False Claims Prevention

POLICY STATEMENT

It is the policy of the Company to put into practice procedures designed to detect and prevent fraud, waste and abuse, and to maintain policies to protect from retaliation those who report in good faith, any concerns of actual or suspected wrongdoing.

SCOPE

This policy applies to all Company executives, Associates, volunteers, interns, contracted parties, patients and all other persons associated with the Company ("All Persons").

PURPOSE

The purpose of this policy is to promote the integrity of all claims for reimbursement submitted by the Company, to ensure compliance with all applicable Federal and State laws designed to prevent fraud, waste and abuse in publicly funded health care programs summarized below, and to ensure that those who in good faith report known or suspected violations of these laws are protected from retribution or retaliation for doing so.

SUMMARY OF FEDERAL AND STATE LAWS

A. Federal False Claims Act, 31 U.S.C. §§3729-3733

The Federal False Claims Act imposes liability on any person who:

(i) knowingly files a false or fraudulent claim for payment to Medicare, Medicaid, or any other federally funded health care program;

(ii) knowingly uses a false record or statement to obtain payment on a false or fraudulent claim from Medicare, Medicaid, or any other federally funded health care program; or

(iii) knowing and improper retention of an overpayment; or

(iv) does any of the above to obtain federally funded health care program money regardless of whether the claim was submitted directly to the government; or

(v) Conspires to violate any requirement of the Federal False Claims Act.

"Knowingly" means (1) having actual knowledge that the information on the claim is false; (2) acting in deliberate ignorance of whether the claim is true or false; or (3) acting in reckless disregard of whether the claim is true or false.

A person or entity found liable under the Federal False Claims Act is generally subject to civil money penalties of between $5,500 and $11,000 per claim plus three times the amount of damages that the government sustained because of the illegal act plus the government cost in recovering penalties and damages. In health care cases, the amount of damages sustained is the amount paid for each claim that is filed that is determined to be false.

Anyone may bring a *qui tam* action under the Federal False Claims Act in the name of the United States. The case is initiated by filing the complaint and all available material evidence under seal with a federal court. The complaint remains under seal for at least 60 days and will not be served on the defendant. During this time, the government investigates the complaint.

The government may also request additional investigation time beyond 60 days. After expiration of the review and investigation period, the government may elect to pursue the case in its own name or decide not to pursue the case. If the government decides not to pursue the case, the person who filed the action has the right to continue with the case on his or her own.

If the government proceeds with the case, the person who filed the action will generally receive between 15% and 25% of any recovery, depending on the contribution of that person to the prosecution of the case. If the government does not proceed with the case, the person who filed the action will be entitled to between 25% and 30% of any recovery, plus reasonable expenses and attorneys" feesand costs.

B. Federal Program Fraud Civil Remedies Act, 31 U.S.C. §§3801-3812

The Federal Program Fraud Civil Remedies Act ("PFCRA") creates administrative remedies for making false claims and false statements. These penalties are separate from and in addition to any liability that may be imposed under the False Claims Act.

The PFCRA imposes liability on people or entities that file a claim that they know or have reason to know:

(i) is false, fictitious, or fraudulent;

(ii) includes or is supported by a written statement that contains false, fictitious, or fraudulent information;

(iii) includes or is supported by a written statement that omits a material fact, which causes the statement to be false, fictitious, or fraudulent, and the person or entity submitting the statement has a duty to include the omitted fact; or

(iv) is for payment for property or services not included as claimed.

A violation of this section of the PFCRA is punishable by a $5,000 civil penalty for each wrongfully filed claim, plus an assessment of twice the amount of any unlawful claim that has been paid. In addition, a person or entity violates the PFCRA by submitting a written statement that the person or entity knows or should know (i) asserts a material fact that is false, fictitious, or fraudulent; or (ii) omits a material fact they had a duty to include, the omission caused the statement to be false, fictitious, or fraudulent, and the statement contained a certification of accuracy. A violation of this section of the PFCRA carries a civil penalty of up to $5,000 in addition to any other remedy allowed under other laws.

C. PROTECTIONS AGAINST RETALIATION

Individuals within an organization who observe activities or behavior that may violate the law in some manner and who report their observations either to management or to governmental agencies ("Whistle Blowers") are provided protections under federal and state law. For example, the Federal False Claims Act includes protections for people who file *qui tam* lawsuits as described previously.

The Federal False Claims Act states that any Associate who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment because of lawful actions taken in furtherance of a qui tam action is entitled to recover damages, as well as all relief necessary to make the Associate whole, including two times the amount of back pay owed to the team member. The Associate can also be awarded litigation costs and reasonable attorneys' fees.

A. The Federal False Claims Act also provides that Associates, agents and contractors engaged in other efforts to stop a violation of the Federal False Claims Act may recover damages for retaliation against them that occurs because of those efforts.

B. As set forth in the State Law Supplement, below, certain state laws provide similar protections against retaliation for "Whistle Blowers."

Available remedies for retaliation against "Whistle Blowers" may include an injunction restraining a continuing violation, reinstatement of the team member including full fringe benefits and seniority rights, compensation for lost wages, benefits, and other remuneration, punitive damages, civil fine, and payment by the employer of reasonable litigation costs and attorneys' fees.

D. State Law Supplements

New Jersey False Claims State Supplement – see attached

E. ROLE OF FALSE CLAIMS LAWS

The false claims laws discussed above are an important part of preventing and detecting fraud, waste, and abuse in federal and state health care programs because they provide governmental agencies the authority to seek out, investigate, and prosecute fraudulent activities. Enforcement activities take place in the criminal, civil, and administrative arenas. This provides a broad spectrum of remedies to combat these problems. Anti-retaliation protections for individuals who make good faith reports of waste, fraud, and abuse encourage reporting and provide broader opportunities to prosecute violators. Statutory provisions, such as anti-retaliation provisions of the Federal False Claims Act, create reasonable incentives for this purpose. Employment protections create a level of security Associates need in order to help in prosecuting these cases.

PROCEDURE

PROCEDURES FOR DETECTING AND PREVENTING FRAUD, WASTE AND ABUSE

Any Associate who knows of or reasonably suspects an incident of fraud, waste, or abuse regarding Medicare, Medicaid, or any other federal or state health care program, or a violation of any of the laws outlined in this policy, by any Associate, supervisor, contractor or agent is required to immediately report such incident to their Department Head/Supervisor or Administrator/Executive Director. Reports may also be made directly to the Company hotline at 844-530-0002 or online at reports@lighthouse-services.com if an Associate has concerns about reporting the incident to their Department Head/Supervisor and/or the Administrator/Executive Director. Likewise, any employee of a contractor, vendor or agent of the Company who has concerns about the work he or she performs should report these concerns to the Company hotline at 1-855-600-5850.

The Company will not tolerate any intimidating or retaliatory act against an individual who in good faith reports practices reasonably believed to be a violation of this policy.

The Company will make this policy available to all Associates, including management, as well as all contractors and agents. Furthermore, the Company will maintain its internal systems and controls to monitor its coding and billing practices on an ongoing basis to ensure compliance with the laws outlined in this policy.

A background screening will include verifying that an individual has not been excluded from participation in state or federally funded health benefit programs, such as Medicare or Medicaid ("excluded individuals or entities"). It may also include verifying that an individual license is not revoked, suspended or under review or lapsed. The Company will monitor various state and federal databases at the time an offer is made and on a monthly basis thereafter to ensure

that required licenses are current and unencumbered, and to prevent the employment or retention of "excluded individuals or entities."

RESPONSIBILITIES

Obligation to Report Violations or Suspected Violations

All Associates should promptly report any activity by fellow Associates, physicians, contractors, vendors, or others that involves actual or suspected violations of laws summarized above pertaining to fraud, waste or abuse, related regulations, Company policies, or the Code of Conduct. Associates who fail to promptly report actual or suspected violations may be subject to disciplinary action up to and including termination.

Reporting Methods

Associates seeking guidance on any compliance issues or wishing to report actual or suspected violations of the law, regulations, policies, or the Code of Conduct have several options. First, Associates are encouraged to discuss the situation with their Department Head/Supervisor. If Associates are uncomfortable talking to their Department Head/Supervisor or do not receive a satisfactory response, a second option is to contact the Company hotline at 844-530-0002 or online at reports@lighthouse-services.com . Associates making written reports are to describe the circumstances as they know them and include any relevant documents relating to the suspected violations. The envelope is to be marked "For Compliance/Personal and Confidential."

Additional reporting resources include the Centers for Medicaid and Medicare Services at 1-800-447-8477 or state resources set forth in the State Law Supplement accompanying this policy.

Confidentiality of Reports

The Company will make every effort to keep the identity of the Associate and the contents of the Associate's reports confidential, to the extent consistent with a thorough investigation and the requirements of state and federal law.

Protection of Reporting Team Member

The Company will not tolerate any retaliation against Associates who make good faith reports of violations, or potential violations of laws, regulations, policies, or any element of the Compliance Program. Associates who attempt to retaliate against the reporting Associate(s) will be subject to disciplinary action. Additionally, Associates who make knowingly false reports with the intent to harm or retaliate against other Associates may be subject to disciplinary action. The Company takes very seriously the many federal and state laws that protect Associates when it receives a good faith report involving what the reporter reasonably believes to be violations of laws, regulations, policies, or the Compliance Program.

Investigation of Reports

Upon receipt of a report, an internal investigation that is appropriate under the circumstances will be conducted.

Corrective Action

If the internal investigation substantiates a violation, corrective action will be taken, including, as appropriate, prompt restitution of any overpayments, notice to appropriate governmental agencies, disciplinary action, and changes in policies and procedures to prevent a recurrence.

Discipline for Violations

Violations of the Compliance Policies will not be tolerated. Based on the internal investigation, disciplinary action may be imposed for any violation of this policy up to and including termination in accordance with applicable Company Human Resources policies and procedures.

Compliance Committee

The Compliance Committee and Compliance Officer(s) are responsible for ensuring that the policies, procedures and other mechanisms to identify and prevent the filing of false claims by or on behalf of the Company referenced above remain effective and current with all applicable state and federal laws.

DEFINITIONS

There are no definitions associated with this policy.

FORMS

Vendor Compliance Disclosure and Attestation Form

INSTRUCTIONS

There are no instructions associated with this policy.

APPENDICES

New Jersey False Claims State Laws

ASSOCIATED POLICIES

Code of Conduct

ADDITIONAL CONTACTS

Subject	Contact	Phone	Fax/Email
Primary Contact	Greg Hook	201-953-0546	ghook@atriumhsl.com

VERSION SUMMARY

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