ***Statement of Intent.*** It is the intent of the Health Center to consistently and fully comply with EMTALA and any similar state laws that regulate access to emergency care.

4.4.2 ***Statement of Policy.*** The Health Center expects any person coming to its facility seeking emergency medical treatment to be immediately screened by Qualified Medical Personnel to determine whether an emergency medical condition exists. If such a condition exists, the Health Center will provide for further

examination and stabilizing treatment within its capacity to stabilize the patient or make an appropriate transfer to another facility that has the capability and capacity to treat the patient's emergency medical condition.

4.4.3 ***Compliance Guidelines.*** By adhering to the following guidelines, the chances of violating EMTALA can be decreased. Whenever a question arises concerning the propriety of a certain course of conduct, appropriate consultation should be sought from department directors, the Health Center's Compliance Officer, the Compliance Committee or legal counsel. Generally, covered persons should comply with the following guidelines:

4.4.3.1 ***Designation of Qualified Medical Personnel.*** The Health Center will designate Qualified Medical Personnel, who shall be either a physician or other person, approved by the governing board, to conduct medical screening examinations.

4.4.3.2 ***Conduct Medical Screening Examinations.*** Any person coming to the Health Center's facilities seeking access to emergency care shall immediately undergo a Medical Screening Examination by Qualified Medical Personnel to determine whether an emergency medical condition exists. The Medical Screening Examination is not triage and must be done before making any inquiry into the ability of the patient to pay for services. The Medical Screening Examination must be done utilizing the resources of the hospital that would be used on any individual presenting with the same signs and symptoms regardless of the ability to pay.

4.4.3.3 ***Stabilizing Treatment or Appropriate Transfer.*** If it is determined that the person does have an Emergency Medical Condition following the Medical Screening Examination, then the patient must be stabilized within the Health Center's capacity to do so and if the Health Center does not have the capability of fully stabilizing the patient then an appropriate transfer, after the Health Center has minimized the risk to the patient, to another facility that has the capability and capacity to treat the patient's Emergency Medical Condition shall be made.

4.4.3.4 ***Acceptance of Appropriate Transfers.*** SRHC will accept appropriate transfers from other facilities if such transfers are within its capacity to treat the patient.

4.4.3.5 ***Maintenance of Records.*** SRHC will maintain required records for EMTALA compliance, appropriate signage, a list of physicians who are on call to provide examination and treatment, and adopt other required policies and procedures to comply with EMTALA.

4.5 ***Privacy and Security Laws. The final Omnibus Rule became effective March 26, 2013 and implements the modifications to the rule mandated by the HITECH***

Act. The federal privacy regulations were published on December 28, 2000, and serve to implement the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act ("HIPAA") which was enacted in 1996 (42 U.S.C. §1320d *et.seq.)*. The HIPAA regulations (45 C.F.R. §164.501 *et. seq*.) form a complex new regulatory infrastructure governing the use and disclosure of health information about individuals. The basic requirement of the privacy rules is to prohibit a health care provider from using or disclosing an individual's protected health information, except as specifically permitted in the regulations. In its most simple form, these regulations continue to follow the sacrosanct law of health care, which is that a person's health information is confidential, absent the authorization of such person or such person's lawful representative to release the information. Violations of the privacy rules can result in civil and criminal penalties under the federal regulations.

4.5.1 ***Statement of Intent.*** It is the intent of the Health Center to consistently and fully comply with HIPAA and, in particular, the privacy and security rules promulgated under it. It is also the intent of the Health Center to comply with other state and federal laws requiring that the health information of patients be kept confidential.

4.5.2 ***Statement of Policy.*** The Health Center will not use and disclose Protected Health Information ("PHI") or electronic PHI of an individual, except as permitted under the federal privacy rules. Under the rules use and disclosure is permitted: (1) to the individual who is the subject of PHI; (2) without the individual's consent in certain treatment situations; (3) with the individual's consent (explicit or by regulatory presumption) for treatment, payment, and healthcare operations; (4) with the individual's authorization for purposes other than treatment, payments and healthcare operations; (5) under certain circumstances without the individual's consent or authorization but with an opportunity to agree or object; and (6) under certain circumstances without the individual's consent or authorization to comply with certain regulatory mandates (e.g. law enforcement activities).

4.5.3 ***Compliance Guidelines.*** Whenever a question arises concerning the propriety of a certain course of conduct, it is expected that the Director of Health Information Systems, who is the Privacy Officer, the Vice-President of Information Technology, who is the Information Security Officer, the Compliance Officer, or legal counsel will be consulted. Generally, covered persons should comply with the following guidelines:

4.5.3.1 ***Understand Protected Health Information.*** Protected Health Information ("PHI") under the privacy rules is health information that: (1) is created or received by a health care provider or other covered entity; (2) relates to an individual's physical or mental health condition, the provision of healthcare to an individual, or the payment for the provision of healthcare to an individual; and (3) identifies the individual or creates a

reasonable basis to believe the information can be used to identify the individual.

4.5.3.2 ***Keep Protected Health Information Confidential.*** Absent a clear patient authorization in writing or statutory or regulatory authority to do so, PHI shall be kept confidential.

4.5.3.3 Individual Rights under the Privacy Rules. Individual rights under the privacy regulations will be honored, including: (1) the right to notice of privacy practices; (2) right to access to PHI; (3) the right to request an amendment to PHI; (4) the right to an accounting of PHI disclosures; (5) the right to request additional protections for PHI; (6) special right with respect to psychotherapy notes; (7) the right to complain about violations of the privacy regulations (8) the right to restrict certain disclosures of PHI to a health plan if the individual pays out of pocket in full for the service.

4.5.3.4 ***Business Associate Agreements.*** "Business associates" are entities, that, on behalf of SRHC, perform a service or function that involves the use or disclosure of PHI. SRHC has written agreements with business associates that provide satisfactory assurances that the business associate will safeguard PHI and that will permit termination of the business associate arrangement if it violates a material term of the contract.

4.6 ***Antitrust Laws.*** Antitrust laws have been in existence for at least 85 years and are encompassed in several different federal laws, including the Sherman Act (15 U.S.C. §1), the Clayton Act (15 U.S.C.§18), the Robinson Patman Act and The Federal Trade Commission Act (15 U.S.C. §45). The purpose of these laws is to promote competition. The premise of the antitrust laws is that free competition will yield the best allocation of economic resources, the lowest price, and the highest-quality products and services. The laws proscribe conduct that is in contravention of these objectives, including agreements to restrain trade, to illegally set prices among competitors, to allocate market share, to enter into group boycotts whereby two or more entities agree to not do business with a third party, and to enter into illegal tying arrangements whereby the sale of one product is illegally conditioned on the purchase of another product. The acts provide for potential civil and criminal penalties against those that violate the laws.

4.6.1 ***Statement of Intent.*** It is the intent of the Health Center to comply with state and federal laws concerning antitrust and unfair competition.

4.6.2 ***Statement of Policy.*** The Health Center expects its covered persons to refrain from conduct that may violate the state and federal laws concerning antitrust and unfair competition. These laws generally prohibit: (1) contracts and conspiracies in restraint of trade; (2) illegal price fixing among competitors; (3) agreements among competitors to divide markets so as to reduce competition; (4) group boycotts that tend to eliminate or reduce the number of competitors in the

market place; (5) unlawful tying arrangements whereby a seller of a product attempts to tie the purchase of one product with another; (6) the creation of unlawful monopolies; and (7) certain types of discriminatory pricing mechanisms.

4.6.3 ***Compliance Guidelines.*** By adhering to the following guidelines, the chances of violating the antitrust laws can be decreased. These guidelines, however, should not be viewed as providing an answer for all situations. Whenever a question arises concerning the propriety of a certain course of conduct, it is expected that the Health Center's Compliance Officer, the Compliance Committee or legal counsel will be consulted. Generally, covered persons should refrain from the following conduct:

4.6.3.1 ***Price Discussions.*** Covered persons should refrain from discussing prices with competitors. This includes prices that the Health Center charges for its services, and the prices that the Health Center pays for services that it purchases in a competitive atmosphere.

4.6.3.2 ***Dividing Markets or Territories***. Covered persons should refrain from dividing markets or territories with competitors. This includes markets for patients as well as markets for physicians, nurses or technical employees that serve those patients to the benefit of the Health Center.

4.6.3.3 ***Tying Products.*** Covered persons should refrain from tying the sale of one product or service to the sale or use of another product.

4.6.3.4 ***Conditional Purchases.*** Covered persons should refrain from making sales or purchases from the Health Center conditional or reciprocal to sales or purchases by the Health Center.

4.6.3.5 ***Participation in Meetings Among Competitors or Trade Associations.*** Covered persons should be cautious about participating in meetings among competitors or in trade associations. Generally, covered persons should refrain from discussing at such meetings: (1) prices or other factors determinative of prices; (2) costs; (3) profit levels; (4) credit terms; (5) allocation of territories among competitors; (6) allocation of customers among competitors; (7) refusal to deal with customers or suppliers; and (8) limitations of service.

4.6.3.6 ***Safe Harbor for Determinations of Fair Market Value.*** In some cases, in order to comply with other areas of the law such as Fraud and Abuse and the requirements of the tax laws that tax exempt organizations avoid private inurement, it is understood that senior management of the Health Center may need to consult with other institutions or providers to determine the fair market value of services that are the subject of a contract. Such contacts for the purpose of complying with such laws are appropriate.

4.7 ***Tax Laws.*** SRHC and several of its subsidiaries are exempt from income taxation under federal and state law. The Internal Revenue Code of 1986, as amended, and the regulations adopted pursuant to it contain restrictions and prohibitions on the organization in order to obtain this exemption as a recognized charitable and health care organization. The violation of tax laws can result in both civil and criminal sanctions. Potentially violations could result in a loss of the Health Center's tax exemption.

4.7.1 ***Statement of Intent.*** It is the intent of the Health Center to take all necessary steps to maintain its tax-exempt status under §501(c)(3) of the Internal Revenue Code of 1986, as amended. The Health Center is organized exclusively for religious, charitable, scientific and educational purposes, and it intends to provide economic, efficient and quality health care to people regardless of age, sex, color, religion, national origin, or ability to pay.

4.7.2 ***Statement of Policy.*** The Health Center is a charitable nonprofit tax exempt corporation organized under the laws of the State of Kansas and qualified as exempt under §501(c)(3) of the Internal Revenue Code of 1986, as amended. As such, the Health Center expects its covered persons to operate its facilities consistent with its charitable purposes and to refrain from conduct that would jeopardize its tax-exempt status. It expects all covered persons to comply with all federal and state tax laws that apply to the Health Center. The Health Center will: (1) be controlled by a board of trustees composed of civic leaders that have no economic interest in it; (2) will operate an active emergency room accessible to the general public; (3) engage in medical research, training, and education; (4) maintain a medical staff open to qualified members of the profession unless there are legitimate reasons for closing the staff or limiting the number of physicians in a given practice area; and (5) participate in and sponsor various programs that improve the health of the community. The Health Center will avoid: (1) private inurement that allows its net earnings to inure to the benefit of private individuals; and (2) intervening in any political campaign on behalf of or in opposition to any candidate for public office.

4.7.3 ***Compliance Guidelines.*** By adhering to the following Guidelines, the chances of jeopardizing the Health Center's tax-exempt status can be decreased. These Guidelines, however, should not be viewed as providing an answer for all situations. Whenever a question arises concerning the propriety of a certain course of conduct, it is expected that the Health Center's Compliance Officer, legal counsel or auditors will be consulted. Generally, covered persons should adhere to the following guidelines:

4.7.3.1 ***Physician Recruitment Programs.*** Where there is a demonstrated community need, the Health Center will only offer recruitment incentives for physicians that are consistent with the Health Center's policies and procedures. In determining the community need for physician recruitment and compensation plans, the Health Center will

consider whether: (1) there is evidence of a population/physician ratio that is deficient in a particular specialty; (2) there is a demand for and a lack of availability of a service for which the physician is being recruited; (3) there is a demonstrated reluctance of physicians to relocate to the community; (4) there is a reasonably expected reduction in the number of medical specialists servicing the Health Center's needs due to retirements within a given specialty; and (5) there is a documented lack of physicians serving indigent or Medicaid patients.

4.7.3.2 ***Compensation Arrangements With Physicians.*** Where there is a demonstrated community need, the Health Center will only enter into compensation arrangements with physicians that are: (1) reasonable; (2) negotiated at arm's length; (3) based on the fair market value of services in similarly situated locales; and (4) do not give the affected physician or physicians control or authority over the Health Center.

4.7.3.3 ***Joint Ventures.*** The Health Center will not enter into joint ventures that involve the sale of or sharing in gross or net revenue streams unless such transactions: (1) serve a demonstrated community need; (2) serve a charitable and exempt purpose; (3) require a sharing and apportionment of risk between the Health Center and participants in such joint ventures; and/or (4) do not disproportionately benefit non-tax-exempt partners or disproportionately risk Health Center assets. Any such joint venture transactions shall be reviewed and approved by qualified tax counsel prior to consummation of the transaction.

4.7.3.4 ***Leases and Loan Transactions***. All leases and loan transactions that the Health Center enters into with for-profit entities shall be negotiated at arm's length and shall be based on fair market value.

4.7.3.5 ***Accessibility to Emergency Department.*** The Health Center will continue to make its Emergency Department accessible to patients or prospective patients, irrespective of the ability of such persons to pay for the services.

4.7.3.6 ***Medical Staff Participation.*** The medical staff will remain open to qualified members ***unless*** there are legitimate reasons for closing the staff or limiting the number of physicians in a given practice area.

4.7.3.7 ***Political Activities.*** The Health Center will not intervene in any political campaign ***on*** behalf of or in opposition to any candidate for public office, and no substantial part of the activities of the Health Center will be to carry on propaganda or attempt to influence federal, state or local legislation.

4.7.3.8 ***Tax Exempt Bond Financings.*** Tax exempt bond financings will be undertaken only under the advice and direction of knowledgeable accountants and legal counsel. Transactions of the health center shall be in compliance with bond covenants and documents.

4.8 ***Environmental Laws***. Environmental laws are very complex because there are so many of them that are spread throughout the statutes and regulations. The authority for enforcement of environmental laws often overlaps among various levels of government and various agencies at each level. Generally, most environmental regulations are organized by media (e.g. air, water, sold waste, etc.) Many of these laws contain civil and criminal penalties for violations.

4.8.1 ***Statement of Intent.*** The Health Center intends to follow all state and federal environmental laws that apply to it.

4.8.2 ***Statement of Policy.*** It is the policy of Salina Regional Health Center to manage and operate its business in the manner that respects our environment and conserves natural resources. The Health Center covered persons will strive to utilize resources appropriately and efficiently, to recycle where possible, and otherwise dispose of all waste in accordance with applicable laws and regulations, and to work cooperatively with the appropriate authorities to remedy any environmental contamination for which the Health Center may be responsible.

4.8.3 ***Compliance Guidelines.*** By adhering to the following guidelines, the chances of violating environmental laws can be decreased. These guidelines, however, should not be viewed as providing an answer for all situations. Whenever a question arises concerning the propriety of a certain course of conduct, it is expected that the appropriate supervisor, director, or member of the administrative staff responsible for environmental issues will be consulted. Generally, covered persons should adhere to the following guidelines:

4.8.3.1 ***Disposal of Wastes.*** All wastes of the health center will be disposed of in accordance with applicable law and regulations and with procedures recommended by applicable vendors. This includes both hazardous wastes that exhibit characteristics of toxicity or flammability and nonhazardous wastes

4.8.3.2 ***Management of Hazardous Materials.*** All hazardous materials will be handled and transported in accordance with applicable law and regulations and with procedures recommended by applicable vendors.

4.8.3.3 ***Property Acquisitions.*** When acquiring real estate, it shall be determined what environmental assessments are necessary and whether any clean up contingencies must be satisfied.

4.9 ***Employment Laws.*** There are many federal and state laws that govern the relationship of employees of SRHC with it and its subsidiaries. SRHC has formulated extensive personnel policies and procedures designed to comply with the requirements of these various laws. The laws govern such things as nondiscrimination, wage payment, employee safety, and employee benefits.

4.9.1 ***Statement of Intent.*** The Health Center intends to follow all state and federal employment laws that apply to it.

4.9.2 ***Statement of Policy.*** The Health Center believes that the fair and equitable treatment of covered persons, patients and other persons is important to fulfilling its vision and goals. It is a policy of the Health Center to recruit, hire, train, promote, assign, transfer, lay off, recall and terminate employees based on their own ability, achievement, experience and conduct without regard to race, color, religion, sex, sexual orientation, gender identity, ethnic origin, age or disability, or any other classification prohibited by law. No form of harassment or discrimination on the basis of sex, sexual orientation, gender identity, race, color, disability, age, religion or ethnic origin or disability or any other classification prohibited by law will be permitted. Each allegation of harassment or discrimination will be promptly investigated in accordance with applicable human resource policies.

4.9.3 ***Compliance Guidelines.*** By adhering to the following guidelines, the chances of violating employment laws can be decreased. These guidelines, however, should not be viewed as providing an answer for all situations. Whenever a question arises concerning the propriety of a certain course of conduct, it is expected that the appropriate supervisor, director, or member of the administrative staff responsible for personnel or employment matters will be consulted in accordance with existing policies and procedures. Generally, covered persons should refrain from the following conduct:

4.9.3.1 ***Personnel Policies and Procedures.*** The Health Center will formulate employee policies and procedures that comply with the requirements of federal and state law. Employees will have access to policies via the Health Center intranet. Employees, supervisors and management will be familiar with the policies and procedures on the intranet.

4.9.3.2 ***Contracts of Employment.*** Employment contracts must be, in writing, designated as such and signed by the President of SRHC or the Chairperson of the Board of Trustees. There are no implied contracts of employment.

4.9.3.3 ***Nondiscrimination.*** The Health Center will recruit, hire, train, promote, assign, transfer, lay off, recall and terminate employees based on their own ability, achievement, experience and conduct without

regard to race, color, religion, sex, sexual orientation, gender identity, ethnic origin, age or disability, or any other classification prohibited by law.

4.10 ***Corporate Laws***. The Health Center is a corporation organized under the laws of the State of Kansas. It also has subsidiary organizations that are similarly organized.

4.10.1 ***Statement of Intent.*** The Health Center intends to follow all state laws and regulations for it and its subsidiary corporations to maintain their corporate structure as a Kansas corporation and to operate under Kansas law.

4.10.2 ***Statement of Policy.*** The Health Center and its subsidiary and affiliated corporations will be incorporated under Kansas law and will continue in good standing with the Kansas Secretary of State and other state administrative agencies. Appropriate licensing will occur for those functions that the Health Center performs as part of its mission. The Health Center will have a document retention policy that provides easy access to important corporate documents and that complies with the requirements of all licensing agencies.

4.10.3 ***Compliance Guidelines.*** By adhering to the following Guidelines, the chances of jeopardizing the corporate existence or licensure of the Health Center can be decreased. These guidelines, however, should not be viewed as providing an answer for all situations. Whenever a question arises concerning the propriety of a certain course of conduct, it is expected that the Health Center's Compliance Officer, legal counsel or auditors and, if necessary, appropriate state agencies, will be consulted. Generally, covered persons should adhere to the following guidelines:

4.10.3.1 ***Filing of Annual Reports.*** The Health Center will timely file annual reports and/or licensing applications with the Kansas Secretary of State and with appropriate licensing agencies. Appropriate docket control systems should be set up within the Health Center to assure that these are completed as required by law.

4.10.3.2 ***Meetings.*** The Health Center and all subsidiary corporations shall timely have all meetings required by their respective bylaws, and all appropriate actions required shall be taken. These include annual meetings of members, trustees, and committees that may be required. Minutes of such meetings shall be prepared and filed in an appropriate and safe location.

ARTICLE 5

COMPLIANCE-RELATED POLICIES AND PROCEDURES

5.1 ***Development of Compliance Policies and Procedures.*** Compliance policies and procedures specific to affected areas of the Health Center that have particular involvement in issues that may affect the substantive areas of the law identified in Article 4 shall be developed and kept current with applicable laws and regulations. Each Department Director shall have responsibility for assuring that their respective policies and procedures are maintained in accordance with the requirements of the law.

5.1.1 ***Objective of Policies and Procedures.*** It is the objective of the policies and procedures to articulate to employees their obligation to make sure that their conduct is consistent with the requirements of the law, to seek clarification when unsure, and to report suspected violations of applicable laws and procedures to appropriate persons.

5.1.2 ***Responsibility for Maintaining Policies and Procedures.*** The compliance policies and procedures for each affected area shall contain a statement of compliance policy for that area and shall define and assign responsibility for the timely and comprehensive updating of both the policy and procedure, necessary training and education, record keeping, and the completion of audit work plans as designated by the Compliance Officer or the Compliance Committee.

5.1.3 ***Availability of Policies and Procedures.*** The compliance policies and procedures shall be readily available to covered persons of each affected area and shall be written so as to enhance the ability of covered persons to follow applicable laws and regulations. The designated manager in each affected area is responsible for ensuring that the compliance policies and procedures as required by this program are developed and maintained in accordance with this policy.

5.2 ***Specialized Compliance Policies and Procedures.*** Laboratory and hospice departments or subsidiaries of SRHC shall contain within their policies and procedures the recommended Compliance Guidances of the Office of the Inspector General for their respective programs. It is understood that such policies and procedures shall be supplemental to and complimentary to this compliance plan and not in replacement of it.

5.3 ***Document Retention Policy.*** The Health Center will have appropriate policies and procedures in place that address: (1) the creation of documents; (2) the distribution of documents; (3) the retention of documents; (4) the storage and retrieval of documents; and (5) the destruction of documents. Such policies and procedures may be specific to individual departments within the Health Center. All such policies shall be consistent with the requirements of law for the retention of such documents. Original corporate documents such as incorporation certificates, articles of incorporation, bylaws, stock certificates, minutes, deeds, other evidences of ownership, licenses, etc., shall be kept in a safe location so as to minimize the risk of accidental destruction.

5.4 ***Reports to Board of Trustees.*** The Compliance Officer shall make regular reports to the Board of Trustees. These reports should present the highlights of the

compliance initiatives, types of audits, training and education, number and type of complaints and other relevant compliance highlights.

5.5 ***Evaluations of Compliance Activities.*** The Compliance Officer should be annually evaluated by Chief Executive Officer, Chairman of the Board and Compliance Committee at least annually. Similarly, the members of the Compliance Committee should be annually evaluated by the Compliance Officer.

ARTICLE 6

PARTICIPATION AND REPORTING

6.1 ***Participation and Reporting.*** It is the responsibility of every covered person in the organization to abide by applicable laws and regulations and support the Health Center's compliance efforts.

6.2 ***Good Faith Reporting of Violations.*** All covered persons are required to report their good faith belief of any violation of the compliance program, a compliance policy or procedure or applicable law. The Health Center, at the request of the covered person, will provide such anonymity to the covered person(s) who reports as is possible under the circumstances, in the judgment of the Health Center, consistent with its obligations to investigate covered person concerns and take necessary corrective action. It should be understood, however, that there may be a point where an individual's identity may become known or may have to be revealed in certain instances when governmental authorities become involved in a suspected violation. There shall be no retaliation in the terms and conditions of employment as a result of such reporting. An employee reporting misconduct involving false claims to management or to governmental agencies are protected under the law. Whistleblowers initiating a *qui tam* action will not be discriminated or retaliated against in any manner by SRHC.

6.3 ***Open Access to Compliance Officer and Response to Questions.*** All covered persons shall have open access to the Compliance Officer of SRHC. In addition to reporting violations, any covered person may request from the Compliance Officer or Compliance Committee clarifications or guidance in the event of any confusion or questions with regard to a hospital policy, procedure or practice. It is requested, but not required, that such requested clarifications be in writing and dated. SRHC may use such requests together with any responses as an educational tool for other covered persons, subject to any confidentiality restrictions that the requestor may make.

6.4 ***To Whom Reports Are Made.*** Any person may report his or her good faith belief of violations of the compliance program, policies or procedures or applicable laws (i) to the Compliance Officer; (ii) to the Health Center Compliance Committee; (iii) to the Health Center Compliance Hotline at 785-452-7848; (iv) by mailing their written concern to the Compliance Officer at P.O. Box 5080, Salina, KS 67402-0580; or (v) by dropping a request in one of the Compliance/HIPAA drop boxes located within the hospital. It is

requested, but not required, that violations be reported in writing. Any employee may make such reports anonymously.

6.5 ***Log of Reports and Inquiries.*** The Compliance Officer shall maintain a log that records calls and reports from drop boxes, the nature of the investigation (if any), and the final disposition. This information should be included in reports to the governing body, the CEO and the Compliance Committee.

ARTICLE 7

BACKGROUND CHECKS OF COVERED PERSONS AND VENDORS

7.1 ***Background Checks of Covered persons and Vendors.*** It is the policy of the Health Center to make reasonable inquiry into the background of prospective covered persons and vendors whose job function or activities may materially impact the Medicare/Medicaid claim development and submission process, the organization's relationship with physicians, or referral patterns between providers.

7.2 ***Screening of Employees.*** All employees shall be screened to determine whether they have been (a) convicted of a criminal offense related to healthcare; or (b) listed by a federal agency as debarred, excluded or otherwise ineligible for federal program participation.

7.3 ***No Contracts with Certain Vendors and Contractors.*** The Health Center will not knowingly contract with or retain on its behalf any person or entity which has been (a) convicted of a criminal offense related to healthcare (unless such person or entity has implemented a compliance program as part of an agreement with the federal government); or (b) listed by a federal agency as debarred, excluded or otherwise ineligible for federal program participation.

7.4 ***Inquiry.*** In attempting to ascertain whether an individual or entity is ineligible, the Health Center will check with the following sources:

- HHS/OIG cumulative sanction report. The Cumulative Sanction Report may be accessed at www.oig.hhs.gov/exclusions. Questions may be directed to: HHS, OIG, OI, Attn: Exclusions, P.O. Box 23871 Washington, DC 20026, (202) 691-2311.
- System Award Management (SAM) excluded parties. The excluded parties report may be accessed at https://www.sam.gov/SAM/pages/public/searchRecords/search.jsf.
- Source for state or local background check (i.e., Kansas Bureau of Investigation, local Sheriff's Department, etc.).

ARTICLE 8

COMPLIANCE EDUCATION

8.1 ***Covered Person Education.*** It is the policy of the Health Center to provide covered persons upon hire and annually thereafter with such training as may be reasonably necessary and appropriate to ensure material compliance with applicable laws relating to Health Center operations. Such training shall be in the areas of Federal and State Statutes, regulations and guidelines, the policies of private payors, if any, corporate ethics, and on the compliance program itself.

8.2 ***Compliance Committee Orientation and Training.*** The Compliance Officer shall conduct an orientation session for new members of the Compliance Committee. At least annually, the Compliance Officer shall review with the committee its designated responsibilities.

8.3 ***Specific Programs on Claims Processing, Billing, False Claims Act and Fraud and Abuse.*** In addition to more generalized training discussed in Section 8.1 above, the Health Center shall provide more specialized training and education program covering claims processing, billing, False Claims Act, and fraud and abuse. Such programs shall include:

8.3.1 ***Patient admitting/registration personnel.*** Not less than annual training relating to one or more of the following subjects: The Health Center's compliance program, an overview of the False Claims Act, and fraud and abuse laws as they relate to the claim development and submission process, a review of Medicare requirements applicable to the admitting/registration process; and the consequences to both individuals and the Health Center of failing to comply with applicable laws.

8.3.2 ***Physician and other patient care personnel.*** Not less than annual training relating to one or more of the following subjects: The Health Center's compliance program, government and private payor reimbursement principles; general prohibitions on paying or receiving remuneration to induce referrals, proper confirmation of diagnoses; submitting of claims for physician services when rendered by a non physician; signing a form for a physician's authorization without such an authorization; alterations to medical records; prescribing medications and procedures without appropriate authorization; proper documentation of services rendered; and the duty to report misconduct.

8.3.3 ***Coding Personnel.*** Not less than annual training relating to one or more of the following subjects: The Health Center's compliance program, an overview of the False Claims Act, and fraud and abuse laws as they relate to the claim development and submission process, a review of Medicare requirements applicable to the coding of claims; and the consequences to both individuals and the Health Center of failing to comply with applicable laws.

8.3.4 ***Billing Personnel.*** Not less than annual training relating to one or more of the following subjects: The Health Center's compliance program, an overview of the False Claims Act, and fraud and abuse laws as they relate to the claim development and submission process, a review of Medicare requirements applicable to the preparation of claims for services; and the consequences to both individuals and the Health Center of failing to comply with applicable laws.

8.3.5 ***Payments for Referrals and Related Fraud and Abuse Issues.*** The Health Center will provide education to covered persons involved in negotiating business relationships with physicians, providers, and vendors on behalf of the organization. Such training will include, at a minimum, not less than annual training relating to one or more of the following subjects: The Health Center compliance program; an overview of the fraud and abuse laws as they relate to prohibitions against payments for referrals, kickbacks and rebates, and other illegal inducements; and the consequences to both individuals and the Health Center of failing to comply with applicable laws.

8.4 ***Documentation.*** The Health Center shall document the training provided to covered persons. The documentation shall include the name and position of the covered person, the date and duration of the educational activity or program, and a brief description of the subject matter of the education.

8.5 ***Qualified Education Activities.*** Education activities include, but are not necessarily limited to, Health Center sponsored programs or educational sessions, viewing educational videos, participation in department meetings in which compliance and the claim development and submission process issues are specifically addressed, attendance at carrier, intermediary or state sponsored educational sessions, attendance at seminars, workshops or similar education sessions. The mediums for such training shall be online programs prepared by the education department or purchased through a third party, Web-based seminars, employee orientation sessions, written materials, teleconferences, and live programs.

ARTICLE 9

AUDITING, MONITORING AND REVIEWING COMPLIANCE

9.1 ***Auditing, Monitoring and Review Policy.*** The Health Center will conduct an ongoing program of evaluating its compliance efforts. This will be done through regular and periodic compliance audits by internal or external auditors who have expertise in Federal and State health care statutes, and Federal health care program requirements. There will also be ongoing monitoring of hospital operations to identify and review deviations from established baselines to detect deviations caused by improper procedures, misunderstanding of rules, and system problems. There will also be periodic reviews of the compliance activities to assure that the compliance program is operating as described

herein. These efforts will focus on those areas that pose the greatest risk to the Health Center.

9.1.1 ***Compliance Audits.*** The Health Center will conduct both internal and external audits of its activities as part of its compliance program. The audits will be executed in accordance with the policies and procedures contained in the applicable auditing tool or protocol utilized by the Health Center. The Health Center will devote such resources as are reasonably necessary to ensure that the audits are (1) adequately staffed; (2) by persons with appropriate knowledge and experience to conduct the audits; (3) utilizing audit tools and protocol which are periodically updated to reflect changes in applicable laws and regulations. The primary focus of the audits will be on the Health Center's compliance with laws governing kickback arrangements, the physician self-referral prohibition, CPT, HCPCS, ICD-10 coding, claim development and submission, reimbursement, cost reporting, and marketing. In addition, special attention will be given to compliance with specific rules and policies that have been the focus of particular attention on the part of Medicare Audit Contractors, Recovery Audit Contractors, and carriers and law enforcement, as evidenced by OIG Work Plan, OIG Special Fraud Alerts, OIG audits and evaluations. These audits may be conducted through any regularly recognized and effective means of audits such as spot audits, focus audits, or comprehensive departmental audits.

9.1.2 ***Monitoring Techniques.*** The Health Center will also develop certain monitoring techniques. The Compliance Officer, with the assistance of department managers may take a "snapshot" of their operations from a compliance perspective. This assessment can be undertaken internally or by outside consultants with authoritative knowledge of health care compliance requirements. This "snapshot" may be used as part of benchmarking analyses, which becomes a baseline for the compliance officer and other managers to judge the Health Center's progress in reducing or eliminating potential areas of vulnerability. For example, this baseline level might include the frequency and percentile levels of various diagnosis codes and the increased billing of complications and co-morbidities.

9.1.3 ***Compliance Reviews.*** There will be periodic (at least annual) reviews of whether this compliance plan has been effectively implemented. These reviews may include on-site visits by the Compliance Officer, interviews with personnel involved in management, operations, coding, claim development and submission, patient care, and other related activities, questionnaires developed to solicit impressions about the compliance activities of the Health Center, reviews of records and documentation of compliance activities and trend analyses. This process will verify effective conformance by all departments with the compliance program. The results of such reviews shall be included in periodic reports made by the Compliance Officer to the Board of Trustees.

9.1.4 Complaint Audits. Upon receipt of a credible allegation or complaint alleging improper or inaccurate billing practices in the Health Center,

the Health Center shall undertake a review of the matter, including an audit meeting reviewing the requirements set forth in Article 9.1.1 above.

9.2 ***Records of Activities***. Records of audits, monitoring activities, and compliance reviews shall be maintained by the Compliance Officer.

ARTICLE 10

COMPLIANCE INVESTIGATION AND RESPONSE POLICY

10.1 ***Statement of Intent.*** The Health Center intends to promptly investigate incidents of noncompliance with any of its Compliance Policies, to take such action as is necessary to bring the Health Center into compliance, and to prevent future incidents of noncompliance.

10.2 ***Purpose of Policy.*** This policy concerning compliance investigations, enforcement, and prevention is to set forth procedures that will be used by the Health Center to respond to reports by covered persons or others that a department or individual employed in a department are engaging in activity that may be contrary to this Compliance Plan or that may be a violation of law.

10.3 ***Investigations.*** The purpose of the investigation shall be to identify those situations in which the Compliance Plan and/or laws or regulations may not have been followed; to identify individuals who may have knowingly or inadvertently been involved in such violations; to facilitate the correction of any practices not in compliance; to implement those procedures necessary to insure future compliance; to protect the Health Center in the event of civil or criminal enforcement actions, and to preserve and protect the Health Center's assets.

10.3.1 ***Control of Investigations.*** All reports received, whether by a managerial employee of a Health Center business unit or directly through the internal audit department, shall be forwarded to the Compliance Officer who shall immediately notify Health Center legal counsel. As soon as practicable after the discovery of the noncompliance, the Compliance Officer shall prepare, for the use of legal counsel, a compliance report. Legal counsel will be responsible for directing the investigation of the alleged problem or incident. In undertaking this investigation, legal counsel may solicit the support of an internal audit, specialized legal counsel and auditors, and internal and external resources with knowledge of the applicable laws and regulations and required policies, procedures or standards that relate to the specific problem in question.

10.3.2 ***Participation by Outside Specialists.*** Outside legal specialists, auditors or other persons or organizations necessary to complete an effective investigation shall be employed by Health Center legal counsel. Such persons or entities shall function under the direction of legal counsel and shall be required to submit relevant evidence, notes, findings and conclusions to legal counsel.

10.3.3 ***Investigative Process.*** Upon receipt of an employee complaint or other information (including audit results) that suggests the existence of a serious pattern of conduct in violation of compliance policies or applicable laws or regulations, an investigation under the direction and control of legal counsel shall be commenced. Steps to be followed in undertaking the investigation shall include, at a minimum:

10.3.3.1 ***Notification of Chief Executive Officer.*** The Chief Executive Officer shall be notified of the nature of the complaint and obtain a memorandum from management authorizing an investigation.

10.3.3.2 ***Commencement of Investigation.*** The investigation shall be commenced as soon as reasonably possible but in no event more than one (1) or two (2) working days following the receipt of the complaint or report.

10.3.3.3 ***Scope of Investigation.*** The investigation shall include, as applicable, but need not be limited to:

a. ***Review of Applicable Compliance Guidelines, Laws, Regulations and Policies and Procedures***. A review of the applicable laws and regulations which might be relevant to or provide guidance with respect to the appropriateness or inappropriateness of the activity in question, shall be immediately undertaken to determine whether or not a problem actually exists**.**

b. ***Interviews.*** An interview of the complainant and other persons who may have knowledge of the alleged problem or process will be conducted to determine whether or not a problem actually exists. If in the course of the investigation it is determined the integrity of the investigation may be at stake due to presence of employees under investigation, those employees shall be removed from their current work activity until the investigation is complete. These steps are taken to prevent destruction of documents, files, or other evidence relative to the investigation.

c. ***No Violation Found.*** If the review results in conclusions or findings that the complained of conduct is permitted under applicable laws, regulations or policy, or that the complained of act did not occur as alleged, or that it does not otherwise appear to be a problem, the investigation shall be closed.

d. ***Potential Violation Found.*** If the initial investigation concludes that conduct may have occurred that is not permitted under applicable laws and regulations, or that additional

evidence is necessary to make such a determination, the investigation shall proceed to the next step.

e. ***Documentary Review.*** The identification and review of representative and pertinent documents shall be conducted to determine the nature of the problem, the scope of the problem, the frequency of the problem, the duration of the problem, and the potential financial magnitude of the problem.

f. ***Departmental Investigation.*** Interviews shall be conducted of the person or persons in the departments and institutions who appeared to play a role in the process in which the problem exists. The purpose of the interview will be to determine the facts related to the complained of activity, and may include, but shall not be limited to:

i. individual understanding of the laws, rules and regulations;

ii. the identification of persons with supervisory or managerial responsibility in the process;

iii. the adequacy of the training of the individuals performing the functions within the process;

iv. the extent to which any person knowingly or with reckless disregard or intentional indifference acted contrary to laws, rules or regulations;

v. the nature and extent of potential civil or criminal liability of individuals or the Health Center.

10.3.3.4 ***Preparation of Summary Report.*** Legal counsel or his or her designee shall prepare a summary report which (1) defines the nature of the problem, (2) summarizes the investigation process, (3) identifies any person whom the investigator believes to have either acted deliberately or with reckless disregard or intentional indifference toward laws, rules and policies, (4) if possible, estimates the nature and extent of the potential penalties. Such report shall be immediately given to the Chief Executive Officer, Chairman of the Board of Trustees, and Compliance Officer.

10.4 ***Responses to Investigations.*** Unless the results of the investigation reveals that the complained about conduct did not occur or that the conduct was not a violation of a law, rule or regulation, the Health Center shall promptly respond to the results of the

investigation. Depending upon the nature of the alleged conduct, the Health Center shall respond according to the following guidelines:

10.4.1 ***Possible Criminal Activity***. In the event the Health Center uncovers what appears to be criminal activity on the part of any employee or business unit, it shall undertake the following steps:

10.4.1.1 ***Stop Conduct.*** It shall immediately stop the conduct related to the problem in the unit(s) where the problem exists until such time as the offending practices are corrected.

10.4.1.2 ***Initiate Disciplinary Action.*** It shall initiate appropriate disciplinary action against the person or persons whose conduct appears to have been intentional, willfully indifferent or with reckless disregard of laws or regulations. Appropriate disciplinary action shall include, at a minimum, the removal of such person or persons from any position with oversight for or impact upon the matter, and may include, in addition, suspension, demotion, and discharge.

10.4.1.3 ***Notification of Appropriate Governmental Entities.*** Legal counsel shall assist the Health Center in determining appropriate agency notifications. The Health Center, through its counsel, shall attempt to negotiate a voluntary disclosure agreement prior to the disclosure. Where only Medicaid is involved, the appropriate state agency and/or the state Attorney General may be notified. In the event that Medicare and Medicaid claims are involved, the Health Center may notify the programs through the local United States Attorney's Office or the local office of the United States Department of Health and Human Services, or the Office of the Inspector General Division, as legal counsel deems appropriate. Any overpayments shall be timely repaid.

10.4.2 ***Non-Criminal Violations.*** In the event the investigation reveals conduct that does not appear to be the result of conduct that is intentional, willfully indifferent, or with reckless disregard for the laws, the Health Center shall nevertheless take the following steps:

10.4.2.1 ***Improper Payments***. In the event the problem results in improper payments by Medicare, Medicaid, or other third party, for payments for services not rendered or provided other than as claimed, it shall:

a. Correct the defective practice or procedure as quickly as possible;

b. Calculate and repay to the appropriate governmental entity duplicate payments or improper payments resulting from the act or omission;

c. Initiate such disciplinary action, if any, as may be appropriate given the facts and circumstances. Appropriate disciplinary action may include, but is not limited to, reprimand, demotion, suspension and discharge.

d. Promptly undertake a program of education at the appropriate business unit to prevent future similar problems.

10.4.2.1 ***No Improper Payment***. In the event the problem has or does not result in an overpayment by the Medicare or Medicaid program or other third party, the Health Center will:

a. Correct the defective conduct, practice or procedure as quickly as possible.

b. Initiate such disciplinary action, if any, as may be appropriate given the facts and circumstances. Appropriate disciplinary action may include, but is not limited to, reprimand, demotion, suspension and discharge.

c. Promptly undertake a program of education at the appropriate business unit to prevent future similar problems.

10.5 ***Discipline for Failure to Participate in Compliance Efforts***. Covered persons may be subject to discipline for failing to participate in organizational compliance efforts, including, but not limited to, those items specified below.

10.5.1 ***Failure to Follow Obligations of Compliance Program.*** The failure of a covered person to perform any obligation required by this compliance program or applicable laws or regulations.

10.5.2 ***Failure to Report Suspected Violations.*** The failure to report suspected violations of compliance program laws or applicable laws or regulations to an appropriate person may be grounds for discipline.

10.5.3 ***Management or Supervisory Failure.*** The failure on the part of a supervisory or managerial employee to implement and maintain policies and procedures reasonably necessary to ensure compliance with the terms of the program or applicable laws and regulations.

10.6 ***Disciplinary Procedures.*** Unless a specific written contract or a law or regulation specifies another disciplinary procedure, the following shall be the appropriate process to follow for the discipline of covered persons:

10.6.1 ***Employees.*** Employees shall be disciplined according to existing Health Center personnel policies and procedures.

10.6.2 ***Medical Staff Appointees.*** Discipline of medical staff appointees shall, unless a contract specifies otherwise, be pursuant to and under the terms and conditions of the Medical Staff Bylaws, Rules and Regulations and the corporate Bylaws of the Health Center.

10.6.3 ***Third Parties.*** Third parties may have their relationships terminated by the Health Center and appropriate mechanisms put in place such that they will be prevented from doing business with the Health Center for a period of time.

10.7 ***Prevention Program.*** Where a violation of the Compliance Program is determined to have occurred, the subject of the violation, shall, once the action is concluded, be reported to the Compliance Officer and Compliance Committee which shall review the matter and determine the extent to which educational programs should be given to prevent further violations. Following review by the Compliance Officer and Compliance Committee, the Board of Trustees shall be advised of the problem, of the corrective action taken, and of the efforts undertaken to prevent the problem from occurring again.

ARTICLE 11

PERIODIC REVIEW OF THE COMPLIANCE PLAN

The Compliance Officer and Compliance Committee shall periodically review this Compliance Plan and determine whether any amendments should be recommended to the Board of Trustees in light of changes in the needs of SRHC or the law. Any proposed amendments to this Compliance Plan shall be effective upon approval by the Board of Trustees. Nothing herein shall prevent the Board of Trustees from amending this Compliance Plan at any time it deems appropriate.

Adopted by the Board of Trustees:

Date: 1/21/22

Chairperson

Secretary