CORPORATE COMPLIANCE PLAN
(the "Plan")

Palatine Nursing Home

ACKNOWLEDGMENT – EMPLOYEES, CONTRACTORS, AND HEALTH CARE PROFESSIONALS

I _____, (print name) _____ (title) have received a copy of the Corporate Compliance Plan descriptions and Standards of Conduct of Palatine Nursing Home.

I acknowledge that:

a. I have received and reviewed Palatine's entire Plan (including all attachments and exhibits). The Plan is available for my reference on the facility's website, shared drive or in the Corporate Compliance Binder located in the upper cabinet outside the Supply Room in the main corridor. I understand the content of this Plan as it applies to me and am fully aware that I must comply with the Plan. I will cooperate fully with the Compliance Officer to the extent necessary or helpful to the implementation of the Plan.

b. Questions and concerns shall be directed to my supervisor or the Compliance Officer without fear of retaliation or retribution.

c. I received in-service training on Palatine's compliance plan and was given the opportunity to ask questions.

d. It is my duty and responsibility to report any, and all actions that I suspect may be instances of noncompliance to the Compliance Officer. I may report such instances as detailed in this Plan without fear of retaliation or retribution.

e. I have not been convicted of an offense that would preclude employment or contractor status in a nursing home and I am not excluded from participation in any federal or state healthcare programs.

f. I will adhere to Palatine's compliance plan, policies, and procedures.

g. A violation of the Standards of Conduct or the facility's policies and procedures, including failure to report noncompliance, will result in one or more disciplinary actions as appropriate, up to and including discharge.

I understand that it is my responsibility to read and become familiar with all information in the body of this Plan. Should there be any questions about the content of the Plan, it is my responsibility to contact Palatine's Compliance Officer for clarification.

Signature: _____

Date: _____

Table of Contents

PALATINE NURSING HOME

CORPORATE COMPLIANCE PLAN

INTRODUCTION

Palatine Nursing Home ("Palatine") is dedicated to furnishing quality nursing care in accordance with all pertinent laws and professional standards of care. In recognition of the complexity and continual changes in various federal and state laws and regulations governing the health care industry, the implementation of compliance plans has become an important part of ensuring conformity with existing law. A compliance plan is a series of internal controls that promote the prevention, detection and resolution of conduct that is illegal or that does not conform to a company's ethical standards. A compliance plan is intended to be a routine part of a company's operations.

This Compliance Plan (the "Plan") covers all parts of Palatine's operations. Its implementation is intended to ensure that Palatine and its employees act in conformity with all applicable federal, state, and local laws relating to the provision of health care services, and the program requirements of government and commercial health plans. This Plan focuses on, but is not limited to, billing, coding, and claims submission, as well as relationships with patients and other health care providers.

The Plan, having been approved by Palatine's owner/operator, constitutes official corporate policy. It applies to Palatine staff (W-2 employees and 1099 contractors, including executives), officers, directors, and members (together, "Palatine Personnel"), physicians rendering services to Palatine residents, vendors that provide healthcare-related services to Palatine, and Palatine's residents and their families.

At the heart of the Plan are the Standards of Conduct which establish the performance expectations under which all Palatine Personnel will carry out their responsibilities.

Palatine Personnel are representatives of Palatine. In order for the Plan to operate successfully, each individual must recognize that he or she has assumed a number of ethical and professional responsibilities, including adhering to the fundamental principles of this Plan, complying with the Standards of Conduct, and reporting violations of our Standards of Conduct.

Palatine Personnel are encouraged to raise questions about any activity they think may be inappropriate, and to direct these questions to Palatine's Compliance Officer. Palatine Personnel are expected to report violations of the Standards of Conduct to the Compliance Officer. The Compliance Officer has the responsibility of reviewing and evaluating all questions and reports. The Compliance Officer is also responsible for assisting management in undertaking any corrective action, if corrective action is necessary. The Compliance Officer will be responsible for monitoring the effectiveness of the corrective actions and for reporting back to management the resolution of the issue or the need for additional actions.

It is our intention that Palatine provide an environment and a process where honest feedback may be provided without fear of retaliation. Questions or reports of potential violations may be made:

- in person to Palatine's Compliance Officer (Roxanne Barrett), your supervisor or any management employee;
- by telephone to Palatine's Compliance Officer at (518) 673-5212, ext. 202; or by e-mail to Palatine's Compliance Officer at rbarrett@palatinenh.com
- by submission of a written Report Form to the Compliance Officer (which can be placed in an envelope marked "*personal and confidential/to be opened only by addressee*"); or
- by dropping a written Report Form in the dedicated locked box located outside the supply room in the main corridor

Palatine will keep confidential the reporting person's identity unless the matter is turned over to law enforcement (or disclosure is required for other legal reasons). A blank Report Form is attached to this Plan.

Questions or reports may be raised anonymously by dropping the Report Form in Palatine's dedicated lock box or by submitting a Report Form in an envelope marked "*personal and confidential/to be opened only by addressee.*" As it is more difficult to explore issues raised anonymously, reports where the person making the report identifies him/herself are preferred. If you decide to raise a question or make a report anonymously, please be as detailed as you can to assist the Compliance Officer to adequately investigate your concern.

It is the obligation of all Palatine Personnel, regardless of position or title, to follow the Standards of Conduct. Any violation of the Standards of Conduct is a serious matter. In no event shall any Palatine Personnel attempt to conceal or cover up any potential wrongdoing by Palatine, its employees, its agents, or its associates. Any individual or entity attempting to conceal or cover up any such act shall be deemed to be acting outside the scope of his/her employment or contractual duties.

Under appropriate circumstances, and after proper procedures have been followed, violation of the Standards of Conduct may subject Palatine Personnel to discipline up to and including termination. To reiterate, however, there will be no retaliation by Palatine or Palatine Personnel resulting from the making of a credible report of a violation of the Standards of Conduct.

The Palatine Standards of Conduct do not constitute an employment contract or any other type of contract. No one should interpret any of the Standards of Conduct or the Compliance Plan as a promise of continued employment or any other continued contractual or other relationship.

Under the Affordable Care Act Section 6102 and 6401(a), Palatine is required to develop a compliance and ethics program that is effective in preventing and detecting criminal, civil, and administrative activities and in promoting quality of care. The Affordable Care Act established the following required components, all of which have been considered and incorporated into this overall Plan:

(1) The facility must have established compliance standards and procedures to be followed by its employees and other agents that are reasonably capable of reducing the prospect of criminal, civil, and administrative violations under the Affordable Care Act.

(2) Specific individuals within high-level personnel of the facility must have been assigned overall responsibility to oversee compliance with such standards and procedures and have sufficient resources and authority to assure such compliance.

(3) The facility must have used due care not to delegate substantial discretionary authority to individuals whom the organization knew or should have known through the exercise of due diligence, had a propensity to engage in criminal, civil, and administrative violations under the Act.

(4) The facility must have taken steps to communicate effectively its standards and procedures to all employees and other agents, such as by requiring participation in training programs or by disseminating publications that explain in a practical manner what is required.

(5) The facility must have taken reasonable steps to achieve compliance with its standards, such as by utilizing monitoring and auditing systems reasonably designed to detect criminal, civil, and administrative violations under the Affordable Care Act by its employees and other agents and by having in place and publicizing a reporting system whereby employees and other agents could report violations by others within the organization without fear of retribution.

(6) The standards must have been consistently enforced through appropriate disciplinary mechanisms, including, as appropriate, discipline of individuals responsible for the failure to detect an offense.

(7) After an offense has been detected, the facility must have taken all reasonable steps to respond appropriately to the offense and to prevent further similar offenses, including any necessary modification to its program to prevent and detect criminal, civil, and administrative violations under the Affordable Care Act.

(8) The facility must periodically undertake reassessment of its compliance program to identify changes necessary to reflect changes within the organization and its facilities.

Additionally, the Federal Deficit Reduction Act of 2005 required the facility to adopt a Deficit Reduction Act Policy (which is attached here and made a part of this Plan as **Appendix B**, as amended). Furthermore, the New York State Office of Medicaid Inspector General required the facility to adopt and maintain a Medical Assistance Provider Compliance Plan (which is attached here and made a part of this Plan as **Appendix C**, as amended).

Palatine's Plan also incorporates the Federal government's compliance program guidelines (including the Office of Inspector General Compliance Program Guidance for Nursing Facilities, dated March 16, 2000, and the Supplemental Guidance, dated September 30, 2008, attached as part of **Appendix C**) including Federal Sentencing Guidelines and has been tailored to fit the needs of our facility.

Additional compliance requirements and obligations of the facility will be incorporated into this Plan as further appendices/attachments.

Palatine's Plan demonstrates the facility's policies and commitment to honest and ethical behavior in all aspects of our delivery of services to residents and relations with third-party payors, employees, agents, and independent contractors. The Plan will provide guidance to employees and health care professionals and will aid in preventing fraud, waste, and abuse while providing high quality care to our residents. The procedures and standards contained in this Plan are intended to generally define the scope of conduct which the Plan is intended to cover and they are not to be considered as all-inclusive. We are committed to devoting the time, energy, and resources necessary to maintain (and update as necessary) an effective Plan.

STANDARDS OF CONDUCT

General Matters

1. Palatine Personnel must cooperate fully and completely with any compliance program or initiative instituted by Palatine.

2. Palatine Personnel must fully and completely comply with Palatine policies and procedures, including any compliance policies and procedures.

3. Violations or suspected violations of the Plan, these Standards, or Palatine policies or procedures must be reported immediately to Palatine's Compliance Officer through any of the available reporting mechanisms. Palatine, through the Compliance Officer, will investigate reports promptly and fully, as appropriate under the circumstances.

4. Palatine Personnel will be open and honest in their business relationships with other Palatine Personnel and, to the extent appropriate, Palatine agents, such as consultants, accountants and outside counsel. Palatine encourages a free flow of information among these individuals. Palatine Personnel are expected to assist in the resolution of any compliance issues that may arise. In response to a request for information from senior management, ownership, the Compliance Officer or Palatine legal counsel, no Palatine Personnel shall knowingly fail to deliver the requested or relevant information, or information that Palatine Personnel should have known was requested or relevant. Similarly, no Palatine Personnel shall provide information that is inaccurate, misleading, or incomplete, or information that the Palatine Personnel should have known was inaccurate, misleading or incomplete.

5. Palatine maintains a policy of non-intimidation and non-retaliation for good faith participation in its Compliance Plan, including but not limited to reporting potential issues, investigating issues, audits and remedial actions, and reporting to appropriate officials as provided in Sections 740 and 741 of the New York State Labor Law.

Quality of Care

1. Palatine is committed to providing care and services necessary to attain or maintain a resident's highest practicable physical, mental, and psychosocial well-being.

2. Palatine observes government regulatory requirements for admission and retention of residents.

3. Palatine has systems in place to ensure that residents receive medications as prescribed.

4. Palatine is committed to maintaining adequate staffing levels and systems of staff training and supervision to ensure quality of care. All Palatine professional staff shall be licensed and skilled at the services they perform, as appropriate and required by law.

5. Special attention is paid to common clinical complications experienced by nursing home residents, including pressure ulcers, dehydration, malnutrition, incontinence, fecal impaction, depression and other mental or psychosocial problems, and medication side-effects and incompatibilities.

6. Every attempt will be made to prevent falls, injuries and elopements to the extent possible.

7. All treatment recommended and provided to residents will be medically necessary and consistent with accepted professional standards of nursing care.

8. Any telephone inquiry by a family member concerning treatment or care of a resident shall be referred to the administrator, director of nursing or physician, as appropriate, and the inquiry.

Resident Rights

1. Residents are admitted, and all services are provided, without discrimination based on an individual's race, color, religion, national origin, gender, marital status, sexual orientation, age, disability or any other characteristic/suspect classification covered by applicable laws and regulations.

2. Palatine endeavors to provide culturally-sensitive care.

3. Palatine residents shall be free of verbal, mental and physical abuse. Any allegations or suspicions of resident abuse or neglect shall be promptly and thoroughly investigated and reported as required under applicable laws.

4. Efforts will be made to manage behavioral problems without unnecessary use of physical or chemical restraints.

5. Residents and their representatives will be accorded appropriate confidentiality, privacy, security, counseling and opportunities for resolution of complaints.

Business Conduct

1. Palatine intends to comply with all federal, state and local laws and regulations.

2. Palatine will not directly or indirectly pay or receive from any person or entity anything of value in exchange for resident referrals or the purchase of any health care item or service in violation of state or federal law. No Palatine Personnel shall offer any financial inducement or gift to prospective residents in order to encourage them to receive services from Palatine.

3. Palatine shall not enter into any financial relationships with any physicians or entities who make referrals to Palatine, except to the extent permitted by federal and state law.

4. Palatine records and documents, including medical records and billing records, will be maintained in accordance with Palatine's records retention program. Documents will be destroyed consistent with this program as well.

5. Palatine's business and resident records are of a highly confidential nature. Except as authorized or required by law, they shall not be disclosed or discussed with anyone not employed by or affiliated with Palatine without the written permission of Palatine or the relevant resident. All disclosures shall be made in accordance with New York and federal rules regulating privacy of individually identifiable health information.

6. All medical records will be, to the best of the Palatine's ability, accurate, complete, and at least as detailed as required by government standards. No alteration may be made to medical records unless the alteration is consistent with applicable standards of practice. Complete medical records will be readily retrievable and available as required under New York and federal law, and certain fees for duplication may apply.

7. Palatine will be forthright and candid in dealing with any governmental inquires. Designated staff will respond to any requests for non-privileged information with complete, factual, and accurate information tendered with a cooperative attitude. Requests for privileged materials will be considered on an item-by-item basis.

8. All advertising, including Internet advertising, shall comply with federal and state laws and regulations.

9. A master copy of Palatine's current Corporate Compliance Plan will be maintained in the cupboard outside of the Supply Room for viewing by all Palatine Personnel upon request.

Billing Practices

1. Palatine Personnel, to the extent applicable to their operational functions, are required to comply with all billing and claims submission requirements promulgated by federal, state and other payors. Palatine will provide training to all billing personnel.

2. Among other rules, billing personnel follow the billing and coding rules and recommendations issued by the Centers for Medicare and Medicaid Services ("CMS"), the Medicare Fiscal Intermediary, the New York State Department of Health, and other applicable regulatory health oversight agencies.

3. Palatine Personnel will secure an appropriate physician's order for services performed.

4. Resident records used as a basis for claims submission will be appropriately organized in a legible form.

5. Proper and timely documentation of all services will be maintained in accordance with federal and New York State regulation.

6. All MDS and other coding related to billing will be accurate and complete.

7. Under no circumstances will claims be submitted for services not performed, or for a level of service that exceeds the level of service actually provided.

8. Compensation for billing staff and billing consultants will not provide any financial incentive to improperly code claims.

9. Residents will be billed any co-payment and deductible amounts after the payor's payment to Palatine. Palatine shall not waive resident co-payments or deductibles unless the resident has demonstrated legitimate financial need, as determined on a case-by-case basis. Financial need must be documented and maintained in the resident's file.

10. Palatine will work towards refunding any resident's credit balance within all applicable federal and state guidelines after receipt from the payor.

Employee Screening

1. Palatine investigates the backgrounds of all professional employees by checking all applicable licensing and certification authorities and the nurse aide registry. Specifically, background investigations shall also include the mandatory exclusion checking required by federal and state law. Such exclusion checking shall apply to employees, contractors/consultants, vendors, and others at the facility and shall consist of, at a minimum, checking (or utilizing an outside vendor to check) the following sources of exclusion and related information:

   - OIG's List of Excluded Individuals/Entities: (http://exclusions.oig.hhs.gov)
   - New York Office of the Medicaid Inspector General/List of Excluded Individuals: (http://omig.ny.gov/search-exclusions)
   - System for Award Management/Parties Excluded from Federal Procurement and Non-procurement Programs: (https://www.sam.gov)
   - Such other sources of exclusion that should be checked as required by law or contractual agreement

   Such websites/databases (as updated) shall be checked by the facility at least **monthly**.

   The following database shall also be checked as required by law:

   - State Registry of Nurse's Aides: (1-800-918-8818) (https://registry.prometric.com)

2. Palatine does not employ or contract with any individual or entity who is currently excluded from participation in Medicare, Medicaid or any other federally or state funded healthcare program.

3. All Palatine Personnel must notify Palatine's Compliance Officer immediately if he or she is excluded, suspended, debarred, or removed, whether voluntarily or involuntarily, from any government or commercial payor or plan.

Conflicts of Interest

1. All Palatine Personnel have agreed to devote substantially all of their time, energy, and ability to the business of the Palatine. Therefore, it is the responsibility of staff and employees to avoid conflicts of interest. A conflict includes any act that results in compromising one's responsibility to Palatine, such as accepting gifts or other items of value from residents or vendors.

2. No outside employment is permitted if it interferes or conflicts with the employee's ability to fulfill his or her responsibility to Palatine.

3. Employees must refuse gifts, loans, or anything of value offered by outside companies or individuals, including residents and families.

4. All decisions by Palatine Personnel relating to the company's operations must be made in the best interest of Palatine's residents and Palatine, and no considerations may undermine this fundamental commitment.

COMPLIANCE PLAN OPERATIONS

A. Compliance Officer

The Plan provides for a Compliance Officer who has been appointed by the Palatine Operator. The Compliance Officer reports directly to the Operator.

The Compliance Officer has overall responsibility for the development, implementation, maintenance, and periodic revision of this Plan. Carrying out this obligation requires the Compliance Officer to assist the Palatine leadership in developing methods to reduce the facility's vulnerability to fraud, abuse, and waste; oversee the development of compliance policies and standards; oversee the activities of the Compliance Committee; provide general assistance and guidance to the Compliance Committee; take whatever action is necessary to investigate a complaint and institute corrective action; and report periodically to the Palatine Operator. The Compliance Officer is responsible for carrying out the day-to-day Plan operations.

The Compliance Officer shall work with Palatine's Compliance Committee, which Committee is described below.

B. Compliance Committee

Palatine's Compliance Committee shall perform the following activities in connection with this Plan:

1. Meet no less frequently than quarterly and shall, no less frequently than annually, review and update the Compliance Committee Charter.

2. Meet periodically with the Compliance Officer, at minimum, on an annual basis, to review the Plan and compliance activities.

3. Coordinate on-going assessment of written standards of conduct, policies, and procedures that promote compliance and ensure adequate internal controls. Revise when necessary.

4. Identify and assess potential areas of noncompliance, including legal requirements and risk areas of the facility, and incorporate them into the Plan in conjunction with the Compliance Officer.

5. Establish methods to achieve compliance with standards, policies, and procedures including auditing and monitoring programs, reporting systems, and development of internal controls to carry out policies of Palatine.

6. Develop a system to respond to reports, complaints, and detected instances of misconduct. Develop corrective action and prevention initiatives.

7. Coordinate the communication, training, and education of plan policies and procedures to those associated with the facility. Establish training programs for employees and health care professionals that address specific risk areas, compliance plan elements, and organizational policies and procedures.

8. Distribute information on health care laws, regulations, compliance bulletins, updates, reminders, and policies and procedures of the facility to relevant personnel.

9. Report periodically to the Compliance Officer on work performed.

C. Investigative Protocol

1. Investigations Generally

A primary duty of the Compliance Officer is to facilitate the reporting of possible misconduct by Palatine Personnel. This Compliance Plan is intended to encourage the reporting of suspected improprieties without fear of retaliatory action by Palatine. ***(See Report Form at Exhibit A)*** The Compliance Officer shall ensure that every report received, whether written or oral, is reviewed and evaluated. In order to effectively carry out the investigative duties of his job, the Compliance Officer will be granted access to all required programmatic and fiscal information necessary to complete a thorough investigation. If, in the judgment of Palatine management, such access should be limited in any way, the matter will be brought forth to the Palatine Operator, which will review the documents in question as well as management's concerns. The Operator will make the ultimate determination as to the Compliance Officer's access to the requested documentation.

Reports shall also be forwarded to Palatine attorneys, as necessary or appropriate, in the discretion of the Compliance Officer. The Compliance Officer shall maintain a report log in which to record reports and their ultimate resolution. ***(See Exhibit B)***. All reports and the report log will be retained in a secure location pursuant to Palatine's record retention policy.

After assessing the report, the Compliance Officer may conclude that an investigation is required. The Compliance Officer may ask Palatine's legal counsel to conduct the investigation or to supervise and direct an investigation conducted by Palatine itself. Alternatively, the Compliance Officer may determine that a report does not warrant further investigation.

If the Compliance Officer is involved personally and directly in any allegation that is raised and/or investigated, he or she will abstain from consideration of any such allegation. In such a case, Palatine's legal counsel will be notified and will provide guidance as to how to conduct the investigation.

Should the Compliance Officer determine that a matter is an emergency requiring immediate action or determine that certain matters are extremely sensitive or confidential, he/she shall notify the Operator immediately. At any time, the President may request a meeting to discuss the progress in resolving the circumstances that gave rise to the emergency situation.

An investigation of a particular practice or suspected violation typically involves review of relevant documentation and records, interviews with staff and physicians, and analysis of applicable laws and regulations. The results of such investigations must be thoroughly documented and shared with the Palatine Operator, on a confidential basis. Precautions should be taken to ensure that critical documents are not destroyed. Records of the investigation will include a description of the investigative process, copies of interview notes and key documents, a log of witnesses interviewed and documents reviewed, the results of the investigation (i.e. overall findings, disciplinary action taken or reports made), and any corrective action taken to prevent similar violations in the future. Where appropriate, legal counsel shall be involved in the supervision or performance of investigations.

2. Investigation Findings and Corrective Action

After completion of an investigation, the Compliance Officer will assess the findings and discuss them with Palatine's legal counsel if counsel is involved. The Compliance Officer is responsible for ensuring that the findings of the investigation and any corrective actions are reported to the Palatine Operator and any appropriate senior management.

The Compliance Officer will determine when the advice of legal counsel should be sought. Legal counsel will advise on matters of attorney/client privilege, disclosure, and whether Palatine has any affirmative duties to report the violations and/or restitution to health care payors.

If an investigation reveals a problem, the Compliance Officer, with the guidance of legal counsel as appropriate, is responsible for drafting a corrective action plan with appropriate management staff. Any recommendation to disclose the results of an investigation to federal and state authorities must be made by the Palatine Operator, based upon the recommendations of the Compliance Officer and legal counsel.

Every corrective action plan will list each practice that is considered problematic and specify what will be done to correct the practice. The scope of possible corrective actions is broad, and may include implementing Palatine Personnel training, disciplinary actions, a refund of any overpayments received, or voluntary reporting to federal or state authorities. All corrective actions must be documented.

In cases where an investigation is initiated based on information provided by a Palatine staff member, the Compliance Officer will provide feedback to a staff member regarding the results of the investigation.

D. Audit Protocol

Palatine is committed to ensuring that the Plan is properly implemented through a system of monitoring and auditing of the business activities of the facility. The Compliance Officer will institute a plan for periodic internal audits of certain facets of Palatine operations. Among the activities of concern are billing, coding, claims submission, documentation, marketing, referral arrangements, contracts, joint ventures, other investments, and the like. While the Compliance Officer will be ultimately responsible for coordinating all formal audits, the audits themselves can be performed by internal or external auditors with expertise in federal and state health care statutes, regulations, and policies.

Auditors must have broad access to records and personnel. The results of the audit process must be communicated to and discussed with the Compliance Officer and Compliance Committee and, if necessary, legal counsel to determine whether any corrective action is required. Whether or not any specific discrepancies, systemic errors, or reports of noncompliance identified in the audit require additional investigation shall be assessed in accordance with the Plan's Investigative Protocol.

1. Periodic Audits

Palatine will conduct or will engage an independent third party to conduct periodic audits of its claims submission process. Palatine will routinely identify compliance risk areas specific to nursing facilities such as Palatine. Periodic audits will focus on these risk areas or areas that are known enforcement priorities of private or government payors and enforcement agents, and also any problems discovered in previous audits. The Compliance Officer will develop the periodic audit plan. The performance of these periodic audits is designed to detect new or existing violations as well as assess systemic and behavioral improvements that have been made since the performance of earlier audits. External auditors should occasionally perform periodic audits, with the involvement of Palatine's attorneys, as appropriate.

A section of the periodic audit plan will review the extent to which the mechanics of the Plan are being followed. For instance, the review will determine whether the Plan has been adequately disseminated, whether appropriate training and education programs have been conducted, and whether the disciplinary process is working properly. The reviewers will also assess whether appropriate records are being kept and if other documentation requirements are being satisfied.

One purpose of the periodic audits is to identify and subsequently correct any existing problems in Palatine's billing, coding, and claims submission process. The audits will involve the selection of a representative sample of claims and all supporting documentation for the various types of services performed by Palatine (including reports, claims, and remittance documents corresponding to the time period covered by the audit).

The audit methodology may include:

- interviews with administrative personnel and physicians;

- review of written materials, medical and financial records, and other documentation;
- trend analysis that spot deviations in specific areas over a given period; and
- analysis and report of results.

While the audit process may cover the entire operation, the following are areas for special consideration:

- billing;
- coding;
- physician ordering procedures;
- medical necessity;
- marketing;
- referrals;
- supplier, hospital, and other contracts;
- record keeping;
- compliance education; and
- joint ventures.

Special attention will be given to new employees and existing employees in new positions.

Corrective action shall be undertaken for any violations that are discovered. The audit results shall also be the basis for identifying training and educational needs of Palatine Personnel. Under the direction of Palatine's legal counsel, as appropriate, and in accordance with the Palatine investigative procedure, the Compliance Officer will undertake a more thorough, formal investigation of any items identified as significant violations of law, the Standards of Conduct, or Palatine's policies and procedures.

2. Disclosure Of Audit Results and Corrective Actions

The Compliance Officer is responsible for ensuring that the findings of the audit and any corrective actions are reported to the Palatine Operator and any appropriate senior management.

The Compliance Officer will determine when the advice of legal counsel should be sought. Legal counsel will advise on matters of attorney/client privilege, disclosure, and whether Palatine has any affirmative duties to report the violations and/or make restitution to Medicare, Medicaid or any other health care payors.
If an audit reveals a problem, the Compliance Officer, with the guidance of legal counsel as appropriate, is responsible for developing a corrective action plan in conjunction with appropriate management staff. The scope of possible corrective actions is broad, ranging from implementing training of Palatine Personnel, disciplinary actions, a refund of any overpayments to Medicare, Medicaid or any other payors, or voluntary reporting to federal or state authorities. Corrective action also includes development of a system to reduce the potential for recurrence of any problems discovered on audit.

If Palatine determines through an audit or any other means that it has received a Medicaid overpayment, Palatine will take immediate steps to quantify the overpayment amount, involving legal counsel if appropriate. In compliance with all applicable federal and state parameters,

Palatine will refund the amount to Medicaid by claim adjustments, claim voids, or self disclosure in accordance with the New York State Office of Medicaid Inspector General's protocol for self-disclosure, as appropriate. Any decision to disclose the results of an investigation or audits to federal and state authorities must be made by the Palatine Operator, based upon the recommendations of the Compliance Officer and legal counsel.

3. Documentation

The Compliance Officer must document the fact that an audit has taken place and ensure that any corrective action required has been completed. Any inquiries to Medicare, Medicaid or other health care payors must be documented if Palatine intends to rely on the response. The Compliance Officer will share Palatine's Corporate Compliance Plan provisions concerning refund of overpayments with Palatine's billing personnel and also will work with billing personnel to ensure they are informed of any overpayment refunds to Medicare, Medicaid or any other payor, even if they are not made as part of the corrective action resulting from an audit or investigation.

If Palatine determines through an audit or any other means that it has received a Medicaid overpayment, Palatine will take immediate steps to quantify the overpayment amount, involving legal counsel if appropriate. In compliance with all applicable federal and state parameters, Palatine will refund the amount to Medicaid by claims adjustments, claim voids or self-disclosure in accordance with the New York State Office of Medicaid Inspector General's protocol for self-disclosure, as appropriate. Any decision to disclose the results of an investigation or audits to federal and state authorities must be made by the Palatine Operator, based upon the recommendations of the Compliance Officer and legal counsel.

E. Training and Education

Palatine believes that continuing education for all affected persons associated with the provider promotes professional excellence and regulatory compliance. All affected persons associated with the provider are Palatine Personnel (including executives), Palatine's Operator, physicians rendering services to Palatine residents, vendors that provide healthcare-related services to Palatine, and Palatine's residents and their families. The Compliance Officer is responsible for monitoring the compliance training provided to these parties. Compliance training will include discussion of compliance issues, expectations and compliance program operation. Palatine Personnel shall inform the Compliance Officer of participation in any external compliance training activities.

Professional licensure, accreditation, and clinical proficiency require that Palatine professional staff enroll in continuing education. Similarly, to keep current with changes in their own fields, Palatine encourages, and in some cases may require, its non-professional personnel to take advantage of appropriate educational opportunities.

Compliance Training/Palatine Personnel

The Compliance Officer will ensure that all Palatine Personnel are afforded regular training and educational programs about regulatory compliance issues affecting Palatine. Palatine's Standards of Conduct shall be distributed to Palatine Personnel. Palatine Personnel also shall receive a summary description of Palatine's corporate compliance plan and a form for making written reports of suspected violations, along with information on various means of making a report. On at least an annual basis Palatine Personnel shall be required to attend a compliance training update.

Any new Palatine staff person (W-2 or 1099, including executives), shall participate in an introductory compliance training program, as part of their general orientation.

Attendance will be taken at any mandatory compliance training program. Failure to attend without obtaining an excused absence approval may result in disciplinary action, up to and including termination. (***See Unexcused Absence Notification Form at Exhibit C***).

Compliance training will be face-to-face and in print form, and may include lectures, videos, and interactive sessions. It may be conducted by Palatine Personnel, outside trainers and lecturers, or a combination of both. Palatine also may elect to send certain Palatine Personnel to external training sessions.

Compliance training will be geared to level of responsibility and job function. Nurses, managers, and billers/coders, will receive more extensive compliance training than other Palatine Personnel. In addition, training for Palatine professionals will focus on medical record documentation and improper referral and investment arrangements. Training for billing personnel, by contrast, will focus on inappropriate coding and billing practices, such as upcoding. Specific appropriate training topics include but are not limited to:

1. As part of their initial orientation to the organization, Palatine Personnel will be oriented to Palatine's Standards of Conduct.

2. All staff will also receive information as to:

   - their responsibility to report compliance related concerns;
   - the identity of the Compliance Officer and Compliance Committee;
   - reporting mechanisms;
   - the federal and New York State false claims acts; and
   - Anti-kickback Laws and Self-Referral prohibitions.

3. In addition to these general training topics, individuals will also receive training on compliance-related topics specific to their job assignments.

   - Billing staff and program supervisors will review policies and procedures designed to ensure that only services that actually took place are billed and that such billing appropriately reflects the service provided.

   - Professional staff will receive training on appropriate documentation of services provided.

   - Administrative staff involved in credentialing will receive training regarding personnel policies which require accessing of exclusion databases prior to hire.

4. All managers will receive training regarding all elements of the Plan. The Compliance Officer will review the plan on an annual basis including all the elements noted above as well as procedures for investigation of allegations of inappropriate billing/conduct and procedures for restitution of funds inappropriately billed.

5. All above-referenced training will take place on an annual basis or more often if required to address identified issues or concerns (or if required as a result of Plan modifications).

Compliance Training/Others

In addition, on at least an annual basis, Palatine will conduct face-to-face compliance training for Palatine's Operator and physicians rendering services to Palatine residents. Palatine's Standards of Conduct shall be distributed to these parties and they also shall receive a summary description of Palatine's Corporate Compliance Plan and a form for making written reports of suspected violations, along with information on various means of making a report.

Palatine will send vendors that provide healthcare-related services the same information by mail. A Vendor Policy is attached here as **Appendix D**.

Any new Palatine appointee or associate including any new individual Operator, any new physician or any new vendor, will receive this same information about Palatine's Corporate Compliance Plan.

As part of their admission packets, Palatine's residents and their families will receive a notice advising of Palatine's Corporate Compliance Plan and mechanisms for making a report.

Documentation o(Training

As part of his responsibilities, the Compliance Officer is required to maintain a log of all educational activities undertaken by Palatine. Appropriate documentation will include a record of the:

- date of educational activity;
- time that educational activity is held;
- attendance list; and
- agenda or subject matter covered.

Copies of all materials disseminated in internal educational sessions will be maintained for review. The training log also should include any internal, external professional or compliance-related training sessions attended by Palatine Personnel.

Monitoring Changes

In addition to overseeing the training program, the Compliance Officer is responsible for monitoring changes that impact on the operation of Palatine. The Compliance Officer may work with associations, outside consultants, and the Palatine billing company, if any, to monitor new information. This information shall be communicated to all appropriate Palatine Personnel as quickly as possible and shall be incorporated into appropriate training programs. In addition, the Compliance Officer shall maintain a library of regulatory compliance-related information and training manuals relevant to Palatine's operation that may be accessed by other Palatine Personnel.

F. Screening Employees and Contractors

Palatine Personnel are expected to be honest and lawful in their business dealings. Palatine will not employ or do business with any individuals who are listed by a federal agency as excluded, debarred, or otherwise ineligible to participate in federally funded health care programs. Applicants for employment with Palatine will be required to disclose any criminal conviction, any civil monetary penalties assessed and paid, and any exclusion action imposed against the individual.

As part of the hiring or contracting process, the Compliance Officer, or his designee, will check the Lists of Excluded Persons maintained by the Office of the Inspector General of the U.S. Department of Health and Human Services (and other applicable databases as detailed in this Plan) to ensure that any prospective Palatine employees as well as contractors, subcontractors, consultants, suppliers, and other business partners (collectively, "Business Partners") have not been excluded from any federally or state funded health care program.

Current Palatine Personnel and Business Partners shall be checked against these lists on at least a monthly basis and in accordance with applicable legal requirements. Any entity with which Palatine contracts shall represent and warrant that it does not employ or contract with excluded individuals and that it queries these lists as well.

(***See Personnel Screening Questionnaires at Exhibit D and Contractor Screening Questionnaire at Exhibit E***).

G. Exit Interviews

The Compliance Officer or his or her designee shall conduct exit interviews with all Palatine Personnel who resign, as soon as possible after the individual's decision to resign has been made and communicated. The exit interview will attempt to solicit information about Palatine's compliance with the Standards of Conduct. The interviewer will report back to the Compliance Officer any irregularities that are discovered or suggested.

H. Annual Report

The Compliance Officer will submit a written annual report to the Palatine Operator summarizing all the activities undertaken during the previous year to implement the Plan, any disciplinary actions taken, and any recommendations for Plan modification.

On an annual basis, the Palatine Operator will evaluate the Compliance Officer to ensure that appropriate actions have been taken regarding adherence to the Plan. If the Operator finds that actions have been inadequate, the Operator will direct appropriate corrective actions to be undertaken. The Operator may also elect to replace the Compliance Officer.

I. Compliance As an Element Of Performance Evaluation

Palatine Personnel who fail to comply with the rules and procedures set forth in this Plan or the laws and regulations governing Palatine's facility will be subject to disciplinary action. Commitment to compliance will also be a factor in performance evaluations and compensation decisions, both positive and negative. Supervisors will be subject to sanctions for failing to adequately instruct staff about, or for failing to detect noncompliance with, applicable policies and legal requirements.

J. Disciplinary Procedures

Palatine will not tolerate illegal or unethical conduct of any sort (business or personal) by its employees. Palatine is prepared to take disciplinary action against any individual who violates the requirements of this Plan or otherwise engages in unethical or unlawful activities. It is the

responsibility of the Compliance Officer to ensure that any Palatine Personnel found to have violated the Standards of Conduct or any provision of the Plan (including the failure to report the misconduct of other personnel or suspected compliance problems) be disciplined in an appropriate, fair, timely, and consistent fashion. Sanctions also will be imposed for encouraging, directing, facilitating, or permitting non-compliant behavior for all affected individuals. Discipline may include, but is not limited to, verbal or written warnings, suspensions with and without pay, and termination.

Selection of the particular sanction is subject to the complete discretion of Palatine. Nevertheless, certain violations of the Compliance Plan are particularly likely to justify immediate termination. These offenses include:

- violation of any state or federal statute;
- failure to report conduct of a Palatine employee, independent contractor or Business Partner that a reasonable person under the circumstances should have known was criminal or a violation of the law;
- failure to report a violation of the Standards of Conduct by any Palatine employee, independent contractor or Business Partner that a reasonable person under the circumstances should have known was a violation of the Standards of Conduct; and
- willfully providing materially false information to Palatine, its attorneys, a government agency, or other person in connection with any matter related to the facility or the provision of any health care service or item.

K. Record Retention

Palatine maintains a uniform system for record creation, distribution, retention, storage, retrieval, and destruction of documents. The types of documents developed under this system include:

- clinical and medical records
- billing, claims documentation, and other financial records
- records necessary to protect the integrity of the facility's compliance process and confirm the effectiveness of the program.

Under no circumstances will documents relating to a pending investigation, audit, or inquiry be destroyed without permission of the Compliance Officer and the approval of legal counsel.

(***See Record Retention Policy at Exhibit F***).

L. Amending the Plan

The Plan may require periodic revision in response to changes in the operation of Palatine, the law, and policies of government and private payor health plans.

The Compliance Officer shall make recommendations to the Operator regarding changes in Palatine's operations to enhance compliance, including appropriate revisions to the Plan. Any change to the Plan shall require Palatine Operator approval, and shall be distributed in a timely manner to Palatine Personnel and other applicable parties as necessary.

EXHIBITS

Exhibit A – Report Form

Exhibit B – Report Log

Exhibit C – Unexcused Absence Notification Form

Exhibit D – Internal Personnel Screening Questionnaires

Exhibit E – External Contractor Screening Questionnaire

Exhibit F – Record Retention

APPENDIX A – Plan to Respond to Investigations
APPENDIX B – Deficit Reduction Act Policy
APPENDIX C – Medical Assistance Provider Compliance Plan
APPENDIX D – Vendor Policy

EXHIBIT A

PALATINE NURSING HOME REPORT FOR SUSPECTED COMPLIANCE VIOLATIONS

NAME:_____(UNLESS YOU WISH TO REMAIN ANONYMOUS)

HOME ADDRESS:_____

TELEPHONE (HOME/CELL and WORK):_____

POSITION:_____

DEPARTMENT:_____

PLEASE FEEL FREE TO USE THE BACK OF THIS PAGE IF NECESSARY

1. Please describe the possible violation, including when it occurred and the person(s) involved.

2. Does this involve a Palatine contractor/subcontractor, or other agent?

3. How did you come to learn of the incident/practice described above?

4. Do you have any evidence to prove the above allegations? If so, describe:

5. Have you discussed the above allegations with anyone else? If so, who?

6. Do you have any further information to provide or any suggestions for verifying or providing additional information about the allegations? Are you aware of any other individuals who may be able to provide additional information?

7. Would you be willing to discuss the above allegations with the Compliance Officer, management, or legal counsel for Palatine?

Place form in an envelope marked "*personal and confidential/to be opened only by addressee*".
If your report is not made anonymously, your identity will be kept confidential unless the matter is turned over to the law enforcement.

EXHIBIT B

PALATINE NURSING HOME

COMPLIANCE OFFICER'S REPORT LOG

DATE REPORTED: _____

REPORTED BY: _____

TITLE: _____

DEPARTMENT: _____

REPORTED TO: _____

TITLE: _____

DEPARTMENT: _____

Incident Description:

_____
_____
_____
_____
_____

Action Taken:

_____
_____
_____
_____

Date Incident Report Closed: _____

Date of Action/Discussion with Reporting Employee: _____

Approved by: _____
Corporate Compliance Officer

EXHIBIT C

PALATINE NURSING HOME
UNEXCUSED ABSENCE NOTIFICATION

Staff Name: _____

Staff Title: _____

Reviewing Personnel: _____

Review Date: _____

It is imperative that all staff attend prescheduled staff meetings due to the content of the information to be discussed. The Palatine Compliance Plan Standards of Conduct require participation in continuing education on "compliance issues."

A staff meeting was prescheduled _____for which the above staff on was not in attendance.

Please notify your Compliance Officer within 5 business days if you feel that this should have been an excused absence and the reason it should be considered excused. After receiving your notice, your Compliance Officer will discuss the need for your participation in any follow-up training. If the Compliance Officer does not receive a response, this notification will become a part of the staff member's permanent record. A pattern of unexcused absences or the failure to participate in any required follow-up training may be the basis for the imposition of disciplinary action.

EXHIBIT D

APPLICANT/EMPLOYEE QUESTIONNAIRE
CLINICAL

Name:_____

Address:_____

Telephone#:_____

Medical/Technical School Attended:_____

Year of Graduation:_____

State(s) Licensed:_____

Certification/Specialty(s):_____

Provider#(s):_____

UPIN#:_____

1. List your current professional licenses, the state of issuance and expiration date.

2. Have you ever had your license suspended or revoked? If so, in which state? Where did this occur? When did this occur? Summarize the reason for this action. (Use the back of page if more space is needed.)

3. Have you ever been convicted of a health-care related felony or misdemeanor (including a plea bargain or other arrangement with prosecuting authorities)? If so, please explain (Use the back of page if more space is needed):

4. Have you ever been excluded, suspended, or debarred from the Medicare or Medicaid programs or any other federal or state program? If so, please explain.

5. List any healthcare or related business in which you, or a member of your family or household, has a direct or indirect ownership or controlling interest of 5% or more. Include Medicare and Medicaid provider numbers for each. (Use the back of page if more room is needed.)

6. Have any of the entities for which you have listed in #5 above been excluded, suspended, or debarred from Medicare, Medicaid, or any other federal or state programs?

7. Have you ever defaulted on a Health Education Assistance Loan? If so, explain.

Palatine will not employ or do business with any individuals who are listed by a federal agency as excluded, debarred, or ineligible to participate in federally or state funded health care programs.

APPLICANT/EMPLOYEE QUESTIONNAIRE
ADMINISTRATIVE/BUSINESS PERSONNEL

NAME:_____
ADDRESS:_____
TELEPHONE NUMBER: _____

1. Have you ever been convicted of a felony or misdemeanor (including a plea bargain or other arrangement with prosecuting authorities)? If so, explain:

2. Have you ever been excluded, suspended or debarred from, or otherwise sanctioned by the Medicare or Medicaid programs or any other federal or state program?

3. List any health-care or health-care related business in which you or a member of your family or household, has a direct or indirect ownership or controlling interest of 5 % or more. Include any Medicare or Medicaid provider numbers for each. Use back of page if more room is needed.

4. Have any of the entities which you have listed in# 3 above been excluded, suspended, or debarred from or otherwise sanctioned by Medicare, Medicaid, or any other federal or state program?

Palatine will not employ or do business with any individuals who are listed by a federal agency as excluded, debarred, or ineligible to participate in federally or state funded health care programs.

EXHIBIT E

PALATINE NURSING HOME
CONTRACTOR/SUBCONTRACTOR SCREENING QUESTIONNAIRE

CONTRACTING COMPANY: _____ DATE: _____

REPRESENTATIVE: _____

TITLE: _____

ADDRESS: _____

TELEPHONE NUMBER: _____

FAX NUMBER: _____

1. Has your organization ever been suspended or debarred by any Medicare or Medicaid Programs, or any other federal or state program?

2. Is it the business practice of your organization to screen applicants who have prior felony and/or misdemeanor convictions (including plea bargain or other arrangements with prosecuting authorities) for relationship of the crime to the position for which they are applying?

3. Do you review the applicable federal and state exclusion lists prior to employing or contracting with an individual or organization/company?

4. Does your organization offer/require continuing education to all employees to keep current on all relevant health-care federal and state fraud and abuse laws?

5. List any other health-care or health-care related businesses in which your organization has an ownership or partnership interest:

6. As an independent contractor of Palatine, your organization agrees to perform routine audits and provide appropriate indemnification and hold harmless protections for the Palatine facility. Should your internal/external auditor suspect a problem, the auditor should immediately suspend review, and report the suspicions to the Palatine Compliance Officer. Palatine requires audits to be performed semi-annually, at a minimum. How do you intend to implement these requirements? Use back of sheet if additional space is needed.

Palatine will not employ or contract to do business with any individuals or organizations who are listed by a federal agency as excluded, debarred, or ineligible to participate in federally or state funded health-care programs.

EXHIBIT F

DOCUMENT RETENTION POLICY

Described below are the Palatine policies and procedures governing retention, destruction, confidentiality, and handling of patient medical records, records of claims submitted, and general business records.

Document retention schedule

The chart below lists, generally, the length of time recommended for Palatine to maintain resident medical records, records of claims submitted to the Centers for Medicare and Medicaid Services ("CMS"), and general business records.

RECORD TYPE	RETENTION PERIOD
Resident medical records (This period is based on the estimated period that medical information may be needed for resident care and to defend litigation.)	11 years
Claims and related records (This period is based on the maximum period allowed for litigation under the False Claims Act plus one year.)	11 years
General business records (Many laws apply to the maintenance of general business records. While the recommendation of 7 years is applicable to most general business records, certain records, such as minutes of meetings of incorporators, shareholders and Operator/managers, must be maintained permanently.)	7 years (Permanently for Operator minutes, etc.)

Suspension of document disposal

Consistent with the policy of Palatine to comply with all applicable laws and regulations, as well as to protect itself from allegations of obstructing an investigation, destruction of designated documents shall be suspended in the following circumstances:

- service of legal process;
- inquiries indicating commencement of litigation; or
- notice from legal counsel or the Compliance Officer.

If the individual responsible for document destruction believes, for any reason, that a document or category of documents should not be destroyed, he/she should contact the Compliance Officer prior to destroying such documents.

Handling Documents

Documents generated by Palatine, by Palatine Personnel or Business Partners, or by using Palatine equipment or property, are owned by Palatine ("Palatine Documents"). Palatine Documents are not to be removed from Palatine premises without express permission from the Compliance Officer. Prior to removal of any document from Palatine, a duplicate should be made and filed appropriately.

APPENDIX A

PLAN TO RESPOND TO INVESTIGATIONS

Purpose of Response Plan

Palatine Nursing Home ("Palatine") is committed to maintaining the highest ethical standards in all aspects of its relationships with governmental and regulatory authorities. The purpose of the Palatine Plan to Respond to Investigations is to organize and facilitate cooperation with any governmental or regulatory agency in the event of (1) execution of a search warrant; (2) service of a subpoena; (3) unannounced inspections; and (4) planned audits, surveys and inspections. The information in this Response Plan shall be communicated to Palatine Personnel through appropriate training. Copies of this written document shall be kept for ready reference by the (1) Compliance Officer/Administrator and Compliance Committee; (2) Director of Nursing; (3) Receptionists/Guards; and (4) Evening and Night Supervisors.

Role of Compliance Officer

Palatine will respond to any governmental inquiries that are required by law through a single designated representative, Palatine's Compliance Officer. (Should the Compliance Officer not be available, the designated "Person in Charge" will act on the Compliance Officer's behalf, in conjunction with the Compliance Committee as appropriate). The Compliance Officer must be notified of any requests for information directed to Palatine. Palatine will provide accurate information when responding to any government or private payor inquiry. The Compliance Officer will ensure that Palatine Personnel are reminded that no documents or records should be given to any third parties without advance express authority from the Compliance Officer. The Compliance Officer has the responsibility of ensuring that Palatine Personnel are instructed not to destroy or alter documents, or create responsive documents, once an audit or investigation has begun. The Compliance Officer may consult Palatine's legal counsel as necessary.

Interviews

While Palatine will likely wish to cooperate in an investigation, it would prefer to do so in concert with its employees. To facilitate such cooperation, Palatine Personnel should refer any request from an investigator to the Compliance Officer. Palatine Personnel should be aware that the government, as a routine matter, may attempt to interview them on Palatine's premises during the course of an audit, the service of a subpoena, or the execution of a search warrant. Government agents also may contact employees at home, unannounced, for interviews.

While Palatine Personnel have the right to speak with an investigator, they do not have an obligation to do so (absent some legal right). Palatine Personnel have the right to refuse to be interviewed, but Palatine cannot tell them not to talk with investigators. If an employee wishes to consent to questioning, they may be interviewed with a facility representative, or an attorney engaged by the facility, present. If an employee wants separate legal representation, the matter should be brought to the attention of the Compliance Officer and discussed with legal counsel. Palatine Personnel should be aware that they have the right to choose the time and place of an interview, and may terminate the interview at any time. Palatine Personnel should be instructed to ask for identification from the individual requesting an interview prior to responding to any questions. They also should be reminded that they have an obligation to tell the truth.

Regardless of Palatine's level of participation, Palatine would like to be advised of any contact or discussions the government has with Palatine Personnel (unless otherwise prohibited by law). Such information should be given to the Compliance Officer as soon as possible after the employee is contacted by the government.

Unscheduled Calls, Visits and Search Warrants

In the event of unscheduled calls or visits by investigators, the Compliance Officer (or his/her designee), in consultation with legal counsel, shall be the sole point of contact and communication. The receptionist/guard on duty is instructed to immediately contact the Compliance Officer if investigators arrive without an appointment. If the Compliance Officer is unavailable, the designated Person in Charge must be contacted. It shall be the responsibility of the Compliance Officer (or designee) to:

1. verify the identity of investigator(s).

2. request permission to photocopy the credentials of all investigators and other personnel; secure current telephone numbers for each investigator or obtain a business card; ascertain whether the investigators are in contact with any attorneys at the New York State Attorney General's Office, the United States Attorney's office or the Criminal and/or Civil Divisions of the Department of Justice in Washington, D.C. (or other health care regulatory oversight agency).

3. demand inspection of any warrant or other authority for investigators being present at Palatine to ensure that the investigators have proper authorization, and retain the original or a copy of each such document.

4. attempt to ascertain from the investigators the nature of the inquiry and the alleged violations or statutes that are the basis for the investigation.

5. ensure that Palatine records are never voluntarily produced -- only under compulsion of subpoena or search warrant, or subject to the advice of Palatine legal counsel.

6. ensure that no attorney-client privileged material, or other privileged material, is produced.

7. ensure that no Quality Assurance Committee work product or records of the Committee (i.e., reports generated by or at the request of the Committee for quality assurance purposes) are produced.

8. ensure that Palatine Personnel do not provide information that was not requested.

9. render courteous cooperation with the investigators, escort agents at all times while on the premises, and act as the sole representative handling oral communications with investigators.

10. be responsible for alerting Palatine legal counsel, as well as ensuring that all investigative activities are within the confines of the investigator's apparent authority.

11. in the case of a search warrant:

    a. immediately notify legal counsel.
    b. arrange to have non-essential employees sent home.
    c. object if agents stray outside the physical space identified in the warrant.
    d. monitor actions of the search team, making notes of areas searched and preparing a general description of items seized.
    e. request permission to copy records critical to Palatine's operation before agents take them, and request that only computer files, not whole computers be taken.
    f. ensure that the agents have left behind an inventory listing items seized once the warrant has been executed.

12. ensure that no statement, other than a receipt, is signed without consulting legal counsel.

13. ensure that any information given to agents is accurate.

Exit Conference

At the conclusion of any investigative visit, audit or inspection the Compliance Officer shall request an exit conference in order to learn additional details of the investigation, if any violations have been discovered during inspections, and if Palatine will be involved in any further investigative activity.

The Compliance Officer shall immediately inform the Operator of all information acquired regarding the investigation so that Palatine may undertake its own internal investigation.

APPENDIX B

DEFICIT REDUCTION ACT POLICY

PURPOSE

Palatine Nursing Home (the "Facility") is committed to its role in preventing health care fraud and abuse and complying with applicable state and federal laws related to health care fraud and abuse. The Federal Deficit Reduction Act of 2005 requires health care providers which receive or make $5 million or more in Medicaid payments during a Federal fiscal year to establish written policies and procedures informing and educating their employees, agents, and contractors about the Federal False Claims Act and other laws, including state laws, which deal with fraud, waste, abuse, and whistleblower protections regarding those issues. To ensure compliance with such laws, the Facility has policies and procedures in place to detect and prevent fraud, waste, and abuse, and also to support the efforts of Federal and State authorities in identifying incidents of fraud and abuse. This policy sets forth information concerning the Facility's existing policies and procedures, including avenues for reporting concerns internally, and contains an overview of the Federal Civil False Claims and Program Fraud Civil Remedies Acts and applicable state laws.

As detailed more fully in the Facility's attached existing Compliance Plan, which is attached here and incorporated into this policy, the Facility is committed to maintaining an effective internal program which ensures compliance with all applicable legal requirements.

POLICIES AND PROCEDURES

The Facility takes health care fraud and abuse very seriously. It is our policy to provide information to all employees, contractors, and agents about the Federal and State false claims acts, remedies available under these provisions and how employees and others can use them, and about whistleblower protections available to anyone who claims a violation of the Federal or State false claims acts. We also advise our employees, contractors, and agents of the steps the Facility has in place to detect health care fraud and abuse.

FEDERAL AND STATE FALSE CLAIMS LAWS

The Role of Federal and State Laws in Preventing Fraud, Waste, and Abuse: The Centers for Medicare and Medicaid Services ("CMS") defines "fraud" as the intentional deception or misrepresentation that an individual knows to be false (or does not believe to be true) and makes, knowing that the deception could result in an unauthorized benefit to himself or another person. CMS defines "abuse" as incidents or practices of providers that are inconsistent with sound medical practice and may result in unnecessary costs, improper payment, or the payment for services that either fail to meet professionally recognized standards of care or are medically unnecessary.

The Federal Government and the State of New York have 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 the 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.

The Federal Civil False Claims and Program Fraud Civil Remedies Acts, applicable State laws, and anti-retaliation provisions are summarized in the following sections. A more complete copy and listing of the applicable Federal and New York Statutes Relating to Filing False Claims is also attached to this policy and made a part hereof. These statutes can also be located at the following website (which website may be amended from time to time):

https://omig.ny.gov/media/54411/download

This listing of statutes is supplemented by the relevant Compliance Alerts and Guidance from the New York Office of the Medicaid Inspector General which can be located at the following websites and which are incorporated here:

https://omig.ny.gov/compliance/compliance-library

https://omig.ny.gov/media/80796/download?attachment (specifically, see Appendix C)

As applicable, the Facility shall also comply with the following Deficit Reduction Act federal guidance from March 20, 2007:

https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD032207Att1.pdf

FEDERAL CIVIL FALSE CLAIMS ACT

The **Civil False Claims Act** (31 U.S.C. §3729 et seq.) is a statute that imposes civil liability on any person who:

- knowingly presents, or causes to be presented, a false or fraudulent claim, record or statement for payment or approval,
- conspires to defraud the government by getting a false or fraudulent claim allowed or paid,
- uses a false record or statement to avoid or decrease an obligation to pay the Government, and
- engages in other fraudulent acts enumerated in the statute.

The term **"knowingly"** as defined in the Civil False Claims Act ("FCA") includes a person who has actual knowledge of the information, acts in deliberate ignorance of the truth or falsity of the information, or acts in reckless disregard of the truth or falsity of the information. No proof of specific intent to defraud is required.

The term **"claim"** includes any request or demand for money or property if the United States Government provides any portion of the money requested or demanded.

Potential civil liability under the FCA currently includes penalties of between five thousand five hundred and ten thousand per claim (adjusted for inflation), treble damages, and the costs of any civil action brought to recover such penalties or damages.

The **Attorney General of the United States** is required to diligently investigate violations of the FCA, and may bring a civil action against a person. Before filing suit the Attorney General may issue an investigative demand requiring production of documents and written answers and oral testimony.

The FCA also provides for **Actions by Private Persons** (qui tam lawsuits) who can bring a civil action in the name of the government for a violation of the Act. Generally, the action may not be brought more than six years after the violation, but in no event more than ten. When the action is filed it remains under seal for at least sixty days. The United States Government may choose to intervene in the lawsuit and assume primary responsibility for prosecuting, dismissing or settling the action. If the Government chooses not to intervene, the private party who initiated the lawsuit has the right to conduct the action.

In the event the government proceeds with the lawsuit, the qui tam plaintiff may receive fifteen to twenty-five per cent of the proceeds of the action or settlement. If the qui tam plaintiff proceeds with the action without the government, the plaintiff may receive twenty-five to thirty percent of the recovery. In either case, the plaintiff may also receive an amount for reasonable expenses plus reasonable attorneys' and costs. These percentages may be amended periodically.

If the civil action is frivolous, clearly vexatious, or brought primarily for harassment, the plaintiff may have to pay the defendant its fees and costs. If the plaintiff planned or initiated the violation, the share of proceeds may be reduced and, if found guilty of a crime associated with the violation, no share will be awarded the plaintiff.

Whistleblower Protection. The Civil False Claims Act (31 U.S.C. 3730(h)) also provides for protection for employees from retaliation. An employee who is discharged, demoted, suspended, threatened, harassed, or discriminated against in terms and conditions of employment because of lawful acts conducted in furtherance of an action under the FCA may bring an action in Federal District Court seeking reinstatement, two times the amount of back pay plus interest, and other enumerated costs, damages, and fees (as amended).

FEDERAL PROGRAM FRAUD CIVIL REMEDIES ACT OF 1986

The **Program Fraud Civil Remedies Act of 1986** ("Administrative Remedies for False Claims and Statements" at 38 U.S.C. §3801 et seq.) is a statute that establishes an administrative remedy against any person who presents or causes to be presented a claim or written statement that the person knows or has reason to know is false, fictitious, or fraudulent due to an assertion or omission to certain federal agencies (including the Department of Health and Human Services).

The term "**knows or has reason to know**" is defined in the Act as a person who has actual knowledge of the information, acts in deliberate ignorance of the truth or falsity of the information, or acts in reckless disregard of the truth or falsity of the information. No proof of specific intent to defraud is required.

The term **"claim"** includes any request or demand for property or money, e.g., grants, loans, insurance or benefits, when the United States Government provides or will reimburse any portion of the money.

The authority, i.e., federal department, may investigate and with the Attorney General's approval commence proceedings if the claim is less than one hundred and fifty thousand dollars. A hearing must begin within six years from the submission of the claim. The Act allows for **civil monetary sanctions** to be imposed in administrative hearings, including penalties incurred per claim and an assessment, in lieu of damages, of not more than twice the amount of the original claim (as amended).

NEW YORK STATE FALSE CLAIMS LAWS AND WHISTLEBLOWER PROVISIONS
FALSE CLAIMS AND STATEMENTS - CIVIL MONETARY PENALTIES:

The New York Social Services Law imposes civil liability for anyone that knowingly makes a false statement or representation, or by deliberate concealment of any material fact, on behalf of him or herself or others, to obtain payment from public funds for services or supplies furnished under a Social Services program (such as Medicaid). The government can recover civil damages for a violation of this statute equal to **three** times the amount falsely overstated or **three** times the amount incorrectly paid.

Additionally, the Department of Health may require the payment of an additional monetary penalty as restitution to Medicaid by any person who fails to comply with the standards of the Medicaid program when such person knew, or had reason to know, that: (1) the payment involved the providing or ordering of care, or supplies that were medically improper, unnecessary or in excess of the medical needs of the person to whom they were furnished; (2) the care, services or supplies were not provided as claimed; (3) the person who ordered or prescribed care, services or supplies which were medically improper was suspended or excluded from Medicaid at the time the care, services or supplies were furnished; or (4) the services or supplies for which payment was received were not, in fact, provided.

The New York False Claims Act (State Finance Law §§187-194) is similar to its federal counterpart in that it imposes civil penalties upon parties who knowingly file false and fraudulent claims for payment from any state or local government. This New York law allows private individuals to file lawsuits in state court. If the lawsuit results in repayment to the government, the individual commencing the action may be able to recover a percentage of the proceeds.

FALSE CLAIMS AND STATEMENTS - CRIMINAL PENALTIES:

The New York State Social Services Law also imposes criminal penalties against any person who by means of a false statement, or by deliberate concealment of any material fact, or by other fraudulent device, obtains or aids or abets any person to obtain public assistance or care to which he or she is not entitled, or does any willful act designed to interfere with the proper administration of public assistance and care. Such a person shall be guilty of a **misdemeanor**, unless the act is a violation of the New York Penal Law, in which case he or she shall be punished in accordance with the Penal Law. Furthermore, it is also fraudulent for any person who, with intent to defraud, presents for payment any false or fraudulent claim for furnishing services or merchandise, or who knowingly submits false information to obtain greater compensation than legally entitled, or who knowingly submits false information to obtain authorization for furnishing services or merchandise under the New York State Social Services Law. Such a person is guilty of a **Class A misdemeanor**, unless the act constitutes a violation of the New York Penal Law.

While various criminal statutes in New York can potentially be applied to the Medicaid program, Penal Law Article 177 focuses specifically on crimes involving health care fraud. A person is guilty of health care fraud when, with intent to defraud a publicly or privately funded health insurance or managed care plan or contract (such as Medicaid), an individual knowingly and willfully provides false information or omits material information for the purpose of requesting payment from a health plan for health care items or services that the person is not otherwise entitled to receive. The criminal penalty imposed on such a person corresponds to the amount of payment wrongfully received from a single health plan in a one-year period.

NEW YORK WHISTLEBLOWER PROTECTIONS:

Under certain circumstances, whistleblower protection is available for employees under New York Labor Law, Section 740. Under the law, it is illegal for employers to take any retaliatory actions (defined to include adverse employment actions or threats to take such adverse employment actions against an employee in the terms of conditions of employment, including but not limited to, discharge, suspension, or demotion) against an employee, whether or not within the scope of the employee's job duties, because such employee does any of the following: discloses, or threatens to disclose to a supervisor or to a public body an activity, policy or practice of the employer that the employee reasonably believes is in violation of law, rule or regulation or that the employee reasonably believes poses a substantial and specific danger to the public health or safety. An employee who is the subject

of such retaliatory action may commence a civil court action within 2 years after the alleged retaliatory action was taken. Such relief may include: (1) an injunction to restrain continued violation; (2) the reinstatement of the employee to the same or equivalent position held before the retaliatory action, or front pay in lieu thereof; (3) the reinstatement of full fringe benefits and seniority rights; (4) the compensation for lost wages, benefits and other remuneration; (5) the payment by the employer of reasonable costs, disbursements and attorneys' fees; (6) a civil penalty of an amount not to exceed $10,000; and/or (7) the payment by the employer of punitive damages, if the violation was willful, malicious, or wanton. Additionally, a court in its discretion may also order that reasonable attorneys' fees and court costs and disbursements be awarded to an employer if the court determines that an action brought by an employee was without basis in law or in fact.

EXAMPLES OF POSSIBLE FALSE CLAIMS

- **Making false statements regarding a claim for payment;**
- **Falsifying information in the medical record;**
- **Double-billing for items or services; and/or**
- **Billing for services or items not performed or never furnished.**

WHAT SHOULD BE DONE IF A FALSE CLAIM HAS BEEN MADE

The Facility strives to maintain an open line of communication and is committed to ensuring that all staff members and consultants feel comfortable communicating and reporting their concerns regarding false claims internally to the Compliance Officer or other management personnel. The Compliance Officer shall maintain regular office hours (and will also schedule special appointments) in order to address compliance issues with staff members and consultants. The Compliance Officer can be notified verbally, by telephone, e-mail or other electronic communication whenever a compliance issue arises. Additionally, the Compliance Officer can also be contacted using the compliance report form which is attached to this Plan at ***Exhibit A*** and is also available in the Facility's business office, whenever a compliance issue arises.

Individuals are not required to report a possible false claims act violation to the Facility first. A report can be made directly to the applicable Federal or State authorities. However, in many instances the Facility believes that the use of its internal reporting process is a better option because it allows the Facility to quickly address potential issues. In any event, the Facility will not retaliate against any individual for informing the Facility or the Federal or State government of a possible false claims act violation.

An employee with questions regarding this policy should contact Roxanne Barrett at (518) 673-5212, ext. 206.

Originally Adopted: January 1, 2007

Latest Revisions: October 2023

APPENDIX C

MEDICAL ASSISTANCE PROVIDER COMPLIANCE PLAN FOR THE NURSING HOME FACILITY (the "Facility")

The New York Office of Medicaid Inspector General ("OMIG") has adopted regulations governing compliance programs for New York medical assistance providers (18 N.Y.C.R.R. Part 521). In order to be eligible to receive medical assistance payments (including from the Medicaid program) for care, services, or supplies, the Facility is required to adopt and implement an effective Medical Assistance Provider Compliance Plan (the "Plan") as it is a residential health care facility subject to the provisions of Article 28 of the New York Public Health Law. These new regulations were initially effective as of July 1, 2009 and the Facility was required and did have this Plan in place within ninety (90) days after July 1, 2009. It is essential that the Facility assures the integration of these regulations into its existing compliance plan and that it continues implementation and maintenance of an effective and comprehensive compliance plan in accordance with applicable legal requirements.

With respect to the Plan, there are seven (7) mandatory elements to a compliance program (as described in New York Social Services Law Section 363-d & Part 521). These elements as detailed more fully below were updated/revised in New York Social Services Law 363-d in April, 2020. The implementing regulations at Part 521 were finalized in December, 2022.

As required by the statute and implementing regulations, the Facility's Plan includes mandatory elements, highlighted below in yellow text. With respect to the elements of an effective compliance plan, the Facility shall also comply with the following OMIG Compliance Program Guidance from 2023:

https://omig.ny.gov/media/80796/download?attachment

This Compliance Program Guidance is attached here and made a part of this Plan. The mandatory elements with which the Facility will comply are as follows:

Element 1: Written policies, procedures and standards of conduct that:

a) Articulate the organization's commitment to comply with all applicable federal and state standards;
b) Describe compliance expectations as embodied in the standards of conduct;
c) Implement the operation of the Compliance Program;
d) Provide guidance to employees and others on dealing with potential compliance issues;
e) Identify how to communicate compliance issues to appropriate compliance personnel;
f) Describe how potential compliance issues are investigated and resolved by the organization;
g) 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;

h) All requirements listed under 42 U.S.C. 1396-a(a)(68)

The Facility has a reputation for conducting itself in accordance with the highest level of business and community ethics and in compliance with applicable Federal and State governing laws. The Facility recognizes the problems that both intentional and inadvertent misconduct in the health care industry can pose. As a result, the Facility is committed to ensuring that it operates under the highest ethical and moral standards and that all of its activities comply with all applicable requirements.

The Plan demonstrates the Facility's policies and commitment to honest and ethical behavior in all aspects of its delivery of services to residents and relations with third-party payors, employers, contractors, agents, and independent contractors. The Plan will provide guidance to employees and health care professionals and will aid in preventing fraud, waste, and abuse while providing high quality care to the Facility's residents.

The Plan begins with the acknowledgment and agreement that it will comply with all applicable Federal, State, and local laws and regulations ("Applicable Legal Requirements"). As detailed more fully in the Facility's attached existing compliance plan, which is attached here and incorporated into this Plan, the Facility is committed to maintaining an effective internal program which ensures compliance with all Applicable Legal Requirements. With this Plan, the Facility will promote and ensure full compliance with its legal mandates and obligations, foster and assure ethical conduct, and provide guidance to each staff member and contractor of the Facility for his/her conduct. The procedures and standards of conduct contained within this Plan are intended to generally define the scope of conduct which the Plan is intended to address but are not to be considered as all inclusive. This Plan is intended to be a living document and will be updated periodically in order to keep the Facility's staff members and contractors informed of the most up-to-date information relating to health care compliance requirements.

All employees/staff members (which shall throughout this Plan include, but not limited to, its executives and governing body members) and Facility contractors/consultants have the obligation and responsibility to understand and to comply with all Applicable Legal Requirements which relate to their positions, and Facility supervisors have the responsibility of ensuring that all staff members and contractors/consultants who report to them are provided with accurate, up-to-date information so that they can comply with such Applicable Legal Requirements. All staff members and contractors/consultants will be held accountable for their individual actions. It is the policy of the Facility to immediately investigate any suspected violations of the Applicable Legal Requirements. If the investigation reveals that a potential violation has occurred, the Facility will take appropriate corrective action which may include reporting the suspected violation to the appropriate authorities for investigation. The Facility will cooperate with any governmental investigation into the circumstances surrounding an alleged violation. Additionally, any violations may

result in disciplinary action by the Facility, up to and including termination (as detailed more fully below).

If a staff member or contractor has any questions regarding the propriety or legality of any particular course of action, the staff member or contractor should immediately seek advice from his/her supervisor or the Facility's Compliance Officer. Similarly, staff members and consultants may report any perceived violations of the Plan and/or Applicable Legal Requirements on a strictly confidential basis by contacting his/her superior or the Facility's Compliance Officer. If the matter at issue involves the individual's superior or the Facility's Compliance Officer, the matter can be discussed with other appropriate management staff or members of the governing body of the Facility.

Additionally, the Facility adopts a policy of non-intimidation and non-retaliation for a staff member and/or consultant's good faith participation in the Plan. Specifically, the Facility shall not take any adverse employment actions against any staff member or consultant for reporting potential compliance issues, for submitting self-evaluations to the Facility, and/or for engaging in any authorized audits or remedial/corrective actions (unless the staff member or contractor/consultant is complicit in the compliance problem). Furthermore, the Facility will comply at all times with the applicable provisions of New York Labor Law Sections 740 and 741 and other Applicable Legal Requirements.

With respect to compliance with the requirements under 42 U.S.C 1396-a(a)(68), the federal Deficit Reduction Act, the Facility shall comply with the Deficit Reduction Act Policy attached here at Appendix B.

The Facility's written policies will be reviewed at least annually and modified, as necessary. The policies will be distributed to all affected individuals (including employees, the Owner and other senior administrators, members, managers, contractors, agents, subcontractors, independent contractors, and governing body and Facility officers).

Element 2: Designation of a compliance officer and a compliance committee who report directly and are accountable to the organization's chief executive or other senior management.

The Facility has appointed a Compliance Officer who has the responsibility for overseeing the day-to-day operation of the Facility's Plan. The Compliance Officer's responsibilities shall include, but not be limited to, understanding all aspects of this Plan, educating staff members and consultants regarding compliance issues, monitoring and reporting of all of the Facility's compliance activities, investigating reports of suspected non-compliance, and such other duties as are necessary to monitor developments and changes in the Applicable Legal Requirements that will affect the Facility.

The Facility has also appointed a Compliance Committee which is empowered to assist the Compliance Officer in evaluating compliance issues and making policy and procedure changes in order to ensure that the Facility remains in compliance with all Applicable Legal Requirements.

The Compliance Officer, the Administrator of the Facility, shall report directly to the Owner/Operator and shall also be responsible for preparing reports for the Facility at the Facility's Compliance meetings. The Compliance Officer shall report compliance and auditing activities to the Facility's governing body. Specifically, the Compliance Officer will prepare and send quarterly reports on the progress of adopting, implementing, and maintaining the compliance program to the Owner and Compliance Committee.

The Compliance Officer shall coordinate the implementation of an annual compliance work plan. The Facility will ensure that the Compliance Officer is allocated sufficient staff and resources to satisfactorily perform his/her responsibilities for the day-to-day operation of the compliance program.

The Compliance Committee will report directly to the Owner, and the Committee will coordinate with the Compliance Officer to ensure that all affected individuals complete compliance training and education during orientation and annually. The Committee's charter will outline the duties and responsibilities, membership, designation of a chair, and meeting frequency (at least quarterly). The Committee shall review and update (if needed) the charter at least annually.

> Element 3: Each provider shall establish and implement effective training and education for its compliance officer and organization employees, the chief executive and other senior administrators, managers and governing body members. Such training and education shall occur at a minimum annually and shall be made a part of the orientation for a new employee and new appointment of a chief executive, manager or governing body member.

The Facility's staff members (including, but not limited to, its executives and governing body members) and its contractors/consultants will receive training and education relating to this Plan at least annually, and more frequently if the Plan is revised or the Applicable Legal Requirements have changed. At these training sessions, the Facility will discuss with its staff members and consultants as applicable the components of this Plan, the Facility's commitment to compliance, as well as staff member and consultant responsibilities. Compliance considerations will be part of the performance evaluation of all staff members and consultants, and such performance will be evaluated annually, or more frequently if the need arises or if compliance concerns are raised by any party.

All new staff members and consultants (including, but not limited to, its executives and governing body members) will receive a copy of the Facility's Plan and will receive compliance training during orientation and thereafter.

All employees and health care professionals shall receive education and training based on their job functions. The Facility shall ensure that all levels of personnel receive adequate and ongoing training. Attendance and description of formal training programs shall be documented.

Compliance training and education will be documented in an annual training plan that is maintained and outlines: (1) required subjects or topics; (2) timing and frequency of training; (3) which affected individuals are required to attend; (4) how attendance is tracked; and (5) how the effectiveness of the training is periodically evaluated.

The Facility acknowledges that only distributing the written policies does not qualify as effective compliance training and education. For example, the Facility may use a self-study approach with contractors. If the Facility utilizes such an approach, it will include a dated distribution letter or have the contractors complete an acknowledgment to evidence that compliance training occurred.

Additionally, the Facility may consider using pre- and post-tests, and surveys to periodically evaluate the effectiveness of the compliance training.

> Element 4: Establishment and implementation of effective lines of communication, ensuring confidentiality between the compliance officer, members of the compliance committee, the organization's employees, managers and governing body, and the organization's first tier, downstream and related entities. Such lines of communication shall be accessible to all and allow compliance issues to be reported including a method for anonymous and confidential good faith reporting of potential compliance issues as they are identified.

With respect to "lines of communication," it will be broadly interpreted to include telephone, e-mail, website-based correspondence, interoffice mail, regular mail, face-to-face interaction, drop box, and any other reasonable means to communicate.

Facility staff members and consultants are required, in good faith, to report behavior and conduct that may constitute a violation of this Plan and/or Applicable Legal Requirements. The failure to report a compliance violation is, in and of itself, a violation of the Facility's Plan. The Facility strives to maintain an open line of communication and is committed to ensuring that all staff members and consultants feel comfortable communicating their concerns to the Corporate Compliance Officer or other management personnel. The Compliance Officer shall maintain regular office hours (and will also schedule special appointments) in order to address compliance issues with staff members and consultants. The Compliance Officer can be notified verbally, by telephone, by e-mail or other electronic communication. Additionally, the Compliance Officer can also be contacted using the compliance report form which is attached to this Plan at ***Exhibit A*** and is also available in the Facility's business office, whenever a compliance issue arises. Intentional false reports or accusations are prohibited and subject to disciplinary action.

It is the core policy of the Facility that it will respect the confidentiality of any compliance communication to the greatest degree possible, acknowledging that complete confidentiality and anonymity in reporting may not be possible in order to conduct a thorough investigation and implement an appropriate plan of compliance correction. The Facility's policies permit individuals to anonymously report all compliance violations, suspected compliance violations, questionable conduct, or questionable practices.

The Facility is committed to ensuring that there will be no retribution against any staff members and consultants when reporting a potential compliance violation committed by third parties.

Element 5: Well-publicized disciplinary standards through the implementation of procedures which encourage good faith participation in the Compliance Program by all affected individuals.

The Facility has a disciplinary policy in place which specifically encourages the good faith participation in the Plan by all staff members and contractors/consultants. The Facility may implement disciplinary action against a staff member and/or contractor/consultant when such staff members and contractors/consultants: (a) fail to report a suspected compliance concern or problem; (b) fail to comply with the Facility's Plan and/or Applicable Legal Requirements; (c) encourage, direct, facilitate, or permit (either actively or passively) non-compliant behavior, including, but not limited to, behavior which may impair the Facility's goodwill and status in the community; (d) fail to detect a compliance problem attributable to the individual's own intentional, negligent, or reckless actions or inactions; (e) refuse to cooperate in the investigation of a suspected violation of the Plan; and/or (f) retaliate against an individual for making a good faith report of a suspected violation of the Plan and/or the Applicable Legal Requirements.

The Facility can take disciplinary action up to and including termination. Some alternative disciplinary methods other than termination include, but are not limited to, the following: (a) oral or written warnings; (b) internal job transfer; (c) temporary probation; (d) temporary suspension (with or without pay); (e) demotion; (f) restitution/reimbursement for losses or damages; (g) mandatory or permissive reporting to the applicable governmental agency or authorities; (h) retraining of staff members or consultants; and/or (i) referral for potential criminal or civil legal actions.

The Facility will consider various factors and circumstances in determining the appropriate imposition of discipline in order to ensure that its disciplinary policies are fairly and firmly enforced. Any disciplinary action shall be based on a consideration of at least the following: (a) the nature of the compliance activity or inactivity; (b) whether the individual(s) involved could reasonably have been expected to identify the activity or inactivity as non-compliant; (c) whether the individual(s) involved were in a position to implement a corrective action plan; and (d) whether the individual(s) involved were unduly influenced to participate in the non-compliant activity or inactivity.

The Facility's disciplinary standards will encourage good-faith participation in the Plan for all affected individuals.

Element 6: Establishment and implementation of an effective system for routine monitoring and identification of compliance risks. The system should include internal monitoring and audits and, as appropriate, external audits, to evaluate the organization's compliance with the medical assistance program requirements and the overall effectiveness of the Compliance Program.

The Facility has adopted an internal audit procedure in which it will review compliance risk areas once a year and report any finding to the Compliance Committee. The Facility will also hire external auditors as appropriate to address the Facility's compliance issues. The Facility will also periodically engage in internal audits.

The Facility shall ensure that its annual compliance program reviews are shared with the Owner, senior management, the Compliance Officer, the Compliance Committee, and other relevant personnel. Additionally, all required Federal and State monthly exclusion check results will be shared with the Compliance Officer and appropriate compliance personnel.

The Facility shall ensure that compliance requirements and Medicaid participation rules are adhered to, monitored, and enforced. The Facility Plan is designed and implemented to prevent, detect, and correct non-compliance with Medicaid program requirements, including fraud, waste, and abuse most likely to occur for the Facility's risk areas and organizational experience. In particular, any identified Medicaid program overpayments will be reported, returned, and explained in accordance with Medicaid self-disclosure program requirements, including but not limited to, the OMIG Self-Disclosure Program Requirements, Instructions & Guidelines from 2023 which are attached here and made part of this Plan, and which can be located at this website:

https://omig.ny.gov/media/80831/download?attachment

With respect to Facility risk areas, OMIG regulations at 18 NYCRR 521-1.3 mandate that the compliance program applies to those areas of operation affected by the Plan and shall apply to at least the following areas: (1) billings; (2) payments; (3) ordered services; (4) medical necessity; (5) quality of care; (6) governance; (7) mandatory reporting; (8) credentialing; (9) contractor, subcontractor, agent, or independent contractor oversight; and (10) other risk areas that are or should reasonably be identified by the Facility through its organizational experience. In this regard, the Facility shall also focus on the following risk areas: coding, claim submission, and cost reports/cost reporting.

Furthermore, in accordance with the OIG Compliance Program Guidance for Nursing Facilities (issued on March 16, 2000) and the OIG Supplemental Guidance Program Guidance for Nursing Facilities (issued on September 30, 2008), copies of which are attached here and made a part of this Plan, the Facility has identified the following risk areas that it will self-evaluate for actual or potential non-compliance:

- Quality of Care of residents
    - Sufficient Facility staffing
    - Comprehensive resident care plans
    - Medication management
    - Appropriate use of psychotropic medications

    - Resident safety (promoting resident safety; resident interactions; and staff screening)

- Submission of accurate claims to payors
    - Proper Reporting of Resident Case-Mix
    - Therapy Services
    - Screening for Excluded Individuals and Entities
    - Restorative and Personal Care Services

- Compliance with the Federal (and State) Anti-Kickback Statute
    - Review of the provision of free goods and services
    - Review of Services Contracts
        - Non-Physician Services
        - Physician Services
    - Review of Facility Discounts
        - Price Reductions
        - Swapping
    - Review of Hospice affiliations
    - Review of Reserved Bed Payments
- Compliance with all Federal and State Physician Self-Referral Laws and Regulations
- Compliance with Anti-Supplementation requirements
- Compliance with Medicare Part D requirements
- Compliance with HIPAA Privacy and Security Rules
- The establishment and maintenance of an ethical culture

The Facility shall also ensure compliance in the following risk areas: quality of care of medical assistance program beneficiaries, quality assessment and assurance, employee screening (including requirements relating to ensuring appropriate licensure and certification), resident inducements, and billing and cost reporting.

It is the Facility's practice to verify the credentialing of providers and persons associated with providers and to make all necessary mandatory reports to appropriate governmental and legal authorities in a timely fashion in accordance with all Applicable Legal Requirements.

The Facility will also ensure that it addresses and audits specific areas of the Medicaid program that are particularly vulnerable to improper payments, including, but not limited to, (a) claims submitted for medical services to deceased beneficiaries; (b) claims submitted after or the failure to reimburse the Medicaid program after third-party liability has been established; and (c) bills submitted to a Medicaid beneficiary for Medicaid-covered services.

The Facility shall complete an annual review of whether the Medicaid compliance program requirements have been met, to determine the effectiveness of its compliance program, and whether any revision or corrective action is required. Examples of documentation that the Facility may utilize in order to demonstrate that it had a system for the routine monitoring and identification of compliance risks are detailed on page 15 of the attached OMIG Compliance Program Guidance document from 2023:

https://omig.ny.gov/media/80796/download?attachment

Element 7: Establishment and implementation of procedures and a system for promptly responding to compliance issues 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 medical assistance programs requirements.

When an individual fails to comply with the Facility's compliance policies and/or Applicable Legal Requirements, or otherwise engages in wrongdoing that has the potential of impairing the Facility's status as a compliant provider, a violation under the Plan has occurred. Staff members and consultants are mandated to report potential violations to the Compliance Officer. When the Compliance Officer or other management personnel are made aware of a potential violation, a prompt investigation will be commenced in order to determine whether a material violation has occurred. If such a violation has occurred, management will take steps to mitigate and resolve the problem, report the situation to the appropriate governmental authorities in accordance with the Applicable Legal Requirements, and implement a plan of compliance correction, as necessary.

Any necessary internal investigation may include a review of some or all of the following: (a) a confidential staff member and/or consultant interview; (b) a review of the agreements with the Facility's business associates and any reports drafted by those business associates; and (c) documents related to any investigations, legal and/or administrative proceedings, whether threatened or pending.

Once the investigation has been completed, the Facility will draft and implement an appropriate plan of compliance correction in order to accomplish at least the following: (a) taking immediate corrective action to cure any problem and implement steps to prevent it from reoccurring; (b) making appropriate restitution; (c) conferring with legal counsel to determine what disclosures, if any, should be made; (d) initiating appropriate and fair disciplinary action; and (e) preparing a report to the Compliance Officer and the Compliance Committee that outlines the alleged misconduct, subsequent findings, and the plan of compliance correction that was adopted or is proposed.

After any internal or external audits or investigations that identify overpayments, the Facility will: (1) conduct internal audits or investigations to identify the root cause of the identified findings and any additional overpayments; (2) report, return and explain any identified additional overpayments to the Medicaid program through the OMIG Self-

Disclosure Program; and (3) implement corrective actions related to the identified findings and follow-up activities to confirm the effectiveness of such corrective actions.

Specifically, as noted above, any identified Medicaid program overpayments will be reported, returned, and explained in accordance with Medicaid self-disclosure program requirements, including but not limited to, the OMIG Self-Disclosure Program Requirements, Instructions & Guidelines from 2023 which are attached here and made part of this Plan, and which can be located at this website:

https://omig.ny.gov/media/80831/download?attachment

The Facility shall make appropriate restitution (including, but not limited to, repaying any overpayments) in accordance with this Self-Disclosure Program Requirements guidance, the statutes and regulations of the New York State Department of Health, and all other Applicable Legal Requirements.

The Facility shall ensure that ongoing training of employees is conducted and documented and that there is routine auditing of billing practices, quality of care issues, existing contracts, and related areas as necessary.

The Facility shall also comply, to the extent applicable and practicable, with the following additional guidance issued by OMIG (attached here) to the extent OMIG intends to continue to enforce such guidance: (1) Compliance Program Assessment Form; (2) Federal False Claims Act Civil Penalties Increase (Compliance Alert 2016-01, July 22, 2016); and (3) Mandatory Compliance Programs' Risk Assessments: Changes in Medicaid Reimbursement Systems (Compliance Alert 2017-1, August 31, 2017).

The Facility shall also incorporate into this Plan the guidance and resources noted on OMIG's website at https://omig.ny.gov/compliance/compliance-library, including the following: Compliance Program Review Module; Compliance Program Self-Assessment Form; Compliance Program Requirements Frequently Asked Questions; and Compliance Program Requirements 2023 (Webinar).

Additional guidance which is issued by OMIG in 2023 and thereafter will be attached here and further incorporated into this Plan.

The Facility will certify that it has adopted and is maintaining an effective compliance program as part of its annual "Certification Statement for Provider Billing Medicaid." This annual certification shall occur on the anniversary date of the Facility's enrollment in Medicaid. Additional information can be found at the following website:

https://omig.ny.gov/compliance/compliance-certification

This Plan is hereby adopted by the Facility and by its governing body in accordance with all Applicable Legal Requirements.

Originally Adopted: September, 2009

Latest Revisions: October, 2023

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Authorized Facility Representative

APPENDIX D

VENDOR POLICY

Introduction:

This Vendor Policy details Palatine's policy as it relates to compliance and sets the standards and commitment with which we require our vendors to operate.

This Vendor Policy (and the Compliance Plan) will be distributed to vendors in coordination with initial implementation of the Compliance Plan, and subsequently to new vendors upon their association with the facility.

Vendors receiving this Vendor Policy shall be deemed to accept the information therein and be committed to the policies and standards, unless the facility is otherwise notified in writing.

Policy:

In an effort to comply with the increasing number of laws and regulations, and because many of our vendors provide services and supplies that require us to submit claims for reimbursement to governmental and private payor programs, Palatine has included the following Vendor Policy in its Compliance Plan. Vendors who provide services or supplies to the facility shall conduct business in an ethical manner and comply with the following standards. It shall be the duty of all persons associated with such vendors to report suspected instances of noncompliance immediately to the facility's Compliance Officer. Vendors shall strive to:

1. Notify the compliance officer of any instance of misconduct or suspected conflict of interest.

2. Notify the compliance officer immediately upon notice that it or its applicable staff have been excluded from any Federal, State, or private payor health care program.

3. Deal openly and honestly with all persons associated with the facility.

4. Practice good faith in all transactions occurring in the course of business.

5. Preserve the facility's and residents' confidentiality in accordance with all legal requirements, including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations ("HIPAA"). Never use or disclose confidential or other information relating to the facility or residents.

6. Respond to invoice or payment inquiries of the facility expeditiously and courteously.

7. Practice good faith efforts in providing the facility with accurate, adequate, and timely information that may or may not be subject to claim submission to a Federal, State, or private payor health care program.

8. Provide invoices or requests for payment to the facility only for services or supplies provided to the facility or residents.

9. Understand and agree that its books and records may be subject to review by health care or government agencies.

10. Comply with State and Federal laws concerning antitrust and unfair competition including price fixing, collusion with competitors, rigging of bids, boycotts, and unfair trade and business practices.

11. Refrain from activity that represents conflict of interest or an unfair business advantage by virtue of business interest or association with the facility.

12. Offer discounts or special terms on purchases only when the discount or special term applies to the general public or entities similar in size and composition of the facility.

13. Never propose an offer, gift, excessive entertainment, contribution, solicitation, or payment to anyone associated with the facility with the intent to induce referrals, influence business decisions, receive an unfair advantage, provide special attention or service, or persuade the facility to do business with it. This does not include giving items of nominal value.

Vendors shall also be required to agree to the terms of the amendment to its services agreement with Palatine – in order to ensure such agreements with vendors specify that the vendors are subject to the terms of the facility's Plan to the extent such vendors are affected by the facility's risk areas and only within the scope of the contracted authority and affected risk areas (including, but not limited to, billings; payments; ordered services; medical necessity; quality of care; governance; mandatory reporting; credentialing; and contractor/subcontractor/agent/independent contractor oversight).

Vendors may review the facility's entire compliance plan or ask questions about the Plan by contacting the facility's Compliance Officer/Administrator.