COMMUNITY HOME HEALTH CARE, INC. DBA COMMUNITY HEALTH AIDE SERVICES

COMPLIANCE MANUAL

REPORTING REQUIREMENTS, CODE OF CONDUCT, COMPLIANCE PROGRAM STRUCTURE & GUIDELINES

Revised: June 2020, May 2021, Reviewed: 01.04.2023

https://commhealthcare.com/

TABLE OF CONTENTS

INTRODUCTION

Community Home Health Care, Inc. DBA Community Health Aide Services (the "Agency") has designed and implemented a comprehensive Compliance Program that sets forth the standards of conduct that all "Personnel" (as defined below) are expected to follow during their employment or course of dealings with the Agency.

(A) **Compliance Program's Code of Conduct**. The Code of Conduct sets forth the mission of the Agency and the general standards of conduct to which all persons employed by or associated with the Agency must adhere.

(B) **Compliance Program Structure and Guidelines**. The Compliance Program Structure and Guidelines set forth the structure of the Compliance Program and describes its day-to-day operation.

All Personnel are required to review and be familiar with the Code of Conduct and the Compliance Program Structure and Guidelines. Once you have reviewed these, you must sign and return the attached Acknowledgment of Receipt to the Compliance Officer.

(C) **Specific Compliance Policies and Procedures**. Certain compliance issues require further detail and instruction. To that end, the Agency has adopted specific Compliance Policies and Procedures covering certain areas. If Personnel have specific responsibilities that are addressed by a Compliance Policy and Procedure, they must ensure that they are familiar with the applicable policy and procedure. These documents are also available upon request to the Compliance Officer at any time or may be accessed on the Agency's website.

(D) **Training.** The Agency will provide our Personnel, including the Compliance Officer, employees, the Chief Executive and other senior administrators, managers and governing body members with mandatory, annual compliance training regarding the Code of Conduct and the Compliance Program. Training will also occur at orientation for new employees and upon appointment of a chief executive, manager or governing body member.

*** * ***

The Agency is dedicated to maintaining the highest ethical standards in compliance with all applicable laws, rules and standards, including Federal health care program requirements (*e.g.*, the Medicare and Medicaid programs). We require that all Personnel cooperate fully with the Compliance Program. In short, we are committed to doing the right thing, and our Compliance Program is designed to assist us in effectively keeping to that commitment. Conduct that is contrary to these expectations will be considered a violation of the Compliance Program.

If you have any questions regarding the Agency's Compliance Program, please refer to the Code of Conduct, the Compliance Program Structure and Guidelines, or speak with the Agency's Compliance Officer for more detailed information.

KEY DEFINITIONS

Unless otherwise defined in the Code of Conduct, the Structure and Guidelines and the Specific Policies and Procedures (collectively referred to as the "Compliance Manual"), the following key terms that are used in the Compliance Manual are defined as follows:

(1) "***Compliance Committee***" means the group established by the Agency to assist the Compliance Officer in overseeing and executing various aspects of the Compliance Program at the Agency.

(2) "***Compliance Officer***" means the individual designated by the Agency to maintain day-to-day responsibility of the Compliance Program.

(3) ***"Federal health care program"*** means any plan or program that provides health benefits whether directly, through insurance or otherwise, which is funded directly, in whole or in part, by the United States Government, and includes certain State health care programs. Examples include, but are not limited to: Medicare, Medicaid, Veterans' programs and the State Children's Health Insurance Programs. The Federal Employees Health Benefits Program is not included in this definition.

(4) **"*Good faith participation in the Compliance Program***" includes, but is not limited to the following:

- Reporting actual or potential compliance issues
- Cooperating or participation in the investigation of compliance issues
- Assisting with or participation in self-evaluations and audits
- Assisting with or participation in remedial actions / resolution of compliance issues
- Reporting to appropriate officials as provided in Sections 740 and 741 of the New York State Labor Law[1]

(5) "***Governing Body***" means the Agency's board of directors.

(6) "***Personnel***" means all affected individuals, which includes, but is not limited to, the Governing Body, all professional staff and employees, and other individuals or entities affiliated or associated with the Agency (including, but not limited to, all contractors, subcontractors, agents, and other persons who perform functions or services on behalf of the Agency or otherwise contribute to the Agency's entitlement to payment under Federal health care programs).

[1] These laws are summarized in the Non-Retaliation, Non-Intimidation for Participation in the Compliance Program Policy.

COMPLIANCE PROGRAM – REPORTING REQUIREMENTS

All Personnel must abide by the Compliance Program and are required to report suspected misconduct or possible violations of the Compliance Program to the Compliance Officer. Personnel may also report issues to the Compliance Hotline.

Personnel may report anonymously, if they so choose (by way of the Hotline or otherwise).

The identity of Personnel reporting by way of the Hotline will be kept confidential, whether requested or not, unless the matter is turned over to law enforcement.

Retaliation or intimidation in any form against an individual who in good faith reports possible unethical or illegal conduct is strictly prohibited. Acts of retaliation or intimidation should be immediately reported to the Compliance Officer or to the Hotline and, if substantiated, the individuals responsible will be disciplined appropriately.

In addition to the reporting requirement, Personnel are encouraged to raise questions and seek clarification whenever they are unsure of a policy, a law or regulation, or a particular situation or course of action.

Name	Contact Information
Compliance Officer **Paul Vershubsky**	Ph: 845.738.1305 Email: **pversh@commhealthcare.com**
Assistant Compliance Officer **Pearl Mordkovych**	Ph: 845.738.1760 Email: **pmordkovych@commhealthcare.com**
Compliance Hotline	Ph: 845.678.8652
CDPAP Hotline	Ph: 845.335.9905

COMMUNITY HOME HEALTH CARE, INC. DBA COMMUNITY HEALTH AIDE SERVICES

CODE OF CONDUCT

CODE OF CONDUCT

This Code of Conduct sets forth the mission and standards of conduct that all Personnel must adhere to and follow. If you have any questions or concerns about anything covered by the Code of Conduct or about any other matter relating to the Compliance Program, or if you wish to report a concern or problem, please contact the Compliance Officer.

I. CODE OF CONDUCT: MISSION AND VALUES

- The Agency's goal is to provide comprehensive at-home services to enhance our clients and their families' lives. We strive to be home health care leaders in the communities that we serve, and will continue to do so by being focused on quality, service, and technology.

- The Agency also strives to provide high quality at-home services without regard to age, race, color, sexual orientation, marital status, religion, sex, or national origin. We have a commitment to conduct our business in compliance with applicable laws, rules and regulations and in accordance with the highest ethical principles. The Agency expects the same from its Personnel. We do not and will not tolerate any form of unlawful or unethical behavior by anyone associated with the Agency. We will follow the letter and spirit of applicable laws, rules and regulations, conduct our business ethically and honestly, and act in a manner that enhances our standing in the community.

II. CODE OF CONDUCT: SCOPE OF APPLICATION TO PERSONNEL

- The Compliance Program - and specifically this Code of Conduct - applies to all "Personnel" (as that term is defined on page 2 of this Compliance Manual).

- All Personnel have a responsibility to help create and maintain a work environment in which compliance concerns may be openly raised, reviewed, discussed and addressed.

III. CODE OF CONDUCT: STANDARDS

General Standards

- Personnel must be honest and lawful in all of their business dealings and avoid doing anything that could create even the appearance of impropriety.

- Personnel must comply with the Code of Conduct; report any action they think may be possibly unlawful, inappropriate or in violation of the Code of Conduct or any compliance policy; cooperate with compliance inquiries and investigations; and work to correct any improper practices that are identified.

- Acts of retaliation or intimidation for good faith reporting of any suspected violation of, or participation in, the Compliance Program will not be tolerated.

Standards Related to Quality of Care

- All personal care and home care services provided to our patients are furnished by Personnel who have been appropriately trained and are qualified to furnish such services. Documentation of such qualifications (e.g., certificate of completion from a State Department of Health approved training program) will be maintained. The Agency will take steps on a regular basis to monitor and ensure such compliance.

- The Agency also appropriately accesses the Home Care Worker's Registry information prior to the worker beginning to provide home care services on the Agency's behalf. The Agency also conducts criminal history record checks pursuant to federal and state law on Personnel involved in providing care.

- In addition to the general credentialing process, the Agency will screen all Personnel to ensure that they are not included on: a) the United States Department of Health and Human Services' Office of Inspector General's List of Excluded Individuals/Entities; (b) the General Services Administration's System for Award Management ("SAM"); (c) the New York State Office of the Medicaid Inspector General's Medicaid Exclusion List; or (e) any other similar or successor list(s) of excluded or debarred individuals or entities.

- If you have been found to have violated the law or receive notification of exclusion from Medicare, Medicaid or any Federal health care program, you must report such information, in writing, to the Compliance Officer within two (2) business days. Upon receipt of any conviction or exclusion report, Compliance Counsel, the Compliance Officer, and the Director of Human Resources will assess whether your conviction or exclusion violates the Compliance Program.

- The Agency has strict standards in place regarding quality of care. The Quality Assurance Director will be responsible for overseeing quality of care issues. The Agency has established processes by which quality assurance reviews are conducted, issues are addressed, and corrective actions are implemented. In addition, the Agency has established protocols for reviewing complaints from patients and third parties and addressing issues which may arise.

- The Agency is committed to protecting and promoting the rights of all patients, including, but not limited to, patients' rights to respect, privacy, to participate in the planning of their own care and to submit complaints about care and services. The Agency will provide all patients with written notice of their rights prior to the initiation of care.

- Health care services will only be provided after a determination has been made by a registered nurse (or by an individual directly supervised by a registered nurse) indicating that the patient's health and safety needs can be met safely and adequately at home by the Agency.

- Home Care services will be provided consistent with the services ordered by a physician and authorized by the Managed Long Term Care ("MLTC") Plan (as applicable) for the patient or as otherwise authorized by contract or applicable regulation.

- Personal care and home health aide services will be furnished under the appropriate supervision of a registered nurse, licensed practical nurse or professional therapist (if the aide carries out simple procedures as an extension of physical therapy, occupational therapy or speech language pathology) and documentation evidencing such supervision will be maintained. The required frequency of nursing supervision visits should be stated in the Plan of Care. The individual responsible for supervising the aide is required to prepare patient-specific written instructions for the aide based on the patient's assessed individualized needs.

- The Agency will only provide rehabilitative services, such as physical therapy, occupational therapy, and speech language pathology, pursuant to a written care plan and a physician order. Orders must include the specific procedures and modalities to be used and the amount, frequency and duration of such services. Services must be reasonable and necessary for treatment of the patient, based on the patient's actual clinical condition. The provision of these services, including session length, will be accurately documented.

Standards Related to Claims Submission and Documenting Services

- Although the Agency does not directly submit claims to Federal health care programs, the services we provide pursuant to contracts with certified home health agencies are submitted for such payment. Those claims are based on our documentation of services and our compliance with applicable law and regulations. All Personnel providing services through the Agency must do so in accordance with regulatory standards as to quality of care, frequency of care and level of care. Additionally, such Personnel must be qualified to provide the service and receive adequate supervision.

- Although the Agency's documentation of service may be submitted to an outside company to perform the billing function, the Agency remains responsible for the accuracy of all claims submitted to private and government payers. The Agency will ensure that the billing company has implemented its own Compliance Program and, among other things, performs regular audits of claims submitted on the Agency's behalf. If any claims submitted are found to have been improper, the Agency will work with the billing company to resolve the issue(s) and refund any overpayments received or take other corrective action, as necessary and appropriate.

- Documentation of patient care must be accurate and truthful, with no misrepresentations regarding services provided. If the entity responsible for submitting claims has any question as to the accuracy of the documentation of services provided or if the medical record is unclear, Agency Personnel must cooperate with any request for clarification or additional information.

- Personnel must take the necessary steps to prevent the submission of claims for payment and reimbursement that are fraudulent, abusive, and inaccurate or for medically unnecessary services. The following practices are prohibited:

  (1) falsifying the amount of time spent providing care to a patient;
  (2) failing to provide services as required by the plan of care/medical orders;
  (3) falsely or inaccurately documenting services in the progress notes or plan of care;

(4) providing misleading information about a patient's medical condition;
(5) failing to meet the standard of supervision required;
(6) forging a health care professional's or patient's signature on documents.

Personnel involved in such activities are subject to termination of employment or contract, and potential criminal and civil liability.

- Personnel must comply with all applicable federal and state laws and regulations governing the submission of billing claims and related statements. In accordance with Federal law,[2] the Agency provides to all Personnel a detailed description of: (i) the federal False Claims Act; (ii) the federal Program Fraud Civil Remedies Act; (iii) state civil and criminal laws pertaining to false claims; and (iv) the whistleblower protections afforded under such laws. The employee handbook also includes specific discussion of these laws, the rights of employees to be protected as whistleblowers, and the Agency's policies and procedures for detecting and preventing fraud, waste, and abuse.

- The Agency will comply with all Federal and State laws relating to matters including, but not limited to: obtaining Advance Beneficiary Notices from Medicare patients for non-covered services; gathering insurance information from patients; and the retention of billing and medical records.

Standards Relating to Business Practices

- The Agency will forgo any business transaction or opportunity that can only be obtained by improper or illegal means, and will not make any unethical or illegal payments to induce or reward the use of our services.

- No Personnel will engage, either directly or indirectly, in any corrupt business practice intended to influence the manner in which the Agency performs its services, or otherwise engages in its business practices.

- All business records must be accurate, truthful and complete, with no material omissions.

- Financial reports, accounting records, research reports, expense accounts, time sheets and other documents must accurately and clearly represent the relevant facts or the true nature of a transaction. Sufficient and competent evidential matter or documentation shall support all cost reports.

- The Agency will not engage in anti-competitive conduct that could produce an unreasonable restraint of trade of a substantial lessening of competition. Communication by employees with competitors about matters that could be perceived to have the effect of lessening competition or could be considered as collusion or an attempt to fix prices should take place only after consultation with legal counsel.

[2] Section 6032 of the Deficit Reduction Act of 2005, codified at 42 U.S.C. §1396a(a)(68).

Standards Relating to Conflicts of Interest

- All Personnel must avoid any and all activities that conflict with their responsibilities and obligations to the Agency and its Patients.

  (1) Personnel must not have an interest in or serve as director, officer, manager, or member of an entity in competition with the Agency, without permission.

  (2) Any Personnel who performs work or renders service for any competitor of the Agency or for any organization which does business with or seeks to do business with the Agency outside the normal course of his or her employment or other engagement with the Agency must notify the Compliance Officer or the Administrator.

  (3) Engaging in business with any Agency vendor, supplier, contractor, or agency of any of their officers or employees that is not conducted on behalf of the Agency is prohibited, unless previously authorized by the Compliance Officer or the Administrator.

  (4) Staff members may not permit their names to be used in any fashion that would tend to indicate a business connection with any organization which does business with or seeks to do business with the Agency without the prior approval of the Compliance Officer or the Administrator.

  (5) The Agency may not be represented by a member, manager, officer, director, or employee, contractor or agent in any transaction in which he or a relative has a personal or financial interest.

- In accordance with the Agency's Conflict of Interest and Related Party Transactions Policy, directors, officers and certain key persons are required to disclose actual and potential conflicts of interest involving themselves or their relatives to the Compliance Officer using the Agency's "Conflict of Interest Disclosure Statement."

Patient Referrals/Marketing Activities

- In general, Federal and State anti-kickback laws prohibit payment to any individual or entity on the basis of the value or volume of referral of patients. This includes the giving of any form of remuneration, including virtually anything of value, in return for a referral. The decision to refer patients is a separate and independent clinical decision made by physicians or other appropriate licensed practitioners. The Agency does not pay physicians, or anyone else, either directly or indirectly, for patient referrals.

- All marketing activities and advertising by Personnel must be truthful and not misleading, must be supported by evidence to substantiate any claims made and must otherwise be in accordance with applicable law. In this regard, our best "advertisement" is the quality of our services. No Personnel should disparage the service or business of a competitor through the use of false or misleading representations.

- Personnel may not offer, pay, solicit or receive any gifts or benefits to or from any person or entity that would compromise the Agency's integrity (or even create an appearance that compromises the Agency's integrity), or under circumstances where the gift or benefit is offered, paid, solicited or received with a purpose of inducing or rewarding business between the parties. The guiding principle is simple: Personnel may not be involved with gifts or benefits that are undertaken to influence any business decision. Cash or cash equivalents may not be given or accepted under any circumstances.

Mandatory Reporting

- As part of its commitment to providing high quality care and services, the Agency complies with all applicable Federal and State mandatory reporting laws, rules and regulations. To this end, the Agency will ensure that all incidents and events that are required to be reported are reported in timely manner, and will monitor compliance with such requirements.

- The Agency will also ensure that it complies with annual certification requirements that may apply to its Compliance Program in accordance with New York Social Services Law and the Federal Deficit Reduction Act of 2005.

- The Agency will ensure that all identified overpayments are timely reported, explained and returned in accordance with applicable law and contractual requirements. It is our policy to exercise reasonable diligence in identifying overpayments and quantifying overpayment amounts, not retain any funds which are received as a result of overpayments and to report, return and explain any overpayments from Federal health care programs within 60 days from the date the overpayment was identified (or within such time as is otherwise required by law or contract). Any monies improperly collected are promptly refunded to the Medicare Administrative Contractor, the Department of Health, the Office of the Medicaid Inspector General or other payer/agency, as applicable.

- Moreover, in certain circumstances (e.g., after an internal investigation confirms possible fraud, waste, abuse or inappropriate claims), and with the advice and assistance of legal counsel, as necessary and appropriate, the Agency will avail itself of the appropriate self-disclosure process and report, as necessary and appropriate, to the New York State Department of Health, Office of the Medicaid Inspector General, the U.S. Department of Health and Human Services, Office of Inspector General, or other appropriate governmental agency.

Standards Relating to Confidentiality and Security

- In compliance with Federal and State privacy laws, all Personnel will keep patient information confidential and secure. The information contained in a patient's health record belongs to the patient and the patient is entitled to the protection of that information. All patient care information is confidential and available only to authorized users and employees who may be providing patient care and to third parties in order to facilitate treatment and/or reimbursement.

- The posting of any patient's information or picture to social media is strictly prohibited.

- The Agency has also implemented and maintains a HIPAA Compliance Program that addresses privacy and security. Personnel must adhere to the standards of the HIPAA Compliance Program.

- Confidential information acquired by Personnel about the business of the Agency must also be held in confidence and not used for personal gain, either directly or indirectly. This includes, but is not limited to personnel data, patient lists, financial data, research data, techniques, computer software, financial results or other business dealings.

Government Inquiries

- Personnel may speak voluntarily with government agents, and the Agency will not attempt to obstruct such communication. It is recommended, however, that Personnel contact the Compliance Officer before speaking with any government agents.

- Personnel must receive authorization from the Compliance Officer before responding to any request to disclose the Agency's documents to any outside party.

- It is the Agency's policy to comply with the law and cooperate with legitimate governmental investigations or inquiries. All responses to requests for information must be accurate and complete. Any action by Personnel to destroy, alter, or change any Agency records in response to a request for such records is strictly prohibited and shall subject the individual to immediate termination of employment or contract and possible criminal prosecution.

COMMUNITY HOME HEALTH CARE, INC. DBA COMMUNITY HEALTH AIDE SERVICES

COMPLIANCE PROGRAM STRUCTURE AND GUIDELINES

COMPLIANCE PROGRAM STRUCTURE AND GUIDELINES

The following eight elements comprise the Compliance Program's Structure and Guidelines. Each element governs a different and important aspect of the Compliance Program.

Element 1: Written Policies and Procedures

- **Formal Policies**. The Code of Conduct, the Compliance Program Structure and Guidelines, and related compliance policies have all been formalized in writing and adopted by the Agency. The Compliance Officer and Compliance Committee will meet at least annually (or more frequently as necessary) to review all Compliance Program documents and make any necessary changes.

- The Agency's written Compliance Policies and Procedures and the Code of Conduct are designed to:

  (1) articulate the Agency's commitment to comply with all applicable federal and state standards;

  (2) describe compliance expectations as embodied in the Code of Conduct Standards;

  (3) implement the operation of the Compliance Program;

  (4) provide guidance to employees and others on dealing with potential compliance issues;

  (5) identify how to communicate compliance issues to appropriate compliance personnel;

  (6) describe how potential compliance issues are investigated and resolved;

  (7) include a policy of non-intimidation and non-retaliation for good faith participation in the compliance program, including but not limited to reporting potential issues, investigating issues, conducting self-evaluations, audits and remedial actions, and reporting to appropriate officials; and

  (8) include all requirements listed under Section 6032 of the Deficit Reduction Act of 2005 as to maintaining and disseminating policies regarding false claims laws and whistleblower protections.

Element 2: Designation of Compliance Office and Compliance Committee

- **Duties of the Compliance Officer**. The Compliance Officer maintains day-to-day responsibility for the Compliance Program. Among other things, the Compliance Officer is responsible for: (i) receiving and responding to all reports, complaints, and questions about compliance issues; (ii) investigating instances of potential legal and ethical violations (and violations of the Code of Conduct); and (iii) taking appropriate corrective action in response to such matters. The Compliance Officer reports directly and is accountable to the Agency's Chief Executive Officer.

- **Duties of the Compliance Committee**. A Compliance Committee has been formed to monitor the operation of the Compliance Program and assist the Compliance Officer in identifying and responding to identified compliance issues and implementing appropriate corrective action. The Compliance Committee works with the Compliance Officer to create and implement the annual Compliance Work Plan, which describes the annual reviews and compliance goals for the year. The Compliance Committee also directly reports and is accountable to the Chief Executive Officer.

- **For more information see:** The Compliance Personnel Policy and the Compliance Monitoring, Risk Assessment and Training Policy.

Element 3: Training and Education

- The Agency's compliance training and education program is designed to train and educate our Personnel, including the Compliance Officer, Governing Body, Chief Executive Officer, senior administration, managers, and employees. Our training and education covers, among other things, compliance issues, expectations and the operation of the Compliance Program. Additional training and education based on the specific issues Personnel may face in their work with the Agency may also be provided.

- At a minimum, such training will take place annually and will be made part of the orientation for all new employees upon hire and upon new appointment of a Chief Executive, manager or Governing Body member. Targeted training and education for specific Personnel will also be provided, as necessary and appropriate.

- **For more information see**: The Compliance Monitoring, Risk Assessment and Training Policy.

Element 4: Effective Lines of Communication

- **Communication System**. The Agency has established and implemented effective lines of communication, ensuring confidentiality, between the Compliance Officer, members of the Compliance Committee and the Agency's employees, managers and Governing Body. The lines of communication are accessible to all Personnel, allow compliance issues to be reported as they are identified and include methods for anonymous and confidential good faith reporting of potential compliance issues.

- **Reporting and Confidentiality**. All Personnel are required to report suspected misconduct, possible violations of Federal or State laws or regulations, or possible violations of the Compliance Program to the Compliance Officer. Personnel may report anonymously, if they so choose (by way of the Hotline or otherwise).The identity of any Personnel reporting in good faith by way of the Hotline will be kept confidential, whether requested or not, unless the matter is turned over to law enforcement.

- **Informing the Compliance Officer.** Upon receiving information regarding a possible violation, the individual informed (if other than the Compliance Officer) shall immediately inform the Compliance Officer so that he or she may address the issue.

Element 5: Disciplinary Standards to Encourage Good Faith Participation in the Compliance Program

The Agency has established well-publicized disciplinary standards to encourage good faith participation in the Compliance Program by all affected individuals.

- **Discipline**. All Personnel will be subject to disciplinary action if they fail to comply with any laws, regulations, or any aspect of the Compliance Program. This includes disciplinary actions for:

  (1) failure to report suspected problems;

  (2) participating in non-compliant behavior;

  (3) encouraging, directing, facilitating, or permitting non-compliant behavior;

  (4) refusal to cooperate in the investigation of a potential violation;

  (5) refusal to assist in the resolution of compliance issues; or

  (6) retaliation against, or intimidation of, an individual for reporting a compliance violation or otherwise participating in the Compliance Program in good faith.

  Such disciplinary actions shall be fairly and firmly enforced. The types of discipline imposed will be commensurate with the severity of the violation, ranging from verbal or written warnings to termination of employment or contract, if appropriate.

- **For more information see**: The Protocols for Investigations and Implementing Corrective Action, Including Discipline; and the Compliance Monitoring, Risk Assessment and Training Policy.

Element 6: The System for Routine Monitoring and Identification of Compliance Risk Areas

The Agency has established a system for the routine identification and assessment of compliance risk areas relevant to its operations. This process includes internal, and, as appropriate, external reviews, audits, and other practices to evaluate the Agency's compliance with federal health care program requirements (*e.g.*, the Medicare and Medicaid Programs) and the overall effectiveness of the Compliance Program.

- **Compliance Assurance Reviews**. The Agency has a process for the routine identification and assessment of compliance risk areas. This process involves the use of periodic reviews, audits, and other practices. As part of that process, and in an effort to detect and prevent fraud, waste and abuse, the Compliance Officer, or designee, will periodically monitor and/or conduct specific reviews of the following risk areas: business practices; coding, billing and documentation practices; issues relating to quality of care and medical necessity of services; the credentialing process; compliance with mandatory reporting requirements; governance; and other potential compliance risk areas that may arise from complaints, risk assessments, and as identified by specific compliance protocols and elsewhere.

- **Risk Assessment and Annual Work Plan**. The Compliance Officer and the Compliance Committee will formulate an annual Compliance Work Plan based on developments arising from internal reviews and issues and external areas of compliance concern. The Work Plan will be approved by the governing body.

- **Tracking New Developments**. The Compliance Officer will ensure that all relevant publications issued by government or third-party payers regarding compliance rules or protocols relevant to the Agency are reviewed and appropriately implemented. Through this process, compliance risk areas specific to the Agency will be identified and incorporated into the Annual Work Plan, or a focused audit, as appropriate. In addition, the Compliance Officer will monitor the Compliance Hotline and any other reports of compliance issues or violations that might be raised. As appropriate, the Compliance Officer will raise issues with the Chief Executive Officer, the Compliance Committee, and, as necessary, with the governing body.

- **For more information see:** The Compliance Monitoring, Risk Assessment and Training Policy; and the Protocols for Investigations and Implementing Corrective Action, Including Discipline.

Element 7: The System for Promptly Responding to Compliance Issues

The Agency has established and implemented procedures and a system for promptly responding to compliance issues as they are raised, investigating potential compliance problems as identified in the course of self-evaluations and audits, correcting such problems promptly and thoroughly to reduce the potential for recurrence, and ensure ongoing compliance with the federal health care program requirements (*e.g.*, the Medicare and Medicaid Programs).

- **Investigations**. All compliance issues, however raised (*i.e.*, whether reported or discovered through audits/self-evaluations), must be brought to the attention of the Compliance Officer. The Compliance Officer will oversee or conduct an inquiry into the issue, using outside counsel or consultants as necessary. All Personnel are required to cooperate in such investigations.

- **Corrective Action and Responses to Suspected Violations**. All Personnel are also required to assist in the resolution of compliance issues. Corrective action will be implemented promptly and thoroughly and may include: conducting training and re-education; revising or creating appropriate forms; modifying or creating new policies and procedures; conducting internal reviews, audits or follow-up audits; imposing discipline (up to and including termination of employment or contract), as appropriate; and making voluntary disclosures and/or refunds to appropriate payers (e.g., NY DOH/OMIG, US DHHS/OIG, etc.).

- **For more information see**: The Compliance Monitoring, Risk Assessment and Training Policy; and the Protocols for Investigations and Implementing Corrective Action, Including Discipline.

Element 8: Policy of Non-Intimidation and Non-Retaliation.

- **Intimidation and Retaliation Are Prohibited**. All Personnel are expected to participate in and comply with this Compliance Program, including the reporting of any violation or

compliance issue. **Retaliation or intimidation in any form against an individual who in good faith reports possible unethical or illegal conduct or for other good faith participation in the Compliance Program is strictly prohibited and is itself a serious violation of the Code of Conduct.** Acts of retaliation or intimidation should be immediately reported to the Compliance Officer and, if substantiated, will be disciplined appropriately.

- **For more information see**: The Non-retaliation, Non-intimidation for Participation in the Compliance Program Policy; and the Protocols for Investigations and Implementing Corrective Action, Including Discipline.

ACKNOWLEDGEMENT

I acknowledge that I have access to and have reviewed Community Home Health Care, Inc. DBA Community Health Aide Services' Compliance Manual, containing the Compliance Program Reporting Requirements, Code of Conduct and Compliance Program Structure and Guidelines.

I affirm the following:

(1) I will follow the standards and procedures set forth in the Compliance Manual (and its related policies and procedures) and will ask questions if I do not understand my responsibilities under the Compliance Program.

(2) If I become aware of any possible violations of the Compliance Program, or if I have concerns or questions about the appropriateness of any practices at the Agency, I will report such issues to the Compliance Officer or via the Compliance Hotline.

(3) I understand that I may be subject to discipline (or other corrective action) if I violate the standards and requirements set forth in the Compliance Manual or any of the Agency's compliance related policies and procedures.

(4) I understand that the Compliance Manual (and its related policies and procedures) will be revised from time to time and I agree to access and review all such updates.

_____

Name (Printed)

_____

Signature

_____

Date

COMMUNITY HOME HEALTH CARE, INC. DBA COMMUNITY HEALTH AIDE SERVICES

Compliance Program Policies and Procedures

COMMUNITY HOME HEALTH CARE, INC. DBA COMMUNITY HEALTH AIDE SERVICES **Compliance Program Policies and Procedures**	
Title: Documentation and Claims Submission Policy	
Reviewed:	**Revised:**

A. POLICY

Community Home Health Care, Inc. DBA Community Health Aide Services (the "Agency") is dedicated to maintaining integrity in its documentation and claims submission practices for the items and services it provides. In conformity with our basic mission and values, claims may only be submitted for actual services rendered and appropriately documented, and only when those items and services are provided in a manner that is consistent with accepted standards of medical care.

B. STANDARDS RELATING TO DOCUMENTATION OF SERVICES

1. Documentation of Time Providing Services. Personnel providing home health and personal care services must document the hours spent in the provision of services. Personnel are to use the electronic visit verification system to record the time spent in in the provision of tasks as set forth in the patient's Plan of Care. In the event that Personnel are unable to use the system, they are to immediately report this to their supervisor and subsequently complete a manual time sheet.

2. Plans of Care. A plan of care must be established for each patient and maintained in the case record. The Agency is responsible for establishing the plan of care. The plan of care must include, at a minimum, the diagnosis, prognosis, need for palliative care, mental status, frequency of each service to be provided, medications, treatments, diet regimens, functional limitations and rehabilitation potential.

The plan of care must be reviewed and/or revised as frequently as necessary to reflect the patient's needs. At a minimum, the plan of care must be reviewed every six (6) months.

Agency Personnel must promptly alert the patient's authorized practitioner and other affected care providers to any significant changes in the patient's condition that indicate a need to revise the plan of care.

3. Medical Orders. Medical orders must reference all diagnoses, medications, treatments, prognoses, need for palliative care, and other pertinent patient information relevant to the plan of care. Such orders must be authenticated by an authorized practitioner within twelve (12) months after admission to the Agency, or prior to billing, whichever is sooner; (ii) authenticated by the authorized practitioner within twelve (12) months after the issuance of any change in medical orders or prior to billing, whichever is sooner, to include all written and oral changes and changes made by telephone by such practitioner; and (iii) reviewed and revised by the authorized practitioner as frequently as indicated by the patient's condition, but at least every six (6) months, except where an authorized practitioner, as part of an authorization, orders personal care services for up to one year for a Medicaid patient.

The Agency is responsible for ensuring that an order from the patient's authorized practitioner is documented for any services that the Agency's personnel provide. Documentation of the practitioner order must be maintained in the patient's record. Pursuant to DOH guidance, the Agency is responsible for obtaining physician/practitioner orders unless the MLTC Plan contract specifies otherwise.

4. Progress Notes. Professional personnel providing care must complete, sign and date progress notes following each patient visit or phone contact. Progress notes must include a summary of patient status and response to the plan of care and any contacts with family, informal supports and other community resources that are relevant to the patient's condition and treatment.

C. STANDARDS RELATING TO CLAIMS SUBMISSION

1. Generally. Although the Agency does not directly submit claims to Federal health care programs, the services we provide pursuant to contracts with certified home health agencies are submitted for such payment. Those claims are based on our documentation of services and our compliance with applicable law and regulations. All persons providing services through the Agency must do so in accordance with regulatory standards as to quality of care, frequency of care and level of care. Additionally, such persons must be qualified to provide the service and receive adequate supervision. Documentation of patient care must be accurate and truthful, with no misrepresentations regarding services provided. If the entity responsible for submitting claims has any question as to the accuracy of the documentation of services provided or if the medical record is unclear, personnel must cooperate with any request for clarification or additional information.

Personnel must take the necessary steps to prevent the submission of claims for payment and reimbursement that are fraudulent, abusive, and inaccurate or for medically unnecessary services. The following practices are prohibited:

- falsifying the amount of time spent providing care to a patient;
- failing to provide services as required by the plan of care/medical orders;
- falsely or inaccurately documenting services in the progress notes or plan of care;
- providing misleading information about a patient's medical condition;
- failing to meet the standard of supervision required;
- forging a health care professional's or patient's signature on documents.

2. Claims Review. Each area will establish and maintain a process for pre and/or post-submission review of a sample of claims to ensure that claims submitted for reimbursement accurately represent services actually provided and are supported by sufficient documentation, are in conformity with any applicable coverage criteria for reimbursement.

3. Other Agencies. The Agency will submit claims only for those services that it has directly rendered or were rendered on its behalf by another agency under a contractual contact.

The Agency will not bill for any services that are the financial responsibility or another agency for which another agency has accurately billed.

4. Documentation Must Support Claims. A claim may be submitted only when appropriate clinical documentation supports the claim and only when such documentation is maintained appropriately organized in a legal form, and available for audit and review. The documentation should record the activity that lead to the record entry, the identity and discipline of the individual providing the service and any information needed to support medical necessity and other applicable reimbursement/coverage criteria. Documentation may include but is not limited to the following:

(a) Plan of Care or Plan of Treatment

(b) Verbal orders

(c) Clinical Notes – all disciplines for each visit

(d) Progress notes – all disciplines

(e) Conference Records (if applicable)

(f) Documentation of telephone conferences

(g) Comprehensive assessment at prescribed frequencies

(h) Discharge summary

(i) History and physical

(j) Medication Profile

(k) Time and activity Report

5. Compliance with Federal and State Law Regarding False Claims and Statements. All personnel shall comply with all applicable federal and state laws and regulations governing the submission of claims and related statements. A detailed description of (i) the Federal False Claims Act; (ii) the Federal Program Fraud Civil Remedies Act; (iii) state civil and criminal laws pertaining to false claims; and (iv) the whistleblower protections afforded under such laws is provided to all personnel.

6. Medical Necessity for Items and Services. The Agency will only submit claims to the billing entity for items and services that are medically necessary or that otherwise constitute a covered item or service. Medical necessity will be determined individually for each item or service provided or ordered by the responsible medical professional. Medicare considers items and services to be reasonable and necessary if they are "for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.'' *42 U.S.C. 1395y(a)(1)(A).* When the Agency provides services to a Medicare beneficiary, the Agency will only bill for those items and services that meet the Medicare standard of being reasonable and necessary for the diagnosis and treatment of a patient.

7. Medicare Patient Notifications. Personnel must provide Medicare patients with appropriate notices of Medicare beneficiary rights and protections. For example, the Home Health Change of Care Notice (HHCCN) is used to notify Original Medicare fee-for-service beneficiaries

receiving home health care benefits of plan of care changes. Other forms required for Original Medicare fee-for service beneficiaries include the "Advance Beneficiary Notice of Non-coverage" (ABN) which must be given prior to provision of any item or service that may not be covered by Medicare and for which the patient may be liable for payment; the "Notice of Medicare Non-coverage" (NOMNC); and the "Detailed Explanation of Non-coverage" (DENC). It is a requirement that Medicare beneficiaries receive written notification before reducing or terminating an item and/or service.

8. No Routine Waiver of Co-Payments, Co-Insurance and Deductible Amounts. The Agency does not routinely waive co-payments, co-insurance and deductible amounts. A waiver of such amounts may only be appropriate if the patient has a documented financial need and if it is in accordance with applicable legal and payer requirements. In general, the Agency will not waive any patient's co-payment, co-insurance or deductible unless the patient has an actual financial need and that need is documented and maintained in an appropriate record. Otherwise, all patients will be billed pursuant to normal procedures for collecting these amounts. Unpaid co-payments, co-insurance and deductible amounts will only be written off if normal, reasonable and good-faith collection efforts have failed and after appropriate consideration is given to the cost of further collection efforts.

9. Correct Use of Provider Identification Numbers. Every insurer to whom claims for payment are submitted, requires the use of identifying numbers on the claim form (e.g., National Provider Identification numbers). Including the appropriate identifying numbers on claim submissions is essential to allow for timely processing of the claim. Moreover, the physician or provider who actually ordered the service must be accurately and correctly reflected on the claim, consistent with payer requirements. The use of another's name or identification number, in lieu of the actual ordering physician, may be considered fraud. If personnel have any questions regarding the correct use of identifying numbers in connection with claims for payment, they should contact the Compliance Officer.

10. Retention of Records. All records that demonstrate the Agency's right to receive reimbursement for services will be retained for a period of no less than ten (10) years from the date the items or services were provided or such time as required by law.

11. Compliance Reviews and Training. The Agency will conduct compliance assurance reviews on a regular basis, implement corrective action, as necessary and appropriate, and will educate and train Personnel regarding applicable documentation and claim submission requirements in accordance with the following policies:

- Compliance Monitoring, Risk Assessment and Training, and
- Protocols for Investigations and Implementing Corrective Action, Including Discipline.

COMMUNITY HOME HEALTH CARE, INC. DBA COMMUNITY HEALTH AIDE SERVICES **Compliance Program Policies and Procedures**	
Title: Compliance Monitoring, Risk Assessment and Training	
Reviewed:	**Revised:**

POLICY

It is the policy of Community Home Health Care, Inc. DBA Community Health Aide Services (the "Agency") to conduct on-going risk assessments by having processes in place to continually monitor compliance with the Agency's Code of Conduct, its Compliance Program Policies and Procedures, and all applicable Federal and State laws, rules and regulations. The Agency will devote such resources as are reasonably necessary to ensure that audits are adequately staffed by persons with appropriate knowledge and experience. To this end, the Agency has established and implemented an effective system for routine monitoring and identification of compliance risks. The Compliance Officer will ensure that specific compliance assurance reviews are conducted in accordance with the following procedures and protocols.

PROCEDURE

A. ON-GOING RISK ASSESSMENT

1. Compliance Assurance Reviews. On a periodic basis, the Compliance Officer, or her designee, will ensure that reviews are conducted to evaluate the Agency's compliance with federal health care program requirements (*e.g.,* the Medicare and Medicaid Programs) and the overall effectiveness of the compliance program. Internal, and as appropriate, external audits of the Agency's documentation, claims submission and business practices are conducted. The Compliance Committee will designate the time for audits and the departments and functions to be audited. Depending on the nature of the review or the results of a review, the Compliance Officer may work with legal counsel or outside consultants.

Such Compliance Assurance reviews may include, but are not limited to, the following:

a. Chart /Documentation Reviews. Periodically, the Compliance Officer, or a designee, will cause chart reviews of a small sample of patient records to be conducted to assess the adequacy and appropriateness of the documentation of services. Such reviews may include, among other items, reviews to ensure patient records contain appropriately signed medical orders, certifications, plans of care, progress notes and other relevant documents; and that patient's needs are addressed.

Reviews will also be conducted to ensure that patients are receiving home health or personal care services for the amount of time allotted by individual care plans.

b. Quality of Care/Medical Necessity Reviews. The Compliance Officer, or designee, will also conduct periodic reviews to ensure that necessary quality assurance systems are in place and effectively functioning, and ensure that open lines of communication exist between

the Agency's Quality Assessment and Improvement Committee and the Compliance Officer and/or Compliance Committee.

The Compliance Officer, or designee, will receive reports regarding quality-related issues, including, but not limited to: access to care; meeting recognized standards of care; preventing and addressing deficiencies in patient care; honoring patients' rights; and ensuring staff are qualified to provide services.

c. Review Tools. The Agency may periodically utilize the NY DOH's LHCSA P & P Manual Review Tool and the OMIG's audit protocols to assess its compliance with State requirements as to its policies, procedures, and documentation practices.

d. Patient Complaints/Satisfaction Surveys. The Compliance Officer will monitor patient complaints and responses to satisfaction surveys to assess whether any patterns arise that are indicative of systemic improper or fraudulent practices.

2. New Employees. It is the responsibility of the Administrator along with the Department Manager to ensure that employees who are new to a position, which has a direct impact on the claims development and submission process, are provided adequate and appropriate training and education. The work of such new employees should be audited or reviewed until the Administrator or Manager is satisfied that the employee's work is adequate to justify cessation of the audit or review.

3. Response to Third Party Audits. Following resolution of audits by third-party payers, the results of the audit will be reviewed by the Compliance Officer or her designee, to determine if those results reflect, among other things, any patterns, systemic deficiencies or problems with compliance with State or Federal rules, regulations or laws, contractual requirements and/or payer policies. If such a pattern, deficiency or problem is identified, appropriate corrective action will be taken, as necessary and appropriate.

4. Review of Compliance Issues. Periodically, the Compliance Officer will review reports received of suspected violations of the Code of Conduct and the Agency's Compliance Program Policies and Procedures to determine if there are any patterns of violations that might indicate broader compliance issues. Corrective action will be implemented as necessary and appropriate.

5. Business Reviews. Periodically, reviews will be conducted to spot check the Agency's business practices to ensure compliance with applicable laws, rules and regulations. Such checks might include, but are not limited to, a review of the Agency's marketing practices, the nature and scope of any free or discounted items or services being provided to patients, and reviews of relationships with physicians, providers and other relevant parties for compliance with Federal and State Anti-kickback and "Stark" laws and regulations. The findings from these reviews and other business practices that may implicate compliance issues, shall be communicated to the Compliance Officer. Corrective action will be implemented as necessary and appropriate.

6. Modification and Revision of Compliance Policies and Procedures. On an least an annual basis, the Compliance Officer will review and evaluate the effectiveness of the operation of the Compliance Program with the assistance of internal and external advisors, as necessary.

Based on such reviews, the Compliance Officer will implement appropriate modifications of, or revisions to, compliance policies and procedures and/or other aspects of the Agency's Compliance Program.

7. Governance. The Compliance Officer will regularly report directly to the Agency's Chief Executive Officer and to the Governing Body regarding compliance issues that may arise. Moreover, the Compliance Officer will ensure that all officers, directors, and key persons complete the annual Conflict of Interest Disclosure form.

8. Mandatory Reporting. The Compliance Officer will conduct reviews to ensure that all regulatory reporting obligations are met. Moreover, the Agency's governing body will ensure that annual New York and Federal compliance certifications (as applicable) are timely completed.

9. Credentialing. The Compliance Officer will ensure that all personnel are appropriately credentialed (*i.e.*, properly licensed/certified and registered) and not listed on any federal or state exclusion list.

10. Annual Work Plan. The Compliance Officer will produce an annual work plan to the Chief Executive Officer and the governing body for their approval that includes the specific compliance issues, audits and risk areas that will be addressed in the coming year. This may include, for instance, matters for which corrective action plans have been implemented that may require auditing or monitoring to confirm compliance. The Compliance Work Plan will address the following risk areas: billing and payments; medical necessity and quality of care issues; governance; mandatory reporting requirements as related to the Medicaid Program; credentialing and other risk areas identified by the Compliance Officer.

11. On-Going Report to the CEO/Governing Body. If any Compliance Assurance reviews detect compliance issues, the Compliance Officer shall report those issues to the Agency's Chief Executive Officer and, as necessary, to the governing body. At the direction of the CEO and/or the governing body, the Compliance Officer shall take all necessary and appropriate corrective action.

12. Recordkeeping. Documentation of the Agency's compliance assurance efforts will be maintained by the Compliance Officer or her designee. Such documentation will include, but not be limited to, copies of audit materials (including results), logs of calls to the Hotline or other compliance reports received by the Compliance Officer, and annual Compliance Work Plans and results of Work Plan activities.

B. TRACKING NEW DEVELOPMENTS

On a continuing basis, the Compliance Officer or her designee, will ensure that all new regulatory, legal and other requirements issued by Federal or State government agencies and commercial payers with which the Agency does business are reviewed by appropriate personnel. For example, such reviews may include, but are not limited to the following:

- Reviewing all new and revised rules and policies governing documentation and claims submission for home care services provided by the Agency;

- Receiving and reviewing relevant Medicare bulletins, Local and National Coverage Determinations, Medicaid updates, or other relevant guidance and policy changes;

- Communicating with the appropriate professional society as to recent initiatives or developments that might affect the Agency, or new practices that might assist the Agency in complying with rules and regulations that specifically apply to it; and

- Reviewing (a) relevant Special Fraud Alerts and relevant Advisory Opinions or other guidance issued by the U.S. Department of Health and Human Services, Office of the Inspector General ("OIG"); (b) compliance alerts, and other guidance issued by the New York State Office of the Medicaid Inspector General ("OMIG"); and (c) guidance and policies issued by other payers with which the Agency does business.

- Reviewing all Work Plans issued by the OIG and OMIG.

Based on any relevant new developments, the Compliance Officer, or her designee, will review existing policies and procedures to ensure that the Agency is in compliance with the requirements of applicable Federal and State law and regulations as well as other contractual obligations. If necessary, appropriate corrective action will be taken.

C. COMPLIANCE TRAINING

1. Policy Statement. It is the Agency's policy that the following Personnel participate in compliance training and education activities annually: the Compliance Officer, employees, the Chief Executive and other senior administrators, managers and Governing Body members. Such training will occur no less than annually and will include applicable laws, regulations and other requirements; how the Agency's Compliance Program operates (including, but not limited to: how and to whom to report issues, confidentiality, the investigation process, corrective actions, disciplinary policies, non-retaliation/non-intimidation policies); and the Agency's expectations for personnel to abide by the Code of Conduct, report issues and assist in their resolution.

New employees will be trained as part of their job orientation within 30 days of start date. Training will also be provided upon new appointment of a Chief Executive, manager or Governing Body member.

The hiring package will provide an overview of fraud and abuse laws, a summary of the standards of conduct, an explanation of the elements of the Compliance Program, including the complaint or reporting process maintaining confidentiality and highlight the Agency's commitment to integrity in its business operations and compliance with applicable laws and regulations. In addition, vendors are provided with information regarding how to access the Agency's Compliance Program Manual through the Agency's website.

This continuing education and training effort is of vital importance. Effective communication of applicable laws, regulations and policies will require development of, and participation in, training and educational programs, and may require dissemination of written materials, on a periodic basis.

The Compliance Officer will be responsible for identifying and developing training regarding specific compliance risk areas.

2. Type and Amount of Training. Training and education may occur in sessions with individual employees, in mandatory in-service meetings or incorporated into special or regular departmental meetings or in some other effective manner. Training may consist of live presentations, videos, question and answer sessions and written material and may occur in-house or through attendance at external workshops and seminars.

Personnel need not have the identical amount of training and education, nor will the focus of training and educational efforts be the same for all personnel. The actual amount of training should reflect applicable necessity, an analysis of risk areas or areas of concern identified by the Agency, including issues identified in OIG and OMIG Work Plans and audit activities, the Agency's compliance experience and the results of periodic audits or monitoring. It is the Agency's intention that, to the extent appropriate, training and educational programs be tailored to those individuals whose job requirements make the information relevant.

3. Code of Conduct/Policies & Procedures. The Compliance Officer is responsible for ensuring that information regarding the Compliance Program, including the Compliance Program Manual which contains the Reporting Requirements, Code of Conduct and the Compliance Program Structure and Guidelines, are distributed to all personnel and for maintaining a file containing each person's signed acknowledgment form. All newly hired personnel must also receive a copy of the Compliance Manual during orientation and sign and return the acknowledgment form to the Compliance Officer. The Compliance Officer also must ensure that specific Compliance Program policies and procedures, are distributed to appropriate personnel, as relevant to their job responsibilities at the Agency.

4. Mandatory Participation. Attendance and participation in training and educational programs is an important part of the Agency's business and professional environment. Thus, all personnel shall participate in appropriate education and training programs appropriate to their position and work at the Agency. These programs will reflect the Agency's commitment to compliance with applicable laws and regulations, and to appropriate ethical, professional and business standards. Adherence to the requirements of continuing education and training will be considered in the overall evaluation of the performance for each individual associated with the Agency. Failure to comply with education and training requirements may result in disciplinary action consistent with the gravity of such non-compliance, and is subject to legal and contractual rights, if any, applicable to such individual. The Compliance Officer will ensure that a process is in place to follow up with any Personnel that miss scheduled training sessions.

5. Recordkeeping. The Compliance Officer shall be responsible for maintaining records of the type of education and training program offered, the dates offered, and proof (e.g., a sign-in sheet)of those who attended the program. Educational and training files, including copies of all written materials, shall be retained for a period of no fewer than ten (10) years from the date the materials were last used.

6. Evaluation of Effectiveness. The Compliance Officer shall periodically (no less than annually) monitor, evaluate and annually assess the effectiveness of the Agency's education and training programs and shall revise such programs as necessary.

COMMUNITY HOME HEALTH CARE, INC. DBA COMMUNITY HEALTH AIDE SERVICES **Compliance Program Policies and Procedures**	
Title: Compliance Personnel	
Reviewed:	**Revised:**

PURPOSE

To describe the responsibilities of Community Home Health Care, Inc. DBA Community Health Aide Services' (the "Agency's") Compliance Officer and Compliance Committee with regards to the Agency's Compliance Program and enforcement of the Agency's policies and procedures.

POLICY AND PROCEDURES

I. COMPLIANCE OFFICER

The Compliance Officer maintains an effective Compliance Program to prevent illegal, unethical, or improper conduct. The Corporate Compliance Officer, together with the Compliance Committee, is authorized to implement all necessary actions to ensure achievement of the objectives of an effective Compliance Program.

The Compliance Officer will know and understand all aspects of the Program and ensure that all responsibilities under the Program are delegated to persons who are morally fit, honest, and capable of making decisions required under the Program. The Compliance Officer has been given all necessary powers and resources to carry out her duties.

The Compliance Officer will consult with counsel, when necessary, to clarify requirements under the Program, rework any requirements that are outdated or vague or make changes to the Program as circumstances may dictate and ensure that compliance issues are properly addressed. The Compliance Officer will also develop and maintain a monitoring and audit process for determining whether compliance standards are being met and that appropriate compliance assurance reviews, audits, and inquiries are conducted. The Compliance Officer is responsible for ensuring that appropriate compliance training takes place and must work with the others as appropriate to develop an effective compliance training program, including appropriate introductory training for new employees and ongoing training for all personnel, including officers and directors.

The Compliance Officer has the authority to review all documents and other information relevant to the Agency's compliance activities including, but not limited to: patient records, claim submission records, records concerning marketing efforts, and records/contracts of arrangements with other parties. The Compliance Officer must be informed of, and have access to, all information concerning any overpayments and all pertinent audits, reviews, or investigations by any state or federal governmental agency.

The Compliance Officer reports directly and is accountable to the Chief Executive Officer. The Compliance Officer will have access to the governing board, as necessary. The Compliance

Officer shall report to the Board at least annually or as necessary, on the status of the Compliance Program and related activities. Such reports may be written or oral.

II. COMPLIANCE COMMITTEE

The Agency has established a Compliance Committee (the "Committee") which works with the Compliance Officer and is responsible for monitoring the implementation and operation of the Program. This Committee works with the Compliance Officer, monitoring the implementation and operation of the Program and reviewing compliance issues and implementing appropriate corrective action. The Committee will be responsible for conducting compliance assurance reviews that will focus on the adequacy of documentation, appropriateness of claims development, and quality of care provided. The Committee will also work with the Compliance Officer in reviewing compliance concerns and implementing appropriate corrective action.

The Committee assists the Compliance Officer in developing an annual Compliance Work Plan.

The Committee must be fully aware of the reporting requirements to State and Federal agencies. The Committee must ensure that any required reports are made consistently and in a timely manner. In addition, the Committee must report to the Compliance Officer regarding any and all incidents, violations of rules, regulations and policy, employee misconduct and any other issue that can be viewed as a reportable event or violation of the Compliance Program.

The Committee shall meet quarterly and may adopt written guidelines for holding meetings and conducting the activities, and operations of the Committee.

The Committee also reports and is accountable to the Chief Executive Officer.

COMMUNITY HOME HEALTH CARE, INC. DBA COMMUNITY HEALTH AIDE SERVICES **Compliance Program Policies and Procedures**	
Title: Compliance Responsibilities of Managers and Directors	
Reviewed:	**Revised:**

PURPOSE

To describe the responsibilities of management and directors throughout Community Home Health Care, Inc. DBA Community Health Aide Services (the "Agency") with regards to the Agency's Compliance Program and enforcement of the Agency's policies and procedures.

POLICY

All department directors, supervisors and managers have the responsibility to help create and maintain a work environment in which ethical concerns can be raised and openly discussed. They are also responsible to ensure that those they supervise understand the importance of the Code of Conduct, Compliance Standards, and related Compliance policies; that personnel are aware of the procedures for reporting suspected wrongdoing; and that all personnel are protected from retaliation and intimidation if they come forward with information about such suspected wrongdoing. Department directors, supervisors and managers who receive compliance-related reports must immediately bring such reports to the attention of the Compliance Officer.

Specifically, each director or manager is responsible for:

1. Implementing and maintaining compliance standards, policies and procedures and manuals applicable to their departments in consultation with the Compliance Officer;

2. Providing training to all employees on compliance standards, policies, procedures, laws and regulations applicable to employees of the department in consultation with the Compliance officer;

3. Enforcing this Program, the Code of Conduct, the Agency's policies and procedures, and applicable laws and regulations;

4. Investigating reports or reasonable indications of violations of this Program, the Code of Conduct, the Agency's policies or procedures, in consultation with the Compliance Officer;

5. Reporting to the Compliance Officer any reports or reasonable indication of violations of applicable law or regulation by any member of the department;

6. Initiating and/or implementing corrective or disciplinary action in the event of violation of the Compliance Program, the Code of Conduct, the Agency's policies, procedures and applicable laws and regulations; and

7. Taking all measures reasonably necessary to ensure compliance with this Program and applicable laws and regulations.

COMMUNITY HOME HEALTH CARE, INC. DBA COMMUNITY HEALTH AIDE SERVICES **Compliance Program Policies and Procedures**	
Title: Compliance Reviews for Excluded Individuals/Entities	
Reviewed:	**Revised:**

I. POLICY

Community Home Health Care, Inc. DBA Community Health Aide Services (the "Agency") is committed to using good faith, reasonable efforts to not knowingly employ, contract with, or otherwise do business with, individuals or entities that are excluded, debarred or suspended from, or otherwise ineligible to participate in, Federal Health Care Programs or in Federal procurement or non-procurement programs.

This Policy and Procedure applies to our relationships and prospective relationships with: (1) all professional and non-professional members, and candidates to become members, of the Agency's staff, whether employed by, contracted with, or volunteers to, the Agency (collectively referred to as "Staff"); (2) all physicians, practitioners and other providers who refer patients to, or order, prescribe or medically direct the provision of, items or services from, the Agency (collectively referred to as "Referring Providers"); and (3) all vendors and contractors who do business with, or seek to do business with, the Agency (collectively referred to as "Vendors").

II. DEFINITIONS

The following definitions apply for purposes of this Policy and Procedure:

A. Federal Health Care Program

A "Federal Health Care Program" is defined as any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government (other than the Federal Employees Health Benefits Program), or any State health care program. For example, some of the better known Federal Health Care Programs include, but are not limited to, Medicare, Medicaid, TRICARE and veterans' programs.

B. Ineligible Person

An "Ineligible Person" means an individual or entity who/which has been excluded, debarred, suspended, terminated from, or is otherwise ineligible to participate in, any Federal Health Care Program or any Federal procurement or non-procurement program, and has not been reinstated after the period of exclusion, debarment, suspension, termination or ineligibility.

C. Exclusion Lists

The "Exclusion Lists" include the following three internet sources that must be checked in accordance with the requirements of this Policy and Procedure:

- https://exclusions.oig.hhs.gov/ (the United States Department of Health and Human Services, Office of Inspector General's ["OIG"] List of Excluded Individuals/Entities);

- https://www.sam.gov/portal/SAM/#11 (the General Service Administration's System for Award Management); and

- https://omig.ny.gov/medicaid-fraud/medicaid-exclusions (the New York State Medicaid Exclusions List, available on the New York State Office of the Medicaid Inspector General's ["OMIG"] website).

Other sources and lists may also be checked as the Agency deems necessary and appropriate. For example, if a potential Staff member's resume or application indicates that he or she worked in a state(s) other than New York, the equivalent state-specific lists, if available, should also be checked. Should any questions arise about the need or advisability of consulting any sources of information in addition to the Exclusion Lists, they should be promptly directed to the Agency's Compliance Officer.

III. PROCEDURES

In order to ensure compliance with this Policy, the Agency will, at minimum, follow the procedures set out below.

A. RESPONSIBILITY FOR SCREENING PROCESS

Initial and monthly screening of Staff, Referring Providers and Potential Vendors is conducted by the Compliance Officer or a designee. If a designee performs the required screenings on behalf of the Agency, the designee will report the results of all such screenings to, and will be supervised by, the Agency's Compliance Officer.

B. PROCEDURES FOR SCREENING.

1. Screening of Potential Staff Members, New Referring Providers and Potential Vendors.

   a) Potential Staff Members. Every candidate to work as a Staff member at or on behalf of the Agency is required to disclose on his or her application form whether he or she is an Ineligible Person. In addition, at minimum, the Agency will also check the names of each potential Staff member against the Exclusion Lists *prior to* contracting with or employing the candidate... If the candidate discloses that he or she is an Ineligible Person, fails to answer the question, appears on any of the Exclusion Lists, or if there is any question as to whether he or she is an Ineligible Person, the procedures set out in section C, below, will be followed.

   b) New Referring Providers. *Prior to* accepting referrals, filling orders or prescriptions from, or furnishing items or services at the medical direction of, a Referring Provider who is new to the Agency, the Agency will, at

minimum, check the name of each such individual or entity against each of the Exclusion Lists. If the new Referring Provider appears on any of the Exclusion Lists, or if there is any question as to whether the individual or entity is an Ineligible Person, the procedures set out in section C, below, will be followed.

c) Potential Vendors. *Prior to* doing business with, or entering into a contract with, any potential Vendor to the Agency (including a Vendor that has previously been a Vendor to the Agency), the Agency will: (i) check the Vendor's name against each of the Exclusion Lists, and (ii) require the Vendor to check its employees and contractors against each of the Exclusion Lists, and confirm to the Agency that none of them appear on any of the Exclusion Lists. If either of these checks results in an Ineligible Person finding, or a question as to whether the Vendor or an individual or entity associated with the Vendor is an Ineligible Person, the procedures set out in section C, below, will be followed.

In addition, in order to help ensure that the Agency and its Vendors are in compliance with this Policy and Procedure, the Agency should, whenever possible, include in its written Vendor contracts/agreements provisions that provide for:

- a representation and warranty by the Vendor that it and its employees and contractors are not Ineligible Persons as of the date the contract/agreement is entered into;

- a representation and warranty by the Vendor that it will check each of the Exclusion Lists prior to hiring employees and contractors, and at least every month thereafter;

- the Vendor to maintain documentation for a defined period of time confirming that (i) it has performed the required checks of the Exclusion Lists and that such checks did not result in any Ineligible Person findings, and (ii) that it will make such documentation available to the Agency at its request;

- the Vendor to immediately disclose to the Agency's Compliance Officer if it, or any of its employees or contractors, becomes an Ineligible Person at any time during the term of the agreement/contract, or at any time thereafter; and

- permitting the immediate termination of the agreement/contract and the Vendor's relationship with the Agency, if, at any time, the Vendor or any of its employees or contractors is found to be or becomes an Ineligible Person.

The Agency and the Compliance Officer may consult with outside counsel, as necessary and appropriate, in connection with these and other compliance-related contractual issues.

2. Regular Checks of Current Staff, Current Referring Providers and Current Vendors.

d) Checks At Least Every Month. The Agency will check the names of all current Staff, current Referring Providers and current Vendors against each of the Exclusion Lists at least every month. If an individual's or entity's name appears on any of the Exclusion Lists, the procedures set out in section C, below, will be followed.

e) Annual Certification by Current Staff. The Agency will also require each current Staff member to certify on his or her annual performance evaluation that he or she is not currently, and has not been at any time since the date of the last such certification, an Ineligible Person. If the Staff member discloses that he or she is an Ineligible Person or fails to answer the question, or if there is any question as to whether he or she is an Ineligible Person, the procedures set out in section C, below, will be followed.

C. RESPONSE TO AN "INELIGIBLE PERSON" FINDING

Should the disclosure or review processes set forth above result in the determination that, or any question as to whether, any individual/entity may be, is, or has been, an Ineligible Person, then the following procedures will be followed:

1. Notification of Compliance Officer/Investigation/Preliminary Actions. The Compliance Officer will be immediately notified. An investigation into the matter will be promptly conducted, in conjunction with outside counsel as necessary and appropriate. The investigation will include a review of all relevant facts and circumstances. At minimum, during the pendency of any such investigation: (a) any Federal Health Care Program claims that are related (whether directly or indirectly) to the items or services provided by, at the medical direction of, or that result from an order, prescription or referral from, the individual/entity who is suspected to be an Ineligible Person, will be immediately suspended, and (b) a suspected Ineligible Person will be immediately removed from any and all responsibility for, and any and all involvement with, Federal Health Care Programs (including administrative and management services). The Agency may also take such other preliminary actions consistent with its Compliance Program and its compliance policies and procedures that it deems necessary and appropriate.

2. Finding of Ineligibility: Potential Staff Members, New Referring Providers and Potential Vendors. If, after the investigation is concluded, a potential Staff member, a new Referring Provider or a potential Vendor (or the potential Vendor's employee or contractor) is found to be an Ineligible Person, the Agency will not hire, contract or do business with, the individual or entity, and will not accept referrals, orders, prescriptions or direction from, any such Referring Provider. Other appropriate corrective action, if necessary, may also be taken in accordance with the Agency's Compliance Program and its compliance policies and procedures.

3. Finding of Ineligibility: Current Staff Members, Current Referring Providers and Current Vendors. If, after the investigation is concluded, a current Staff member, current Referring Provider or current Vendor (or the Vendor's employee or contractor) is found to be an Ineligible Person, the Agency will take all appropriate corrective action.

This may include, but is not limited to, one or more of the following: suspension or termination of an individual's employment or contract with, or work for, the Agency; termination of a Vendor's contract; permanent suspension of claims that are related (directly or indirectly) to the Ineligible Person; the timely return of monies improperly received, in accordance with applicable law, regulation, guidance and/or contract; and/or self-disclosure or reporting to the appropriate government agency(ies), or other payors, in accordance with applicable law, regulation, guidance and/or contract.

At minimum, an Ineligible Person will be removed from any and all responsibility for, and any and all involvement with, Federal Health Care Programs (including administrative and management services), and the Agency will cease submitting claims to, or seeking or causing payments to be made from, Federal Health Care Programs that relate in any way, whether directly or indirectly, to items or services provided by, at the medical direction of, or that result from an order, prescription, or referral from the Ineligible Person, in accordance with applicable law, regulation and guidance.

Other appropriate corrective action, if necessary, may also be taken in accordance with the Agency's Compliance Program and its compliance policies and procedures.

The Agency may consider reinstating an Ineligible Person only following confirmation that the individual/entity has been reinstated into the applicable Federal Health Care Program(s) and that the individual/entity is no longer an Ineligible Person. Any decision regarding reinstatement will be made in the Agency's sole discretion.

D. MAINTENANCE OF DOCUMENTATION

The search results page of the checks of the Exclusion Lists or other proof that the required checks of the Exclusion Lists have been performed will be maintained by the Compliance Officer or her designee. In addition, records of any investigations, corrective action, disciplinary action or other action taken in accordance with this Policy and Procedure will also be maintained by the Compliance Officer or/her designee. All such documentation will be maintained for no less than ten (10) years from the later of: (a) the last date on which the Exclusion Lists were searched, (b) the conclusion of the investigation, (c) the imposition or ending date (as the case may be) of any corrective, disciplinary or other action, or (d) for such longer period of time as may be required by applicable law, regulation or contractual requirement.

COMMUNITY HOME HEALTH CARE, INC. DBA COMMUNITY HEALTH AIDE SERVICES **Compliance Program Policies and Procedures**	
Title: Compliance Reviews of Staff Credentials	
Reviewed:	**Revised:**

I. POLICY

Community Home Health Care, Inc. DBA Community Health Aide Services (the "Agency") is committed to ensuring that all individuals employed by, or who contract with us have the proper credentials, experience and expertise required to discharge their responsibilities. To this end, the Agency is committed to using good faith efforts to not employ or contract with professionals or personal care and home care workers who are not currently licensed or certified and registered with the State (or who do not otherwise have the required credentials).

II. PROCEDURES

In order to ensure compliance with the above Policy Statement, the Agency will, at minimum, take the following actions:

A. New Employees/Contractors – Professionals. Before hiring or retaining any professional licensed by the NY State Department of Education, the Agency will appropriately query available websites, including, but not limited to (as applicable):

1. http://www.op.nysed.gov/opsearches.htm (links to the NY State Education Department's web page for license or certification verification);

2. http://www.op.nysed.gov/opd/ (links to the NY State Education Department's web page for disciplinary action against professional licensees); and

3. http://www.health.ny.gov/professionals/doctors/conduct/ (links to the NY Office of Professional Medical Conduct's webpage for disciplinary action against Physicians and Physician Assistants);

B. New Employees/Contractors – Personal Care and Home Care Aides. All personal care and home care services provided to our patients will be furnished by personnel who have been appropriately trained and are qualified to furnish such services. Documentation of such qualifications (e.g., certificate of completion from a State Department of Health approved training program) will be maintained.

1. Background Checks. The Agency appropriately accesses the Home Care Worker's Registry information prior to the worker beginning to provide home care services for the Agency. The Agency also conducts criminal history record checks pursuant to federal and state law on personnel involved in providing care. This investigation is conducted before hiring and includes a questionnaire specifically requiring the prospective

employee or contractors to disclose any criminal convictions and/or exclusion from participation in any federal health care program. The Agency routinely checks all applicable state and federal government databases of individuals and entities excluded from participation in federal/state health care programs.

2. Health Assessments. The health status of all new personnel will be assessed and documented prior to the assumption of patient care duties. Personnel shall not assume direct patient care duties unless they are free from a health impairment which is of potential risk to the patient or which may interfere with the performance of his/her duties. This includes, but is not limited to, habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter a person's behavior.

At a minimum, the following records will be maintained for all personnel who have direct patient contact:

- Verified personal identification, employment history and license/certification documentation;
- Certificates and/or documentation of immunization against rubella, measles, tuberculin skin tests and influenza, as required by law and regulations; and
- Annual, or more frequent as necessary, health status assessments.

Other available information or resources may also be used from time-to-time, as necessary and appropriate.

C. Monthly Reviews. Appropriate website searches (and/or searches/diligence of other appropriate information or resources) will be performed monthly on all nurses then employed by, or contracted with, the Agency.

D. Annual Certification. In addition, the Agency will require each current licensed professional and personal care / home care worker to certify that: (a) he or she has not been convicted of a crime; and (b) that their New York State license certification (and registration, as applicable) or other required credentials to practice their profession are current.

E. Corrective Action. Should the Agency determine that: (a) any individual is or has been convicted of a crime; or (b) that an individual's New York State license / certification and/or registration (or other required credentials) is not current, then the following action will be taken:

- First, the Compliance Officer will be immediately notified.
- Second, if the determination relates to an individual that has an existing relationship with the Agency, the individual will be immediately suspended from providing any services to, or on behalf of, the Agency (including, but not limited to, patient care services) pending the outcome of the

investigation provided for below. In addition, any billing by, or related directly or indirectly to, that individual will be immediately suspended.

- Third, an investigation of the matter will be immediately undertaken (with the assistance of compliance counsel, as necessary), and appropriate corrective and disciplinary action will be promptly implemented in accordance with our Compliance Program (including, but not necessarily limited to, and as appropriate the return of monies improperly received and the termination of the relationship).

- Fourth, if the determination relates to an individual that does not have an existing relationship with the Agency, that person will not be hired or retained, or otherwise become affiliated with the Agency.

F. Documentation Retention. Records of the above reviews and any investigations, corrective action and/or disciplinary action taken will be maintained in the individual's personnel file or in another appropriate file for at least ten (10) years.

COMMUNITY HOME HEALTH CARE, INC. DBA COMMUNITY HEALTH AIDE SERVICES **Compliance Program Policies and Procedures**	
Title: Compliance with Anti-Referral Laws	
Reviewed:	**Revised:**

POLICY

It is the policy of Community Home Health Care, Inc. DBA Community Health Aide Services (the "Agency") that all personnel shall comply with applicable Federal and State Anti-Referral laws and related regulations. The Agency has instituted various procedures to ensure compliance with these laws and to assist in preventing fraud, waste and abuse in Federal health care programs.

A. OVERVIEW OF THE FEDERAL ANTI-REFERRAL LAWS

1. The Federal Anti-Kickback Statute. Under the Federal Anti-Kickback Statute, it is a crime to knowingly and willfully solicit, receive, offer or pay any remuneration (including any kickback, bribe or rebate), directly or indirectly, overtly or covertly, in cash or in kind: (i) in return for or to induce the referral of an individual for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, or (ii) in return for or to induce the purchasing, leasing, ordering or arranging (or the recommending of such) of any good, facility, item or service for which payment may be made in whole or in part under a federal health care program. "Federal health care program" under this statute generally includes ***all*** health care programs that receive ***any*** funding from the United States government (including, but not limited to, Medicare and Medicaid), as well as certain specified State health care programs.

The Federal Anti-Kickback Statute has been broadly interpreted by a number of courts to prohibit remuneration which is offered or paid when the circumstances show that ***one*** purpose of the arrangement is to induce referrals or otherwise engage in the prohibited conduct — ***even if*** the arrangement has other, wholly legitimate, business aspects to it.

There are, however, a number of statutory exceptions as well as a series of regulatory "safe harbors" under the Federal Anti-Kickback Statute. If an arrangement meets every requirement of an applicable exception or "safe harbor" it will be protected from prosecution under the statute. On the other hand, the failure of an arrangement to fit squarely within a safe harbor or exception does not necessarily render the arrangement illegal *per se* or otherwise actionable. Instead, in such cases, the arrangement will be analyzed in light of the governing law and regulations and, in particular, the intent of the parties (i.e., whether the arrangement is intended to induce referrals or otherwise violate the law).

Violation of the Federal Anti-Kickback Statute may result in significant fines (up to $100,000) and/or imprisonment (of up to ten years) for ***both sides*** of an illegal kickback arrangement. In addition, substantial civil monetary penalties and exclusion from Federal and State health care programs may also result from violations of the Federal anti-kickback statute.

2. The Federal "Stark" Law. In general terms, the Federal "Stark" law prohibits a physician from making a referral to an entity for certain specified "designated health services" that are paid for by Medicare[3] to an entity when the physician (or his or her immediate family member) has a "financial relationship" (that is, an ownership interest, an investment interest or a compensation relationship) with that entity, unless an exception to the law is squarely met. If the referral is prohibited, so too is the submission of a claim for payment by the entity that receives the prohibited referral.

Currently, the Federal "Stark" law covers the following "designated health services": (a) Clinical laboratory services; (b) Physical therapy services; (c) Occupational therapy services; (d) Radiology services, including magnetic resonance imaging, computerized axial tomography scans, and ultrasound services; (e) Radiation therapy services and supplies; (f) Durable medical equipment and supplies; (g) Parenteral and enteral nutrients, equipment, and supplies; (h) Prosthetics, orthotics, and prosthetic devices and supplies; (i) Home health services; (j) Outpatient prescription drugs; (k) Inpatient and outpatient hospital services; and (l) Outpatient speech-language pathology services.

In addition to the conduct directly prohibited by the law, the statute also prohibits "circumvention schemes," i.e., those arrangements that are designed to obtain referrals indirectly that cannot be made directly.

The Federal "Stark" law contains a number of statutory exceptions. In addition, there are also a series of regulatory exceptions to the "Stark" law. A number of the "Stark" exceptions are similar (but not identical) to the Federal Anti-Kickback "Safe Harbors."

Unlike the Federal Anti-Kickback Statute, however, if the Federal "Stark" law is implicated, all relevant exceptions must be squarely met, or the law will have been violated. The Federal "Stark" law is a "strict liability" law. In other words, unlike with the Federal Anti-Kickback Statute, the intent of the parties is irrelevant from a "Stark" perspective.

The penalties for violating the Federal "Stark" law include: (i) the denial of, or the requirement to refund, any payments for services that resulted from an unlawful referral; (ii) civil monetary penalties of up to $15,000 for each service for which a person presents or causes to be presented a bill or claim that they know or should know results from a prohibited referral, or for which a required refund has not been made,[4] plus assessments of up to three times the amount

[3] On its face, the Federal "Stark" law only prohibits referrals for "designated health services" that are paid for by Medicare. However, the Social Security Act prohibits any Federal financial participation payment to a State for "designated health services" furnished on the basis of a referral that would result in a denial of payment under Medicare if Medicare covered the services in the same way as the State plan. In other words, arrangements that would be improper under the Federal "Stark" law may extend to State Medicaid Programs and prevent the State from receiving Federal matching funds for those services.

[4] Administrative penalties under the Civil Monetary Penalties Law may be imposed by the Federal Office of Inspector General. These penalties are subject to adjustments for inflation and have increased to $26,820, for each service, as of January 17, 2020. For "circumvention schemes," a civil monetary penalty of up $172,137 (as of January 17, 2020) may be imposed on any physician or entity that knows or should know that the scheme/arrangement has a principal purpose of assuring referrals by the physician to a particular entity that could not be directly made under the law.

claimed in lieu of damages; and (iii) exclusion from the Medicare and Medicaid programs as well as other Federal and/or State health-care programs.

B. OVERVIEW OF RELEVANT STATE ANTI-REFERRAL LAWS

1. New York's Anti-Kickback Statute. Similar to the Federal law, New York State also makes it a crime to offer, agree to give or give any payment or other consideration in any form to another person to the extent such payment or other consideration is given: (i) for the referral of services for which payment is made under the Medicaid Program; or (ii) to purchase, lease or order any good, facility, service or item for which payment is made under the Medicaid Program. Medicaid providers who violate this statute may be found guilty of a misdemeanor crime punishable by fines of up to $10,000, or imprisonment for up to one year or both; except that Medicaid providers that violate this statute and obtain money or property having a value in excess of $7,500 may be found guilty of a class E felony.

2. The New York State "Stark" Law (the "Health Care Practitioners Referrals" Law). In New York State, a practitioner may not make a referral to a health care provider for clinical laboratory services, pharmacy services, radiation therapy services, x-ray or imaging services or physical therapy services if the practitioner or a member of his immediate family has a financial relationship (including an ownership interest, an investment interest or a compensation arrangement) with that provider, unless a statutory or regulatory exception is met (and again, there are a number of varied exceptions that exist).

Unlike its Federal counterpart, the New York State Stark law covers all payers. If the referral is prohibited, so too is any demand for payment. The New York State "Stark" law also covers any cross-referral scheme designed to make referrals indirectly that could not be made directly. A provider or practitioner that collects any amount under a prohibited referral is jointly and severally liable to the payer. In addition, disciplinary action (including license revocation) by the appropriate State licensing authority is also a possibility. As with the Federal "Stark" law, if the New York State "Stark" law is implicated, all applicable exceptions must be met, or the law will have been violated (i.e., it, too is a "strict liability" law and the intent of the parties is irrelevant).

C. COMPLIANCE WITH ANTI-REFERRAL LAWS

It is the Agency's intent to at all times comply with the anti-referral laws to which it is subject. Given the complexity of these laws, outside counsel will be consulted as necessary to ensure the Agency's on-going compliance.

The decision to refer a patient is a separate and independent clinical decision made by the referring physician or practitioner. The Agency will not knowingly and willfully offer, pay, solicit or receive remuneration to induce or reward the referral of business reimbursable under any Federal or State health care program. Nor will the Agency otherwise engage in any relationship or arrangement that violates the anti-referral laws. Moreover, it is the Agency's policy to avoid relationships or arrangements that create an appearance of illegality or impropriety.

1. Marketing Activities. All marketing activities and advertising by Agency personnel must be based on the merits of the services provided and *not* on any promise, express or

implied, of remuneration for referrals. In addition, all marketing activities and advertising must be truthful and not misleading, and must be supported by evidence to substantiate any claims made and must comply with all applicable legal requirements. The Agency's best advertisements are the quality of the medical services we provide. Agency personnel should not disparage the services or business of a competitor through the use of false or misleading representations. All marketing materials must be reviewed and approved by the Compliance Officer before they are disseminated. The Compliance Officer may consult with legal counsel, as necessary and appropriate.

D. QUESTIONS

To the extent that you have any questions regarding the propriety of an existing or prospective arrangement or relationship (whether under the laws discussed herein, under our compliance policies, or otherwise), you are encouraged to contact the Agency's Compliance Officer, Paul Vershubsky . He may be reached by email at pversh@commhealthcare.com or by telephone at 845.738.1305. In addition, compliance concerns may be submitted via the Compliance Hotline at 845.678.8652.

COMMUNITY HOME HEALTH CARE, INC. DBA COMMUNITY HEALTH AIDE SERVICES **Compliance Program Policies and Procedures**	
Title: Compliance with Federal and State False Claims Laws: Overview of the Laws Regarding False Claims and Whistleblower Protections	
Reviewed:	**Revised:**

BACKGROUND/PURPOSE

Community Home Health Care, Inc. DBA Community Health Aide Services (the "Agency") is committed to complying with the requirements of Section 6032 of the Federal Deficit Reduction Act of 2005, and preventing and detecting any fraud, waste, or abuse. To this end, the Agency maintains a Compliance Program and strives to educate its work force on fraud and abuse laws, including the importance of submitting accurate claims and reports to the Federal and State governments. The Agency has instituted various procedures, which are set forth in our Compliance Manual and various Compliance Program policies and procedures, to ensure compliance with these laws and to assist us in preventing fraud, waste and abuse in Federal health care programs. In furtherance of this policy and to comply with the Deficit Reduction Act, the Agency disseminates this policy to all personnel (including management, contractors and other agents) to ensure that such persons are aware of certain relevant Federal and State laws, and that submission of a false claim can result in significant administrative and civil penalties under the Federal False Claims Act and other Federal and New York State laws.

POLICY

To assist the Agency in meeting its legal and ethical obligations, any personnel who reasonably suspects or is aware of the preparation or submission of a false claim or report or any other potential fraud, waste, or abuse related to a Federally or State funded health care program is required to report such information to the Compliance Officer. Any personnel who report such information will have the right and opportunity to do so anonymously and will be protected against retaliation and intimidation for coming forward with such information both under our internal Compliance Program policies and procedures and Federal and State law. However, the Agency retains the right to take appropriate action against any personnel who has participated in a violation of Federal or State law or the Agency's Compliance Program.

The Agency is committed to investigating any suspicions of fraud, waste, or abuse swiftly and requires all personnel to assist in such investigations. Corrective action will be promptly and thoroughly implemented, as necessary and appropriate. Failure to report or assist in an investigation or resolution of fraud and abuse is a breach of the personnel's obligations to the Agency and may result in disciplinary action, up to, and including termination of employment or affiliation with the Agency.

I. RELEVANT LAWS:

II. FEDERAL LAWS

A. The Federal False Claims Act (31 USC §§ 3729-3733)

The False Claims Act ("FCA") provides, in pertinent part, as follows:

§ 3729. False claims

(a) LIABILITY FOR CERTAIN ACTS.--

(1) IN GENERAL. – Subject to paragraph (2), any person who --

(A) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;

(B) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim;

(C) conspires to commit a violation of subparagraph (A), (B), (D), (E), (F), or (G);

(D) has possession, custody, or control of property or money used, or to be used, by the Government and knowingly delivers, or causes to be delivered, less than all of that money or property;

(E) is authorized to make or deliver a document certifying receipt of property used, or to be used, by the Government and, intending to defraud the Government, makes or delivers the receipt without completely knowing that the information on the receipt is true;

(F) knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the Government, or a member of the Armed Forces, who lawfully may not sell or pledge property; or

(G) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government, is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C. 2461),[5] plus 3 times the amount of damages which the Government sustains because of the act of that person.

(2) REDUCED DAMAGES.--If the court finds that—

(A) the person committing the violation of this subsection furnished officials of the United States responsible for investigating false claims violations with all

[5] Although the statutory provisions of the Federal False Claims Act authorizes a range of penalties of from between $5,000 and $10,000, those amounts have been adjusted for inflation and increased by regulation to not less than $11,665 and not more than $23,331 for penalties assessed after June 19, 2020, whose associated violations occurred after November 2, 2015. *See 28 C.F.R. §85.5*.

information known to such person about the violation within 30 days after the date on which the defendant first obtained the information;

(B) such person fully cooperated with any Government investigation of such violation; and (C) at the time such person furnished the United States with the information about the violation, no criminal prosecution, civil action, or administrative action had commenced under this title with respect to such violation, and the person did not have actual knowledge of the existence of an investigation into such violation, the court may assess not less than 2 times the amount of damages which the Government sustains because of the act of that person.

(3) **COSTS OF CIVIL ACTIONS.**--A person violating this subsection shall also be liable to the United States Government for the costs of a civil action brought to recover any such penalty or damages.

(b) **DEFINITIONS.**--For purposes of this section--

(1) the terms "knowing" and "knowingly" –

(A) mean that a person, with respect to information--

(i) has actual knowledge of the information;

(ii) acts in deliberate ignorance of the truth or falsity of the information; or

(iii) acts in reckless disregard of the truth or falsity of the information; and

(B) require no proof of specific intent to defraud;

(2) the term "claim"—

(A) means any request or demand, whether under a contract or otherwise, for money or property and whether or not the United States has title to the money or property, that—

(i) is presented to an officer, employee, or agent of the United States; or

(ii) is made to a contractor, grantee, or other recipient, if the money or property is to be spent or used on the Government's behalf or to advance a Government program or interest, and if the United States Government—

(I) provides or has provided any portion of the money or property requested or demanded; or

(II) will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded; and

(B) does not include requests or demands for money or property that the Government has paid to an individual as compensation for Federal employment or as an income subsidy with no restrictions on that individual's use of the money or property;

(3) the term "obligation" means an established duty, whether or not fixed, arising from an express or implied contractual, grantor-grantee, or licensor-licensee relationship, from a fee-based or similar relationship, from statute or regulation, or from the retention of any overpayment; and

(4) the term "material" means having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property.

(c) **EXEMPTION FROM DISCLOSURE.**--Any information furnished pursuant to subsection (a)(2) shall be exempt from disclosure under section 552 of title 5.

(d) **EXCLUSION.**--This section does not apply to claims, records, or statements made under the Internal Revenue Code of 1986.

While the False Claims Act imposes liability only when the claimant acts "knowingly," it does not require that the person submitting the claim have actual knowledge that the claim is false. A person who acts in reckless disregard or in deliberate ignorance of the truth or falsity of the information, also can be found liable under the Act. 31 U.S.C. 3729(b).

In sum, the False Claims Act imposes liability on any person who submits a claim to the federal government, or submits a claim to entities administering government funds that he or she knows (or should know) is false. An example may be a physician who submits a bill to Medicare for medical services she knows she has not provided. The False Claims Act also imposes liability on an individual who may knowingly submit a false record in order to obtain payment from the government. An example of this may include a government contractor who submits records that he knows (or should know) are false and that indicate compliance with certain contractual or regulatory requirements. The third area of liability includes those instances in which someone may obtain money from the federal government to which he may not be entitled, and then uses false statements or records in order to retain the money. An example of this so-called "reverse false claim" may include a hospital which obtains interim payments from Medicare or Medicaid throughout the year, and then knowingly files a false cost report at the end of the year in order to avoid making a refund to the Medicare or Medicaid program.

In addition to its substantive provisions, the FCA provides that private parties may bring an action on behalf of the United States. 31 U.S.C. 3730 (b). These private parties, known as "qui tam relators," may share in a percentage of the proceeds from an FCA action or settlement.

Section 3730(d)(1) of the FCA provides, with some exceptions, that a qui tam relator, when the Government has intervened in the lawsuit, shall receive at least 15 percent but not more than 25 percent of the proceeds of the FCA action depending upon the extent to which the relator substantially contributed to the prosecution of the action. When the Government does not intervene, section 3730(d)(2) provides that the relator shall receive an amount that the court decides is reasonable and shall be not less than 25 percent and not more than 30 percent

B. Administrative Remedies for False Claims (31 USC Chapter 38. §§ 3801–3812)

This statute allows for administrative recoveries by federal agencies. If a person submits a claim that the person knows is false or contains false information, or omits material information,

the agency receiving the claim may impose a penalty of up to $5,000 for each claim.[6] The agency may also recover twice the amount of the claim.

Unlike the False Claims Act, a violation of this law occurs when a false claim is submitted rather than when it is paid. Also unlike the False Claims Act, the determination of whether a claim is false, and the imposition of fines and penalties is made by the administrative agency, not by prosecution in the federal court system.

III. NEW YORK STATE LAWS

New York's false claims laws fall into two categories: civil and administrative; and criminal laws. Some apply to recipient false claims and some apply to provider false claims, and while most are specific to healthcare or Medicaid, some of the "common law" crimes apply to areas of interaction with the government.

A. Civil And Administrative Laws

1. NY False Claims Act (State Finance Law, §§187–194)

The NY False Claims Act closely tracks the federal False Claims Act. It imposes penalties and fines on individuals and entities that file false or fraudulent claims for payment from any state or local government, including health care programs such as Medicaid. The penalty for filing a false claim is equal to the amount that may be imposed under the federal FCA (as may be adjusted for inflation) and the recoverable damages are between two and three times the value of the amount falsely received. In addition, the false claim filer may have to pay the government's legal fees.

The Act allows private individuals to file lawsuits in state court, just as if they were state or local government parties. If the suit eventually concludes with payments back to the government, the person who started the case can recover 25-30% of the proceeds if the government did not participate in the suit of 15-25% if the government did participate in the suit.

2. Social Services Law §145-b -- False Statements

It is a violation to knowingly obtain or attempt to obtain payment for items or services furnished under any Social Services program, including Medicaid, by use of a false statement, deliberate concealment or other fraudulent scheme or device. The state or the local Social Services district may recover three times the amount incorrectly paid. In addition, the Department of Health may impose a civil penalty of up to ten thousand dollars per violation. If repeat violations occur within five years, a penalty of up to thirty thousand dollars per violation may be imposed if the repeat violations involve more serious violations of Medicaid rules, billing for services not rendered, or providing excessive services.

[6] Although the statutory provisions of the Program Fraud Civil Remedies Act authorizes a penalty up to $5,000, that amount has been adjusted for inflation and increased by regulation to not more than $$11,665 for penalties assessed after June 19, 2020, whose associated violations occurred after November 2, 2015. *See 28 C.F.R. §85.5.*

3. Social Services Law § 145-c – Sanctions

If any person applies for or receives public assistance, including Medicaid, by intentionally making a false or misleading statement, or intending to do so, the needs of the individual or that of his family shall not be taken into account for the purpose of determining his or her needs or that of his family for six months if a first offense, for twelve months if a second offense (or if benefits wrongfully received are at least one thousand dollars but not more than three thousand nine hundred dollars), for eighteen months if a third offense (or if benefits wrongfully received are in excess of three thousand nine hundred dollars), and five years for any subsequent occasion of any such offense.

B. Criminal Laws

1. Social Services Law §145 – Penalties

Any person who submits false statements or deliberately conceals material information in order to receive public assistance, including Medicaid, is guilty of a misdemeanor.

2. Social Services Law § 366-b – Penalties for Fraudulent Practices

(a) Any person who obtains or attempts to obtain, for himself or others, medical assistance by means of a false statement, concealment of material facts, impersonation or other fraudulent means is guilty of a Class A misdemeanor.

(b) Any person who, with intent to defraud, presents for payment and false or fraudulent claim for furnishing services, knowingly submits false information to obtain greater Medicaid compensation or knowingly submits false information in order to obtain authorization to provide items or services is guilty of a Class A misdemeanor.

3. Penal Law Article 155 – Larceny

The crime of larceny applies to a person who, with intent to deprive another of his property, obtains, takes or withholds the property by means of trick, embezzlement, false pretense, false promise, including a scheme to defraud, or other similar behavior. It has been applied to Medicaid fraud cases.

(a) Fourth degree grand larceny involves property valued over $1,000. It is a Class E felony.

(b) Third degree grand larceny involves property valued over $3,000. It is a Class D felony.

(c) Second degree grand larceny involves property valued over $50,000. It is a Class C felony.

(d) First degree grand larceny involves property valued over $1 million. It is a Class B felony.

4. Penal Law Article 175 – False Written Statements

Four crimes in this Article relate to filing false information or claims and have been applied in Medicaid fraud prosecutions:

(a) § 175.05, Falsifying business records involves entering false information, omitting material information or altering an enterprise's business records with the intent to defraud. It is a Class A misdemeanor.

(b) § 175.10, Falsifying business records in the first degree includes the elements of the § 175.05 offense and includes the intent to commit another crime or conceal its commission. It is a Class E felony.

(c) § 175.30, Offering a false instrument for filing in the second degree involves presenting a written instrument (including a claim for payment) to a public office knowing that it contains false information. It is a Class A misdemeanor.

(d) § 175.35, Offering a false instrument for filing in the first degree includes the elements of the second degree offense and must include an intent to defraud the state or a political subdivision. It is a Class E felony.

5. Penal Law Article 176 – Insurance Fraud

Applies to claims for insurance payment, including Medicaid or other health insurance and contains six crimes.

(a) Insurance Fraud in the 5th degree involves intentionally filing a health insurance claim knowing that it is false. It is a Class A misdemeanor.

(b) Insurance fraud in the 4th degree is filing a false insurance claim for over $1,000. It is a Class E felony.

(c) Insurance fraud in the 3rd degree is filing a false insurance claim for over $3,000. It is a Class D felony.

(d) Insurance fraud in the 2nd degree is filing a false insurance claim for over $50,000. It is a Class C felony.

(e) Insurance fraud in the 1st degree is filing a false insurance claim for over $1 million. It is a Class B felony.

(f) Aggravated insurance fraud is committing insurance fraud more than once. It is a Class D felony.

6. Penal Law Article 177 – Health Care Fraud

Applies to claims for health insurance payment, including Medicaid, and contains five crimes:

(a) Health care fraud in the 5th degree is knowingly filing, with intent to defraud, a claim for payment that intentionally has false information or omissions. It is a Class A misdemeanor.

(b) Health care fraud in the 4th degree is filing false claims and annually receiving over $3,000 in aggregate. It is a Class E felony.

(c) Health care fraud in the 3rd degree is filing false claims and annually receiving over $10,000 in the aggregate. It is a Class D felony.

(d) Health care fraud in the 2nd degree is filing false claims and annually receiving over $50,000 in the aggregate. It is a Class C felony.

(e) Health care fraud in the 1st degree is filing false claims and annually receiving over $1 million in the aggregate. It is a Class B felony.

IV. WHISTLEBLOWER PROTECTIONS

A. Federal False Claims Act (31 U.S.C. §3730[h])

The Federal False Claims Act provides protection to qui tam relators (individuals who commence a False Claims action) who are discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of their employment as a result of their furtherance of an action under the FCA. 31 U.S.C. 3730(h). Remedies include reinstatement with comparable seniority as the qui tam relator would have had but for the discrimination, two times the amount of any back pay, interest on any back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees.

B. NY False Claim Act (State Finance Law §191)

The New York State False Claim Act also provides protection to qui tam relators (individuals who commence a False Claims action) who are discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of their employment as a result of their furtherance of an action under the Act. Remedies include reinstatement with comparable seniority as the qui tam relator would have had but for the discrimination, two times the amount of any back pay, interest on any back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees

C. New York Labor Law §740

An employer may not take any retaliatory action against an employee if the employee discloses information about the employer's policies, practices or activities to a regulatory, law enforcement or other similar agency or public official. Protected disclosures are those that assert that the employer is in violation of a law that creates a substantial and specific danger to the public health and safety or which constitutes health care fraud under Penal Law §177 (knowingly filing, with intent to defraud, a claim for payment that intentionally has false information or omissions). The employee's disclosure is protected only if the employee first brought up the matter with a supervisor and gave the employer a reasonable opportunity to correct the alleged violation. If an employer takes a retaliatory action against the employee, the employee may sue in state court for reinstatement to the same, or an equivalent position, any lost back wages and benefits and attorneys' fees. If the employer is a health provider and the court finds that the employer's retaliatory action was in bad faith, it may impose a civil penalty of $10,000 on the employer.

D. New York Labor Law §741

Certain health care employers may not take any retaliatory action against an employee if the employee discloses certain information about the employer's policies, practices or activities to a regulatory, law enforcement or other similar agency or public official, to a news media outlet or to a social media forum available to the public at large. Protected disclosures are those that assert that, in good faith, the employee believes constitute improper quality of patient care or improper quality of workplace safety. The employee's disclosure is protected only if the employee first brought up the matter with a supervisor and gave the employer a reasonable opportunity to correct the alleged violation, unless the danger is imminent to the public, a specific patient or a specific employee and the employee believes in good faith that reporting to a supervisor would not result in corrective action. If an employer takes a retaliatory action against the employee, the employee may sue in state court for reinstatement to the same, or an equivalent position, any lost back wages and benefits and attorneys' fees. If the employer is a health provider and the court finds that the employer's retaliatory action was in bad faith, it may impose a civil penalty of $10,000 on the employer.

COMMUNITY HOME HEALTH CARE, INC. DBA COMMUNITY HEALTH AIDE SERVICES **Compliance Program Policies and Procedures**	
Title: Conflicts of Interest and Related Party Transactions	
Reviewed:	**Revised:**

I. OVERVIEW

A. **Purpose**. Community Home Health Care, Inc. DBA Community Health Aide Services (the "the Agency") is committed to providing high quality in-home care to our patients and ensuring that our business practices comply with all applicable legal requirements and Agency policies. This Policy and Procedure is intended to be a guide for members of the Board of Directors, Officers, Key Persons[7] and other employees of the Agency (collectively referred to herein as "Personnel") who may find themselves in a position where their personal interests could cause, or be perceived to cause, a conflict with the interests of the Agency, our patients and/or the community we serve.

B. **Basic Requirements**. As set forth in more detail below, all potential or actual Conflicts of Interest and Related Party Transactions must be reported and appropriately addressed as required by this Policy. If you are uncertain whether a particular transaction or matter presents a Disclosable Conflict of Interest or a Related Party Transaction, it should be disclosed pursuant to this Policy.

Failure to adhere to this Policy will be considered a breach of the individual's obligation to the Agency, and may result in disciplinary action. Personnel are thus expected to read and understand this Policy and to review it at least annually in order to be alert to situations that could pose an actual or potential conflict of interest.

Underlying the requirements of this Policy is the expectation that Personnel will at all times do the following:

- act fairly, reasonably and in the Agency's best interests;
- act in compliance with all applicable legal requirements, including, but not limited to, the requirements concerning Related Party Transactions described below;
- refrain from personal considerations of any kind that conflict with, or that appear to conflict with, the best interests of the Agency, our patients and/or the community we serve; and
- immediately disclose any potential conflicts of interest in accordance with the procedures set forth in this Policy.

At the time of disclosure, the Agency, through review by the Audit Committee and the Board of Directors, will determine whether and to what extent such conflict of interest should limit

[7] Capitalized words and phrases used throughout this Policy are defined either in the body of the Policy or in the Appendix to this Policy.

the individual's participation in his or her position or the particular transaction or matter under consideration. In general, Personnel must refrain from participating in the consideration or determination of any transaction or matter as to which they have an actual or potential conflict.

In adopting this Policy, the Audit Committee and the Board of Directors recognize that:

- Many conflicts that are properly disclosed can be adequately managed without detriment to the reputation, integrity or position of the Agency and the individual.

- In most cases, problems associated with actual or perceived conflicts of interest do not arise from the conflicts per se, but rather from the failure to openly acknowledge and actively manage them.

- It is important to outline the process for identifying, assessing and managing actual and potential conflicts to assure that both the integrity of the Agency and its core activities are protected.

II. OVERSIGHT OF THIS POLICY

The adoption, implementation of and compliance with this Policy shall be overseen by the Board of Directors, with the Audit Committee assisting the Board in fulfilling its responsibilities as more fully detailed below.

The Agency's Compliance Officer is authorized to assist the Audit Committee and the Board with the implementation of, and compliance with, this Policy. Such assistance may include, but is not necessarily limited to, having the Compliance Officer: (1) gather the Conflict of Interest Disclosure Statements; (2) track the successful completion of the Statements; and (3) assist the Audit Committee in organizing the Statements for the Committee's and the Board's review. The Board of Directors, however, will at all times retain overall responsibility for all aspects of the oversight of this Policy.

III. PROCEDURES FOR DISCLOSURE OF CONFLICTS

A. <u>What is a "Disclosable Conflict of Interest"?</u> As a general matter, any financial or related interest must be disclosed when the interest of Personnel in a transaction or entity creates the appearance (or the actuality) that the Personnel may not be able to act in the best interests of the Agency. Some representative examples of possible conflicts of interest that must be disclosed include, but are not limited to, those situations when Personnel, or Relatives of Personnel:

1. <u>Related Party Transaction</u>. Have a financial interest in any transaction, agreement or arrangement in which the Agency or any Affiliate of the Agency is or intends to be a participant.

2. <u>Relationships with Vendors and Competitors</u>. Have any financial interest in a vendor, competitor or entity with which the Agency does business or intends to do business or which competes with the Agency; is a member, owner, sole proprietor, partner, shareholder, director, trustee or officer of such vendor, competitor or entity; or has a contractual or employment relationship with such vendor, competitor or entity.

3. **Personal Interest**. Represents the Agency in any matter in which the person has a personal interest (financial or otherwise).

4. **Personal Gain**. Uses, or has the opportunity to use, knowledge about the Agency for personal gain, profit or advantage;

5. **Business Relationships with Directors, Officers or Key Persons**. When a Director, Officer or Key Person has a family or business relationship with another Director, Officer or Key Person.

6. **Gifts and Other Benefits**. Accepts gifts, entertainment or other favors from a vendor, competitor or entity with which the Agency does business or intends to do business under circumstances from which it might be inferred that the gift or gratuity was being given to influence the Personnel's actions or decisions on behalf of the Agency.

7. **Quality of Care**. Has a familial, financial or business relationship that does or has the potential to affect the safety or quality of care, treatment and services provided to patients. Such relationships can include the receipt of hospitality, loans, gratuities or other financial benefits from any patient, patient family member or visitor

8. **Other Organizations**. Is an officer or a director or trustee of, or has a direct or indirect substantial financial interest in, another corporation, firm or other entity – including another healthcare organization – with which the Agency does business or intends to do business.

9. **Other Conduct**. Engages in any other conduct that interferes with, or appears to interfere with, the best interests of the Agency or with the Personnel's responsibilities to the Agency.

Other examples may arise, particularly in certain contexts within which the Agency conducts its day-to-day operations. It is not possible to provide an exhaustive listing of every situation in which a conflict of interest, or the appearance of a conflict of interest, may arise. Note, however, that De Minimis Transactions and Ordinary Course of Business Transactions, as defined in the Appendix to this Policy, are not covered by this Policy. Even in such cases, however, the affected party may not intervene or seek to Improperly Influence the person tasked with making the decision or reviewing the transaction. Further, the person tasked with making the decision or reviewing the transaction should not consider or be influenced by the affected party's involvement in decisions or matters that may affect the decision-maker/reviewer. If you are uncertain about a particular transaction or matter, it should be disclosed pursuant to this Policy.

Additional examples of conflict of interest risk areas are provided in Appendix B.

B. **How and When to Disclose**. Personnel must disclose any potential conflicts as follows:

1. **Annual Written Conflict of Interest Disclosure Statement.** Directors, Officers and Key Persons will, at least annually, file a written Conflict of Interest Disclosure Statement with the Agency's Compliance Officer, who will provide copies of all completed Statements to the Chair of the Audit Committee.

The Compliance Officer will track the completion of all Disclosure Statements, will gather the Statements from Personnel, and will transmit all of the Statements for initial review by the Audit Committee.

2. Continuing Obligation to Disclose and Update. Personnel have an affirmative and continuing obligation to disclose any conflicts of interest as they arise and, as applicable, to update his or her annual written Conflict of Interest Disclosure Statement, if he or she is otherwise required under this Policy to file a Disclosure Statement. All such updated Disclosure Statements will be filed with the Compliance Officer who will provide copies of all updated or new disclosures to the Chair of the Audit Committee for the Committee's review and consideration.

Personnel who are not required to file an annual Disclosure Statement under this Policy must disclose any conflict that arises when identified, and must do so to the Compliance Officer or his or her designee, who will forward such disclosure, as appropriate, to the Chair of the Audit Committee.

3. Requirements Specific to the Board. The following additional disclosure requirements apply to Directors, as applicable:

(a) Directors' Disclosure Statements. For Directors, the Conflict of Interest Disclosure Statement will specifically include, among other Disclosable Conflicts of Interest, a statement identifying, to the best of the Director's knowledge, any entity of which he or she is an officer, director, trustee, member, owner (either as a sole proprietor or a partner), or employee and with which the Agency has a relationship.

(b) Prior to the Initial Election of a Director. Prior to the initial election of any Director, the individual proposed for a Director position shall complete, sign and submit a written Conflict of Interest Disclosure Statement identifying, to the best of the proposed Director's knowledge, any entity of which he or she is an officer, director, trustee, member, owner (either as a sole proprietor or a partner), or employee and with which the Agency has a relationship, and any transaction in which the Agency is a participant and in which the proposed Director might have a Disclosable Conflict of Interest.

(c) Additional Disclosure Requirements for Directors. If, during the course of a Board or Board-level committee meeting, discussion, or deliberation, any actual or potential conflict of interest becomes apparent to a Director, that Director must disclose such actual or potential conflict to the Board or committee. If another Director becomes aware of any actual or potential conflict of interest, he or she shall disclose such conflict if the conflicted Director is absent. In both cases, such disclosure shall be a matter of record.

4. Disclosure by Agency Employees. Agency employees have a continuing obligation to promptly disclose any actual or potential conflict of interest or other Disclosable Conflict of Interest when it is identified, but in all events prior to deliberations involving the applicable employee. On no less than an annual basis, the Agency will send a reminder to all employees concerning their obligations under this Policy. Required disclosures are to be directed

to the Compliance Officer or his or her designee and will be forwarded, as appropriate, to the Chair of the Audit Committee. If the employee is in doubt as to whether they have a Disclosable Conflict of Interest, he/she should err on the side of disclosure and report the matter to the Compliance Officer for review.

IV. THE REVIEW PROCESS

A. **Review by the Audit Committee of the Board**. The Audit Committee will conduct a full review of all matters that raise an actual or potential conflict of interest, or that create the appearance of an actual or potential conflict of interest. In conducting its review, the Audit Committee:

1. Will consider all relevant facts and circumstances involved in the matter, and in particular, what is fair, reasonable and in the best interests of the Agency and the community we serve;

2. Will exclude the affected individual(s) from being present at or participating in the deliberations or voting on the potential conflict of interest;

3. Will prohibit the affected individual(s) from any attempt to Improperly Influence the deliberations or voting on the matter; and

4. Will permit the affected individual(s), upon request of the Committee, to present information concerning the matter at a meeting prior to commencement of deliberations or voting on the matter.

B. **Report to the Board of Directors**. The Audit Committee will make an initial determination as to whether a conflict of interest exists or may exist, and recommend what course the Agency should take in connection with the matter. The Compliance Officer and outside counsel, as needed, shall assist the Audit Committee in reporting its recommendations and findings to the entire Board of Directors. The Board of Directors shall review the recommendations and findings of the Audit Committee and make its findings which shall be final and binding.

C. **Corrective Actions**. If, after review and consideration, it is determined that a potential or actual conflict of interest does exist, then the Agency will implement the following corrective actions to protect the Agency's best interests:

1. **Generally**. Personnel for whom an actual or potential conflict of interest is found to exist will take no part in consideration, deliberation or decision-making as to the underlying matter that is the subject of the potential conflict.

2. **Recusal**. The conflicted Personnel must recuse him or herself from discussion (including informal discussions) of matters affected by the conflict of interest, including physical absence from discussions, deliberations, voting or decision making either during consideration by management or during Board or Board Committee meetings.

3. **Quorum**. A conflicted Director will not be counted in determining a quorum for any vote on the matter that is the subject of the potential conflict.

4. **Personal Influence**. The conflicted Personnel will not use his or her personal influence – in any way or at any time - with respect to the matter that is the subject of the potential conflict.

5. **Significant Conflicts**. If the conflict is so significant as to be incompatible with the mission, strategic priorities, or best interests of the Agency, a determination will be made by the Board whether it is appropriate for the individual to continue serving on the Board, as a member of a Board committee, or as an Officer or Key Person of the Agency.

D. **Additional Special Rules for Related Party Transactions-Generally**. In addition to the considerations outlined above, all Related Party Transactions (as defined in the Appendix) are subject to the following additional special rules:

1. **Fair and Reasonable**. The Agency may not enter into a Related Party Transaction unless the transaction is determined to be fair, reasonable and in the Agency's best interest at the time of the determination.

2. **Disclosure of Material Facts**. In considering the Related Party Transaction, the Audit Committee and the Board of Directors shall ensure that any Director, Officer or Key Person who has an interest in the Related Party Transaction has disclosed in good faith all material facts concerning such interest; and

3. **No Participation**. No Related Party may participate in the deliberations or voting relating to any Related Party Transaction. However, the Audit Committee and the Board of Directors may request that a Related Party present information concerning a Related Party Transaction at a meeting prior to the commencement of deliberations or voting relating thereto.

4. **Contemporaneous Documentation**. Contemporaneous documentation of the Audit Committee's and the Board of Directors' review of a Related Party Transaction will include, at a minimum, a summary of the matter, a summary of the deliberations, consideration of any alternatives, the vote and the basis for the determination, including, but not necessarily limited to, whether the matter is as fair and reasonable to the Agency as would otherwise then be obtainable by the Agency.

E. **Additional Related Party Rules When a "Substantial" Financial Interest Exists**. With respect to any Related Party Transaction involving the Agency and in which a Related Party has a "substantial" financial interest in the transaction, agreement or arrangement, the following shall also apply:

1. Prior to entering into the transaction, the Audit Committee and the Board of Directors shall consider alternative transactions to the extent available;

2. The transaction must be approved by not less than a majority vote of the members present at the meeting; and

3. The Audit Committee and the Board of Directors must contemporaneously document in written minutes the basis for its approval or disapproval, including its consideration of any alternative transactions.

V. MISCELLANEOUS PROVISIONS

A. **Training**. The Agency will conduct training and education for all Directors, Officers, Key Persons, and employees on this Policy, including as to what constitutes Disclosable Conflicts of Interest, required disclosures, when and how disclosures are to be made, the review and determination process and other related matters at the individual's orientation and on a regular basis thereafter.

1. All staff will receive education regarding this Policy and the disclosure requirements at the time of orientation with annual update/reminders thereafter. Such education will include a review of this Policy.

2. Board Members, Officers and Key Persons will receive a copy of this Policy annually and will receive specific training regarding conflicts of interest in accordance with their governance responsibilities. Ongoing education will also be provided as new issues are identified.

3. The Compliance Officer will provide a copy of this Policy to any Personnel upon request.

B. **Compensation Decisions**. All compensation must be in a reasonable amount for services rendered and must be in compliance with all other legal requirements. No person who may benefit from such compensation may be present at or otherwise participate in any deliberation or vote concerning his or her compensation. However, such person may be asked to present information as background or answer questions at a meeting prior to the commencement of deliberations or voting relating thereto.

C. **Violations of this Policy**. If the Audit Committee or Board has reasonable cause to believe any Personnel, including a Director, Officer or Key Person, has failed to disclose actual or potential conflicts of interest, it shall inform such Personnel of the basis for such belief and afford him or her an opportunity to explain the alleged failure to disclose. If, after hearing the individual's response and making further investigation as warranted by the circumstances, the Audit Committee or the Board determines that such Personnel has failed to disclose an actual or possible conflict of interest, it shall take appropriate disciplinary and corrective action.

This Policy was approved and adopted by the _____ on _____, 20__

_____
[Title]

APPENDIX A: DEFINITIONS

This Appendix sets forth the definitions of a number of important words and phrases that are used throughout this Policy.

1. *"Affiliate".* An "Affiliate" of the Agency means any entity controlled by, or in control of, the Agency.

2. *"Board".* "Board" means the Board of Directors or any other body constituting a Governing Board as defined below.

3. *"De Minimis Transaction".* For purposes of this Policy, a "De Minimis Transaction" is one that is immaterial or insignificant to the Agency, taking into account all relevant factors, including but not limited to: (i) the Agency's overall business or financial operations; (ii) any impact the transaction might have on the quality of care, treatment or services provided to our patients, and/or (iii) the size and scope of the particular transaction.

4. *"Disclosable Conflict of Interest".* "Disclosable Conflict of Interest" means any circumstance that gives rise to, or appears to give rise to, an actual or potential conflict of interest between a Director's, Officer's, Key Person's, or employee's personal interest (or the personal interests of a Relative of a Director, Officer, Key Person or employee) and the best interests of the Agency, its patients and/or the community it serves. In addition, every Related Party Transaction is a Disclosable Conflict of Interest.

5. *"Governing Board".* "Governing Board" means the body responsible for the management of the Agency.

6. *"Improperly Influence".* "Improperly Influence" means coercing, manipulating, misleading, or fraudulently influencing the decision-making when a Director, Officer, or Key Person knew or should have known that their action, if successful, could result in the outcome which they could not deliberate or vote on directly.

7. *"Key Person".* "Key Person" "means any person, other than a Director or Officer, whether or not an employee of the Agency, who (i) has responsibilities, or exercises powers or influence over the Agency as a whole similar to the responsibilities, powers, or influence of Directors and Officers; (ii) manages the Agency, or a segment of the Agency that represents a substantial portion of the activities, assets, income or expenses of the Agency; or (iii) alone or with others controls or determines a substantial portion of the Agency's capital expenditures or operating budget. Key Persons may include, but are not limited to Senior Management and all Department Heads, and other employees (including physicians) who are in a position to exercise substantial influence over the affairs of the Agency, as determined in accordance with current laws, rules and regulations.

8. *"Officer".* "Officer" means those individuals designated as officers in the by-laws of the Agency and those who are otherwise appointed as officers of the Agency in accordance with the Agency's by-laws.

9. ***"Ordinary Course of Business Transaction".*** An "Ordinary Course of Business Transaction" is one that is consistent either with the Agency's consistently applied past practices in similar transactions or with common practices in the industry in which the Agency operates. Examples of Ordinary Course of Business Transactions include, but are not limited to: (i) a nonprofit entity that uses the local electric utility for its electrical service and supply, and a 35% shareholder of the local electric utility is a board member; (ii) where the general counsel of a health system has a written, established, and enforced policy for the selection, retention, evaluation and payment of outside counsel, and a board member is a partner of, and has a greater than 5% share in, one the firms retained by the general counsel; and (iii) a grandson of a board member has just graduated from a university nursing school. He applies for and is selected by the facility's nursing department for a tuition repayment benefit and will receive a salary and overtime, consistent with the facility's written policy regarding recruitment of new nursing graduates.

10. ***"Related Party".*** "Related Party" means (i) any Director, Officer or Key Person of the Agency or any Affiliate of the Agency; (ii) any Relative of any Director, Officer or Key Person of the Agency or any Affiliate of the Agency; or (iii) any entity in which any individual described in (i) or (ii) has a 35% or greater ownership or beneficial interest or, in the case of a partnership or professional corporation, a direct or indirect ownership interest in excess of 5%.

11. ***"Related Party Transaction".*** "Related Party Transaction" means any transaction, agreement or any other arrangement in which a Related Party has a financial interest and in which the Agency or any Affiliate of the Agency is a participant, except that a transaction shall not be a Related Party Transaction if: (i) the transaction or the Related Party's Financial Interest in the transaction is a De Minimis Transaction, (ii) the transaction would not customarily be reviewed by the Board or boards of similar organizations in the Ordinary Course of Business and is available to others on the same or similar terms, or (iii) the transaction constitutes a benefit provided to a Related Party solely as a member of a class of the beneficiaries that the Agency intends to benefit as part of the accomplishment of its mission which benefit is available to all similarly situated members of the same class on the same terms.

12. ***"Relative".*** "Relative" of an individual means (i) his or her spouse, or domestic partner, as defined under New York Public Health Law § 2994-a, (ii) his or her ancestors, brothers and sisters (whether whole or half-blood), children (whether natural or adopted), grandchildren, great-grandchildren, or (iii) spouses of brothers, sisters, children, grandchildren, and great-grand- children..

13. ***"Director".*** "Director" means any member of the Governing Board of the Agency, whether designated as director, trustee, manager, governor, or by any other title.

14. ***"Vendor/Third Party".*** "Vendor/Third Party" includes all vendors, third parties, suppliers, consultants, other health care providers, educational institutions, manufacturers, payers and other third parties seeking to do, or currently engaged in business or competition with the Agency or its Affiliates.

APPENDIX B:

EXAMPLES OF CONFLICT OF INTEREST RISK AREAS

Purchasing and Contracting. Purchasing and contracting decisions should be based on vendor/third party history, quality, service, price and other factors necessary to advance the interests of the Agency. In addition to the other requirements in this Policy, personnel of the corporate services company who have any financial or other disclosable interests in a vendor/third party, either directly or indirectly through Relatives, must report such interests in writing to their supervisor with a copy to the Compliance Officer. It will then be determined whether the interest in question is of sufficient magnitude to warrant the disqualification of the conflicted personnel from the selection, negotiation, purchasing and contracting process with the vendor/third party.

Gifts and Gratuities. It is prohibited for any Personnel to accept hospitality, loans or other financial benefits from any patient, patient family member, vendor/third party, contractor, individual, company or other concern that does business with the Agency, is under consideration to do business with the Agency, or is a competitor of the Agency. This prohibition applies whenever the thing of value is offered under circumstances from which it could be inferred that the Personnel's action was for his or her own benefit and not solely for the benefit of the Agency. Accordingly, any such gifts or gratuities must be reported to the Compliance Officer to determine whether a Disclosure Statement must be completed. The Agency's policy on gifts and gratuities does not preclude the acceptance of items of nominal value such as flowers, holiday cookies or candy that are clearly tokens of appreciation. Similarly, business entertainment can only be provided or received consistent with what is reasonable under the circumstances, as a token of appreciation and for hospitality, and not for the purpose of influencing the business behavior of the recipient. In such cases a Disclosure Statement need not be completed. If Personnel are in doubt as to whether a gift or gratuity falls within the proper application of this Policy, they should err on the side of disclosure and immediately disclose the facts in accordance with this Policy.

Grants. Various Personnel and departments of the Agency may receive grants from government agencies, private industry, and various philanthropies to conduct research or other projects in association with the Agency. While the receipt of such funds is to be encouraged in appropriate cases, the receipt and use of grants must be subject to adequate safeguards to ensure that an appearance of impropriety, or actual impropriety, is not created. The receipt and use of all grant funds at the Agency should be based on the appropriateness of the proposed research or project. To the extent any Personnel have any financial or other disclosable interests in the grantor, either directly or indirectly through Relatives, they must report such interests in writing in accordance with this Policy.

COMMUNITY HOME HEALTH CARE, INC. DBA COMMUNITY HEALTH AIDE SERVICES **Compliance Program Policies and Procedures**	
Title: Conflicts of Interest Disclosure Statement	
Reviewed:	**Revised:**

All Directors, Officers and Key Persons of Community Home Health Care, Inc. DBA Community Health Aide Services (the "Agency") must complete this Conflict of Interest Disclosure Statement (the "Disclosure Statement") at least annually. In addition, every Director, Officer and Key Person has an affirmative obligation to update his or her annual Disclosure Statement whenever there are new or changed facts or circumstances that create a Disclosable Conflict of Interest, as defined in the Agency's Conflicts of Interest and Related Party Transactions Policy (the "Conflicts Policy").

Prior to completing this Disclosure Statement, Directors, Officers and Key Persons are required to review the current version of the Conflicts Policy (attached). The Appendix to the Conflicts Policy contains definitions of key words and phrases used throughout both the Conflicts Policy and this Disclosure Statement.

If you are not certain a disclosure is required, you should disclose.

All completed Disclosure Statements are to be filed with the Compliance Officer.

* * *

Please answer the following questions. Question numbers 1 through 8 are to be completed by all Directors. Officers and Key Persons only need to complete questions 2 through 8.

If your answer to any question is **YES**, please (1) identify all of the parties involved in each such circumstance, matter or transaction (including yourself, your Relative(s), if any (and their relationship to you) and all other parties); (2) describe your and, if applicable, your Relative's financial interests in each such circumstance, matter or transaction (including, by way of example, ownership interests, beneficial interests, compensation interests or other financial interests); (3) disclose all material facts relating to each such circumstance, matter or transaction; and (4) disclose all other relevant information relating to each such circumstance, matter or transaction.

Questions

1. **[For Directors Only]** Please identify, to the best of your knowledge, any entity of which you are an officer, director, trustee, member, owner (either as a sole proprietor or a partner), or employee and with which the Agency has a relationship, and any transaction in which the Agency is a participant and in which you might have a Disclosable Conflict of Interest.

_____ Yes, I have a Disclosure **_____ No, I Do Not Have A Disclosure**

2. Are you or any Relative of yours currently involved in, or are you or any Relative of yours currently planning to be involved in, any circumstance, matter or transaction that gives rise to, or appears to give rise to, an actual or potential conflict of interest between your or your Relative's personal interest and the best interests of the Agency?

____ YES _____ NO

3. Do you, or a Relative have any financial Interest in, or receive compensation from, a Vendor?

_____ YES _____ NO

4. Do you, or a Relative, have a family or business relationship with any Agency personnel, including but not limited to, Board Members, Officers, or other Key Persons?

_____ YES _____ NO

5. Are any of your Relatives employed by, or have a compensation arrangement with, the Agency or any Affiliate of the Agency?

_____ YES _____ NO

6. Do you, or a Relative, have any type of contractual or employment relationship with an Agency Vendor?

_____ YES _____ NO

7. Have you received any gifts, gratuities, hospitality, loans, or other favors from any patient, patient family member or any Vendor that does, or may do business with, the Agency?

_____ YES _____ NO

8. After having reviewed the current Conflicts Policy, including the examples of Disclosable Conflicts of Interest contained therein, are there any other transactions, arrangements, circumstances, relationships or matters: (a) that you have not disclosed above, (b) that in any way involve the Agency or any affiliate of the Agency, (c) in which you or any Relative of yours are involved in any way, and (d) that gives rise to, or appears to give rise to, an actual or potential conflict of interest <u>between</u> your or your Relative's personal interest <u>and</u> the best interests of the Agency, or any of its affiliates?

_____ YES _____ NO

PLEASE USE THIS PAGE TO PROVIDE ADDITIONAL INFORMATION, IF NECESSARY. DON'T FORGET TO COMPLETE THE ATTESTATION ON THE NEXT PAGE.

ATTESTATION AND ACKNOWLEDGMENT

I attest to and acknowledge that:

- I have read and understand the Agency's current Conflicts Policy;
- My answers to the above questions are made in good faith and are true, accurate and complete to the best of my knowledge as of the date I completed this Disclosure Statement (as indicated below); and
- I understand that I have a continuing obligation to update this Disclosure Statement whenever there are new or changed facts or circumstances that create a Disclosable Conflict of Interest. I will promptly provide an updated Disclosure Statement to the Compliance Officer whenever there are any such new or changed facts or circumstances that require me to do so, in accordance with the Agency's Conflicts Policy.

Signature	Date
Name (Please Print)	Title

COMMUNITY HOME HEALTH CARE, INC. DBA COMMUNITY HEALTH AIDE SERVICES **Compliance Program Policies and Procedures**	
Title: Gifts and Benefits	
Reviewed:	**Revised:**

I. POLICY

Personnel[8] of Community Home Health Care, Inc. DBA Community Health Aide Services (the "Agency") may not engage, either directly or indirectly, in any corrupt business practice, including bribery, kickbacks or payoffs, intended to influence or reward favorable decisions of any patient, physician/practitioner, government representative, contractor, vendor, or any other person in a position to benefit the Agency or its employees.

Personnel are strictly prohibited from soliciting any gift or benefit, either individually or on behalf of the Agency. In addition, Personnel may not offer, pay or receive any gifts or benefits to or from any person or entity: (i) that makes referrals to us, (ii) to which we make referrals, or (iii) with which we do business, under circumstances where the gift or benefit is offered, paid or received with a purpose of inducing or rewarding referrals of health care items or services, or other business between the parties. Personnel are strictly prohibited from offering or giving any gifts or benefits to government employees or officials.

The guiding principle of this Policy is simple: Personnel may not be involved with gifts or benefits that are undertaken: (i) in return for or to induce referrals, or (ii) in return for or to induce the purchasing, leasing, ordering or arranging (or the recommending of any of the foregoing) of any item or service.

This Policy applies to our interactions with providers who refer patients to us or to which we make referrals, and to our interactions with our vendors (including, but not limited to, medical supply companies from which we purchase). This Policy also applies to patients and potential patients.

For the purposes of this Policy, "gifts and benefits" include, but are not limited to, anything of value provided at no charge or at a discount. This includes, but is not limited to: cash, cash equivalents (e.g., checks, gift certificates, and stocks), prizes, meals, artwork, tickets to sporting or entertainment events, and sponsorship of recreational or social activities.

This Policy does not preclude the acceptance of items of nominal value, which are clearly tokens of friendship or business hospitality, such as fruit, cookies or candy that a vendor may provide during the holiday season that are shared among staff.

[8] "Personnel" means all affected individuals, which includes, but is not limited to, the Governing Body, all professional staff and employees, and other individuals or entities affiliated or associated with Community (including, but not limited to, all contractors, subcontractors, agents, and other persons who perform functions or services on behalf of Community or otherwise contribute to Community's entitlement to payment under Federal health care programs).

Gifts or benefits to spouses or immediate family members of Personnel are not permitted. "Immediate family members" for purposes of this Policy includes any of the following: your husband or wife; birth or adoptive parent, child or sibling; stepparent, stepchild, stepbrother, or stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law; grandparent or grandchild; and spouse of a grandparent or grandchild.

II. PROCEDURE

To the extent that you have any question or concern regarding the applicability of this Policy to a particular circumstance, you are required to contact the Compliance Officer.

A failure to follow this Policy may result in disciplinary action in accordance with the terms of our Compliance Program.

COMMUNITY HOME HEALTH CARE, INC. DBA COMMUNITY HEALTH AIDE SERVICES **Compliance Program Policies and Procedures**	
Title: Non-Retaliation, Non-Intimidation for Good Faith Participation in the Compliance Program	
Reviewed:	**Revised:**

I. POLICY

The purpose of this Policy is to ensure that all Personnel understand Community Home Health Care, Inc. DBA Community Health Aide Services' (the "Agency's") commitment to prohibiting intimidation, retaliation, harassment and discrimination for "good faith participation in the Compliance Program" (as defined below).

It is the Agency's policy that Personnel[9] who in good faith report any action or suspected action taken by or within the Agency that is illegal, fraudulent, or in violation of any adopted policy of the Agency shall not suffer intimidation, harassment, discrimination or other retaliation, or in the case of employees, adverse employment consequences.

Intimidation or retaliatory action in any form by any individual associated with the Agency is strictly prohibited and is itself a serious violation of the Code of Conduct and this Policy. This includes, but is not limited to, any adverse employment action and any other negative treatment, resulting from good faith participation in the Compliance Program.

II. PROCEDURES

A. Oversight of This Policy

The adoption and implementation of, and compliance with, this Policy shall be overseen by the Board of Directors, with the Audit Committee assisting the Board in fulfilling its responsibilities. The Board may, in its discretion, authorize certain functions relating to the implementation of, and compliance with, this Policy to be performed by one or more employees, officers or directors, but the Board will, at all times, retain overall responsibility for all aspects of the oversight of this Policy. The Compliance Officer has been designated by the Board to administer this Policy and report to the Audit Committee on issues related to this Policy.

B. Participation in the Compliance Program

"Good faith participation in the Compliance Program" includes, but is not limited to:

- reporting actual or potential issues or concerns, including but not limited to, any action or suspected action taken by or within the Agency that is illegal, fraudulent or in violation of any adopted Agency policy;

[9] "Personnel" means all affected individuals, which includes, but is not limited to, the Governing Body, all medical staff and employees, and other individuals or entities affiliated or associated with Community (including, but not limited to, all contractors, subcontractors, agents, and other persons who perform functions or services on behalf of Community or otherwise contribute to Community's entitlement to payment under Federal health care programs).

- cooperating with or participating in the investigation of such matters;
- assisting with or participating in self-evaluations, audits, and/or implementation of remedial actions; or
- reporting to appropriate regulatory officials as provided in New York Labor Law §§ 740 and 741.[10]

C. Reporting And Confidentiality

As required by the Agency's Compliance Program, all Personnel are expected to report suspected misconduct or possible violations of the Compliance Program to the Compliance Officer, at the number or e-mail address below. Personnel may also report compliance issues or concerns to the Compliance Hotline. Personnel may report compliance issues or concerns anonymously, if they choose (by way of the Hotline or otherwise).

If you report through the Hotline your identity will be kept confidential, whether requested or not, unless the matter is turned over to law enforcement.

Name	Contact Information
Compliance Officer **Paul Vershubsky**	Ph: 845.738.1305 Email: pversh**@commhealthcare.com**
Compliance Hotline	Ph: 845.678.8652
CDPAP Hotline	Ph: 845.335.9905

D. Investigation of Intimidation / Retaliation Complaints

- All allegations of intimidation or retaliation for good faith participation in the Compliance Program will be promptly investigated. The Compliance Officer, or designee, will oversee the investigation and take all necessary and appropriate actions. The Compliance Officer, or designee, will be assisted by internal staff and/or may solicit the support of external resources (including counsel), as necessary and appropriate.
- All individuals who may have relevant information will be promptly interviewed. At the outset of the interview process, the interviewee will be

[10] For a brief summary of New York Labor Law §§ 740-741, as of April 2021, please see the appendix to this Policy.

reminded that retaliation and intimidation is unlawful and a violation of the Agency's Code of Conduct. The interviewee will also be reminded of the Agency's disciplinary policy regarding failure to cooperate (See the "Protocols for Investigations and Implementing Corrective Action, Including Discipline").

- All documentation related to the investigation will be kept secured in a central location under the control of the Compliance Officer or designee. Such investigative files will be kept separate from Personnel files.

- If the Compliance Officer determines that an individual was improperly intimidated or retaliated against for good faith participation in the Compliance Program, the Agency will, in accordance with the Agency's Compliance Program, take all appropriate corrective action as to the individual who was intimidated or retaliated against, subject to the oversight of the Board.

- In addition, if the Compliance Officer determines that an individual was intimidated or retaliated against for good faith participation in the Compliance Program, appropriate disciplinary action will be taken against the offending person, in accordance with the Agency's Compliance Program, subject to the oversight of the Board.

- The Agency may terminate contracts and affiliations as a result of retaliation or intimidation.

- In order to prevent retaliation or intimidation against employees who in good faith participate in the Compliance Program, all terminations of employment must be approved by the Director of Human Resources, in consultation with the Chief Executive Officer, prior to being effectuated. Director of Human Resources, in consultation with the Chief Executive Officer must be advised of the employee's participation in the Compliance Program prior to the termination decision or other adverse employment action being made.

- A person that is subject of a whistleblower complaint may not be present at or participate in Board or Committee deliberations or vote on the matter relating to such complaint. The Board or designated Committee, in its discretion, may request that a person who is subject of a whistleblower complaint present information as background or answer questions at a Board or Committee meeting prior to the commencement of deliberations or related voting.

E. Reporting to the Governing Body

The Compliance Officer will advise the Audit Committee regarding any alleged acts of retaliation or intimidation in violation of this Policy on an on-going basis.

F. Distribution of Policy

This Policy shall be distributed to all Personnel (including directors, officers and employees), and to volunteers who provide substantial services to the Agency.

APPENDIX:

A BRIEF SUMMARY OF NEW YORK LABOR LAW §§ 740 & 741[11]

New York Labor Law §§ 740 and 741 are laws that provide protection to "whistleblowers" in certain cases. In general terms:

- Section 740 prohibits retaliatory action, including discharge, suspension, demotion or other adverse employment action, by an employer against an employee if the employee: (a) discloses or threatens to disclose to a supervisor or to a public body (broadly defined in the law to include various legislative, judicial, regulatory, administrative, public and law enforcement bodies, members, employees and officials) an activity, policy or practice of the employer that is in violation of a law, rule or regulation which creates and presents a substantial and specific danger to the public health or safety, or which constitutes "health care fraud" (as defined under the New York Penal Law), (b) provides information to, or testifies before, any public body conducting an investigation, hearing or inquiry into any such violation of a law, rule or regulation by the employer, or (c) objects to, or refuses to participate in, any such activity, policy or practice.

- Section 741 prohibits certain defined health care employers from taking retaliatory action, including discharge, suspension, demotion, penalization, discrimination or other adverse employment action, against any employee if the employee: (a) discloses or threatens to disclose to a supervisor, to a public body (broadly defined in the law to include various legislative, judicial, regulatory, administrative, public and law enforcement bodies, members, employees and officials, as well as executive branch departments and any division, board, bureau, office, committee or commission of such bodies), to a news media outlet or to a social media forum available to the public at large, an activity, policy or practice of the employer or agent that the employee, in good faith, reasonably believes constitutes improper quality of patient care or improper quality of workplace safety; or (b) objects to, or refuses to participate in, any activity, policy or practice of the employer or agent that the employee, in good faith, reasonably believes constitutes improper quality of patient care or improper quality of workplace safety.

Under both laws, an employee is protected only if he/she first brings the matter to the attention of a supervisor and gives the employer a reasonable opportunity to correct the activity, policy or practice. However, prior disclosure to a supervisor is not required if the matter involves a disclosure or threat to disclose an activity, policy or practice of the employer or agent that the employee, in good faith, reasonably believes constitutes improper quality of patient care or

[11] This Appendix is not intended to be a comprehensive description of the law, a legal interpretation or legal advice.

improper quality of workplace safety that presents an imminent threat to public health or safety or to the health of a specific patient or specific employee, and the employee reasonably believes, in good faith, that reporting to a supervisor would not result in corrective action.

If retaliatory action is taken by an employer, the employee may sue in accordance with the respective laws' requirements. The employee may sue for, among other things, an injunction, reinstatement to the same or an equivalent position, reinstatement of full fringe benefits and seniority rights, lost wages, benefits and other remuneration, and reasonable costs, disbursements and attorneys' fees. Civil penalties may also be imposed on health care employers that act in bad faith in taking retaliatory action in certain cases.

COMMUNITY HOME HEALTH CARE, INC. DBA COMMUNITY HEALTH AIDE SERVICES **Compliance Program Policies and Procedures**	
Title: Protocols for Investigations and Implementing Corrective Action, Including Discipline	
Reviewed:	**Revised:**

POLICY

To be effective and to combat fraud, waste and abuse in the course of operations, a compliance program must institute procedures for investigating compliance issues and implementing appropriate corrective action. Therefore, Community Home Health Care, Inc. DBA Community Health Aide Services (the "Agency") has established and implemented procedures and a system for promptly responding to compliance issues as they are raised, investigating potential compliance problems as identified in the course of self-evaluations and audits, correcting such problems promptly and thoroughly to reduce the potential for recurrence, and ensure ongoing compliance with federal health care programs requirements (*e.g.*, Medicare and Medicaid). Below are the procedures that the Agency has adopted.

PROCEDURE

A. INVESTIGATION

A compliance problem may be uncovered as the result of a report to the Compliance Officer, an internal compliance assurance review, the review of a new regulation or governmental fraud alert, or from another source. Such problems might include, any of the following: errors or inconsistencies in time or task entries; evidence that the Agency is submitting claims for services that were not performed or ordered; that patient care documentation is not adequate; or suspect financial relationships with other providers who have a referral relationship with the Agency.

Upon receiving a report or otherwise learning of a possible compliance issue, the Compliance Officer will bring such report to the attention of the Compliance Committee**.** The Compliance Officer or her designee(s) will promptly conduct an investigation and take all necessary and appropriate actions. Such investigations may be undertaken under the supervision and direction of outside counsel, as necessary and appropriate. All Personnel are expected to cooperate in any investigation.

In undertaking investigations, the Compliance Officer shall consult with the respective manager and/or member of the Compliance Committee who has responsibility for the unit. The Compliance Officer may utilize other Agency employees (consistent with appropriate confidentiality), outside attorneys, outside accountants and auditors or other consultants or experts for assistance or advice.

Depending on the nature of the potential compliance issue, an investigation may include interviews with Personnel, documentation reviews and a root cause analysis. The objective of such an investigation will be to determine whether, first, a compliance issue exists or there has been a violation of the Compliance Program (including the Agency's compliance policies and procedures, the Code of Conduct or other applicable laws, regulations or requirements. If an issue

or violation does exist, then the investigation will attempt to determine its root cause so that appropriate and effective corrective action may be instituted.

If the matter concerns potentially improper or incorrect billing or related issues, the investigation may include, for example, the selection for review of a small, random sampling of claims "in the pipeline" (that is, claims for services that have been performed, documented and coded, but not yet submitted for payment) along with the related supporting documentation. If the review of these claims warrants, the sample will be expanded to additional claims "in the pipeline" so that the extent of any problem may be more accurately assessed. During these reviews, any claims that appear to be improper or inadequate will be held and not submitted for payment until all questions regarding them have been resolved. As appropriate, retrospective claims review may also be conducted. If it is determined at the conclusion of such an investigation that any claims were submitted in error to the government or any other payer, any payments received will be promptly refunded in accordance with applicable law, regulation and/or contractual requirement(s) (see the General Guidelines for Refunding Overpayments, below).

The Compliance Officer or his/her designee(s) will sufficiently document their investigative steps and may prepare a report which

1. Defines the nature of the situation or problem

2. Summarizes the investigation process

3. Identifies any personnel involved and

4. Estimates the nature and extent of the resulting overpayment by the government or another entity, if this is possible.

B. CORRECTIVE ACTION, DISCIPLINE AND REFUNDING OVERPAYMENTS

1. Corrective Action – Generally. Whenever a compliance issue is uncovered, regardless of the source, the Compliance Officer will ensure that prompt, thorough, appropriate and effective corrective action is implemented. In discharging this responsibility, the Compliance Officer may work in consultation with outside counsel and others, as appropriate to correct the problem. All Personnel are expected to assist in the resolution of compliance issues.

Any corrective action and response implemented must be designed to ensure that the violation or problem does not recur (or to reduce the likelihood that it will recur) and must be based on an analysis of the root cause of the issue. In addition, the corrective action plan should include, whenever applicable, a review of the effectiveness of the corrective action following its implementation. If such a review establishes that the corrective action plan has not been effective, then additional or new corrective actions must be implemented.

Corrective actions may include, but are not limited to, the following:

- Informing and discussing with the offending personnel both the violation and how it may be avoided in the future;

- Providing remedial education (formal or informal) to ensure that there is an understanding of the applicable laws, rules, regulations and/or requirements;

- Conducting a follow-up review to ensure that the problem is not recurring;

- Having personnel go through a cycle or cycles of remedial education and/or focused audits;

- Imposing discipline, as set forth below;

- Suspending claims submission, in whole or in part, of the services provided by a specific individual;

- Refunding any past payments that resulted from any improper claims, to the extent required or otherwise appropriate (see the General Guidelines for Refunding Overpayments, below);

- Self-disclosing to an appropriate governmental agency or other payer, to the extent required or otherwise appropriate (including, but not limited to the federal DHHS, OIG and the New York State DOH and OMIG);

- Modifying or improving the Agency's business practices; and/or

- Modifying or improving the Compliance Program to better ensure continuing compliance with applicable Federal and State laws, rule, regulations and/or contractual requirements.

If it appears that a larger, systemic problem may exist, then possible modification or improvement of the Agency's compliance, claims development and submission and/or other practices will be considered. Such action might include, in addition to that listed above, creating new procedures, or modifying existing procedures, so as to ensure that similar issues will not recur in the future. Possible changes or additions to procedures will be reviewed by the Compliance Officer and will be approved by the Compliance Committee.

The Compliance Officer will report to the CEO and the governing body regarding which corrective actions have been implemented and whether the compliance problem was corrected within a reasonable amount of time.

2. Discipline. All Agency Personnel are expected to adhere to the Code of Conduct, the Compliance Program, and applicable Agency compliance policies and procedures. If the Compliance Officer concludes, after an appropriate investigation, that there has been a violation, appropriate discipline may be imposed. The Compliance Officer will be responsible for collaborating with the Agency's Administration and the Human Resource Manager regarding appropriate action. Discipline may include, but is not necessarily limited to verbal warnings, suspension and or termination from employment and/or affiliation with the Agency, and/or other appropriate action.

All personnel are subject to the same disciplinary action for committing similar offenses. The consequences of noncompliance will be consistently applied and enforced. The commitment to compliance applies to all personnel levels within the Agency.

Disciplinary action will be taken, and will be fairly and firmly enforced regardless of the offending Personnel's level or position as appropriate for actions including, but not limited to, the following:

- failing to report suspected problems;
- authorizing or participating in non-compliant behavior;
- encouraging, directing, facilitating or permitting either actively or passively, non-compliant behavior;
- refusing to cooperate in the investigation of a potential violation;
- failure to assist in the resolution of compliance issues; and/or
- intimidating or retaliating against an individual for good faith reporting of a compliance violation or other good faith participation in the Compliance Program.

The type of disciplinary action imposed will be determined by the Agency, in its discretion, and will depend on a variety of factors. Such factors may include, but are not necessarily limited to: (1) the nature of the violation; (2) the time period affected; (3) the amount involved; (4) whether the violation was committed intentionally, recklessly, negligently, or mistakenly; (5) whether the individual has committed any other violations in the past; (6) whether the individual self-reported his or her misconduct; and/or (7) whether (and the extent to which) the individual cooperated in connection with the investigation of the misconduct.

The foregoing is not intended, and shall not be viewed, as a limitation on the Agency's right or ability to impose more than one disciplinary sanction in a particular situation, to impose any other or additional disciplinary sanctions that may be appropriate and permissible in a particular situation, or to take any other actions, measures or sanctions that may be appropriate and permissible in a particular situation.

3. Guidelines for Refunding Overpayments.

It is the Agency's policy:

- to not knowingly retain any payments to which it is not entitled. To that end, reports or other information indicating that an overpayment may have been received must be immediately brought to the Compliance Officer's attention;
- to exercise reasonable diligence in timely investigating and quantifying any and all potential overpayments; and

- to promptly report, return and explain in writing to the appropriate government agency, contractor or payer (including but not limited to, the New York State Department of Health or the New York State OMIG), any identified overpayments in accordance with applicable legal, regulatory, contractual and/or other requirements or guidance.

Note that governmental and private insurance payers may have different rules concerning when and how identified overpayments must be handled.

For example, under the Federal Affordable Care Act statute (the "ACA"), Medicare and Medicaid overpayments must be reported, returned and explained in writing within 60 days of the date the overpayment is identified. For Medicare Part A and Part B purposes, an overpayment is considered to have been "identified" when a person has or should have, through the exercise of "reasonable diligence," determined that an overpayment has been received and has quantified the amount of the overpayment. "Reasonable diligence" includes both proactive compliance activities conducted in good faith to monitor the receipt of overpayments, as well as investigations conducted in good faith and in a "timely manner" in response to obtaining "credible information" about a potential overpayment. Medicare considers a "timely manner" to be at most six (6) months from receipt of credible information, except in extraordinary circumstances. Once an overpayment has been "identified," the person must report, return and explain in writing the overpayment within 60 days.

With regard to Medicaid, the Agency will exercise reasonable diligence to determine whether it has received any overpayments and, if so, to quantify the amount of the overpayment. The Agency will, as appropriate, report, return and explain in writing any identified Medicaid overpayments within 60 days of identifying the overpayment, to the New York State Office of the Medicaid Inspector General ("OMIG)), through its self-disclosure program. The requirements of OMIG's self-disclosure program and related information may be found at: https://omig.ny.gov/provider-resources/self-disclosure.

Any questions regarding when and how potential overpayments are to be addressed by the Agency must be immediately brought to the attention of the Compliance Officer, who may consult with outside counsel, as necessary and appropriate.

C. RECORDKEEPING

The Compliance Officer will maintain a record of all investigations, corrective actions and disciplinary actions imposed pursuant to this Policy. Such records shall be maintained for no fewer than ten (10) years from the later of the conclusion of the investigation or the imposition of the corrective action or disciplinary action(s), or for such longer period of time as may be required by applicable law, regulation or contract.

D. PERIODIC REVIEW OF THIS POLICY

The Agency will periodically review this Policy and Procedure (no less than annually) to ensure that it is modified as necessary in order to remain current with applicable law, regulation and guidance, as well as our contractual requirements.

COMMUNITY HOME HEALTH CARE, INC. DBA COMMUNITY HEALTH AIDE SERVICES **Compliance Program Policies and Procedures**	
Title: Record Retention	
Reviewed:	**Revised:**

PURPOSE

The purpose of this Policy is to: (1) ensure that records are retained for appropriate periods of time; (2) allow for records that are no longer useful to be methodically destroyed; and (3) provide that records to be retained are stored methodically, economically and consistently by Community Home Health Care, Inc. DBA Community Health Aide Services (the "Agency").

POLICY

It is the Agency's policy to retain records (e.g., patient records, business records) in accordance with applicable: (1) federal, state and/or local laws and regulations; (2) statutes of limitation, and/or (3) contracts. Unless otherwise stated, records may be maintained on microfilm, microfiche, optical disk systems or other similar technologies ("Electronic Records"). Unless otherwise provided herein, the original hard copies of Electronic Records, if any, may be destroyed provided the safeguards discussed below are put into place.

The Agency will ensure the security, privacy and confidentiality of records, including patient records, as required by law or by accrediting agencies.

1) DEFINITIONS

a) Records

For purposes of this Policy, the term "Records" refers to information that is created, received, and/or maintained by the Agency (regardless of physical form or medium) that contains information with operational, legal, fiscal, vital or historical value.

The term "Records" includes, but is not limited to: corporate documents, tax documents, reimbursement documents, completed and signed forms, contracts, documents related to contracts, insurance documents, general ledgers, audit reports, financial reports, correspondence, legal opinions, real estate documents, directives and policies, official meeting minutes, personnel records, benefit programs, purchasing requisitions and invoices, accounts payable and receivable documents, and patient records (including, but not limited to, clinical data, patient demographic, clinical research and financial data).

The term Records may also include e-mail if the communications, messages, documents, files, and other data transmitted with the e-mail contain information that falls within the definition of a Record, as defined above. If the e-mail qualifies as a Record due to its content, the only copy that must be retained is the sender's copy. If someone other than the sender is required to take action pursuant to the e-mail message, that person should also retain a copy. All other e-mail messages and attachments are considered non-records (as defined below) and should be purged from the

computer system when the e-mail is no longer needed, unless the e-mail is subject to a document hold.

Records can only be disposed of when the specified retention period set forth in the Record Retention Schedule has expired and only in accordance with the procedures set forth in this Policy, provided such Records are not subject to a document hold.

b) Non- Records

Information with no operational, legal, fiscal or historical value (regardless of physical form or medium) is considered a non-record. This includes duplicates and copies of existing, maintained Records, blank forms, routine notices, personal email, post-it notes, telephone messages and other forms of messages that contain no substantive data relevant to the business operation of the Agency. In addition, drafts generally constitute non-records, unless it has been determined that a particular draft, or series of drafts, should be retained, in which case the drafts shall be filed with, and retained for the retention period for, the Record to which the draft is related.

The Record Retention Schedule does not apply to non-records. All non-records should be disposed of as soon as they are no longer administratively needed, unless the non-records are subject to a document hold.

c) Electronic Records

For purposes of this Policy, the term Electronic Records refers to Records maintained on optical disk systems or other similar technologies ("electronic format"), regardless of whether it was originally created in electronic format or the original paper document is scanned into electronic format.

Provided the Electronic Record is properly safeguarded in accordance with this Policy:

- Electronic Records need not be printed or retained in paper format; and
- The original paper copy of the Record that was scanned into an Electronic Record may be destroyed provided the Agency ensures that the Electronic Records are (i) an accurate reproduction of the original Records; and (ii) readily available.

d) Vital Records

Vital Records are Records that are essential to the continued operation of the Agency. They also include those Records essential to the protection of the rights and interests of the Agency and of the individuals for whose rights and interests the Agency has responsibility.

Each department within the Agency must identify and designate as Vital Records those documents that: (1) are essential to the continuity of the Agency or to the Agency's legal and financial status; (2) are necessary for the Agency's fulfillment of obligations to employees, patients, regulatory and accrediting agencies, or other individuals or entities; (3) establish ownership of assets which would otherwise be difficult to prove; or (4) have other significance to the Agency that warrants retention.

Vital Records include, but are not limited to: all certificates of incorporation and all amendments thereto; corporate bylaws; staff bylaws, rules and regulations; reports of inspections and surveys by outside agencies; and all licenses, permits and certifications required by law for the operation of the Agency and required for employees and personnel.

2) PROCEDURE

a) Maintaining all Business Records

The Records Retention Schedule attached to this policy provides required retention periods for certain specific types of documents. All departments should refer to the Records Retention Schedule to determine the appropriate retention periods for business and patient records. This Record Retention Schedule does not represent each and every document that could be maintained by the Agency. There may be documents not listed on this Record Retention Schedule that also need to be retained. If a question arises regarding the retention period a document that is not listed on this Record Retention Schedule, the Compliance Officer should be contacted.

b) Periodic Review

The Agency will conduct a file review and purge process on a periodic basis, as necessary. This process consists of identifying and destroying unnecessary duplicate and multiple copies of documents, including drafts; reviewing and destroying documents which have exceeded their required retention period; and identifying, grouping and labeling documents which require retention and transferring these documents to the designated records storage site. Documents will be destroyed only in accordance with the Records Retention Schedule. If there is any question as to how long a particular document should be retained, that document should not be destroyed until the question has been resolved.

Periodically, the Agency will review the documents at its record storage site, to determine which records have reached their disposal date and to arrange for destruction of the documents.

c) Departing Employees

The business files of employees who are terminating their employment or transferring within the Agency will be reviewed by the employee and his/her supervisor concurrent with the employee's departure as appropriate. These files are the property of the Agency and employees and staff members are prohibited from removing or destroying any documents upon departure.

d) Labeling and Marking

Records to be retained should be labeled and marked with a disposal date equal to or beyond the period established for retention. Record storage containers and systems must be labeled in sufficient detail that they may be promptly and accurately identified should retrieval prove necessary. The disposal date should always be December 31 of the last year for which the file must be retained. For example, a document dated May 23, 2020 with a three-year retention period would be designated for destruction on December 31, 2023.

e) Confidentiality

Patients' medical records, employee medical records and other records subject to confidentiality restrictions must be stored securely and destroyed in a manner that ensures confidentiality of any patient information therein and renders the information unrecognizable, such as shredding, mutilation or incineration.

f) Conflict with Contractual Requirements

To the extent that contractual records retention requirements exceed the records retention periods listed in the attached retention schedule or specify the retention of documents not listed in the schedule, the contractual requirements will control. Originals of documents related to open contracts and subject to contractual retention requirements should not be destroyed.

g) Vital Records

Each department must identify and designate as vital records those records that: (1) are essential to the continuity of the Agency or to the Agency's legal and financial status; (2) are necessary for fulfillment of obligations of the shareholders, employees, customers, patients or other outside interests; (3) establish the Agency's ownership of assets which would otherwise be difficult to prove; or (4) have other significance to the Agency that warrants retention. Vital records must be duplicated and the duplicates must be stored in an off-site location for reconstructive use in the event of catastrophic document loss.

h) Electronic Storage

Records generated and maintained in the Agency's information systems or equipment will be reviewed periodically, no less than annually, to ensure that the Policy requirements are applied to these documents. Electronic Records must be adequately protected against destruction, whether by archival storage of duplicated photographic or electronic medium or by other suitable means providing equivalent protection. In addition, prior to the destruction of any originals of Electronic Records, the Agency must ensure that the Electronic Records are:

(1) an accurate reproduction of the original documents; and

(2) readily available to local, state and federal surveyors.

i) Investigations and Litigation

Upon the Agency's receipt of notice regarding the initiation of an investigation or audit by an outside agency (e.g., a Medicare or Medicaid audit) or the service of legal process, the appropriate office will notify all departments in possession of potentially relevant documents as promptly as practicable and direct them to cease the destruction of any relevant documents, and segregate those documents in a secure location, pending formal notice in writing that the investigation or litigation has been concluded. Relevant Records shall be retained and only in accordance with instructions from legal counsel, segregated and stored in a secure location until such time as the Agency receives notice that the hold has been lifted and that the Records are again subject to the retention periods in the Record Retention Schedule.

j) Destruction of Records

Records that have satisfied their legal, fiscal, administrative and archival requirements may be destroyed upon expiration of the retention period set forth in the Record Retention Schedule, unless the Record is the subject of a document hold, in which case such Records must not be destroyed. If there is any question as to how long a particular Record should be retained, that Record should not be destroyed until the question has been resolved.

i) Records Destruction Authorization

Upon identification of Records for which the retention period has expired, a "Records Destruction Authorization" form must be completed and must include: the date and method of destruction (if an outside vendor was used, the vendor that performed the service); a description of the disposed Records; inclusive dates covered by the Records; a statement that the Records were destroyed in the normal course of business; and the signature of the appropriate management staff who approved the destruction prior to the destruction of the Records. All Records Destruction Authorization forms must be maintained permanently.

ii) Methods of Record Destruction

Records subject to confidentiality restrictions (such as patients' records, employee medical records and other similar records), regardless of format or medium, must be destroyed in a manner that ensures confidentiality and renders the information unrecognizable. Accordingly, the following approved methods should be used to destroy Records:

- Paper Records: Paper Records should be destroyed by crosscut shredding, burning, pulping or pulverizing.

- Electronic Records: Electronic Records, including all back-up tapes, should be either physically destroyed or destroyed by degaussing, zeroization or other method to render the previous electronic data unrecoverable and impossible to reconstruct.

Electronic Storage Media: Data storage devices, such as tapes, CDs and floppy disks, should be physically destroyed rather than overwritten with other data to ensure that the data is irretrievable. Documents stored in the "cloud" may also be deleted as appropriate.

k) Interpretation

Any questions regarding the application of this Policy or retention requirements for specific types of records should be referred to the Compliance Officer.

RECORD RETENTION SCHEDULES

ACCOUNTING RECORDS

1. Annual financial statements	Permanent
2. Data for acquired/divested	Permanent
3. Chart of accounts	Permanent
4. General Ledger	20 years
5. Annual audit records	10 years
6. A/R/ invoices	8 years
7. Journal entries	8 years
8. Special reports	8 years
9. Canceled checks	8 years
10. A/P paid invoices	8 years
11. Business expense records	8 years
12. Accounts payable	7 years
13. Accounts receivable	7 years
14. Audit reports	7 years
15. Expense reports	7 years
16. Inventory records	7 years
17. Loan documents	7 years after final paymt.
18. Sales records	7 years
19. Purchase orders	7 years
20. Data for non-acquired/non divested	5 years
21. Credit card receipts	3 years
22. Cash receipts	3 years
23. Monthly financial statements	3 years
24. Stop payment orders	3 years
25. Bank reconciliations	3 years

TAX RECORDS

1. Federal tax return (not payroll)	Permanent
2. State & local tax returns	Permanent
3. Form 990 & supporting documentation	Permanent
4. Form 990-T & supporting documentation	Permanent
5. Payroll taxes (W2, W3)	Permanent
6. Payroll taxes (Form 941, state w/h forms, state unemployment returns)	8 years (or longer)
7. Unclaimed property filings & supporting documents	6 years (or longer)
8. City & State excise tax reports & supporting documents	5 years (or longer)
9. Supporting documentation for taxes	4 years
10. 1099 forms	8 years

PAYROLL RECORDS

1. Payroll registers	Permanent
2. State unemployment tax records	Permanent
3. W-2 forms	8 years
4. W-4 forms	8 years
5. Cancelled payroll checks	8 years
6. Changes or adjustments to salary	8 years
7. Deductions register	8 years
8. Earnings records	8 years
9. Wage	6 years
10. . Salary	6 years
11. . Payroll deductions	6 years
12. . Time cards or forms	5 years
13. Garnishments	4 yrs after unemployment
14. . State employment forms	4 years
15. Wage rate tables	3 years
16. Cost of living tables	3 years

I**NSURANCE RECORDS**

1. Policies (including expired)	Permanent
2. Claims for loss/damage, accident reports, appraisals	5 years

WORKPLACE RECORDS

1. Incorporation & Reorganization records (Articles of Incorporation, By-laws, etc.)	Permanent
2. Meeting minutes	Permanent
3. Corporate Records	Permanent
4. Policy Statements	10 years
5. Employee directories	5 years

LEGAL RECORDS

1. Trademark registration	Permanent
2. Copyright registration	Permanent
3. Patents	Permanent
4. Real estate contracts & records	20 yrs – Permanent
5. Personal injury records	8 years
6. Leases	6 yrs after termination
7. Court documents & records	5 yrs following close
8. Deposition transcripts	5 yrs following close
9. Litigation claims	5 yrs following close
10. General contracts	3 yrs after termination
11. Discovery materials	3 yrs following close

PERSONNEL RECORDS

1. Employment & termination agreements	Permanent
2. Accident reports	6 years
3. Incentive plans (after expiration)	6 years
4. Medical and safety records	6 years
5. Pension plans (after expiration)	6 years
6. Retirement plans (after expiration)	6 years
7. Disciplinary warnings, demotion, lay-off & discharge	5 years following emplymt
8. Promotions, raises, reclassifications & job descriptions	5 years following emplymt
9. Beneficiary information	3 years following emplymt.
10. Employment applications (persons hired)	3 years following emplymt
11. Employee resumes & employment history	3 years following emplymt
12. Evaluations	3 years following emplymt
13. Promotions & raises	3 years following emplymt
14. Employment applications (persons not hired)	1 year
15. Education assistance	While employed
16. Sick leave benefits	While employed

CLIENT FILES

1. Case Notes and Billing files	10 years following payment received

COMMUNITY HOME HEALTH CARE, INC. DBA COMMUNITY HEALTH AIDE SERVICES **Compliance Program Policies and Procedures**	
Title: Responding to Government Inquiries	
Reviewed:	**Revised:**

I. POLICY

It is Community Home Health Care, Inc. DBA Community Health Aide Services' (the "Agency") policy to comply with the law and cooperate with legitimate governmental investigations or inquiries.

II. PROCEDURES

A. Regulators. Federal and State regulators, as well as representatives from other governmental agencies, may come to the Agency to conduct on-site surveys or inquiries. All regulators entering the Agency should be directed to the Compliance Officer or in her absence, the Executive Director. Upon "reasonable notice,"[12] the Agency must grant timely access to its facilities and records to the Medicaid Inspector General, the Medicaid Fraud Control Unit of the Attorney General's Office, or the Department Of Health for the purpose of audits, investigations, reviews, or other statutory functions. However, Personnel should not turn over any Agency records without prior approval from the Compliance Officer or the Executive Director.

B. Law Enforcement Officers. The Agency encourages Personnel to fully cooperate with law enforcement officers and investigations.

1. Personnel Interviews. Personnel may speak voluntarily with law enforcement officers, and the Agency will not attempt to obstruct any government inquiry or prevent any Personnel from speaking with such officers. However, Personnel should be aware that they are permitted to refuse to speak with any officer and have the right to request that a representative of the Agency or legal counsel be present before they speak with an officer. If a law enforcement officer goes to any Personnel's home, the individual has the right to refuse to speak with the officer and to have an Agency representative or counsel present. Personnel may also request that the interview take place at the Agency.

- Before speaking with law enforcement officers, it is recommended that the Personnel ask for the officer's name and telephone number and identification, and then contact his or her supervisor and the Compliance Officer**,** who should then contact legal counsel.

- Personnel are also reminded that, while they may speak with government agents in their personal capacity, they may not present themselves as an

[12] "Reasonable notice" means a written request made by a properly identified agent of the Medicaid Inspector General, the Medicaid Fraud Control Unit of the Attorney General's Office, or the Department Of Health either, during hours that the Agency is open for business, or mailed to the Agency. The request must include a statement of the authority for the request, the definition of "reasonable notice" and the penalties for failure to comply.

official representative of the Agency without first obtaining authorization from the Agency.

2. Law Enforcement Officers with a Subpoena, Civil Investigative Demand or Section 504.3 Notice. If investigators from a law enforcement agency appear at the Agency with a subpoena,[13] a Civil Investigative Demand[14] or a Section 504.3 request[15] for specific records, the following should occur:

- Immediately Contact the Compliance Officer**.** Once the individual being served with the Subpoena, Civil Investigative Demand or a Section 504.3 request has obtained proper identification from the law enforcement officer or investigator, he or she should contact the Compliance Officer immediately. No records or information should be given to any law enforcement officer or investigator without prior approval of the Compliance Officer or the Executive Director who may first consult with outside counsel, as necessary and appropriate. Generally, a subpoena, Civil Investigative Demand or a Section 504.3 request must give the Agency adequate time to reply; thus, a law enforcement officer should not arrive at the Agency expecting an immediate response to such documents.

- Contact Legal Counsel. The Compliance Officer or the Executive Director should contact legal counsel upon receiving a subpoena, Civil Investigative Demand or a Section 504.3 request. Although the Agency intends to fully cooperate with all lawful investigations, some of the requested material may be privileged and should be reviewed by attorneys prior to disclosure.

- Accurate Response. Any response to a subpoena, Civil Investigative Demand or a Section 504.3 request must be accurate and complete.

3. Law Enforcement Officers with a Search Warrant. A valid search warrant enables law enforcement officers to enter a premise, search for evidence of criminal activity, and seize that evidence for use in a criminal prosecution. Law enforcement officers with a search warrant, however, do not have unlimited authority. The Agency aims to minimize disruption should law enforcement officers execute a search warrant. If a law enforcement officer presents a search warrant at the Agency, Personnel should do the following:

---

[13] A Subpoena may be issued by: (i) the U.S. Department of Justice (*e.g.,* the U.S. Attorney's Office; FBI, DEA); (ii) the U.S. Department of Health and Human Services' Office of Inspector General; (iii) the NY State Office of the Attorney General's Medicaid Fraud Control Unit; and (iv) the Office of the Medicaid Inspector General. Subpoenas from other law enforcement agencies may or may not require a judge's order.

[14] A Civil Investigative Demand may be issued by the U.S. Department of Health and Human Services' Office of Inspector General.

[15] A Section 504.3 request for records may be issued by: (i) the NY State Department of Social Services; (ii) the United States Department of Health and Human Services; (iii) the NY State Office of the Attorney General's Medicaid Fraud Control Unit; and (iv) the NY State Department of Health, including the Office of the Medicaid Inspector General.

- Advise the Compliance Officer or the Executive Director of the Agency of the Search. The individual should immediately tell the Compliance Officer or the Executive Director about the search warrant and the presence of the investigators.

- Contact Legal Counsel Immediately. Any Personnel served with a warrant should request the opportunity to call legal counsel. If this request is refused, the individual, in a respectful manner, should indicate that the refusal violates the Agency's rights and should document the refusal in detail.

- Request a Copy of the Search Warrant and Accompanying Affidavit. A search warrant contains limits as to what areas may be searched and what property may be seized. Personnel should be aware of these limits and ensure that the officers confine their search to its proper boundaries.

- Do Not Consent to the Search. Although it is important to be cooperative with the investigators, it is equally important to tell them that the Agency objects to the search and is complying under compulsion of law.

- Protect Personnel. Investigators will normally use the execution of a search warrant as an opportunity to question Personnel. The search warrant, however, does not give the investigators authority to require Personnel to answer questions. Personnel should be cooperative and respectful, but may refuse to answer questions without an attorney present. Personnel may be sent home or to another section of the office during the execution of a search warrant. Some persons will be selected to remain with counsel and monitor the search.

- Keep Records Regarding the Search. The search should be carefully monitored and recorded. Records should include the names and backgrounds of the investigators, times, dates and scope of the search, areas searched, and a detailed list of items seized. Personnel should request permission to video the search; if such request is refused, the refusal should be documented. Investigators should never be left alone in any area of the Agency during a search.

- Be Cooperative. Personnel should be cooperative and not do anything that will impede, obstruct or antagonize the investigators during their search. Such impediments could be considered obstruction of justice and lead to a person's arrest.

III. NO DESTRUCTION OR ALTERATION OF RECORDS OR EVIDENCE

The Agency's response to any subpoena or other government request for information must be complete and accurate. Personnel may not alter, destroy or mutilate any document or record or alter, delete or download any material from any computer, word processor, disk, tape or other device (except in accordance with the Agency's Record Retention Policy). Even additions to

records intended, in good faith, to add appropriate entries to "complete" the records are *absolutely* prohibited once a subpoena or government request for a document has been received. Any such action will subject the Personnel involved to immediate discharge from employment or affiliation with the Agency and possible criminal prosecution. If a document is required to be retained, it must be preserved in its original form.

COMMUNITY HOME HEALTH CARE, INC. DBA COMMUNITY HEALTH AIDE SERVICES **Compliance Program Policies and Procedures**	
Title: Social Media and Recordings	
Reviewed:	**Revised:**

POLICY

Except as otherwise provided in this policy, Community Home Health Care, Inc. DBA Community Health Aide Services (the "Agency") restricts the posting to any social media during working hours and the use of any recording devices, or cameras of any kind, including, but not limited to, cellular telephone cameras, digital cameras, audio recorders, or similar devices capable of recording visual and/or audio images (collectively "Recording Devices"). Each image or audio file collected by a Recording Device shall be referred to in this Policy as a "Recording."

Posting to social media is not a business-related activity and should be done during personal (non-work) time only. While the Agency respects an employee's right to use social media as a medium of self-expression, the Agency has established strict rules – outlined below – regarding such postings.

The use of Recording Devices by personnel during working hours is strictly prohibited absent prior authorization from the Agency and the written consent of the patient (prior to recording).

Recordings of a patient collected by Agency employees, contractors, physicians or other health care practitioners on behalf of the Agency shall be considered protected health information, and, if the Recordings were created for treatment purposes, will be maintained in a protected and secure manner as part of the patient's medical record.

Requests for use of Recordings in the legal process or legal proceedings must be approved by the Compliance Officer or her designee.

Failure to comply with this policy will result in corrective or disciplinary action including, where appropriate, employment termination and possible legal liability.

SOCIAL MEDIA GUIDELINES

Definition: Social media is the practice of posting information to various Internet platforms, including but not limited to such platforms as Facebook, Twitter, and Instagram.

- If you publish or post to social media and the subject matter of your post has something to do with the work you do, or with subjects relating to the Agency, you must make it clear that the views expressed are solely your personal views and do not necessarily represent the views of the Agency.
- Do not disclose confidential or proprietary information related to the Agency. Consult the Agency confidentiality policy for guidance about what constitutes confidential information.

- Do not cite or reference the Agency's patients / client's names or pictures, as that is a breach of patient privacy.
- We require that you will be respectful to the Agency, our employees, our patients, our partners and affiliates, and others (including our competitors). Threats posted to social media made to the Agency's management, staff or patients will result in disciplinary action and dismissal.
- You may not provide a link from your social media site to the Agency's website without express permission from the Administrator of the applicable agency.
- If you have any questions about these guidelines or any matter related to your social media site that these guidelines do not address, please direct them to the Compliance Officer.

COMMUNITY HOME HEALTH CARE, INC. DBA COMMUNITY HEALTH AIDE SERVICES

Compliance Program Documents

Sample Annual Work Plan

	COMPLIANCE ACTIVITY	RESPONSIBILITY	SCHEDULED	COMPLETED	COMMENTS
A.	**REVIEWS BASED ON OIG/OMIG ANNUAL WORK PLAN**				
	☐				
	☐				
	☐				
	☐				
B.	**REVIEWS BASED ON GOVERNMENTAL ACTIVITY/AUDITS**				
	☐				
	☐				
	☐				
	☐				
C.	**REVIEWS BASED ON COMPLIANCE ISSUES RAISED TO THE COMPLIANCE OFFICER**				
	☐				

	COMPLIANCE ACTIVITY	RESPONSIBILITY	SCHEDULED	COMPLETED	COMMENTS
	☐				
	☐				
	☐				
D.	**COMPLIANCE REVIEWS**				
	☐ Review of OIG, OMIG and GSA Exclusion Lists		Monthly		
	☐ Professional Staff Credential Reviews		Annually		
	☐ Monitor Audits by Medicare, Medicaid & Other Third Party Payers (Including Commercial)				
	☐ Chart and Billing Reviews				
	☐ Use of ABNs				
	☐ Billing Denials				

	COMPLIANCE ACTIVITY	RESPONSIBILITY	SCHEDULED	COMPLETED	COMMENTS
	☐ Other Compliance Issues, e.g., ☐ Supervisory visits ☐ Incident reporting ☐ Care Plans – content and timeliness ☐ Medical orders – content and authentication ☐ Prompt completion of progress notes ☐ Patient Complaints/Satisfaction Surveys ☐ Other				
E.	**ANNUAL REVIEW OF COMPLIANCE PROGRAM**				
	☐ Annual Review of Code of Conduct				
	☐ Annual Review of Compliance Structure & Guidelines				
	☐ Annual Review of Compliance Program Policies and Procedures				
	☐ Other _____				

	COMPLIANCE ACTIVITY	RESPONSIBILITY	SCHEDULED	COMPLETED	COMMENTS
F.	**REVIEW NEW DEVELOPMENTS AND PROACTIVELY IDENTIFY ISSUES**				
	☐ Review Compliance Literature		On-Going		
	☐ Review Internet Web Sites for New Developments (OMIG/OIG/CMS/DOH, etc.)		On-Going		
	☐ Review OIG Special Fraud Alerts and Advisory Opinions		On-Going		
	☐ Interviews with key staff				
	☐ Other _____				
G.	**TRAINING**				
	☐ New Employee Orientation Training				
	☐ Annual Compliance Training				
	☐ Specialized/Periodic Training		As Needed		
	☐ Other _____				
H.	**COMMUNICATION WITH STAFF**				
	☐ Update Poster				

	COMPLIANCE ACTIVITY	RESPONSIBILITY	SCHEDULED	COMPLETED	COMMENTS
	☐ Memos to Staff				
	☐ Other _____				

Compliance Resolution

WHEREAS, Community Home Health Care, Inc. DBA Community Health Aide Services (the "Agency") is committed to providing the highest quality in-home services to our patients pursuant to the highest ethical, business and legal standards; and

WHEREAS, this commitment extends to all of the Agency's interactions, including those with: our patients, other health care providers, the companies with which we do business and the public and private entities from which reimbursement for our services is sought and received; and

WHEREAS, the Agency is further committed to ensuring its continuing compliance with all applicable State and Federal laws and regulations, and to avoiding even the appearance of impropriety in our interactions with others.

NOW, THEREFORE, BE IT:

RESOLVED, as a means of continuing our commitment to these standards of conduct, we have retained the law firm of Garfunkel Wild, P.C., to help us review, revise and update our compliance program (the "Compliance Program") in order to ensure that all persons working for and associated with the Agency will continue to comport themselves according to the highest ethical and legal standards of behavior. The Compliance Program will assist us in improving upon our determination to act legally and ethically at all times; and be it further

RESOLVED, that the Agency's Compliance Program will strive to: (i) ensure that all persons working for and associated with us comport themselves according to the highest ethical, business and legal standards of behavior, and (ii) embody our determination to act legally and ethically at all times; and be it further

RESOLVED, that the Agency's Compliance Program will at all times include, but not be limited to, the following:

(i) Compliance Officer. The Compliance Program will have a Compliance Officer, who will be accountable for the daily functioning and monitoring of the Compliance Program. Among other things, the Compliance Officer will ensure that the auditing, document review, educational, reporting and evaluation aspects of the Compliance Program are carried out. He or she will also be available to all personnel to report any possible illegal or unethical conduct.

(ii) Compliance Program Documents. The Compliance Manual will include a written Code of Conduct, the Compliance Program Structure and Guidelines and various policies and procedures that will set forth the Agency's expectations and standards, including, but not limited to, policies for non-intimidation and non-retaliation for good faith participation in the Compliance Program, and procedures for: (i) reporting, reviewing, monitoring and responding to compliance issues (including disciplinary guidelines); (ii) continued, periodic reviews or self-audits of our business practices; and (iii) periodic training and education of our personnel.

(iii) Open Lines of Communication. The Compliance Program will encourage all of our personnel to actively participate in the Agency's on-going compliance efforts.

(iv) Meeting All Other Requirements. The Compliance Program will be designed to meet all of the applicable legal and regulatory requirements for an effective Compliance Program and will be updated periodically to ensure its continued operation and effectiveness.

The Agency believes and expects that the continued improvement of our Compliance Program will become an established part of our corporate culture, and will exemplify and demonstrate our continuing commitment to the highest business and ethical standards.

THE FOREGOING IS HEREBY APPROVED AND ADOPTED:

By: _____ Date: _____

[ON COMMUNITY'S LETTERHEAD]

MEMORANDUM

To: All Personnel

From: **[_____]**

Subject: Compliance Program

Date: _____, 2023

The purpose of this memo is to communicate important information concerning our Compliance Program.

Community Home Health Care, Inc. DBA Community Health Aide Services (the "Agency") is, and always has been, committed to compliance with the highest ethical, legal and business standards. As part of our continuing commitment to compliance, we have recently updated our Compliance Program Manual, which includes reporting requirements, a Code of Conduct and the Compliance Program Structure and Guidelines. These documents set forth standards that everyone associated with the Agency is expected to follow. A copy of the Compliance Program Manual may be downloaded from the Agency's website. It is important that all personnel read and understand the Code of Conduct and Compliance Structure and Guidelines contained in the Manual, and then sign and return the attached acknowledgement to the Compliance Officer.

Paul Vershubsky is the Compliance Officer for the Agency. She may be reached at any time by telephone at 845.738.1305 or by e-mail at pversh@commhealthcare.com with any compliance questions, issues or concerns. Personnel may also call our Compliance Hotline at any time at 845.845.8652.

Your questions or concerns may be raised anonymously, if you prefer. The identity of personnel reporting through the Compliance Hotline will be kept in the strictest confidence, whether requested or not, unless the matter is turned over to law enforcement. ***Be assured that retaliation or intimidation against any personnel for making a good-faith report, requesting clarification about applicable laws or policies or participating in any compliance-related investigation or other aspect of the Compliance Program is a violation of our Code of Conduct and is strictly prohibited.***

We encourage and expect each of you to work with us as we continue to develop our Compliance Program so that we can ensure that it will be a success.

Thank you for your cooperation.

COMMUNITY HOME HEALTH CARE, INC.
DBA COMMUNITY HEALTH AIDE SERVICES

COMMITMENT TO COMPLIANCE

At the Agency, we strive to earn the trust of our patients and the respect of the communities we serve. To help us do that, we have implemented a Compliance Program and Code of Conduct.

- **Who is responsible?** All Personnel, including nurses, practitioners, employees, independent contractors, supervisors, managers, officers, directors and entities with which we do business.
- **What are the rules that must be followed?** The standards set forth in the Code of Conduct provide an overview of the rules that you are expected to follow. All Personnel are provided with a copy of the Code of Conduct and the Compliance Program Structure and Guidelines. We expect everyone to conduct themselves pursuant to the highest ethical, business, and legal standards. If you suspect that someone is doing anything that is illegal or unethical, you must report it.

Examples of what needs to be reported:

- Improper documentation of patient care.
- Giving or accepting something of value in exchange for referrals.
- Improper marketing practices.
- Any activity or business practice that could possibly be interpreted as unethical or illegal.

How to Report Compliance Violations:

Contact the Compliance Officer, Paul Vershubsky, at 845.738.1305 or by email at pversh@commhealthcare.com.

Call the "Hotline" anonymously at 845.678-8652.

Call the CDPAP "Hotline" at 845-335-9905.

- All reported compliance issues will be investigated.
- You may raise the issue anonymously if you wish. If you report through the Hotline your identity will be kept confidential unless the matter is turned over to law enforcement.
- Be assured that intimidation or retaliation against anyone who in good faith raises a compliance issue or otherwise participates in the Agency's Compliance Program is strictly prohibited.

FOR MORE INFORMATION REGARDING OUR COMPLIANCE PROGRAM, VISIT THE AGENCY'S WEBSITE AT: https://commhealthcare.com/