ELM YORK ASSISTED LIVING
COMPLIANCE PROGRAM & COMPLIANCE POLICIES

Updated March 24, 2025

I. INTRODUCTION and APPLICABILITY

Elm York Assisted Living ("the Company") is subject to the provisions of article 36 of the Public Health Law and therefore is required to adopt and implement an effective Compliance Program (18 NYCRR Part 521-1). This document provides the essential details and structure of the Company's Compliance Plan and Policies and Procedures.

A condition of the Company receiving payment under the MA (Medical Assistance) program is the adoption, implementation, and maintenance of an effective compliance program which satisfies the requirements of 18 NYCRR Subpart 521-1. This Compliance program shall comply with Subpart 521-1 and all directives of the department (NY State Department of Social Services) and OMIG.

The Company strives to maintain good faith efforts to comply with all applicable laws, regulations, and standards. The goal of this Compliance Plan is to ensure that the Company adheres to all applicable Medicaid laws, rules, and regulations regarding the provision of services and corresponding billing practices. This includes but is not limited to, ensuring proper documentation of services, proper coding, billing, and claims submission, as well as prompt detection, and appropriate corrective action to prevent fraud, waste, and abuse.

All "affected individuals" are subject to this Compliance Plan and Policies and Procedures. Affective individuals are everyone who is affected by Elm York Assisted Living's risk areas. Included are all Company employees, volunteers, interns, appointees, associates, consultants, independent contractors, vendors/contractors, and subcontractors, agents, chief executive and other senior administrators, managers, executives, Governing Body members, corporate and officers. Any reference within this plan to "affected individuals" is meant to include anyone in these positions and who are affected by one or more Company risk areas.

Contractors, agents, subcontractors, and independent contractors are hereinafter referred to collectively, unless otherwise noted, as "contractor" or "contractors". The Company shall ensure that contracts with contractors specify that the contractors are subject to the required provider's compliance program, to the extent that such contractors are affected by the required provider's risk areas and only within the scope of the contracted authority and affected risk areas. The Company shall ensure that such contracts include termination provisions for failure to adhere to the required provider's compliance program requirements.

The Company is ultimately responsible for the adoption, implementation, maintenance, enforcement, and effectiveness of this compliance program.

The purpose of this compliance plan includes the following:

- ✓ Affirm the Company's commitment to accurate and lawful documentation and submission of all claims for services to Medicare and other third-party payors.
- ✓ Help all affected individuals to meet legal and ethical standards governing the company.
- ✓ Promote the prevention, detection, and proper resolution of any non-compliant acts.
- ✓ Prevent or correct loss to government and other third-party payors, due to unlawful claims.
- ✓ Prevent or limit Company exposure to damages due to unlawful or otherwise non-compliant acts.

All affected individuals are required to comply with all Federal and New York State laws, rules and regulations as well as Company policies and procedures as detailed in this Compliance Plan. Affected individuals who fail to comply may be subject to disciplinary action and possible termination of their association with the Company.

II. WRITTEN STANDARDS OF CONDUCT

Elm York Assisted Living believes that the best method to prevent, detect and correct fraud, waste and abuse is through proper implementation of this plan and these written policies and procedures. This Compliance Program and Manual applies to all affected Individuals and other persons associated with the Company's Medicaid services. These written policies and procedures are available, accessible and applicable to all affected individuals. This program contains policies and procedures designed to ensure compliance with all applicable State and Federal laws and regulations. The Deficit Reduction Act of 2005 requires dissemination of information about both the federal False Claims Act ("FCA") and other laws, including State laws, dealing with fraud, waste, and abuse and whistleblower protections for reporting those issues. The Company supports the efforts of government authorities in identifying, correcting, and preventing fraud, waste, and abuse. The Standards of Conduct Policy appears below.

III. COMPLIANCE PROGRAM COMPONENTS AND POLICIES

A. Standards Of Conduct

The Company has a standard of maintaining the highest level of professional and ethical standards in the conduct of its business. The Company places the highest importance upon its reputation for honesty, integrity, and high ethical standards.

These standards can only be achieved and sustained through the proper actions and conduct of all Company personnel. Every employee, including management employees, executives, officers and the governing body, is obligated to conduct themself in a manner to ensure the maintenance of these standards. Such actions and conduct will be important factors in evaluating each employee's judgment and competence. Affected individuals who ignore or disregard the principles of this code will be subject to appropriate disciplinary actions. Any Board member who violates the standards of the Code of Conduct will be subject to expulsion from the Board. Compliance with the Code of Conduct will be addressed in the performance evaluations of Company affected individuals, and periodic reviews of independent contractors and agents. The Company expects all personnel will act in accordance with the Company's standards of conduct, and that they must refuse to participate in unethical or illegal conduct, and that they must report any unethical or illegal conduct to the Chief Compliance Officer.

The Company expects that all personnel comply with the licensure, certification, and credentialing requirements associated with their position and the performance of their duties, in accordance with applicable federal, state and local laws and regulations.

Affected individuals must be cognizant of all applicable federal and state laws and regulations that apply to and impact upon the provision of services, documentation, billing functions, as well as the day-to-day activities of the Company and its affected individuals and agents. This includes the requirements regarding confidentiality of personal health information. Each affected individual who is materially involved in any provision of service, documentation, coding or billing functions has an obligation to familiarize themselves with all such applicable laws and regulations, and affected individuals must adhere at all times to the requirements thereof. Where any question or uncertainty regarding these requirements exists, it is incumbent upon, and the obligation of, each affected individual to seek guidance from a knowledgeable officer of the Company, such as the Chief Compliance Officer.

The elements of the Company's code of conduct are implemented through the compliance program described herein (the Compliance Program). The purpose of the Compliance Program is to assist all Company affected individuals through the

development and implementation of internal controls and procedures; to adhere to statutes and regulations applicable to State and Federal health care programs.

This Compliance Program is intended to prevent both inadvertent and intentional noncompliance with applicable statutory, regulatory, and other requirements; to promote the detection of noncompliance if it occurs, to discipline offenders when appropriate, and to educate affected individuals on the importance of compliance and the Company's compliance procedures.

This Compliance Program will be reviewed as needed, at least annually and updated as needed to ensure that the Company maintains the highest possible compliance procedures. The Company recognizes the importance of educating its affected individuals on up-to-date compliance standards and procedures and is committed to ensuring such education.

The standards of conduct set forth in this Compliance Program constitute the Company's plan, policies and procedures. Any questions or concerns relating to any compliance related matter should be immediately referred to the Company's Chief Compliance Officer.

B. Written Policies and Procedures

The Company recognizes its obligation to comply with all applicable Medicaid program policies and regulations and all other governing laws and regulations.

The Company will draft, revise, approve and adopt policies and procedures to ensure a sound Compliance Program that is in compliance with section 521-1. The Company will ensure that all such actions are completed with proper oversight by the governing authority and adherence to all applicable Federal and State laws, regulations, and standards.

The written policies and procedures herein describe the compliance program elements, including but not limited to, expectations, obligations, lines of communication, standards of conduct, reporting requirements, etc.

The Corporate Compliance Officer will draft Compliance Program policies and procedures necessary to provide guidance and requirements for significant elements of the program. They will be reviewed by the Compliance Committee and if approved are presented to the Governing Authority for ultimate approval. If approved, they are added

to the Compliance Plan and disseminated to affected individuals. They are also added to the training plan.

The Compliance Plan is reviewed and amended (if necessary) annually, more often, if necessary to determine if they have been implemented, if they are being followed by affected individuals, if they are effective, and whether updates are required.

C. Compliance Officer

The Company will, at all times, have a Chief Compliance Officer ("CCO") who reports to the Chief Executive Officer and provides reports to the Governing Authority.

The Company will ensure that the CCO is allocated sufficient staff and resources to satisfactorily perform their responsibilities for the day-to-day operation of the compliance program based on the company's risk areas and organizational experience.

The Company will ensure that the CCO and appropriate compliance personnel have access to all records, documents, information, facilities and affected individuals that are relevant to carrying out their compliance program responsibilities.

The CCO is Phyllis Robinson.

The CCO can be reached directly as follows:

- by telephone (Office 718-879-1427, Hotline 347-713-2983),
- e-mail (phyllisr@yorkhc.com),
- in person at the corporate office.
- anonymous "drop box" located in the Elm York Assisted Living offices at 100-13 Ditmars Blvd.

Company's CCO will have the following responsibilities:

1. The oversight, monitoring, implementation and maintenance of the Compliance Program and the ongoing evaluating of its effectiveness;
2. Holding and chairing regular meetings with managers and affected individuals regarding the Company's compliance efforts, expectations and results;
3. Providing regular (at least quarterly) reports to the Company's Governing Authority regarding the Company's compliance efforts and strategies to improve the Compliance Program;

4. Regularly revising the Compliance Program to improve the Company's compliance efforts and respond to changes in laws, regulations, and payor health plans.
5. Ensuring that all of the Company's affected individuals have read and understood this Compliance Program, and obtained a signed acknowledgment or a roster record of such;
6. Developing, coordinating, and participating in compliance education and training programs and ensuring that the governing body, and all other affected individuals are properly educated and trained on the compliance program and its policies and responsibilities;
7. Developing corrective compliance action plans and communicating said plans directly to the Company's CEO;
8. Maintaining a reference source related to the compliance process and assuring that all affected individuals periodically review said material;
9. Regularly checking the anonymous "drop box" located in the Elm York Assisted Living offices at 100-13 Ditmars Blvd.
10. Drafting, implementing, and updating this compliance program, at least annually, to conform with changes to Federal and State laws, rules, regulations, policies & standards.
11. Conducting an annual review of Company's compliance efforts and providing the review to the CEO and the Governing Authority. This review includes determining if the written policies, procedures, the training program and the standards of conduct have been implemented and are effective, whether affected individuals are following the policies, procedures, and standards of conduct, and whether any updates are required.
12. Ensuring that the HHS-OIG's List of Excluded Individuals and Entities (http://exclusions.oig.hhs.gov/), the General Services Administration's List of Parties Debarred from Federal Programs- System for Awards Management https://www.sam.gov/index.html, and the OMIG website http://www.omig.ny.gov/ have been checked with respect to all affected individuals and independent contractors.
13. Assisting the Company in establishing methods to improve the efficiency, quality of services, and reducing the vulnerability to fraud, waste and abuse;
14. Investigating and independently acting on matters related to the compliance program, including designing and coordinating internal investigations and documenting, reporting, coordinating, and pursuing any resulting corrective action with all internal departments, contractors and oversight agencies;

15. The compliance officer shall report directly and be accountable to the chief executive .

D. Compliance Committee

The Company shall designate a compliance committee which is responsible for coordinating with the compliance officer to ensure that the Company is conducting its business in an ethical and responsible manner, consistent with its compliance program.

The Company shall outline the duties and responsibilities, membership, designation of a chair and frequency of meetings in a compliance committee charter.

The Company's designation of a compliance committee shall meet the following requirements:

- The compliance committee's responsibilities shall include:
  - coordinating with the compliance officer to ensure that the written policies and procedures, and standards of conduct are current, accurate and complete, and that the training topics are timely completed,
  - coordinating with the compliance officer to ensure communication and cooperation by affected individuals regarding compliance related issues, internal or external audits, or any other function or activity required by Subpart 521-1,
  - advocating for the allocation of sufficient funding, resources, and staff for the compliance officer to fully perform their responsibilities,
  - ensuring that the Company has effective systems and processes in place to identify compliance program risks, overpayments and other issues, and effective policies and procedures for correcting and reporting such issues; and
  - advocating for adoption and implementation of required modifications to the compliance program.
- Membership in the committee shall, at a minimum, be comprised of senior managers.
- The compliance committee shall meet no less frequently than quarterly and shall, no less frequently than annually, review and update the compliance committee charter.
- The compliance committee shall report directly and be accountable to the required provider's chief executive and governing body.

E. Risk Areas

The Company compliance program is developed to address the Company's risk areas, which are those areas of operation that pose the potential for waste, fraud, and abuse. These include:

- billings
- payments
- ordered services
- medical necessity
- quality of care
- governance
- mandatory reporting
- credentialing
- contractor, subcontractor, agent, or independent contract oversight
- Providers excluded from participating in the Medicaid program
- Billing for services by providers who do not have necessary and up to date credentials required by statute or regulation.
- Discriminatory admission and discharge of residents
- Failure of the Company to adhere to ALP/LHCSA licensing requirements
- Failure to comply with conflict-of-Interest statutes, such as:
    - Anti-kickback statute (42 U.S.C. 1320-a-76)
    - Stark physician referral law (42 USC 1395n)
    - Joint ventures between parties, one of whom can refer Medicaid business to the other
- other risk areas that are or should reasonably be identified by the Company through its organizational experience.

The following are areas of potential noncompliance. This list is not all-inclusive of all potential areas of noncompliance; however, affected individuals should pay special attention to the following areas:

FRAUD- an intentional deception or misrepresentation to obtain payment from a governmental healthcare program (e.g., Medicaid)

- Intentionally billing for a more expensive service than was actually provided.
- intentionally billing for services that were not provided at all.
- Intentionally billing for more hours of care than were provided.
- Billing for items or services not actually rendered.

- Duplicate billing
- Failure to promptly notify Medicaid of any known overpayment **within 60 days.**
- Knowing failure to return overpayments made by Medicaid **within 60 days.**
- Billing for anything other than the RUG category assigned by a UAS nurse for whom a current certification has been provided.

WASTE- an act involving payment or the attempt to obtain payment for items or services where there was no intent to deceive or misrepresent, but where the outcome of poor or inefficient methods results in unnecessary costs.

ABUSE- obtaining payment for items or services when there is no legal entitlement to that payment and the individual or entity has not knowingly and/or intentionally misrepresented facts to obtain payment.

- Insufficient documentation for services performed and reimbursement claimed.
- False dating of amendments to documentation
- Falsified plans of care
- Knowingly relying on untimely and/or forged physician certifications on a Medical Evaluation

F. Billing Procedures

Claim Development and Submission Process

It shall be the policy of the Company to adhere to the following:

- Prior to billing, provide for sufficient and timely documentation of all personal care services, including subcontracted services, to ensure that only accurate and properly documented services are billed.
- Ensure that a claim should be submitted only when appropriate documentation is maintained, appropriately organized in legible form, and available for audit and review.
- Provide that the compensation for billing personnel and billing consultants, if any,

does not include any financial incentive to submit claims regardless of whether they meet applicable criteria for reimbursement or accurately represent the services rendered.

- Establish and maintain a process for pre and post submission review of claims to ensure that claims submitted for reimbursement accurately represent medically necessary services that were actually provided, supported by sufficient documentation, and in conformity with all applicable criteria for reimbursement.

In anticipation of claims being made to Medicaid, services should be evaluated for appropriateness and must be consistent with the plan of care.

Authorized Services: Claims should only be submitted for services that the Company has documentation of authorization by the physician or other appropriately licensed individual.

Plan of Care: The Company must take all responsible steps to ensure that the plan of care is developed in accordance with the services authorized by a physician.

The plan of care must be dated, and signed by the LHCSA nurse
The plan of care must be periodically reviewed by the LHCSA nurse

Should the LHCSA nurse determine that the physician's orders are inconsistent with the resident's needs; the LCHSA nurse must notify the ordering physician.

The following are some of the documents that are required, in order to substantiate the ability to bill for ALP services:

- Medical Evaluation (DSS 4449-C) or Interim Medical Evaluation (DSS 4568)
- Uniform Assessment System – New York (UAS)
- Plan of Care
- Service Documentation – Aide Activity Sheet and Toileting Sheet (if the person is on a toileting program)
- Census Confirmation

Preventing and Detecting Fraudulent Activities

Elm York Assisted Living and the ACF/ALP implement the following practices to prevent waste, fraud, or abuse.

1. Billable services are overseen by Nursing Supervisors on a daily and ongoing

basis.

2. All services are attested to by the HHA in writing on the Aide Activity Sheet (AAS) and Toileting Sheet (if applicable).
3. All AASs are reviewed by a member of the quality assurance team.
4. All required documents are reviewed by central compliance staff for each claim date, prior to billing.
5. A claim is not submitted for payment unless all required documents are reviewed and accounted for. Said documents are scanned and electronically stored for safe keeping.
6. Issues of concern are to be brought to the attention of the Corporate Compliance Director for appropriate follow-up.
7. A different member of the Central Compliance Team conducts a quarterly audit of a random sample of patient and employee records, to reconfirm all required documentation is appropriate, properly completed and accounted for.
8. **Excluded Individuals-** In accordance with the requirements of section 515.5, The Company will confirm the identity and determine the exclusion status of affected individuals. The Company will review the following State and Federal databases prior to hire and at least every thirty (30) days:

- New York State Office of the Medicaid Inspector General Exclusion List;
- Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities
- GSA SAM Exclusion List

The Company shall require contractors to comply with the provisions of this paragraph.

G. Conflicts of Interest

It is the Company's policy that all Governing Board members, and all other affected individuals, act in the best interest of the Company at all times, and not engage in any activity in which the individual's private interests' conflict with Company's interests. Generally, a conflict of interest exists when an obligation or a situation resulting from an individual's personal activities or financial affairs may adversely influence his or her judgment in the performance of their duty to the Company. There may be cases in which an apparent conflict of interest is more theoretical than real, but it is important to resolve such concerns promptly.

For the protection of both the Company and the individual, it is essential that potential conflicts of interest be fully disclosed and resolved before they are realized. In all cases where it is unclear whether there is a conflict, the individual should fully disclose the matter to the CCO.

Not all possible conflicts of interest can be anticipated. However, below are examples of certain situations in which a conflict exists or may exist. The purpose of these descriptions is to provide guidance to persons covered by this Program, and to enable such persons to avoid situations in which personal activities and financial affairs are, or may appear to be, in conflict with an individual's responsibility to act in the best interest of the Company.

1. Relationship with Supplier and others whom the Company conducts business

A conflict of interest may exist when a Board member or other affected individual, directly or indirectly, owns an interest in, has a financial relationship with, or serves as a director, Board member, employee, consultant, or agent to an entity that is a supplier or vendor to the Company. This policy does not preclude a Board Member or Company employee from investing in a publicly traded corporation with which the Company does business. However, where a Board member or employee is an investor in, or has a relationship with, a company with which the Company does business, a conflict may exist, and the relationship should be disclosed to the CCO. Approval for the continuance of such relationship must be obtained, in writing, from the CCO.

2. Performance of Work or activities unrelated to Company employment

A conflict of interest may exist when an individual undertakes to engage in an independent business venture or to perform work or service for another business or organization so that the activity prevents such individual from devoting the time and effort required to adequately and professionally fulfill their responsibilities to the Company.

3. Misappropriation of Business Opportunities

A conflict of interest may exist when an individual, without the knowledge and consent of the Company, provides for themselves, or to another person or organization, the benefit of any business venture, opportunity, or potential opportunity that such Affiliate learns about or develops in the course of their duties for the Company and which is related to any current or prospective business of the Company.

H. Compliance Program Training and Education

The Company's compliance training has two essential objectives: (1) to provide training to all affected individuals and companies to prepare them to perform their responsibilities in accordance with this Compliance Program, and (2) advising all affected individuals that adherence to proper compliance practices is a condition of continued employment.

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The Company will maintain a Training and Education Plan that will include annual corporate compliance program training. The training plan shall, at a minimum, outline the subjects or topics for training & education, the timing & frequency of the training, which affected individuals are required to attend, how attendance will be tracked, and how the effectiveness of the training will be periodically evaluated. The Company will provide compliance training & education in a form and format accessible and understandable to all affected individuals, consistent with federal and State language and other access laws, rules or policies.

The training and education shall include, at a minimum, the following topics:

- The Company's risk areas and organizational experience
- The Company's compliance policies and procedures
- The role of the CCO and the compliance committee
- How affected individuals can obtain additional information and clarification.
- The requirement that affected individuals and companies report potential compliance-related issues to the compliance officer and senior management, including the obligation of affected individuals to report suspected illegal or improper conduct and the procedures for submitting such reports
- Protection from intimidation and retaliation for good faith participation in the compliance program and whistleblower protections
- Disciplinary standards, with an emphasis on those standards related to the Company's compliance program and prevention of fraud, waste, and abuse
- How the Company responds to compliance issues and implements corrective action plans
- Requirements specific to the MA program and the Company's category or categories of service
- Coding and billing requirements and best practices, if applicable
- Required service documentation
- Claim development and billing procedures.
- All other matters deemed necessary to effectively train affected individuals in the Compliance Program

New affected individuals will receive compliance training within 60 days of their start date. Thereafter, affected individuals will receive refresher training and updates on an annual basis or more frequently as appropriate.

The Company will utilize appropriate training methods to include distribution and discussion of written compliance material, in-house training, and outside seminars.

Specific elements of compliance training and coding and billing training are described below.

The Company will provide compliance training to all affected individuals, providers and vendors and members of the governing authority. This training will be provided under the direction of the Chief Compliance Officer. All new personnel will receive training regarding the Compliance Program as part of the orientation process. Ongoing training will also be provided with respect to changes in the Compliance Program and new legal and/or regulatory requirements. Training will also focus on targeted risk areas as identified by the CCO. This training will emphasize the importance of sound compliance practices, which are essential to the operation of the Company. The training will happen on scheduled days as well as impromptu as part of the workday activities. All affected individuals will be educated as to their role and obligations in the Compliance Program and the consequences of noncompliance. All compliance training will be documented.

The Company's affected individuals and governing body will receive training which includes:

1. Standards of Conduct
2. Compliance Policies and Procedures
3. Compliance Officer and Compliance Committee
4. Government payor reimbursement principles;
5. General prohibitions on paying or receiving remuneration to induce referrals;
6. Improper alterations of clinical records;
7. Providing personal care services with proper authorization;
8. Maintaining documentation of services rendered;
9. Resident rights and education;
10. Duty to report misconduct;
11. Whistleblower Protections;
12. Disciplinary Standards;
13. Lines of Communication;
14. Responding to Compliance Issues.
15. All other matters deemed necessary to properly and adequately train all affected individuals and companies on the Compliance Plan, Policies and Procedures.

I. Lines of Communication

Open lines of communication are essential to the proper implementation of the Compliance Program. All affected individuals and other persons associated with the provider's Medicaid services are covered by this program and are urged to discuss compliance-related matters and direct their questions to their supervisor and/ or the CCO. Additionally, all affected individuals are advised of the following:

- They must report conduct, which a reasonable person would in good faith, believe to be potential fraud, waste, abuse or erroneous.
- They may report through any of the following means:
  - Anonymously through the "drop" box;
  - Telephone the CCO;
  - E-mail the CCO;
  - Report the activity to a supervisor or to the CCO in person.

- To knowingly fail or refuse to report fraudulent or erroneous conduct is a violation of the Compliance Program and can result in disciplinary action.

All compliance-related questions and/or noncompliance concerns will be promptly addressed by the CCO. The CCO will be responsible for investigating and resolving all reports of fraudulent or erroneous conduct, and to implement appropriate corrective action.

The confidentiality of all individuals who report violations of this compliance plan, including but not limited to fraudulent or erroneous conduct, will be maintained by the Company, unless the matter is subject to a disciplinary proceeding, referred to, or under investigation by, Medicaid Fraud Control Unit, OMIG or law enforcement, or disclosure is required during a legal proceeding, however such persons will be protected under the Company's non-intimidation and non-retaliation policy.

The Company maintains a policy of non-intimidation and non-retaliation for good faith participation in our compliance program including, but not limited to: (a) reporting potential compliance issues to appropriate personnel; (b) participating in investigation of potential compliance issues; (c) self-evaluations; (d) audits (e) remedial actions (f) reporting instances of intimidation or retaliation; and (g) reporting potential fraud, waste or abuse to the appropriate State or Federal entities.

Again, there will be no retribution, intimidation, or retaliation for reporting conduct, which a reasonable person, acting in good faith, would believe to be fraudulent or erroneous, regardless of whether the conduct ultimately proves to be fraudulent or erroneous.

J. Disciplinary Standards

All affected individuals who are responsible for compliance-related violations will be subject to the Company's disciplinary process. Thus, all affected individuals who fail to report suspected problems, participate in non-compliant behavior, or encourage, direct, facilitate or permit, either actively or passively, non-compliant behavior, will be subject to these disciplinary policies. Such policies will be fairly enforced. Discipline may include the following:

- Disciplinary action begins with oral warnings. This level applies to those violations or actions that have little impact and do not violate billing procedure. After correction, additional training will be provided to the affected individual (s) to further educate them on the compliance policies and procedures.
- The next level of disciplinary action is a written warning/reprimand. An example of this would be if it was determined that an affected individual(s) who received a verbal warning prior continued to participate in non-compliant behavior or encourage, direct, facilitate or permit, either actively or passively, non-compliant behavior. Additional training will be provided to the affected individual (s), educating them on the proper compliance policy or procedure. Repeat offenses might require additional written warnings and depending on the circumstances might require termination.
- Depending on the type of non- compliant behavior, an affected individual would face disciplinary action that could include probation, demotion, or temporary suspension. The direct Supervisor and/or the Administrator would review the investigation results and determine which action is indicated.
- Discharge from employment could occur depending on the circumstances and findings of an investigation into non-compliant behavior. The direct Supervisor, the Administrator and Governing Body members would determine if discharge from employment was required.
- Referral to law enforcement and/or oversight agencies, if indicated.

Disciplinary actions shall conform with collective bargaining agreements, when applicable.

Discipline may include the following for providers and vendors:

- Referral for appropriate sanctioning by regulatory agencies and/or criminal prosecution
- Termination of contract, for cause, for any person associated with the provider's Medicaid services by the terms of a contract or other agreement.

K. Auditing and Monitoring

The Company regularly evaluates the effectiveness of its Compliance Program through a monitoring and audit process. The Chief Compliance Officer will be responsible for this ongoing analysis. The key elements of the monitoring and evaluation process are as follows:

- **Internal Compliance Audits**

The Company regularly evaluates the Compliance Program to determine whether its policies and procedures are effective, current, and complete, and whether any revision or corrective action is required. Any MA program overpayments identified will be reported, returned, and explained in accordance with the provisions of Subpart 521-3 and the Company will promptly take corrective action to prevent recurrence.

Whenever the policies and procedures are found to be inadequate, ineffective, or outdated, they will be revised as appropriate (e.g., updates of rate codes, changes in applicable laws and regulations, etc.). Audits focus on the risk areas identified earlier.

The Company engages multiple audit processes to ensure compliance. They include the following:

- Service documentation is reviewed on a daily and weekly basis by compliance staff assigned to the ALP.
- The documentation is thereafter reviewed by a separate member of the compliance team at the corporate office on a weekly basis. Billing is held if the documentation is deemed inadequate to justify submission of the claim. Any compliance concerns or questions are directed to the CCO for review and action, if indicated.
- A separate member of the compliance team reviews a random sample of patient and employee records on a quarterly basis. Any compliance

concerns or questions are directed to the CCO for review and action, if indicated.

- **Internal Audit Key Elements**

The Company's review process conducted by the CCO and/or the compliance committee may include:

- Visits and interviews of residents and/or affected individuals.
- Analysis of service and census records;
- Testing of billing staff regarding reimbursement criteria and official coding guidelines;
- Assessment of existing relationships with physicians, hospitals, and other potential referral sources;
- Examination of the Company's complaint logs;
- Reviewing the personnel records of individuals with past compliance reprimands and monitoring their current compliance performance;
- Interviews with personnel involved in management, operations, claims development and submission, patient care, and other related activities;
- Reviews of clinical documentation, financial records, and other source documents that support claims for reimbursement and Medicaid cost reports;
- Validation of credentials of physicians who authorize services provided by the Company;
- Review of resident care plans and supporting materials and documentation.
- Any other matters, persons and documents deemed germane to the audit.

The Company shall document the design, implementation and results of its effectiveness review, and any corrective action implemented. The results of annual compliance program reviews shall be shared with the chief executive, senior management, the compliance committee, and the governing body.

- **External Compliance Audits**

External audits are performed when required by law or when deemed necessary by the CCO. Additionally, external audits may be conducted by Federal, State, or other oversight bodies.

The design, implementation, and results of any internal or external audits shall be documented, and the results shared with the compliance committee, Chief Executive and the governing body.

L. Response to Compliance Issues

For each instance in which the CCO becomes aware of noncompliance, the CCO must take prompt action to conduct an investigation, and document his or her findings as to the following:

- Whether, in fact, there is noncompliance.
- What parties are responsible for such noncompliance.
- What corrective action plan is appropriate? A corrective action plan may include re-training, disciplinary actions, the formulation of procedures to prevent future noncompliance and other actions to improve the Compliance Program;
- Promptly implement the corrective action
- Determine whether a particular violation is reportable under applicable State or Federal law.

The Company shall document any disciplinary action taken and the corrective action implemented. If there is credible evidence or the CCO/Compliance Committee credibly believes that a State or Federal law, rule or regulation has been violated, the Company will promptly report such violation to the appropriate governmental entity, where such reporting is otherwise required by law, rule, or regulation. The compliance officer will maintain copies of any reports submitted to governmental entities.

M. Anti-Kickback and Self-Referral Policy

The Company complies with Federal and State anti-kickback statutes, as well as the Stark physician self-referral law. These policies provide that:

All of the Company's contracts and arrangements with actual or potential referral services are reviewed and comply with applicable statutes and regulations;
The Company does not submit or cause to be submitted to Federal health care programs claims for patients who were referred to the Company pursuant to contracts or financial arrangements that violate the anti-kickback statute, Stark physician self-referral law or similar Federal or State statutes and regulations;

The Company does not offer or provide gifts, free services, or other incentives to patients, relatives of patients, physicians, hospitals, contractors, assisted living facilities,

or other potential referral sources for the purpose of inducing referrals.

N. Non-Intimidation, Non-Retaliation and Whistleblower Protections

The Company has a policy of non-intimidation, and non-retaliation covering all affected individuals, including Medicaid recipients and their family members, for good faith participation in the Compliance Program, including, but not limited to reporting potential issues, cooperating, or participating in the investigation of issues, participating in self-evaluations, remedial actions, and/or making reports to appropriate officials of inappropriate conduct. Acts of intimidation or retaliation will be considered a significant breach of the Company's Compliance Policies and will be thoroughly investigated and addressed through the disciplinary process, if verified.

Whistleblower laws protect anyone who believes that they have suffered adverse consequences for reporting or filing a complaint.

Adverse actions may include:

- Firing or laying off
- Demoting
- Denying overtime or promotion
- Disciplining
- Denying benefits
- Failing to hire or rehire
- Intimidation or harassment
- Making threats
- Reassignment to a less desirable position or actions affecting prospects for promotion (such as excluding an employee from training meetings)
- Reducing or changing pay or hours
- More subtle actions, such as isolating, ostracizing, mocking, or falsely accusing the employee of poor performance
- Blacklisting (intentionally interfering with an employee's ability to obtain future employment)
- Constructive discharge (quitting when an employer makes working conditions intolerable due to the employee's protected activity)

- Reporting or threatening to report an employee to the police or immigration authorities

Anyone perpetrating an adverse action against someone who files a complaint will be considered to have violated the Company's Compliance Policies. The matter will be thoroughly investigated and addressed through the disciplinary process, if verified.

O. Records Retention

The Company will retain all records demonstrating that it has adopted, implemented, and operated an effective compliance program and has satisfied the requirements of Subpart 521-1, for a minimum of six years. The Company will make available to the Department of Health, OMIG, and Medicaid Fraud Control Unit (MFCU) upon request, copies of such records.

P. New Employee Policy

- For all new affected individuals with discretionary authority to make compliance decisions or with compliance oversight, the Company will conduct a reasonable and prudent review of the information obtained during the application process including a reference check as part of evaluating candidates for employment by Company.
- The Company will not employ those for whom a recent conviction of a criminal offense related to health care or a dependent population is uncovered through the application process.
- The Company will prohibit the employment of individuals that are ineligible for participation in federal health programs.

Q. Certification

Required providers, including the Company are required to certify to the Department of Social Services, upon enrollment and annually thereafter, using a form and manner required by OMIG and the Department, that the required provider has met the requirements of section 363-d of the Social Services Law and this Subpart (521-1).

R. Annual Financial Report

The Company will submit Annual Financial reports to the New York State Department of Health, as required. It is the Company's policy to supply complete and accurate data for such reports.

S. Applicable Laws

- **Federal False Claims Act (31 U.S.C 3729-33)**

The federal government has enacted criminal and civil laws pertaining to the submission of false or fraudulent claims for payment or approval to the federal and State governments and to private payors. These false claims laws, which provide for criminal, civil, and administrative penalties, provide governmental authorities with broad authority to investigate and prosecute potentially fraudulent activities, and also provide anti-retaliation provisions for individuals who make good faith reports of waste, fraud, and abuse. This Act imposes significant liability on providers who submit a "false claim". A "false claim" includes- as an example- billing for services not provided, billing for services in which the provider falsely certified compliance with a law, rule, or regulation or certified that the services were provided and failure to report and return an overpayment.

- **Deficit Reduction Act of 2005**

  Requires the education and training of all affected individuals on Federal and State false claims laws, whistleblower protections and Company policies and procedures for detecting and preventing fraud, waste, and abuse.

- **New York State False Claims Act (NY Fin. Law 187-194)**

On April 9, 2007, the New York State government enacted the New York False Claims Act ("New York FCA"), which imposes civil penalties on anyone who submits false or fraudulent claims for payment or approval to the State governments and to private payors. This false claims act provides state and local governmental authorities with broad authority to investigate and prosecute potentially fraudulent activities, and also provides anti-retaliation provisions for individuals who make good faith reports of fraud, abuse, and waste.

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- **Social Security Act, Section 1902 (a)(68)(A): Sec. 1902. [42 U.S.C. 1396a]**

A State plan for medical assistance must— provide that any entity that receives or makes annual payments under the State plan of at least $5,000,000, as a condition of receiving such payments, shall—

establish written policies for all employees of the entity (including management), and of any contractor or agent of the entity, that provide detailed information about the False Claims Act established under sections 3729 through 3733 of title 31, United States Code, administrative remedies for false claims and statements established under chapter 38 of title 31, United States Code, any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs.

Other Fraud Laws include the Federal Criminal Health Care Fraud Law (18 USC Section 1347), Federal Program Fraud Civil Remedies Act 31 USC 3801-12, the NYS Criminal Health Care Fraud Law (Penal Law Section 177.00 et seq.), Social Services Law 145-b, and 366-b.

Consistent with this Compliance Program, the Company bills only for services that are actually ordered, coded accurately, and documented as a medical necessity. It is the responsibility of every employee of these entities to be familiar with this Compliance Program and to be sensitive to any situations that may violate it and their obligation to report such violations. Claims of ignorance, good intentions and bad advice are not acceptable as excuses for non-compliance. Those in supervisory positions have the additional responsibility to verify that supervised personnel understand and comply with the standards of professional and business conduct set forth in this Compliance Program.

The Company expects all personnel will act in accordance with the standards of conduct, that all personnel must refuse to participate in unethical or illegal conduct, and all personnel must report any unethical or illegal conduct to the Chief Compliance Officer.

IV. ADOPTION BY THE GOVERNING AUTHORITY

This Compliance Program has been adopted by the Governing Authority as of the 23rd day of September, 2009 and amended on May 30, 2010, September 5, 2011, February 2, 2012, January, 2013, April 2018, April 2019, December 7, 2021, December 16, 2022, April 27,2023, and March 26, 2024.

The Compliance program was reviewed with no amendments occurring on March 29, 2013, February 2014, November 7, 2014, January 2015, January 2016, May 30 2017, February 2020, March 24, 2025.

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ACKNOWLEGEMENT FORM

I, _____, hereby acknowledge that I have received training on, reviewed, understand, and received a copy of Company's Corporate Compliance Program. If at any point I have questions regarding my obligations under the Compliance Program, I shall obtain clarification from the Chief Compliance Officer. If I suspect or am aware of any conduct that may be fraudulent or erroneous, I understand that I am obligated to report this conduct to the Chief Compliance Officer. I understand that I will not suffer any retribution, intimidation, or retaliation for reporting such conduct. I further understand that I may be disciplined if I do not report conduct which I suspect or know is fraudulent or erroneous.

Signed: _____

Date: _____

Elm York/ Madison York Rego Park/ Madison York Assisted Living is committed to providing equal housing opportunity. As part of this commitment, we will modify our rules, policies, practices, and services to meet the needs of individuals with disabilities upon request if the accommodation is reasonable and necessary to allow you to fully use and enjoy residing in our community.

It is our policy to reject reasonable accommodation requests only when they are not related to a disability-based need, impose an undue financial and administrative burden, or fundamentally alter the nature of the services we provide. In such case, we will discuss reasonable alternatives that may meet the requesting individual's needs. We will bear any incidental costs of providing a reasonable accommodation.

Procedure for making request
Requests for reasonable accommodation may be submitted in writing. If you need a reasonable accommodation due to a disability, we encourage you to submit the attached form. The request need not be in writing to be considered. Nor must it be made using the attached form to be considered a valid request for a reasonable accommodation.

If you are making a reasonable accommodation request to us, fully describe the required accommodation on the Reasonable Accommodation Request Form. Please include any additional information that you believe would be useful in assisting us to evaluate the request.

Verification and Documentation
If your disability or disability-related need is not obvious, we may request that you provide verification that you have a disability-related need for the request accommodation. If you are an application for admission and your disability-related need is documented in your medical evaluation or nursing assessment, we will let you know if we require further documentation.

Providing disability-related accommodations
We will discuss your request for a reasonable accommodation with you. If the accommodation is approved, we will provide a letter explaining how and when the accommodation can be provided.
If a specific accommodation cannot be made because it is an undue financial and administrative burden or because it would be a fundamental alteration of the services

provided by us, then we will discuss alternative accommodations that may address your disability-related need. If no alternative meets your disability-related needs, or if you and the facility cannot agree on a reasonable alternative, we will notify you of the denial in writing in a reasonable amount of time and will provide an opportunity for you to make a revised reasonable accommodation request. If your request is part of your application for admission, we will address it in writing as part of our application denial.

Reasonable Accommodation Request

Name: _____

Address:

_____

_____

_____

Phone: _____

I am requesting a reasonable accommodation on behalf of: _____
(Name of person or self)

Please describe the reasonable accommodation you are requesting and the disability-related reason for your request:

_____

_____

_____

_____

Date: _____ Signature: _____

This form, along with any additional information, should be submitted to: Admissions Director

If you have any questions, please contact the Admissions Director

For office use only

□ Approved
□ Denied Reason: _____

Elm York/ Madison York Rego Park/ Madison York Assisted Living do not discriminate against any person on basis of race, color, national origin, religion/creed, sex, disability (including the use of a wheelchair), marital or partnership status, age, sexual orientation, gender identity, lawful source of income, immigration status, lawful occupation, status as a victim of domestic violence, or military status.

Elm York/ Madison York Rego Park/ Madison York Assisted Living does not discriminate and does not permit discrimination including, but not limited to, bullying, abuse, harassment, or differential treatment on the basis of actual or perceived sexual orientation, gender identity or expression, or HIV status , or based on association with another individual on account of that individual's actual or perceived sexual orientation, gender identity or expression, or HIV status.

Residents may file a complaint with the office of the NYS long-term care Ombudsman program 800-994-6494 if you believe that you have experienced this kind of discrimination.

Policy:

The ACF ("Company") will require that all managers, supervisors and staff adhere to sound principles of proper conduct at all times and in all activities that reflect on the services, activities, reputation, and professional standing of the Company in the community and with regard to the residents and families currently being served, previously served or potentially served by the Company.

1. Conflicts of Interest

Employees should always act in the best interest of the Company and not permit outside interests to interfere with their job duties. The company prohibits employees from using their position with the Company or the Company's relationship with its clients, vendors, or contractors for private gain or to obtain benefits for themselves or members of their family.

For purposes of this policy, a potential conflict of interests occurs when an employee's outside interests (for example, financial or personal interests) interfere with the Company's interests or the employee's work-related duties. For example, a conflict of interest can occur when an employee is in a position to influence a decision that may result in a personal gain for the employee or the employee's family member as a result of Company's business dealings.

If you have a question about whether a situation is a potential conflict of interest, please contact the Human Resources Department.

2. Favors and Gifts

Business decisions should be made in the best interests of the Company. The Company prohibits employees from seeking or accepting any gifts, favors, entertainment, payment or loans for themselves or their family members from any client/vendor/supplier/contractor or other party doing business with the Company. If an employee violates this policy, the Company will take prompt corrective action, including discipline, if appropriate. Accepting a gift from a client may result in a violation of state and/or federal law and may result in termination.

3. Romance in the Workplace

In order to minimize the risk of conflicts of interest and promote fairness, the company maintains the following policy with respect to personal relationships in the workplace:

No person in a management or supervisory position shall have a romantic or dating relationship with an employee whom he or she directly supervises or whose terms or conditions of employment he or she may influence (examples of terms or conditions of employment include promotion, termination, discipline and compensation). In addition, no employees working in the same department shall have such a relationship. A department is defined as a group of employees who report directly to the same supervisor.

To the extent possible, a supervisor or manager who has had a previous romantic or dating relationship with a subordinate or employee whose terms and conditions he or she may influence will not be involved in decisions relating to that individual's promotions, raises, termination or other terms and conditions of employment.

All employees engaged in a romantic or dating relationship are required to notify the Human Resources Department. At the discretion of the Company, one of the individuals involved in the relationship may be subject to transfer or termination of employment.

4. Relationships with Clients

All employees are prohibited from dating current or previous clients where no pre-existing relationship existed prior to the employee's hire date. All professionals must comply with the requirements of their respective professional ethical rules with regard to relationships with clients. In the event an employee has a relationship with a client that disrupts the Company's workplace, impacts client care, or gives rise to a legitimate ethical concern, the Company, at its discretion, may discipline or terminate the employee's employment.

5. Standards of Conduct

Violation of this Standards of Conduct policy may lead to disciplinary action, which, based on the circumstances of the individual case, could result in corrective action up to and including discharge. The following is a non-exhaustive list of conduct that may violate this Policy:

- Misrepresentation or omission of facts in applying for or maintaining employment, including the falsification of references.

- Being rude or discourteous to clients, other employees, vendors, doctors or other business contacts.
- Falsifying records.
- Engaging in fraud.
- Removing employer property from the premises without authorization.
- Stealing or attempting to steal client, employer or employee property.
- Taking the Company's property for personal use, without management approval.
- Excessive unexcused tardiness or absences.
- Engaging in poor or improper timekeeping.
- Fighting on employer property at any time.
- Violation of the Company's Drug and Alcohol policy.
- Theft of medications from worksite or client.
- Leaving your work area without permission.
- Violation of the Company's Equal Employment Opportunity and/or Harassment and/or Sexual Harassment policies.
- Violation of any Company rule or policy.
- Substandard work performance.
- Mishandling or unauthorized use of equipment or supplies.
- Submission of false or inaccurate claim information to payors.
- Smoking in unauthorized areas.
- Presence in unauthorized or non-assigned areas.
- Failure to wear your assigned Company identification badge while at work, if required.
- Refusal to wear or use designated protective clothing and/or equipment.
- Willfully violating or disregarding safety regulations.
- Failure to immediately (within 1 hour of occurrence) report a personal on the job injury.
- Offering, soliciting or accepting a bribe, loan, gift or gratuity in violation of Company policy.
- Violation of the dress code.
- Lack of personal cleanliness and acceptable grooming.
- Failure to report a communicable disease.
- Failure to observe fire rules.
- Posting or removing notices or literature from bulletin boards or other areas without authorized permission.
- Refusal to submit packages/bags for inspection upon request of a supervisor prior to leaving the premises.
- Harassing, intimidating, coercing, threatening, assaulting, discriminating against or otherwise interfering with the rights of another employee, applicant, client, client's family member, or visitor.

- Refusing to work assigned overtime.
- Unauthorized sale or soliciting of sales, of any item(s) or product(s).
- Refusal to carry out any reasonable work-related assignment, instruction or regulation, or disruption or attempted disruption of the Company's operations or business.
- Gambling on employer premises at any time.
- Sleeping on the job.
- Using offensive or profane language on the Company's premises.
- Bringing dangerous or unauthorized weapons onto employer premises.
- Disclosing Protected Health Information to unauthorized third parties.
- Unauthorized disclosure of business secrets or other confidential information.

The Company may consider an employee's job performance, prior violation of work rules, and other relevant circumstances in determining whether to counsel, warn, suspend or discharge an employee. It is up to the employee's supervisor and the Company's management to decide whether corrective action, up to and including dismissal, is appropriate.

Employees are required to inform Human Resources of any outside employment for evaluation of potential conflict. Any outside employment of employee must be disclosed if existing when hired by YORKMG. YORKMG, at its sole discretion, will determine if employee's outside employment interferes or conflicts with the performance of employee's duties for YORKMG. Employee may not use YORKMG's property or time scheduled to work for YORKMG for conducting outside employment.

6. Dress Code and Grooming

The Company strives to maintain a professional atmosphere that is conducive to our business environment, contributes to the morale of all employees and projects an image of efficiency and professionalism. Employees are relied upon to exercise common sense and good judgment regarding their clothing and appearance in the workplace and to dress in a manner that is consistent with the goals of this policy. Generally, employees should maintain a clean and neat appearance in the workplace and dress according to the requirements of their positions, which may include concerns regarding safety/interactions with clients/customers and accurately representing our organization's image to the public.

Any employee who is not dressed in proper professional attire consistent with this policy will be considered unsuitable to work and may be asked to go home and return to work appropriately dressed. In such a case, the employee will not be compensated for time spent away from work. Employees who disregard this policy and its standards will be subject to discipline.

Company Identification Tags must be worn by all staff and must be visible at all times while on duty.

Any questions about the requirements of this policy or what constitutes appropriate workplace attire should be directed to the employee's supervisor or the Human Resources Department.

General Guidelines:
The Company maintains a business casual environment, but some clothing and grooming guidelines should be observed. Below are general guidelines outlining examples of acceptable and not acceptable workplace attire. Since it is impossible to list every type of clothing, this list is intended as guidance only and should not be considered a complete list.

Staff must adhere to uniform requirements for their specific work location, if a uniform is so mandated.

- Direct Care Staff (Nursing, Home Care, etc.):

  Providers may wear scrubs and/or business casual attire with or without a lab coat. Co-employer requirements (e.g. Home Health Aide dress code) supersede this provision.

- Administrative and Client Services (Case Management, etc.): Business Casual

Examples of appropriate clothing for employees working within the administrative office include:

- Slacks (no Jeans)
- skirts (no shorter than 4 inches above the knee) dresses (no shorter than 4 inches above the knee)
- capris (below the knee) button down shirts w/ collar
- sweaters/cardigans blazers/vests
- blouses
- dress shoes, dress sandals, loafers, boots
- sleeveless blouses (permitted if fitted appropriately to arm)

Example of clothing that are <u>not</u> appropriate include:

- jeans
- shorts of any kind

- skirts and dresses shorter than four (4) inches above the knee
- t-shirts
- tank tops
- track suits, sweat suits, spandex, or any type of gym/work-out wear
- sweatshirts
- sleeveless tops
- midriff-baring tops or any clothing that is too revealing (too low cut, midriff showing, exposed undergarments)
- baseball caps/hats/knit caps
- flip flops/heels over 4 inches
- clothing with rips or holes
- open-toed shoes
- Crocs

- Support Services Staff (Medication Assistance, Housekeeping, Maintenance, Kitchen, Dining Room, etc.)

Uniform attire as required by work duties and work location.
Comfortable and safe footwear (i.e. closed toe shoes, no sandals/flip flops, etc.).
Personal protective equipment as required to safely perform the assigned tasks.

Employee shall not have visible tattoos that are offensive. The wearing of nose rings shall be limited to small post nose rings or otherwise in good taste and within generally accepted office standards for personal appearance. Employer reserves the right to request an employee cover any visible body tattoo consistent with this policy and generally accepted office standards for personal appearance. Employees shall not wear oversized grommet or gauge style earrings unless covered or capped. Hair is to be clean, well groomed, and a natural color (i.e. no pink, orange, blue). Distracting extremes in hair styling, dyeing, bleaching, coloring and shaving designs into the hair are not permitted. Hair and hair accessories must not be distracting or extreme.

Any employee requiring an accommodation of this policy as a result of religious beliefs or a disability should contact Human Resources.