DESOTO MEMORIAL HOSPITAL

# CORPORATE COMPLIANCE PROGRAM MANUAL

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The Compliance Program is intended to promote legal and ethical behavior; provide a guide for the conduct of all employees; and prevent and detect violations of the law.

DeSoto Memorial Hospital
Corporate Compliance Program Manual

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## DMH Corporate Compliance Program

### I. Introduction

1.1 Notice of Adoption of the DMH Corporate Compliance Program. This Corporate Compliance Program ("Compliance Program") was adopted by The DeSoto County Hospital District "Board") d/b/a DeSoto Memorial Hospital ("DMH"), on the 27th day of January 2011. The Board may make modifications to this Compliance Program from time to time. In addition to this document, DeSoto Memorial Hospital has established and maintains various operational practices, policies and procedures, which are incorporated by reference herein. Nothing in this Compliance Program diminishes an employee's responsibility to follow those operational policies and procedures.

1.2 Policy of Compliance with Existing Laws. Each employee of DMH and member of the Board is required to comply with all applicable laws and regulations, whether or not specifically addressed in this Compliance Program. It is the responsibility of each employee and Board member to act honestly and with integrity in all dealings and to seek appropriate guidance when necessary. This Compliance Program is intended to (a) promote legal and ethical behavior; (b) provide a guide for the conduct of all employees; and (c) prevent and detect violations of law.

1.3 Application of Compliance Program. This Compliance Program applies to all employees and members of the Board. DMH will strive to have vendors, independent contractors of DMH and all others employed by other organizations and doing work on behalf of DMH commit to compliance with this Program and the Code of Conduct. Employees who work with consultants, independent contractors, and vendors or who process their invoices should be aware that the Compliance Program applies to such individuals or companies. All employees are encouraged to monitor carefully the activities of contractors in his or her areas. If any employee is unclear as to (a) the existence of, interpretation of, or application of any law, or (b) whether any action complies with the law, this Compliance Program, or policies or procedures, the employee should submit their question to the Corporate Compliance Officer ("Compliance Officer") or to a member of Senior Leadership, the Facility Privacy Officer ("FPO"), or the Facility Information Security Officer ("FISO").

1.4 Consequences of a Violation of the Compliance Program. Each employee of DMH and member of the Board must carry out his or her duties for DMH in accordance with the Compliance Program. Conduct that fails to comply with the Compliance Program or Code of Conduct, or fails to comply with federal, state or local law, is not authorized by DMH, is outside the scope of any employment or other contractual relationship, and may result in progressive disciplinary action or termination of such relationship.

### II. Structure

2.1 DMH. The Compliance Program is intended to clearly illustrate the unconditional commitment of the organization to the highest standards of ethics and compliance. That commitment permeates all levels of the organization. The Compliance Officer, Senior Leadership, the FPO, and the FISO are available to provide support and guidance to individuals throughout the Hospital in meeting the standards set forth in the Code of Conduct and this Compliance Program.

2.2 Hospital Corporate Compliance Committee ("Compliance Committee").

(a) Members of the Hospital Compliance Committee consist of:

* The Corporate Compliance Officer (Chairperson)
* A member of the Board
* A Physician member of the Medical Staff
* The Chief Executive Officer ("CEO")
* The Chief Financial Officer ("CFO")
* The Director of Nursing ("DON")
* The Facility Privacy Officer ("FPO")
* The Facility Information Security Officer ("FISO")
* Department Directors/Managers/Staff as specifically appointed

(b) The Compliance Committee:

* provides oversight to ensure the effectiveness of the Compliance Program;
* assures corrective action is taken in the event of any failure to adhere to the Compliance Program:
* assists in the development of the standards of conduct and policies and procedures to promote adherence to the Compliance Program:
* assists in establishing priorities based on regulatory and high risk areas to develop and implement mechanisms and controls to ensure compliance with policies and procedures and the Code of Conduct as part of daily operations;
* determines compliance educational needs and assists in assuring that educational programs meet that need;
* assists with the determination of the appropriate strategy/ approach to promote adherence with the Compliance Program, establishes appropriate systems for the detection of potential violations and evaluates their effectiveness; and
* assists with the review and evaluation of any submission of conflict of interest with organizational policy and procedure.

2.3 Corporate Compliance Officer ("Compliance Officer"). The Compliance Officer of DeSoto Memorial Hospital is responsible for ensuring that the Compliance Program is implemented and monitored, and oversees the day-to-day activities of the Compliance Program. The Compliance Officer is not responsible for performing all compliance-related tasks. Rather, the role of the Compliance Officer is to coordinate compliance activities conducted by individuals throughout the Hospital. All actions of the Compliance Officer are subject to review and approval by the CEO and the Board.

(a) The Compliance Officer, who reports to the CEO and the Board:
- * serves as a focal point for compliance activities and has the authority to review all documents and records relevant to compliance activities;
- * develops, oversees and monitors the implementation of the compliance program;
- * reports on a regular basis to the Board, the CEO and the Compliance Committee on the progress of implementation;
- * assists the Hospital's Board, CEO and Compliance Committee in establishing methods to reduce vulnerability to fraud, abuse, and waste;
- * periodically revises the program to reflect the changes in the needs of the organization, the law and the policies and procedures of the government and private payer health plans;
- * participates in providing educational and training programs throughout the organization, focusing on the elements of the Compliance Program;
- * assists the organization's financial management in coordinating internal compliance review and monitoring activities;
- * investigates and acts on matters related to compliance, to include the flexibility to design and coordinate internal investigations and any resulting corrective action with all Hospital departments, providers and sub-providers, agents and, if appropriate, independent contractors; and
- * develops policies and programs to encourage managers and employees to report suspected fraud and other improprieties without fear of retaliation.

2.4 Resources for Guidance. Several options are available for obtaining guidance on an ethics or compliance issue. Each employee should use the Code of Conduct as guidance when dealing with difficult issues. We encourage the resolution of issues at a department level whenever possible. It is good practice, when the employee is comfortable with it and thinks it appropriate under the circumstances, to seek guidance first with his/her supervisor. If this is uncomfortable or inappropriate, another option is to discuss the issue with your Senior Leader (CEO, CFO or DON) or the Director of Human Resources. Additionally, individuals are always free to contact the Compliance Officer directly at extension 697 or 993-7697, or the Facility Privacy Officer at extension 645, or the Compliance Hotline (Value Line) at 1-800-273-8452. If you need to contact the Compliance Officer or the Privacy Officer urgently and do not get an answer at the numbers above within a reasonable period of time, please contact the Hospital Switchboard and ask the operator to contact them for you.

DMH makes every effort to maintain, within the limits of the law and applicable regulations, the confidentiality of the identity of any individual who reports possible misconduct. There shall be no retribution or discipline for anyone who reports a possible violation in good faith or cooperates with an investigation of a report of a possible violation. Any person who deliberately makes a false accusation with the purpose of harming or retaliating against another colleague is subject to progressive corrective action, up to and including dismissal.

## III. Personal Obligation to Report

We are committed to ethical and legal conduct that is compliant with all relevant laws, regulations, and policies and procedures and to correcting wrongdoing wherever it may occur in the organization. Each employee and Board member is responsible for his/her own conduct. In addition to the Hospital Corporate Compliance Committee and the Corporate Compliance Officer, other personnel shall assist in the implementation, administration and enforcement of the Compliance Program as requested. Each employee and Board member is responsible for complying with all applicable laws, regulations, and policies and procedures in the performance of his/her duties, whether job duties or contractual duties. It is the duty of each individual to be adequately trained to perform his/her duties and to comply with applicable law. It shall also be the duty of each person to recognize compliance issues and behavior violations and promptly seek guidance as necessary.

3.1 Reports of Suspected Violations. Each individual has a duty under the Compliance Program to promptly report in good faith to his/her immediate supervisor, other appropriate management staff, or the Corporate Compliance Officer any possible wrongdoing or violations of applicable federal and state laws and/or regulations. As used herein, a "suspected violation" occurs when an employee has reasonable cause to believe that a violation of any federal or state law and/or regulation or violation of the Compliance Program has occurred or may occur. DMH will not retaliate or discriminate against any employee who makes a good faith report or who is involved in any manner or who cooperates with an investigation of a suspected violation. However, it is a violation of the Compliance Program to make a report of a suspected violation, which is knowingly false, malicious or otherwise not in good faith.

3.2 Self-Reporting. To be effective, the Compliance Program depends to a great extent upon self-reporting and acceptance of responsibility by any individual who has made a mistake, even inadvertently, in the normal course of business, whether or not due to lack of knowledge or inattention. DMH must follow the appropriate laws and regulations pertinent to self-reporting. To the extent an employee self-reports a potential wrongdoing, both the self-reporting and the acceptance of responsibility will be taken into account in formulating a response.

3.3 Methods of Reporting. DMH desires to establish open lines of communication between all employees and the Corporate Compliance Officer to provide for the successful implementation and operation of the Compliance Program. DMH has an open door and non-retribution policy available to all employees acting in good faith to encourage communication, dialogue and the reporting of suspected violations. If the Compliance Officer is unavailable, or if an employee suspects the Compliance Officer of condoning the activity being reported, the employee should make a report to his/her immediate supervisor, other appropriate management staff, the President/CEO, or to a member of the Board.

## IV. Internal Investigations of Reports

DMH is committed to investigating all reported concerns promptly and confidentially to the extent possible. When a report of a suspected violation is received on a matter that does not concern compliance issues, that report is referred to the appropriate individual within DMH. Whenever the Compliance Officer learns of any allegation of a suspected violation, from any source, and where the allegation reasonably may constitute a criminal or civil health care-related offense, he/she will promptly conduct a preliminary review of the allegation. Advice from legal counsel may be sought to determine the seriousness of the allegation. If the Compliance Officer reasonably determines that it is necessary to conduct an internal investigation of the alleged misconduct, then he/she will promptly initiate an internal investigation. The internal investigation will be completed within a timely manner. All internal investigations and their results are reported to the CEO and the Board. At the direction of the Compliance Officer, and subject to approval of a the CEO and/or the Board, an employee under investigation may be removed from his/her current work activity and placed on administrative leave with or withour pay pending completion of an investigation or preliminary review. The Compliance Officer will take appropriate steps to secure or prevent the destruction of documents and other evidence relevant to the investigation. Internal investigations are treated confidentially to the degree possible. Information is disclosed or otherwise released solely on a need to know basis.

## V. Corrective Action

The Compliance Officer, at the direction of the CEO and/or the Board, may implement any corrective actions deemed reasonably necessary to ensure adherence with the Compliance Program and any applicable federal, state or local laws and regulations. These corrective actions may include, when appropriate, prompt reimbursement of any improper payments to Federal Health Care Programs. If unlawful conduct is detected, all efforts will be made to stop the conduct immediately and to implement an action plan to avoid the conduct in the future. At the direction of the CEO and/or the Board, the Compliance Officer will report violations to appropriate governmental authorities and/or enforcement agencies as required by law.

All violators of the Compliance Program and Code of Conduct will be subject to progressive corrective action up to and including immediate dismissal in accordance with approved Policy and Procedure.

## VI. Auditing and Monitoring

DMH is committed to the monitoring of compliance with its policies and practices. Regular auditing and monitoring of compliance activities is an additional feature of the Compliance Program. Compliance reports created by ongoing monitoring, as well as follow-up reports of potential compliance issues, shall be held confidential by the Corporate Compliance Committee and the Compliance Officer, and is submitted to appropriate individuals as defined by this program.

DMH will utilize periodic, ad hoc audits by internal and/or external auditors.

The audits will focus on those areas, which have specific substantive exposure to government enforcement actions. If it is determined that any error or deviation is caused by improper procedures, misunderstanding of the rules, including fraud or other systemic problems, DMH will take appropriate steps to correct the problem. Additionally, supervisory personnel shall monitor and audit the performance related to compliance of personnel in their areas periodically, with such monitoring and auditing to occur at least annually.

6.1 Advice from Payers. To the extent any employee requests advice from the government, its agents charged with administering a Federal Health Care Program, or any private insurance payers, DMH personnel will document and retain a record of such request for advice and the corresponding response, if any. Each employee receiving such advice shall be responsible for providing a copy of the advice, if written, or a memorandum describing the advice, if oral, to the Compliance Officer upon request.

VII. Statement of Compliance

DMH requires each employee, Medical Staff member, and Board member to sign a statement of compliance confirming they have received and read the Code of Conduct and understand it represents mandatory policies of DMH. Every year, the employee will be asked to sign the statement as part of the process of the annual education program. New employees will be required to sign this statement as a condition of employment. Volunteers will be required to sign the statement at the time they begin working at DMH. Medical Staff members will be required to sign the statement at the time of initial appointment and at the time of each subsequent reappointment. Board members will be required to sign the statement annually.

Adherence to and support of DMH Code of Conduct and Compliance Program and participation in related activities and training will be considered in decisions regarding the terms, conditions and privileges of employment, including: hiring, promotion, and compensation for all employment candidates and employees.

VIII. Information and Education

DeSoto Memorial Hospital has instituted and maintains an ongoing education and training program. Education and training are a critical part of the Compliance Program. Education and training will involve all new and all existing DMH personnel, which shall require participation from all employees in regular Compliance Education training so that each person is knowledgeable of the Code of Conduct and procedures for reporting potential problems/concerns. The majority of this education and training will be part of the annual mandatory education and/or the annual clinical competencies.

In January 2007, all DMH employees received a copy of the detailed brochure titled "Preventing and Detecting Fraud, Waste and, Abuse in Federal Health Care Programs" to satisfy the requirement of the Deficit Reduction Act of 2005 that we inform employees about false claims and whistleblower laws beginning in 2007. New employees receive this information and brochure during orientation. The Compliance Officer will be responsible for coordinating

appropriate education for the Medical Staff members and Board members on an ongoing basis as needed, but not less than annually.

DMH will maintain updated records of the education and training received by employees, volunteers, Medical Staff members and Board members.

IX. Cooperation with Government Investigations or Other Litigation

The policy of DMH is to cooperate with any reasonable and lawful demand by the government made in the course of a government investigation. DMH policy prohibits the obstruction of justice. Any employee receiving a legal document, including a subpoena, warrant or notice of investigation, concerning DMH, shall notify the Compliance Officer immediately. Every employee is expected to cooperate in DMH's response to such an investigation.

9.1 Preservation of Records. DMH regularly destroys records in a manner that is consistent with the federal and state laws and regulations governing the retention of records. However, no person shall destroy, directly or indirectly, a record or other document that the employee knows is the subject of a pending subpoena, pending litigation or pending investigation.

X. Human Resource Issues

10.1 Background Checks Before Hiring New Employees. The Human Resources department will conduct appropriate criminal background, cumulative sanctions and reference checks prior to a decision to offer employment to any person. DMH will not retain as an employee or independent contractor, or any person it knows to have been convicted of a criminal offense related to health care or who is debarred by the General Services Administration (www.epls.gov) or is excluded, or otherwise ineligible for participation of any Federal Health Care Program, as defined by 42 U.S.C. 1320a-7b(f).

10.2 OIG/GSA Sanction Queries. Queries to identify individuals who have been deemed to be Ineligible Persons will be conducted in accordance with the Screening Requirements--Ineligible Persons Policy located in the Compliance Policy and Procedure cabinet in Meditech.

10.3 Reasonable Compensation Required. Compensation paid to employees, independent contractors, and others must be reasonable and consistent with the fair market value of the services provided. Questions concerning compensation arrangements should be directed to the Compliance Officer or to a member of Senior Leadership.

10.4 Legal Review of Relationships with Other Health Care Providers. Employment and independent contractor agreements must satisfy a number of complex federal and state laws that are specific to the health care industry. It is the intention of DMH for all of its relationships with other health care providers to function in a manner that is consistent with those laws. No employee should make a unilateral judgment about the availability of an exception to any law. The Compliance Officer shall coordinate the services of approved legal counsel, under the direction of the CEO, to ensure that all relationships with other health care providers are appropriate and in

compliance with such laws.

10.5 Exit Interviews on Termination of Employment. DMH will attempt to conduct an exit interview for all employees terminating employment with DMH for any reason. Inquiry shall be made at the exit interview concerning any potential wrongdoing of which such employee is aware. At that time, each such employee will be requested to provide a report of any otherwise reportable incidents.

## XI. Coding and Billing Standards and Procedures

DMH is committed to maintaining the accuracy of every claim it processes and submits. Employees involved in entering charges and procedure codes are expected to monitor compliance with applicable laws and rules relating to such billing procedures. Any false, inaccurate or questionable claims should be reported immediately to the Compliance Officer or to a member of Senior Management. All denials, from all payment sources, shall be reviewed by the Finance Department and appropriate action taken. It is the policy of DMH that every patient is entitled to complete and accurate disclosure of charges by DMH associated with that patient.

11.1 Specific Billing Standards. All employees must refrain from inaccurate or false billing practices. In particular, employees must refrain from knowingly performing the following:

a. Billing for items or services not provided or rendered;
b. Misrepresenting the services actually rendered;
c. Filing duplicate claims;
d. "Up coding" to more complex procedures than were actually performed;
e. "Down coding" to less complex procedures than were actually performed;
f. Unbundling (i.e., billing services separately, which are required to be billed collectively);
g. Falsely indicating that a particular health care professional attended a procedure or that services were otherwise rendered in a manner they were not (e.g., the use of an unlicensed physician or the improper use of allied health professionals or physician extenders by filing claims for services that such professionals are not, under applicable laws and regulations, permitted to deliver, or representing that a physician provided a service that actually was provided by a physician extender);
h. Billing for services or items that are not medically necessary;
i. Falsely certifying that certain services were medically necessary;
j. Failing to provide medically necessary services or items;
k. Billing excessive charges; or
l. Failing to refund credit balances as required by state or federal health care programs;

Employees who prepare or submit claims should be alert for these and other errors. No employee should knowingly submit any false claim to any payer. A bill should be submitted only when appropriate, legible documentation has been maintained and is available for audit and review.

11.2 Assignment and Reassignment. If any employee has a question whether DMH

may bill for a particular service, either on behalf of a physician or on its own behalf, the question should be directed to his/her immediate supervisor following the chain of command or the Compliance Officer for review. Employees should not submit claims for services provided by other entities or claims prepared by other entities, including outside consultants, without review and acceptance from the Compliance Officer or designee. Special care should be taken in reviewing these claims, and employees should request documentation from outside entities, if necessary, to verify the accuracy of the claims.

11.3 Waiver of Co-payments and Deductibles. DMH does not routinely waive co-payments or deductibles, except to the extent such waiver is consistent with applicable federal and state laws and regulations. Waivers based on a determination of financial hardship of a particular patient are permissible under certain circumstances. No waivers will be permitted except upon the prior written approval of the Director of Patient Financial Services, the CFO or the Compliance Officer. DMH shall make reasonable collection efforts for co-insurance or deductible amounts. Waiver of co-payment or deductible is permitted where it is pursuant to a negotiated discount with a health plan and there is full disclosure of the waiver.

11.4 Communication from Clinical Staff. Billing and coding staff are able to communicate to and receive communications from clinical staff at all times. Procedures for which the clinical staff has not answered reimbursement staff questions will not be billed until the queries are answered satisfactorily. All documentation necessary for accurate coding will be provided to the reimbursement staff.

11.5 Use of Billing/Coding Consultants. DMH may employ consultants to assist on a variety of billing, coding or other reimbursement issues. Such consultants shall not be paid on a percentage basis relating to an increase in reimbursement to DMH (e.g., a contingent fee contract) unless reviewed and approved by the CEO, CFO and/or the Compliance Officer. All such contracts will expressly allocate the responsibilities of each party to monitor compliance.

XII. Anti-Kickback/Fraud and Abuse Standards and Procedures

12.1 Payments to Referral Sources. DMH expects all individuals employed by DMH and the Board to refrain from conduct that violates any anti-kickback or fraud and abuse laws (the "Anti-Kickback Statutes"). See 42 U.S.C. 1320a-7a. These laws prohibit: (a) direct, indirect and disguised payments Okla. Stat. 1-742. These laws prohibit (a) direct, indirect and disguised payments in exchange for the referral of patients; (b) the submission of false, fraudulent or misleading claims to any government entity or third party payer; and (c) making false representations to any person or entity in order to gain or retain participation in a Federal or State Health Care Program or to obtain payment for any service. The Compliance Program prohibits any employee or Board member from paying or accepting a payment to induce the referral of a patient to or by DMH. No one acting on behalf of DMH may offer gifts, loans, rebates, services, or payment of any kind to a referral source for DMH, related to a patient, nor may anyone acting on behalf of DMH accept

gifts, loans, rebates, services or payment of any kind related to the referral of a patient by DMH without consulting the Compliance Officer. These requirements apply to all oral or written agreements pursuant to which physicians or other health care providers receive any remuneration from DMH.

A number of safe harbor regulations have been adopted under the Federal Anti-Kickback Statute. See e.g., 42 C.F.R. 1001.952. Analysis of an activity under the Anti-Kickback Statute and the safe harbors is complex and depends upon the specific facts and circumstance of each case. No employee or Board member should make a unilateral judgment on the availability of a safe harbor for a payment practice, investment, discount or other arrangement.

Any questions should be brought promptly to the attention of the Compliance Officer for review with legal counsel prior to implementation. The Compliance Officer will coordinate with legal counsel to ensure the review of any discounts offered to DMH by providers, suppliers and vendors, as well as discounts offered by DMH to insurance companies or other third party payers. Likewise, rentals of space and equipment, agreements for professional services, management services and consulting services are brought to the attention of the Compliance Officer by legal counsel as necessary. Finally, joint ventures involving employed physicians or other health care providers must be reviewed by the Compliance Officer.

## XIII. Patient Referrals

It is the policy of DMH that patients or the patient's legal representatives are free to select their health care providers and suppliers. The choice of a hospital, diagnostic facility, home health agency or supplier should be made by the patient with guidance from his/her physician as to which providers are qualified and medically appropriate.

13.1 Self-Referral Proscriptions. Under the Federal "Stark" Law, codified 42 U.S.C. 1395nn, and the regulations promulgated thereunder, physicians are prohibited from referring patients to an entity for the performance of certain "designated health services" if the physician or his/her immediate family has a financial relationship with the entity and the designated health services are to be paid for by a Federal Health Care Program. All arrangements or transactions of DMH involving self-referral by a physician must be reviewed by the Compliance Officer. The Compliance Officer, in conjunction with legal counsel, shall decide if an appropriate exception to the self-referral statutes exists.

## XIV. Physician Relationships

14.1 Recruitment. The recruitment and retention of physicians requires special care to comply with applicable federal and state laws and regulations. Each recruitment package or commitment shall be in writing and consistent with applicable federal and state laws and regulations, and will be reviewed by the legal counsel in consultation with the Compliance Officer.

14.2 Agreements with Physicians. All agreements with physicians, in which the physician is receiving goods or services from DMH or providing goods or

services to DMH, shall be submitted in advance to legal counsel for review and acceptance in consultation with the Compliance Officer. Where a physician is to be paid for time spent working for the benefit of DMH, the CEO or CEO-designated individual or committee shall document the reasonableness of the rate paid and the need for the service. Compensation decisions shall be made without regard to the volume of referrals from the physician. All such agreements shall specify the particular duties or responsibilities of the physician.

14.3 Medical Directors. All Medical Director contracts executed by physicians who are employed/engaged by DMH shall be in writing, and reviewed and accepted in advance by legal counsel in consultation with the Compliance Officer and the CEO. All such contracts shall set forth, with specificity, the duties of the Medical Director. Compensation shall be paid only for duties actually performed. Compensation shall be not be paid for tasks the physician is already obligated to perform by contract, law, or otherwise.

XV. Clinical Laboratory Tests

15.1 Ordering of Tests, Customized Profiles, Standing Orders. For each clinical laboratory test ordered, there must be an order/requisition that is signed by the ordering physician or authorized representative with documentation to support the medical necessity of the service the DMH Laboratory has provided and billed. DMH is aware of the following as issues related to customized profiles/panels: (a) the Medicare reimbursement paid for each component of the customized profile; (b) that using a customized profile may result in the ordering of tests which are not covered, reasonable or necessary; and (c) that the Office of Inspector General takes the position an individual who knowingly causes a false claim to be submitted may be subject to sanctions and remedies available under civil, criminal or administrative law.

If standing orders are used, they should be renewed periodically by the Director of Laboratory Services in collaboration with the Director of Nursing.

15.2 Improper Inducements. DMH Laboratory shall not accept improper inducements from a physician for the purpose of gaining business from the laboratory. In particular, DMH Laboratory shall not enter into arrangements where the laboratory: (a) charges a physician a price below fair market value for the physician's non-federal health care program tests; (b) offers free phlebotomy services for patients of a provider; or (c) offers free laboratory testing for a provider or a family member of a provider.

XVI. Antitrust Compliance

All employed by DMH and the Board must comply with applicable antitrust and similar laws which regulate competition. Examples of conduct prohibited by the antitrust laws include:
(a) agreements to fix prices;
(b) bid rigging;
(c) collusion with competitors (including price sharing);

(d) unlawful boycotts;
(e) certain exclusive dealing;
(f) price discrimination agreements;
(g) unfair trade practices including bribery, misappropriation of trade secrets, deception, intimidation and similar unfair practices.

All employees of DMH and the Board are expected to promptly seek advice from the Compliance Officer when confronted with business decisions involving a risk of violation of the antitrust laws.

XVII. Confidentiality

All DMH employees are in possession of and have access to a broad variety of confidential, privileged, sensitive and/or proprietary information. The inappropriate release or unauthorized disclosure of such information could be injurious to patients, to other individuals, and to DMH. Each employee has an obligation to protect and safeguard confidential, privileged, sensitive and/or proprietary information in a manner designed to prevent the direct or indirect, inappropriate, unauthorized or unlawful disclosure of such information. Each employee shall strive to maintain the confidentiality of patient and other confidential information in accordance with applicable legal and ethical standards.

Revisions By: Shirley A. Spicer, Corporate Compliance Officer
Trudy A. Williams, Corporate Compliance Officer
Becki Cox, Corporate Compliance Officer
References: Federal Law, including the HIPAA and HITECH; "Stark," Title 42: Federal Register; Anti-Kickback Statutes; "Safe Harbors"; the the Office of Inspector General's Compliance Program Guidance for Hospitals.
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Becki Cox 5-15-19
Becki Cox, Corporate Compliance Officer Date

05/15/2019
Vince Sica, CEO Date

Lori A Colucci, BSN, RN 5/20/2019
Lori Colucci, DON Date

5/20/19
Dan Hogan, CFO Date

Robert W. Heine Jr. 5-15-19
Robert Heine, Chairman of the Board Date

## CORPORATE COMPLIANCE INFORMATION FLOWCHART