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February 24, 2017

BY EMAIL (erik.bodin@vdh.virginia.gov) ONLY
Mr. Erik O. Bodin, Director
Office of Licensure and Certification
9960 Mayland Drive, Suite 401
Henrico, VA 23233-1485

Re: Request for Additional Information – Response # 11

Dear Mr. Bodin,

Response # 11 to the questions received from your office on December 22, 2016, has been uploaded to the Citrix ShareFile platform.

Please contact me if you have any difficulty or questions in accessing the Citrix ShareFile platform. As permitted under Virginia Code § 15.2-5384.1.C.1 and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D), the material that the parties believe to be proprietary is clearly marked and submitted in separate electronic files for confidential treatment.

Responses to the following questions are submitted as part of Response # 11:

Section V. Additional Information

F. Exclusive Contracts
1

H. Banking Relationships
3

I. Insurance Relationships
3

Updates to previously submitted responses have been uploaded for the following questions:

G. Governance
5

Additional responses will be provided as soon as possible. Please let me know if you or your staff has any questions related to the enclosed documents.

Sincerely,

Francis C. Oroszlan

cc: Peter Boswell
Allyson K. Tysinger

3734641

RESPONSE #11

TO QUESTIONS

SUBMITTED DECEMBER 22, 2016

BY

VIRGINIA DEPARTMENT OF HEALTH

IN CONNECTION WITH

APPLICATION FOR LETTER AUTHORIZING COOPERATIVE AGREEMENT

Pursuant to Virginia Code § 15.2-5384.1

and the regulations promulgated thereunder at 12VAC5-221-10 *et seq.*

Submitted by: Mountain States Health Alliance

Wellmont Health System

Date: February 24, 2017

V.F.1.

F. Exclusive Contracts and Other Contracts

1. Please provide a listing of any officer, board member, advisory board member, employee, and their immediate family members that are a party directly or through stock ownership to a contract with either Applicant or their subsidiaries. Please provide financial disclosure statements of these individuals filed during the five (5) year historical baseline period.

JOINT RESPONSE: As modified and agreed by the Commissioner,[14] please see the following exhibits provided with Response G-5 in response to this request:

Exhibit G-5A	MSHA Conflict of Interest Statements Last Five Years – **PROPRIETARY**
Exhibit G-5A.1	MSHA Code of Ethics and Business Conduct Policies
Exhibit G-5A.2	MSHA Conflict of Interest Policy
Exhibit G-5B	WHS Disclosure of Conflict of Interest Statements Last Five Years – **PROPRIETARY**
Exhibit G-5B.1	WHS Conflict of Interest Policy and Code of Conduct Policy

[14] In letter dated January 30, 2017 from Ms. Allyson Tysinger, Senior Assistant Attorney General, to the Applicants in response to the Applicants' letter dated January 13, 2017 with proposal to respond to this request.

V.G.5. Amended - #2

5. Please provide all disclosure of conflict of interest statements that have been filed in the three (3) most recent years by any board member, executive officer or physician that operates under an exclusive contract with any health care facility.

MSHA AMENDED RESPONSE: We have amended **Exhibit G-5A** in order to include conflict of interest statements for the last five years (see Requests V.F-1, V.H-3, V.I-3).

MSHA believes that **Exhibit G-5A** is proprietary, confidential and competitively sensitive under federal antitrust laws. MSHA will submit this Exhibit separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information that is required to remain confidential under Virginia Code Section 15.2-5384.1.C.1 and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).

INDEX OF DOCUMENTS:

- Exhibit G-5A MSHA Conflict of Interest Statements Last Five Years – **PROPRIETARY**
- Exhibit G-5A.1 MSHA Code of Ethics and Business Conduct Policies – previously submitted to the Commissioner
- Exhibit G-5A.2 MSHA Conflict of Interest Policy – previously submitted to the Commissioner

WHS AMENDED RESPONSE: We have amended **Exhibit G-5B** in order to include conflict of interest statements for the last five years (see Requests V.F-1, V.H-3, V.I-3).

WHS believes that **Exhibit G-5B** contains confidential information. WHS will submit this Exhibit separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information that is required to remain confidential under Virginia Code Section 15.2-5384.1.C.1 and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).

INDEX OF DOCUMENTS:

- Exhibit G-5B WHS Disclosure of Conflict of Interest Statements Last Five Years– **PROPRIETARY**
- Exhibit G-5B.1 WHS Conflict of Interest Policy and Code of Conduct Policy – previously submitted to the Commissioner

V.H.3.

3. Please provide a listing of all directors, board members, employees, physicians, and their immediate family members that have a fiduciary responsibility in any bank that provides services to the Applicants.

JOINT RESPONSE: As modified and agreed by the Commissioner,[30] please see the following exhibits provided with Response G-5 in response to this request:

Exhibit G-5A	MSHA Conflict of Interest Statements Last Five Years – **PROPRIETARY**
Exhibit G-5A.1	MSHA Code of Ethics and Business Conduct Policies
Exhibit G-5A.2	MSHA Conflict of Interest Policy
Exhibit G-5B	WHS Disclosure of Conflict of Interest Statements Last Five Years – **PROPRIETARY**
Exhibit G-5B.1	WHS Conflict of Interest Policy and Code of Conduct Policy

[30] In letter dated January 30, 2017 from Ms. Allyson Tysinger, Senior Assistant Attorney General, to the Applicants in response to the Applicants' letter dated January 13, 2017 with proposal to respond to this request.

V.I.3.

3. Please provide a listing of all directors, board members, employees, physicians, and their immediate family members that have a fiduciary responsibility in any insurance carrier that provides services to the Applicants.

JOINT RESPONSE: As modified and agreed by the Commissioner,[31] please see the following exhibits provided with Response G-5 in response to this request:

Exhibit G-5A	MSHA Conflict of Interest Statements Last Five Years – **PROPRIETARY**
Exhibit G-5A.1	MSHA Code of Ethics and Business Conduct Policies
Exhibit G-5A.2	MSHA Conflict of Interest Policy
Exhibit G-5B	WHS Disclosure of Conflict of Interest Statements Last Five Years – **PROPRIETARY**
Exhibit G-5B.1	WHS Conflict of Interest Policy and Code of Conduct Policy

[31] In letter dated January 30, 2017 from Ms. Allyson Tysinger, Senior Assistant Attorney General, to the Applicants in response to the Applicants' letter dated January 13, 2017 with proposal to respond to this request.

LIST OF EXHIBITS FOR RESPONSE #11

SECTION V	
G-5A	MSHA Conflict of Interest Statements Last Five Years ***This information will be submitted separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information required to remain confidential under Virginia Code Section 15.2-5384.1.C.1, and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).**
G-5A.1	MSHA Code of Ethics and Business Conduct Policies – previously submitted to the Commissioner
G-5A.2	MSHA Conflict of Interest Policy – previously submitted to the Commissioner
G-5B.1	WHS Conflict of Interest Policy and Code of Conduct Policy – previously submitted to the Commissioner

Policy Manual:	Administration/Operational
Manual Section:	Board
Policy Number:	BD-000-006
Effective Date:	August 5, 2016
Supersedes:	August 2013
Reviewed Date:	August 5, 2016

I. TITLE: CODE OF ETHICS AND BUSINESS CONDUCT

II. PURPOSE:

To describe the ethical framework within which Mountain States Health Alliance conducts its patient care and business operations.

III. SCOPE:

All team members

IV. FACILITIES/ENTITIES:

Tennessee: FWCH, IPMC, JCCH, JCMC, SSH, UCMH, WPH, Niswonger Children's Hospital, New Leaf, Kingsport Day Surgery (a separate legal entity managed by MSHA), Princeton Transitional Care, Unicoi County Nursing Home

Virginia: DCH, JMH, NCH, RCMC, SCCH, Clearview Psychiatric Unit, Francis Marion Manor Health & Rehabilitation, Green Oak Behavioral Health (Geriatric Behavioral Health Inpatient Program – DCH), Norton Community Physicians Services (NCPS), Community Home Care (CHC), Abingdon Physician Partners (APP)

BRMMC

Home Health / Hospice

ISHN

Wilson Pharmacy, Inc.

Mountain States Pharmacy at Norton Community Hospital

V. DEFINITIONS:

Not Applicable

VI. POLICY:

A. Mountain States Health Alliance, its Board of Directors, Medical / Dental Staff, employees, and independent contractors conduct patient care according to the Patient-Centered Care Philosophy and all business operations in an ethical manner. Our behavior is guided by our mission, vision, and core values statements and the following general principles.

1. We shall treat everyone with dignity, respect, and courtesy.
2. All team members are considered as caregivers, and all caregivers cooperate with one another through a common focus on the best interests and

personal goals of the patient.

3. Our primary commitment is to the health, safety, and rights of the patient, whether an individual, family, friends, group, or community.
4. Care is provided in a healing environment of comfort, peace, support, openness and honesty.
5. We shall provide services only to those patients for whom we can safely care within this organization, and no patient with a medical necessity will be turned away due to an inability to pay or for any other reason unrelated to patient care.
6. Care is customized and reflects patient needs, values, and choices and is based on continuous healing relationships, with the patient being the source of control for their care.
7. Patient confidentiality is preserved with knowledge and information being shared only among care partners, physicians, and other caregivers with a "need to know".
8. Caregivers owe the same duties to self as to others, including the responsibility to preserve integrity and safety, to maintain competence, and to continue personal and professional growth.
9. We shall adhere to a uniform standard of care throughout the organization.
10. We shall continuously seek to improve our skills and the quality of our care and add new technology in a prudent manner, while striving to cut costs.
11. We shall make clinical decisions on identified patient health care needs, not financial risks or incentives.
12. We shall abide by all professional standards, laws and regulations governing the operations of our organization, and we shall fairly and accurately represent ourselves and our capabilities.
13. We shall meet, or exceed, all standards and requirements imposed upon us by licensing and accrediting bodies.

VII. PROCEDURE:

A. The Code of Ethics and Business Conduct conveys the standards of ethical and legal behavior that is expected of all team members, Physicians / Allied Health Personnel, Independent contractors, and vendors.

B. The Code of Ethics and Business Conduct booklet is provided to all new team members during orientation, to new vendors or independent contractors and is provided to all new Physicians / Allied Health Personnel.

1. Individuals receiving a hard-copy of The Code of Ethics and Business Conduct must sign an acknowledgment of receipt or complete a computerized acknowledgment of receipt.
2. The Code of Ethics and Business Conduct document is accessible at all times in electronic format on the MSHA Intranet.

C. The Code of Ethics and Business Conduct is reviewed annually and modifications are submitted to the Board for approval.

D. All individuals subject to the Code of Ethics and Business Conduct are expected to adhere to the Standards.

1. Failure to do so will result in disciplinary action up to and including termination of employment, removal from the Medical Staff or be excluded as a participating vendor.

LINKS:

Code of Ethics and Business Conduct – MSHA

_____ _____

Chair, MSHA Board Date

_____ _____

President and Chief Executive Officer, MSHA Date

Document Metadata

Document name:	Code of Ethics and Business Conduct
Policy Number:	BD-000-006
Original Location:	/Mountain States Health Alliance/ADMINISTRATION _ OPERATIONAL/Board/Policies
Created on:	07/01/2000
Published on:	09/06/2016
Last Review on:	08/05/2016
Next Review on:	08/05/2019
Creator:	Jones, Myra L *RN - Clinical Standards (Policy & Procedure)*
Committee:	Board Policy Committee
Owner/SME:	Levine, Alan *President & Chief Executive Officer - MSHA*
Manager:	Wilkes, Bo *Assistant Vice President, Corporate Operations*
Author(s):	Carter, Paige *Corporate Director - Corporate Audit Services* Belisle, Tim *Senior Vice President - Compliance Officer/General Counsel*
Approver(s):	Levine, Alan *President & Chief Executive Officer - MSHA*
Publisher:	Jones, Myra L *RN - Clinical Standards (Policy & Procedure)*

Summary of Changes/Updates:

Updated section IV and LINKS section; no other revisions to policy.

MOUNTAIN STATES
HEALTH ALLIANCE

CODE OF ETHICS
and
BUSINESS CONDUCT

Message from the CEO

Mountain States Health Alliance is committed to Bringing Loving Care to Health Care. As part of our Mission, we are guided by a set of principles referred to as our *Code of Ethics and Business Conduct* ("the Code"). This Code incorporates the ethical conduct expected of all of us as we strive to provide caring and compassionate services to others. It also represents our commitment to conducting business with integrity and in compliance with all applicable laws and regulations. The reputation of our organization is reflected in how we treat our patients, how we treat each other and how we conduct our business operations. Because this is so important, this code is a policy of Mountain States.

We must all comply with the Code of Ethics and Business Conduct in our every day actions, as it supports our values of integrity, service, leadership and excellence. In doing so, we share a common path in pursuing a world class healthcare system, which is critical to our future. The Code embodies our pledge to our patients, colleagues, physicians, volunteers, contractors, vendors/suppliers, regulators and all those we may encounter in our journey. The spirit of the Code of Ethics and Business Conduct can be summed up in just a few words.....

We follow the Code of Ethics and Business Conduct because "It's the right thing to do."

It is not possible to include every situation you may encounter within your daily activities in the Code of Ethics and Business Conduct. Therefore, we have invested in a robust compliance function within Mountain States to provide guidance and resources should you ever have a question about a situation. Our compliance hotline is anonymous, and we encourage you to report any activity which you think places our organization at risk due to non-compliance with policies or activity you think may not be ethical or legal. We have strict non-retaliation policies, so your anonymity will be protected, and actions will not be permitted to be taken against you for reporting issues in good faith. If you have questions or concerns about the Code or other related policies or procedures, you should contact your Supervisor, a Member of Management, your Facility Compliance Officer or the Corporate Audit and Compliance Services Department. If you wish to remain anonymous, you may call the MSHA AlertLine.

I am grateful you chose to be a part of the Mountain States health Alliance team, and believe if we all follow the best standards for conduct, we will all share the satisfaction of being part of something special.

MSHA CODE OF ETHICS AND BUSINESS CONDUCT

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MSHA CODE OF ETHICS AND BUSINESS CONDUCT

MSHA Mission

Mountain States Health Alliance is committed to Bringing Loving Care to Health Care. We exist to identify and respond to the healthcare needs of individuals and communities in our region and to assist them in attaining their highest possible level of health.

MSHA Vision

We passionately pursue healing of the mind, body and spirit as we create a world-class healthcare system.

MSHA Core Values

Integrity ..... Honesty in Everything We Do
Service ..... With Caring and Compassion
Leadership .... With Creativity and Innovation
Excellence ..... Always Pursuing a Higher Standard

Definitions

When used herein, the following words have the associated meanings:

A. **Corporate Audit and Compliance Services (CACS):** The independent advisory department of MSHA designed to assist Mountain States Health Alliance in attaining its Mission and Vision by promoting and helping to maintain an effective system of internal controls and compliance with laws, rules and regulations.

B. **Team Member:** An individual that may be employed, contracted or volunteers with Mountain States Health Alliance or an entity in which Mountain States Health Alliance is a majority member, to work in a facility, clinic, office, subsidiary or other operation owned or managed by Mountain States Health Alliance.

C. **Mountain States Health Alliance (MSHA):** The entity known as Mountain States Health Alliance, including facilities, clinics, offices, subsidiaries and other operations that have adopted the Compliance Program of Mountain States Health Alliance.

D. **Stakeholder:** A collective reference that includes all Team Members, Physicians/Allied Health Personnel and Vendors.

E. **Physician/Allied Health Personnel (AHP):** An individual who holds a position on the professional staff of an MSHA facility as a result of having been granted an appointment to such staff by the Board of Directors of MSHA, pursuant to the MSHA bylaws.

F. **Vendor:** An individual or entity who does business with MSHA by providing supplies, goods or services to MSHA.

I. Medical Compliance and Ethics Standards

Standard 1.1 Professional Standards

MSHA prides itself in providing quality patient care with the utmost degree of professionalism. Team Members must display a superior level of professionalism and integrity while engaged in the organization's business. Licensed and certified Team Members are expected to abide by the ethical standards set forth by professional organizations. Team Members should respond honestly and in good faith, striving for excellence in performing job duties, observing all laws and regulations and using MSHA assets only for legitimate business purposes.

MSHA mandates that Team Members in certain professions must maintain current licensure, registration or certification in order to practice. MSHA will not hire or retain in employment any professional Team Member who cannot present a current license or valid temporary permit. Current licensure in another state does not satisfy this requirement or allow the professional to practice in Tennessee or Virginia in the absence of a reciprocal agreement between the states. Failure to present evidence of licensure, registration or certification renewal on or before the renewal date may result in suspension from duty until the current license, registration or certification is obtained.

Standard 1.2 Quality Patient Care

As our Mission statement affirms, MSHA is committed to bringing loving care to health care. This is accomplished by providing care that occurs in the course of systematic processes designed to ensure the delivery of safe, effective and timely care through compassionate approaches. The delivery of quality patient care services requires specialized knowledge, judgment and skill derived from the principles of biological, physical, behavioral, psychosocial, medical and nursing sciences. Services must be planned, coordinated, provided, delegated and supervised by professional healthcare providers who assess and recognize the unique physical, emotional and spiritual needs of each person. Patient care encompasses not only the recognition of disease and health, but also education and advocacy. The medical staff, nurses and allied health professionals must collaborate as an interdisciplinary team to achieve positive patient outcomes.

Each Stakeholder should strive to provide services and to achieve the best attainable outcome for patients at the lowest possible cost. Stakeholders are expected to adhere to care guidelines; requirements of accreditation bodies; federal, state and local regulations; organizational policies and other standards related to patient care. Federal agencies such as the Centers for Medicare and Medicaid Services (CMS) that administer the Medicare and Medicaid programs require health care organizations such as MSHA to comply with health and safety standards referred to as Conditions of Participation (CoPs) and Conditions of Coverage (CfCs). These standards are the foundation for improving quality and protecting the health and safety of our patients. CMS also ensures that the standards of accrediting organizations recognized by CMS must meet or exceed the Medicare standards set forth in the CoPs/CfCs.

Standard 1.3 Emergency Care

MSHA adheres to the Emergency Medical Treatment and Active Labor Act (EMTALA) to provide emergency treatment to patients, regardless of ability to pay. MSHA is required by law to provide a presenting patient with a medical screening examination to determine whether an emergency exists and to provide stabilizing care within its capabilities for emergency medical conditions. Patients will only be transferred to another facility if MSHA does not have necessary equipment or services available or the patient/family requests a transfer to another facility.

Standard 1.4 Patient Rights

MSHA is committed to the observance of a patient's rights, personal preferences and individual values as reasonably possible. Patients will be provided information regarding their rights. Patients have a right to competent, considerate, and courteous treatment and services within our capacity without discrimination as to age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, gender identity or expression. This encompasses the right to receive care in a safe setting and be free from neglect, exploitation, verbal, mental, physical and sexual abuse and harassment from staff, other patients or visitors.

These rights also include but are not limited to the right to participate in decisions regarding the consent to or refusal of medical care; the right to receive information in a manner understood by the patient and receive assistance with communication, including an interpreter if necessary; the right to privacy and confidentiality of clinical records as outlined in the MSHA Notice of Privacy Practices; the right to be free from restraint/seclusion unless medically necessary to ensure safety; and the right to visitors of choice.

Patients have the right to designate a surrogate decision maker or legal representative to exercise the rights of the patient. Patients are provided information about advance directives regarding treatment decisions, financial matters and the designation of a healthcare decision maker. Stakeholders must make reasonable efforts to determine the wishes of a patient and/or representative regarding advance directives in order to protect the rights of the patient. If a patient's decision about medical treatment conflicts with MSHA policies, the situation should be evaluated in accordance with MSHA policies and applicable federal and state laws. Patients have the right to file complaints or grievances if they believe a violation of their rights has occurred; or regarding the quality or appropriateness of care. MSHA maintains a board approved policy regarding the patient/guest complaint and/or grievance process.

In addition, if asked to participate in an investigational study or clinical trial, patients will receive information upon which to base their decision. MSHA will protect patients and their rights during research, investigation and clinical trials involving human subjects by providing information to make informed decisions, including but not limited to describing expected benefits, potential discomforts and risks, and alternatives; procedures to be followed and how they may refuse to participate, and such refusal will not compromise access to MSHA services.

Standard 1.5 Patient Confidentiality

It is not only the right of every patient to expect confidentiality and privacy; it is mandated by federal and state laws. Patient information as defined by various privacy laws such as the Health Information Portability and Accountability Act (HIPAA) provide protections for individually identifiable health information held by MSHA and other entities doing business with MSHA. These regulations give patients a range of rights while balancing the need for health information by Stakeholders to deliver patient care and for other business purposes. Stakeholders must access, use and disclose patient information only as permitted by job duties and in accordance with federal and state regulations, and MSHA policies.

Some of the rights afforded to patients include but are not limited to the right to request to inspect and a obtain copy of the medical information used to make decisions about their care; the right to request an amendment to certain information within their medical record; and the right to an accounting of disclosures regarding release of information by MSHA to others. MSHA provides various avenues regarding patient privacy such as policies, the provision of a Notice of Privacy Practices, education and other methods to ensure that the rights of patients are ensured in accordance with applicable regulations.

Standard 1.6 Admission, Transfer and Discharge Practices

Admission, transfer and discharge processes are based on medical necessity, not hospital fiscal conditions. MSHA does not admit, transfer or discharge patients simply on the ability to pay. Patients whose specific condition cannot be safely treated are transferred to an accepting organization only under specific circumstances and in accordance with MSHA policies. Admission, transfer and discharge are conducted in an ethical manner and in accordance with local, state and federal rules and regulations and MSHA policies.

II. Business Compliance and Ethics Standards

Standard 2.1 Conflict of Interest

A conflict of interest arises when a Stakeholder's exercise of judgment or discretion in the course of job responsibilities is or may be influenced by personal considerations, or if the interests of MSHA are compromised or jeopardized by those considerations. Stakeholders have a responsibility to put the interests of MSHA ahead of other employment, business, financial or personal interests that they, as individuals, or family members may have. Stakeholders must refrain from engaging in an employment, business, financial or personal activity or practice that conflicts with the interest of MSHA or the provision of health care to its patients or that might negatively impact the reputation of MSHA.

Stakeholders are required to disclose any employment, consulting or other business relationships that they may have with an MSHA competitor, customer or supplier by completing a Conflict of Interest Disclosure Statement and submitting it to Corporate Audit and Compliance Services (CACS). Stakeholders may not use their positions at MSHA to profit personally or to assist others in profiting in at the expense of MSHA. Team Members are required to disclose immediately, to their direct Supervisor and CACS, any situation that may constitute a conflict of interest. Board Members, Administrative Staff, Department Directors and other selected individuals are required to complete a Conflict of Interest Disclosure Statement annually. Team Members are expected to avoid even the appearance of a conflict of interest.

The existence of a conflict of interest is not always obvious. The following are a few examples of potential conflicts; other transactions may also constitute conflicts.

1. A Team Member or immediate family member (parent, sibling, child or spouse) directly or indirectly holds a financial interest in an outside organization that does business with MSHA or is a competitor of MSHA, where the interest is sufficient to potentially affect decisions or actions of the Team Member.
2. A Team Member or immediate family member serves as a director, officer, consultant, agent, or in any other type of decision-making capacity of an organization that does business with MSHA or is a competitor of MSHA.
3. A Team Member or immediate family member uses confidential information obtained in the course of employment at MSHA for personal gain or the benefit of others.
4. A Team Member uses MSHA facilities, equipment or resources in any political campaign.

Team Members are encouraged to consult with their Supervisor or CACS to discuss any concerns.

Standard 2.2 Medical Records Coding and Billing of Third Parties

Federal and state regulations govern third party billing of our insured patients. Stakeholders are required to ensure that patient records, documents and bills are prepared and maintained accurately and completely. To achieve this, Stakeholders must:

1. Abide by MSHA policies, federal and state laws and regulations, third party requirements, etc. that govern documentation, coding and billing practices.
2. Ensure accurate, complete, truthful and timely documentation is made in the patient medical record for all services performed.
3. Use appropriate procedure, diagnosis and billing codes that are supported by adequate documentation in the medical record.
4. Ensure that services were actually rendered and appropriately documented before bills or claims are submitted for payment.
5. Take necessary steps to verify the accuracy of information and, if necessary, contact other Team Members or physicians to obtain additional information.

MSHA will not knowingly submit claims for payment or reimbursement that are false, fraudulent, inaccurate, incomplete or fictitious. Team Members are obligated to notify their Supervisor or CACS of billing practices that deviate from policy or requests to deviate from accepted practices.

Standard 2.3 Financial Reporting and Record Keeping

MSHA records, including but not limited to financial, clinical and personnel records, must be accurate, timely, reliable and properly retained. Financial information must reflect actual transactions and conform to generally accepted accounting principles. MSHA maintains a system of internal controls to provide assurances that transactions are authorized by Management and properly recorded. Financial records are audited annually by an external certified accounting firm selected by the MSHA Corporate Audit and Compliance Committee of the Board.

MSHA is required by federal and state laws to disclose certain information regarding operating costs and statistical data. These laws describe allowable costs and reimbursement practices. MSHA is required to retain certain types of medical and business records for specified time periods. Team Members must be familiar with specific policies applicable to the information they work with and comply with the record retention and destruction requirements.

The following standards govern record keeping. MSHA will:

- Not misrepresent facts or falsify records.
- Maintain those documents required by law and necessary to do business.
- Preserve the confidentiality of patient records.
- Maintain records in accordance with legal requirements.
- Destroy records only in accordance with the records retention policy.
- Make records available for periodic inspection by authorized persons.

Standard 2.4 Kickbacks and Referrals

Federal and state laws govern the relationships between hospitals and physicians in an effort to prohibit soliciting or receiving, or offering or paying, anything of value to induce the referral of patients or business insured by certain government programs; or in return for receiving services, supplies, patients or other business related to such government programs.

Stakeholders must ***NOT*** accept or offer anything of value in exchange for the direct or indirect referral of patients or business or for receiving services, supplies, patients or other business. Limited exceptions are discussed in *Standard 5.3 Acceptance of Gifts and Gratuities* and *Standard 5.4 Business Inducements.* Any uncertainty should be resolved on the advice of Corporate Audit and Compliance Services and/or MSHA Legal Counsel prior to the offer of acceptance.

Examples of prohibited kickback/referral activities include, but are not limited to, the following:

- Payments to referral sources (such as physicians or other hospitals) that exceed the fair market value of the services we are receiving OR accepting payments that exceed the fair market value of the services we provide when MSHA is the referral source.
- Giving free or unreasonably discounted goods or services to referral sources OR accepting free or unreasonably discounted goods or services when MSHA is the referral source (including free or discounted radiology, laboratory, ambulance, pharmacy and therapy services or supplies).

- Payment arrangements with vendors, suppliers or others who are in a position to make referrals to MSHA where the payments by MSHA are based on the amount or volume of business referred by the other party, rather than the actual value of the goods or services.

Standard 2.5 Antitrust and Competition

Team Members must comply with antitrust and similar laws that regulate competition. These laws are designed to foster free and open competition in the marketplace and generally forbid any kind of understanding or agreement between competitors to fix or control fees for services, terms, conditions of treatment, patients, divide markets, boycotts, or to engage in any other conduct that restrains competition. MSHA will compete fairly in the market.

Team Members cannot participate in any discussion, understanding, agreement, plan or scheme with a competitor or potential competitor that restricts competition. For MSHA, a "competitor" may be another hospital or, depending on the circumstances, another healthcare provider. Discussions or other communications with competitors about the division of either patients, geographic areas or services; the circumstances under which business will be conducted with suppliers, insurance companies, patients or customers (including boycotts); or specific marketing efforts are prohibited. Discussions with competitors regarding the future business plans of MSHA; or pricing, reimbursement or salary levels should not occur.

Standard 2.6 Information Owned by Others

Like MSHA, other organizations and individuals have intellectual property that must be protected, but may be disclosed for a particular business purpose. Any Team Member receiving another party's confidential information must proceed with caution to prevent any accusations that the information was misappropriated or misused. Any Team Member having knowledge of another party's confidential or restricted information must not use, copy, distribute or disclose that information, unless done so in accordance with the terms of an agreement. Stakeholders should not duplicate copyrighted materials in any form without written permission of the license holder for use on MSHA premises or elsewhere.

Care should be taken in acquiring software from others. As intellectual property, software is protected by copyright laws and may also be protected by patent, trade secret laws or as confidential information. Such software includes computer programs, databases and related documentation owned by the party with whom you are dealing or by another party. The terms and conditions of software license agreements, such as provisions not to copy or distribute programs must be strictly followed. Software acquired for personal use should not be copied or used in the course of work for MSHA or placed on MSHA-owned computer system.

Standard 2.7 Lobbying/Political Activity

As a tax-exempt, not-for-profit corporation laws prohibit MSHA from donating, either directly or indirectly, corporate funds, goods, or services (including Team Members' work time) to any individual who holds a political office or is a candidate for political office. Therefore, these general rules must be followed:

- Team Members ***May Not*** contribute MSHA money or property, or the services of any Team Member, to a political candidate, party, organization, committee or individual, which would violate applicable law.
- Team Members ***May*** personally participate in and contribute to political organizations or campaigns as private individuals, not as representatives of MSHA, using their own personal time and funds. Team Members will at all times let it be known that the views expressed are theirs as individuals and not those of MSHA.

MSHA may publicly offer recommendations regarding legislation or regulations being considered. MSHA may analyze and take public positions on issues that have a relationship to the operations of the organization. These recommendations and positions may be proposed only by individuals officially appointed by MSHA Administration.

Standard 2.8 Tax Laws

As a not-for-profit organization, MSHA has a legal and ethical obligation to comply with tax laws, to engage in activities to further its charitable purpose, and to ensure that its resources are used to further the public good. To maintain this tax exemption, which is critical to the organization's continued existence, MSHA must avoid what the tax laws refer to as "private inurement" and "private benefit." This means that non-exempt individuals or entities must pay fair market value for the use of MSHA services, supplies, equipment, properties or other assets. Personal items cannot be purchased through MSHA, even if the purchaser reimburses the organization. Tax returns and related information must be filed according to applicable laws.

Standard 2.9 Standards of Conduct for Vendors, Contractors and Consultants

MSHA will enter into business relationships only with vendors, contractors and consultants (also referred to as a third party) who have in effect and abide by standards of ethics and compliance comparable to those reflected in this Code. If a Team Member is uncertain about the standards adhered to by a vendor, contractor or consultant, prior to entering into the business relationship, the Team Member is obligated to provide a copy of this Code to the third party. The Team Member must inform the third party that MSHA expects vendors, contractors and consultants to abide by comparable standards, to the extent applicable and relevant to their operations.

Standard 2.10 Marketing and Public Relations Practices

MSHA aims to conduct ourselves professionally with truth, accuracy, fairness and accountability to the public which we serve, holding to fundamental values and dignity of the individual, and the freedom of speech, assembly and the press. MSHA marketing materials reflect only those services available, the level of licensure and accreditation, and comply with truth in advertising and non-discrimination laws and regulations. Events will be held under the auspices of MSHA Public Relations must be coordinated through the appropriate MSHA Department and/or by designated individuals. MSHA respects the privacy of our patient. Public relations involving patients or patient information will require approved authorizations unless exempted by regulation or law.

Standard 2.11 Ineligible Persons

MSHA will not contract with, employ, or grant hospital privileges to any person or company who has been excluded from participation in federally funded programs (referred to as an "Ineligible Person"). Pending the resolution of criminal charges or proposed debarment or exclusion, individuals and companies with whom MSHA currently contracts who are charged with criminal offenses related to health care, or proposed for debarment or exclusion, will be removed from direct responsibility for or involvement in any federally-funded health care program. If resolution results in conviction, debarment or exclusion of the individual or company, MSHA will immediately cease contracting with or employing that Ineligible Person. Before employing an individual, credentialing for medical/allied health professional (AHP) staff or entering into a contract or agreement, MSHA will ensure that the proposed employee, contractor, physician/AHP or vendor is not an Ineligible Person by performing sanction checks to verify that an individual has not been excluded from participation in federally funded programs. Sanction checks are performed monthly on all active Team Members, credentialed medical/AHP staff and vendors.

III. Employment Compliance and Ethics Standards

Standard 3.1 Fair and Equitable Treatment of Team Members

MSHA is an equal opportunity employer. Team Members are afforded non-discriminatory terms, conditions and privileges of employment in accordance with law, regardless of age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, gender identity or expression, veteran status or factors protected by law. Consistent with the MSHA philosophy of respect for the rights and dignity of each Team Member, harassment is not be sanctioned or tolerated. MSHA expects all Team Members to demonstrate proper respect for each other, regardless of position. It is the policy of MSHA to comply with wage and hour laws; and statutes regulating employer-employee relationships. Management is available to discuss employment concerns that Team Members may have. Human Resources representatives may be contacted to assist in resolving employment issues. Employment practices are set forth in policies. Team Members should consult these for information.

Standard 3.2 Health and Safety Precautions

MSHA is committed to complying with federal, state and local health and safety laws and standards. Team Members are expected to know and follow safety-related standards and regulations that apply to their positions. Additionally, Team Members should be aware of and effectively perform duties during disasters and code situations. Team Members should refer to specific policies and/or manuals regarding the environment of care or related procedures. MSHA requires Team Members to report to their Supervisor, Safety Officer or a member of the Safety Committee any existing or potentially dangerous condition that is a threat to the health and well-being of individuals or that is a violation of policy. MSHA is committed to maintaining a safe workplace for our Team Members, patients, visitors and customers.

Standard 3.3 Use of Illegal Drugs or Alcohol

MSHA maintains a safe working environment without the presence of illegal drugs or alcohol. Unlawful use of controlled substances is inconsistent with the behavior expected of Stakeholders. Inappropriate behavior could subject Stakeholders, patients and visitors to unacceptable safety risks while undermining our ability to operate effectively and efficiently. Stakeholders are prohibited from the use, sale, possession, manufacture or purchase of illegal drugs or alcohol while at work or on MSHA premises. Stakeholders are not allowed on MSHA premises while under the influence of illegal drugs, legal drugs improperly used or alcohol unless at a facility seeking emergency treatment. Any Stakeholder having knowledge of another Stakeholder or a concern of an individual who appears to be impaired must immediately notify MSHA Management.

Standard 3.4 Pharmaceuticals, Prescription Drugs, Controlled Substances

Many Stakeholders have responsibility for or access to prescription drugs, controlled substances, related supplies, paraphernalia, hypodermic needles, drug samples and other regulated pharmaceuticals in the course of their duties. MSHA is legally responsible for the proper distribution and handling of these pharmaceutical products. Federal, state and local laws covering prescription drugs and controlled substances are intended to maintain the integrity of our national drug distribution system and protect consumers by assuring that prescription drugs are safe and properly labeled. These laws include prohibitions against diversion of prescription drugs or controlled substances, including a drug sample, in any amount for any reason to an unauthorized individual or entity. The distribution of adulterated, misbranded, mislabeled, expired or diverted pharmaceuticals is a violation of federal and state law for which severe criminal penalties may be imposed on individual violators, as well as on their employer.

MSHA providers who dispense and/or prescribe controlled substances will comply with controlled substance monitoring programs to promote the appropriate use of controlled substances for legitimate purposes while preventing abuse and diversion of controlled substances. Stakeholders must be diligent and vigilant in their obligations to handle and dispense prescription drugs and controlled substances in accordance with laws, regulations and internal policies.

IV. Environmental Compliance and Ethics Standards

Standard 4.1 Environmental Standards

MSHA is committed to observing and complying with all federal, state and local health, safety and environmental laws. Stakeholders are required to ensure that:

- Medical waste, environmentally sensitive materials and hazardous materials are disposed of in a proper manner.
- Infectious materials and medical equipment are properly handled and stored.
- Personal protective equipment is used appropriately.
- Spills/accidents involving infectious/hazardous materials are promptly reported and handled in the approved manner.
- Confidential patient and/or business information is properly shredded or destroyed.

MSHA is concerned with the protection of the environment and strives to conserve natural and man-made resources. Team Members are charged with using resources appropriately and efficiently, reducing waste and recycling or shredding as appropriate. Noncompliance should be reported to a Supervisor, the Safety Officer, a Member of the Safety Committee, the HIPAA Privacy or Security Officer, or to the Corporate Audit and Compliance Services Department. Efforts will be made to work cooperatively with appropriate authorities to remedy any environmental contamination for which MSHA may be responsible.

V. Basic Workplace Compliance and Ethics Standards

Standard 5.1 Confidentiality and Proprietary Information

Throughout the course of employment, Stakeholders may have access to and become knowledgeable about information that is confidential and/or proprietary. Stakeholders are expected to maintain confidentiality during and subsequent to employment with MSHA. Examples include, but are not limited to, the following:

- Medical information pertaining to patients and beneficiaries
- Payment and reimbursement information
- Team Member records and/or Negotiations with Team Members or organizations
- Company financial records; Business plans or Business strategies
- Computer programming and processing information
- Customer lists
- Product and pricing strategies

Stakeholders possessing proprietary information must handle the information in a manner as to protect against improper access, use or disclosure. Confidential or proprietary information may not be used directly or indirectly for personal gain, nor can it be disclosed to anyone or posted in publicly available sources without authorization. Team Members must return all confidential and proprietary information to MSHA upon termination of employment with the organization.

Standard 5.2 Travel and Entertainment

Travel and entertainment expenses should be consistent with Team Member job responsibilities and the needs and resources of MSHA. Team Members should not have a financial gain or loss as a result of business travel and entertainment. Team Members are expected to exercise reasonable judgment and discretion with MSHA financial resources and use them as carefully as they would their own. Team Members are required to comply with Business Travel and Entertainment policies and Departmental travel and entertainment requirements.

Standard 5.3 Acceptance of Gifts and Business Gratuities

When gifts or items of value are offered from a vendor, patient or anyone external to MSHA, there may be a concern that the donor's motivation is improper, such as expecting to receive special treatment in exchange for the gift. Team Members should not accept gifts, entertainment or favors from a supplier, potential supplier, patient or competitor of MSHA if it may be inferred that the gift is intended to influence, or possibly influence, the Team Member. Under certain circumstances, acceptance of non-monetary items may be allowed. MSHA has adopted policies to establish the parameters around such practices.

Standard 5.4 Business Inducements

Team Members may not offer, give, solicit or receive any form of bribe or other improper payment from a vendor or anyone external to MSHA as an inducement for business or special treatment. While commissions, rebates, discounts and allowances are acceptable under certain circumstances, the rules governing those circumstances are complex. No such arrangement should be entered into without explicit approval of MSHA Management and/or MSHA Legal Counsel prior to the arrangement.

Standard 5.5 Proper Use of Corporate Assets

MSHA assets made available to Team Members are to be used for authorized business purposes and not for non-business or personal purposes. Team Members are personally responsible and accountable for the proper use of company property and expenditure of company funds. Team Members are expected to protect MSHA assets, property, facilities, equipment and supplies against loss, theft, damage, inappropriate use or disclosure by ensuring that internal controls exist and are followed. Improper use of assets, including theft or embezzlement of funds or other property belonging to MSHA or MSHA customers, for anything other than an authorized purpose is a serious violation and will lead to appropriate disciplinary action.

VI. Communicating Legal and Ethical Issues

Standard 6.1 Responsibility to Report Problems or Concerns

The Standards in this Code of Ethics and Business Conduct are designed to promote honesty, fairness and to ensure compliance with regulatory requirements. It is the responsibility of every Stakeholder to ensure associations with patients, co-workers, community members and businesses are honest and law abiding. This imposes on each Stakeholder an affirmative obligation to know MSHA policies, laws and regulations that relate to their responsibilities. The reputation of MSHA depends upon each Stakeholder to report questionable behavior, unethical conduct or suspected violation of policies or laws. Every Stakeholder is responsible for making appropriate persons within the organization aware of potential or known concerns or problems.

Standard 6.2 No Retaliation for Reporting Problems or Concerns

MSHA encourages Stakeholders to discuss legal and ethical issues that may arise while performing job responsibilities and requires Team Members to report concerns to appropriate persons within the organization for investigation or follow-up. In order to protect those Stakeholders coming forth in good faith to relate these issues, MSHA has implemented a non-retaliation policy. MSHA will not tolerate retaliation against any Stakeholder who, in good faith, reports a legal or ethical concern either internally or to external parties, such as the federal government, state or accrediting bodies that govern our operations.

VII. Doing Business with the Government

Standard 7.1 Medicare and Medicaid/State Programs

MSHA participates in Medicare and Medicaid/State programs, all of which are governed by complex laws and regulations imposing strict requirements that may be significantly different from, and more extensive than, those encountered in non-government commercial contracts. Medicare and Medicaid/State programs have multifaceted payment guidelines that identify the circumstances under which, and how much, those programs will reimburse for goods and services rendered to patients covered under those programs. These guidelines are often different than directives received from other third-party payers.

Violations of these laws and regulations can result in criminal sanctions being imposed, not only on the persons actively involved, but also on the organization on whose behalf those persons act. MSHA could be precluded from further participation in federally funded programs. Strict compliance with Medicare and Medicaid/State laws and regulations is essential. Stakeholders are expected to strive toward compliance in performing respective duties while conducting business for, or with, MSHA and MSHA patients.

Standard 7.2 Federal and State False Claims Act

Federal and State governments have false claims acts to help prevent and detect fraud, waste and abuse in healthcare programs. In summary, under these acts, a civil action may be brought against any person who "knowingly" submits or causes another to submit a false or fraudulent claim for payment by a government agency, which can result in significant fines and penalties.

Under the Tennessee Medicaid False Claims Act, the Virginia Fraud Against Taxpayers Act and the Federal False Claims Act, a person (relator) may bring a civil action (referred to as a qui tam lawsuit) under each act for both the person and the state (the TN Act and the VA Act) and/or the U.S. Government (under the Federal Act). Generally, if the civil lawsuit is successful, the relator (referred to as the whistleblower) will be entitled to between 15 to 30 percent of the government's recovery as well as reasonable attorney fees and costs. Under each false claims act there are protections for whistleblowers to protect them from being discharged, demoted, suspended, threatened, harassed or discriminated against as a result of lawful actions. An employee may bring an action in court for such protections under the acts.

MSHA operates under a system-wide no-retaliation philosophy, which means Team Members will not be retaliated against for reporting in good faith compliance and ethical concerns.

Standard 7.3 Responding to Government Inquiries

It is a policy of MSHA to comply with reasonable and lawful request by government officials for information. Requests might include information related to patient care, billing and financial practices or operational issues. When possible, Team Members should seek to obtain government requests/inquiries in writing; if this is not possible, Team Members should independently document the specific request for information. Team Members are expected to provide truthful and accurate information in a timely manner to a government request for information. MSHA will not tolerate false statements made by Team Members to government agencies and will take action against Team Members for violations.

While Team Members are expected to comply with such requests, MSHA is entitled to safeguards provided by law against disclosure of certain information. Examples of information that might not be subject to disclosure include, but are not limited to:

- Patient information protected by medical record privacy laws
- Quality assurance data compiled by MSHA to comply with federal and state requirements
- Information collected as part of the MSHA peer review process to review and evaluate the credentials of healthcare providers furnishing services within our organization
- Employee records

Team Members must consult with their Supervisor if there is any question concerning whether information requested by a government official is subject to disclosure. Policies may apply to disclosures of information including patient information. Team Members should maintain copies of or a list identifying information disclosed in response to an audit.

Any Team Member receiving a subpoena from the government must notify Corporate Audit and Compliance Services and/or MSHA Legal Services immediately. Team Members are not permitted to respond to subpoenas without permission and direction of MSHA Legal Counsel. This measure is required to ensure that the delivery of MSHA healthcare services and business operations are not compromised as a result of responding to a government subpoena.

Any Team Member who is requested to provide information regarding MSHA operations or confidential information in response to a government request, regardless of where the request for information is made (i.e., on MSHA premises or at the Team Member's home), should report the existence of the communication to their Departmental Director and Corporate Audit and Compliance Services. Requests for patient information should be directed to the Medical Records/Health Information Management Department. Team Members have the right to not respond to such inquiries before consulting with MSHA Legal Counsel.

Standard 7.4 Hiring of Former Government Employees

Specific rules exist to eliminate the appearance of a conflict of interest by former government employees who, upon termination of their government service, seek employment with those who do business with the government. Clearance from MSHA Legal Counsel must be obtained prior to discussing the employment or possible retention of a current or former government employee.

Standard 7.5 Offering Gifts, Meals or Gratuities to Government Personnel

Payment for meals, refreshments, travel or lodging expenses for government employees are governed by strict guidelines which prohibit any type of gratuity, with very few exceptions, and strict compliance is required. Unlike other circumstances, laws regarding this issue can easily be violated if anything of value is given to a government employee, even if there is no intent to influence an official action or decision.

VIII. Compliance Education

MSHA is committed to providing education to Team Members regarding this Code of Ethics and Business Conduct. MSHA requires that all Stakeholders read this Code thoroughly, attest to having read and understood it, and comply with the Standards contained in this Code. Team Members are expected to complete compliance training. New Team Members will receive training as part of orientation. Satisfactory completion of training and adherence to MSHA standards and policies will be a factor in Team Member evaluations

IX. Sanctions for Violations

Stakeholders are expected to abide by this Code of Ethics and Business Conduct, policies, laws and regulations that affect the operations of our business. MSHA maintains a policy of zero tolerance for violations of MSHA standards, policies and regulatory requirements.

Disciplinary actions will be taken for:

- Authorization of or participation in actions that violate the Code
- Failure to report a violation of the Code or to cooperate in an investigation
- Failure by the Management of a violator to detect and report a violation of the Code, if such failure reflects inadequate supervision or lack of oversight
- Retaliation against an individual for reporting a violation or possible violation of the Code

Disciplinary action may result in verbal or written warnings, corrective action programs, employment or contractual termination, institution of peer review, etc. as applicable. Actions will be determined on a case-by-case basis in accordance with MSHA policies.

X. How to Report Problems or Concerns

Team Members are encouraged to talk to a Supervisor about concerns. Management is responsible for using resources throughout the organization to assist in upholding the Standards of the Code of Ethics and Business Conduct, MSHA policies and regulatory requirements. If an issue is raised and appears to not be receiving appropriate attention, or if the Team Member feels the answer from the Supervisor is not acceptable, concerns should be raised to the next level and/or to the Department Director. If this individual is unable to resolve the issue, the issue should be elevated to the Facility Compliance Officer, a Human Resources representative, Corporate Audit and Compliance Services, MSHA Legal Counsel, the Ethics Committee Consultant and/or a Vice President.

A concern may be reported anonymously by calling the MSHA Compliance AlertLine. The Compliance AlertLine is designed to permit a Stakeholder to report a compliance concern or to obtain clarification on compliance issues. Calls to the AlertLine are answered confidentially by trained operators from an external agency 24 hours a day, 7 days a week. There is no caller ID function and caller identification is not required. A caller may remain anonymous and will be given a follow-up code to call back and request a status of the reported concern.

MSHA Compliance AlertLine: **1-800-535-9057**

*****Additional resources may be found on the following page*****

Stakeholders may also report quality of care or patient safety issues to:

The Joint Commission:	Online:	www.jointcommission.org
	Email:	patientsafetyreport@jointcommmission.org
	Fax:	630-792-5636
	Mail:	The Joint Commission One Renaissance Blvd. Oakbrook Terrace, IL 60181

The Healthcare Facilities Accreditation Program:

	Online:	www.hfap.org
	Fax:	312-202-8298
	Mail:	HFAP c/o Complaint Dept 142 E Ontario St. Chicago, IL 60611

State of Tennessee:	Online:	www.tn.gov
	Tele:	877-287-0010 (toll free)
	Mail:	Division of Health Care Facilities Centralized Complaint Intake Unit 665 Mainstream Dr. 2nd Floor Nashville, TN 37243

State of Virginia:	Online:	www.vdh.virginia.gov
	Email:	OLC-Complaints@vdh.virginia.gov
	Fax:	804-527-4503
	Tele:	800-955-1819 (toll free)
	Mail:	Office of Licensure and Certification Complaint Intake-VA Dept of Health 9960 Mayland Dr. Suite 401 Henrico, VA 23233

Other resources available throughout MSHA include:

Coding Questions Request Line	**423-431-6070**
Billing/Reimbursement Patient Accounts	**423-431-1700**
Employment/Human Resources-Corporate	**423-302-3251**
Employment/Human Resources-NCH/DCH	**276-679-9698**
Environmental/Infection Control	Call Facility Main Number
Ethics Consult or House Supervisor	Call Facility Main Number
Conflicts of Interest/Corporate Compliance Officer	**423-302-3394**
Contracts, Kickbacks, Legal Counsel	**423-302-3411**
HIPAA Privacy/HIPAA Security	**423-302-3401/423-302-3407**

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Committee:	Board Policy Committee
Owner/SME:	Levine, Alan *President & Chief Executive Officer - MSHA*
Manager:	Belisle, Tim *Senior Vice President - Compliance Officer/General Counsel*
Author(s):	Carter, Paige *Corporate Director - Corporate Audit Services* Belisle, Tim *Senior Vice President - Compliance Officer/General Counsel*
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Summary of Changes/Updates:

Revised and replaces Code of Ethics and Business Conduct - Norton Community Hospital.

UNCONTROLLED WHEN PRINTED

Policy Manual:	Administration/Operational
Manual Section:	Board
Policy Number:	BD-000-007
Effective Date:	March 23, 2015
Supersedes:	February 2012
Reviewed Date:	March 23, 2015

I. TITLE: CONFLICT OF INTEREST POLICY OF MOUNTAIN STATES HEALTH ALLIANCE

II. PURPOSE:

To define the process regarding conflict of interest disclosure for Mountain States Health Alliance.

III. SCOPE:

All team members

IV. FACILITIES/ENTITIES:

MSHA Corporate

Tennessee: FWCH, IPMC, JCCH, JCMC, SSH, UCMH, WPH, Niswonger Children's Hospital, Kingsport Day Surgery, Princeton Transitional Care, Unicoi County Nursing Home

Virginia: DCH, JMH, NCH, RCMC, SCCH, Francis Marion Manor Health & Rehabilitaiton, Norton Community Physicians Services (NCPS), Community Home Care (CHC)

BRMMC owned and managed practices

Home Health/Hospice

ISHN

Wilson Pharmacy, Inc.

Mountain States Pharmacy at Norton Community Hospital

V. DEFINITIONS:

A. If The following terms shall have the following meanings when used in this Policy:

1. "**Affiliate**" shall mean any organization that controls, is controlled by, or is related by common control to this Corporation.
2. "**Board Committee**" means any committee that has specific authority to take final action relative to the charitable, business or clinical aspects of this Corporation delegated to it by the Board or the Bylaws of this Corporation, as opposed to committees that are simply advisory.
3. "**Board Member**" shall refer to all Directors and Trustees of this Corporation, and members of all Board Committees, whether appointed, elected, or ex officio, and including, but not limited to, physicians.

4. "**Compensation**" shall mean any remuneration, whether direct or indirect, including any gifts or favors that are substantial in nature.

5. "**Conflicting Interest**" shall mean service as a member, shareholder, trustee, owner, partner, director, officer, or employee of any organization or governmental entity that either:

   a. Competes with this Corporation or any Affiliate, or

   b. Is involved or is likely to become involved in any litigation or adversarial proceeding with this Corporation or any Affiliate, or

   c. Is seeking or soliciting funds or other substantial benefits from this Corporation

6. "**Financial Interest**" shall mean any arrangement or transaction pursuant to which an Interest Person has, directly or indirectly, through business, investment or family, either:

   a. A present or potential ownership, investment interest or compensation arrangement in any entity with which this Corporation or any Affiliate has or may have a transaction or arrangement; or a compensation arrangement with this Corporation or any entity or individual with which this Corporation or any Affiliate has or may have a transaction or arrangement.

VI. POLICY:

A. Disclosure of Conflicting Interests

1. Every Person Covered by this Policy shall submit in writing to the Chief Executive Officer (CEO) a Conflict of Interest Disclosure Statement listing all Financial and Conflicting Interests.

2. Each Statement will be resubmitted with any necessary changes each year or as any additional Conflicting or Financial Interests arise. The Chairman of the Board shall become familiar with all such Disclosure Statements in order to guide his conduct should a conflict arise.

3. The Vice Chairman of the Board shall be familiar with the Disclosure Statement filed by the Chairman.

B. Procedure to be Followed at Meetings

1. Whenever the Board or Board Committee is considering a transaction of arrangement with an organization, entity or individual in which a Person Covered by this Policy has a Financial or Conflicting Interest, the following shall occur:

   a. The Interested Person must disclose the Financial or Conflicting Interest to the Board or Board Committee;

   b. The Board Chair, the Board Committee or the Board shall ask the Interested Person to leave the meeting during discussion of the matter that gives rise to the potential conflict. If asked, the Interested Person

shall leave the meeting, although he may make a statement or answer any questions on the matter before leaving;

c. The Interested Person will not vote on the matter that gives rise to the potential conflict; and

d. The Board or Board Committee must approve the transaction or arrangement by a majority vote of the Board Members present at a meeting that has a quorum, not including the vote of the Interested Person.

2. In addition, if an Interested Person has a Financial Interest in a transaction or arrangement that might involve personal financial gain or loss for the Interested Person, the following should be observed in addition to the provisions described above:

a. If appropriate, the Board or Board Committee may appoint a non-interest person or committee to investigate alternatives to the proposed transaction or arrangement;

b. In order to approve the transaction, the Board or Board Committee must first find, by a majority vote of the Board Members then in office, without counting the vote of the Interested Person, that the proposed transaction or arrangement is in the Corporation's best interest and for its own benefit; the proposed transaction is fair and reasonable to the Corporation; and, after reasonable investigation, the Board or Board Committee has determined that the Corporation cannot obtain a more advantageous transaction or arrangement with reasonable efforts under the circumstances;

c. The Interested Person will not be present for the discussion or vote regarding the transaction or arrangement; and

d. The transaction or arrangement must be approved by a majority vote of the Board Members, not including any Interested Persons.

C. Minutes of Meetings

1. Minutes of all Board and Board Committee Meetings shall include the following:

a. The names of the persons who disclosed Conflicting or Financial Interest, the nature of the Conflicting or Financial Interests and whether the Board determined there was a conflict of interest; and

b. The names of the persons who were present for discussions and votes relating to the transaction or arrangement; the content of these discussions, including any alternatives to the proposed transaction or arrangement; and a record of the vote.

D. Dissemination and Acknowledgement of Policy

1. This policy shall be distributed to all Persons Covered by this Policy.

2. Each Person covered by this Policy shall sign an annual statement that the person:

   a. Received a copy of the policy;

   b. Has read and understands the policy;

   c. Agrees to comply with the policy;

   d. Understands that the policy applies to the Board and all Board Committees; and

   e. Understands that this Corporation and its Affiliates are organized to advance charitable purposes and that in order to maintain tax-exempt status they must continuously engage primarily in activities which accomplish one or more tax-exempt purposes.

E. Compensation Committee

1. All medical staff members who receive, directly or indirectly, compensation from the Corporation for any services rendered as an employee or as an independent contractor, shall not serve as a member of any compensation committee established by the Corporation.

2. No interested person serving on any committee established by the Corporation shall vote on any matters pertaining to that person's compensation.

F. Penalties for Non-Compliance

1. Failure to comply with this Policy shall constitute grounds for removal from office and, in the case of Key Management Personnel, termination of employment.

G. Competitive Bidding

1. To assure this Corporation, the general public, and outside vendors of objective evaluations of outside proposals for the provision of goods and services, a competitive bidding process has been established as follows:

   a. Under normal circumstances, this Corporation will obtain competitive bids.

   b. The decision to select a vendor for the provision of good and services will be based upon a combination of factors (price competitiveness, quality, delivery time, service and other valid considerations).

H. Periodic Reviews

1. To ensure that the Corporation operates in a manner consistent with its charitable purposes and that it does not engage in activities that could jeopardize its status as an organization exempt from federal income tax, periodic reviews shall be conducted. The periodic review shall, at a minimum, include the following subjects:

a. Whether compensation arrangements and benefits are reasonable and are the result of arm's-length bargaining.

b. Whether acquisitions or other arrangements with providers result in inurement or impermissible private benefit.

c. Whether partnership and joint venture arrangements and arrangements with other organizations conform to written policies, are properly recorded, reflect reasonable payments for goods and services, further the Corporation's charitable purposes and do not result in inurement or impermissible private benefit.

d. Whether arrangements to provide health care and arrangements with other health care providers, employees, and third party payors further the Corporation's charitable purposes and do not result in inurement or impermissible private benefit.

LINKS:

Board Members' Confidentiality Agreement

Conflict of Interest Disclosure Statement

_____ _____

Chair, MSHA Board Date

Wellmont Health System

Effective:	*09/2013*
Approved:	*09/2016*
Last Revised:	*09/2016*
Custodian:	*Geanna Walker: AUDIT SPECIALIST AND PROGRAM COORDINATOR*
Policy Area:	*Compliance*
Regulatory:	
Applicability:	*Wellmont Health System*

Conflict Of Interest Policy

Policy Statement:

Members of the Board of Directors ("Directors"), members of any Board of Directors Committee ("Committee Members"), members of any affiliates' Boards of Directors ("Affiliate Directors"), Officers and Management Employees of Wellmont Health System, including its subsidiaries and affiliates ("Wellmont") have responsibility to ensure that they conduct themselves in an ethical and unbiased manner, act in the best interest of Wellmont and disregard personal interests when considering Wellmont's business affairs. This Policy sets forth the obligation of the Directors, Committee Members, Affiliate Directors, Officers and Management Employees to identify and appropriately disclose Conflicts of Interest and outlines procedures designed to ensure that any transactions or arrangements involving Conflicts of Interest are approved and documented in a manner which satisfies applicable legal requirements. This Policy is intended to supplement but not replace any applicable state or federal laws governing conflicts of interest applicable to nonprofit charitable corporation.

Procedure:

A. Identifying Conflicts of Interest

A Conflict of Interest arises when financial or other personal considerations of a Director, Committee Member, Affiliate Directors, Officer or Management Employee of Wellmont directly or indirectly affect, may affect or may have the appearance of affecting the individual's professional judgment in carrying out his or her responsibilities to Wellmont. If an actual or potential Conflict of Interest exists with respect to an entity that is part of Wellmont, the actual or potential Conflict of Interest is considered to exist with respect to all entities which are part of Wellmont. Examples of situations in which a Conflict of Interest may exist and which therefore merit careful case by case evaluation include the instances in which a Director, Committee Member, Officer or Management Employee, or any of their respective Family Members or Controlled Entities:

a. Has an ownership or investment interest in an entity which sells any goods or services to, or purchases any goods or services from Wellmont;

b. Is a party to any transaction or arrangement with Wellmont involving the receipt of any Compensation from Wellmont for services rendered to Wellmont;

c. Is a party to any transaction or arrangement with Wellmont involving the purchase, sale or lease of any property to or from Wellmont;

d. Is a party to any transaction or arrangement which competes with Wellmont; or

e. Receives gifts, gratuities or special favors from vendors of Wellmont.

A Conflict of Interest does not arise when a Director, Committee Member, Affiliate Directors, Officer or Management Employee, or any of their respective Family Members or Controlled Entities: (a) owns securities of a publicly traded company for investment purposes so long as the combined ownership of the Director, Committee Member, Affiliate Directors, Officer or Management Employee and their respective Family Members and Controlled Entities does not exceed 5% of the outstanding securities of the company, or (b) gives or receives gifts of nominal value which clearly are tokens of respect or friendship.

B. Annual Disclosure of Conflicts of Interest

Duty to Disclose. Given that perception regarding Conflicts of Interest may vary from person to person, the most effective way to address such matters is to establish a system for disclosures and evaluations of Conflicts of Interest. All Directors, Committee Members, Affiliate Directors, Officers and Management Employees of Wellmont are required to accurately and fully disclose the existence of any actual or potential Conflicts of Interest by completing the electronic Conflict of Interest Disclosure Form (as such form may be modified from time to time) in accordance with the process described herein.

Disclosure Process. Annually, the Compliance Department will distribute electronically to all Directors, Committee Members, Affiliate Directors, Officers and Management Employees a link to the Conflict of Interest Disclosure Form, which shall be promptly, accurately and fully completed by the Directors, Committee Members, Officers and Management Employees upon receipt. In addition to such annual disclosure, Directors, Committee Members, Officers and Management Employees are required to promptly notify the Compliance Department in writing regarding any new Conflicts of Interest or changes in circumstances which gave rise to a previously reported Conflict of Interest. Any questions that Directors, Committee Members, Officers and Management Employees may have in connection with reporting a Conflict of Interest or completing the Conflict of Interest Disclosure Form shall be directed to the Chief Compliance Officer or designee.

Conflict of Interest Disclosure Forms Review. All reported disclosures of any actual or potential Conflicts of Interest shall be reviewed by the Chief Compliance Officer or designee and addressed as follows:

a. The Chief Compliance Officer or designee shall coordinate with General Counsel the review and resolution of any Conflicts of Interest reported by Management Employees;

b. The Chief Compliance Officer or designee shall coordinate with General Counsel and the Board, or any committee designated by the Board, the review and resolution of any Conflicts of Interest reported by the CEO, COO or CFO of Wellmont or by any other individuals who directly report to the CEO of Wellmont;

c. The Chief Compliance Officer or designee shall coordinate with the Board Chair the review and resolution of the Conflicts of Interest reported by Directors, Committee Members, and Affiliate Directors.

Additional Information. In addressing any reported Conflicts of Interest, the Chief Compliance Officer or designee may seek from Directors, Committee Members, Affiliate Directors, Officers and Management Employees any information relevant to ensuring compliance with this Policy. Because the integrity and credibility of Wellmont is enhanced by disclosure, it is expected that Directors, Committee Members, Officers and Management Employees will provide promptly and accurately any relevant information requested. The information received shall be handled confidentially unless public disclosure is part of the conflict of interest management plan, or is required by law.

Resolution of Conflicts of Interest. All Conflicts of Interest shall be resolved in a manner which appropriately protects the interests of Wellmont. All such resolutions shall be documented and maintained by the Chief Compliance Officer or designee.

C. Additional Disclosures at Board Meetings

When a Director has a newly arisen actual or potential Conflict of Interest which was not previously disclosed through the disclosure process outlined above with respect to a transaction or arrangement being considered at a Board meeting, the Director shall disclose the Conflict of Interest to all individuals present at the meeting before the transaction or arrangement is considered by the Board. Following such disclosure, the disclosing Director shall be required to leave the meeting and the Board shall determine whether a Conflict of Interest exists by a majority vote. If it is determined that a Conflict of Interest exists: (a) for a consummated transaction or arrangement, the Board shall investigate appropriate steps to mitigate or eliminate the Conflict of Interest, including, without limitation, restructuring or terminating the transaction or arrangement, if necessary; and (b) for a proposed transaction or arrangement which has not yet been consummated, the Board shall authorize the transaction or arrangement only if the Board determines by a majority vote of disinterested Directors that the transaction or arrangement is in the best interests of Wellmont and that Wellmont cannot with reasonable efforts obtain a more advantageous transaction or arrangement from a person or entity that would not give rise to a Conflict of Interest.

D. Compliance

Annual Affirmation of Compliance. Each Director, Committee Member, Affiliate Directors, Officer and Management Employee shall annually sign a statement which affirms that such person (a) has received a copy of this Policy, (b) has read and understands the Policy, (c) has agreed to comply with the Policy, and (d) understands that Wellmont is a charitable organization and that in order to maintain its Federal tax exemption, Wellmont must engage primarily in activities which accomplish its tax-exempt purposes.

Violations of this Policy. Violations of the requirements of this Policy by any Director, Officer, Committee Member, or Affiliate Directors, if not resolved, shall result in that Director, Officer, Committee Member or Affiliate Directors being relieved of his or her duties as a Director, Officer, Committee Member or Affiliate Directors, as applicable. Violations of the requirements of this policy by a Management Employee shall, if not resolved, subject the individual to discipline, including, where appropriate, termination, pursuant to Wellmont's human resources policies.

DEFINITIONS:

For purposes of this Policy and the Conflict of Interest Disclosure Form, the following terms shall have the following meanings:

"Affiliate Director" means a director of any hospital, physician, or other subsidiary Board under the control and governance of the Board.

"Board" means the Board of Directors of Wellmont Health System.

"Compensation" means direct or indirect remuneration, as well as loans, gifts or favors which are substantial in nature.

"Conflict of Interest" means a set of circumstances where financial or other personal considerations of a Director, Committee Member, Officer or Management Employee directly or indirectly affect, may affect or may have the appearance of affecting the individual's professional judgment in carrying out his or her responsibilities to Wellmont.

"Controlled Entity" means any entity in which a Director, Committee Member, Officer or Management Employee, or any of their respective Family Members, directly or indirectly (a) possesses 50% or more of the voting rights, or (b) owns 50% or more of the stock or capital or profits interest.

"Family Member" or "***Family Relationship"*** means a (a) spouse, (b) sibling (whether by whole or half blood) and their spouses, (c) parent or stepparent, and (d) child (natural or adopted), grandchild, great grandchild and their spouses.

"Financial Interest" means a covered individual shall be deemed to have a Financial Interest if the individual has, directly or indirectly, through business, investment or family relationship:

a. An ownership or investment interest in any entity with which the Corporation has, or is considering to have, a transaction or arrangement, or;
b. A compensation arrangement with the Corporation or with any entity or individual with which the Corporation has, or is considering to have, a transaction or arrangement, or;
c. A potential ownership, investment interest, or compensation arrangement with any entity or individual with which the Corporation is negotiating, or considering to negotiate, a transaction or arrangement.

"Management Employee" means any employee of Wellmont who (a) holds a director authority or higher position, or (b) has authority to direct expenditures of Wellmont's resources of a material threshold consistent with the Wellmont policy titled Contracts Management ID #1088826, attachment titled Contract Signature Authority Grid.

"Officer" means any person designated as an officer pursuant to Wellmont's Corporate Bylaws.

Scope:

Directors, Committee Members, Officers and Management Employees

Regulatory Agency Standard(s):

IRC Sec. 4958 and Sarbanes Oxley Sec 402; TJC: LD.02.02.01 and LD.02.04.01

Attachments:

No Attachments

Approval Signatures

Step Description	Approver	Date
System Policy Approval Committee	Cheryl Perkins: QUALITY FACILITATOR	09/2016
WHS President	Bart Hove: PRESIDENT/CEO WHS	08/2016
Compliance Specialist and Program Coordinator	Judy Martin: SYSTEM PRIVACY OFFICER, COMPLIANCE & ETHICS	08/2016

WELLMONT HEALTH SYSTEM

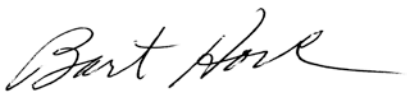
Dear Wellmont Health System Directors, Officers, Employees and Medical Staff Members:

Consistent with Wellmont Health System's mission and values, providing high quality health care services in compliance with ethical standards and applicable laws is vital to our organization. To promote ethical and lawful conduct throughout our organization, Wellmont Health System implemented a system-wide Compliance Program. As the foundation of the Compliance Program, Wellmont Health System adopted a Code of Conduct which expresses the organization's commitment to conduct its business with integrity, ethically, and in accordance with applicable laws.

The Code of Conduct identifies the standards that everyone within our organization must understand and follow and is intended to be a resource for resolving questions about appropriate conduct in the work place. At Wellmont Health System, open lines of communication, and prompt reporting of any compliance concerns are expected and encouraged. The objective is to enable each of you to bring forward any concerns you may have regarding the proper operations of the organization and any deviations from the standards articulated in the Code of Conduct without fear of retribution. While the Code of Conduct is a great resource, it cannot replace each person's sense of fairness, judgment, honesty and integrity. Thus, if you encounter a situation that is not addressed in the Code of Conduct but which just does not feel right, it is important to discuss the situation with your supervisor, Compliance Liaison or Corporate Compliance Officer.

The importance of each individual's involvement and participation in the Compliance Program cannot be overemphasized. Each person within our organization is essential to the success of our Compliance Program and needs to be fully committed to compliance with the Code of Conduct. Thank you for your contributions and commitment to our organization's compliance efforts.

Very truly yours,



Bart Hove
President and Chief Executive Officer

5638071.9

WELLMONT HEALTH SYSTEM

CODE OF CONDUCT

COMPLIANCE WITH CODE OF CONDUCT

Wellmont Health System's Compliance Program is designed to promote ethical and lawful conduct by all entities and facilities comprising Wellmont Health System (collectively, "Wellmont Health System"). This Code of Conduct ("Code") outlines ethical and legal standards for the conduct of our organization's operations. Compliance with this Code is required of all Wellmont Health System Employees, directors, officers and Medical Staff members. Failure to abide by the Code may lead to disciplinary action, ranging from verbal warning to immediate termination. The Code does not provide any additional employment or contract rights to Employees or other persons.

REPORTING VIOLATIONS

Wellmont Health System Employees have an obligation to report concerns and potential violations of this Code to their supervisors, Compliance Liaison or Corporate Compliance Officer. The report can be made on a confidential or anonymous basis through the Corporate Compliance and Ethics Hotline (800-500-0333). No employee of Wellmont Health System may discourage or prohibit another employee from reporting a violation or potential violation of this Code or applicable laws. There will be no retribution for asking questions or raising concerns about the Code or for reporting possible improper conduct. Employees who report compliance concerns in good faith will not suffer adverse employment consequences or be discriminated against as a result of making a report. Wellmont Health System has an Open Door Policy to encourage reporting of compliance related concerns and potential violations of this Code (see Exhibit A).

LEGAL REQUIREMENTS

All actions taken by or on behalf of Wellmont Health System must be consistent with the Code and applicable laws. The legal requirements outlined below are designed to provide guidance with respect to compliance with applicable laws. However, it is important to understand that these descriptions do not fully address all applicable legal requirements and that compliance with all applicable laws is expected, even if those laws are not specifically described in the Code. Wellmont Health System has developed a set of compliance and

other policies that expand on and more fully address many principles covered in the Code and it is important to be familiar with and follow those policies. If any questions arise with respect to compliance with any law, such questions should be directed to the appropriate Compliance Liaison or to Corporate Compliance Officer.

1. **Billing and Coding.** The Federal False Claims Act prohibits healthcare providers from knowingly submitting false or fraudulent claims for payment to Federal healthcare programs, including claims for services not rendered, claims that characterize the service differently from the service actually provided or claims that do not comply with applicable legal requirements. State laws contain similar prohibitions. Wellmont Health System implemented policies and procedures to facilitate accurate coding and billing for services provided to our patients. All claims submitted to any payor must be accurate and cost reports must be prepared consistent with applicable laws. Knowingly presenting or causing to be presented claims to any payor which are false or fraudulent is prohibited. For more detailed information about the Federal and state false claims laws and Wellmont's related policies, see the Wellmont Health System False Claims Information Policy attached to this Code as Exhibit B.

2. **Antikickback Law.** The Federal Antikickback Law applies to relationships with physicians and other referral sources and prohibits direct or indirect remuneration in exchange for the referrals of patients. Wellmont Health System accepts patients based on their health care needs and our ability to provide the needed services. No payments or other remuneration shall be given to anyone in exchange for patient referrals.

3. **Physician Self-Referral.** Federal physician self-referral law, commonly known as the Stark Law, prohibits a physician from referring a patient to an entity for designated health services (which include, among others, hospital services, laboratory services, home health services, physical therapy) payable by Medicare if the physician has a "financial relationship" with the entity. "Financial relationship" includes a compensation arrangement or an investment interest. The Stark Law is a strict liability law, which means that if a prohibited referral is made, the Stark Law is violated regardless of the intent. The Stark Law disallows Medicare payments for services provided pursuant to prohibited referrals. All Wellmont Health System's arrangements with physicians must be structured to assure compliance with the Stark Law, as well as other applicable requirements. Any proposed arrangement with physicians which

may implicate the Stark Law shall be evaluated and approved by the Corporate Compliance Officer, in consultation with the legal counsel.

4. **Health Information Privacy and Security.** The HIPAA privacy rules outline numerous requirements related to the use and disclosure of patient protected health information ("PHI"). The general rule is that it is impermissible to use or disclose PHI without a patient's written authorization unless an exception applies and that PHI must only be accessed if it is necessary to perform the individual's job responsibilities. The HIPAA security rules require implementation of numerous security standards to safeguard electronic PHI. The HITECH Act requires patients to be notified if their PHI is improperly disclosed placing the patient at risk of financial, reputational or other harm. Wellmont Health System's privacy and security policies and procedures detail the standards for the appropriate use and disclosure of PHI and everyone within the organization must understand and follow these policies and procedures. Our Corporate Privacy Officer and Privacy Coordinators are excellent resources who can provide clarification on any questions related to the proper use and disclosure of PHI.

5. **Occupational Health and Safety.** The health and safety of patients, visitors and employees are important to Wellmont Health System. It is the policy of Wellmont Health System to comply with all applicable laws pertaining to health and safety, including the Occupational Safety and Health Act, regulations of the Centers for Disease Control and Prevention, the Drug Enforcement Administration and the Food and Drug Administration. It is the responsibility of every employee to understand and comply with all relevant standards applicable to such individual's workplace activities. It is important that each employee immediately notifies the supervisor of any workplace injury or any situation creating a danger of workplace injury so that immediate corrective measures can be taken.

6. **Drug Free Workplace.** Wellmont Health System is a drug-free workplace. Except to the extent that service of alcoholic beverages at official Wellmont Health System functions is authorized, it is specifically prohibited to use alcohol at Wellmont Health System functions and to possess, use, be under the influence of, distribute, transfer, manufacture or sell alcohol or drugs as a Wellmont Health System representative or on Wellmont Health System's time.

7. **Environmental Compliance.** As a healthcare provider, Wellmont Health System is subject to compliance with various environmental

laws concerning the handling of hazardous materials, potentially infectious medical waste and other wastes. Wellmont Health System Employees must (a) understand how their job duties impact the environment, (b) utilize resources appropriately and efficiently, (c) dispose of all waste in accordance with applicable laws, and (d) avoid pollution. It is essential to immediately notify the supervisor of any situation involving improper disposal of hazardous waste or any other situation that may be damaging to the environment.

8. **Employment Practices.** Wellmont Health System will recruit, hire, train, promote, assign, transfer and terminate employees based on their ability, performance, experience and conduct without regard to race, color, religion, sex, national origin, age, disability, or any other classification prohibited by law. The organization promotes diversity in the workplace. Wellmont Health System is committed to providing a work environment where everyone is treated respectfully and fairly, and that is free from any form of prohibited harassment, including sexual or racial harassment. Wellmont Health System will not tolerate any harassing, intimidating or disruptive conduct that interferes with work performance or creates an intimidating, hostile or offensive work environment. Each allegation of harassment or discrimination will be promptly investigated in accordance with applicable human resources policies.

9. **Antitrust.** All employees must comply with applicable antitrust laws that regulate competition and protect consumers from unfair trade practices. Examples of conduct prohibited by antitrust laws include: (a) agreements to fix prices, bid rigging, collusion (including price sharing) with competitors; (b) gaining so-called "monopoly power" to control prices or exclude competitors; (c) boycotts, certain exclusive dealing and price discrimination agreements; and (d) unfair trade practices including bribery, misappropriation of trade secrets, deception, intimidation and similar unfair practices. To avoid violating these laws, Employees shall not discuss prices with competitors and shall not engage in any actions that involve boycotting or refusing to deal with any payor or vendor. It is also inappropriate to provide past, current or expected price lists, financial terms of managed care contracts or similar information to competitors or accept such information from a competitor of Wellmont Health System.

10. **Tax.** As a tax-exempt entity, Wellmont Health System is required to act in compliance with applicable tax exempt laws, to engage in activities that support the organization's charitable purposes and to ensure that resources are used to further the interests of the

organization, rather than the private or personal interests of any individual. Consistent with these principles, Wellmont Health System will avoid compensation arrangements with Employees, physicians and vendors in excess of fair market value for the services provided and will accurately report required information to appropriate governmental authorities.

11. **Intellectual Property.** Federal and State laws protect intellectual property which includes copyrights, trademarks, patents, and trade secrets. Copyright laws provide protection when an original work of authorship such as a book or an article, a computer software program, or a recorded program is fixed in a tangible medium of expression. Trademark laws protect consumers from confusion about the source and quality of goods or services. Patent laws give an inventor exclusive rights to make, use, and sell the patented invention. Wellmont Health System employees shall not misappropriate confidential or proprietary information belonging to another person or entity or utilize any publication, document, computer program, information, or product in violation of a third party's interest in that product. Employees are responsible to ensure they do not improperly copy any documents or computer programs in violation of applicable copyright laws or licensing agreements.

12. **Lobbying and Political Activity.** No individual may contribute money, property, or services at Wellmont Health System's expense to any political candidate, party, organization, committee, or individual in violation of any applicable law. While it is permissible to participate in and contribute to political organizations or campaigns, this must be done on individual basis and not as representatives of Wellmont Health System and using individual's own funds. Wellmont Health System has a number of contractual arrangements with governmental bodies and officials. All transactions with governmental bodies and officials shall be conducted in an honest and ethical manner and any action to influence the decision-making process of governmental bodies or officials by an improper offer of any benefit is prohibited.

PATIENT PROTECTION

1. **Patient Care Standards.** Wellmont Health System is committed to providing high quality, safe, compassionate, and cost effective health care services. Our health care services shall be consistent with applicable laws and professional standards regarding patient safety and comfort. We shall treat all patients with dignity and respect and

provide care that is safe and appropriate. Patient care related standards may be contained in various policies of Wellmont Health System and are dictated by numerous legal standards, such as Medicare hospital conditions of participation, hospital licensing requirements, The Joint Commission Standards, and many others. Every employee shall understand and follow the laws, professional standards and Wellmont Health System policies and procedures related to patient care and shall strive to provide exceptional patient care at all times.

2. **Quality of Care Concerns.** Employees have the most direct link to our patients and our operations and are in the best position to identify potential problems. Therefore, Wellmont Health System relies on its employees to provide feedback to make improvements to patient care services. In any circumstance where an employee has a concern about patient safety or quality of patient care, the employee is obligated to promptly raise the issue with the supervisor, Compliance Liaison or Corporate Compliance Officer, so that the issue can be properly evaluated and addressed. Examples of actions which constitute noncompliance in the patient care area include conduct that endangers a patient, failure to provide appropriate care for a patient, theft of patient's property, rudeness to a patient or a patient's family, or failure to timely report malfunction of medical equipment, or any injury to a patient caused by any medical device.

3. **Patient Rights.** Health care services provided by Wellmont Health System are available to all patients without regard to age, gender, disability, race, religion or national origin. Our organization respects cultural heritage of every patient and our Employees must be sensitive and respectful of each patient's cultural preferences and needs. Each of our patients is given a statement of patient rights which explain that each patient has, among other rights, the right to make informed decisions about health care services, the right to refuse treatment and the right to confidentiality of medical information. Each employee is responsible for knowing and understanding patient rights and ensuring that care provided to our patients is consistent with and supports patient rights.

4. **Emergency Treatment.** Wellmont Health System complies with the Federal Emergency Medical Treatment and Active Labor Act ("EMTALA") in providing an emergency medical screening examination and stabilizing treatment to every patient regardless of the ability to pay. In an emergency situation, or if a patient is in labor, medical screening examination and the necessary stabilizing treatment shall not be delayed in order for the patient to provide

payment information for the services. If a patient has an emergency medical condition, the patient may be transferred to another facility only if the patient care needs cannot be met or if the patient requests the transfer and other legal requirements are met.

BUSINESS ETHICS AND RELATIONSHIPS

Wellmont Health System shall conduct all business transactions consistent with high ethical standards and applicable laws and without any conflict of interest or improper inducements. The standards set forth below are intended to guide employees in determining the appropriateness of the listed activities or behaviors within the context of Wellmont Health System's business relationships, including relationships with vendors, providers, contractors, third-party payers, and governmental entities.

1. **Conflict of Interest.** A conflict of interest arises when there is a conflict between one's personal stake in a matter and his or her fiduciary responsibility to Wellmont Health System caused by a financial interest, position, activity or other relationship with a third party. Wellmont Health System directors, officers and employees are obligated to ensure that they remain free of conflicts of interests in the performance of their responsibilities for the organization. All possible conflicts of interest which may affect or be perceived as affecting a decision on a proposed Wellmont Health System transaction or arrangement shall be appropriately disclosed. If there is any doubt or concern about whether specific conduct or activities are ethical, present a conflict of interest, or otherwise inappropriate, those questions should be directed to the appropriate Compliance Liaison or Corporate Compliance Officer.

2. **Serving on Boards.** Employees, directors, officers, and committee members must disclose all board of directors' activities in their annual conflict of interest disclosure statement. Wellmont Health System retains the right to prohibit membership on any board of directors where such membership may conflict with the best interests of Wellmont Health System. If not disclosed and approved in accordance with Wellmont Policy, no director, officer or employee shall be a director or officer of an organization that competes with or provides services for Wellmont Health System. All fees and compensation (other than reimbursement for expenses arising from board participation) that are received for board services provided during normal work time shall be paid directly to Wellmont Health System. Questions regarding whether board participation might

present a conflict of interest should be discussed with the Compliance Liaison or Corporate Compliance Officer.

3. **Gifts.** Employees shall not accept gifts, favors, services, entertainment, or other things of value to the extent that such things might influence decision-making or actions affecting Wellmont Health System. Similarly, the offering or giving of money, services, or other things of value by Wellmont Health System with the expectation of influencing the judgment or decision-making process of any purchaser, supplier, customer, government official, or other person is absolutely prohibited. Employees shall not solicit any gratuities or gifts from patients and may only accept non-monetary gratuities and gifts of a nominal value from patients. If a patient or other individual wishes to make a monetary gift, he or she should be referred to the Wellmont Health System Foundation. For additional information on acceptance of gifts, please reference Wellmont Health System's policy and procedure on the Intranet.

4. **Vendor Relationships.** Employees may not utilize "insider" information for any business activity conducted by or on behalf of Wellmont Health System. All business relations with contractors must be conducted at arm's length and in compliance with applicable policies. [Employees may retain gifts from vendors that have a nominal value. If an employee has any concern whether a gift should be accepted, the employee should consult with his/her supervisor. To the extent possible, these gifts should be shared with the recipient's employees. At a vendor's invitation, an individual may accept meals or refreshments of reasonable value at the vendor's expense. Occasional attendance at a local theater or sporting event, or similar entertainment, at the vendor's expense, may also be accepted. In most circumstances, a regular business representative of the vendor should be in attendance with the employee. Attendance at local, vendor-sponsored workshops, seminars and training sessions is permitted. Attendance, at vendor expense, at out-of-town seminars, workshops and training sessions is permitted only with the approval of the employee's supervisor.

5. **Inducements.** Wellmont Health System employees shall not seek to gain any advantage through the improper use of payments, business courtesies or other inducements. Offering, giving, soliciting, or receiving any form of bribe, kickback, or other improper payment is prohibited. Appropriate commissions, rebates, discounts, and allowances are customary and acceptable business inducements, provided that they are approved by the Legal Department and they do not constitute illegal or unethical payments. Employees may provide

gifts, entertainment, and meals of nominal value to Wellmont Health System's customers, current and prospective business partners, and other persons when such activities have a legitimate business purpose and are reasonable and consistent with all applicable laws. Any gifts or non-monetary benefits to any physician shall be consistent with the Stark Law and approved by the Legal Department.

DOCUMENTATION AND CONFIDENTIALITY

1. **Accurate Documentation.** Timely, accurate and complete documentation is important to safe and efficient patient care. In addition, clinical documentation is the basis for the coding and billing determinations. Each of our employees is responsible for the accuracy and integrity of our organization's documents. Wellmont Health System Employees are required to prepare, maintain, and retain all medical and billing records and other documents in accordance with applicable legal and professional standards.

2. **Proprietary and Confidential Information.** Information pertaining to Wellmont Health System's competitive position, business operations and strategies, payment, financial and reimbursement related information, marketing strategies, personnel data, patient data, medical staff related files, supplier information, and information relating to negotiations with vendors is important to the organization and must be protected from improper disclosure. This information may be shared only with Employees having a need to know such information to perform their professional responsibilities to our organization. Care and safeguarding steps must be taken to maintain integrity and confidentiality of this information. Any employee who believes that confidentiality of any such information has been compromised, must immediately report the issue to the supervisor, Compliance Liaison or Corporate Compliance Officer.

3. **Use of Electronic Media.** All communication systems, including computers, portable electronic devices, electronic mail, Intranet, internet access, phones, voicemail, and other electronic media, are the property of Wellmont Health System and shall be used only to conduct business of Wellmont Health System. Personal use of the organization's communication system is not permitted. There shall be no expectation of privacy in any information transmitted through or stored in the organization's communication system. Use of the organization's communication system unlawfully or for personal business is grounds for disciplinary action.

ORGANIZATIONAL RESOURCES

All employees will strive to preserve and protect Wellmont Health System's assets by making prudent and effective use of the organization's resources and properly and accurately reporting its financial condition. The standards set forth below are intended to guide employees by articulating Wellmont Health System's expectations as they relate to activities that may affect the organization's financial integrity or that reflect a reasonable and appropriate use of the assets of a non-profit entity.

1. **Financial Records.** All financial reports, accounting records, research reports, expense accounts, time sheets and other documents must accurately and clearly represent the relevant facts and the true nature of a transaction. Improper or fraudulent accounting, documentation or financial reporting is prohibited.

2. **Travel Expenses.** All travel and entertainment expenses incurred by employees should be consistent with the employee's job responsibility and the organization's needs and resources. Employees must comply with Wellmont Health System's policies relating to travel and entertainment expenses and ensure that all expenses are reasonable and appropriately incurred for the benefit of the organization.

3. **Asset Protection.** Employees shall not convert any resources or assets of Wellmont Health System for personal use. All property and business of the organization shall be conducted in a manner designed solely to advance the interests of Wellmont Health System. Prior to engaging in any activity on company time that will result in remuneration to the employee, or the use of Wellmont Health System's equipment, supplies, materials, or services for personal or non-work-related purposes, employees shall obtain the approval of the supervisor.

Approved by:

Leadership Corporate Compliance Committee on: April 10, 2013

Audit and Compliance Committee of the Board on: August 28, 2013

Wellmont Health System Board of Directors on: September 10, 2013

Exhibit A
Open Door Policy

Wellmont Health System ("Wellmont") is committed to providing quality care to our patients and to complying with applicable legal standards and the principles set forth in the Code of Conduct. Wellmont employees have the most direct link to the patients and operations of our organization and are in the best position to identify potential compliance issues or concerns which may affect our organization. Therefore, Wellmont Health System has adopted this Open Door Policy and encourages all employees with legitimate concerns regarding any compliance issues, any patient care issues or other issues which may affect our organization to promptly raise those issues within the organization, so that they can be evaluated and addressed as necessary.

Employees with legitimate concerns about compliance issues should raise their concerns with appropriate Wellmont personnel in the order listed below:

1. Immediate supervisor,
2. Employee's department head,
3. Senior leadership team member for the employee's facility/division,
4. Chief Executive Officer of the employee's facility/division,
5. Senior leadership team member of Wellmont Health System.

When reporting a compliance issue, each employee is expected to present relevant facts, his or her concerns and offer potential solutions to an identified issue. In the event that a satisfactory resolution has not been reached in any step of this process, and the employee continues to be concerned about the issue, the employee should raise the issue with the next individual listed above, until the issue has been appropriately addressed and resolved.

If at any time an employee is uncomfortable reporting a legitimate concern to his or her immediate supervisor, or other member of management as set forth above, the employee may choose to report the concern to the Divisional Compliance Liaison or the Corporate Compliance Officer. If requested by the employee, confidentiality of the employee's identity will be maintained to the extent possible. An employee may also make a report on a confidential or anonymous basis through the EthicsLine, which is Wellmont Health System's Corporate Compliance and Ethics Hotline.

EthicsLine:
Via phone at 800-500-0333
Via e-mail at Wellmont.myethicsline.com

Additional information about reporting of compliance concerns is set forth in Wellmont Health System's Policy on Reporting Compliance Concerns, which all employees are expected to be familiar with and follow at all times.

EXHIBIT B

False Claims Information Policy

Deficit Reduction Act Requirements. The Deficit Reduction Act of 2005 ("DRA") requires that any entity receiving Medicaid payments of at least $5 million establish for its employees, agents and contractors written policies that provide information about the Federal False Claims Act, administrative remedies for false claims and statements and state false claims laws. These policies also must include information regarding the entity's procedures for detecting and preventing fraud, waste and abuse.

Wellmont Health System Policy. This False Claims Information Policy addresses the requirements contained in the DRA pertaining to false claims information. One of the primary goals of Wellmont Health System's Corporate Compliance Program is to ensure effective processes for preventing, detecting and addressing any activity that may constitute a violation of law, including any Federal or state law pertaining to false claims. In furtherance of the goals of the Corporate Compliance Program, the purpose of this Policy is to inform our employees, agents, contractors and Medical Staff members of (a) the Federal, Tennessee and Virginia false claims laws, (b) methods to report actions that may constitute a violation of the Federal, Tennessee or Virginia false claims laws or the policies and procedures of Wellmont Health System, and (c) Wellmont Health System's policy prohibiting retaliation against any employee, agent, contractor or Medical Staff member who reports any actions that may constitute a violation of applicable policies or laws, including the false claims laws.

Federal False Claims Act. The Federal False Claims Act prohibits knowingly presenting or causing to be presented a false or fraudulent claim for payment to any Federal healthcare program, including Medicare and Medicaid, knowingly making a false record or misrepresentation to obtain payment for a false claim from any Federal healthcare program, or conspiring to defraud any Federal healthcare program by getting a false claim paid. Examples of actions that could constitute a violation of the Federal False Claims Act include:

- Filing false or fraudulent claims for payment or approval;
- Making or entering any charge for a service that was not provided or not ordered by a physician or other appropriately licensed person;
- Recording a charge for a service that differs in any way from the actual service provided (e.g., entering an incorrect CPT code);

- Submitting separate claims to maximize reimbursement for tests and procedures that are required to be billed together (i.e., unbundling);
- Falsely certifying that a service was medically necessary to obtain payment;
- Making or using, or causing another to make or use, any false record or statement in connection with obtaining payment for a false or fraudulent claim; or
- Filing a false or fraudulent cost report.

Violations of the Federal False Claims Act may result in any or all of the following penalties:

- Civil penalties of between $5,500-$11,000 for each false claim;
- An additional penalty equal to three times the amount of each false claim, as determined by the government depending on the relevant circumstances;
- Recoupment by a federal healthcare program of any reimbursement received for services covered by a false claim; and
- Exclusion or suspension from participation in Federal healthcare programs.

The False Claims Act permits *qui tam* suits to be brought by private individuals who are entitled to a portion of the monetary recovery if the action is successful and protects whistleblowers from retaliation.

The Program Fraud Civil Remedies Act of 1986. The Program Fraud Civil Remedies Act of 1986 establishes an administrative remedy against any person who presents or causes to be presented a claim or written statement that the person knows or has reason to know is false, fictitious or fraudulent or is supported by a statement asserting a material fact which is false, fictitious or fraudulent to certain federal agencies, including the U.S. Department of Health and Human Services. The law allows for penalties of $5,000 per claim and an assessment of up to twice the amount of the original claim.

Tennessee False Claim Laws. Tennessee has enacted a Medicaid False Claims Act and a Tennessee False Claims Act. Both laws prohibit conduct similar to that prohibited under the Federal False Claims Act. The Medicaid False Claims Act makes it unlawful to knowingly present, or cause to be presented, a false or fraudulent claim for payment or approval under the Tennessee Medicaid program, to knowingly make, use, or cause to be made or

used, a false record or statement material to a false or fraudulent claim to get a false or fraudulent claim paid or approved under the Medicaid program, or to conspire to commit such violations. Violators are subject to a civil penalty of not less than $5,000 and not more than $25,000 per false claim, plus three (3) times the amount of damages which the state sustains because of the violation and the costs of a civil action brought to recover any such penalty or damages.

The Tennessee False Claims Act makes it unlawful to knowingly present or cause to be presented to an officer or employee of the state a false claim for payment or approval, to knowingly make, use, or cause to be made or used a false record or statement to get a false claim paid or approved by the state, or to conspire to defraud the state by getting a false claim allowed or paid by the state. The Tennessee False Claims Act does not apply to any claims covered under the Medicaid False Claims Act. Violators of the Tennessee False Claims Act are subject to liability for three times of the amount of damages sustained by the state, a civil penalty of not less than $2,500 and not more than $10,000 for each false claim and the state's costs of the civil action to recover the penalties.

Both the Medicaid False Claims Act and the Tennessee False Claims Act allow state officials to file a lawsuit or a private individual to file a qui tam lawsuit on behalf of the state. State officials may choose to participate in the qui tam lawsuit or allow the individual to proceed alone on the state's behalf. If the case is successful, the individual is entitled to a portion of the state's monetary recovery. Employees who assist or participate in an action under Tennessee's False Claims Act or the Medicaid False Claims Act are protected from workplace retaliation.

Virginia False Claims Laws. Virginia enacted a Virginia Fraud Against Taxpayers Act which applies to false claims in connection with the state's healthcare programs. This Act makes it unlawful to knowingly present, or cause to be presented, a false or fraudulent claim for payment or approval to any State agency, knowingly make, use, or cause to be made or used, a false record or statement material to a false or fraudulent claim or to conspire to commit such violations. Violators of this law are liable to the Commonwealth of Virginia for a civil penalty of not less than $5,500 and not more than $11,000, plus three times the amount of damages sustained by the State, as well as for the State's reasonable attorneys fees and costs of a civil action brought to recover any such penalties or damages. The Fraud Against Taxpayers Act also permits *qui tam* suits by private individuals and protects such whistleblowers from retaliation.

Reporting Potential Violations. Any employee, agent, contractor or Medical Staff member who in good faith believes an activity may not comply with the Federal or state false claims laws or any of Wellmont Health System's policies

or procedures shall report the activity consistent with the Open Door Policy. While Wellmont Health System encourages reporting of any suspect activity internally consistent with the mechanism outlined in the Program, individuals also have the right to bring a civil action on their own or in conjunction with the government for a violation of the Federal False Claims Act or the state false claims laws and may recover damages or a portion of the recovery obtained by the government if such action is successful.

No Retaliation. No employee, agent, contractor or Medical Staff member shall be subject to adverse or discriminatory action by Wellmont Health System for reporting in good faith any wrongdoing or suspect activity or for participating in any investigation or providing assistance with respect to any action that may be brought against Wellmont Health System, including, without limitation, bringing a civil action for a violation of Federal or state false claims laws. Employees, agents, contractors and Medical Staff members shall report immediately any action believed to be retaliation against any individual for reporting suspect activities or wrongdoing. Individuals determined to have engaged in retaliation or discriminatory treatment in response to a report of wrongdoing or suspect activity will be subject to disciplinary or other corrective action, including termination consistent with applicable policies of Wellmont Health System.

Compliance Program Information. Wellmont Health System's Corporate Compliance Program includes detailed policies and procedures designed to detect, prevent and report any actions which constitute violations of applicable laws, policies and procedures. Copies of the Corporate Compliance Program are available to employees, agents, contractors and Medical Staff members upon request to the Corporate Compliance Officer and can also be found at.

REFERENCES

31 U.S.C. §§ 3729-3733
31 U.S.C. §§ 3801-3812
TCA § 4-18-108, et. seq.
TCA §71-5-181, et. seq.
Va. Code Ann. § 8.01-216.1 et. seq.