

CORPORATE INTEGRITY AGREEMENT
BETWEEN THE
OFFICE OF INSPECTOR GENERAL
OF THE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
AND
AMERICAN HEALTHCARE, L.L.C.

I. PREAMBLE

American HealthCare, L.L.C. (“AHC”) hereby enters into this Corporate Integrity Agreement (“CIA”) with the Office of Inspector General (“OIG”) of the United States Department of Health and Human Services (“HHS”) to promote compliance by AHC with the statutes, regulations, and written directives of Medicare, Medicaid, and all other Federal health care programs (“Federal health care program requirements”). AHC’s compliance with the terms and conditions of this CIA shall constitute an element of AHC’s present responsibility with regard to participation in the Federal health care programs.

This CIA is being entered into in conjunction with and as part of a Settlement Agreement between the United States and, among others, William C. Cranwell and AHC. William Cranwell has an ownership interest in AHC and certain health care entities and related entities in the Commonwealth of Virginia that are managed or operated by AHC. Pursuant to the Settlement Agreement, William Cranwell has agreed to be excluded for a period of twenty years pursuant to 42 U.S.C. § 1320a-7(b)(7) and 42 U.S.C. § 1320a-7(a)(1) from participation in the Federal health care programs. AHC and William Cranwell agree to comply with the terms and conditions of a trust arrangement pursuant to Section III.H.6, the Second WCC Blind Trust Agreement at Exhibit A (the “Blind Trust Agreement”), and Appendix C (collectively, the “Trust”) for the duration of this CIA. Except as explicitly permitted by OIG, during the term of this CIA, no “Immediate Family Member and/or Member of Household” (as defined in 42 U.S.C. § 1320a-7(j)) shall be in a role that meets the definition of a Covered Person, as set forth in Section II.C.2. William Cranwell hereby agrees and attests by affidavit (attached as Exhibit B to this CIA) that for the duration of this CIA, he does not and shall not participate in any manner, directly or indirectly, in the management or control of the operations of AHC or any entity that meets the definition of “Covered Person” as set forth in Section II.C.2.

AHC acknowledges its accountability for the health and safety of its patients and residents. AHC agrees that, except in the case of a bona fide sale or other arms-length transaction to a third party pursuant to Section XI.A, it will not assign its management responsibilities for any Covered Facility as defined in Section II.C.1, unless that new manager is also made a party to this CIA.

II. TERM AND SCOPE OF THE CIA

A. The period of the compliance obligations assumed by AHC under this CIA shall be five years after the Effective Date of this CIA (“Effective Date”) (unless otherwise specified). The Effective Date shall be the date on which the final signatory of this CIA executes this CIA. Each one-year period, beginning with the one-year period after the Effective Date, shall be referred to as a “Reporting Period.”

B. Sections VII, VIII, IX, X, and XI shall expire no later than 120 days after OIG’s receipt of: (1) AHC’s final annual report; or (2) any additional materials submitted by AHC pursuant to OIG’s request, whichever is later.

C. The scope of this CIA shall be governed by the following definitions:

1. “Covered Facilities” shall mean the entities and operations listed in Appendix B.

2. “Covered Persons” shall mean:

a. AHC’s officers, directors (including members of the AHC Executive Committee), and employees;

b. individuals directly involved in administering or managing the Trust, including, but not limited to, the Trustee and the Trust Advisor (as defined in the Blind Trust Agreement); and

c. AHC’s contractors, agents, and third parties engaged to:

i. prepare or submit claims, reports, or other requests for reimbursement for items or services reimbursable by Federal health care programs;

ii. provide, market, or document items or services reimbursable by Federal health care programs (as defined in 42 U.S.C. § 1320a-7b(f)), including, but not limited to, individuals responsible for performing patient care and resident care duties, making assessments of patients and residents that affect treatment decisions or reimbursement, and making decisions or providing oversight about staffing and patient and resident care; or

iii. perform any function that relates to or is covered by this CIA.

d. except as otherwise set forth in Section III.G, “Covered Persons” does not include Temporary Staff, as defined in Section III.G.

3. “Relevant Covered Persons” shall mean Covered Persons who are involved in the delivery of patient and resident care items or services (including individuals who are responsible for quality assurance, setting policies or procedures, or making staffing decisions) and/or in the preparation or submission of claims and cost reports for reimbursement from any Federal health care program.

III. CORPORATE INTEGRITY OBLIGATIONS

AHC shall establish a Compliance Program that includes the following elements:

A. Compliance Officer and Committees.

1. *Compliance Officer.* Within 120 days after the Effective Date, AHC shall appoint an individual to serve as its Compliance Officer. The Compliance Officer shall be responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements set forth in this CIA and with Federal health care program requirements. The Compliance Officer shall be a member of senior management of AHC, shall make periodic (at least quarterly) reports regarding compliance matters directly to the Executive Committee of AHC, and shall be authorized to report on such matters to the Executive Committee at any time. The Compliance Officer shall be responsible for monitoring the day-to-day compliance activities engaged in by AHC as well as for any reporting obligations created under this CIA. The

Compliance Officer shall also ensure that any quality of care problems are appropriately addressed and corrected.

AHC shall report to OIG, in writing, any changes in the identity or position description of the Compliance Officer, or any actions or changes that would affect the Compliance Officer's ability to perform the duties necessary to meet the obligations in this CIA within 15 days after such a change.

2. *Compliance Committee.* Within 120 days after the Effective Date, AHC shall appoint a Compliance Committee. The Compliance Committee shall, at a minimum, include the Compliance Officer, a member of the Executive Committee, and other members of senior management necessary to meet the requirements of this CIA (e.g., senior executives of relevant departments, such as billing, clinical, human resources, audit, and operations). The Compliance Officer shall chair the Compliance Committee and the Committee shall support the Compliance Officer in fulfilling his or her responsibilities (e.g., shall assist in the analysis of AHC's risk areas and shall oversee monitoring of internal and external audits and investigations).

AHC shall report to OIG, in writing, any changes in the composition of the Compliance Committee, or any actions or changes that would affect the Compliance Committee's ability to perform the duties necessary to meet the obligations in this CIA within 15 days after such a change.

3. *Quality Assurance Committee.* AHC represents to OIG that it has established a Quality Assurance Committee. To the extent that AHC's Quality Assurance Committee does not already meet the requirements of this Section, within 120 days after the Effective Date, the role of the Quality Assurance Committee shall be revised to meet the following requirements. The Quality Assurance Committee shall address issues concerning quality of care in the Covered Facilities. At a minimum, the Committee shall include the Compliance Officer, the President and Chief Executive Officer, the Vice President of Clinical Services, the Senior Vice President of Operations, the Corporate Nurse Consultant for Compliance, each Regional Director of Operations, and any other appropriate officers or individuals necessary to thoroughly implement the requirements of this CIA that relate to quality of care in the Covered Facilities. For each Quality Assurance Committee meeting, there shall be a member of the Clinical Service Teams and senior representatives from the Covered Facilities (including Covered Facility

physicians), chosen on a rotating and random basis, to report to the Committee on the adequacy of care being provided at their facilities.

This Committee shall, at a minimum: (a) review the adequacy of AHC's system of internal controls, quality assurance monitoring, and patient and resident care; (b) ensure that AHC's response to state, federal, internal, and external reports regarding quality of care issues is complete, thorough, and resolves the issue(s) identified; and (c) ensure that AHC adopts and implements policies and procedures that are designed to ensure that each individual cared for at a Covered Facility receives the highest practicable physical, mental, and psychosocial level of care attainable. The individuals who serve on this Committee shall be readily available to the Compliance Officer, the Clinical Service Teams, and the Independent Review Organization(s) required under this CIA to respond to any issues or questions that might arise.

AHC shall report to OIG, in writing, any changes in the composition of this Committee, or any actions or changes that would affect the Committee's ability to perform the duties necessary to meet the obligations in this CIA within 15 days after such a change.

B. Written Standards.

1. *Code of Conduct.* Within 120 days after the Effective Date, AHC shall establish a written Code of Conduct. The Code of Conduct shall be distributed to all Covered Persons within 120 days after the Effective Date. AHC shall make the promotion of, and adherence to, the Code of Conduct an element in evaluating the performance of all employees. The Code of Conduct shall, at a minimum, set forth:

- a. AHC's commitment to full compliance with all Federal health care program requirements, including its commitment to prepare and submit accurate claims consistent with such requirements;
- b. AHC's requirement that all Covered Persons shall be expected to comply with all Federal health care program requirements and with AHC's own Policies and Procedures as implemented pursuant to Section III.B (including the requirements of this CIA);

- c. the requirement that all Covered Persons shall be expected to report to the Compliance Officer or other appropriate individual designated by AHC suspected violations of any Federal health care program requirements or of AHC's own Policies and Procedures (if there are credible allegations of patient or resident harm, such report shall be made immediately);
- d. the possible consequences to both AHC and Covered Persons of failure to comply with Federal health care program requirements and with AHC's own Policies and Procedures and the failure to report such non-compliance; and
- e. the right of all individuals to use the Disclosure Program described in Section III.F, and AHC's commitment to maintain confidentiality, as appropriate, and non-retaliation with respect to such disclosures.

Within 120 days after the Effective Date, each Covered Person shall certify, in writing, that he or she has received, read, understood, and shall abide by AHC's Code of Conduct. New Covered Persons shall receive the Code of Conduct and shall complete the required certification within 15 days after becoming a Covered Person or within 120 days after the Effective Date, whichever is later.

AHC shall annually review the Code of Conduct to determine if revisions are appropriate and shall make any necessary revisions based on such a review. Any such revised Code of Conduct shall be distributed within 30 days after finalizing such changes. Each Covered Person shall certify that he or she has received, read, understood, and shall abide by the revised Code of Conduct within 30 days after the distribution of such revisions.

With regard to Code of Conduct certifications for Covered Persons (including Relevant Covered Persons) who are contractors, agents, or third parties (referred to collectively in this Paragraph III.B.1 as "contractors"), AHC shall: (a) attempt to negotiate or renegotiate contracts with contractors to require such contractors to meet the Code of Conduct certification requirements above; (b) make the Code of Conduct available to all contractors; and (c) use its best efforts to obtain contractors' Code of

Conduct certifications. The Compliance Officer shall keep a record of all contractors' Code of Conduct certifications.

2. *Policies and Procedures.* To the extent that AHC does not already have Policies and Procedures that meet the requirements of this Section, within 120 days after the Effective Date, AHC shall implement additional written Policies and Procedures or revise existing Policies and Procedures regarding the operation of AHC's compliance program and its compliance with all Federal and state health care statutes, regulations, directives, and guidelines, including the Federal health care program requirements. At a minimum, the Policies and Procedures shall address:

- a. the subjects relating to the Code of Conduct identified in Section III.B.1;
- b. the proper preparation and submission of cost reports to Medicare and Medicaid, including, but not limited to federal and state requirements regarding unallowable costs and allowable costs;
- c. 42 U.S.C. § 1320a-7b(b) (the "Anti-Kickback Statute") and 42 U.S.C. § 1395nn (the "Stark Law"), and the regulations and other guidance documents related to these statutes, and business or financial arrangements or contracts that induce the unlawful referral of Federal health care program beneficiaries in violation of the Anti-Kickback Statute or the Stark Law;
- d. the requirements set forth in Section III.D.
- e. measures designed to ensure that AHC complies with all requirements applicable to Medicare's Prospective Payment System ("PPS") for skilled nursing facilities, including, but not limited to: ensuring the accuracy of the clinical data required under the Minimum Data Set ("MDS") as specified by the Resident Assessment Instrument User's Manual; ensuring that the Covered Facilities are appropriately and accurately using the Resource Utilization Groups classification system ("RUGs"); and ensuring the accuracy of all billing-related activities;

f. measures designed to ensure that AHC fully complies with Titles XVIII and XIX of the Social Security Act, 42 U.S.C. §§ 1395 - 1395ggg and 1396-1396v, and all regulations, directives, and guidelines promulgated pursuant to these statutes, including, but not limited to, 42 C.F.R. Parts 424, 482, and 483, and any other state or local statutes, regulations, directives, or guidelines that address quality of care in nursing homes;

g. measures designed to ensure compliance with federal and state requirements pertaining to incident, accident, and abuse and neglect reporting for patients and residents; and measures designed to ensure that AHC has a system to collect and analyze reports at the facility and corporate levels relating to incidents, accidents, abuse, and neglect of patients and residents. The reports required under this system shall be of a nature to provide the Quality Assurance Committee meaningful information to be able to determine: (i) if there are quality of care problems and (ii) the scope and severity of any such problems;

h. measures designed to ensure that residents and patients are discharged only for the reasons authorized by and in accordance with the procedures established by applicable law and not discharged for financial reasons unless authorized by law;

i. measures designed to ensure the coordinated interdisciplinary approach to providing care to residents of patient care facilities, including, but not limited to, resident assessment and care planning; nutrition and hydration; diabetes care; special needs; wound care; infection control; abuse and neglect policies and reporting procedures; protection from harm procedures; appropriate drug therapies; appropriate mental health services; provision of basic care needs; resident rights and restraint use; activities of daily living care, including incontinence care; therapy services; quality of life, including accommodation of needs and activities; and assessment of resident capability to make treatment decisions;

j. measures designed to ensure that AHC provides a safe and functional environment for all residents and that all residents are free from mistreatment, corporal punishment, involuntary seclusion, neglect, misappropriation of property, and verbal, sexual, physical, and mental abuse;

k. measures designed to ensure that AHC adequately supervises, monitors, and safeguards all residents, including those with histories of exhibiting behaviors that cause injury to themselves or others;

l. measures designed to ensure that staff members provide residents with appropriate basic care services that meet the residents' individual needs;

m. measures designed to ensure that physical and chemical restraints are used only pursuant to accepted professional standards and that they are never used as punishment or for the convenience of staff and that appropriate physicians' orders are obtained and followed before physical restraints are used;

n. measures designed to ensure that psychotropic medication is used only in accordance with accepted professional standards and only where there is an appropriate psychiatric or neuropsychiatric diagnosis, and that psychotropic medication is never used as punishment, in lieu of a training program, for behavior control or in lieu of a psychiatric or neuropsychiatric diagnosis, or for the convenience of staff;

o. measures designed to ensure that residents receive adequate and appropriate nursing care, and that nurses perform their responsibilities in keeping with accepted professional standards of care by adequately identifying health care problems, notifying physicians of health care problems, monitoring and intervening to ameliorate such problems, and keeping appropriate records of residents' health care status;

p. measures designed to ensure that staffing needs decisions are based on the needs of the patients and residents at each Covered Facility and upon achieving the level of care required by Federal health care program requirements and state laws, including, but not limited to, 42 C.F.R. § 483.30 and not solely upon financial concerns;

q. measures designed to inform Covered Persons about 42 C.F.R. § 483.30 (re: sufficient nursing staff) and that staffing levels are a critical aspect of patient and resident care, and, if any person has concerns about the level of staffing that there are methods for reporting such concerns;

r. measures designed to minimize the number of individuals working at any Covered Facility who are on a temporary assignment or not employed by AHC, and measures designed to create and maintain a standardized system to track the number of individuals at each facility who fall within this category so that the number/proportion of or changing trends in such staff can be adequately identified by AHC and the Clinical Service Teams;

s. measures designed to promote adherence to the compliance and quality of care standards set forth in the applicable statutes, regulations, and in this CIA, by including such adherence as a significant factor in determining the compensation to Administrators of the Covered Facilities, and the individuals responsible for such compliance at the regional and corporate level;

t. measures designed to ensure that individuals and entities that contract with AHC are appropriately supervised to ensure that the contractor is acting within the parameters of AHC's Policies and Procedures and Federal health care program requirements;

u. measures designed to ensure that compliance issues identified internally (e.g., through reports to supervisors, hotline complaints, internal audits, patient and resident satisfaction surveys, internal reviews of Center for Health Systems and Research Analysis

(“CHSRA”) quality indicators, internal surveys, or Clinical Site Visit Reports or Mock Survey Reports (pursuant to Section III.E.1)) or externally (e.g., through Centers for Medicare and Medicaid Services (“CMS”) or State survey agency reports, consultants, or audits performed by the Independent Review Organization) are promptly and appropriately investigated and, if the investigation substantiates compliance issues, AHC assesses the nature and scope of the problems, implements appropriate corrective action plans, and monitors compliance with such plans. Such measures shall include the requirement that the appropriate Covered Facility administrator review each CMS and state survey agency report and plan of correction and certify in writing to the appropriate government agency as to whether AHC has corrected the survey deficiencies noted and has achieved substantial compliance with the Medicare and Medicaid conditions of participation. Such measures shall also provide for the documentation and tracking of the internal review of all CMS and state survey agency reports and plans of correction;

v. measures designed to effectively collect and analyze staffing data, including staff-to-resident ratio and staff turnover;

w. measures designed to ensure that AHC provides an ongoing structured program of activities designed to meet the individual interests and physical, mental, and psychosocial well-being of each patient and resident, and provides medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each patient and resident;

x. measures designed to ensure that all residents and patients are served in the least restrictive environment and most integrated setting appropriate to their needs; and

y. measures designed to ensure that AHC has internal quality control systems, including but not limited to systems that promote quality of care and respond to care issues in a timely and effective manner;

Within 120 days after the Effective Date, the relevant portions of all new and revised Policies and Procedures shall be distributed to all individuals whose job functions relate to those Policies and Procedures. Appropriate and knowledgeable staff shall be available to explain the Policies and Procedures to those individuals.

At least annually (and more frequently, if appropriate), AHC shall assess and update as necessary the Policies and Procedures. Within 30 days after the effective date of any revisions, the relevant portions of any such revised Policies and Procedures shall be distributed to all individuals whose job functions relate to those Policies and Procedures.

C. Training and Education.¹

1. *General Training.*² Within 120 days after the Effective Date, AHC shall provide at least one hour of general training to each Covered Person. This training, at a minimum, shall explain AHC's:

- a. CIA requirements; and
- b. Compliance Program (including the Code of Conduct and the Policies and Procedures as they pertain to general compliance issues).

New Covered Persons shall receive the general training described above within 15 days after becoming a Covered Person or within 120 days after the Effective Date, whichever is later. After receiving the initial training described above, each Covered Person shall receive at least one hour of general training annually. Training may be provided either in person, via videoconference, teleconference, computer-based programs, or through applicable on-line programs.

¹ See Section III.G regarding training for "Temporary Staff."

² See Section III.C.4 regarding training for contractors, agents, and third parties.

2. *Specific Training.*³ Within 120 days after the Effective Date, each Relevant Covered Person involved in the delivery of patient and resident care items or services (including individuals who are responsible for quality assurance, setting policies or procedures, or making staffing decisions) shall complete at least six hours of specific training in addition to the general training required above. The specific training for these Relevant Covered Persons shall include a discussion of the Policies and Procedures set forth in Section III.B applicable to the delivery of patient and resident care items or services , including, but not limited to:

- a. the submission of accurate information (e.g., MDS) to Federal health care programs;
- b. policies, procedures, and other requirements applicable to the documentation of medical records;
- c. the personal obligation of each individual involved in the delivery and/or documentation of patient and resident care to ensure that the information provided is accurate;
- d. applicable state and federal reimbursement statutes, regulations, and program requirements and directives;
- e. the legal sanctions and consequences for improper submissions to Federal health care programs and improper contracting or financial arrangements; and
- f. examples of violations of the Anti-Kickback Statute and the Stark Law and a review of AHC's contracting Policies and Procedures related to contracts with potential referral sources or referral recipients as developed pursuant to Section III.D and the personal obligation of each individual involved in the contracting process to know the legal requirements and policies of AHC.

³ See Section III.C.4 regarding training for contractors, agents, and third parties.

Within 120 days after the Effective Date, each Relevant Covered Person involved in the preparation or submission of claims or cost reports for reimbursement from any Federal health care program shall complete at least six hours of specific training in addition to the general training required above. The specific training for these Relevant Covered Persons shall include a discussion of the Policies and Procedures set forth in Section III.B applicable to the preparation or submission of claims and cost reports for reimbursement, including, but not limited to:

- a. the submission of accurate claims for services rendered to Federal health care program beneficiaries and claims for payment through the submission of cost reports and information forms;
- b. the personal obligation of each individual involved in the reimbursement process to ensure that the information provided is accurate;
- c. applicable state and federal reimbursement statutes, regulations, and program requirements and directives;
- d. the legal sanctions and consequences for improper submissions to Federal health care programs and improper contracting or financial arrangements;
- e. examples of proper and improper claim submission practices and examples of violations of the Anti-Kickback Statute and the Stark Law; and
- f. a review of AHC's contracting Policies and Procedures related to contracts with potential referral sources or referral recipients as developed pursuant to Section III.D and the personal obligation of each individual involved in the contracting process to know the legal requirements and policies of AHC.

Persons providing the training shall be knowledgeable about the subject area. Training may be provided either in person, via videoconference, teleconference, computer-based programs, or through applicable on-line programs.

Relevant Covered Persons shall receive this training within 30 days after the beginning of their employment or becoming Relevant Covered Persons or within 120 days after the Effective Date, whichever is later. A Relevant Covered Person who has completed the specific training shall review a new Relevant Covered Person's work, to the extent that the work relates to the delivery of patient care items or services and/or the preparation or submission of claims or cost reports for reimbursement from any Federal health care program, until such time as the new Relevant Covered Person completes his or her applicable training.

After receiving the initial training described in this Section, each Relevant Covered Person shall receive at least four hours of specific training annually. AHC shall annually review the training, and, where appropriate, update the training to reflect changes in Federal health care program requirements, any issues discovered during internal audits or IRO audits, and any other relevant information.

In addition, each Covered Facility shall conduct periodic training on an "as needed" basis (but at least semi-annually) on those quality of care issues identified by the Quality Assurance Committee and the Compliance Committee. In determining what training should be performed, these Committees shall review the complaints received, satisfaction surveys, staff turnover data, any state or Federal surveys, including those performed by the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO") or other such private agencies, any internal surveys, and the CHSRA quality indicators. Such training will be for a minimum of four hours total annually. Such training shall be provided to Relevant Covered Persons involved in the delivery of patient and resident care items or services.

Training provided to Relevant Covered Persons in the 90-day period prior to the Effective Date that satisfies the requirements of this Section III.C.2. shall be deemed to meet the time frame obligation imposed by this Section, but does not obviate the requirements for attendance certifications.

3. *Certification.* Each Relevant Covered Person and Covered Person who is required to attend training shall certify, in writing, that he or she has received the required training. The certification shall specify the type of training received and the date received. The Compliance Officer (or designee) shall retain the certifications, along with all course materials. These shall be made available to OIG, upon request.

4. *Exception for Contractors, Agents, and Third Parties.* With regard to training and certification for Covered Persons (including Relevant Covered Persons) who are contractors, agents, or third parties (referred to collectively in this Paragraph III.C.4 as “contractors”), AHC shall: (a) attempt to negotiate or renegotiate contracts with contractors to require such contractors to meet all of the training and certification requirements of this CIA; (b) make the general training and specific training, where appropriate, available to all contractors; and (c) use its best efforts to encourage contractors’ attendance and participation in the general and specific training. The Compliance Officer shall keep a record of all contractors’ participation in the general and specific training.

D. Contractual Compliance with the Anti-Kickback Statute and the Stark Law.

This Section shall apply to every arrangement or transaction that:

(1) (a) involves, directly or indirectly, the offer, payment, solicitation, or receipt of anything of value; and (b) is between AHC and any actual or potential source of health care business or referrals to AHC or any actual or potential recipient of health care business or referrals from AHC. The term “source” shall mean any physician, contractor, vendor, agent, or other person or entity in a position to generate or accept health care business or referrals. The term “health care business or referrals” shall be read to include referring, recommending, arranging for, ordering, leasing, or purchasing of any good, facility, item, or service for which payment may be made in whole or in part by a Federal health care program; or

(2) is between AHC and a physician (or a physician’s immediate family member (as defined at 42 C.F.R. § 411.351)) who makes a referral (as defined at 42 U.S.C. § 1395nn(h)(5)) to AHC for designated health services (as defined at 42 U.S.C. § 1395nn(h)(6)).

The arrangements and transactions described above, and the written versions thereof, are collectively referred to as “Arrangements.” The party(ies) to an Arrangement other than AHC shall be referred to herein as “Other Party(ies).”

Within 120 days after the Effective Date, AHC shall create procedures reasonably designed to ensure that each Arrangement does not violate the Anti-Kickback Statute and/or the Stark Law, and shall implement procedures to evaluate all existing

Arrangements, to the extent not already so evaluated, to determine whether such Arrangements violate the Anti-Kickback Statute and/or the Stark Law. AHC shall summarize all Arrangements in the form provided at Appendix E. AHC shall update the summary at Appendix E annually and shall submit the summary with each Annual Report.

Prior to entering into new Arrangements or renewing existing Arrangements, AHC shall ensure that all Arrangements are in compliance with the Anti-Kickback Statute and Stark Law, and the regulations, directives, and guidance related to these statutes, and comply with the following requirements:

1. The Arrangement shall be set forth in writing and signed by AHC and the Other Party(ies);
2. The Arrangement shall include a provision that all Covered Persons shall comply with AHC's Compliance Program, including the training related to the Anti-Kickback Statute and the Stark Law. Additionally, AHC shall provide each Other Party with a copy of its Code of Conduct and Stark and Anti-Kickback Policies and Procedures;
3. AHC and Other Party(ies) shall certify through the Arrangement, at the time of signing the Arrangement and upon contract renewal, that the Arrangement is not intended to generate referrals for services or supplies for which payment may be made in whole or in part under any Federal health care program; and
4. AHC shall require the Other Party(ies) to certify, at the time of signing the Arrangement, that the Other Party(ies) shall comply with AHC's compliance program and with the Anti-Kickback Statute and the Stark Law.

AHC shall retain and make available to OIG, upon request, copies of all Arrangements subject to this Section and, to the extent available, all non-privileged communications related to the Arrangements and the actual performance of the duties under the Arrangements. Nothing in this CIA, or any other communication or report made pursuant to this CIA, shall constitute a waiver by AHC of its attorney-client, attorney work-product, or other applicable privileges. Notwithstanding that fact, the existence of any such privilege shall not be used by AHC to avoid its obligations to comply with the provisions of this CIA.

E. Review Procedures.

1. *Quality Reviews.*

a. AHC Clinical Site Visits and Mock Surveys. AHC certifies to OIG that it currently utilizes two Clinical Service Teams (“CSTs”) to perform Clinical Site Visits of each Covered Facility at least once per month. Each CST is staffed by a Corporate Nurse Consultant (a Registered Nurse) and a Corporate Rehabilitation Consultant (a licensed therapist or therapy assistant) and performs on-site visits of approximately one-half of the Covered Facilities to evaluate the quality of care provided at each of those facilities. During each Clinical Site Visit, the CST reviews all secondary tracking, risk management meeting minutes, ten percent of resident records, and quality indicators. At the end of each Clinical Site Visit, the CST develops a Clinical Site Visit Report, containing the CST’s observations, any identified deficiencies, and recommendations, and discusses this Report with the facility’s Administrator and Director of Nursing. As necessary, the facility’s Administrator and Director of Nursing develop a Plan of Action to address any deficiencies identified by the CST. Any such Plan of Action is reviewed by the Regional Director of Operations and applicable CST prior to the next Quality Review.

In addition, the Corporate Nurse Consultant for Compliance, along with members of the CSTs, conducts Mock Surveys of each Covered Facility at least once annually. At the end of each Mock Survey, the Corporate Nurse Consultant for Compliance develops a Mock Survey Report, containing observations, any identified deficiencies, and recommendations from the Mock Survey, and discusses this Report with the appropriate Facility Administrator and Director of Nursing. The Corporate Nurse Consultant for Compliance also sends the Mock Survey Report to the appropriate Regional Director of Operations. As necessary, the Facility Administrator and Director of Nursing develop a Plan of Action to address any deficiencies identified in the Mock Survey.

AHC shall continue to conduct its Clinical Site Visits and Mock Surveys in the manner certified to OIG on the Effective Date or in a manner that devotes at least equal resources to performing the function of quality review at the Covered Facilities.

b. Reports to OIG. AHC shall notify OIG within 15 days after any material changes to the form, manner, or frequency of these Clinical Site Visits or Mock Surveys. AHC shall make available to OIG all Clinical Site Visit Reports, Mock Survey Reports, and Plans of Action. If requested by OIG, AHC shall participate in conference calls with OIG to discuss quality of care issues in the Covered Facilities. AHC shall provide OIG a report within 72 hours of any incident involving a patient's or resident's: (i) death or injury related to the use of restraints or psychotropic medications; (ii) suicide; (iii) death or injury related to abuse or neglect (as defined in the applicable federal guidelines). Each such report shall contain the full name, social security number, and date of birth of the resident, the date of incident, and a brief description of the events surrounding the incident.

c. Independent Quality Monitor. In the event OIG has reason to believe that there are quality of care issues at any Covered Facility that are not adequately addressed by AHC, OIG may, at its sole discretion, require AHC to appoint an independent quality monitor ("Monitor") for one or more of the Covered Facilities. AHC's selection of a Monitor shall be subject to OIG's approval, which shall not be unreasonably withheld.

If a Monitor is required pursuant to this Subsection, the terms and conditions of the Monitor's obligations and responsibilities, the Monitor's access to the Covered Facilities and documents related to patient care, and the obligations and responsibilities of AHC shall be determined by OIG and shall be consistent with other CIAs where OIG has required a Monitor.

Prior to requiring a Monitor, OIG shall notify AHC of its intent to do so and provide a written explanation of why OIG believes a Monitor

is necessary. Among the factors that the OIG will consider in making its determination to initially require, or to continue to require, a quality monitor are the following:

(i) the quality of care being rendered at the Covered Facilities, as measured by an analysis of the state survey and certification reports, the Minimum Data Set (MDS) reports, internal documents, and any other information available to make such an assessment;

(ii) whether any quality of care problems are systemic or widespread, as opposed to isolated incidents;

(iii) whether quality of care problems have led to actual harm or immediate jeopardy to patients or residents;

(iv) whether survey deficiencies concern potential violation of the requirements set forth in the regulations governing resident behavior and facility practices (42 C.F.R. § 483.13), quality of life (42 C.F.R. § 483.15), or quality of care (42 C.F.R. § 483.25);

(v) whether there are deficiencies with a scope and/or severity level of H, I, K, or L in the subject areas listed in the preceding paragraph;

(vi) whether the Covered Facilities exhibit systemic or repeated failure to meet survey standards for patient care;

(vii) whether a quality of care infrastructure has been put in place and is effective in identifying and responding to quality of care issues;

(viii) whether AHC is effective in determining the scope and severity of any quality of care problems;

(ix) whether AHC is able to create and implement effective corrective action plans;

(x) whether AHC is able to monitor those corrective action plans over time to determine their continued efficacy;

(xi) AHC's cooperation with the OIG in determining whether the terms of the CIA have been met and whether its patients and residents are receiving quality care; and

(xii) any other relevant factors relating to quality of care.

To resolve any concerns raised by OIG, AHC may request a meeting with OIG to discuss the results of any Quality Reviews or any other reports regarding quality of care at the Covered Facilities; present any additional or relevant information; or propose alternatives to the Monitor. AHC shall provide any additional information as may be requested by OIG under this Subsection in an expedited manner. OIG will meet with AHC if requested and will attempt in good faith to resolve any quality of care concerns with AHC prior to requiring a Monitor. However, the final determination as to whether or not to require a Monitor shall be made at the sole discretion of OIG.

If a Monitor is required pursuant to this Subsection, AHC will enter into a contract with the Monitor that establishes a cap on the dollar amount for the Monitor's fees and expenses. The Monitor may retain additional personnel, including, but not limited to, independent Consultants, if needed to help meet the Monitor's obligations under this CIA; however, the work of the additional personnel will be incorporated into the established cap. Failure to pay the Monitor within 30 calendar days of submission of an invoice for services previously rendered shall constitute a breach of the CIA and shall subject AHC to one or more of the remedies set forth in Section X.

2. Claims Review.

a. Retention of Independent Review Organization. Within 120 days after the Effective Date, AHC shall retain an entity (or entities), such

as an accounting, auditing, or consulting firm (hereinafter “Independent Review Organization” or “IRO”), to perform reviews to assist AHC in assessing and evaluating its billing and coding practices and certain other obligations pursuant to this CIA and the Settlement Agreement. Each IRO retained by AHC shall have expertise in the billing, coding, reporting, and other requirements of the particular section of the health care industry pertaining to this CIA, including, but not limited to, the MDS and RUGs, and in the general requirements of the Federal health care program(s) from which AHC seeks reimbursement. Each IRO shall assess, along with AHC, whether it can perform the IRO review in a professionally independent fashion taking into account any other business relationships or engagements that may exist. The IRO reviews shall address and analyze AHC’s billing and coding to the Federal health care programs (“Claims Review”) and, pursuant to Section III.E.2.c below, for the first Reporting Period shall analyze whether AHC sought payment for certain unallowable costs (“Unallowable Cost Review”).

b. Frequency of Claims Review. The Claims Review shall be performed annually and shall cover a review period as defined in Section 2.e of Appendix A to this CIA. The IRO(s) shall perform all components of each annual Claims Review as described in Appendix A to this CIA.

c. Frequency of Unallowable Cost Review. The IRO Review shall perform the Unallowable Cost Review for the first Reporting Period.

d. Retention of Records. The IRO and AHC shall retain and make available to OIG, upon request, all work papers, supporting documentation, correspondence, and draft reports (those exchanged between the IRO and AHC related to the reviews).

3. *Claims Review Process.* Each Claims Review shall include a Discovery Sample and, if necessary a Full Sample and a Systems Review. AHC facilities will be selected pursuant to procedures outlined in Section III.E.3.a below. The applicable definitions, procedures, and reporting requirements for the Claims Reviews are outlined in Appendix A to this CIA, which is incorporated by reference.

a. Selection Process. AHC will perform the Claims Review on a minimum of 15% of its Covered Facilities, but in no event less than three Covered Facilities. AHC will randomly select, in a statistically valid manner, these Covered Facilities using the following process:

(i) The Covered Facilities will be divided into two groups. Group A will include Covered Facilities with Medicare Net Revenue of greater than \$1,000,000 from the previous calendar year. Group B will include Covered Facilities which received Medicare Net Revenue of \$1,000,000 or less from the previous calendar year.

(ii) For each Claims Review, AHC will randomly select, in a statistically valid manner, from a pool of all Covered

Facilities at least two Covered Facilities from Group A and one Covered Facility from Group B. If more than three Covered Facilities are selected for the Claims Review, then the random selection of the Covered Facilities must utilize a ratio of two to one: two Covered Facilities from Group A for every one Covered Facility from Group B.

(iii) Each Covered Facility selected during the First Review Period or Subsequent Review Periods must be put back in the pool of Covered Facilities for selection of future reviews.

b. Discovery Sample.

i. The IRO shall randomly select and review a statistically valid random sample of a minimum of 50 Medicare Paid Claims submitted by or on behalf of each Covered Facility as selected pursuant to procedures in Section III.E.3.a above. If the reviewer chooses to stratify the Discovery Sample, the strata shall be determined prior to selecting the random sample of Paid Claims and an explanation of how the strata was determined shall be included in the Claims Review Report. The Paid Claims shall be reviewed based on the supporting documentation available at AHC or under AHC's control and applicable billing and coding regulations and

guidance to determine whether the claim submitted was correctly coded, submitted, and reimbursed.

ii. The IRO shall notify each Covered Facility of the Paid Claims that were selected for review. The IRO shall obtain all appropriate medical records, billing, and related supporting documentation. If the Covered Facility cannot produce the medical records or any other supporting documentation necessary to make an accurate claim determination, the IRO shall consider the relevant portion of the UB-92 which lacks proper documentation to be billed in error.

iii. The dollar difference (i.e., the amount that was paid versus the amount that should have been paid) will be determined for each Paid Claim.

(A) If the Error Rate (as defined in Appendix A) for the Discovery Sample is less than 5%, no additional sampling is required, nor is the Systems Review required. (Note: The threshold listed above does not imply that this is an acceptable error rate. Accordingly, AHC should, as appropriate, further analyze any errors identified in the Discovery Sample. AHC recognizes that OIG or another HHS component, in its discretion and as authorized by statute, regulation, or other appropriate authority may also analyze or review Paid Claims included, or errors identified, in the Discovery Sample.)

(B) If the Discovery Sample indicates that the Error Rate is 5% or greater, the IRO shall perform a Full Sample and Systems Review as described below.

c. Full Sample.

i. If necessary, as determined by procedures set forth in III.E.3.a the IRO shall perform an additional sample of Paid Claims using commonly accepted sampling methods and in

accordance with Appendix A.⁴ The Full Sample should be designed to (1) estimate the actual Overpayment in the population with a 90% confidence level and with a maximum relative precision of 25% of the point estimate and (2) conform with CMS's statistical sampling for overpayment estimation guidelines. The Full Sample should be selected from the applicable review period as described in Section A.2.d of Appendix A. The Paid Claims shall be reviewed based on supporting documentation available at AHC or under AHC's control and applicable billing and coding regulations and guidance to determine whether the claim submitted was correctly coded, submitted, and reimbursed. For purposes of calculating the size of the Full Sample, the Discovery Sample may serve as the probe sample, if statistically appropriate. Additionally, AHC may use the Items sampled as part of the Discovery Sample, and the corresponding findings for those 50 Items, as part of its Full Sample, if statistically appropriate. OIG, in its full discretion, may refer the findings of the Full Sample (and any related workpapers) received from AHC to the appropriate Federal health care program payor, including the Medicare contractor (e.g., carrier, fiscal intermediary, or DMERC), for appropriate follow-up by that payor. Within 15 days of any such referral, OIG shall notify AHC that a referral has been made.

c. Conducting the Claims Review.

i. For each UB-92 (Paid Claim) in the Discovery Sample and/or Full Sample, the IRO shall review each MDS and the associated medical record documentation supporting the MDS. The review process shall entail an evaluation of each MDS and verification that each entry that affects the RUG code outcome for the MDS is supported by the medical record for the corresponding period of time consistent with the assessment reference date ("ARD") specified on the MDS.

⁴The IRO shall conduct the Full Sample for each individual Covered Facility for which of the Discovery Sample's Error Rate was 5% or greater.

ii. The IRO shall perform an evaluation of the data on the UB-92 and determine whether the variables that affect the RUG assignment outcome for each MDS are supported by the medical record for the corresponding time period consistent with the assessment reference date specified in the MDS. This shall include the following issues:

(A) The accuracy of the MDS coding and the resulting RUG category selection based on the documentation within the medical record. Documentation in the medical record should support the following:

- accuracy of assessment reference date;
- activities of daily living and the look-back period used;
- special treatments and procedures along with the look-back periods;
- nursing restorative with look-back periods;
- supplement for PPS with look-back periods used (e.g., estimated therapies and minutes for the 5-Day MDS); and
- resulting RUG category.

(B) The demonstration of medical necessity in the medical record by verifying the presence of physician orders for the services reflected as necessary in the MDS;

(C) The accuracy of the associated UB-92s. At a minimum these claims shall be reviewed for the following:

- coverage period;
- revenue codes;
- HIPPS codes (RUG categories and the modifiers for assessment type); and
- units of service.

iii. In those cases where an incorrect MDS has been identified, the IRO shall re-enter data from that MDS into grouper software to verify that the correct RUG code assignment was properly assigned on the UB-92. If an incorrect RUG code was assigned, this shall be considered an error.

iv. If there is insufficient support for an MDS data point(s) that results in a downward change in RUG assignment, the IRO should consider the dollar difference to be an Overpayment.

v. If an incorrect RUG was used, but it did not result in an Overpayment, it will be noted in the Claims Review Report.

d. Claims Review Report. The IRO shall prepare a report based upon each Claims Review performed for each Covered Facility the IRO reviewed (the "Claims Review Report"). Information to be included in the Claims Review Report is detailed in Appendix A.

e. Systems Review. If the Discovery Sample for any Covered Facility selected for review identifies an Error Rate of 5% or greater, then AHC's IRO shall perform a systems review ("Systems Review") at that facility. The Systems Review shall include testing or verification of AHC's systems, processes and/or operations as described below for each Paid Claim that resulted in an Overpayment in the Discovery Sample or Full Sample ("Overpayment Claim"). The Systems Review shall consist of a thorough review and inquiry of the following:

i. AHC's documentation, coding, billing, and reporting operations relating to the Overpayment Claim. As part of this review, the IRO is expected to evaluate the presence, application, and adequacy of:

(A) AHC's billing and medical record documentation and coding process;

(B) AHC's billing policies and procedures to ensure proper coding and billing;

(C) AHC's internal controls to ensure accurate coding and claims submission;

(D) AHC's reporting operations or mechanisms that ensure appropriate communication between AHC and its fiscal intermediaries; and

(E) corrective action plans to correct any inaccurate coding or billing processes or individual claim forms.

ii. For each Overpayment Claim, the IRO shall make a report to AHC (and to OIG as described below) that shall include the IRO's recommendations to correct the identified deficiency. In addition, for each Overpayment Claim the IRO shall test the applicable AHC system(s) to ensure the potential deficiency is not a systemic problem. AHC will correct any identified deficiency within three months of the discovery of the deficiency or will provide OIG with a reason why it cannot correct the deficiency within that time frame. AHC will report its findings regarding any potential deficiencies and corrective actions in its Systems Review Report.

f. Systems Review Report. The IRO shall prepare a report based upon each Systems Review performed ("Systems Review Report"). Information to be included in the Systems Review Report is detailed in Appendix A.

g. Repayment of Identified Overpayments. In accordance with Section III.J.1, AHC agrees to repay within 30 days any Overpayment(s) identified in the Discovery Sample or the Full Sample (if applicable), regardless of the Error Rate, to the appropriate payor and in accordance with payor refund policies. AHC agrees to make available to OIG any and all documentation that reflects the refund of the Overpayment(s) to the payor and the associated documentation. Any dispute between AHC and the IRO

with regard to any Overpayment shall be disclosed to OIG and resolved in coordination with the payor and in accordance with the payor's policies.

4. *Unallowable Cost Review and Report.* The IRO shall conduct a review of AHC's compliance with the unallowable cost provisions of the Settlement Agreement. The IRO shall determine whether AHC has complied with its obligations not to charge to, or otherwise seek payment from, federal or state payors for unallowable costs (as defined in the Settlement Agreement) and its obligation to identify to applicable federal or state payors any unallowable costs included in payments previously sought from the United States, or any state Medicaid program. This unallowable cost analysis shall include, but not be limited to, payments sought in any cost reports, cost statements, information reports, or payment requests already submitted by AHC or any of its subsidiaries. To the extent that such cost reports, cost statements, information reports, or payment requests, even if already settled, have been adjusted to account for the effect of the inclusion of the unallowable costs, the IRO shall determine if such adjustments were proper. In making this determination, the IRO may need to review cost reports and financial statements from the year in which the Settlement Agreement was executed, as well as from previous years.

The IRO shall prepare a report based upon the Unallowable Cost Review performed. The Unallowable Cost Review Report shall include the IRO's findings and supporting rationale regarding the Unallowable Cost Review and whether AHC has complied with its obligation not to charge to, or otherwise seek payment from, Federal or State payors for unallowable costs (as defined in the Settlement Agreement) and its obligation to identify to applicable Federal or State payors any unallowable costs included in payments previously sought from such payor.

5. *Validation Review.* In the event OIG has reason to believe that: (a) AHC's Claims Review or Unallowable Cost Review fails to conform to the requirements of this CIA; or (b) the IRO's findings or Claims Review results are inaccurate, OIG may, at its sole discretion, conduct its own review to determine whether the Claims Review or Unallowable Cost Review complied with the requirements of the CIA and/or the IRO's findings or Claims Review results are inaccurate ("Validation Review"). AHC shall pay for the reasonable cost of any such review performed by OIG or any of its designated agents so long as it is initiated within year after AHC's final submission (as described in Section II) is received by OIG.

Prior to initiating a Validation Review, OIG shall notify AHC of its intent to do so and provide a written explanation of why OIG believes such a review is necessary. To resolve any concerns raised by OIG, AHC may request a meeting with OIG to discuss the results of any Claims Review or Unallowable Cost Review claims or findings; present any additional or relevant information to clarify the results of the Claims Review or Unallowable Cost Review or to correct the inaccuracy of the Claims Review; or propose alternatives to the proposed Validation Review. AHC shall provide any additional information as may be requested by OIG under this Section in an expedited manner. OIG will attempt in good faith to resolve any Claims Review or Unallowable Cost Review with AHC prior to conducting a Validation Review. However, the final determination as to whether or not to proceed with a Validation Review shall be made at the sole discretion of OIG.

6. *Independence Certification.* The IRO shall include in its report(s) to AHC a certification or sworn affidavit that it has evaluated its professional independence with regard to the Claims Review or Unallowable Cost Review and that it has concluded that it was, in fact, independent.

F. Disclosure Program.

AHC represents that it has established a toll-free hotline for AHC employees, residents, and patients to report complaints, comments, or concerns to AHC's administration. To the extent that AHC's hotline does not meet the requirements of this Section, within 120 days after the Effective Date, AHC shall expand the hotline program to establish a confidential Disclosure Program, as follows. The Disclosure Program must include a mechanism (e.g., a toll-free compliance telephone line) to enable employees, contractors, agents, patients, residents, family members, or other individuals to disclose, to the Compliance Officer or some other person who is not in the disclosing individual's chain of command, any identified issues or questions associated with AHC's policies, conduct, practices, or procedures with respect to quality of care or a Federal health care program, believed by the individual to be a potential violation of criminal, civil, or administrative law or the applicable standard of care. AHC shall appropriately publicize the existence of the disclosure mechanism (e.g., via periodic e-mails to employees), and shall post notices of its existence prominently in the lobby and gathering areas (e.g., dining rooms, activity rooms, waiting rooms) of each of the Covered Facilities.

The Disclosure Program shall emphasize a non-retribution, non-retaliation policy, and shall include a reporting mechanism for anonymous communications for which

appropriate confidentiality shall be maintained. Upon receipt of a disclosure, the Compliance Officer (or designee) shall gather all relevant information from the disclosing individual. The Compliance Officer (or designee) shall make a preliminary, good faith inquiry into the allegations set forth in every disclosure to ensure that he or she has obtained all of the information necessary to determine whether a further review should be conducted. For any disclosure that is sufficiently specific so that it reasonably:

- (1) permits a determination of the appropriateness of the alleged improper practice; and
- (2) provides an opportunity for taking corrective action, AHC shall conduct an internal review of the allegations set forth in such a disclosure and ensure that proper follow-up is conducted, including that the inappropriate or improper practice ceases immediately.

The Compliance Officer (or designee) shall maintain a disclosure log, which shall include a record and summary of each disclosure received (whether anonymous or not), the status of the respective internal reviews, and any corrective action taken in response to the internal reviews. The disclosure log shall be available to OIG, upon request.

G. Temporary Staff Requirements

“Temporary Staff” includes any staff, part-time employees, or pool employees retained to work at AHC on a contractual basis or otherwise for 160 hours or less out of any consecutive 52-week period during the term of this CIA. Temporary staff who work greater than 160 hours are required to fulfill all obligations required of Covered Persons. Within 5 business days of commencing work for AHC, AHC shall obtain written documentation from its Temporary Staff showing:

1. *Code of Conduct.* That the Temporary Staff has received and read AHC’s Code of Conduct and that the Temporary Staff understands that AHC’s Code of Conduct applies to the Temporary Staff.

2. *Policies and Procedures.* That the Temporary Staff has received and read all of AHC’s Policies and Procedures, if any, applicable to the job functions for which the Temporary Staff has been engaged.

3. *Disclosure Program.* That the Temporary Staff has received notice of, and education on, the appropriate use of the Disclosure Program.

4. *General and Specific Training.* That the Temporary Staff has received appropriate training for the services for which the Temporary Staff has been engaged by

AHC. Except as provided in this Section, Temporary Staff are not required to receive either General or Specific training required by this CIA, provided AHC obtains and maintains all documentation evidencing compliance with this Section III.G.

H. Ineligible Persons.

1. *Definition.* For purposes of this CIA, an “Ineligible Person” shall be an individual or entity who: (a) is currently excluded, debarred, suspended, or otherwise ineligible to participate in the Federal health care programs or in Federal procurement or non-procurement programs; or (b) has been convicted of a criminal offense that falls within the ambit of 42 U.S.C. § 1320a-7(a), but has not yet been excluded, debarred, suspended, or otherwise declared ineligible.

2. *Screening Requirements.* AHC shall not hire as employees or engage as contractors any Ineligible Person. To prevent hiring or contracting with any Ineligible Person, AHC shall screen all prospective employees and prospective contractors prior to engaging their services by: (a) requiring applicants to disclose whether they are Ineligible Persons; and (b) appropriately querying the General Services Administration’s List of Parties Excluded from Federal Programs (available through the Internet at <http://epls.arnet.gov>) and the HHS/OIG List of Excluded Individuals/Entities (available through the Internet at <http://oig.hhs.gov>) (these lists shall hereinafter be referred to as the “Exclusion Lists”). Nothing in this Section affects the responsibility of (or liability for) AHC to refrain from billing Federal health care programs for services of the Ineligible Person.

3. *Review and Removal Requirement.* Within 120 days after the Effective Date, AHC shall review its list of current employees and contractors against the Exclusion Lists. Thereafter, AHC shall review its list of current employees and contractors against the Exclusion Lists semi-annually. In addition, AHC shall require employees and contractors to disclose immediately any debarment, exclusion, suspension, or other event that makes the employee an Ineligible Person.

If AHC has actual notice that an employee or contractor has become an Ineligible Person, AHC shall remove such person from responsibility for, or involvement with, AHC’s business operations related to the Federal health care programs and shall remove such person from any position for which the person’s compensation or the items or services rendered, ordered, or prescribed by the person are paid in whole or part, directly or indirectly, by Federal health care programs or otherwise with Federal funds at least

until such time as the person is reinstated into participation in the Federal health care programs.

4. *Pending Charges and Proposed Exclusions.* If AHC has actual notice that an employee or contractor is charged with a criminal offense related to any Federal health care program, or is proposed for exclusion during his or her employment or contract term, AHC shall take all appropriate actions to ensure that the responsibilities of that employee or contractor have not and shall not adversely affect the quality of care rendered to any beneficiary, patient, or resident, or the accuracy of any claims submitted to any Federal health care program.

5. *Criminal Background Checks.* AHC shall ensure that it: (a) complies with all federal and state requirements regarding criminal background checks for Covered Persons; (b) prior to extending an offer of employment, obtains a sworn statement from each applicant that the applicant does not have any criminal convictions or pending criminal charges (see, Virginia Code § 32.1-126.01); (c) within ten days after employment begins, obtains the results of a criminal background check for any individual who will be in a position that involves patient or resident care; and (d) if the results of the criminal background check indicate that the employee is not eligible for continued employment, AHC shall immediately dismiss the employee and notify OIG within ten days of such dismissal.

6. *Role of William C. Cranwell.* As stated in Section I, William C. Cranwell is excluded from Medicare, Medicaid, and other Federal health care programs for a period of twenty years. OIG affirms that the operation of the Covered Facilities owned or operated, directly or indirectly, by William Cranwell should continue, pursuant to the terms of this CIA and the Trust, for the benefit of the residents and patients of these facilities. On January 15, 2002, William Cranwell entered into the WCC Blind Trust Agreement (which is the predecessor to the Second WCC Blind Trust Agreement at Exhibit A), under which an appointed trustee has accepted assignment of William Cranwell's right, title, and interest in any entity owned, directly or indirectly, by William Cranwell or operated by a company owned, directly or indirectly, by William Cranwell that receives Federal health care program reimbursement. The terms and conditions of the Trust shall be as set forth in the Blind Trust Agreement, attached as Exhibit A and as may be amended, and as set forth in Appendix C. If there is any inconsistency, now or in the future, between Appendix C and Exhibit A, Appendix C shall control.

I. Notification of Government Investigation or Legal Proceedings.

Within 30 days after discovery, AHC shall notify OIG, in writing, of any ongoing investigation known to AHC or legal proceeding conducted or brought by a governmental entity or its agents involving an allegation that AHC has committed a crime or has engaged in fraudulent activities. This notification shall include a description of the allegation, the identity of the investigating or prosecuting agency, and the status of such investigation or legal proceeding. AHC shall also provide written notice to OIG within 30 days after the resolution of the matter, and shall provide OIG with a description of the findings and/or results of the proceedings, if any.

In addition, within 15 days after notification, AHC shall notify OIG, in writing, of any adverse final determination made by a Federal, State or local Government agency or accrediting or certifying agency (e.g., JCAHO) regarding quality of care issues.

J. Reporting.

1. *Overpayments*

a. Definition of Overpayments. For purposes of this CIA, an “Overpayment” shall mean the amount of money AHC has received in excess of the amount due and payable under any Federal health care program requirements.

b. Reporting of Overpayments. If, at any time, AHC identifies or learns of any Overpayment, AHC shall notify the payor (e.g., Medicare fiscal intermediary or carrier) within 30 days after identification of the Overpayment and take remedial steps within 60 days after identification (or such additional time as may be agreed to by the payor) to correct the problem, including preventing the underlying problem and the Overpayment from recurring. Also, within 30 days after identification of the Overpayment, AHC shall repay the Overpayment to the appropriate payor to the extent such Overpayment has been quantified by that date. If not yet quantified, within 30 days after identification, AHC shall notify the payor of its efforts to quantify the Overpayment amount along with a schedule of when such work is expected to be completed. Notification and repayment to the payor shall be done in accordance with the payor’s

policies, and for Medicare contractors, shall include the information contained on the Overpayment Refund Form, provided as Appendix D to this CIA. Notwithstanding the above, notification and repayment of any Overpayment amount that routinely is reconciled or adjusted pursuant to policies and procedures established by the payor should be handled in accordance with such policies and procedures.

2. *Material Deficiencies.*

a. Definition of Material Deficiency. For purposes of this CIA, a “Material Deficiency” means anything that involves:

- i. a substantial Overpayment;
- ii. a matter that a reasonable person would consider a probable violation of criminal, civil, or administrative laws applicable to any Federal health care program for which penalties or exclusion may be authorized; or
- iii. a violation of the obligation to provide items or services of a quality that meets professionally recognized standards of health care where such violation has occurred in one or more instances and presents an imminent danger to the health, safety, or well-being of a Federal health care program beneficiary or places the beneficiary unnecessarily in high-risk situations.

A Material Deficiency may be the result of an isolated event or a series of occurrences.

b. Reporting of Material Deficiencies. If AHC determines through any means that there is a Material Deficiency, AHC shall notify OIG, in writing, within 30 days after making the determination that the Material Deficiency exists. The report to OIG shall include the following information, to the extent that such information is available to AHC at the time the report is submitted (if such

information is not available at the time the report is submitted, AHC shall forward it to OIG as soon as it becomes available):

i. If the Material Deficiency results in an Overpayment, the report to OIG shall be made at the same time as the notification to the payor required in Section III.J.1, and shall include all of the information on the Overpayment Refund Form, as well as:

(A) the payor's name, address, and contact person to whom the Overpayment was sent; and

(B) the date of the check and identification number (or electronic transaction number) by which the Overpayment was repaid/refunded;

ii. a complete description of the Material Deficiency, including the relevant facts, persons involved, and legal and Federal health care program authorities implicated;

iii. a description of AHC's actions taken to correct the Material Deficiency; and

iv. any further steps AHC plans to take to address the Material Deficiency and prevent it from recurring.

IV. NEW BUSINESS UNITS OR LOCATIONS

In the event that, after the Effective Date and if permitted pursuant to the Trust, AHC changes locations or sells, closes, purchases, or establishes a new business unit or location related to the furnishing of items or services that may be reimbursed by Federal health care programs, AHC shall notify OIG of this fact as soon as possible, but no later than within 30 days after the date of change of location, sale, closure, purchase, or establishment. This notification shall include the address of the new business unit or location, phone number, fax number, Medicare provider number (if any), and the corresponding contractor's name and address that has issued each Medicare provider number. All Covered Persons at each such new business unit or location shall be subject

to the applicable requirements in this CIA (e.g., completing certifications and undergoing training).

V. IMPLEMENTATION AND ANNUAL REPORTS

A. Implementation Report. Within 150 days after the Effective Date, AHC shall submit a written report to OIG summarizing the status of its implementation of the requirements of this CIA. This Implementation Report shall include:

1. the name, address, phone number, and position description of the Compliance Officer required by Section III.A, and a summary of other non-compliance job responsibilities the Compliance Officer may have;
2. the names and positions of the members of the Committees required by Section III.A;
3. a copy of AHC's Code of Conduct required by Section III.B.1;
4. a copy of all Policies and Procedures required by Section III.B.2;
5. a copy of all training materials used for the training required by Section III.C, a description of such training, including a description of the targeted audiences, length of sessions, which sessions were mandatory and for whom, percentage of attendance, and a schedule of when the training sessions were held;
6. a certification by the Compliance Officer that:
 - a. the Policies and Procedures required by Section III.B have been developed, are being implemented, and have been distributed to all appropriate Covered Persons;
 - b. all Covered Persons have completed the Code of Conduct certification required by Section III.B.1; and
 - c. all Covered Persons (including Relevant Covered Persons) have completed the applicable training and executed the certification(s) required by Section III.C.

Any exception to this certification shall be set forth and explained in detail. The documentation supporting this certification shall be available to OIG, upon request.

7. a description of the Disclosure Program required by Section III.F;
8. the identity of the IRO(s), a summary/description of all engagements between AHC and the IRO(s) including, but not limited to, any outside financial audits or reimbursement consulting, and the proposed start and completion dates of the Claims Review and Unallowable Cost Review;
9. certifications from the IRO(s) regarding its professional independence from AHC;
10. a summary of personnel actions (other than hiring) taken pursuant to Section III.H;
11. to the extent that Appendix B has changed, a list of all of AHC's locations (including locations and mailing addresses), the corresponding name under which each location is doing business, the corresponding phone numbers and fax numbers, each location's Medicare provider identification number(s), and the name and address of the Medicare contractor to which AHC currently submits claims;
12. the information required by Section III.D, in the form provided at Appendix E;
13. a description of AHC's corporate structure, including identification of any parent and sister companies and subsidiaries and their respective lines of business; and
14. the certification required by Section V.C.

B. Annual Reports. AHC shall submit to OIG Annual Reports with respect to the status of, and findings regarding, AHC's compliance activities for each of the five Reporting Periods.

Each Annual Report shall include:

1. any change in the identity, position description, or other noncompliance job responsibilities of the Compliance Officer and any change in the membership of the Committees described in Section III.A;
2. a certification by the Compliance Officer that:
 - a. all Covered Persons have completed any Code of Conduct certifications required by Section III.B.1;
 - b. all Covered Persons (including Relevant Covered Persons) have completed the applicable training and executed the certification(s) required by Section III.C;
 - c. AHC has complied with its obligations under the Settlement Agreement: (i) not to resubmit to any Federal health care program payors any previously denied claims related to the Covered Conduct addressed in the Settlement Agreement, and not to appeal any such denials of claims; (ii) not to charge to or otherwise seek payment from Federal or State payors for unallowable costs (as defined in the Settlement Agreement); and (iii) to identify and adjust any past charges or claims for unallowable costs;
 - d. AHC has effectively implemented all plans of correction related to problems identified under this CIA, AHC's Compliance Program, or any internal audits.

Any exception to this certification shall be set forth and explained in detail. The documentation supporting this certification shall be available to OIG, upon request.

3. a summary of any significant changes or amendments to the Policies and Procedures required by Section III.B and the reasons for such changes (e.g., change in contractor policy) and copies of any compliance-related Policies and Procedures;

4. AHC's response and corrective action plan(s) related to any issues raised by the Clinical Site Visits or Mock Surveys;
5. a copy of all training materials used for the training required by Section III.C (to the extent it has not already been provided as part of the Implementation Report), a description of such training conducted during the Reporting Period, including a description of the targeted audiences, length of sessions, which sessions were mandatory and for whom, percentage of attendance, and a schedule of when the training sessions were held;
6. a complete copy of all reports prepared pursuant to the IRO(s)' Claims Review (and Systems Review, if applicable) and Unallowable Cost Review, including a copy of the methodology used, along with a copy of the IRO's engagement letter;
7. AHC's response and corrective action plan(s) related to any issues raised by the IRO(s);
8. a revised summary/description of all engagements between AHC and the IRO, including, but not limited to, any outside financial audits, compliance program engagements, or reimbursement consulting, if different from what was submitted as part of the Implementation Report;
9. certifications from the IRO regarding its professional independence from AHC;
10. a summary of Material Deficiencies (as defined in Section III.J) identified during the Reporting Period and the status of any corrective and preventative action relating to all such Material Deficiencies;
11. a report of the aggregate Overpayments that have been returned to the Federal health care programs. Overpayment amounts shall be broken down into the following categories: inpatient Medicare, outpatient Medicare, Medicaid (report each applicable state separately, if applicable), and other Federal health care programs. Overpayment amounts that are routinely reconciled or adjusted pursuant to policies and procedures established by the payor do not need to be included in this aggregate Overpayment report;

12. a summary of the disclosures in the disclosure log required by Section III.F that: (a) relate to Federal health care programs; or (b) allege abuse or neglect of patients and residents;
13. a description of any personnel actions (other than hiring) taken by AHC as a result of the obligations in Section III.H, and the name, title, and responsibilities of any person who is determined to be an Ineligible Person under Section III.H, and the actions taken in response to the obligations set forth in that Section;
14. a summary describing any ongoing investigation or legal proceeding required to have been reported pursuant to Section III.I. The summary shall include a description of the allegation, the identity of the investigating or prosecuting agency, and the status of such investigation or legal proceeding;
15. a description of all changes to the most recently provided list (as updated) of AHC's locations (including addresses) as required by Section V.A.11, the corresponding name under which each location is doing business, the corresponding phone numbers and fax numbers, each location's Medicare provider number(s), and the contractor name and address that issued each Medicare provider number;
16. the updated information required by Section III.D, in the form provided at Appendix E;
17. the certification required by Section V.C; and
18. the certifications and reports required by Appendix C, Paragraph 5.

The first Annual Report shall be received by OIG no later than 60 days after the end of the first Reporting Period. Subsequent Annual Reports shall be received by OIG no later than the anniversary date of the due date of the first Annual Report.

C. Certifications. The Implementation Report and Annual Reports shall include certifications by the Compliance Officer and AHC's President and Chief Executive Officer that: (1) to the best of his or her knowledge, AHC is in compliance with all of the requirements of this CIA, except as otherwise described in the applicable report; and (2) he or she has reviewed the Report and has made reasonable inquiry regarding its content

and believes that, upon such inquiry, the information is accurate and truthful. Each Report shall also include a certification from the Trustee (as defined in the Blind Trust Agreement) that he or she has reviewed the Annual Report and agrees with the statements made therein.

D. Designation of Information: AHC shall clearly identify any portions of its submissions that it believes are trade secrets, or information that is commercial or financial and privileged or confidential, and therefore potentially exempt from disclosure under the Freedom of Information Act (“FOIA”), 5 U.S.C. § 552. AHC shall refrain from identifying any information as exempt from disclosure if that information does not meet the criteria for exemption from disclosure under FOIA.

VI. NOTIFICATIONS AND SUBMISSION OF REPORTS

Unless otherwise stated in writing after the Effective Date, all notifications and reports required under this CIA shall be submitted to the following entities:

OIG: Administrative and Civil Remedies Branch
Office of Counsel to the Inspector General
Office of Inspector General
U.S. Department of Health and Human Services
Cohen Building, Room 5527
330 Independence Avenue, S.W.
Washington, D.C. 20201
Phone: 202.619.2078
Facsimile: 202.205.0604

AHC: David W. Tucker
President and Chief Executive Officer
American HealthCare, LLC
2965 Colonnade Drive, Suite 200
Roanoke, VA 24018-3541
Phone: 540-774-4263
Facsimile: 540-774-0831

Trustee: William Hopkins, Sr., Esq.
Martin, Hopkins & Lemon, P.C.
1000 First Union Tower

10 South Jefferson Street
Roanoke, VA 24011-1314
Phone: 540.982.1000
Facsimile: 540.982.2015

Unless otherwise specified, all notifications and reports required by this CIA may be made by certified mail, overnight mail, hand delivery, or other means, provided that there is proof that such notification was received. For purposes of this requirement, internal facsimile confirmation sheets do not constitute proof of receipt.

VII. OIG INSPECTION, AUDIT AND REVIEW RIGHTS

In addition to any other rights OIG may have by statute, regulation, or contract, OIG or its duly authorized representative(s) may examine or request copies of AHC's books, records, and other documents and supporting materials and/or conduct on-site reviews of any of AHC's locations for the purpose of verifying and evaluating: (a) AHC's compliance with the terms of this CIA; and (b) AHC's compliance with the requirements of the Federal health care programs in which it participates. The documentation described above shall be made available by AHC to OIG or its duly authorized representative(s) at all reasonable times for inspection, audit, or reproduction. Furthermore, for purposes of this provision, OIG or its duly authorized representative(s) may interview any of AHC's employees, contractors, or agents who consent to be interviewed at the individual's place of business during normal business hours or at such other place and time as may be mutually agreed upon between the individual and OIG. AHC shall assist OIG or its duly authorized representative(s) in contacting and arranging interviews with such individuals upon OIG's request. AHC's employees may elect to be interviewed with or without a representative of AHC present.

VIII. DOCUMENT AND RECORD RETENTION

AHC shall maintain for inspection all documents and records relating to reimbursement from the Federal health care programs, or to compliance with this CIA, for six years (or longer if otherwise required by law).

IX. DISCLOSURES

Consistent with HHS's FOIA procedures, set forth in 45 C.F.R. Part 5, OIG shall make a reasonable effort to notify AHC prior to any release by OIG of information

submitted by AHC pursuant to its obligations under this CIA and identified upon submission by AHC as trade secrets, or information that is commercial or financial and privileged or confidential, under the FOIA rules. With respect to such releases, AHC shall have the rights set forth at 45 C.F.R. § 5.65(d).

X. BREACH AND DEFAULT PROVISIONS

AHC is expected to fully and timely comply with all of its CIA obligations.

A. Stipulated Penalties for Failure to Comply with Certain Obligations. As a contractual remedy, AHC and OIG hereby agree that failure to comply with certain obligations set forth in this CIA may lead to the imposition of the following monetary penalties (hereinafter referred to as “Stipulated Penalties”) in accordance with the following provisions.

1. A Stipulated Penalty of \$2,500 (which shall begin to accrue on the day after the date the obligation became due) for each day AHC fails to have in place any of the obligations described in Section III:

- a. a Compliance Officer;
- b. a Compliance Committee;
- c. a Quality Assurance Committee;
- d. a written Code of Conduct;
- e. written Policies and Procedures;
- f. a requirement that Covered Persons (including Relevant Covered Persons) be trained; and
- g. a Disclosure Program.

2. A Stipulated Penalty of \$2,500 (which shall begin to accrue on the day after the date the obligation became due) for each day AHC fails to retain an IRO, as required in Section III.E.

3. A Stipulated Penalty of \$2,500 (which shall begin to accrue on the day after the date the obligation became due) for each day AHC fails to meet any of the deadlines for the submission of the Implementation Report, the Annual Reports, or the reports required under Paragraph 5 of Appendix C to OIG.

4. A Stipulated Penalty of \$2,000 (which shall begin to accrue on the date the failure to comply began) for each day AHC employs or contracts with an Ineligible Person and that person: (a) has responsibility for, or involvement with, AHC's business operations related to the Federal health care programs; or (b) is in a position for which the person's salary or the items or services rendered, ordered, or prescribed by the person are paid in whole or part, directly or indirectly, by Federal health care programs or otherwise with Federal funds (the Stipulated Penalty described in this Subsection shall not be demanded for any time period during which AHC can demonstrate that it did not discover the person's exclusion or other ineligibility after making a reasonable inquiry (as described in Section III.H) as to the status of the person).

5. A Stipulated Penalty of \$1,500 for each day AHC fails to grant access to the information or documentation as required in Section VII. (This Stipulated Penalty shall begin to accrue on the date AHC fails to grant access.)

6. A Stipulated Penalty of \$1,000 for each day AHC fails to comply fully and adequately with any obligation of this CIA. In its notice to AHC, OIG shall state the specific grounds for its determination that AHC has failed to comply fully and adequately with the CIA obligation(s) at issue and steps AHC shall take to comply with the CIA. (This Stipulated Penalty shall begin to accrue 10 days after AHC receives notice from OIG of the failure to comply.) A Stipulated Penalty as described in this Subsection shall not be demanded for any violation for which OIG has sought a Stipulated Penalty under Subsections 1-5 of this Section.

B. Timely Written Requests for Extensions. AHC may, in advance of the due date, submit a timely written request to OIG for an extension of time to perform any act or file any notification or report required by this CIA. Notwithstanding any other provision in this Section, if OIG grants the timely written request with respect to an act, notification, or report, Stipulated Penalties for failure to perform the act or file the notification or report shall not begin to accrue until one day after AHC fails to meet the revised deadline set by OIG. Notwithstanding any other provision in this Section, if OIG denies such a timely written request, Stipulated Penalties for failure to perform the act or file the notification or report shall not begin to accrue until three business days after AHC

receives OIG's written denial of such request or the original due date, whichever is later. A "timely written request" is defined as a request in writing received by OIG at least five business days prior to the date by which any act is due to be performed or any notification or report is due to be filed.

C. Payment of Stipulated Penalties.

1. *Demand Letter.* Upon a finding that AHC has failed to comply with any of the obligations described in Section X.A and after determining that Stipulated Penalties are appropriate, OIG shall notify AHC of: (a) AHC's failure to comply; and (b) OIG's exercise of its contractual right to demand payment of the Stipulated Penalties (this notification is hereinafter referred to as the "Demand Letter").

2. *Response to Demand Letter.* Within 10 days after the receipt of the Demand Letter, AHC shall either: (a) cure the breach to OIG's satisfaction and pay the applicable Stipulated Penalties; or (b) request a hearing before an HHS administrative law judge ("ALJ") to dispute OIG's determination of noncompliance, pursuant to the agreed upon provisions set forth below in Section X.E. In the event AHC elects to request an ALJ hearing, the Stipulated Penalties shall continue to accrue until AHC cures, to OIG's satisfaction, the alleged breach in dispute. Failure to respond to the Demand Letter in one of these two manners within the allowed time period shall be considered a Material Breach of this CIA and shall be grounds for exclusion under Section X.D.

3. *Form of Payment.* Payment of the Stipulated Penalties shall be made by certified or cashier's check, payable to: "Secretary of the Department of Health and Human Services," and submitted to OIG at the address set forth in Section VI.

4. *Independence from Material Breach Determination.* Except as set forth in Section X.D.1.c, these provisions for payment of Stipulated Penalties shall not affect or otherwise set a standard for OIG's decision that AHC has materially breached this CIA, which decision shall be made at OIG's discretion and shall be governed by the provisions in Section X.D, below.

D. Exclusion for Material Breach of this CIA

1. *Definition of Material Breach.* A Material Breach of this CIA means:

- a. a failure by AHC to report a Material Deficiency, take corrective action, and make the appropriate refunds, as required in Section III.J;
- b. a repeated or flagrant violation of the obligations under this CIA, including, but not limited to, the obligations addressed in Section X.A;
- c. a failure to respond to a Demand Letter concerning the payment of Stipulated Penalties in accordance with Section X.C;
- d. a failure to retain and use an IRO in accordance with Section III.E;
- e. violation of the terms and conditions of the Trust in accordance with Section III.H.6; or
- f. a failure to meet an obligation under the CIA that has a material impact on the quality of care rendered to any residents and patients of AHC.

2. *Notice of Material Breach and Intent to Exclude.* The parties agree that a Material Breach of this CIA by AHC constitutes an independent basis for AHC's exclusion from participation in the Federal health care programs. Upon a determination by OIG that AHC has materially breached this CIA and that exclusion is the appropriate remedy, OIG shall notify AHC of: (a) AHC's Material Breach; and (b) OIG's intent to exercise its contractual right to impose exclusion (this notification is hereinafter referred to as the "Notice of Material Breach and Intent to Exclude"). The exclusion may be directed at AHC or one or more of the Covered Facilities, depending upon the facts of the breach.

3. *Opportunity to Cure.* AHC shall have 30 days from the date of receipt of the Notice of Material Breach and Intent to Exclude to demonstrate to OIG's satisfaction that:

- a. AHC is in compliance with the obligations of the CIA cited by OIG as being the basis for the Material Breach;
- b. the alleged Material Breach has been cured; or

c. the alleged Material Breach cannot be cured within the 30-day period, but that: (i) AHC has begun to take action to cure the Material Breach; (ii) AHC is pursuing such action with due diligence; and (iii) AHC has provided to OIG a reasonable timetable for curing the Material Breach.

4. *Exclusion Letter.* If at the conclusion of the 30-day period, AHC fails to satisfy the requirements of Section X.D.3, OIG may exclude AHC from participation in the Federal health care programs. OIG shall notify AHC in writing of its determination to exclude AHC (this letter shall be referred to hereinafter as the “Exclusion Letter”). Subject to the Dispute Resolution provisions in Section X.E, below, the exclusion shall go into effect 30 days after the date of the Exclusion Letter. The exclusion shall have national effect and shall also apply to all other Federal procurement and non-procurement programs. Reinstatement to program participation is not automatic. If at the end of the period of exclusion, AHC wishes to apply for reinstatement, AHC shall submit a written request for reinstatement in accordance with the provisions at 42 C.F.R. §§ 1001.3001-.3004.

E. Dispute Resolution

1. *Review Rights.* Upon OIG’s delivery to AHC of its Demand Letter or of its Exclusion Letter, and as an agreed-upon contractual remedy for the resolution of disputes arising under this CIA, AHC shall be afforded certain review rights comparable to the ones that are provided in 42 U.S.C. § 1320a-7(f) and 42 C.F.R. Part 1005 as if they applied to the Stipulated Penalties or exclusion sought pursuant to this CIA. Specifically, OIG’s determination to demand payment of Stipulated Penalties or to seek exclusion shall be subject to review by an HHS ALJ and, in the event of an appeal, the HHS Departmental Appeals Board (“DAB”), in a manner consistent with the provisions in 42 C.F.R. §§ 1005.2-1005.21. Notwithstanding the language in 42 C.F.R. § 1005.2(c), the request for a hearing involving Stipulated Penalties shall be made within 10 days after receipt of the Demand Letter and the request for a hearing involving exclusion shall be made within 25 days after receipt of the Exclusion Letter.

2. *Stipulated Penalties Review.* Notwithstanding any provision of Title 42 of the United States Code or Chapter 42 of the Code of Federal Regulations, the only issues in a proceeding for Stipulated Penalties under this CIA shall be: (a) whether AHC was in full and timely compliance with the obligations of this CIA for which OIG demands payment; and (b) the period of noncompliance. AHC shall have the burden of

proving its full and timely compliance and the steps taken to cure the noncompliance, if any. OIG shall not have the right to appeal to the DAB an adverse ALJ decision related to Stipulated Penalties. If the ALJ agrees with OIG with regard to a finding of a breach of this CIA and orders AHC to pay Stipulated Penalties, such Stipulated Penalties shall become due and payable 20 days after the ALJ issues such a decision unless AHC requests review of the ALJ decision by the DAB. If the ALJ decision is properly appealed to the DAB and the DAB upholds the determination of OIG, the Stipulated Penalties shall become due and payable 20 days after the DAB issues its decision.

3. *Exclusion Review.* Notwithstanding any provision of Title 42 of the United States Code or Chapter 42 of the Code of Federal Regulations, the only issues in a proceeding for exclusion based on a Material Breach of this CIA shall be:

- a. whether AHC was in Material Breach of this CIA;
- b. whether such breach was continuing on the date of the Exclusion Letter; and
- c. whether the alleged Material Breach could not have been cured within the 30-day period, but that: (i) AHC had begun to take action to cure the Material Breach within that period; (ii) AHC has pursued and is pursuing such action with due diligence; and (iii) AHC provided to OIG within that period a reasonable timetable for curing the Material Breach and AHC has followed the timetable.

For purposes of the exclusion herein, exclusion shall take effect only after an ALJ decision favorable to OIG, or, if the ALJ rules for AHC, only after a DAB decision in favor of OIG. AHC's election of its contractual right to appeal to the DAB shall not abrogate OIG's authority to exclude AHC upon the issuance of an ALJ's decision in favor of OIG. If the ALJ sustains the determination of OIG and determines that exclusion is authorized, such exclusion shall take effect 20 days after the ALJ issues such a decision, notwithstanding that AHC may request review of the ALJ decision by the DAB. If the DAB finds in favor of OIG after an ALJ decision adverse to OIG, the exclusion shall take effect 20 days after the DAB decision. AHC shall waive its right to any notice of such an exclusion if a decision upholding the exclusion is rendered by the ALJ or DAB. If the DAB finds in favor of AHC, AHC shall be reinstated effective on the date of the original exclusion.

4. *Finality of Decision.* The review by an ALJ or DAB provided for above shall not be considered to be an appeal right arising under any statutes or regulations. Consequently, the parties to this CIA agree that the DAB's decision (or the ALJ's decision if not appealed) shall be considered final for all purposes under this CIA.

5. *Review by Other Agencies.* Nothing in this CIA shall affect the right of CMS or any other Federal or State agency to enforce any statutory or regulatory authorities with respect to AHC's compliance with applicable Federal and state health care program requirements.

XI. EFFECTIVE AND BINDING AGREEMENT

Consistent with the provisions in the Settlement Agreement pursuant to which this CIA is entered, and into which this CIA is incorporated, AHC and OIG agree as follows:

(The remainder of this page is intentionally blank.)

A. This CIA shall be binding on the successors, assigns, and transferees of AHC, or any of the Covered Facilities. However, at AHC's or a successor's, assignee's, or transferee's request and upon a bona fide arms-length sale (including the transfer of all management and operations) of a Covered Entity to a third party unrelated to AHC or William Cranwell, OIG, in its sole discretion, will evaluate whether it is appropriate to suspend CIA obligations for that Covered Entity.

B. This CIA shall become final and binding on the date the final signature is obtained on the CIA;

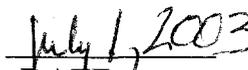
C. Any modifications to this CIA shall be made with the prior written consent of the parties to this CIA;

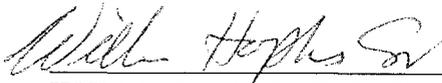
D. OIG may agree to a suspension of AHC's obligations under the CIA in the event of AHC's cessation of participation in Federal health care programs. If AHC withdraws from participation in Federal health care programs and is relieved of its CIA obligations by OIG, AHC shall notify OIG at least 30 days in advance of AHC's intent to reapply as a participating provider or supplier with the Federal health care programs. Upon receipt of such notification, OIG shall evaluate whether the CIA should be reactivated or modified.

E. The undersigned AHC signatories represent and warrant that they are authorized to execute this CIA. The undersigned OIG signatory represents that he is signing this CIA in his official capacity and that he is authorized to execute this CIA.

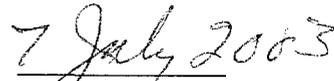
INDIVIDUALLY AND ON BEHALF OF AHC

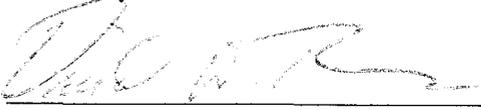

WILLIAM C. CRANWELL


DATE



WILLIAM HOPKINS, SR.
Trustee for William Cranwell


DATE



DAVID W. TUCKER
President and CEO of AHC


DATE

ON BEHALF OF THE OFFICE OF INSPECTOR GENERAL
OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

Larry J. Goldberg

LARRY J. GOLDBERG

Assistant Inspector General for Legal Affairs
Office of Counsel to the Inspector General
Office of Inspector General
U. S. Department of Health and Human Services

8/1/03

DATE

APPENDIX A

A. Claims Review.

1. *Definitions.* For the purposes of the Claims Review, the following definitions shall be used:

- a. Overpayment: The amount of money AHC has received in excess of the amount due and payable under any Federal health care program requirements.
- b. Item: Any discrete unit that can be sampled (e.g., code, line item, beneficiary, patient encounter, etc.).
- c. Paid Claim: A UB-92 submitted by AHC and for which AHC has received reimbursement from the Medicare program.
- d. Population: All Items for which AHC has submitted a code or line item and for which AHC has received reimbursement from the Medicare program (i.e., a Paid Claim) during the 12-month period covered by the Claims Review.
- e. Error Rate: The Error Rate shall be the percentage of net Overpayments identified in the sample. The net Overpayments shall be calculated by subtracting all underpayments identified in the sample from all gross Overpayments identified in the sample. (Note: Any potential cost settlements or other supplemental payments should not be included in the net Overpayment calculation. Rather, only underpayments identified as part of the Discovery Sample or Full Sample (as applicable) shall be included as part of the net Overpayment calculation.)

The Error Rate is calculated by dividing the net Overpayment identified in the sample by the total dollar amount associated with the Items in the sample.

2. *Other Requirements.*

- a. Paid Claims without Supporting Documentation. For the purpose of appraising Items included in the Claims Review, any Paid Claim for which

AHC cannot produce documentation sufficient to support the Paid Claim shall be considered an error and the total reimbursement received by AHC for such Paid Claim shall be deemed an Overpayment. Replacement sampling for Paid Claims with missing documentation is not permitted.

b. Sample Selection. All Claims Review samples (i.e., Discovery Samples and Full Samples) should be selected according to a Statistically Valid Random Selection Methodology.

c. Use of First Samples Drawn. For the purposes of all samples (Discovery Sample(s) and Full Sample(s)) discussed in this Appendix, the Paid Claims associated with the Items selected in each first sample (or first sample for each strata, if applicable) shall be used. In other words, it is not permissible to generate more than one list of random samples and then select one for use with the Discovery Sample or Full Sample.

d. Type of Claims Review. The Claims Review shall consist of a variable appraisal sample (dollar amount in error). For purposes of determining dollar amounts associated with errors, all associated MDS information on the Sampling Unit, a single UB-92 bill, shall be reviewed.

e. Review Periods. The review periods for the Claims Reviews shall be as follows. The review period for the first year Claims Review is from the Effective Date through the start date of the first Claims Review (“First Review Period”). The review period of subsequent Claims Reviews shall be defined as including the twelve-month period preceding the starting date of that year’s Claims Review (“Subsequent Review Periods”). For each Claims Review, the pool from which claims are randomly selected for review will include those claims with a date of service during the relevant review period.

f. Non-compliance Reporting. If AHC becomes aware that any facility (including those not selected to be included as part of an annual Claims Review) is potentially experiencing non-compliance with the Federal health care program requirements for claims submissions, AHC shall, after reasonably determining whether further review is warranted, in addition to its other CIA obligations, conduct a review of the potential area of non-compliance. If warranted, AHC shall develop a corrective action plan and conduct appropriate follow-up to ensure that any inappropriate or improper practice(s) related to claims submission is appropriately addressed. All such instances of inappropriate or improper claims submission, regardless

of whether the facility was selected in the Claims Review, shall be reported to OIG, pursuant to Section III.I of this CIA.

B. Claims Review Report. The following information shall be included in the Claims Review Report for each Discovery Sample and Full Sample (if applicable).

1. *Claims Review Methodology*.

a. Claims Review Objective. A clear statement of the objective intended to be achieved by the Claims Review.

b. Sampling Unit. A description of the Item as that term is utilized for the Claims Review. The Sampling Unit shall be paid UB-92s with a date of service during the relevant review periods.

c. Claims Review Population. A description of the Population subject to the Claims Review.

d. Sampling Frame. A description of the sampling frame, which is the totality of Items from which the Discovery Sample and, if any, Full Sample has been selected and an explanation of the methodology used to identify the sampling frame. In most circumstances, the sampling frame will be identical to the Population.

e. Source of Data. A description of the documentation relied upon by the IRO when performing the Claims Review (e.g., medical records, physician orders, certificates of medical necessity, requisition forms, local medical review policies, CMS program memoranda, Medicare carrier or intermediary manual or bulletins, other policies, regulations, or directives).

f. Review Protocol. A narrative description of how the Claims Review was conducted and what was evaluated.

2. *Statistical Sampling Documentation*.

a. The number of Items appraised in the Discovery Sample and, if applicable, in the Full Sample.

b. A copy of all printouts of the random numbers generated by the “Random Numbers” function of the statistical sampling software used by the IRO for the selection of each Discovery Sample and each Full Sample.

c. A copy of the statistical software printout(s) estimating how many Items are to be included in the Full Sample, if applicable.

- d. A description or identification of the statistical sampling software package used to conduct the sampling.
- e. The Sampling Frame used in the Discovery and Full Sample will be available to OIG upon request.

3. *Claims Review Findings.*

a. Narrative Results.

- i. A description of AHC's billing and coding system(s), including the identification, by position description, of the personnel involved in coding and billing.
- ii. A narrative explanation of the IRO's findings and supporting rationale (including reasons for errors, patterns noted, etc.) regarding the Claims Review, including the results of the Discovery Sample, and the results of the Full Sample (if any) with the gross Overpayment amount, the net Overpayment amount, and the corresponding Error Rate(s) related to the net Overpayment.

b. Quantitative Results.

- i. For each Claims Review, the total number and percentage of instances in which the IRO determined that the Paid Claims submitted by AHC ("Claim Submitted") differed from what should have been the correct claim ("Correct Claim"), regardless of the effect on the payment.
- ii. For each Claims Review, the total number and percentage of instances in which the Claim Submitted differed from the Correct Claim and in which such difference resulted in an Overpayment to AHC.
- iii. Total dollar amount of Paid Claims included in the sample and the net Overpayment associated with the sample.
- iv. Error Rate for each Discovery Sample and Full Sample.
- v. The level of precision achieved by each Full Sample at a 90% Confidence Level.
- vi. A spreadsheet of the Claims Review results that includes the following information for each Paid Claim appraised: Federal health care program billed; beneficiary health insurance claim number; date

of service; RUG submitted; RUG reimbursed; allowed amount reimbursed by payor; if applicable, correct RUG (as determined by the IRO); correct allowed amount (as determined by the IRO); and, if applicable, dollar difference between allowed amount reimbursed by payor and the correct allowed amount (as determined by the IRO). (See Attachment 1 to this Appendix.)

4. *Systems Review Report.* The Systems Review Report will incorporate the IRO's findings and supporting rationale for the Systems Review performed for each Overpayment Claim identified in the Discovery Sample and Full Sample. Specifically, the Systems Review Report will include the following:

- a. any identified deficiencies in AHC's medical record documentation, coding process, policies and procedures, internal controls, reporting mechanisms or corrective action plans;
- b. any weakness or potential weaknesses in AHC's medical record documentation, coding process, policies and procedures, internal controls, reporting mechanisms or corrective action plans; and
- c. any recommendations that the IRO may have to improve any of these systems, operations, or processes.

5. *Credentials.* The names and credentials of the individuals who: (a) designed the statistical sampling procedures and the review methodology utilized for the Claims Review; and (b) performed the Claims Review.

APPENDIX B

FACILITY TRADE NAME	LESSEE AND OPERATOR OF FACILITY	FINANCING	LOCATION/ MAILING ADDRESS	PHONE NUMBER	FAX NUMBER	MEDICARE AND MEDICAID PROVIDER ID NUMBER(S)	NAME AND ADDRESS OF THE MEDICARE CONTRACTOR
Heritage Hall- Big Stone Gap	AHC X, LLC	GMAC	2045 Valley View Dirve Big Stone Gap, VA 24219	276-523- 3000	276-523- 0531	49-5086 49-5088	United Government Services, LLC P.O. Box 6280 Charleston, West Virginia 25362
Heritage Hall- Blacksburg	AHC X, LLC	GMAC	3610 South Main Street Blacksburg, VA 24060	540-951- 4109	540-951- 4109	49-5356 49-5356-8	United Government Services, LLC P.O. Box 6280 Charleston, West Virginia 25362
Heritage Hall- Blackstone	AHC X, LLC	GMAC	900 South Main Street P.O. Box 550 Blackstone, VA 23824	434-292- 5301	434-292- 6041	49-5363 49-5353-3	United Government Services, LLC P.O. Box 6280 Charleston, West Virginia 25362
Heritage Hall- Clintwood	AHC X, LLC	GMAC	Route 607, P.O. Box 909 Clintwood, VA 24228	276-926- 4693	276-926- 9128	49-5271 49-5278	United Government Services, LLC P.O. Box 6280 Charleston, West Virginia 25362
Heritage Hall- Dillwyn	AHC X, LLC	GMAC	9 Brickyard Drive P.O. Box 580 Dillwyn, VA 23926	434-983- 2058	434-983- 1727	49-5268 49-5275	United Government Services, LLC P.O. Box 6280 Charleston, West Virginia 25362
Heritage Hall- King George	AHC X, LLC	GMAC	8443 Kings Highway P.O. Box 529 King George, VA 22485	540-775- 4000	540-775- 3637	49-5251 49-5253	United Government Services, LLC P.O. Box 6280 Charleston, West Virginia 25362
Heritage Hall- Leesburg	AHC X, LLC	GMAC	122 Morven Park Rd., NW Leesburg, VA 22075	703-777- 8700	703-777- 1532	49-5212 49-5220	United Government Services, LLC P.O. Box 6280 Charleston, West Virginia 25362
Heritage Hall- Nassawadox	AHC X, LLC	GMAC	9468 Hospital Avenue P.O. Box 176 Nassawadox, VA 23413	757-442- 5600	757-442- 9401	49-5228 49-5232	United Government Services, LLC P.O. Box 6280 Charleston, West Virginia 25362
Heritage Hall- Tazewell	AHC X, LLC	GMAC	121 Ben Bolt Avenue Tazewell, VA 24651	276-988- 2515	276-988- 5468	49-5103 49-5105	United Government Services, LLC P.O. Box 6280 Charleston, West Virginia 25362
Heritage Hall- Wise	AHC X, LLC	GMAC	9434 Coeburn Mtn. Road P.O. Box 1009 Wise, VA 24293	276-328- 2721	276-328- 1463	49-5350 49-5310	United Government Services, LLC P.O. Box 6280 Charleston, West Virginia 25362

FACILITY TRADE NAME	LESSEE AND OPERATING ENTITY	FINANCING	LOCATION/ MAILING ADDRESS	PHONE NUMBER	FAX NUMBER	MEDICARE AND MEDICAID PROVIDER ID NUMBER(S)	NAME AND ADDRESS OF THE MEDICARE CONTRACTOR
Heritage Hall- Brookneal	Brookneal Life Care Corp/ AHC VII, LLC	PAMI	633 Cook Avenue Brookneal, VA 24528	434-376- 3740	434-376- 3776	49-5193 49-5194	United Government Services, LLC P.O. Box 6280 Charleston, West Virginia 25362
Heritage Hall- Charlottesville	Albemarle Life Care Corp/ AHC VII, LLC	PAMI	505 West Rio Road Charlottesville, VA 22901	434-976- 7015	434-978- 1601	49-5129 49-5135	United Government Services, LLC P.O. Box 6280 Charleston, West Virginia 25362
Heritage Hall- Front Royal	Front Royal Life Care Corp/ AHC VII, LLC	PAMI	400 West Strasburg Road Front Royal, VA 22630	540-636- 3700	540-636- 8558	49-5252 49-5253	United Government Services, LLC P.O. Box 6280 Charleston, West Virginia 25362
Heritage Hall- Grundy	Grundy Life Care Corp/ AHC VII, LLC	PAMI	Route 5, Box 104 Grundy, VA 24614	276-935- 8144	276-935- 2316	49-5210 49-5216	United Government Services, LLC P.O. Box 6280 Charleston, West Virginia 25362
Heritage Hall- Laurel Meadows	Laurel Meadows Life Care Corp/ AHC VII, LLC	PAMI	16600 Danville Pike Laurel Fork, VA 24352	276-398- 2117	276-398- 3122	49-5274 49-5275	United Government Services, LLC P.O. Box 6280 Charleston, West Virginia 25362
Heritage Hall- Lexington	Lexington Life Care Corp/AHC VII, LLC	PAMI	205 Houston Street Lexington, VA 24450	540-464- 8181	540-464- 8184	49-5272 49-5277	United Government Services, LLC P.O. Box 6280 Charleston, West Virginia 25362
Heritage Hall- Virginia Beach	VA Beach Life Care Corp/AHC VII, LLC	PAMI	5580 Daniel Smith Road Virginia Beach, VA 234462	757-499- 7029	757-499- 1266	49-5185 49-5186	United Government Services, LLC P.O. Box 6280 Charleston, West Virginia 25362

APPENDIX C CONDITIONS OF THE TRUST

1. Trust and Trustee

Pursuant to the Trust, as defined in the CIA (“Trust”), William C. Cranwell’s ownership or control interests in any entity that receives Federal health care program reimbursement shall be placed in trust, pursuant to the Blind Trust Agreement. The Trust shall be administered by a Trustee, who shall be independent from Mr. Cranwell and shall not consult with Mr. Cranwell regarding AHC or discuss AHC with Mr. Cranwell, except as permitted under the Blind Trust Agreement. The Trustee certifies to OIG that he or she is independent from Mr. Cranwell and will not have contact with Mr. Cranwell regarding AHC, except as permitted under the Blind Trust Agreement.

Should OIG determine at any time that the Trustee has violated the terms of this Appendix or the Blind Trust Agreement, including, but not limited to, through prohibited contact with Mr. Cranwell, OIG shall be authorized, at its sole discretion, to require replacement of the Trustee. In the event OIG determines that the Trustee has violated the terms of this Appendix or the Blind Trust Agreement, OIG shall notify Mr. Cranwell and the Trustee of the alleged violation and specify the basis for its belief that such violation has occurred. In order to resolve the allegations raised by OIG, within five business days of receipt of the notice from OIG, Mr. Cranwell or the Trustee may request a meeting with OIG for purposes of discussing the alleged violation and presenting any additional relevant information. Mr. Cranwell and the Trustee agree to provide any information requested by OIG in an expedited manner. OIG will review in good faith Mr. Cranwell’s and the Trustee’s response to OIG’s notice, along with any information submitted by Mr. Cranwell and the Trustee, and, if a meeting was requested, be available to meet and confer in good faith with Mr. Cranwell and the Trustee or their legal representatives to attempt to resolve any alleged violation regarding the Trustee’s compliance with this Agreement and the Blind Trust Agreement. OIG shall be authorized to evaluate any proposed replacement Trustee to determine whether OIG will approve of the replacement.

Should the Blind Trust Agreement be terminated or amended in any material respect, OIG shall be given at least 30 days notice prior to the effective date of such termination or amendment. OIG reserves the right to determine whether any such termination or amendment would constitute a material breach of the Trust.

To the extent that this Appendix C contains certain exceptions to the Trustee’s role with regard to the operations and management of the assets in the Trust and permits Mr. Cranwell to exercise discretion with regard to AHC (see Paragraphs 2 and 3 of this Appendix C), OIG reserves the right to examine any proposed transactions or arrangements (including any sale, transfer, lease, or financing of AHC or any of the

Covered Facilities) to ensure that the underlying purposes of the Trust will continue to be satisfied.

2. Covered Facilities

Mr. Cranwell certifies that the Covered Facilities (as defined in Section II.C.1 of the CIA) are the only entities in which he has an ownership or control interest within the meaning of 42 U.S.C. § 1320a-3(a)(3) that provide or supply health care items or services that are reimbursed by the Federal health care programs. (Mr. Cranwell's ownership interest in the Covered Facilities at the time of the execution of the CIA shall be referred to as the "Allowed Ownership Interest.") Mr. Cranwell represents that he has placed his ownership interests in the Covered Facilities in the Trust. Mr. Cranwell represents that he shall not have or acquire any ownership or control interest as defined at 42 U.S.C. § 1320a-3(a)(3) in any entity that provides or supplies health care items or services that are reimbursed by the Federal health care programs other than the Allowed Ownership Interest. During the term of the CIA, AHC shall not acquire any new ownership or control interest in any entity that provides or supplies health care items or services that are reimbursed by the Federal health care programs without prior notice to OIG.

Mr. Cranwell shall also not manage, direct, participate in, influence, or attempt to influence, directly or indirectly, the management, operations, or daily affairs of AHC, including through the hiring or firing of or giving direction to the Trustee, or any officer, director, employee, or agent of AHC in any respect. Furthermore, Mr. Cranwell represents that he shall not receive any profit distributions or other payment based on the Allowed Ownership Interest, except as permitted herein. Mr. Cranwell and AHC further acknowledge that if, during the period of the CIA, Mr. Cranwell: (1) has any ownership or control interest in the Covered Facilities other than the Allowed Ownership Interest, or (2) except as permitted herein, receives any profit distributions or other payment based on the Allowed Ownership Interest, OIG may rescind the releases in Paragraph III.E of the Settlement Agreement and proceed to exclude AHC under Section X.D of the CIA.

To the extent permitted in the Blind Trust Agreement, Mr. Cranwell shall have the right to sell, transfer, lease, or finance (including pledging as security) his ownership interests in AHC and the Covered Facilities to a third party (but not to an immediate family member or a member of his household, as defined at 42 U.S.C. § 1320a-7(j)). Any such sale, transfer, lease, or financing shall comply with any applicable federal and state regulations regarding the change of ownership of skilled nursing facilities and the notice required under such regulations shall also be provided to OIG. With regard to any such sale, transfer, lease, or financing, Mr. Cranwell shall have the right to: (a) determine the timing of any decision to sell, transfer, or lease the stock or assets of any or all of AHC or

any Covered Facility or to grant a security interest in some or all of the Covered Facilities; (b) approve or disapprove of the selection of any buyer and the terms of any sale; (c) arrange the lease, financing, or refinancing of any Covered Facility with any third party; and (d) receive the remainder of the proceeds for any such sale, transfer, lease, or financing in proportion to his ownership interest after the proceeds have first been applied to satisfy AHC's and Mr. Cranwell's obligations pursuant to the Plea Agreements and Settlement Agreement.

3. Lease and Loan Arrangements

Mr. Cranwell, or entities owned in whole or in part or operated by him, hold certain lease arrangements with AHC and the Covered Facilities. These lease arrangements are listed at Exhibit C. AHC has provided to OIG, pursuant to independent real estate market valuations, evidence of the fair market value of each of these leases. All lease payments under these leases shall be made only pursuant to valid and documented leases and, during the term of this CIA, shall be made to the Trustee to be handled pursuant to the Trust. Lease payments under these leases shall be comprised solely of debt service, real estate taxes, and a fair market rate of return consistent with the independent real estate market valuations received by OIG. Subject to 30 days prior notification to OIG, the lease(s) may be terminated only if: (1) the Covered Facilities are sold, leased, or otherwise transferred to an unrelated third party in an arm's length transaction; (2) the parties to the lease(s) mutually agree to terminate the lease(s); or (3) the lease(s) is breached. Additionally, any material revisions to the lease(s) will be subject to 30 days prior notification to OIG.

Mr. Cranwell, or entities owned or operated by him, have extended (and may in the future extend) certain loans, directly, indirectly, or as capital contributions to AHC or to one or more of the Covered Facilities secured by interests in one or more of the Covered Facilities. Present outstanding loans are listed at Exhibit D. All loan payments shall be made pursuant to valid and documented loans. Any such loan payments shall be limited to amounts scheduled to be paid pursuant to the terms of each loan and shall not include any additional or accelerated payments, except as permitted under the terms of the loan. During the term of this CIA, all loan payments shall be made to the Trustee to be handled pursuant to the Trust.

4. Fines

Through the Trust, the Trustee may pay certain fines, penalties, or costs, including attorneys' fees, related to or arising out of William Cranwell's and HCMF's Plea Agreements, or other investigation, prosecution, or settlement of charges against HCMF

or any of its owners, officers, or employees by OIG or any other Federal or State agency as provided in the Settlement Agreement.

5. Reporting Requirements

During the term of the CIA, in addition to the Implementation Report and as a part of the Annual Reports required under the CIA, Mr. Cranwell, AHC, and the Trustee shall provide annual reports and two additional reports covering each of the first two 90-day periods commencing on the date of the execution of the CIA as follows. The first two of these reports shall be submitted to OIG within 10 days of the end of the period covered by the report.

Each report by Mr. Cranwell shall include a certification from Mr. Cranwell that for the period covered by the report Mr. Cranwell has: (1) been in compliance with those terms of the CIA and Trust that impose personal obligations on Mr. Cranwell; (2) not had any ownership or control interest in any entity that provides or supplies health care items or services that are reimbursed by the Federal health care programs other than the Allowed Ownership Interest; (3) not received any profit distributions or other payment based on his ownership interest in the Covered Facilities, except as permitted herein; and (4) not personally or otherwise outside of the Trust received any lease or loan payment pursuant to the leases and loans listed at Exhibits C and D.

Each report by AHC shall include a certification from AHC's President and Chief Executive Officer that for the period covered by the report, Mr. Cranwell has had no ownership or control interest in AHC or the Covered Facilities other than the Allowed Ownership Interest. AHC's report shall also include a description of all contacts and communications between Mr. Cranwell and any officers, directors, employees, or agents of AHC regarding AHC during the period covered by the report.

Each report by the Trustee shall include a certification that for the period covered by the report, Mr. Cranwell has had no ownership or control interest in AHC or the Covered Facilities other than the Allowed Ownership Interest and that the Trustee is independent from Mr. Cranwell and is administering the trust in accordance with the Trust. The Trustee's report shall also include a description of all contacts and communications between Mr. Cranwell and the Trustee or any of the Trustee's employees or agents, if any, regarding AHC during the period covered by the report.

Each certification required by this Paragraph shall state that the person signing the certification understands that the certification is being made in a document being

submitted to the United States Government and that false or fraudulent statements are subject to criminal prosecution pursuant to 18 U.S.C. § 1001.

OVERPAYMENT REFUND

TO BE COMPLETED BY MEDICARE CONTRACTOR

Date: _____
 Contractor Deposit Control # _____ Date of Deposit: _____
 Contractor Contact Name: _____
 Phone # _____
 Contractor Address: _____
 Contractor Fax: _____

TO BE COMPLETED BY PROVIDER/PHYSICIAN/SUPPLIER

Please complete and forward to Medicare Contractor. This form, or a similar document containing the following information, should accompany every voluntary refund so that receipt of check is properly recorded and applied.

PROVIDER/PHYSICIAN/SUPPLIER NAME _____
 ADDRESS _____
 PROVIDER/PHYSICIAN/SUPPLIER # _____
 CHECK NUMBER# _____
 CONTACT PERSON: _____
 PHONE # _____ AMOUNT OF CHECK \$ _____
 CHECK DATE _____

REFUND INFORMATION

For each Claim, provide the following:

Patient Name _____
 HIC # _____
 Medicare Claim Number _____
 Claim Amount Refunded \$ _____
 Reason Code for Claim Adjustment: _____ (Select reason code from list below. Use one reason per claim)
(Please list all claim numbers involved. Attach separate sheet, if necessary)
 Note: *If Specific Patient/HIC/Claim #/Claim Amount data not available for all claims due to Statistical Sampling, please indicate methodology and formula used to determine amount and reason for overpayment:* _____

For Institutional Facilities Only:

Cost Report Year(s) _____
 (If multiple cost report years are involved, provide a breakdown by amount and corresponding cost report year.)

For OIG Reporting Requirements:

Do you have a Corporate Integrity Agreement with OIG? Yes No

Reason Codes:

<u>Billing/Clerical Error</u>	<u>MSP/Other Payer Involvement</u>	<u>Miscellaneous</u>
01 - Corrected Date of Service Documentation	08 - MSP Group Health Plan Insurance	13 - Insufficient
02 - Duplicate HMO	09 - MSP No Fault Insurance	14 - Patient Enrolled in an
03 - Corrected CPT Code	10 - MSP Liability Insurance	15 - Services Not Rendered
04 - Not Our Patient(s)	11 - MSP, Workers Comp.(Including Black Lung	16 - Medical Necessity
05 - Modifier Added/Removed	12 - Veterans Administration	17 - Other (Please Specify)
06 - Billed in Error		
07 - Corrected CPT Code		

