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Compliance Plan



Compliance Plan

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Compliance Plan

Introduction

Springstone and its hospitals strive to provide quality, cost-effective healthcare while adhering to the highest ethical standards and complying with all applicable federal and state laws. To evidence this commitment, Springstone has developed and implemented this Compliance Plan, which is intended to provide a compliance roadmap for the company and its hospitals.

The Springstone Compliance Plan:

- Establishes an administrative framework for conducting an effective and diligent compliance effort
- Creates effective communication channels to deliver the company's commitment to ethical business practices and receive feedback regarding adherence to these practices
- Outlines a commitment to educate personnel regarding compliance requirements and how to conduct their job activities in compliance with state and federal law and according to the policies and procedures of the Compliance Plan
- Implements monitoring and auditing functions to measure the effectiveness of the Plan and to address problems in an efficient and timely manner
- Outlines enforcement and discipline components that ensure that all personnel take their compliance responsibilities seriously
- Identifies the company's significant operating and legal risks and develops a plan to minimize those risks

The Springstone Board of Managers is responsible for the operation and oversight of the Compliance Plan; however, the day-to-day responsibility for the operation and oversight of the Compliance Plan rests with the Corporate Compliance Officer, the Corporate Compliance Committee and the Compliance Officer for each Springstone hospital.

Administrative Structure

The compliance efforts for Springstone are managed and overseen by a Corporate Compliance Officer, a Compliance Committee and the Hospital Compliance Officer for each facility.

A. Corporate Compliance Officer

The Corporate Compliance Officer is responsible for directing and assuring the active functioning of the company's compliance efforts. General responsibilities include the following:

- Supervise implementation of the Compliance Program and coordinate all compliance efforts
- Assure that all hospital employees, medical staff and contractors or agents receive a copy of the Springstone Code of Conduct and Springstone Compliance Plan and, depending on an individual's particular job responsibilities, any other written compliance policies and guidelines that may be relevant
- Establish a Compliance Committee, educate committee members regarding their compliance responsibilities and chair and oversee activities of Compliance Committee
- Develop and approve compliance education and training materials; document and implement tracking mechanisms to document attendance at or completion of required training; oversee annual employee attestations regarding commitment to compliance
- Coordinate compliance personnel issues with the hospital's human resources department to ensure that compliance is an integral part of performance assessment and that the National Practitioner Data Bank and Cumulative Sanction Report are checked with respect to all employees and agents.
- Develop communications (e-mails, newsletters, etc.) that encourage employees to report possible improper or illegal conduct
- Implement and operate retaliation-free reporting channels, including an anonymous telephone hotline
- Identify and assess areas of hospital operations that present the greatest compliance risk; prioritize resources to address those risk areas



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- Work with Compliance Committee to identify risk areas warranting compliance audits
- Monitor and evaluate the Compliance Plan's effectiveness through internal and external audits; oversee internal or external resources conducting compliance audits; assess results and develop any necessary responses
- Oversee and document any compliance investigations, working with counsel as the situation warrants
- Report on a regular basis to the Springstone Board of Managers regarding day-to-day compliance efforts; promptly report the results of material or significant investigations
- Keep current with laws, regulations and policies applicable to compliance in order to provide the best possible advice and guidance; obtain copies of all OIG regulations, special fraud alerts and advisory opinions to ensure that the company's compliance policies reflect the guidance provided by the OIG
- Ensure that the hospital appropriately disciplines employees who do not adhere to the Code of Conduct and compliance policies
- Periodically (at least annually), with the Compliance Committee, assess the adequacy of the hospital's Code of Conduct and Compliance Plan and revise as necessary

B. Corporate Compliance Committee

The Corporate Compliance Committee is responsible for supporting the Compliance Officer in developing, monitoring and assessing the Compliance Plan. The committee consists of six to eight senior officers representing the company's significant operating areas, including finance, billing, legal, QA, risk management, clinical operations and human resources. The committee meets at least quarterly, or more frequently as necessary, and has the following duties and responsibilities:

- Continually analyze the hospital's risk environment, the legal requirements with which it must comply and specific risk areas
- Assess and revise existing compliance policies and procedures to assure compliance with the law, regulations and policies and procedures of government and private payer health plans
- Assist the appropriate personnel in designing and coordinating internal and external compliance reviews and monitoring activities



- Review the results of hotline calls and trends and disposition of matters reported
- Review the results of investigations and resulting corrective action plans for hospital departments, providers, or contractors
- Assess and revise policies and programs to promote compliance and encourage reporting of suspected fraud and other improprieties without fear of retaliation and to ensure proper response to reports of non-compliance
- Review the hospital's compliance training efforts
- Maintain minutes of the Committee's meetings summarizing the items addressed and actions taken at each meeting
- Maintain the confidentiality of any sensitive or proprietary information learned by a member through the Compliance Committee process

C. Hospital Compliance Officer

An individual is designated at each Springstone hospital to be the designated Hospital Compliance Officer. This individual will serve as a compliance resource at the local hospital level and will be responsible for the following:

- Conduct compliance training and ensure that all hospital personnel participate in compliance training at least annually
- Assist the Corporate Compliance Officer with compliance audits, as requested
- Assist the Corporate Compliance Officer with investigation and resolution of hotline calls from hospital personnel
- Serve as a communication liaison between the activities of the Corporate Compliance Officer and Compliance Committee and the hospital
- Report on the status of hospital compliance training and compliance audits at the hospital governing board meetings

Communications

Springstone's commitment to an active compliance effort is repeatedly communicated to employees through a variety of channels to encourage communication and the reporting of incidents of potential fraud and misconduct.

A. Communications to Employees

In addition to formal compliance training, employees, medical staff and outside contractors receive frequent reminders of the company's commitment to compliance, the various avenues for reporting concerns, and the hospital's strict policy of non-retaliation for reporting potential compliance issues. Such communications may take the following forms:

- Periodic memos from the CEO
- Compliance articles in hospital newsletters
- E-mails
- Inserts in paychecks

B. Communications from Employees

Processes are in place to ensure that employees, medical staff and contractors know about the various communication channels they may use to express compliance concerns. Anyone who suspects improper or illegal activity is expected to report it. In some circumstances, a failure to report such activity may be grounds for discipline.

Seeking Clarification of Policy

Hospital employees may seek clarification from a supervisor, the Compliance Officer, any member of the Compliance Committee or the Hospital Compliance Officer regarding any confusion or questions about a compliance policy or procedure. Questions directed to the Compliance Committee and responses are documented and dated, and if appropriate, shared with other staff so that standards, policies and procedures can be updated and improved to reflect necessary changes or clarifications

How to Report Potential Wrongdoing

Reports of concerns may be made orally or in writing, and should initially be directed to an employee's supervisor. If an employee is not comfortable reporting concerns to a supervisor, or if an employee is not satisfied with the response to his or her inquiries, the concerns should be directed to the hospital's Compliance Officer or to a Compliance Committee member. Issues of concern may also be reported anonymously by calling the hospital's compliance hotline at **(888) 470-3470**.



Responsibilities of Managers and Supervisors

Managers and Supervisors will respond appropriately and honestly when possible wrongdoing is brought to their attention. It is their responsibility to relay reports of noncompliance to the Compliance Officer. In keeping with the policy allowing anonymous reports, a manager or supervisor may decline to identify the employee who originally made the report.

Communicating Compliance Activities to Board of Managers

The Corporate Compliance Officer maintains a tracking log of all concerns and complaints received, as well as the results of any investigations conducted and the outcome of the investigation. The Compliance Officer reports at least quarterly to the company's Board of Managers regarding compliance efforts. Such reports include a report on all allegations of wrongdoing, the results of any investigations conducted and any subsequent disciplinary or remedial action taken, recent training efforts undertaken and an overview of current auditing and monitoring efforts. It may also include statistical and trending information.

Records Retention

The hospital document retention plan includes provisions to ensure that all records related to reports of wrongdoing are preserved in accordance with law and to assure maximum protection under the attorney-client privilege and attorney work-product doctrine.

Protection of Employees

Every effort is made to maintain, within the limits of the law, the confidentiality of the identity of any individual who reports possible misconduct. There will be no retribution or discipline for anyone who reports a possible violation in good faith.

Departing Employees

Departing employees are asked to submit to an exit interview. One of the purposes of the exit interview is to determine if the employee has knowledge of wrongdoing, unethical behavior or criminal misconduct. The interview may also be used to obtain information about unsafe or unsound business practices.

C. Compliance Hotline

Springstone has established a toll-free Compliance Hotline to receive questions about compliance practices and reports of suspected improper or illegal activities. **The phone number for the Compliance Hotline is (888) 470-3470.** Callers may remain anonymous, although callers are encouraged to provide as much information as possible so that reports



can be properly investigated. No one who calls with either a question or a report of suspected misconduct will suffer any kind of retaliation or adverse action, as long as the call was made in good faith.

The people answering the calls on the Compliance Hotline are not employees of Springstone or its hospitals. The person answering the telephone will ask the caller if he or she wants to remain anonymous. If so, the call will be assigned a number. The number can be used to call back and obtain information about the status of the question or concern. The person taking the call will document the call and forward it to the Corporate Compliance Officer.

All questions and reports to the Compliance Hotline are kept confidential to the extent practicable. The Compliance Officer will disclose questions and reports on a “need to know” basis, except as required by law. Similarly, if a caller chooses to identify himself or herself, the Compliance Officer will keep the caller’s identity confidential and disclose the caller’s identity on to a “need to know” basis, except as required by law. In general, “need to know” means that disclosure will be made only to the extent necessary to allow for a full investigation of reports of suspected misconduct and for the implementation of any appropriate corrective actions or disciplinary sanctions.

Responding to Detected Offenses

The Corporate Compliance Officer will review all allegations of potential wrongdoing arising from hotline reports, informal communications or audits conducted by the hospital. An initial assessment is made to determine the need to involve legal counsel to advise or direct the process and to assess the need for legal privilege to protect the process. At the same time, an assessment is made to determine the appropriate resources required to conduct an investigation commensurate with the gravity of the allegation. The Compliance Officer conducts or oversees the initial investigation, along with legal counsel where it is warranted. Executive management is immediately notified if a serious allegation appears valid. Additional resources may be required to fully investigate a situation and outside resources may be utilized to conduct a full investigation. Records of an investigation contain:

- Documentation of the alleged violation
- A description of the investigative process
- Copies of interview notes and key documents
- A log of the witnesses interviewed and the documents reviewed
- The results of the investigation

If the investigation indicates that a violation has occurred, appropriate corrective action will be taken, including the following:

- Prompt restitution of any overpayments
- Notification to the appropriate government agency, where appropriate



- Review of current policies and procedures to determine if clarification is needed
- System modification
- Staff education
- Referral to criminal and /or civil law enforcement authorities
- Possible disciplinary action of involved employees, up to and including termination

Education and Training

Compliance training is provided on a regular basis to ensure that all employees are educated as to the purpose, contents and requirements of the Compliance Program. The training program consists of two components: general training and supplemental training. The Corporate Compliance Officer, working with the Compliance Committee and hospital personnel as appropriate, develops and continuously updates such training information.

General training covers the material contained in the Code of Conduct and the Compliance Program, as well as other applicable laws, policies and procedures. It reinforces the need for strict compliance with applicable statutes, regulations, policies and procedures and advises employees about disciplinary action that may result from failure to comply. General compliance training is provided to all new employees as a part of new employee orientation. The training is updated on an annual basis thereafter. All employees receive a minimum of one hour of compliance training annually.

Supplemental training covers those items that may present a heightened risk of non-compliance, particularly those directly affected by the statutes, regulations, policies, procedures and program guidelines for Medicare, Medicaid and all other federal healthcare programs. Likely areas for potential supplemental training include the following:

- Government and private payer reimbursement principles
- General prohibitions on paying or receiving remuneration to induce referrals
- Proper confirmation of diagnoses
- Submitting a claim for physician services when rendered by a non-physician (e.g., the “incident to” rules and the physician physical presence requirement)
- Signing a form for a physician without the physician’s authorization
- Alterations to medical records
- Prescribing medications and procedures without proper authorization
- Proper documentation of services rendered
- Duty to report misconduct
- Patient confidentiality
- Other areas identified by this Plan or by the Compliance Committee as representing high risk areas



Attendance and participation in training is a condition of continued employment. Upon completing Compliance Program training, each employee is required to sign a written acknowledgement confirming his or her pledge to adhere to the Compliance Program and that the individual understands that failure to comply with the Compliance Program will result in disciplinary action, up to and including, termination of employment.

Auditing and Monitoring Compliance Efforts

Springstone actively uses monitoring and auditing functions to assess the effectiveness of its Compliance Program. The types of audits and areas to be audited are determined each year by the Compliance Committee. Audits are conducted by using outside resources such as counsel, auditors or other healthcare experts or through internal personnel or through an internal audit function. Audits may include the review of a statistically valid random sample of cases, staff interviews, and trend analysis studies. The results of such audits are presented to the Compliance Committee, which assesses the results and recommends any necessary corrective measures. Such corrective measures may include additional auditing, monitoring, new policies, additional training and education. Monitoring efforts are also used to ensure compliance with laws governing:

- kickback arrangements
- the physician self-referral prohibition
- coding
- claims development and submission
- reimbursement
- cost reporting
- marketing practices

While the Compliance Officer and Compliance Committee periodically assess the company's risk areas to determine which areas may warrant a compliance audit, certain areas by their nature present significant hospital risk potential. Accordingly, coding and billing audits are conducted at least annually and more frequently where warranted. Similarly, a review of the hospital's marketing practices and payments to physicians is conducted at least annually.

At least annually, a review is performed to assess whether the Compliance Program's elements have been satisfied, e.g., whether there has been appropriate dissemination of the program's standards, training, ongoing education programs and disciplinary actions.

Enforcement and Discipline

Any employee who violates the Compliance Program or healthcare laws, regulations, or program requirements is subject to disciplinary measures, up to and including termination. Such measures will be consistent with Springstone's progressive discipline policies.



Physicians with privileges who violate the Compliance Program or healthcare laws, regulations, or program requirements are subject to discipline, up to and including the loss of privileges. Such measures will be consistent with the medical staff by-laws.

If an agent or contractor violates the Compliance Program or healthcare laws, regulations, or program requirements, the company will take appropriate measures such as terminating the contract, requiring repayment or requiring additional training and education.

Springstone has established a process to ensure that it does not knowingly hire, employ, or contract with any individual or entity whom the company knows or should have known, after reasonable inquiry, (a) has been convicted of a criminal offense related to healthcare (unless the individual or entity has been reinstated to participation in Medicare after being excluded because of the conviction), or (b) is currently listed by a federal agency as excluded, suspended or otherwise ineligible for participation in federal or federally funded programs such as Medicare and Medicaid.

Identification of Risks; Standards and Policies

The Corporate Compliance Officer and Compliance Committee assess the company's risk priorities at least annually. The areas identified below represent a starting point for this effort. These are areas that have been identified by the OIG as high risk areas to assist hospitals in focusing their compliance efforts. It also serves as a starting point for the hospital's educational efforts. This is not an exclusive list of the hospitals risk areas and others will be identified over time. Detailed standard and policies for complying with the healthcare laws and regulations implicated by these risk areas are contained in the hospital's clinical policies and procedures and are periodically reviewed to ensure that they fully address the risks presented by these areas. Further, such policies are periodically assessed to ensure consistency with the policy recommendations set forth in the OIG 1998 Model Compliance Program Guidance for Hospitals and the OIG 2005 Supplemental Compliance Program Guidance for Hospitals which can be found at <http://oig.hhs.gov>.

A. Billing and Coding Risks

Billing for items or services not actually rendered. Submitting a claim that represents that the hospital performed a service, all or part of which was not performed.

Providing medically unnecessary services. Intentionally seeking reimbursement for a service that is not warranted by a patient's current and documented medical condition.

Upcoding. Using a billing code that provides a higher payment rate than the billing code that actually reflects the service furnished to the patient.



DRG creep. Using a Diagnosis Related Group (DRG) code that provides a higher payment rate than the DRG code that accurately reflects the service furnished to the patient.

Duplicate billing. Submitting more than one claim for the same service or submitting a claim to more than one primary payor at the same time.

False cost reports. Submitting unallowable costs due the failure to provide proper controls over costs included in a hospital's Medicare cost report; shifting certain costs to areas that are below their reimbursement cap; shifting non-Medicare related costs to Medicare cost centers.

Unbundling. Submitting bills piecemeal or in fragmented fashion to maximize the reimbursement for various tests or procedures that are required to be billed together and therefore at a reduced cost.

Credit balances. Failing to refund credit balances.

Admission and Discharge Issues. Failing to follow the "same-day" rule; same-day discharge and readmission issues such premature discharges, medically unnecessary readmissions or incorrect discharge coding.

Supplemental Payment Considerations. Improperly reporting the costs of "pass-through" items; abuse of DRG outlier payments.

Use of Information Technology. Failing to fully understand the impact of computer systems and software that affect coding, billing or the generation or transmission of information related to the federal healthcare programs or their beneficiaries.

B. Risks Arising from the Referral Statutes: The Physician Self-Referral Law (the "Stark" Law) and the Federal Anti-Kickback Statute.

The Stark Law. The Stark law prohibits hospitals from submitting-and Medicare from paying-any claim for a "designated health service" (DHS) if the referral of the DHS comes from a physician with whom the hospital has a prohibited financial relationship. A financial relationship can be almost any kind of direct or indirect ownership or investment relationship or direct or indirect compensation arrangement, whether in cash or in-kind, between a referring physician (or immediate family member) and a hospital.

Any financial relationship between a hospital and a physician who refers to the hospital must fit into an exception or the statute has been violated. As a rule, there are no exceptions for inadvertence or error. Accordingly, Springstone has adopted, at a minimum, specific policies to address the following aspects of physician relationships:



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- frequent and thorough review of all contracts and leases with physicians to ensure that all conditions supporting the exceptions are fully satisfied
- appropriate processes for making and documenting reasonable, consistent and objective determinations of fair market value
- monitoring the total value of monetary and non-monetary compensation provided annually to each referring physician,
- tracking the provision and value of medical staff incidental benefits

Compliance with a Stark law exception does not immunize an arrangement under the anti-kickback statute. Rather the Stark law sets a minimum standard for arrangements between physicians and hospitals. Even if a hospital-physician relationship qualifies for a Stark law exception, it is still reviewed for compliance with the anti-kickback statute.

The Federal Anti-Kickback Statute. The anti-kickback statute is a criminal prohibition against payments (in any form, whether the payments are direct or indirect) made purposefully to induce or reward the referral or generation of federal healthcare program business. The statute extends equally to the solicitation or acceptance of remuneration for referrals or the generation of other business payable by a federal healthcare program. Although liability under the anti-kickback statute ultimately turns on a party's intent, neither a legitimate business purpose for the arrangement nor a fair market value payment, will legitimize a payment if there is also an illegal purpose (i.e., an intent or desire to induce federal healthcare program business.).

Relationships with physicians may represent a significant referral sources for a hospital and accordingly all relationships with physicians are carefully reviewed as described above. In addition a hospital may receive referrals from other healthcare professionals such as physician assistants and nurse practitioners, and from other providers and suppliers such as, mental health clinics, nursing facilities and other hospitals. Each of these relationships is evaluated to ensure that the anti-kickback statute is not violated.

Certain arrangements or practices that may present a significant potential for abuse are identified below and an initial framework for assessing the risk associated with those practices are described below. Further tools for analysis are available in the OIG 2005 Supplemental Compliance Program Guidance and in relevant Special Fraud Alerts available at <http://oig.hhs.gov/fraud.html>.

Joint Ventures. Any joint venture with an entity in a position to refer or generate federal healthcare program business presents the potential that remuneration from such a venture might be a disguised payment for past or future referrals to the venture. Accordingly, the company considers the following factors in evaluating such ventures.

- How the joint venture participants are selected and retained
- The manner in which the joint venture is structured
- The manner in which the investments are financed and profits are distributed



Whenever possible, joint ventures are structured to satisfy one of the safe harbors for investments interests.

Compensation Arrangements with Physicians. Typical compensation arrangements with physicians include medical director agreements, employment agreements, personal or management services agreements, space or equipment leases or agreements for the provision of billing, nursing or other staff services. All remuneration flowing between hospitals and physicians is at fair market value for actual and necessary items furnished or services rendered based upon an arm's length transaction and does not take into account the value or volume of any past or future referrals or other business generated between the parties. A starting point for evaluating these arrangements is a consideration of the following factors:

- The items and services obtained from the physician are legitimate, commercially reasonable and necessary to achieve a legitimate business purpose of the hospital.
- The compensation represents fair market value in an arm's-length transaction.
- The services could not be obtained from a non-referral source at a cheaper rate or under more favorable terms.
- The determination of fair market value is based upon a reasonable methodology that is uniformly applied and properly documented in writing.
- Safeguards are in place to ensure that physicians do not use hospital space, equipment or personnel to conduct their private practice.

Whenever possible, Springstone structures physician compensation arrangements to satisfy one of the anti-kickback safe harbors.

Relationships with other Healthcare Entities. When furnishing inpatient, outpatient and related services, a hospital may direct or influence referrals for items and services reimbursable by federal healthcare programs. For example a hospital may refer patients to, or order times or services from, home health agencies, skilled nursing facilities, durable medical equipment companies, laboratories, pharmaceutical companies, and other hospitals. When a hospital is the referral source for other providers or suppliers, payments or remuneration from such other providers or suppliers is carefully reviewed to ensure compliance with the anti-kickback statute.

Physician Recruitment Arrangements. Incentives provided to recruit a physician or other healthcare professional to join a hospital's medical staff pose substantial fraud and abuse risks. All physician recruitment arrangements are reviewed in advance, with particular emphasis on the following issues:

- The size and value of the recruitment benefit
- The duration of payout of the recruitment benefit
- The physician's current practice—size and location
- The hospital and community need for the recruitments



Discounts. All discounts are properly disclosed and accurately reflected on hospital cost reports. There are no links or connections, explicit or implicit, between discounts offered or solicited for that business and a hospital's referral of business billable by the seller directly or Medicare or another federal healthcare program. Hospital personnel understand the discount safe harbor requirements.

Medical Staff Credentialing. Certain medical staff credentialing practices may implicate the anti-kickback statute such as conditioning privileges on a particular number of referrals or requiring the performance of a particular number of procedures, beyond volumes necessary to ensure clinical proficiency. Credentialing practices are reviewed periodically for compliance with these concerns.

Malpractice Insurance Subsidies. Any subsidy of a physician's malpractice insurance raises the issue of whether the payments are being used to influence referrals. All malpractice insurance subsidy arrangements are reviewed closely to ensure that there is no improper inducement to referral sources.

C. Substandard Care

The OIG may exclude a hospital from participating in federal healthcare programs if the hospital provides items or services that fail to meet professionally recognized standards of healthcare. To achieve quality related goals the hospital continually measures its performance against comprehensive standards. Springstone has developed its own quality of care protocols and has implemented mechanisms for evaluating compliance with those protocols. In addition the company takes an active part in monitoring the quality of medical services provided at each hospital by appropriately overseeing the credentialing and peer review of the medical staff.

D. Relationships with Federal Healthcare Beneficiaries

Hospitals are prohibited from offering remuneration to a Medicare or Medicaid beneficiary that the hospital knows or should know is likely to influence the beneficiary to order or receive items or services from a particular provider. The definition of "remuneration" expressly includes the offer or transfer of terms or services for free or other than fair market value, including the waiver of all or part of a Medicare or Medicaid cost-sharing amount. Specific items of concern include the following:

Gifts. Springstone prohibits offers of gifts or gratuities to beneficiaries if the remuneration is something that is likely to influence a beneficiary's selection of a particular provider. The restriction does not apply to items or services valued at less than \$10 per item and \$50 per patient in the aggregate on an annual basis. The company has educated its employees to ensure their understanding of these restrictions.



Cost Sharing Waivers. In general, a hospital is obligated to collect cost-sharing amounts owed by federal health care program beneficiaries. Waving owed amounts may constitute prohibited remuneration to beneficiaries. Certain waivers of Part A inpatient cost-sharing amounts may be protected by structuring them to fit in the safe harbor for waivers of beneficiary inpatient coinsurance and deductible amounts, e.g., waived amounts may not be claimed as bad debt, the waivers must be offered uniformly across the board, and waivers may not be made as part of any agreement with a third part payer (other than a Medicare SELECT plan.) The rules for this safe harbor are understood by employees with billing responsibility. In addition, a hospital may waive cost-sharing amounts on the basis of a beneficiary's financial need under certain circumstances. These circumstances are understood by billing personnel and each hospital uses a reasonable set of financial need guidelines that are based on objective criteria and appropriate for the hospital's location.

Free Transportation. While a hospital is prohibited from offering free transportation to Medicare or Medicaid beneficiaries to influence their selection of a particular provider, the hospital can offer free local transportation of low value (within the gift exception above). Certain other complimentary transportation programs may be permissible under currently evolving rules. Prior to undertaking such transportation efforts, each hospital will have processes in place to ensure that all statutory and regulatory requirements relating to free transportation are met.

E. HIPAA Privacy and Security Rules

Springstone is subject to detailed rules that govern the use and disclosure of individuals' health information and standards for individuals' privacy rights to understand and control how their health information is used. These rules can be found at <http://www.hhs.gov/ocr/hipaa>. Penalties for failing to comply with these rules are significant. The company has developed privacy procedures to ensure compliance with the Health Insurance Portability and Accountability Act (HIPAA) and HITECH rule and has instituted training programs to educate all employees of their obligations with respect to these requirements.

F. Other Hospital Practices

A variety of billing issues exist with respect to making sure that a hospital is billing the government appropriately or otherwise observing the applicable guidelines for services involving the situations described below.

- Discounts to uninsured patients
- Provision of preventive care services
- Professional courtesy for a range of practices involving free or discounted services (including "insurance only" billing) furnished to physicians and their families and staff



To the extent a hospital undertakes these practices, it is done in the context of understanding fully the laws and regulations pertinent to such practices and employees are educated as to those laws and regulations.