



# Community Health Systems Code of Conduct



2019-2020



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CODE OF CONDUCT

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# COMMUNITY HEALTH SYSTEMS<sup>1</sup>

## CODE OF CONDUCT

### STATEMENT OF BELIEFS

We believe that each community served is different and that the success of each facility depends upon the actions of each colleague, physician, contractor, and agent of that facility. We have adopted the following Statement of Beliefs that summarizes the commitments of the organization's constituents to our patients, colleagues, physicians, and the communities served.

We are dedicated to providing personalized, caring, cost effective, and efficient service to our patients with satisfaction as our top priority.

We recognize the value of each colleague in providing quality, personalized care to our patients. We encourage colleague involvement in quality improvement to improve processes on an ongoing basis. We advocate participation in community activities.

We are committed to involving physicians in partnership, both as consumers of service and as providers in ensuring quality care.

We demonstrate that Safety is a core value with our highly reliable leadership methods, SAFE error prevention behaviors and communications.

We are devoted through services, quality, and innovation to provide continued healthcare leadership in the communities we serve.

Although aspects of the Compliance Program focus on various legal areas, the primary focus of the Compliance Program is to ensure that internal policies and controls, training and education, and auditing and monitoring are in place to help prevent, detect, and deter fraud, abuse, and waste in government health care programs. Accordingly, we are dedicated to compliance with all federal, state, and local laws, rules, and regulations, including privacy and security of patient health information, coding, billing, and documentation guidelines, and financial arrangements.

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<sup>1</sup> Community Health Systems, Inc. ("CHSI") is a stock holding company whose shares are traded on the New York Stock Exchange ("NYSE"). Its subsidiary companies and partnerships own or lease and operate their respective hospitals and other assets and businesses. Community Health Systems, Inc. does not have any employees. Throughout this document, we refer to Community Health Systems, Inc. and its consolidated subsidiaries in a simplified manner and on a collective basis, using words like "we," "our," "our organization," "CHS" and the "Company". This drafting style is suggested by the Securities and Exchange Commission, or SEC, and is not meant to indicate that Community Health Systems, Inc. or any other subsidiary of Community Health Systems, Inc. owns, controls, or operates any asset, business, or property. The hospitals, operations, and businesses are owned and operated, and professional services provided, by distinct and indirect subsidiaries of Community Health Systems, Inc. CHSPSC, LLC ("CHSPSC"), an indirect subsidiary of CHSI, provides professional and consulting services to the local operating entities pursuant to the terms of professional services agreements with the local entities. CHSI has no employees, and those officers and directors of CHSI who are individually identified in this document are employed by CHSPSC.

## **WELCOME**

Dear Colleagues,

It is my pleasure to welcome you to Community Health Systems.

When you decided to join our organization, you made an important personal and professional decision. Your decision included a responsibility not only to provide high quality healthcare, but also to personally conduct yourself in such a way that is consistent with the organization's commitment to operate with the highest standards of integrity and behavior.

Every person, business or government entity that comes in contact with a CHS representative expects this level of commitment, and so do we. It's the way we do business.

We have created a Code of Conduct which starts with our Statement of Beliefs and is an integral part of our compliance program. It should be used with policies and procedures, applicable regulations and laws and good common sense. It serves as a solid framework for business decisions and, pursuant to the Affordable Care Act and similar laws, it is mandatory that each of us comply with this Code of Conduct every single day.

As a condition of your association with CHS, it is required that you read the Code of Conduct so that you are aware of these standards.

Thank you very much.

Sincerely,

Wayne T. Smith

## **INTRODUCTION**

The Code of Conduct (the “Code”) is designed to provide all persons and businesses associated with Community Health Systems, Inc. and its subsidiaries (collectively “CHS” or the “organization”) including directors, officers, colleagues, physicians, contractors, and agents with guidance to perform their daily activities in accordance with the organization’s ethical standards and all federal, state, and local laws, rules, and regulations. The Code is an integral component of the organization’s Compliance Program and reflects our commitment to achieve our goals within the framework of the law through a high standard of business ethics and compliance. This Code of Conduct has been adopted by the Board of Directors of Community Health Systems, Inc. and by each subsidiary.

The Code encompasses a summary of many topics from Compliance policies and other department policies. The Compliance policies and other department policies and procedures provide more specific guidance relating to the topics presented in the Code. It is the obligation of CHS colleagues to be knowledgeable about and adhere to these policies as well as the Code.

The Code is based on federal, state and local regulatory compliance and therefore compliance with all policies incorporated into the Code of Conduct is mandatory. Failure to comply with any of the provisions of this Code of Conduct may result in disciplinary action by your specific facility for colleagues and cancellation of contractual or business relationships with physicians, contractors, vendors, and agents. Violations of portions of this Code relating to federal healthcare benefit programs may lead to severe consequences including, but not limited to, civil monetary penalties and/or exclusion from federal healthcare benefit programs for colleagues, physicians, contractors, vendors, agents, facilities, or CHS. Questions or concerns regarding interpretation of this Code or any Compliance policy should be addressed to a supervisor, the Facility Compliance Officer (FCO)<sup>2</sup>, the Corporate Compliance and Privacy Officer, or the Confidential Disclosure Program.

## **THE ROLE OF MANAGEMENT**

Though all CHS colleagues are required to follow the Code of Conduct, all managers, directors, supervisors, board members, and corporate staff are expected to set the example by conducting their business affairs consistent with the highest ethical and legal standards. Managers must ensure their staff has the tools to perform assigned tasks according to applicable laws, rules, regulations, and policies. In addition, the Board of Directors of Community Health Systems, Inc. has established the Executive Compliance Committee (the “Committee”). The Committee is responsible for the adoption, amendment, and ultimate enforcement of the Compliance Program. The standing members of this committee are:

Wayne T. Smith, Chairman and Chief Executive Officer  
Tim Hingtgen, President and Chief Operating Officer  
Kevin Hammons, Executive Vice President and Chief Financial Officer  
Lynn T. Simon, M.D., MBA, President, Clinical Operations and Chief Medical Officer  
Ben Fordham, Executive Vice President, General Counsel and Assistant Secretary  
Beth Witte, Vice President, Internal Audit  
Michael Lynd, Senior Vice President, Financial Services  
Andi Bosshart, Senior Vice President, Corporate Compliance and Privacy Officer

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<sup>2</sup> Facility Compliance Officer (“FCO”) collectively refers to Compliance Officers of any CHS affiliated entity including but not limited to hospitals, home health or hospice agencies, ambulatory surgery centers, physician practices, skilled nursing facilities, and inpatient rehabilitation facilities.

Employees of CHSPSC, which provides professional and consulting services to CHSI's affiliates, provide advice and recommendations on particular functions or areas of expertise.

The Corporate Compliance and Privacy Officer is Andi Bosshart. Ms. Bosshart is an employee of CHSPSC. The responsibilities of the Corporate Compliance and Privacy Officer include:

- € Overseeing and monitoring the implementation of the Compliance Program.
- € Designing and deploying a comprehensive compliance risk assessment program to identify potential risks to the organization.
- € Creating routine and focused auditing and monitoring activities pursuant to identified potential risks to the organization, and acting upon the results of those assessments to mitigate and correct inappropriate or inadequate controls, up to and including reporting to appropriate government authorities.
- € Meeting regularly with the Executive Compliance Committee to discuss compliance risks, progress of implementation of risk mitigation activities, and assisting the Committee with establishing plans and methods to reduce the organization's vulnerability to fraud, abuse and waste.
- € Periodically revising the Program in light of changes in the needs of the organization, and in the law and policies and procedures of government and private payer health plans.
- € Developing, coordinating, and participating in a multifaceted education and training program that focuses on the elements of the Compliance Program, meeting federal requirements, and seeks to ensure that all appropriate colleagues and management are knowledgeable of, and in compliance with, pertinent federal and state laws and regulations.
- € Seeking to ensure independent contractors, vendors and/or agents who furnish medical and other services to the facilities are aware of the requirements of the Compliance Program.
- € Coordinating personnel issues with appropriate managers to assure colleagues, medical staff and independent contractors have not been sanctioned or excluded from participation in any federal health care program.
- € Assisting the organization's financial officers in coordinating internal review and monitoring activities, including periodic reviews of facilities.
- € Independently investigating and acting on matters related to compliance, including the flexibility to design and coordinate internal investigations (e.g., responding to reports of problems or suspected violations) and any resulting corrective action with all facilities, departments, providers and sub-providers, vendors, agents and, if appropriate, independent contractors.
- € Developing policies and programs that encourage the reporting of suspected fraud and other improprieties without fear of retaliation.
- € Preparing and submitting all periodic reports required under the Compliance Program to the Executive Compliance Committee, the Board Audit and Compliance Committee, and the government under any Corporate Integrity Agreements or compliance reporting requirements for settlement agreements.

## **THE ROLE OF THE INDIVIDUAL**

Every CHS colleague is required to comply with the Code of Conduct. Each individual is expected to perform his/her daily activities with the highest standards of ethics and compliance. Colleagues should notify their FCO, their Facility Privacy Officer (“FPO”), the Corporate Compliance and Privacy Officer or the Confidential Disclosure Program of any known or suspected violations of law, the Code of Conduct, or Compliance Policy. The only way we can address concerns and live up to our expectations for ethical conduct is if we learn about those concerns as soon as they arise.

### ***Grievance Resolution***

If an individual is concerned about a personnel action that does not involve any violation of law, the Code of Conduct, or Compliance Policy, he/she may file a grievance at the facility where he/she is employed. Your facility Human Resources Department can provide a grievance resolution form and assistance in preparing and presenting a grievance. Information provided or received as part of the grievance process is held in strict confidence. Refer to your Handbook or contact your Human Resources Department for more information.

## **CODE OF CONDUCT IN THE WORKPLACE**

### ***Harassment, Discrimination, Retaliation, and Violence***

Everyone has a right to a work environment free of unlawful harassment, discrimination, and retaliation based on race, color, religion, sex, sexual orientation, gender identity, national origin, age, disability, genetic information, citizenship, veteran status, military or uniformed services, or other legally protected characteristics or conduct. We will not tolerate any unlawful harassment of colleagues or applicants. The organization will take action to fairly and objectively address any complaints of unlawful harassment, discrimination, retaliation, or workplace violence. If you experience or witness such behavior, contact your facility Human Resources Department, the FCO, the Corporate Compliance and Privacy Officer, or the Confidential Disclosure Program.

Licensure and certification boards have legal standards that govern medical practitioners’, physicians’, nurses’ and other hospital personnel duties and behavior. Accordingly, anyone who observes or that is otherwise made aware of disruptive behavior by a practitioner should document the behavior and report it to the facility Human Resources Department, the FCO, or a member of administrative management. “Disruptive conduct” includes conduct that poses a threat to patient care or exposes the hospital and/or Medical Staff to liability.

Workplace violence, such as robbery, assault, battery, vandalism, and other crimes will not be tolerated. Colleagues may not bring firearms, explosive devices, or other weapons or dangerous materials into any hospital, practice, agency, home health agency, physician clinic, ambulatory surgery center, office building or affiliated facility. Colleagues who witness any form of violence are required to report the conduct to the facility Security Officers, the Human Resources Director, the FCO, the Corporate Compliance and Privacy Officer, or the Confidential Disclosure Program.

## ***Equal Opportunity***

We value the talents and skill sets of each colleague. The organization is determined to provide an equal opportunity environment and to comply with all laws, regulations, and policies. It is the policy of each CHS affiliate to provide equal opportunity without regard to race, color, religion, sex, sexual orientation, gender identity, national origin, age, disability, genetic information, citizenship, veteran status, military or uniformed services, or other legally protected characteristics.

## ***Investments and Conflicts of Interest***

Outside financial interests that might influence decisions or actions of colleagues in the performance of their duties for the organization are to be avoided. Potential conflicts of interest might include:

- € A personal or family interest in an enterprise that has a business relationship with the organization or a facility.
- € An investment in another business that competes with the organization or a facility.

Any potentially conflicting financial interest owned or acquired (including by gift or inheritance) must be disclosed immediately to the Corporate Compliance and Privacy Officer. Divestiture of such interest may be required if the financial interest is deemed to be in conflict with the organization's best interests. This does not apply to minimal holdings of the stock or other securities of a corporation whose shares are publicly traded and which may also do business or compete with a facility or the organization.

## ***Relationships with Vendors and Suppliers***

When conducting business with vendors or suppliers including physicians, colleagues are expected to maintain impartial relationships with the organization's vendors and suppliers and should be motivated solely to acquire goods, purchase services, and make other transactions on terms most favorable to the organization. Care must be exercised to avoid even the appearance of favoritism on behalf of a vendor or supplier due to personal relationships. Colleagues or their families may not accept any gifts (except those of nominal value), special discounts or loans (other than from established banking or financial institutions), excessive entertainment, or substantial favors from any organization or individual that conducts or is seeking to conduct business with the organization. Reasonable judgment should be used in the determination of "excessive or substantial," and acceptance made only with the approval of a department director or higher level member of management.

Periodically, a vendor may sponsor seminars, training, product demonstrations, or other types of meetings. Vendor-sponsored training offered by a vendor participating in the group purchasing organization, HealthTrust Purchasing Group (HPG), including travel and lodging, may be paid by the vendor when the business value outweighs any recreational or entertainment value of the event. Appropriate approvals must be obtained in advance. Questions should be directed to the Corporate Compliance and Privacy Officer.

Travel associated with attending the HealthTrust Purchasing Group ("HPG") annual conference or participation on an HPG committee is acceptable with prior approval from the colleague's Vice President, or higher level leader.

Colleagues or their families should not offer, give, solicit, or accept kickbacks, rebates, or anything of value to or from any representative of a vendor, supplier, customer, potential customer, patient, physician, financial institution, or similar entity. Cash gifts or tips or cash substitutes in any amount or from any source are strictly prohibited. Such practices are unethical and in many cases illegal.

*Reference: Discounts and Waivers Policy, Policy on Purchasing Goods and Vendor Relationships (Discounts), Business Courtesies and Other Miscellaneous Financial Arrangements with Potential Referral Sources, and your employee handbook.*

## ***Professional Licenses, Certifications, and Credentials***

Colleagues who are required to maintain professional licenses, certifications, or other credentials are personally responsible for maintaining these items in a current and up-to-date status while complying with all pertinent federal, state, local, or professional requirements governing their field of expertise. Proof of current professional licenses, certifications, or credentials must be supplied upon request. No colleague requiring a professional license, certification, or credential will be allowed to perform his or her job duties or contracted assignments until such time he/she meets this requirement. Falsification of certification, licensure, or credentials will lead to disciplinary action up to and including termination.

## ***Substance Abuse and Controlled Substances***

The use of intoxicants, substances causing impairment, or illegal drugs including prescription drugs prescribed for someone other than the colleague while on the job or on the premises is prohibited. Use of such substances off the job or off premises may also be the subject of disciplinary action by your employing facility. Your facility will require substance testing on pre-employment, for cause, and random bases. In addition, we have implemented other drug screening programs to detect and deter the inappropriate use of drugs in the workplace.

At times, colleagues may need to take prescription or over-the-counter drugs that could impair their job performance. It is important for such persons to notify their supervisor if their medication could adversely affect their job performance.

## ***Use of Organizational Assets***

The assets of the organization are to be used solely for the benefit of the organization. Each colleague is responsible for assuring that assets are used only for valid purposes. These assets include, but are not limited to, physical plants, equipment, computers, corporate funds, drugs, medical supplies, services, individually identifiable health information, personally identifiable information, payment card data, office supplies and facility business operations that have not been shared with the general public. These assets will not be used to provide personal gain for colleagues or others. Improper use or removal of the organization's assets is a violation of the Code of Conduct and possibly a violation of the law.

Our organization may not transfer any of our assets to other people except for fair market value consideration and in the ordinary course of business. Computer equipment, hard drives, and other electronic media devices must be disposed of through a CHSPSC approved secure IT asset disposition vendor such as Iron Mountain, or a method defined by policy. Donation of such equipment may only be considered for equipment without memory functionality or that has had memory removed/sanitized via a CHSPSC-approved method. Donations may only be provided to associations or organizations such as schools, charities, or social services groups. Donations, trades, or sales to workforce members, vendors, physicians, or similar individuals are prohibited. Any exception to this policy must be approved by the CHSPSC Information Security Officer and the Corporate Compliance and Privacy Officer.

## ***Health, Safety, and the Environment***

We are committed to providing a safe and healthy workplace for all colleagues, customers, patients, and visitors. We are equally committed to minimizing any negative impact upon the environment. These commitments can be achieved through the awareness and cooperation of all colleagues. We are a learning organization, learning from safety events and near misses as they are communicated via the Patient Safety Organization.

Each colleague is responsible for abiding by safe operating procedures, guarding his/her own health along with his/her colleagues, utilizing pollution control systems, and following safe and sanitary procedures for the disposition of industrial and hazardous waste materials. We are committed to sustaining a highly reliable environment for safety and service. Colleagues should report to a supervisor, department head, the Facility Compliance Officer, the Corporate Compliance and Privacy Officer, or the Confidential Disclosure Program any condition they perceive to be unsafe, unhealthy, or hazardous to the environment. In the event a report of unsafe practices is made, we will review the matter using the Fair Culture Principles.

## ***Inside Information and Securities Trading***

Inside information, such as acquisition plans, financial and operating data (before it is publicly released), marketing plans, or other business material is nonpublic information. At times, colleagues may become aware of inside information, but the use of inside information for personal gain is strictly prohibited and possibly against the law. In addition, disclosing inside information to colleagues, relatives, or friends in an effort to influence their decision to buy, sell, or hold the parent company's or any other company's securities or stock options is strictly prohibited. Inside information should only be shared with people inside the organization whose jobs require the information. For more information, see the Insider Trading Policy in myPolicies.

Colleagues may not engage in any illegal or improper acts to acquire a competitor's trade secrets, customer lists, technical developments, or operations. In addition, a competitor's employees shall not be hired for the purpose of obtaining confidential or proprietary information about the competitor. Competitor's personnel, customers, or suppliers must not be urged or coerced to disclose confidential or proprietary information about the competitor, nor shall such information be sought from competitor's employees subsequently hired by the organization.

## ***Government or Union Officials***

Colleagues will not offer any government employee, union official, or their representatives any meals, entertainment, or gifts that would cause the donor or the recipient to be in violation of any law, regulation, or policy.

# **THE CODE OF CONDUCT AND OUR CUSTOMERS**

## **Patients**

### ***Confidentiality of Patient Information***

When a patient enters a CHS affiliated facility, a large amount of personal, medical, and insurance data is collected and used to satisfy information needs including the ability to make decisions about a patient's care. We consider patient information highly confidential. Colleagues are expected to take care to protect the privacy of individually identifiable health information at all times. All of the facilities within the organization have specific policies describing patient confidentiality and release of information rules that conform to federal, state, and local laws governing the release or disclosure of health information. Each facility has a designated Facility Privacy Officer who conducts or assists with investigations of potential privacy breaches.

Colleagues must never disclose or release confidential patient information including pictures, texts, or recordings in a manner that violates the privacy rights of a patient. Policies on obtaining patient authorization for release of information and confidentiality, and consent to photography or cinematography must be strictly followed before creating or obtaining video, pictures or recordings of patients, patient information, or activities occurring in patient care areas. Patient information may only be discussed or released in accordance with our HIPAA policies in the myPolicies library, which may require either a patient-directed request, a request from a patient's personal representative, or the express written authorization of the patient. Colleagues should not access or use any patient information, including that of themselves, their family members or friends, or of subordinates or co-workers, unless it is necessary to perform his/her job.

*Because of privacy laws, colleagues shall not post statements, stories, pictures, or recordings of patients or individually identifiable health information on any social networking site including but not limited to Instagram, SnapChat, LinkedIn, Pinterest, Facebook, Tumblr, Twitter or YouTube. The use of personal devices for capture and/or transmittal of patient recordings or pictures is strictly prohibited unless conducted through a CHSPSC approved solution for specific patient care functions. Texting individually identifiable health information is prohibited unless sent through a CHSPSC approved solution.*

*Anyone who inappropriately accesses, obtains, uses, or discloses individually identifiable health information may be in violation of the Health Insurance Portability and Accountability Act ("HIPAA") Privacy or Security Rules and may face criminal and/or civil penalties of up to \$250,000 and up to ten years imprisonment.*

In some circumstances, a patient's written authorization for release of information is not required. For example, a patient or a patient's personal representative may request a copy of the patient's medical records. Patient information can be requested from another healthcare institution or physician without the patient's authorization for treatment purposes. Some federal, state, and local agencies may require hospitals to release information without the patient's written authorization under such circumstances as a court order, a search warrant, a subpoena duces tecum, situations of suspected child abuse, various registries, and federal healthcare programs. When in doubt, contact the Health Information Management Director, the FPO, the Vice President of Health Informatics & Information Management, or the Senior Vice President, Corporate Compliance and Privacy Officer.

*Reference: Compliance with HIPAA Privacy Regulations, Definitions; HIPAA Policies and Procedures; Disclosure of PHI to Law Enforcement; Privacy Sanctions Policy; Notice of Privacy Practices; Release of Protected Health Information (PHI) Policy; Right to Access Protected Health Information (PHI) Policy*

## ***Emergency Medical Treatment***

All hospitals must comply with the Emergency Medical Treatment and Active Labor Act (“EMTALA”) when providing emergency medical care. All persons arriving on a hospital’s property or in the emergency department and requesting a medical examination for an emergency medical condition will receive a medical screening examination to determine if such a condition exists. Colleagues should escort any person seeking this examination and/or treatment to the emergency department. If an emergency medical condition exists, the patient will be provided with medical treatment to stabilize the condition and/or an appropriate transfer to another facility. Medical screening or treatment will not be delayed to inquire about an individual’s ability to pay including obtaining or verifying insurance information or advising the patient of his/her financial responsibility for payment of services rendered if he/she receives treatment.

*Reference: EMTALA – Medical Screening/Stabilization Policy*

## ***Patient Rights***

Patients have a right to healthcare at the organization’s facilities without regard to age, gender, sexual orientation, gender identity or expression, race, ethnicity, cultural, language, physical or mental disability, or religious background. Facilities shall not discriminate against patients whose care is paid for under the Medicare, Medicaid, or other governmental payer programs.

Upon admission, each patient, or when appropriate the patient’s representative, will receive a written copy of the patients’ rights and responsibilities. Patients’ rights include but are not limited to the following concepts:

- € Informed consent
- € A safe environment
- € Patient choice for providers of goods and services
- € Privacy and confidentiality
- € Accommodations for vision, speech, hearing, cognitive impairments or language translation services, free of charge
- € Pain management
- € Participation in care decisions, including the provision of advanced directives to providers
- € Risks, benefits, and alternatives to treatments and procedures
- € Outcomes of care and treatment
- € Information about the bill for services
- € Receipt of the Notice of Privacy Practices
- € Ability to access and request an accounting of disclosures, a restriction of use or disclosure of protected health information, or an amendment to the medical record

All patients’ rights also apply to persons who may have legal guardianship or responsibility for healthcare decisions on behalf of the patient.

*Reference: Patient Rights and Responsibilities Policy; Patient Rights and Responsibilities Form 100-ADM-1901*

## ***Human Subject Research***

All human subject research activities, regardless of whether the research is subject to U.S. federal regulations, will be guided by one of the following statements of ethical principles: (a) The World Medical Association's Declaration of Helsinki (as adopted in 1996 or 2000); (b) The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research of the U.S. National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research; or (c) other appropriate international ethical standards recognized by U.S. federal departments and agencies that have adopted the U.S. Federal Policy for the Protection of Human Subjects, known as the Common Rule.

*Reference: Human Subjects Research and Institutional Review Board Policy; and Federal-wide Assurance (FWA) for the Protection of Human Subjects; US Department of Health and Human Services (HHS), Office for Human Research Protections (OHRP).*

## **Physicians**

### ***Financial Arrangements***

The organization has established policies regarding the financial relationships, including ownership and compensation arrangements, between CHS affiliates and physicians and any other referral sources. All agreements for the payment or receipt of money, goods, services, or anything of value with physicians must be in writing and comply with the federal law and regulations commonly known as the Stark Law. Such financial relationships must also be reviewed to ensure compliance with the federal Anti-Kickback Statute. All facilities are prohibited from entering into side agreement(s) (written or verbal agreements that modify a formal written contract) with physicians. Before accepting physician agreements, they must be approved by both the appropriate Operational Leaders and the Corporate Legal Department. These approvals must be obtained even if the agreement complies with the Compliance policies. Issuance of payment to physicians under agreements must be supported by all required documentation, e.g., certification of hours of service or submission of executed agreement with request for payment.

### ***Referrals***

We will not pay for referrals nor will we accept payment for referrals made to other entities. All payments made to physicians and/or other entities must be pursuant to current fully executed written agreements and must be at fair market value for actual services performed. We will not consider the value or volume of referrals, or other business generated between parties in determining where to enter into an arrangement or in setting the compensation to be paid or received.

*Reference: Business Courtesies and Other Miscellaneous Financial Arrangements with Physicians and Physician Family Members Policy*

## **Third Party Payers**

### ***Coding and Billing***

All individuals responsible for coding and billing for services will adhere to all official coding and billing guidelines, rules, regulations, statutes, and laws. Colleagues are prohibited from knowingly causing or permitting false or fraudulent claims. Furthermore, colleagues shall not engage in any intentional deception or misrepresentation intended to influence any entitlement or payment under any state or federal healthcare benefit program. Claims must only reflect the actual services ordered, documented, and performed. Coding of diagnoses and procedures will be in accordance with CMS recognized coding guidelines.

The organization will maintain a routine auditing and monitoring program to verify the accuracy and validity of coded data and claims regardless of the source of payment.

*Reference: Coding Compliance Policy.*

### ***Cost Reports***

Facilities receive reimbursement under government and certain non-government healthcare programs that require the filing of reports on the costs of operation. The organization will comply with all federal, state, and local laws, rules, and regulations relating to all cost reports. We will utilize acceptable practices to determine allowable costs and reimbursement for the costs of services provided to program beneficiaries. Questions regarding the completion and/or settlement of a cost report should be directed to the CHSPSC Revenue Management Department.

## **ACCREDITING BODIES AND REGULATORY COMPLIANCE**

CHS affiliated facilities seek accreditation from various agencies and accrediting bodies; all standards required by those accrediting bodies must be followed. All colleagues should relate with accrediting agencies and bodies in a forthright manner. No action, either directly or indirectly, will be taken to mislead a surveyor or survey team.

Healthcare services may be provided only pursuant to federal, state, and local laws, rules, and regulations. These laws and regulations may include, but are not limited to, certificates of need, licenses, permits, certifications, access to treatment, consent to treatment, medical record maintenance, release of information and confidentiality, patient rights, advance directives, medical staff membership and privileges, organ donation, and Medicare and Medicaid regulations.

Facilities and colleagues must comply with all applicable federal, state, and local laws, rules, and regulations. Any colleague who witnesses or suspects any violations of any law or regulation must immediately report said violation or suspected violation to a supervisor, the Facility Compliance officer, the Corporate Compliance and Privacy Officer, or the Confidential Disclosure Program.

During a survey or government inspection, colleagues must not destroy, conceal, or alter any documents. Furthermore, colleagues must not lie or make misleading comments to a surveyor or government inspector. Colleagues must not obstruct others from providing accurate information to the surveyor or government inspector, nor mislead nor delay the communication of information or provision of records relating to a surveyor or inspector's requests.

Facilities must notify their assigned Corporate Survey Management Director, preferably by email, in the event of a visit or inspection by a survey team.

Upon presentation of a search warrant, subpoena, or other criminal or administrative legal process by a law enforcement official (e.g., FBI, State Bureau of Investigation, US Department of Justice, HHS Office of the Inspector General, State Attorney General, etc.), notify the Executive Vice President, General Counsel at 615-465- 7371 or the Senior Vice President, Chief Litigation Counsel at 615-465-7370.

*Reference: Regulatory Survey Notification Process Policy*

## **FINANCIAL, BUSINESS AND MEDICAL INFORMATION, AND INFORMATION SYSTEMS**

### ***Financial Reporting and Records***

As a public organization, our integrity and reputation depend upon the accuracy and completeness of our financial statements. All accounts and financial records must be maintained strictly in accordance with the CHSPSC Financial Policies and Procedures, as amended from time to time. Colleagues must always keep in mind that each bookkeeping and financial entry will ultimately be incorporated into our consolidated financial statements. Our consolidated financial statements are certified by our officers as being true and materially accurate and not misleading and are presented to the public and the federal government in accordance with generally accepted accounting principles and all Securities and Exchange Commission rules and regulations. All personnel who make bookkeeping and financial entries, prepare financial reports and statements, and disperse assets (especially cash) have special ethical obligations as you perform your duties. When you sign your annual acknowledgement of the CHS Code of Conduct, you are certifying adherence with the following principles:

To the best of my knowledge and ability:

1. I act with honesty and integrity, and I avoid actual or apparent conflicts of interest.
2. I provide constituents with information that is accurate, complete, objective, relevant, timely and understandable.
3. I comply with the rules and regulations of federal, state, provincial and local governments, and other appropriate private and public regulatory agencies.
4. I act in good faith, responsibly, with due care, competence and diligence, without misrepresenting material facts or allowing my independent judgment to be subordinated.
5. I respect the confidentiality of proprietary financial and accounting information acquired in the course of my work except when authorized or otherwise legally obligated to disclose.
6. I share knowledge and maintain skills important and relevant to my constituents' needs.
7. I proactively promote ethical behavior in the preparation and maintenance of the organization's books and accounts and financial records.
8. I achieve responsible use of and control over all assets and resources employed or entrusted to me.

## ***Proprietary Information***

Many laws and regulations govern publicly traded companies associated with healthcare. Proprietary information acquired during the course of employment or contract with the organization is not to be discussed with anyone outside the organization and only discussed within the organization on a need to know basis. Except with proper written authorization by the appropriate personnel of your facility or where required by law, colleagues may not use, or disclose to others, any trade secrets or confidential technology, proprietary information, customer lists, or any other proprietary knowledge gained as a result of his/her employment. Upon separation of employment from your facility, colleagues are prohibited from taking, retaining, copying, or directing any other person to take, retain or copy any proprietary or confidential information belonging to any CHS-affiliated entity without prior written permission, regardless of the form the proprietary or confidential information takes: papers, data, client lists, books, records, files, or any other form.

## ***Retention and Disposal of Documents and Records***

Legal and regulatory practice requires the retention of certain records for various periods of time, particularly in the following areas: health information, patient accounting, tax, personnel, health and safety, environment, contract, and corporate office. In addition, no records or files may be destroyed when there is pending or imminent litigation, government investigation, or an audit; relevant records must not be destroyed until the matter is concluded. Destruction of records and/or files to avoid disclosure in a legal proceeding may constitute a criminal offense. Colleagues should consult the organization's various record retention policies before any records and/or files are destroyed. All medical and business records must be retained in accordance with the laws in the state in which the facility is located. Affiliates should have a regular process to identify and destroy records eligible for destruction.

*Reference: Document and Record Retention Policy; Document and Record Retention Schedule*

## ***Electronic Media, Records, and Documents***

Many different types of media are used by us to create, store, maintain, and communicate information. Electronic media such as telephones, other communications systems, e-mail, Internet access, and voice mail are provided to colleagues for business use. Since these electronic media are the property of the organization, colleagues should assume these communications are not private and may be monitored. Unless authorized by the appropriate personnel at your facility or required or authorized by law, any confidential patient information, non-public proprietary business information (trade secrets, intellectual property, company financial data, plans, strategies, research, analyses), or other legally confidential information must not be conveyed by any media sources unless appropriate security measures are in place. Unless authorized, never send or forward such information via email unless approval has been granted by a manager and the data is appropriately encrypted. Colleagues must not use the organization's electronic media to distribute or transmit any unlawful or obscene materials.

Email and internet access shall be used only by authorized users in the performance of their assigned job duties. Responsible, incidental personal use is acceptable, provided that it does not (a) interfere with the colleague's (or another colleague's) performance of job duties, (b) use the resources in a manner that limits or impedes their use of access for legitimate business purposes, or (c) violate this or any other organization or facility policy.

*Reference: Electronic Communications Policy*

## **POLITICAL ACTIVITIES AND CONTRIBUTIONS**

We support colleague participation in civic affairs and political activities. However, these affairs and activities must not create a conflict of interest with the organization nor reduce the individual's work performance. Colleagues must recognize that involvement and participation in political activities is on an individual basis, on their own time, and at their own expense. When colleagues speak on public issues, they must make it clear to the audience that their comments are their own personal viewpoints.

No colleague is authorized to contribute, directly or indirectly, any assets of any CHS affiliate including cash or the work time of any colleague, to any political office holder, party or campaign of any candidate for federal, state, or local office without following the appropriate approval process set forth in the CHSPSC Financial Policies and Procedures.

## **COMMUNITY SERVICE**

We encourage colleagues to participate in community service projects.

## **THE COMPLIANCE PROGRAM**

### **Program Structure**

The Compliance Program has been developed and adopted in furtherance of the understanding and commitment of the management of the organization that all activities of the organization and the organization's colleagues and those acting on their behalf shall be conducted in a legal and ethical manner. Although aspects of the Compliance Program focus on various legal areas, the primary focus of the Compliance Program is to ensure that internal policies and controls, training and education, and auditing and monitoring are in place to help prevent, detect, and deter fraud, abuse, and waste in government health care programs.

We are committed to the development and implementation of an effective and voluntary compliance program that meets or exceeds the requirements and expectations of government regulators and industry norms and standards.

We are committed to creating and maintaining a culture that promotes prevention, detection, and resolution of instances of conduct that do not conform to federal, state, or local laws, rules, and regulations; federal health care benefit program requirements; or the Code of Conduct.

The structure of the Compliance Program is guided and approved by the Executive Compliance Committee. There is also a Corporate Compliance and Privacy Officer, a Corporate Compliance Work Group, Facility Compliance Committees, FPOs, and FCOs. Additional elements of the ongoing Compliance Program include:

- € Maintenance, publication, and distribution of the Code of Conduct and Compliance policies and procedures.
- € Design and implementation of standard auditing and monitoring functions.
- € Use of standard audit results to determine targets for improvement and education.
- € Preparation and implementation of system-wide policies, procedures, and tools to comply with federal, state and local laws, statutes, regulations, and any Corporate Integrity Agreement requirements (e.g., the False Claims Act, Stark, Anti-Kickback Statute, HIPAA, etc.).
- € Performance of new hospital acquisition compliance assessments.
- € Continuation of the compliance training and education program.
- € Enhancement of the Confidential Disclosure Program.
- € Investigation of reports received through the Confidential Disclosure Program.
- € Formal risk assessment of CHS affiliates and of the Compliance Program.
- € Periodic reports to the CHS Board of Directors Audit and Compliance Committee (Board Compliance Committee).

The Senior Vice President, Corporate Compliance and Privacy Officer for CHS is Ms. Andi Bosshart.

### ***Reporting Questions or Concerns***

Questions or concerns about potential compliance or privacy violations may be addressed to any of the following:

- € Your supervisor or department head
- € Any supervisor or department head
- € Your Facility Compliance Officer
- € Your Facility Privacy Officer
- € The Corporate Compliance and Privacy Officer
- € The Confidential Disclosure Program Hotline at 1-800-495-9510

If a colleague feels a question or concern is not resolved appropriately, the colleague should report the matter immediately to the Confidential Disclosure Program hotline or to the Corporate Compliance and Privacy Officer.

### ***Reporting Violations***

Violations and unresolved suspected violations of any laws, rules, regulations, and/or the Code of Conduct must be reported to the Corporate Compliance and Privacy Officer or through the Confidential Disclosure Program.

Failure to report a known or suspected violation of the law, Code of Conduct, or any Compliance Policy could subject an individual to disciplinary action. However, intentionally false or misleading reports made with the intent to damage another person's reputation violate the Code of Conduct.

## ***Federal and State False Claims Act Laws***

The federal Deficit Reduction Act requires that certain entities, such as CHS, provide affiliated employees, contractors, and agents with information related to the federal False Claims Act (FCA) law. This law provides that civil penalties may be imposed against any person or entity that knowingly presents or causes to be presented a false or fraudulent claim to a federal healthcare program for payment. In addition to civil monetary penalties, violators of the federal False Claims Act may be subject to treble damages for each false claim submitted to federal healthcare programs. The federal False Claims Act includes whistleblower protection provisions that protect any individual who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against for filing an action under the federal False Claims Act.

Many states have enacted False Claims Act statutes that contain provisions that are similar to the federal statute, including whistleblower provisions.

*Reference: Preventing, Detecting and Reporting Fraud, Waste and Abuse. State DRA Guidelines are available as a subset to this policy*

## ***Confidential Disclosure Program***

We have established a Confidential Disclosure Program for all colleagues and other individuals of all subsidiaries and affiliated facilities to report known or suspected conduct or activities by any person engaged in the performance of duties for the organization that violates the Code of Conduct, any Compliance Policy, HIPAA Privacy Policy, or any federal, state, or local laws, rules, and regulations. This program may also be used for individuals who are uncertain whether an action violates the Code and would like to communicate with the organization on a confidential basis.

An individual reporting known or suspected improper conduct is not required to identify himself/herself. Anonymous calls and communications will be investigated and acted upon in the same manner as calls where the caller or writer reveals his/her identity. No effort will be made to determine the identity of an individual making an anonymous report unless the individual admits to engaging in improper conduct. Individuals are encouraged to describe the conduct or incident in sufficient detail to enable the organization to investigate the matter.

CHS policy, the Deficit Reduction Act, the Fraud Enforcement Recovery Act, the FCA, and other state and federal laws provide protection from retribution or retaliation against any person for reporting actual or suspected violations of the Code, law, or policy. Any supervisor who attempts to divert, discourage, or retaliate against a colleague for reporting a compliance concern will be subject to severe discipline, up to and including discharge.

## **Confidential Disclosure Program Hotline: 1-800-495-9510**

**Address:** Corporate Compliance and Privacy Officer  
Community Health Systems  
4000 Meridian Boulevard  
Franklin, Tennessee 37067

### ***Investigation of Known or Suspected Violations***

Prompt, appropriate, confidential investigations into all Program calls, letters, and other forms of communication, both direct and indirect, including reports of site visits conducted by Compliance Work Group members, their staff, or consultants will be made. The CHSPSC Compliance and Privacy Officer or her designee will coordinate any findings from the investigations and recommend corrective and/or disciplinary actions.

All colleagues are required to cooperate with the investigation efforts.

### ***Corrective Action***

Once a reported violation is substantiated through the investigation process, corrective action will be initiated. When appropriate, the affiliated facility will return any overpayment amounts, notifying the correct governmental agency of the overpayment situation. Corrective action will be taken promptly to prevent similar occurrences at any CHS affiliated facility.

### ***Discipline***

Violations of the Code of Conduct or the organization's compliance policies will be subject to the organization's normal disciplinary procedures. Disciplinary action that may be taken by your facility includes, but is not limited to, informal counseling, verbal and/or written warnings, investigative or disciplinary suspension, termination, probation, demotion, and/or incentive compensation withholding. The type of disciplinary action that is applicable is decided on the facts of each situation.

## *Acknowledgement*

Under applicable laws such as the Affordable Care Act, the Code of Conduct is a mandatory policy. All colleagues will sign a form indicating they have reviewed a copy of the Code and agree to abide by the Code of Conduct, all laws and regulations. In addition, all colleagues will reaffirm these actions on an annual basis.

Compliance with the Code of Conduct and other policies will be considered by affiliated entities in employee evaluations and in decisions regarding promotion and compensation for all their employees.

Nothing in this Code is intended to create enforceable employee contract rights.

Revision adopted by the Board of Directors of Community Health Systems, Inc. on September 11, 2019 (supersedes the revision adopted September 12, 2018).

## ***ACKNOWLEDGEMENT***

I acknowledge that I have received, read and understand the Community Health Systems (“CHS”) Code of Conduct.

I agree to abide by the compliance policies summarized in the Code of Conduct and all federal, state, and local laws, rules and regulations for the duration of my association with CHS.

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Signature

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Printed Name

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Date

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Facility

CHS-CODE-ACK 09-11-2019



Community Health Systems
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