# COMPLIANCE & ETHICS PROGRAM MANUAL

## PREPARED BY BRICKER & ECKLER LLP
## IN COLLABORATION WITH
## LEADINGAGE OHIO

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# COMPLIANCE POLICY MANUAL OUTLINE

## I. POLICY STATEMENT

McGregor (the "Company") is committed to providing high quality services, and to providing those services in a highly ethical manner. Our high standards apply to our relationships with residents and their families, other health care providers, suppliers we do business with, and private and governmental payors. To meet this commitment, all Company employees and agents ("Personnel") must act in compliance with all applicable state and federal laws and regulations and in a manner that avoids even the appearance of impropriety. The Company does not and will not tolerate any form of unlawful or unethical behavior by anyone associated with Company. We expect and require that all Personnel work diligently to earn the respect and trust of all parties with whom we interact by acting fairly, honestly, and in a legal manner. To ensure that these expectations are met, the Company has developed and implemented a compliance and ethics program ("Compliance Program").

Company's Compliance Program is designed to meet the requirements of the Centers for Medicare and Medicaid Services ("CMS") Requirements of Participation for nursing facilities and to demonstrate Company's good faith effort to comply with applicable laws and regulations and Medicare and Medicaid program requirements. Our Compliance Program is based on the seven core elements of an effective compliance program as identified by the Department of Health and Human Services Office of Inspector General ("OIG").

To help our Personnel fulfill their personal commitment to this high standard of ethical behavior, the Company's Board of Directors ("Board") has adopted this Compliance Manual ("Manual") as part of our overall Compliance Program. The acceptance of a position at the Company is conditioned upon acceptance of, and compliance with, the standards set forth in this Manual and the Compliance Program described in it. The Company realizes that, though this Manual provides substantive guidance regarding its legal obligations, it cannot, nor is it intended to, take the place of a personal commitment on behalf of each of us to the highest standards of ethical behavior. Thus, in your daily life and work, if you encounter a situation or are considering a course of action which may seem to be within Manual guidelines, but you are worried that the contemplated action simply "does not feel right," please discuss the situation with your supervisor or notify the Compliance Officer (you may do so anonymously as described in this Manual if you wish). We ask you to assist us and all of our colleagues in supporting these values and principles.

Very truly yours,

Ann Conn,
Chief Operating Officer

## II. COMMITMENT TO COMPLIANCE

The Company has made an ongoing commitment to ensuring that its activities are conducted in accordance with applicable federal and state laws and regulations ("Applicable Laws"), the requirements of federal, state, and private health plans, and ethical business practices. The Company is also committed to exercising due diligence to prevent and detect conduct that potentially violates criminal, civil and/or administrative laws and regulations.

It is Company's intent to comply in good faith and to the best of its ability with all Applicable Laws. To help Company keep its commitment to compliance, Company has developed the Compliance Program and this Manual.

**The Purposes and Objectives of Company's Compliance Program**

- Establish an effective compliance and ethics program that meets legal requirements and prevents, detects, and corrects criminal, civil and administrative violations of law and promotes quality of care;

- Establish written compliance and ethics standards of conduct, policies, and procedures to be followed by Personnel to reduce the prospect of violations of Applicable Laws and promote quality of care;

- Ensure proper documentation of the Company's compliance efforts;

- Designate an individual or individuals to serve as the compliance contact with responsibility for directing the Company's overall compliance program;

- Ensure that sufficient resources and authority are provided to the individuals with responsibility for oversight of the compliance program to reasonably assure compliance with Company's compliance and ethics standards, policies, and procedures;

- Assign specific individuals within the high-level personnel of Company with the overall responsibility to oversee compliance with Company's compliance and standards, policies and procedures;

- Ensure that discretionary authority with respect to compliance issues not be given to inappropriate persons who may be expected to engage in criminal, civil or administrative violations of law;

- Provide a means of informing Personnel of the compliance and ethics standards and procedures they are expected to follow through a training program or in another practical manner which explains the requirements of the compliance and ethics program;

- Develop effective lines of communication between Personnel—managers, employees, volunteers, and agents alike – including maintenance of a reporting system by which Personnel can report suspected violations anonymously within the Company without fear of retaliation and ensuring the integrity of reports;

- Help the Company to consistently enforce the compliance and ethics standards, policies, and procedures in this Manual by establishing written disciplinary guidelines to be applied in the event of violations of the compliance and ethics program, including failure to detect and report such a violation to the Compliance Officer;

- Adopt and implement a process for internal monitoring and auditing designed to detect criminal, civil and administrative violations of law to help ensure compliance with Applicable Law;

- Help the Company promptly respond to detected violations and develop plan(s) of corrective action to prevent further similar violations; and

- Annually review the compliance and ethics program and revise it as needed to prevent the recurrence of violations and reflect changes in Applicable Law and Company to improve its performance in deterring, reducing, and detecting violations and promoting quality of care.

## III. CODE OF CONDUCT

- Company Personnel shall respect a resident's dignity and will treat the resident with consideration, courtesy and respect.

- It is everyone's job to maintain Company's integrity and reputation.

- Company Personnel will provide appropriate treatment and services based upon a comprehensive assessment and plan of care that address each resident's clinical conditions.

- Company will assure its Personnel have sufficient education, licenses, background experiences, training, and supervision to render service to its residents.

- No deficiency or error should be ignored or covered up. A problem should be brought to the attention of those who can properly assess and resolve the problem.

- No claims for payment or reimbursement of any kind that are false, fraudulent, inaccurate or fictitious may be submitted. No falsification of medical, time or other records that are used for the basis of submitting claims will be tolerated. No goods or services shall be given, solicited, offered, or accepted related to the attempt to influence business relationships.

- Company will bill only for the services that are medically appropriate, ordered by the resident's physician, actually rendered and which are fully documented in the resident's medical records. If the services must be coded, only billing codes that accurately describe the services provided will be used.

- Company Personnel shall respect and protect the confidentiality of resident records and other personal information.

- Personnel shall promptly report all suspected violations of the Code of Conduct, compliance policies, operational policies, laws or regulations to their supervisor and/or the Compliance Officer.

I certify that I have received, read, and will abide by Company's Code of Conduct.

_____
Employee Signature

_____
Printed Name

_____
Date

[Copy retained in employee's personnel file]

## IV. DESIGNATION OF A COMPLIANCE OFFICER AND COMPLIANCE COMMITTEE

In order to coordinate our compliance activities, the Company shall appoint a Compliance Officer, who will report directly to Company's Chief Executive Officer with respect to the individual's compliance responsibilities.

The Compliance Officer's primary responsibilities include:

- Overseeing and monitoring the implementation of the Company's Compliance Program;

- Reporting on a regular basis to the Company's Chief Executive Officer, compliance committee, and the Board on the progress of implementation of the Compliance Program and assisting Company in establishing methods to improve Company's efficiency and quality of services, and to reduce Company's vulnerability to fraud, waste, and abuse;

- Reviewing annually and updating this Manual, as appropriate, in light of changes to Applicable Law, the scope of the Company's business operations, industry best practices, or other relevant factors to improve Company's performance in deterring, reducing, and detecting violations and promoting quality of care;

- Developing, coordinating and participating in an educational and training program that focuses on the elements of Company's Compliance Program as described in this Manual and seek to ensure that all Personnel understand and comply with the policies in this Manual and all Applicable Laws;

- Ensuring that independent contractors, volunteers, and agents who provide services to the Company are aware of the Company's commitment to ethical and legal behavior, particularly in regard to billing, marketing, and compliance with Applicable Law as well as residents' rights.

- Coordinating personnel issues with the Human Resources/Personnel office to ensure that: (1) all medical staff and relevant independent contractors are checked against the National Practitioner Database ("NPDB"); and (2) all employees, medical staff, independent contractors, volunteers, and agency staff are checked against the Lists (as defined below in this Manual).

- Assisting in the coordination of internal auditing and monitoring activities, including periodic reviews of the Compliance Program and, in conjunction with the Security Officer, privacy and security controls to ensure compliance with HIPAA and HITECH; and

- Investigating and acting on matters related to compliance, including responding to reports of problems or suspected violations of law and coordinating any resulting corrective action(s).

The Compliance Committee shall assist the Compliance Officer in overseeing and administering the Compliance Plan. Committee members function as the "eyes" and "ears" of the Compliance Program to identify potential issues that may not otherwise come to the attention of the Company. The Committee members monitor their departments of the Company and assist with development of internal systems and controls to carry out Company's policies. Committee members also help determine appropriate strategy approaches to promote compliance with this Manual and to detect any potential violations. Committee members also assist the Company in developing a system to solicit, evaluate, and respond to complaints and problems, and to identify deficiencies and implement corrective actions. Members of the Compliance Committee may include representatives from departments such as human resources, finance, vendor relations/contracting, billing/coding, facilities management, admissions, nursing, case management, and quality. The Chief Executive Officer, with input from the Compliance Officer, shall select the Compliance Committee members.

## V. COMPLIANCE STANDARDS

The following is a list of areas that present a significant degree of legal risk for the Company. As part of the Company's overall compliance plan, it has adopted the following policies focusing on the risk areas listed below. The Company has also developed other corporate and billing policies to address specific billing and other topics which are not incorporated into this Manual but which are provided to all relevant Personnel.

### A. Submission of Accurate Claims

*1. Applicability*

This policy applies to all bills generated by the Company, whether such bills are generated for residents or private or governmental payors.

*2. Policy Statement*

The Company expects billing activities to be performed in a manner consistent with Applicable Law and third-party payor regulations and requirements, as expressed in the following sources:

- The Medicare Claims Processing Manual and the Medicare Benefits Policy Manual;
- Applicable billing instructions provided by governmental and private payors;
- CMS Program Memoranda and Transmittals; and
- The results of beneficiary assessment data extrapolated from the Minimum Data Set ("MDS") to assign an accurate resource utilization group ("RUG") to the beneficiary.

The Company will not accept the following conduct:

- Knowingly and willfully making, or causing to be made, any false statement or misrepresentation of a material fact in any application for a benefit or payment;

- Knowingly and willfully making, or causing to be made, any false statement or misrepresentation of a material fact for use in determining rights to a benefit or payment;

- Concealing or failing to disclose an event affecting the initial or continued right to any benefit or payment, with the intent to fraudulently secure the benefit or payment in an amount greater than is due when no such benefit is authorized;

- Knowingly and willfully converting a benefit or payment for a use other than for the use of the person in whose name the application for the benefit was made;

- Knowingly presenting, or causing to be presented, a request for payment in violation of the terms of an assignment or an agreement with the payor;

- Knowingly filing a false or fraudulent claim for payment to the federal or state government;

- Knowingly using a false record or statement to obtain payment on a false or fraudulent claim;

- Knowingly billing for inadequate or substandard care;

- Entering into any agreement, combination, or conspiracy to defraud the federal or state government or any department or agency thereof, by obtaining or attempting to obtain the payment or allowance of any false or fictitious claim;

- Submitting claims to Medicare Part A for residents not eligible for Part A coverage of SNF services;

- Double billing resulting in duplicate payment;

- Billing for items or services not rendered or provided or billing for items or services different from those provided;

- Improper billing for therapy services including: (1) improper utilization of therapy services to inflate the severity of RUG classifications; (2) overutilization of therapy services billed on a fee-for-service basis to Medicare Part B; or (3) stinting on therapy services provided to residents covered by Medicare Part A;

- Billing for services that were not actually ordered by the resident's treating physician or other authorized individual (even if such services were provided);

- Billing separately for any service that is included in the per diem rate or is the type of service that is reimbursed as part of a bundled reimbursement, or splitting a bill to create the appearance that the services were rendered over a period of days when all treatment occurred during one visit;

- Billing residents for items or services that are included in the per diem rate or otherwise covered by a third-party payor;

- Billing for care provided by unqualified or unlicensed clinical personnel;

- Billing for services ordered or furnished by an Ineligible Person (as defined below);

- Billing at a higher or more intensive level of service than is provided including improper reporting of resident case-mix by providing misleading information about a resident's condition on the MDS and/or falsely or fraudulently completing the MDS, which results in assigning a resident to a higher RUG category (aka "RUG Creep");

- Failing to identify and refund credit balances;

- Altering documentation or forging a physician signature on documents used to verify that services were ordered and/or provided;

- False cost reports; or

- Failure to maintain sufficient documents to support the diagnosis, justify treatment, document the course of treatment and results, and promote continuity of care.

The Company shall only submit claims for payment when such claims are complete, accurate, and correctly identify the items and services provided.

**B. Documentation**

*1. Applicability*

This policy applies to all residents' medical records generated as a result of treatment and services provided by or arranged to be provided by the Company.

*2. Policy Statement*

Timely, accurate and complete documentation is important to resident care. All clinical personnel must document in the appropriate resident record information that is a true and accurate representation of the services provided. All medical records documentation shall be written legibly and include information necessary for the Company's billing personnel to accurately submit claims to federal, state and commercial payors or invoices for residents, including, but not limited to:

- the name of the provider;
- the date of service;
- the site in the which the service was provided; and
- a description of the services provided.

The Company shall adopt uniform policies for the maintenance and documentation of medical records. Information charted in a resident's record should meet applicable documentation guidelines of American Medical Association ("AMA") and CMS and must be sufficient to support the type and level of service coding selected for billing. Documents that comprise any part of the resident chart shall be directed to the appropriate medical records department for inclusion in the official resident chart.

No individual may change information in a resident's record except to correct an error using methods and policies established by the Manual and in accordance with Applicable Law.

**C. Duplicate Billing**

*1. Applicability*

This policy applies to all bills generated by the Company, whether such bills are generated for residents or private or governmental payors.

*2. Policy Statement*

Duplicate billing occurs when more than one claim for payment is submitted for the same resident, for the same service, for the same date of service, or the same claim is submitted to more than one payor as primary. The Company recognizes its obligation to ensure that only one claim is submitted for each item or service provided and shall take the following steps to guard against duplicate billing:

- All vendors providing billing hardware and software to the Company shall demonstrate the ability of their products to detect and prevent duplicate billing;

- All billing personnel will be made aware of their obligations to prevent and detect duplicate billings;

- Intake or other forms will be periodically reviewed to ensure that they contain all information needed to determine the primary payor; and

- All Personnel are directed to bring duplicate billing situations to the attention of the Compliance Officer.

**D. Billing Agents**

*1. Applicability*

This policy applies to all arrangements with billing agents.

*2. Policy Statement*

The Company currently is responsible for its own billing. The Company shall not enter into any agreement(s) with billing agent(s) without prior review by the Compliance Officer. The Company shall periodically monitor the performance of its billing agents, if any, to help ensure proper payment of all bills.

The compensation for billing department coders and billing consultants shall in no way provide any incentive to improperly upcode claims.

**E. Upcoding, Unbundling, and Proper Reporting of Resident Case Mix**

*1. Applicability*

This policy applies to all bills generated by the Company, whether such bills are generated for residents or private or governmental payors.

*2. Policy Statement*

"Upcoding" occurs when a provider bills using a code to maximize reimbursement when such code is not the most appropriate code to describe the item or service provided.

"Unbundling" (sometimes referred to as "fragmenting") occurs when a provider submits a bill for individual components when a payor requires the components to be billed as a unit.

"RUG" assignments are based on the level and intensity of services required by a resident. Accurate RUG assignments are essential to prevent upcoding.

To guard against upcoding, unbundling and improper RUG assignments, the Company shall take the following steps:

- To prevent upcoding and unbundling, the Company shall submit claims, or cause claims to be submitted, using coding requirements found in the most current CMS publications or other applicable payor guidelines;

- Company shall adopt policies and train staff to accurately report resident assessments and information regarding residents' conditions and needs;

- Company will not rely on outdated MDS assessments when assigning RUG classifications to residents;

- MDS assessments will be completed at established intervals throughout a resident's stay in accordance with CMS rules and regulations; and

- Only medically necessary therapy services ordered by a treating physician will be provided to residents and factored into each resident's RUG classification.

## F. Record Creation, Maintenance, and Retention

*Policy Statement*

The Company shall maintain a records system that ensures complete and accurate medical record documentation. Personnel shall ensure that all nursing and therapy services as well as MDS information is complete, timely, and accurate. Company and Personnel shall ensure that the privacy and confidentiality of resident records is maintained in accordance with applicable privacy laws.

The Company shall maintain all resident records and other records and documents necessary to confirm Company's compliance with Applicable Law. Company shall maintain such records in a safe place and limit access to such records and documents in order to prevent accidental or intentional fabrication or destruction of records.

The Company shall retain, at a minimum, all of the following information regarding each item or service provided for a minimum of seven (7) years after a resident's discharge:

- Relevant information from the treating physician concerning the resident's diagnosis;

- Any documentation from the resident's medical record that the Company deems necessary to assure itself that coverage criteria have been met;

- All documentation that supports the resident's RUG assignment;

- All documentation that supports the medical necessity of all items and services furnished to residents; and

- All medical records created or relied upon by the Company to bill for services provided by the Company or Company's contractors.

## G. Resubmission of Denied Claims

*1. Applicability*

This policy applies to all bills generated by the Company, whether such bills are generated for residents or private or governmental payors.

*2. Policy Statement*

The Company shall make every effort to ensure that all bills contain accurate and complete information. The Company shall only alter information on a previously submitted bill to the extent that such alterations are permitted in accordance with Applicable Law and supported by written documentation in the Company's possession at the time the original bill was submitted.

## H. State and Federal Anti-Kickback Laws

*Policy Statement*

The federal anti-kickback law prohibits health care providers from engaging in certain practices that are common in other business sectors, such as offering or receiving gifts to reward past or potential new referrals. To comply with state and federal anti-kickback laws, no Personnel shall:

- Knowingly and willfully pay, offer to pay, solicit, or receive any remuneration, directly or indirectly, overtly or covertly, in cash or in kind, in exchange for the referral of residents for any item or service which is covered in whole or in part by a federal health care program, including Medicare and Medicaid.

- Arrange for or recommend the purchase of goods or services for which payment may be made in whole or in part under a federal health care program, including Medicare or Medicaid, in exchange for remuneration.

- Arrange for or contract for services at a discount linked, directly or indirectly, to referrals of other federal health care program business (e.g.,

receiving a discount on Part A ambulance services in exchange for referrals of Part B ambulance services) (sometimes referred to as "swapping").

The penalties for noncompliance with kickback laws can be very severe. Several exceptions to state and federal anti-kickback laws expressly permit arrangements which may, at first, appear to violate these statutes. However, because laws regarding state and federal anti-kickback statutes are complicated, legal review is required in order to determine whether a given arrangement fully complies with an exception. Therefore, all Personnel are encouraged to report to the Compliance Officer any behavior or any agreements which appear to violate this policy.

"Significant transactions" include, without limitation:

- Discounted sales or purchase agreements, including agreements that result in Company receiving non-covered items at below-market prices or no charge in exchange for Company's order of Medicare-reimbursed items;
- Joint venture agreements;
- All agreements with physicians, including the medical director;
- Space and/or equipment rental agreements;
- All arrangements that involve Company providing a supplier access to residents' medical records or other information needed to bill Medicare;
- Agreements with durable medical equipment ("DME") suppliers, diagnostic testing facilities, rehabilitation companies, and physical, occupational and speech therapists;
- Agreements with any hospital, hospice provider, or home health agency related to the transfer of any resident to or by Company's facility or that condition acceptance of a Medicare beneficiary for admission to Company's facility on the condition that the hospital pays Company an amount over and above what Company would receive from Medicare;
- Agreements with actual or potential referral sources, including any arrangement that provides Company with free goods or services, such as equipment, supplies, consulting services, or staff; and
- Any reserved bed arrangement between the Company and a hospital.

## I. State and Federal Physician Self-Referral ("Stark") Laws

*Policy Statement*

To comply with state and federal physician self-referral, or "Stark" laws, Company will evaluate all financial relationships with physicians services (including owners,

investors, medical directors, and consultants) who treat residents and/or refer or order services that are "designated health services" ("DHS") provided by the Company and billed to Medicare Part B (e.g., laboratory services, physical therapy services, occupational therapy services). For each physician in a position to refer DHS services to the Company, Company shall:

- Enter into an appropriate written agreement signed by all parties that meets all applicable legal requirements, including commercial reasonableness and fair market value, for all periods of time that physician is in a position to refer individuals for DHS at Company.

No physician working for the Company shall refer a Medicare or Medicaid beneficiary to an entity with whom the physician or a member of the physician's immediate family has: (i) a compensation relationship; or (ii) an ownership or investment interest, unless an exception applies.

The penalties for noncompliance with the physician self-referral laws can be very severe. Several exceptions to state and federal physician self-referral laws expressly permit arrangements which may, at first, appear to violate these statutes. However, these laws are very complicated and require legal review in order to determine whether a given arrangement fully complies with an exception. Therefore, all Personnel are encouraged to report to the Compliance Officer any behavior, arrangement, or agreement which appears to violate this policy.

## J. Anti-Supplementation

*1. Applicability*

This policy applies to all bills generated by the Company, whether such bills are generated for residents or private or governmental payors.

*2. Policy Statement*

As a condition of its Medicare provider agreement and under applicable Medicaid regulations, Company must accept applicable Medicare and Medicaid payment (including any beneficiary coinsurance or copayments) for covered items and services as the complete payment. Company will not:

- Condition acceptance of a resident upon receiving payment from a hospital or a resident's family in an amount greater than Company would receive from Medicare or Medicaid; and

- Accept supplemental payments, including, but not limited to, cash and free or discounted items and services, from a hospital or other source merely because the Company believes the Medicare or Medicaid payment to be inadequate.

This policy shall not be interpreted to prevent the Company from receiving charitable donations unrelated to the care of a specific resident.

## K. Medicare Part D

*1. Applicability*

This policy applies to all residents who elect to participate in Medicare Part D.

*2. Policy Statement*

Medicare Part D extends voluntary prescription coverage to all Medicare beneficiaries. When a resident selects a particular Part D plan, it may be that the Part D plan that best satisfies the resident's needs does not have an arrangement with the Company's pharmacy. Company will work with its chosen pharmacy provider to assure that they recognize the Part D plans chosen by Company's residents or add additional pharmacies to achieve that objective. Company shall not:

- Act in any way to frustrate a resident's freedom of choice in choosing a Part D plan;
- Require, request, coach or steer any resident to select or change a Medicare Part D plan for any reason;
- Knowingly and/or willingly allow the pharmacy serving the Company to request, coach or steer any resident to select or change a Medicare Part D plan for any reason; and
- Accept any payments from any plan or pharmacy to influence a resident to select a particular Medicare Part D plan.

## L. Quality of Care

*1. Policy Statement*

Company is committed to providing care and services to attain or maintain residents' highest practicable physical, mental, and psychosocial well-being. Many factors contribute to the quality of care that the Company provides to its residents. The following factors have been identified as essential to meeting the high standards demanded by the Company and payors.

*a.* *Sufficient Staffing*. Company will periodically assess its staffing patterns to ensure that sufficient number and appropriately trained/skilled staff members are present, including on weekends, to competently care for the unique acuity of Company's residents. In

performing its assessment, Company will consider resident case-mix, staff skill levels, staff-to-resident ratios, staff turnover, staff schedules, disciplinary records, payroll records, timesheets and adverse event/drug reports. The level of staffing assessment will measure the actual "on-floor" staffing levels.

*b.* *Resident Care Plans*. Every resident in Company's facility shall have an accurate assessment of the resident's functional capacity and a comprehensive resident care plan that includes measurable objectives and time tables to meet the medical, nursing, and mental and psychosocial needs for the resident. Each resident care plan shall be developed with input from the resident and his/her family or guardians and an interdisciplinary team that includes all disciplines involved in the resident's care as well as the attending physician responsible for overseeing and supervising the care rendered to the resident.

c. *Restorative and Personal Care Services*. Company is committed to providing its residents appropriate restorative and personal care services to accommodate individual resident needs and preferences and allow residents to attain and maintain their highest practicable functioning. Specifically, these services include, but are not limited to, care to avoid pressure ulcers, active and passive range of motion, ambulation, fall prevention, incontinence management, bathing, dressing and grooming activities.

*d.* *Medication Management*. Company has in place medication management processes to properly prescribe, administer, and monitor prescription drug usage that promote resident safety, minimize adverse drug interactions, and ensure that irregularities in a resident's drug regimen are promptly discovered and addressed. A consulting pharmacist shall review each resident's drug regimen at least once per month. Any irregularities discovered by the pharmacist will be promptly reported to the attending physician and facility's director of nursing.

*e.* *Use of Psychotropic Medications*. Company shall not use any medication as a means of chemical restraint for the purpose of discipline or convenience. All medications administered to residents shall be to treat residents' medical symptoms. Company will ensure there is an adequate indication for use of such medication and monitor, document, and review the use of each resident's psychotropic drugs. Resident drug regimens must be free from unnecessary drugs. For residents who specifically require anti-psychotic medications, unless contraindicated, residents must receive gradual dose decreases and behavioral interventions aimed at reducing medication use.

*f.* *Resident Safety*. Company will not tolerate mistreatment, neglect and/or abuse of its residents (collectively "abuse"). Abuse of residents can result from resident-on-resident interaction or resident and staff interactions. Company has mechanisms in place to screen staff that comply with Applicable Law to ensure it has a workforce that will maintain the safety of Company's residents. Any employee that witnesses what they believe to be abuse of a resident must immediately report the incident to the Compliance Officer at (216) 851-8200 ext. 2050. Reporting may be done on a confidential basis and Company is committed to protecting employees that report abuse from retaliatory conduct. Company shall also publicize the number to report abuse to residents, family members, visitors, and others who witness incidents they believe may constitute abuse. Upon receipt of an allegation of abuse, the Compliance Officer will immediately initiate an investigation and report his/her findings and recommendations to senior management for corrective action, as appropriate, including reporting to law enforcement as required by Applicable Law.

*g.* *Resident's Rights.* Company and its Personnel shall protect the rights of residents to a dignified existence that promotes freedom of choice, self-determination, and reasonable accommodation of individuals. Company will not tolerate any practices that result in:

- Discriminatory admission or improper denial of access to care;
- Constitute verbal, mental or physical abuse, corporal punishment or involuntary seclusion;
- Deny *residents* personal privacy and access to their personal records upon request or fail to protect the privacy and confidentiality of those records;
- Deny a resident's right to participate in care and treatment decisions; or
- Fail to safeguard a resident's financial affairs.

## M. Gifts and Other Inducements to Medicare and Medicaid Beneficiaries

*1. Applicability*

This policy applies to all Company interactions with residents who are Medicare or Medicaid beneficiaries.

*2. Policy Statement*

Company and its Personnel and other individuals or entities performing functions and services on Company's behalf are prohibited from providing gifts or other items or services of value for free or at a discount to Medicare or Medicaid beneficiaries which are likely to influence their decision to receive Medicare or Medicaid reimbursable items or services from Company or to influence them to continue to receive such items or services from Company. Some in-kind items or services (not cash or cash-equivalent) are permitted, as long as certain conditions are met. Any Personnel who is considering offering any gifts or other items or services of value to Medicare or Medicaid beneficiaries must consult with the Compliance Officer to determine whether the proposed gift, item or service is permitted. Examples of situations that would require consultation with the Compliance Officer include:

- Proposed waiver of a beneficiary's coinsurance or deductible

- Offering any gift or gratuity to a resident or prospective resident who is a Medicare or Medicaid beneficiary

The Compliance Officer will track all gifts and other items and services of value provided to Medicare and Medicaid beneficiaries for free or at a discount in accordance with federal requirements.

## N. Marketing, Generally

*1. Applicability*

This policy applies to all of the Company's marketing activities.

*2. Policy Statement*

The Company will use its best efforts to ensure that all marketing materials and activities are as honest, straight-forward, fully informative, and non-deceptive as possible, while still effectively promoting the Company's products and/or services. In furtherance of this goal, the Company's marketing materials shall not state or imply that it:

- Will waive residents' copayments or deductibles; or

- Is offering "free" services to prospective residents.

## O. Dealing with Overpayments

*1. Applicability*

This policy applies to all bills generated by the Company, whether such bills are generated for residents or private or governmental payors.

*2. Policy Statement*

An overpayment is the amount of money received in excess of the amount due and payable. Examples of overpayments include, without limitation, the following:

- Being paid twice for the same service;
- Being paid for services that were provided, but not ordered, by an appropriate individual;
- Being paid for services billed with the wrong billing code;
- Being paid for medically unnecessary or non-covered services;
- Billing for services separately that should be billed using a bundled code;
- Being paid for services not rendered (including services of substandard quality and services for which there is inadequate documentation);
- Being paid for services ordered/performed by an Ineligible Person (as defined below);
- Being paid for services ordered/performed by non-licensed person (including lapsed licenses);
- Tainted claims resulting from violation of self-referral ("Stark") or Anti-Kickback laws; or
- Credit balances, which occur when payments, allowances or charge reversals posted to an account exceed the charges to the account (e.g., an account shows a credit greater than a deficit). The Company shall adopt procedures for monitoring credit balances, determine the reason for such credit balances, and attempt to refund the excess credit to the appropriate person.

Overpayments must be refunded promptly to the appropriate resident(s), guarantor(s), or third-party payor(s). All accounts with overpayments should not remain unprocessed and should be promptly refunded. If an overpayment is suspected or discovered, this should be immediately brought to the attention of the Company's Compliance Officer. Overpayments received from Medicare and Medicaid shall be returned within sixty (60) days after the overpayment is identified.

**P. Dealing with Excluded Individuals or Entities**

*1. Applicability*

This policy applies to Company and all of its wholly-owned subsidiaries.

*2. Policy Statement*

This Policy sets forth the requirement that Covered Persons, as defined below, immediately disclose to Company if they are subject to debarment, exclusion, suspension, or any other event that makes the Covered Person an Ineligible Person, as defined below.

- Company shall not knowingly employ, contract with, engage the services of, or grant medical staff privileges to any Ineligible Person (as defined below).

- Company shall not knowingly bill any Federal health care program for items or services that are administered, furnished, ordered, or prescribed by any Ineligible Person (as defined below).

- Company shall screen all prospective Covered Persons against the Lists (defined below), as defined below, at initial hire, appointment, engagement, or credentialing and annually thereafter.

a. Initial screenings shall be conducted as follows:

  - Board Members - Company shall screen all prospective Board of Directors members against the Lists at the time of appointment to the Board and shall retain documentation that such screening was performed.

  - Employees – Company's Human Resources Department shall screen all prospective employees against the Lists prior to making an offer of employment and shall retain documentation that such screening was performed in the employee's personnel file.

  - Vendors, Contractors, and Suppliers – Company's Human Resources Department shall screen all prospective vendors, contractors, and suppliers against the Lists prior to entering into any contractual transactions and shall retain documentation that such screening was performed in the Human Resources Department's files.

  - Agency Staff - All agency staffing contracts shall require that the agency screen all of their employees, agents and subcontractors who are or may be performing work at Company to confirm that such individuals are not Ineligible Persons and provide evidence of such screening. If the staffing company will not provide such evidence of screening,

Company will screen any agent staff against the Lists before allowing the individual to begin working at Company.

- Students/Volunteers - The hosting Company department shall screen all prospective students and volunteers against the Lists prior to allowing a student or volunteer to begin a rotation or internship at Company. In the event the student's school or educational program has already screened this individual, Company's Human Resources Department may simply request a copy of the documentation of such screening.

b. The Human Resources Department, or the Compliance Officer's designee, shall screen all Covered Persons annually. Documentation of screening shall be kept on file with Company's Human Resources Department. The Human Resources Department shall review the results of the annual screenings and communicate them to the Compliance Committee.

c. All Covered Persons shall disclose to Company immediately any debarment, exclusion, suspension, or other event that makes that Covered Person an Ineligible Person.

d. If Company has actual notice that a Covered Person has become an Ineligible Person, Company shall remove such Covered Person from responsibility for, or involvement with, Company's business operations related to the Federal health care programs and shall remove such Covered Persons from any position for which the Covered Person's compensation or the items or services furnished, ordered, or prescribed by the Covered Person are paid in whole or part, directly or indirectly, by Federal health care programs or otherwise with Federal funds until such time as the Covered Person is reinstated into participation in the Federal health care programs.

e. If Company has actual notice that a Covered Person is charged with a criminal offense that falls within the scope of Ohio Criminal Records Check Law, Ohio Administrative Code § 3701-13-01 et seq., or is proposed for exclusion during the Covered Person's employment or contract term or during the term of the physician's or other practitioner's medical staff privilege, Company shall take all appropriate actions to ensure the quality of care rendered to any resident and/or the accuracy of any claims submitted to any Federal health care program.

f. All new Company contracts with vendors will include language requiring that vendors screen their employees and other staff who will provide services at/for Company against the Lists and that no excluded individuals are assigned to work at Company.

*Definitions*

**Covered Persons** includes: Board members, employees, vendors, contractors, suppliers, students, volunteers, and agency staff.

**Ineligible Person** shall include an individual or entity who:

a. Is currently excluded, debarred, suspended, or otherwise ineligible to participate in the Federal health care programs or in Federal procurement or non-procurement programs; or

b. Has been convicted of a criminal offense that falls within the scope of the Ohio Criminal Records Check Law, Ohio Administrative Code § 3701-13-01 et seq., or another offense for which exclusion, debarment, or suspension is mandatory, but has not yet been excluded, debarred, suspended, or otherwise declared ineligible.

**GSA List** means the General Services Administration ("GSA") System for Award Management. This GSA List is available on the internet in a searchable format at http://www.sam.gov.

**HHS/OIG List** means the HHS/OIG List of Excluded Individuals/Entities. The HHS/OIG List is available on the internet in a searchable format at http://exclusions.oig.hhs.gov/.

**The Lists** means the GSA List and the HHS/OIG List, collectively.

**Federal health care programs** means any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government or a State health care program (with the exception of the Federal Employees Health Benefits Program) (section 1128B(f) of the Social Security Act). The most significant Federal health care programs are Medicare, Medicaid, Tricare and the Veterans programs.

## Q. Referrals to Hospice

*1. Applicability*

This policy applies to all relationships between the Company and hospice providers.

*2. Policy Statement*

Hospice services for terminally ill residents may, at times, be provided in the Company's facility. Under no circumstances will Company accept from any hospice provider:

- Free goods or services, or goods or services at below fair-market value, in exchange for hospice referrals;

- Payment of room and board payments in excess of what the Company receives directly from the resident's payor;

- Referrals from hospice providers to Company in exchange for referrals to the hospice provider; and

- Free care provided by the hospice provider to Company's residents for whom the Company is receiving Medicare payment.

## R. Gifts and Entertainment

*1. Applicability*

This policy applies to all entertainment and gifts provided by or proposed to be provided to any employee of Company by any person or entity that has or desires to have a business relationship with the Company. For purposes of this Compliance Program, "business relationship" shall mean any person or entity that currently contracts with Company or seeks to obtain a contract from or with Company to provide goods or services to Company related to the provision of services billable to any payor.

*2. Policy Statement*

Company and Personnel shall not solicit, accept, or offer any gift or gratuity of more than nominal value from potential referral sources or any individuals or entities with which Company has a business relationship. Company and Personnel will not accept any gift they believe is offered in an attempt to influence business relationships. The general guideline for receiving gifts is that gifts or entertainment will only rarely be consistent with Company policy and should be brought to the attention of the Compliance Officer for review and consideration of whether the gift or entertainment may be accepted.

The only generally acceptable gifts and entertainment include, but are not limited to the following examples:

- Promotional items such as key chains, pens, note pads; and

- Materials provided to assist in the education of staff regarding changes to Applicable Law or other industry updates (i.e., speakers made available to address current topics in the long term care industry);

In all cases, if Personnel have questions regarding gifts or entertainment offered or provided to Personnel, the Compliance Officer should be

notified of the specific gift or entertainment provided or offered for further consideration and review.

## VI. TRAINING AND EDUCATION

### A. Compliance Affidavit

Within 30 days after adoption of this Manual, all Company employees shall complete a copy of the Compliance Affidavit attached hereto as **Exhibit A** and return such affidavit to the Compliance Officer. New Company employees shall complete and return a copy of the Compliance Affidavit within 30 days of their start date.

### B. General Training

The Company is committed to the proper education and training of all Personnel, including the Company's officers, managers, and employees (including temporary employees and contracted/agency staff) at all levels. In order to encourage compliance, all Personnel will participate in general training sessions addressing the following areas:

- Applicable Law, CMS manual instructions, policies of private payors, and corporate ethics;
- Appropriate and sufficient documentation, including proper documentation in clinical and financial records;
- Residents' rights;
- Updates regarding the Company's overall compliance program;
- Fraud and abuse laws, including updates regarding state and federal anti-kickback and self-referral ("Stark") statutes; and
- The duty of all Personnel to report suspected violations of the standards described in this Manual or other unethical behavior.

Such general training sessions shall occur annually, unless the Compliance Officer or the Board of Directors determines that a different training schedule is appropriate. All Personnel attending such general training sessions will be required to sign an affidavit acknowledging attendance at the general training session (see **Exhibit B**). Failure to comply with training requirements will be a factor in the annual evaluation of employees and may result in disciplinary action.

### C. Continuing Education; Specialized Training

The Compliance Officer shall, as necessary, update all Personnel on relevant policy revisions, special fraud alerts issued by government authorities, changes in

Applicable Law or reimbursement methodology, relevant case law developments, or changing industry practices that may impact the Company's overall compliance program. In addition to general training, Personnel with duties relating to coding and billing, including contractors, shall also attend specialized training sessions as determined appropriate by the Compliance Officer or the Board of Directors.

## VII. DEVELOPING EFFECTIVE LINES OF COMMUNICATION

### A. Reporting Potential Violations

The Company's commitment to ethical and legal business practices cannot succeed without open lines of communication between the Compliance Officer and Personnel. Any individual may report instances of alleged unethical or illegal conduct directly to the Compliance Officer. The Company shall also establish a mechanism to receive reports of alleged unethical or illegal conduct from all Personnel, as well as provide an access point for persons to receive information or ask compliance-related questions. The Compliance Hotline is 216-851-8200 ext. 2050. Such reports may be made anonymously, however all individuals making reports are encouraged to provide as much information as possible, including name, in order to facilitate investigation of all allegations. The identity of all individuals making reports to the Compliance Officer will be held in strict confidence, but depending on the circumstances, the identity of the reporter may become known or have to be revealed. Failure to report knowledge of wrongdoing may itself result in disciplinary action. Any supervisor, Company officer, or Company director receiving a report of alleged unethical or illegal conduct must immediately advise the Compliance Officer of such report.

### B. No Retaliation

No adverse action or any form of retaliation or retribution will be taken against anyone who in good faith reports potential instances of fraud, abuse, unethical or illegal conduct. Examples of possible retaliation include discharge, demotion, suspension, threats, harassment, or discriminated against in any other manner in the terms and conditions of employment because of lawful acts by the employee in furtherance of an action to report in good faith suspected or potential instances of fraud, abuse, unethical or illegal conduct.

### C. Investigation of Reports

Upon receiving a report of a potential instance of fraud, abuse, unethical, or illegal conduct or other credible information suggesting that Company has received an overpayment, the Compliance Officer shall, after consultation with the Company's legal counsel, promptly initiate an internal investigation. One purpose of the investigation will be to determine any changes necessary to prevent the occurrence of further similar situations. Reports of possible violations of law will be investigated by corporate or outside legal counsel, depending upon the circumstances. The purpose of the internal investigation is to obtain facts necessary

to determine whether any violations of the law have occurred and the Company's legal obligations with respect to responding to the report. All phases of the investigation of the report, to the extent possible, will be handled so as to keep it within the attorney-client privilege. Appropriate steps must be taken to prevent the destruction of documents or other relevant evidence. If disciplinary action is determined to be warranted as a result of the investigation, it should be promptly imposed. The Compliance Officer shall maintain an accurate summary record of complaints received and resolved, including any relevant documents (including interview notes and log of witnesses interviewed and documents reviewed) and recommended corrective action. Such records shall be retained for a period of six (6) years.

The Compliance Officer shall review the circumstances that gave rise to the investigation to determine whether similar problems have been uncovered or modifications of the Compliance Program are necessary to prevent and detect other inappropriate conduct or violations.

## D. Confidentiality

*1. Investigations*

The identity of any person who reports any potential instance of fraud, abuse, unethical, or illegal conduct to the Compliance Officer shall be held in confidence and not disclosed except as permitted or required by law. All reports shall be held in confidence and in a secure manner. Disclosure of such confidential information shall be made only on a need-to-know basis and as permitted or required by law. Unauthorized disclosure of confidential information shall be grounds for appropriate disciplinary action.

*2. Investigations by Government Agencies*

Any employee, agent, or independent contractor of the Company who becomes aware of any contact by an agent, representative, investigator, auditor or attorney from: (1) the Ohio Medicaid Fraud Control Division of the Attorney General's Office; (2) the United States Department of Health and Human Services; (3) the Office of Inspector General (OIG); (4) the Department of Justice or United States Attorney's Office; or (5) the Federal Bureau of Investigation, must immediately report the contact to the Compliance Officer. All requests for information from or about the Company, whether for conversation or documents, by any of these individuals must be reported immediately to the Compliance Officer.

No Personnel have the authority to disclose the existence of an internal or external investigation to any other person without permission of the Compliance Officer. No Personnel have the authority to disclose the existence of an internal or external investigation to the press.

## VIII. ENFORCING STANDARDS—DISCIPLINARY GUIDELINES

Compliance with Company's Compliance Program is a condition of each employee's employment with Company. Noncompliance with the standards set forth in this Manual will result in appropriate disciplinary action. Managers and supervisors are responsible for adequately instructing the individuals who report to them and for detecting instances of noncompliance with applicable policies and Applicable Law if reasonable diligence would have led the manager or supervisor to discover the problem or violation sooner and given Company an opportunity to correct them earlier. Disciplinary action shall be applied in an appropriate and consistent manner. The degree of disciplinary action will depend on the behavior. Disciplinary or remedial actions may include oral or written counseling, oral warnings, suspension, termination, change in job duties, termination of a third-party contract or arrangement, or other appropriate sanctions. In addition to disciplinary or remedial action, Company may also retrain appropriate Personnel, refund previous payments received, resubmit claims to ensure accurate payment, modify policies and procedures, and take other steps to reduce or mitigate the impact of the noncompliance. Behavior evidencing a knowing disregard of policy, a reckless disregard for policy, or other behavior that has the potential to impair the Company's status as an honest, reliable company, will be met with more severe disciplinary measures.

## IX. INTERNAL AUDITING AND MONITORING

In order to ensure compliance with the standards set forth in this Manual, the Company shall conduct an ongoing evaluation process that includes internal auditing and monitoring activities. This monitoring shall consist, in part, of communication between Personnel and the Compliance Officer and communication between the Compliance Officer and Company's governing body.

### A. Baseline Audit

The Company shall conduct initial, or "baseline," audits of various aspects of its business practices. These audits will focus on the following areas (and others as identified by Company):

- Coding and billing;
- Documentation;
- Quality of care;
- Claims development and submission;
- Reimbursement; and
- Compliance with Applicable Laws that have been the focus of particular attention on the part of CMS and other government enforcement authorities, as evidenced by educational and other communications, OIG special fraud

alerts, advisory opinions, settlements, audits and evaluations, and other sources.

## B. Future Auditing

After the completion of a baseline audit, the Company shall, from time to time as deemed necessary by its Board of Directors, but at least annually, conduct a follow-up audit(s) to determine the Company's compliance with changes in Applicable Law or requirements of private payors, to determine the effectiveness of any corrective action taken as a result of the baseline audit and detect any significant variations from acceptable values in the Company's baseline audit.

If significant variations are found, or if it appears that the Company's corrective action has not been effective, the Compliance Officer shall undertake an investigation to determine the cause of such variation or lack of effectiveness of corrective action.

If the inquiry reveals that the variation occurred for legitimate, explainable reasons, no further actions will be taken. If the inquiry reveals that the variation occurred for inappropriate reasons, corrective action will be taken to prevent future occurrences of a similar nature, and disciplinary action may be taken against responsible individuals. If the inquiry reveals that corrective action has proven ineffective, this fact will be discussed with the Company's governing body and alternate action will be implemented.

## C. Audit Techniques

The Company may utilize some or all of the following techniques in performing a baseline audit or a subsequent audit:

- Testing billing staff on their knowledge of reimbursement coverage criteria and official coding guidelines (e.g., present hypothetical scenarios of situations experienced in daily practice and assess responses);
- Assessment of existing relationships with physicians and other potential or existing referral sources;
- Unannounced audits, mock surveys, and investigations;
- Examination of the Company's complaint logs;
- Checking Personnel records to determine whether any individuals who have been reprimanded for compliance issues in the past are now conforming to Company policies;
- Reevaluation of deficiencies cited in past surveys for State requirements and Medicare participation requirements to confirm whether corrective action

corrected the underlying problem and whether the deficiency continues to exist;

- Validation of qualifications of nursing facility physicians and other staff, including verification of applicable State license renewals and screening for Ineligible Persons;

- Interviews with personnel involved in management, direct resident care, operations, sales and marketing, claim development and submission, and other related activities;

- Reviews of medical necessity documentation (e.g., physician orders and other documents) supporting claims for reimbursement; and

- Reviews of MDS assessments and RUG classifications to verify the accuracy of RUG classifications.

Reviewers shall have appropriate qualifications and experience to conduct the audits and be objective and independent of line management to the extent reasonably possible,

### D. Audit Report

For each year that an audit is conducted, the Compliance Officer will prepare a written report to the Company's Board of Directors regarding the results of all audit(s) performed in the previous year, including audits conducted as a result of a report of possible noncompliance. This report will protect the confidentiality of the person(s) who made reports to the Compliance Officer pursuant to policies set forth in this Manual. The report will include a description of the number of situations reported, the types of situations reported, the results of investigations, the actions taken in response, and the steps taken to prevent future occurrences of a similar nature.

### E. Refunding of Overpayments

If an audit reveals that the Company may have received an overpayment from a governmental or private payor, the Compliance Officer shall meet with legal counsel to discuss the Company's legal obligations regarding return of such overpayment.

## X. CORRECTIVE ACTION

Violations of Company's Compliance Program, failure to comply with Applicable Law, and other types of misconduct threaten Company's status as a reliable, honest, and trustworthy provider of health care. The goal of the Company's Compliance Program is to prevent, detect and promptly correct activity that does not comply with the standards set forth in this Manual. Detected but uncorrected deficiencies can seriously endanger the reputation and legal status of Company. Attempts should always be made to discuss and

resolve issues in cooperation with the persons involved. Nonetheless, fraud, abuse, illegal, or unethical conduct shall be dealt with promptly. Prompt and decisive actions to correct problems must be taken. Appropriate corrective action should be consistent with the nature of the conduct and the surrounding circumstances including, without limitation, implementation of a corrective action plan, the requirement that future billing be handled in a designated way, that additional training and education take place, that restrictions be placed on billing by certain medical staff members, that filing of amended or revised claims be made, that repayment of an overpayment be made in a timely manner, and/or that the matter be disclosed to external authorities (such as the Medicare contractor, CMS, or OIG). It may also include restructuring of business relationships, including, where necessary, the termination and/or renegotiation of existing contracts.

## XI. LIST OF EXHIBITS

**A. Compliance Affidavit**

**B. Attendance Sheet for Compliance Program Education Seminar**

## XII. LIST OF ADDENDA

**1.** Compliance Standards Specific to Hospice Providers
**2.** Fraud, Waste and Abuse Addendum

## EXHIBIT A

## COMPLIANCE AFFIDAVIT

I hereby acknowledge and affirm that I have read and reviewed the Compliance Manual of McGregor (the "Company"). I also acknowledge that I have been encouraged to ask any questions I might have regarding its requirements.

I understand that it is a condition of my employment to comply with the requirements of the Compliance Manual and the Company's overall Compliance Program. I also realize that I am required to report potential violations of the Compliance Manual when I am told of potential violations by any person or I witness the violation myself. I understand that I will not be punished for reporting in good faith misconduct of any magnitude or which involves any level of Company personnel. I have been informed that I will be disciplined for failing to report such violations. I am familiar with the Company's methods to report misconduct and the identity of the Compliance Officer.

I certify that I have not been excluded from participation in any federal or state health care program. I have not been criminally convicted of any crime regarding federal or state health care programs or any offense involving patient abuse or neglect or financial misconduct (such as fraud or embezzlement).

_____
Employee Signature

_____
Printed Name

_____
Date

**EXHIBIT B**

**ATTENDANCE SHEET**
**FOR**
**COMPLIANCE PROGRAM EDUCATION SEMINAR**

Date: _____ Location: _____
Time: _____

By signing at the space provided below, the undersigned hereby certifies that: (1) he/she has attended the compliance education seminar regarding the overall Compliance Program of McGregor (the "Company") and (2) that he/she has received a copy of any written materials distributed at this seminar.

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## ADDENDUM 1

## COMPLIANCE STANDARDS SPECIFIC TO HOSPICE PROVIDERS

*i.* *Applicability*

This policy constitutes specific compliance standards applicable to the hospice business of the Company ("Hospice"). It is intended that all provisions of this Manual and all other applicable policies of Company shall also apply to Hospice and shall be read in concert with these standards. References to "residents" in the rest of this Manual shall be interpreted as patients for purposes of Company's hospice business to the extent such references are applicable to hospice.

*ii.* *Policy Statement*

The Company expects that hospice services will be provided in accordance with the hospice licensing *requirements*, the Medicare conditions of participation, and other Applicable Law. Company shall ensure that:

- Hospice patients (or their authorized representatives) are fully informed of the determination of the patient's life limiting condition and about the palliative nature of the care and services that may be provided if the individual elects the Medicare Hospice Benefit and the consequences thereof, including, but not limited to, waiving the right to receive standard Medicare benefits related to the terminal illness including all treatment for the purposes of curing the terminal illness;

- Only patients that are "terminally ill" – defined as the individual has a medical prognosis such that the individual's life expectancy is six months or less if the illness runs its normal course - may be admitted to Hospice. Before admitting a patient for hospice services, the hospice physician and attending physician must thoroughly review and certify the admitting diagnosis and prognosis. The patient's medical record must contain documentation to support the terminally ill certification as well as documentation of the clinical progression/status of the patient's disease and medical condition;

- There are no other arrangements with other health care provider(s) that are also submitting claims for services already covered by the Medicare Hospice Benefit or for services that are unallowable for reimbursement under the Medicare Hospice Benefit. If these situations occur, Company will work with the other health care providers to coordinate care and ensure appropriate billing;

- Medical records and plans of care of hospice patients are complete and accurate and comply with Medicare (or the applicable payor) requirements. The plan of care must be reviewed and updated at intervals specified in the plan by the attending physician, hospice physician, and the Interdisciplinary Group, and such reviews/updates shall be documented. Company and its Personnel shall not falsify patient medical records or plans of care to exaggerate the negative aspects regarding a hospice patient's condition to justify reimbursement or falsely date amendments to medical records;

- Hospice does not seek reimbursement for services that are not reasonable and necessary for the palliation or management of the hospice patient's terminal illness;

- Hospice does not bill for hospice care provided to a patient until the plan of care has been established by the hospice physician and the Interdisciplinary Group;

- Sufficient oversight of hospice patients is provided to ensure the patient remains eligible for the Medicare Hospice Benefit;

- Adequate and complete services to review hospice patients' medical conditions and status are rendered by the Hospice's Interdisciplinary Group;

- Levels of care and utilization of care are appropriate and consistent with the needs of the patient, family and/or lawful representative. Needed care to Hospice patients shall not be denied in order to keep costs low. Additionally, the Company shall ensure that no pressure is placed on a Hospice patient to revoke the Medicare Hospice Benefit when the patient is still eligible for and desires such care. Although a hospice may discharge a patient it if discovers that the patient is not terminally ill, hospices should not encourage a patient to revoke the benefit merely to avoid the obligation to pay for hospice services that become costly;

- No eligible patient shall be denied hospice services solely because the referring physician delayed in making a referral. In such circumstances, the referring physician should be educated regarding the risks, costs, and quality of care problems associated with late referrals; and

- Hospice and Hospice Personnel shall not offer or give any incentives to potential referral sources (such as physicians, nursing homes, hospitals, patients).

Hospice may see terminally ill patients in skilled nursing facilities or nursing facilities ("Facility"). While hospice services may be appropriate and beneficial to terminally ill Facility residents who wish to receive palliative care, arrangements between nursing homes and hospices are vulnerable to fraud and abuse due to the nursing home being in a position to influence referrals and/or make decisions regarding hospices they will permit to provide services to their residents. As such, Company shall ensure that the following are met:

- Hospice must have a written agreement in place with each Facility, prior to the provision of hospice services, under which Hospice takes full responsibility for the professional management of the patient's hospice care and the Facility provides room-and-board;

- Any payment by Hospice to a Facility for room-and-board for a Hospice patient shall not exceed the amount that the Facility would have otherwise received directly from the payor if the patient had not been enrolled in hospice;

- Hospice shall not delegate or otherwise depend on Facility staff to provide Hospice's services, nor shall Hospice provide less or fewer services or care than normally provided to Hospice patients not residing in a Facility;

- Hospice will collaborate with the Facility as to the services required by each patient in accordance with the patient's Plan of Care. When changes in the Plan of Care are needed, Hospice will appropriately communicate with Facility and document such changes;

- Hospice shall not improperly relinquish the provision of core services and professional management responsibilities to nursing homes, volunteers or other privately-paid professionals. Other non-core services may be provided at fair market value pursuant to a written agreement. Hospice shall retain professional management for all contracted services;

- Hospice shall not provide staff, at its expense, to the Facility that would otherwise be performed by the Facility; and

- Hospice may not offer free or below fair market value goods or services, to induce a Facility to refer patients to the Hospice.

As part of Hospice's monitoring program, Company will:

- Periodically review the appropriateness of the Interdisciplinary Group services;

- Periodically review the level of services being provided including, but not limited to, the use of general inpatient care;

- Periodically review the appropriateness of the admission standards required by Hospice in the acceptance of patients;

- Regularly review Hospice's length of stay to ensure sufficient oversight of patients including, but not limited to, in particular, those patients receiving more than six consecutive months of hospice and their continued eligibility for hospice care;

- Review, as necessary, any delays in admission; and

- Periodically review documentation showing revocation of the Medicare Hospice Benefit.

**Hospice Marketing**

Company will use its best efforts to ensure that all marketing materials and practices between its Hospice and nursing facilities and other potential or actual referral sources are in compliance with Applicable Law and do not offer or imply to offer incentives to influence the selection of a particular hospice. Additionally, Company shall ensure that Hospice does not engage in:

- High pressure marketing of Hospice services to ineligible beneficiaries or otherwise engage in marketing that offers incomplete or inadequate information about the Medicare Hospice Benefit to induce beneficiaries to elect hospice;

- Improper patient solicitation through inappropriate activities including, but not limited to "patient charting" (i.e., improper review of patient charts of a hospital patient or nursing facility resident by a hospice without the patient/resident’s permission for the sole purpose

of determining if the patient/resident is eligible for hospice care and to solicit hospice referrals); or

- Sales commissions based upon length of stay in hospice.

## ADDENDUM 2

## FRAUD, WASTE, AND ABUSE ADDENDUM

As required by 42 U.S.C 1396a(a)(68) and Ohio Revised Code 5162.15, Company must provide the following detailed information to all employees, agents and contractors of Company about federal and state False Claims Acts and laws pertaining to civil and criminal penalties for false claims and statements, and whistleblower protections under such laws, and Company's policies and procedures to detect and prevent fraud, waste, and abuse.

### A. Federal False Claims Act

The federal False Claims Act, 31 USC 3729-3733, among other things, applies to the submission of claims for payment under any federal program, including claims submitted by health care providers for payment by Medicare, Medicaid, and other federal health care programs. The False Claims Act provides the federal government a civil remedy for fraudulent claims.

The False Claims Act prohibits, among other things:

1. Knowingly presenting or causing to be presented to the federal government a false or fraudulent claim for payment or approval;

2. Knowingly making or using, or causing to be made or used, a false record or statement in order to have a false or fraudulent claim paid or approved by the government;

3. Conspiring to defraud the government by getting a false or fraudulent claim allowed or paid; and

4. Knowingly making or using, or causing to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the government.

"Knowingly" means acting with actual knowledge or with reckless disregard or deliberate indifference to the truth or falsity of information. Examples of false claims include falsifying medical records submitted, billing for services not rendered or goods not provided, duplicating billing to obtain double compensation, and billing certifying or prescribing medically unnecessary services.

The United States Attorney General may bring civil actions against individuals and entities for violations of the False Claims Act. As with most other civil actions, the government must establish its case by preponderance of the evidence rather than by meeting the higher burden that applies in criminal cases. Penalties under the False Claims Act include three times the amount of any overpayment, and civil monetary penalties ranging from $5,500 to $11,000 per claim (for violations prior to November 2, 2015), $10,781 - $21,563 per claim (for violations between November 2, 2015 – February 2, 2017), $10,957 - $21,916 per claim (for violations that occurred between February 3, 2017 – January 28, 2018), and $11,181 - $22,363 (for violations on or after January 29, 2018) and annual inflation adjustments to the penalty range thereafter, plus attorney fees. The False Claims Act allows private individuals to bring "whistleblower" actions on behalf

of the federal government for violations of the Act. The government may decide to intervene and take over the whistleblower action, or decline to intervene and allow the whistleblower to pursue the action. The False Claims Act protects whistleblowers by imposing penalties, including two times back pay, interest and attorneys' fees, upon individuals and entities that retaliate against whistleblowers.

## B. Program Fraud Civil Remedies Act of 1986

The Program Fraud Civil Remedies Act of 1986 (PFCRA), 31 USC Chapter 38, authorizes federal agencies such as the Department of Health and Human Services ("HHS") to investigate and assess penalties for the submission of false claims or statements to the agency. The conduct prohibited by the PFCRA is similar to that prohibited by the False Claims Act. A person may be liable under the PFCRA for making, presenting, or submitting, or causing to be made, presented, or submitted, a claim or statement that the person knows or has reason to know:

a) Is false, fictitious, or fraudulent;

b) Includes or is supported by any written statement which asserts a material fact which is false, fictitious, or fraudulent;

c) Includes or is supported by any written statement that –

   i. Omits a material fact;

   ii. Is false, fictitious, or fraudulent as a result of such omission; and

   iii. Is a statement in which the person making, presenting, or submitting such statement has a duty to include such material fact; or

d) Is for payment for the provision of property or services, which the person has not provided as claimed.

The government agency may assess twice the amount of its damages and a civil penalty of up to $11,463 for each false or fictitious claim. The United States Attorney General has exclusive authority to enforce such assessments and penalties in federal court.

## C. Ohio Laws

There also may be liability under Ohio laws for false or fraudulent claims with respect to the Medicaid program expenditures, including:

a) Medicaid Fraud, Ohio Revised Code Sec. 2913.40

   The Medicaid Fraud Act imposes criminal penalties for among other things:

   i. Knowingly making or causing to be made a false or misleading statement or representation for use in obtaining Medicaid reimbursement.

   ii. Doing either of the following with the purpose to commit fraud or knowingly facilitating a fraud:

1. charging, soliciting, accepting or receiving any amount in addition to the amount of reimbursement due from Medicaid and any authorized deductibles or co-payments;

2. soliciting, offering or receiving any remuneration other than authorized deductibles and co-payments, in cash or in kind, including kickbacks or rebates, in connection with the furnishing of goods or services for which payment may be made under the Medicaid program.

iii. Knowingly altering, destroying concealing or removing any records necessary to support a Medicaid claim or cost report.

b) Medicaid Eligibility Fraud, Ohio Revised Code Sec. 2913.401

The Medicaid Eligibility Fraud Act imposes criminal penalties on persons for knowingly making false or misleading statements, concealing an interest in property, or failing to disclose a transfer of property for purposes of determining eligibility to receive Medicaid benefits.

c) Falsification, Ohio Revised Code Sec. 2921.13

Ohio criminal law prohibits persons from knowingly making false statements or swearing or affirming the truth of a false statement for the purpose of securing payment of benefits administered by a governmental agency or paid out of a public treasury, for the purpose of securing a provider agreement with the government, or in connection with any report that is required or authorized by law, such as the Medicaid cost report.

d) Offenses by Medicaid Providers, Ohio Revised Code Sec. 5111.03

The Medicaid Provider Offenses Statute prohibits Medicaid providers from acting "by deception" to obtain or receive or attempt to obtain or receive payments to which the provider is not entitled, or to falsify any report or document relating to Medicaid. "Deception" includes acting with reckless disregard or deliberate ignorance of the truth or falsity of information or withholding information. Penalties for violation of the Medicaid Provider Offenses Statute include interest on excess payments, three times the amount of excess payments, civil penalties of $5,000 to $10,000 per claim, recovery of the costs of enforcement, and termination of the Medicaid provider agreement. The Ohio Attorney General may enforce the provisions of this statute in state court.

e) Any other state law pertaining to civil or criminal penalties for false claims and statements with respect to the Medicaid program, including any law that prohibits:

i. Knowingly presenting, or causing to be presented, a false or fraudulent claim for payment or approval to the Medicaid program;

ii. Knowingly making, using, or causing to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Medicaid program;

iii. Conspiring to defraud the Medicaid program by getting a false or fraudulent claim allowed or paid;

iv. Knowingly making, using, or causing to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Medicaid program.

## D. Protection for "Whistleblowers"

It is the policy of Company to detect and prevent any activity that may violate the False Claims Act, the Program Fraud Civil Remedies Act of 1986 or the State Medicaid Fraud Laws cited in this policy. If any Personnel has knowledge or information that any such activity may have taken place, the Personnel should notify his or her supervisor or contact the Compliance Officer or call the Compliance Hotline at 216-851-8200 ext. 2050. Information may be reported to the Hotline anonymously. In addition, federal and state law and Company policy prohibit any retaliation or retribution against persons who report suspected violations of these laws to law enforcement officials or who file "whistleblower" lawsuits on behalf of the government. Anyone who believes that he or she has been subject to any such retribution or retaliation should also report this to the Compliance Officer or the Hotline.

## E. Fraud, Waste and Abuse Prevention and Detection

Company has developed, as part of its Compliance Program, detailed written policies for the prevention and detection of fraud, waste, and abuse in government and commercial health care programs, and for the role of employees, contractors and agents in preventing and detecting fraud, waste and abuse in such programs. Company's policies and procedures for the prevention and detection of fraud, waste and abuse have been provided to employees, contractors and agents in the form of the Code of Conduct and this Manual and may be accessed in the public drive under corporate compliance, or additional copies may be obtained from the Compliance Officer. If any employee, contractor or agent has any questions regarding such policies and procedures, the employee should contact the Compliance Officer at 216-851-8200 ext. 2050.