CORPORATE INTEGRITY AGREEMENT
BETWEEN THE
OFFICE OF INSPECTOR GENERAL
OF THE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
AND
NATIONAL HEALTHCARE CORPORATION

I. PREAMBLE

National Healthcare Corporation ("NHC") 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 its officers, directors, employees ("Covered Persons") and "Covered Contractors" as defined below, who provide patient care to Federal health care beneficiaries or who are involved in NHC's billings or related submissions to the Federal health care programs with the statutes, regulations and written directives of Medicare, Medicaid and all other Federal health care programs (as defined in 42 U.S.C. § 1320a-7b(f)) ("Federal health care program requirements"). The term Covered Persons does not include part-time or per diem employees who are not reasonably expected to work more than 160 hours per year, except that any such individuals shall become Covered Persons at the point when they work more than 160 hours during any 12 month period. Contemporaneously with this CIA, NHC is entering into a Settlement Agreement with the United States, and this CIA is incorporated by reference into the Settlement Agreement.

For the purposes of this CIA, a "Covered Contractor" is an entity (or individual) that, although not a Covered Person, either provides patient care to Federal health care program beneficiaries in NHC facilities or participates in NHC's billings or related submissions to Federal health care programs for NHC on a regular basis (i.e., more often than two-weeks over a 52-week period).

Prior to execution of this CIA, NHC voluntarily established a corporate compliance program (known as the Corporate Compliance and Ethics Program) that applies to NHC and its affiliates. The Corporate Compliance and Ethics Program

establishes corporate integrity policies and procedures and, as represented by NHC, is aimed in part at ensuring that NHC's participation in Federal health care programs is in conformity with the statutes, regulations and other directives applicable to the programs. NHC agrees that during the term of this CIA it will continue to operate its Corporate Compliance and Ethics Program in a manner that meets the requirements of this CIA. NHC may modify its Corporate Compliance and Ethics Program, but at a minimum, NHC shall ensure that it complies with the integrity obligations that are enumerated in this CIA.

II. TERM OF THE CIA

The period of the compliance obligations assumed by NHC under this CIA shall be five years from the effective date of this CIA (unless otherwise specified). The effective date of this CIA shall be the date on which the final signatory of this CIA executes this CIA.

Sections VII, VIII, IX, X and XI shall remain in effect until OIG has completed its review of the final annual report and any additional materials submitted by NHC pursuant to OIG's request.

III. CORPORATE INTEGRITY OBLIGATIONS

NHC hereby agrees to establish or maintain, as appropriate, a Compliance Program that includes the following elements:

A. Compliance Officer and Committee.

1. *Compliance Officer.* NHC has appointed an individual to serve as its Compliance Officer. The Compliance Officer shall be responsible for assuring development and implementation of 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 is a member of senior management of NHC, shall make periodic (at least quarterly) reports regarding compliance matters directly to the CEO and/or to the Board of Directors of NHC, and shall be authorized to report on such matters to the Board of Directors at any time. The Compliance Officer is

responsible for monitoring the day-to-day compliance activities engaged in by NHC and shall be responsible for any reporting obligations created under this CIA.

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, must be reported to OIG, in writing, within 15 days of such a change.

2. *Compliance Committee.* Within 90 days of the effective date of this CIA, to the extent not already accomplished, NHC shall appoint a Compliance Committee. The Compliance Committee shall, at a minimum, include the Compliance Officer and any other members of senior management necessary to meet the requirements of this CIA (e.g., senior executives of each major department, such as accounting, patient care, human resources, audit, and operations). The Compliance Officer shall direct the Compliance Committee in the performance of its functions and the Committee shall support the Compliance Officer in fulfilling his/her responsibilities (e.g., shall assist in the analysis of the organization's risk areas and shall oversee monitoring of internal and external audits and investigations).

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, must be reported to OIG, in writing, within 15 days of such a change.

B. Written Standards.

1. *Code of Conduct.* To the extent not already accomplished, within 90 days of the effective date of this CIA, NHC shall establish and distribute to all Covered Persons a Code of Conduct. NHC 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. NHC'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. NHC's requirement that all of its Covered Persons shall be expected to comply with all Federal health care program requirements and with NHC's own Policies and Procedures as implemented pursuant to section III.B (including the requirements of this CIA);

c. the requirement that all of NHC's Covered Persons shall be expected to report to the Compliance Officer or other individual designated by the NHC, or to the Confidential Disclosure Program identified in Section III E., suspected violations of any Federal health care program requirements or of NHC's own Policies and Procedures implemented pursuant to Section III.B.2;

d. the possible consequences to both NHC and Covered Persons of failure to comply with all Federal health care program requirements and with NHC's own Policies and Procedures implemented pursuant to Section III.B.2 or of failure to report such non-compliance; and

e. the right of all individuals to use the Confidential Disclosure Program described in section III.E, and NHC's commitment to maintain confidentiality, as appropriate, and non-retaliation with respect to disclosures.

To the extent not already accomplished, within 90 days of the effective date of the CIA, each Covered Person shall certify, in writing, that he or she has received, read, understood, and will abide by NHC's Code of Conduct. New Covered Persons shall receive the Code of Conduct and shall complete the required certification within two weeks after becoming a Covered Person or within 90 days of the effective date of the CIA, whichever is later.

NHC 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 of finalizing such changes.

Covered Persons shall certify that they have received, read, understood and will abide by the revised Code of Conduct within 30 days of the distribution of such revisions.

For each of its Covered Contractors, NHC shall: (1) require in its contract with the Covered Contractor that the Covered Contractor acknowledges NHC's Compliance Program and Code of Conduct; (2) ensure that the Code of Conduct is provided (either by NHC or the Covered Contractor) to all Covered Contractors; (3) require in the contract with the Covered Contractor that the Covered Contractor obtain and retain (subject to review by NHC and/or the OIG) signed certification from all of its employees who provide patient care to Federal health care program beneficiaries at NHC facilities or participate in billings or related submissions to Federal health care programs for NHC that they have received, read, and understand the Code of Conduct and agree to abide by the requirements of the Compliance Program. NHC shall require future contracts with Covered Contractors to include the above-described provisions. Within 120 days of the execution of this CIA, NHC shall attempt in good faith to reform contracts with its then-current Covered Contractors to include a provision pursuant to which the contractors will provide assurance satisfactory to NHC that these requirements will be met.

2. *Policies and Procedures.* Within 120 days of the effective date of this CIA, to the extent not already accomplished, NHC shall implement written Policies and Procedures regarding the operation of NHC's compliance program and its compliance with 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 preparation of true and accurate claims for reimbursement (including cost reports or other equivalent reporting mechanisms) submitted to Federal health care programs;

c. the proper allocation of costs subject to reimbursement through the Federal health care programs.

The Policies and Procedures shall be available to OIG, upon request.

Within 120 days of the effective date of the CIA, the relevant portions of the Policies and Procedures shall be made available to all individuals whose job functions are related to those Policies and Procedures. Appropriate and knowledgeable staff should be available to explain the Policies and Procedures.

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

C. Training and Education.

1. *General Training.* Within 120 days of the effective date of this CIA, NHC shall provide at least two hours of general training to each Covered Person. This training shall explain NHC'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).

All training materials shall be made available to OIG, upon request.

New Covered Persons shall receive the general training described above within 30 days of becoming a Covered Person or within 120 days after the effective date of this CIA, whichever is later. After receiving the initial training described above, each Covered Person shall receive at least one hour of general training annually.

Those Covered Persons who have already received at least one hour of general training on the Compliance Program within one hundred and twenty (120) days prior to the Effective Date of this CIA need only to be trained about the existence and requirements of this CIA.

2. *Specific Training.* Within 120 days of the effective date of this CIA, each Covered Person who is directly or indirectly involved in the preparation of claims for reimbursement from any Federal health care program (hereinafter referred to as the "Clinical Relevant Covered Persons") shall receive at least six hours of specific training in addition to the general training required above. Within 150 days of the effective date of this CIA, each Covered Person who is directly or indirectly involved in the preparation and submission of claims for reimbursement from any Federal health care program (hereinafter referred to as the "Billing Relevant Covered Persons"[1]) shall receive at least six hours of specific training in addition to the general training required above. This specific training shall include a discussion of

a. the submission of accurate bills for services rendered to Federal health care program patients;

b. policies, procedures and other requirements applicable to the documentation of medical records;

c. the personal obligation of each individual involved in the billing process to ensure that such billings are accurate;

d. applicable reimbursement statutes, regulations, and program requirements and directives;

e. the legal sanctions for improper billings; and

f. examples of proper and improper billing practices.

All training materials shall be made available to OIG, upon request. Persons providing the training must be knowledgeable about the subject area.

New Relevant Covered Persons shall receive this training within 30 days of the beginning of their employment or becoming Relevant Covered Persons or within 120

---

[1] The Billing Relevant Covered Persons and the Clinical Relevant Covered Persons shall be referred to collectively as "Relevant Covered Persons".

days of the effective date of this CIA, whichever is later. A NHC employee who has completed the specific training shall review a new Relevant Covered Person's work, to the extent that the work relates to the preparation or submission of claims for reimbursement from any Federal health care program, until such time as the new Relevant Covered Person completes applicable training.

If NHC has provided specific training that satisfies the requirements set forth above in Section III.C.2 to Relevant Covered Persons within one hundred and twenty (120) days prior to the Effective Date of this CIA, OIG shall credit that training for purposes of satisfying NHC's specific training obligations for the first year of this CIA.

After receiving the initial training described in this section, every Relevant Covered Person shall receive at least two hours of specific training annually, in addition to other periodic training provided by NHC.

3. *Certification.* Each individual who is required to attend training shall certify, in writing, or in electronic form if computerized training is given, 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 his or her designee) shall retain the certifications, along with all course materials. These shall be made available to OIG, upon request.

D. Review Procedures.

1. *General Description.*

a. Retention of Independent Review Organization. Within 90 days of the effective date of this CIA, NHC shall retain an entity (or entities), such as an accounting, auditing or consulting firm (hereinafter "Independent Review Organization" or "IRO"), to perform agreed-upon procedures engagements (hereafter "Reviews") to assist NHC in evaluating its coding and billing practices and its compliance obligations pursuant to this CIA and the Settlement Agreement. Each Independent Review Organization retained by NHC shall have expertise in the billing, coding, reporting and other

requirements of the particular section of the health care industry pertaining to this CIA and in the general requirements of the Federal health care program(s) from which NHC seeks reimbursement.

b. Types of Engagements. The Independent Review Organization(s) shall conduct two separate engagements. One engagement shall address NHC's coding and billings to the Federal health care programs ("Billing Engagement"). The second engagement shall address NHC's compliance with the obligations assumed under this CIA and the Settlement Agreement ("Compliance Engagement"). The IRO shall produce a separate report for each engagement.

c. Frequency of Billing and Compliance Engagements. The Billing Engagement shall be performed annually and shall cover each of the one-year periods beginning with the effective date of this CIA. However, the IRO shall generate a Systems Review Report for only the first, third and fifth one-year periods beginning on the effective date of this CIA. The IRO(s) shall perform all components of each annual Billing Engagement that are designated herein as IRO responsibilities. The Compliance Engagement shall be performed by the IRO for the first one-year period beginning with the effective date of this CIA.

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

2. *Billing Engagement.* The Billing Engagement shall be composed of two separate reviews, a "Claims Review and a "Systems Review". The Claims Review and corresponding Claims Review Report are discussed in detail in Appendix A to this CIA, which is incorporated by reference.

a. Claims Review. The IRO shall perform a Claims Review which will review Medicare (Part A) claims and focus on the Minimum

Data Set ("MDS"). The Claims Review shall be performed in accordance with the procedures set forth below and in Appendix A to this CIA. The Claims Review shall consist of a variable appraisal (dollar amount in error) sample. Because this engagement is designed as a variable appraisal, for the purposes of determining dollar amounts associated with errors, the final sampling unit will be a single claim (UB-92) and each associated MDS.

The Claims Review shall consist of a two-stage process of claims review. For each annual Claims Review, the IRO shall randomly select one-fifth of NHC's facilities. The first stage of the claims review shall be conducted using a random sample of thirty claims from each of those selected facilities. The second stage of the review will be conducted using claims at facilities which exceed the error rate threshold set forth below. NHC shall retain copies of all of its work papers compiled with respect to its internal audits, which work papers shall be available to the OIG upon request.

1. First Stage of Claims Review (Probe Sample). The first stage of the Claims Review shall consist of a probe sample of thirty (30) claims at each facility selected as part of the random sample. The IRO shall select a stratified random sample of paid Medicare claims (UB-92s) throughout the year for each of the facilities selected. The probe sample cannot be used as part of any full sample reviewed during the second stage of the Claims Review. The probe sample will be used to identify facilities that have exceeded a designated financial error rate and to determine the appropriate sample sizes for expanded sample reviews of the designated facilities in accordance with specified RAT-STATS parameters.

2. Selection of Facilities for Second Stage of Claims Review. The second stage of the Claims Review will be performed for each individual facility selected as part of the probe sample in the first stage for which the financial error rate (i.e., a downward change in a Resource Utilization Group ("RUG") assignment that would result in

an over-payment) was greater than 5%. Nothing in this CIA or its attachments shall relieve NHC of its responsibility to correct inaccuracies and repay Overpayments noted in its probe sample. To the extent that a financial threshold is used (*i.e.* - the 5% error rate), it has no bearing on other matters (such as extrapolation of overpayments).

3. Second Stage of Claims Review. The second stage of the Claims Review shall be a full sample of Medicare paid claims (UB-92s) (randomly selected by IRO using the RAT-STATS software referenced below in section III.D.2.e) during the annual reporting period at each applicable facility. This sample shall be selected at the end of each year. The full sample must contain a sufficient number of sample units to generate sample results that provide, at a minimum, a 90% confidence interval and a maximum precision (relative precision, i.e., semi-width of the confidence interval) of plus or minus 25% of the point estimate (i.e., the upper and lower bounds of the 90% confidence interval shall not exceed 125% and shall not fall below 75% of the midpoint of the confidence interval, respectively).

4. Claims Review Analysis. For each claim selected in the first and second stage, the associated MDS and the medical record documentation supporting the MDS will be reviewed. The review process shall entail an evaluation of the 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. In addition, data from the MDS will be re-entered into the IRO's MDS data entry software program to verify that the correct RUG code assignment was properly assigned on the UB-92. A financial error will be logged if there is insufficient support for an MDS data point(s) that results in a downward change in RUG assignment that would result in an overpayment.

b. Claims Review Report. The IRO shall prepare a report based upon each Claims Review performed ("Claims Review Report"). The Claims Review Report shall be created in accordance with the procedures set forth in Appendix A to this CIA.

c. Systems Review. NHC shall prepare and provide to the IRO documentation as to the procedures and controls affecting the submission and billing process, subject to the annual assessment as specified in the CIA. The submission and billing process (e.g., flow of documents, processing activities) and related controls should be documented in the form of flow charts, narratives, excerpts from policies and procedures manuals, control questionnaires, etc. In order to perform its Systems Review, the IRO shall perform all necessary procedures, including but not limited to, a review of all appropriate documentation and discussions with all appropriate personnel, in order to test the effectiveness of the controls identified in the process documentation and comment on the effectiveness of the related controls, including, but not limited to, the following:

i. NHC's billing systems and/or operations relating to claims submitted to all Federal health care programs (including, but not limited to, the operation of the billing system, safeguards to ensure proper claim submission and billing, and procedures to correct inaccurate billing);

ii. NHC's documentation and coding systems and/or operations relating to claims submitted to all Federal health care programs (including, but not limited to, the process by which claims are coded (*e.g.* - RUGs codes assignments), safeguards to ensure proper coding, and procedures to correct inaccurate coding); and

iii. NHC's cost report, cost statement, information statement and payment request preparation process relating to any and all costs submitted to Federal health care programs (including,

but not limited to, the steps NHC takes to ensure that the proper information is being recorded on submissions to Federal health care programs and safeguards to ensure that only proper costs and dollar amounts are being submitted for reimbursement to such programs).

d. Systems Review Report. The IRO shall prepare a report based upon each Systems Review performed ("Systems Review Report"). The Systems Review Report shall include the IRO's findings and supporting rationale regarding:

i. the strengths and weaknesses in NHC's billing systems and/or operations;

ii. the strengths and weaknesses in NHC's documentation and coding systems and/or operations;

iii. the strengths and weaknesses in NHC's cost report, cost statement, information statement and payment request preparation process relating to any and all costs submitted to Federal health care programs; and

iv. any recommendations the IRO may have to improve any weaknesses identified in the systems, operations, and processes specified in sections III.D.2.d.i-iii.

e. Statistical Sampling and Appraisal Method. All matters related to this CIA that involve statistical sampling or appraisal shall be conducted using the OIG's Office of Audit Services Statistical Sampling Software, also known as "RAT-STATS," available on the Internet at www.hhs.gov/oig/oas/ratstat.html. Wherever the CIA requires the use of a random sample, the sample shall be selected and appraised using RAT-STATS and NHC shall retain all of the supporting documentation related to the selection and appraisal of the samples.

3. *Compliance Engagement.*

a. Compliance Review. The IRO shall conduct a review of NHC's compliance activities ("Compliance Review"). The Compliance Review shall consist of a review of NHC's compliance with the obligations set forth in each section of this CIA, and a review of NHC's compliance with certain provisions of the Settlement Agreement.

i. CIA Obligations Review. The IRO shall evaluate NHC's compliance with the obligations set forth in each section of this CIA.

ii. Unallowable Costs Review. The IRO shall determine whether NHC has complied with its obligation (as defined in Paragraph 11 of the Settlement Agreement) not to charge to, or otherwise seek payment from, Federal or State payors for Unallowable Costs (as defined in Paragraph 11 of 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. The procedures to be performed by the IRO will include procedures to verify that the list of Unallowable Costs (as provided to the IRO pursuant to Paragraph 3.a.iii of this Section) is consistent with NHC's obligations in Paragraph 11 of the Settlement Agreement, that the costs have been provided to the appropriate payors, and that the costs have been removed from previously filed requests for payment from the United States and any State Medicaid program or from any such requests yet to be filed. 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 NHC or any of its subsidiaries, and to request,

and agree, that such cost reports, cost statements, information reports or payment requests, even if already settled, be adjusted to account for the effect of the inclusion of the unallowable costs. In making this determination, the IRO may need to review cost reports and/or financial statements from the year of the Settlement Agreement, as well as from previous years.

iii. NHC shall prepare and provide to the IRO a list of all Unallowable Costs and shall further indicate which of these Unallowable Costs have been included in payments sought in any cost reports, cost statements, information reports, or payment requests already submitted by NHC or any of its subsidiaries to any Federal or State Medicaid programs. This list of Unallowable Costs shall include a description of the nature of the cost, the dollar value of the unallowable cost, the time period during which the unallowable cost was incurred and, if appropriate, an identification of the NHC facility or location to which the cost is attributable.

b. Compliance Review Report. The IRO shall prepare a report based upon the Compliance Review performed (the "Compliance Review Report"). The Compliance Review Report shall include:

i. the IRO's findings, supporting rationale, and a summary of such findings and rationale regarding NHC's compliance with the terms of each section of the CIA, as applicable; and

ii. the IRO's findings and supporting rationale regarding whether NHC 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 .

4. *Validation Review.* In the event the OIG has reason to believe that: (a) NHC's Billing or Compliance Engagement fails to conform to the requirements of this CIA or (b) the findings or Claims Review results are inaccurate, the OIG may, at its sole discretion, conduct its own review to determine whether the Billing and Compliance Engagement comply with the requirements of the CIA and/or the findings or Claims Review results are inaccurate. NHC agrees to pay for the reasonable cost of any such review performed by the OIG or any of its designated agents so long as it is initiated before one year after the final submission (as described in section II) is received by the OIG. Prior to proceeding with such an independent review, the OIG shall notify NHC of its intent to do so and its reasons for believing such a review is necessary, and shall in good faith attempt to resolve any Billing or Compliance Review issues without proceeding with an independent review.

E. Confidential Disclosure Program.

NHC has established and shall maintain a Confidential Disclosure Program, which includes a toll-free compliance telephone line (the NHC ValuesLine) to enable 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 NHC's policies, practices or procedures with respect to a Federal health care program, believed by the individual to be a potential violation of criminal, civil or administrative law. NHC shall continue to publicize the existence of the confidential disclosure mechanism (e.g., via periodic e-mails to employees or by posting the information in prominent common areas).

The Confidential Disclosure Program shall continue to emphasize a non-retribution, non-retaliation policy, and include a reporting mechanism for anonymous, confidential communications. 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, NHC shall conduct an internal review of the allegations set forth in such a disclosure and ensure that proper follow-up is conducted.

The Compliance Officer (or his or her designee) shall maintain a confidential disclosure log, which shall include a record and summary of each disclosure received, the status of the respective internal reviews, and any corrective action taken in response to the internal reviews. The confidential disclosure log shall be available to OIG, upon request.

F. Ineligible Persons.

1. *Definition.* For purposes of this CIA, an "Ineligible Person" shall be any individual or entity who: (a) is currently excluded, debarred 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 related to the provision of health care items or services, but has not yet been excluded, debarred or otherwise declared ineligible.

2. *Screening Requirements.* NHC agrees that it shall not hire or engage as contractors any Ineligible Person and NHC shall establish and implement procedures to prevent this occurrence. To prevent hiring or contracting with any Ineligible Person, NHC 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) reviewing 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://www.hhs.gov/oig) (these lists will hereinafter be referred to as the "Exclusion Lists").

3. *Review and Removal Requirement.* Within 90 days of the effective date of this CIA, NHC shall review its list of current employees and Covered Contractors against the Exclusion Lists. Thereafter, NHC shall review the list annually. In addition, NHC shall require employees and Covered Contractors to disclose immediately any debarment, exclusion or other event that makes the individual an Ineligible Person.

If NHC has notice that an employee or Covered Contractor has become an Ineligible Person, NHC shall remove such person from responsibility for, or involvement with, NHC's business operations related to the Federal health care programs and shall remove such person from any 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 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 NHC has notice that an employee or Covered 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, the NHC 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.

G. Notification of Government Investigation or Legal Proceedings.

Within 30 days of discovery, NHC shall notify OIG, in writing, of any ongoing investigation or legal proceeding conducted or brought by a governmental entity or its agents involving an allegation that NHC 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. NHC shall also provide written notice to OIG within 30 days of the resolution of the matter, and shall provide OIG with a description of the findings and/or results of the proceedings, if any.

H. Reporting of Overpayments and Material Deficiencies.

1. *Overpayments*

a. Definition of Overpayments. For purposes of this CIA, an "overpayment" shall mean the amount of money NHC has received in excess of the amount due and payable under any Federal health

care program requirements. NHC may not subtract any underpayments for purposes of determining the amount of relevant "overpayments."

b. Reporting of Overpayments. If, at any time, NHC identifies or learns of any overpayments, NHC shall notify the payor (e.g., Medicare fiscal intermediary or carrier) and repay any identified overpayments within 30 days of discovery and take remedial steps within 60 days of discovery (or such additional time as may be agreed to by the payor) to correct the problem, including preventing the underlying problem and the overpayments from recurring. Notification and repayment to the contractor should be done in accordance with the contractor policies and program guidelines, and for Medicare contractors, must include the information contained on the Overpayment Refund Form, provided as Appendix B to this CIA.

2. *Material Deficiencies.*

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

i) a substantial overpayment; or

ii) a matter that a reasonable person would consider a potential violation of criminal, civil, or administrative laws applicable to any Federal health care program for which penalties or exclusion may be authorized.

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

b. Reporting of Material Deficiencies. If NHC determines that there is a Material Deficiency, NHC shall notify OIG, in writing, within 30 days of making the determination that the Material Deficiency exists. The report to the OIG shall include the following information:

i) If the Material Deficiency results in an overpayment, a report of same shall be made to the OIG at the same time as the notification to the payor required in section III.H.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) on 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 NHC's actions taken to correct the Material Deficiency; and

iv) any further steps NHC 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 of this CIA, NHC changes locations or purchases or establishes new business units related to the furnishing of items or services that may be reimbursed by Federal health care programs, NHC shall notify OIG of this fact as soon as possible, but no later than within 90 days of the date of change of location, purchase or establishment or NHC's next-filed 10Q report to the Securities and Exchange Commission, whichever is earlier. This notification shall include the location of the new operation(s), phone number, fax number, Medicare provider number(s) (if any), and the corresponding contractor's name and address that has issued each Medicare provider number. All Covered Persons and Covered Contractors at such locations 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 120 days after the effective date of this CIA, NHC 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;

2. the names and positions of the members of the Compliance Committee required by section III.A;

3. a copy of NHC's Code of Conduct required by section III.B.1;

4. the summary of the Policies and Procedures required by section III.B.2;

5. a description of the training required by section III.C, 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 made available to all appropriate Covered Persons;

b. all Covered Persons have completed the Code of Conduct certification required by section III.B.1; and

c. except as otherwise noted, all Covered Persons have completed the applicable training and executed the certification(s) required by section III.C.;

The documentation supporting this certification shall be available to OIG, upon request.

7. a description of the Confidential Disclosure Program required by section III.E;

8. the identity of the IRO(s) and the proposed start and completion dates of the first annual review;

9. a summary of personnel actions taken pursuant to section III.F.;

10. a list of all of NHC'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 contractor's name and address that issued each provider identification number;

11. to the extent not already furnished to OIG, or if modified, a description of NHC's corporate structure, including identification of any parent and sister companies, subsidiaries and their respective lines of business; and

12. the certification required by section V.C.

B. Annual Reports. NHC shall submit to OIG Annual Reports with respect to the status of and findings regarding of NHC's compliance activities for each of the five one-year periods beginning on the effective date of the CIA. (The one-year period covered by each Annual Report shall be referred to as "the Reporting Period").

Each Annual Report shall include:

1. any change in the identity or position description of the Compliance Officer and/or members of the Compliance Committee described in section III.A;

2. a certification by the Compliance Officer that:

a. all Covered Persons have completed the annual Code of Conduct certification required by section III.B.1;

b. all Covered Persons have completed the applicable training and executed the certification(s) required by section III.C;

c. NHC 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; and (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.

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);

4. a description of the training required by section III.C 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;

5. a complete copy of all reports prepared pursuant to the IRO's billing and compliance engagements, including a copy of the methodology used, along with a copy of the IRO's engagement letter;

6. NHC's response and corrective action plan(s) related to any issues raised by the IRO(s);

7. a summary of Material Deficiencies (as defined in III.H) identified during the Reporting Period and the status of any corrective and preventative action relating to all such Material Deficiencies;

8. a report of the aggregate overpayments that have been returned to the Federal health care programs. Overpayment amounts should be broken down into the following categories: inpatient Medicare, outpatient Medicare, Medicaid (report each applicable state separately) and other Federal health care programs;

9. a summary of the disclosures in the confidential disclosure log required by section III.E that: (a) relate to Federal health care programs; or (b) allege abuse or neglect of patients;

10. a description of any personnel actions (other than hiring) taken by NHC as a result of the obligations in section III.F, and the name, title, and responsibilities of any person that falls within the ambit of section III.F.4, and the actions taken in response to the obligations set forth in that section;

11. a summary describing any ongoing investigation or legal proceeding required to have been reported pursuant to section III.G. 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;

12. a description of all changes to the most recently provided list (as updated) of NHC's locations (including locations and mailing addresses) as required by section V.A.10, the corresponding name under which each

location is doing business, the corresponding phone numbers and fax numbers, each location's Federal health care program provider identification number(s), and the contractor name and address that issued each provider identification number; and

13. the certification required by section V.C.

The first Annual Report shall be received by the OIG no later than one year and 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 a certification by the Compliance Officer that: (1) except as otherwise described in the applicable report, NHC is in compliance with all of the requirements of this CIA, to the best of his or her knowledge; and (2) the Compliance Officer has reviewed the Report and has made reasonable inquiry regarding its content and believes that the information is accurate and truthful.

D. Designation of Information: NHC 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 exempt from disclosure under the Freedom of Information Act ("FOIA"), 5 U.S.C. § 552. NHC 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 of this CIA, all notifications and reports required under this CIA shall be submitted to the following entities:

OIG:

Civil Recoveries Branch - Compliance Unit
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, SW
Washington, DC 20201
Phone 202.619.2078
Fax 202.205.0604

NHC: Carol Ann Hempfner, Corporate Compliance Officer
NHC
100 E. Vine Street, Suite 800
Murfreesboro, TN 37130
Phone 615.890.2020
Fax 615.890.0123

With a copy to:

Richard F. LaRoche, Jr.
NHC Office of General Counsel
P. O. Box 1398
Murfreesboro, TN 37133-1398
Phone 615.890.2020
Fax 615.890.0123

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 NHC's books, records, and other documents and supporting materials and/or conduct on-site reviews of any of NHC's locations for the purpose of verifying and evaluating: (a) NHC's

compliance with the terms of this CIA; and (b) NHC's compliance with the requirements of the Federal health care programs in which it participates. The documentation described above shall be made available by NHC 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 NHC'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. NHC agrees to assist OIG or its duly authorized representative(s) in contacting and arranging interviews with such individuals upon OIG's request. NHC's employees may elect to be interviewed with or without a representative of NHC present.

VIII. DOCUMENT AND RECORD RETENTION

NHC 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, the OIG shall make a reasonable effort to notify NHC prior to any release by OIG of information submitted by NHC pursuant to its obligations under this CIA and identified upon submission by NHC as trade secrets, or information that is commercial or financial and privileged or confidential, under the FOIA rules. With respect to such releases, NHC shall have the rights set forth at 45 C.F.R. § 5.65(d). NHC shall refrain from identifying any information as exempt from release if that information does not meet the criteria for exemption from disclosure under FOIA.

X. BREACH AND DEFAULT PROVISIONS

NHC 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, NHC 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 NHC fails to have in place any of the following:

a. a Compliance Officer as described by section III.A.1;

b. a Compliance Committee as described by section III.A.2;

c. a written Code of Conduct as described by section III.B.1;

d. written Policies and Procedures as described by section III.B.2;

e. a requirement that Covered Persons be trained as described in section III.C; and

f. a Confidential Disclosure Program as described in section III.E.

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 NHC fails to retain an IRO, as required in section III.D.

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 NHC fails to meet any of the deadlines for the submission of the Implementation Report or the Annual Reports 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 NHC employs or contracts with an Ineligible Person and that person: (i) has responsibility for, or involvement with, NHC's business operations related to the Federal health care programs; or (ii) 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 paragraph shall not be demanded for any time period during which NHC can demonstrate that it did not discover the person's exclusion or other ineligibility after making a reasonable inquiry (as described in section III.F) as to the status of the person).

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

6. A Stipulated Penalty of $1,000 for each day NHC fails to comply fully and adequately with any obligation of this CIA not already covered in paragraphs 1-5. In its notice to NHC, OIG shall state the specific grounds for its determination that NHC has failed to comply fully and adequately with the CIA obligation(s) at issue and steps the NHC must take to comply with the CIA. (This Stipulated Penalty shall begin to accrue 10 days after the date that OIG provides notice to NHC of the failure to comply.)

B. Timely Written Requests for Extensions. NHC may, in advance of the due date, submit a timely written request 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 NHC 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 two business days after NHC 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 NHC 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 NHC of: (a) NHC's failure to comply; and (b) the 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 of the receipt of the Demand Letter, NHC 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 NHC elects to request an ALJ hearing, the Stipulated Penalties shall continue to accrue until NHC 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 NHC 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 NHC to report a material deficiency, take corrective action and make the appropriate refunds, as required in section III.H;

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; or

d. a failure to retain and use an Independent Review Organization in accordance with section III.D.

2. *Notice of Material Breach and Intent to Exclude.* The parties agree that a material breach of this CIA by NHC constitutes an independent basis for NHC's exclusion from participation in the Federal health care programs. Upon a determination by OIG that NHC has materially breached this CIA and that exclusion should be imposed, OIG shall notify NHC of: (a) NHC'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").

3. *Opportunity to Cure.* NHC 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. NHC is in full compliance with this CIA;

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) NHC has begun to take action to cure the material breach; (ii) NHC is pursuing such action with due diligence; and (iii) NHC has provided to OIG a reasonable timetable for curing the material breach.

4. *Exclusion Letter.* If at the conclusion of the 30-day period, NHC fails to satisfy the requirements of section X.D.3, OIG may exclude NHC from participation in the Federal health care programs. OIG will notify NHC in writing of its determination to

exclude NHC (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, NHC wishes to apply for reinstatement, NHC must 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 NHC 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, NHC 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 ALJ and, in the event of an appeal, the 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 of the receipt of the Demand Letter and the request for a hearing involving exclusion shall be made within 25 days of 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 NHC was in full and timely compliance with the obligations of this CIA for which the OIG demands payment; and (b) the period of noncompliance. NHC shall have the burden of proving its full and timely compliance and the steps taken to cure the noncompliance, if any. If the ALJ agrees with OIG with regard to a finding of a breach of this CIA and orders NHC to pay Stipulated Penalties, such Stipulated Penalties shall become due and payable 20 days after the ALJ issues such a decision unless NHC 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 NHC 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) NHC had begun to take action to cure the material breach within that period;

(ii) NHC has pursued and is pursuing such action with due diligence; and

(iii) NHC provided to OIG within that period a reasonable timetable for curing the material breach and NHC 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 the NHC, only after a DAB decision in favor of OIG. NHC's election of its contractual right to appeal to the DAB shall not abrogate the OIG's authority to exclude NHC upon the issuance of an ALJ's decision in favor of the OIG. If the ALJ sustains the determination of the OIG and determines that exclusion is authorized, such exclusion shall take effect 20 days after the ALJ issues such a decision, notwithstanding that NHC 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.

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.

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, NHC and OIG agree as follows:

A. This CIA shall be binding on the successors, assigns, and transferees of NHC;

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; and

D. The undersigned NHC 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.

ON BEHALF OF NHC

Richard Parfitt, SVP & Gen. Counsel — 11-15-00 DATE

Carol Ann Hempfner, Corporate Compliance Officer — 11-15-00 DATE

_____ DATE

eflt

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

11/14/03

Lewis Morris
Assistant Inspector General for Legal Affairs
Office of Inspector General
U. S. Department of Health and Human Services

Date

AMENDMENT TO THE CORPORATE INTEGRITY AGREEMENT
BETWEEN THE
OFFICE OF INSPECTOR GENERAL OF THE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
AND
NATIONAL HEALTHCARE CORPORATION

The Office of Inspector General ("OIG") of the Department of Health and Human Services and National HealthCare Corporateion ("NHC") entered into a Corporate Integrity Agreement ("CIA") on November 15, 2000.

A. Pursuant to section XI.C. of NHC's CIA, modifications to the CIA may be made with the prior written consent of both the OIG and NHC. Therefore, the OIG and NHC hereby agree that NHC's CIA will be amended as follows:

Section III.D., Review Procedures of the CIA is hereby superceded by the attached new section III.D., Review Procedures.

Appendix A of NHC's CIA is hereby superceded by the attached new Appendix A.

B. The OIG and NHC agree that all other sections of NHC's CIA will remain unchanged and in effect, unless specifically amended upon the prior written consent of the OIG and NHC.

C. The undersigned NHC signatory represents and warrants that he or she is authorized to execute this Amendment. The undersigned OIG signatory represents that he is signing the Amendment in his official capacity and that he is authorized to execute this Amendment.

D. The effective date of this Amendment will be the date on which the final signatory of this Amendment signs this Amendment.

ON BEHALF OF NATIONAL HEALTHCARE CORPORATION

Carol Ann Hempfner

10/22/02
DATE

Carol Ann Hempfner
Compliance Officer
National HealthCare Corporation

Richard F. LaRoche

10/22/02
DATE

Richard F. LaRoche, Jr.
Secretary
National HealthCare Corporation

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

10/24/02
DATE

LEWIS MORRIS
Assistant Inspector General for Legal Affairs
Office of Inspector General
U.S. Department of Health and Human Services

D. Review Procedures.

1. *General Description.*

a. Retention of Independent Review Organization. Within 90 days of the effective date of this CIA, NHC shall retain an entity (or entities), such as an accounting, auditing or consulting firm (hereinafter "Independent Review Organization" or "IRO"), to perform agreed-upon procedures engagements (hereafter "Reviews") to assist NHC in evaluating its coding and billing practices and its compliance obligations pursuant to this CIA and the Settlement Agreement. Each Independent Review Organization retained by NHC shall have expertise in the billing, coding, reporting and other requirements of the particular section of the health care industry pertaining to this CIA and in the general requirements of the Federal health care program(s) from which NHC seeks reimbursement.

b. Types of Engagements. The Independent Review Organization(s) shall conduct two separate engagements. One engagement shall address NHC's coding and billings to the Federal health care programs ("Billing Engagement"). The second engagement shall address NHC's compliance with the obligations assumed under this CIA and the Settlement Agreement ("Compliance Engagement"). The IRO shall produce a separate report for each engagement.

c. Frequency of Billing and Compliance Engagements. The Billing Engagement shall be performed annually and shall cover each of the one-year periods beginning with the effective date of this CIA. However, the IRO shall generate a Systems Review Report for only the first, third and fifth one-year periods beginning on the effective date of this CIA. The IRO(s) shall perform all components of each annual Billing Engagement that are designated herein as IRO responsibilities. The Compliance Engagement shall be performed by

the IRO for the first one-year period beginning with the effective date of this CIA.

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

2. *Billing Engagement.* The Billing Engagement shall be composed of two separate reviews, a "Claims Review and a "Systems Review". The Claims Review and corresponding Claims Review Report are discussed in detail in Appendix A to this CIA, which is incorporated by reference.

a. Claims Review. The IRO shall perform a Claims Review which will review Medicare (Part A) claims and focus on the Minimum Data Set ("MDS"). The Claims Review shall be performed in accordance with the procedures set forth below and in Appendix A to this CIA. The Claims Review shall consist of a variable appraisal (dollar amount in error) sample. Because this engagement is designed as a variable appraisal, for the purposes of determining dollar amounts associated with errors, the final sampling unit will be a single claim (UB-92) and each associated MDS.

The Claims Review shall consist of a two-stage process of claims review. For each annual Claims Review, the IRO shall randomly select one-fifth of NHC's facilities. The first stage of the claims review shall be conducted using a random sample of fifty claims from each of those selected facilities. The second stage of the review will be conducted using claims at facilities which exceed the error rate threshold set forth below. NHC shall retain copies of all of its work papers compiled with respect to its internal audits, which work papers shall be available to the OIG upon request.

1. First Stage of Claims Review (Discovery Sample). The first stage of the Claims Review shall consist of a discovery

sample of fifty (50) claims at each facility selected as part of the random sample. The IRO shall select a stratified random sample of paid Medicare claims (UB-92s) throughout the year for each of the facilities selected. The discovery sample will be used to identify facilities that have exceeded a designated financial error rate and to determine the appropriate sample sizes for expanded sample reviews of the designated facilities in accordance with specified RAT-STATS parameters.

2. Selection of Facilities for Second Stage of Claims Review. The second stage of the Claims Review will be performed for each individual facility selected as part of the discovery sample in the first stage for which the financial error rate (i.e., a downward change in a Resource Utilization Group ("RUG") assignment that would result in an over-payment as defined in Appendix A) was greater than 5%. (Note: The threshold listed above does not imply that this is an acceptable error rate. Accordingly, NHC should, as appropriate, further analyze any errors identified in the Discovery Sample. NHC recognizes that the OIG or other 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.) Moreover, nothing in this CIA or its attachments shall relieve NHC of its responsibility to correct inaccuracies and repay Overpayments noted in its discovery sample. To the extent that a financial threshold is used (*i.e.* - the 5% error rate), it has no bearing on other matters (such as extrapolation of overpayments).

3. Second Stage of Claims Review. If necessary, the second stage of the Claims Review the IRO shall perform an additional sample of Paid Claims using commonly accepted sampling methods and in accordance with Appendix A. The Full Sample shall be selected at the end of each year and

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 the Centers for Medicare and Medicaid Services' statistical sampling for overpayment estimation guidelines. . The Paid Claims shall be reviewed based on supporting documentation available at NHC or under NHC'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, NHC 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. The OIG, in its full discretion, may refer the findings of the Full Sample (and any related workpapers) received from NHC 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.

4. Claims Review Analysis. For each claim selected in the first and second stage, the associated MDS and the medical record documentation supporting the MDS will be reviewed. The review process shall entail an evaluation of the 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. In addition, data from the MDS will be re-entered into the IRO's MDS data entry software program to verify that the correct RUG code assignment was properly assigned on the UB-92. A financial error will be logged if there is insufficient support for an MDS data point(s) that results in a downward change in RUG assignment that would result in an overpayment.

b. Claims Review Report. The IRO shall prepare a report based upon each Claims Review performed ("Claims Review Report"). The Claims Review Report shall be created in accordance with the procedures set forth in Attachment I to this CIA.

c. Repayment of Identified Overpayments. In accordance with section III.H.1 of the CIA, NHC 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. NHC agrees to make available to the OIG any and all documentation that reflects the refund of the Overpayment(s) to the payor and the associated documentation.

c. Systems Review. If NHC's Discovery Sample identifies an Error Rate of 5% or greater, NHC shall prepare and provide to the IRO documentation as to the procedures and controls affecting the submission and billing process, subject to the annual assessment as specified in the CIA. The submission and billing process (e.g., flow of documents, processing activities) and related controls should be documented in the form of flow charts, narratives, excerpts from policies and procedures manuals, control questionnaires, etc. In order to perform its Systems Review, the IRO shall perform all necessary procedures, including but not limited to, a review of all appropriate documentation and discussions with all appropriate personnel, in order to test the effectiveness of the controls identified in the process documentation and comment on the effectiveness of the related controls, including, but not limited to, the following:

i. NHC's billing systems and/or operations relating to claims submitted to all Federal health care programs (including, but not limited to, the operation of the billing system, safeguards to ensure proper claim submission and billing, and procedures to correct inaccurate billing);

ii. NHC's documentation and coding systems and/or operations relating to claims submitted to all Federal health care programs (including, but not limited to, the process by which claims are coded (*e.g.* - RUGs codes assignments), safeguards to ensure proper coding, and procedures to correct inaccurate coding); and

iii. NHC's cost report, cost statement, information statement and payment request preparation process relating to any and all costs submitted to Federal health care programs (including, but not limited to, the steps NHC takes to ensure that the proper information is being recorded on submissions to Federal health care programs and safeguards to ensure that only proper costs and dollar amounts are being submitted for reimbursement to such programs).

d. Systems Review Report. The IRO shall prepare a report based upon each Systems Review performed ("Systems Review Report"). The Systems Review Report shall include the IRO's findings and supporting rationale regarding:

i. the strengths and weaknesses in NHC's billing systems and/or operations;

ii. the strengths and weaknesses in NHC's documentation and coding systems and/or operations;

iii. the strengths and weaknesses in NHC's cost report, cost statement, information statement and payment request preparation process relating to any and all costs submitted to Federal health care programs; and

iv. any recommendations the IRO may have to improve any weaknesses identified in the systems, operations, and processes specified in sections III.D.2.d.i-iii.

e. Statistical Sampling and Appraisal Method. All matters related to this CIA that involve statistical sampling or appraisal shall be conducted using the OIG's Office of Audit Services Statistical Sampling Software, also known as "RAT-STATS," available on the Internet at www.hhs.gov/oig/oas/ratstat.html. Wherever the CIA requires the use of a random sample, the sample shall be selected and appraised using RAT-STATS and NHC shall retain all of the supporting documentation related to the selection and appraisal of the samples.

3. *Compliance Engagement.*

a. Compliance Review. The IRO shall conduct a review of NHC's compliance activities ("Compliance Review"). The Compliance Review shall consist of a review of NHC's compliance with the obligations set forth in each section of this CIA, and a review of NHC's compliance with certain provisions of the Settlement Agreement.

i. CIA Obligations Review. The IRO shall evaluate NHC's compliance with the obligations set forth in each section of this CIA.

ii. Unallowable Costs Review. The IRO shall determine whether NHC has complied with its obligation (as defined in Paragraph 11 of the Settlement Agreement) not to charge to, or otherwise seek payment from, Federal or State payors for Unallowable Costs (as defined in Paragraph 11 of 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. The procedures to be performed by the IRO will include procedures to verify that the list of Unallowable Costs (as provided to the IRO pursuant to Paragraph 3.a.iii of this Section) is consistent with NHC's obligations in Paragraph 11 of the Settlement Agreement, that the costs have been provided to the appropriate payors, and that the costs have been removed from previously filed requests for payment from the United States and any State Medicaid program or from any such requests yet to be filed. 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 NHC or any of its subsidiaries, and to request, and agree, that such cost reports, cost statements, information reports or payment requests, even if already settled, be adjusted to account for the effect of the inclusion of the unallowable costs. In making this determination, the IRO may need to review cost reports and/or financial statements from the year of the Settlement Agreement, as well as from previous years.

iii. NHC shall prepare and provide to the IRO a list of all Unallowable Costs and shall further indicate which of these Unallowable Costs have been included in payments sought in any cost reports, cost statements, information reports, or payment requests already submitted by NHC or any of its subsidiaries to any Federal or State Medicaid programs. This list of Unallowable Costs shall include a description of the nature of the cost, the dollar value of the unallowable cost, the time period during which the unallowable cost was incurred and, if appropriate, an identification of the NHC facility or location to which the cost is attributable.

b. Compliance Review Report. The IRO shall prepare a report based upon the Compliance Review performed (the "Compliance Review Report"). The Compliance Review Report shall include:

i. the IRO's findings, supporting rationale, and a summary of such findings and rationale regarding NHC's compliance with the terms of each section of the CIA, as applicable; and

ii. the IRO's findings and supporting rationale regarding whether NHC 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 .

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

Prior to initiating a Validation Review, the OIG shall notify NHC of its intent to do so and provide a written explanation of why the OIG believes such a review is necessary. To resolve any concerns raised by the OIG, NHC may request a meeting with the OIG to discuss the results of any Claims Review, Systems Review, or Compliance Review submissions or findings; present any additional or relevant information to clarify the results of the Claims Review, Systems Review, or Compliance Review or to correct the inaccuracy of the Claims Review; and/or propose alternatives to

the proposed Validation Review. NHC agrees to provide any additional information as may be requested by the OIG under this section in an expedited manner. The OIG will attempt in good faith to resolve any Claims Review, Systems Review or Compliance Review issues with NHC 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 the OIG.

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

APPENDIX A

A. Claims Review.

1. **Definitions**. For the purposes of the Claims Review (section III.D.2.a of the CIA), the following definitions shall be used:

a. Overpayment: The amount of money NHC has received in excess of the amount due and payable under any Federal health care program requirements.

b. Item: A Medicare claim (UB-92) and each associated MDS.

c. Paid Claim: A Medicare claim (UB-92) submitted by NHC and for which NHC has received reimbursement from the Medicare program

d. Population: All Items for which NHC has submitted a code or line item and for which NHC has received reimbursement from the Medicare program (i.e., a Paid Claim) during the 12-month period covered by the Claims Review. To be included in the Population, an Item must have resulted in at least one Paid Claim.

e. Error Rate: The Error Rate shall be the percentage of net overpayments identified in the sample. 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 NHC cannot produce documentation sufficient to support the Paid Claim shall be considered an error and the total reimbursement received by NHC for such Paid Claim shall be deemed an Overpayment. Replacement sampling for Paid Claims with missing documentation is not permitted.

b. 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.

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. Sampling Unit. A description of the Item as that term is utilized for the Claims Review (*i.e.* - a Medicare UB-92 claim).

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

c. Claims Review Objective. A clear statement of the objective intended to be achieved by 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. **Claims Review Findings.**

a. a description of NHC's billing and coding system(s), including the identification, by position description, of the personnel involved in coding and billing;

b. the IRO's findings, supporting rationale, and a summary of such findings and rationale 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. Note: for the purpose of this reporting, 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; and

c. the IRO's findings and recommendations concerning the Systems Review (if any).

3. **Statistical Sampling Documentation.**

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

b. A copy of the printout of the random numbers generated by the "Random Numbers" function of the statistical sampling software used by the IRO.

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

d. A description or identification of the statistical sampling software package used to conduct the sampling.

4. **Claims Review Results.**

a. Total number and percentage of instances in which the IRO determined that the Paid Claims submitted by NHC ("Claims Submitted") differed from what should have been the correct claim ("Correct Claim"), regardless of the effect on the payment.

b. 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 NHC.

c. Total dollar amount of paid Items included in the sample and the net Overpayment associated with the sample.

d. Error Rate in the sample.

e. 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, procedure code submitted, procedure code reimbursed, allowed amount reimbursed by payor, correct procedure code (as determined by the IRO), correct allowed amount (as determined by the IRO), dollar difference between allowed amount reimbursed by payor and the correct allowed amount. (See Attachment 1 to this Appendix.)

5. **Systems Review.** Observations and recommendations on possible improvements to the system(s) and process(es) that generated the Overpayment(s) in the sample Population.

6. **Credentials.** The names and credentials of the individuals who: (1) designed the statistical sampling procedures and the review methodology utilized for the Claims Review; and (2) performed the Claims Review.

Attachment 1

Claim Review Results

Federal Health Care Program Billed	Bene HIC #	Date of Service	Procedure Code Submitted	Procedure Code Reimbursed	Allowed Amount Reimbursed	Correct Procedure Code (IRO determined)	Correct Allowed Amt Reimbursed (IRO determined)	Dollar Difference between Amt Reimbursed and Correct Allowed Amt