CENTRAL ISLAND HEALTHCARE

CODE OF CONDUCT

We are committed to providing the highest quality of care in an ethical, honest, and lawful manner. The Code of Conduct ("Code") guides us to prevent fraud, waste and abuse, and remain in compliance with federal and state laws and regulations, including, but not limited to, the Deficit Reduction Act, Health Insurance Portability and Accountability Act (HIPAA), False Claims Act, and Omnibus Budget and Reconciliation Act of 1987. This Code further sets forth the standards and expectations for promoting ethical and legal behavior and a culture of compliance. The Code applies to all members, partners, employees, contractors and vendors ("Workforce member(s)[1]"). In New York, "Affected Individuals" are to be considered part of the Workforce members.[2]

I. COMPLIANCE WITH THE CODE

Workforce members are required to comply with the Code; expected to observe the highest ethical and legal standards; and comply with applicable laws and regulations. We are all expected to:

> Do things the right way.

> Perform our job legally and ethically.

> Demonstrate honesty and excellence in our work.

> Report concerns that may violate the Code, laws or policies and procedures.

We are a team and it is never acceptable to overlook actual or potential wrongdoing.

II. QUALITY OF CARE

We strive to provide excellent care. As Workforce members, we are expected to provide residents with superior care guided by our principles of kindness, compassion, service and excellence. Below are only some of the requirements which guide us in meeting our goals for each resident, as applicable:

> Timely completion of assessments and interdisciplinary care plans;

> Provision of individualized treatment and services to address resident needs;

> Accurate dispensing of medications to and monitoring of residents; and,

> Reassessment of outcomes to measure and confirm quality care goals.

[1] The term "Workforce members" used in the Code refers to all members, partners, employees, contractors and vendors of the facility who engage in patient or resident activity, by way of supporting, billing or providing for care or using, accessing or maintaining patient/resident information.

[2] "Affected Individuals" are defined by 18 NYCRR Subpart 521-1.2 as "all persons who are affected by the required provider's risk areas including the required provider's employees, the chief executive and other senior administrators, managers, contractors, governing body and corporate officers."

CODE OF CONDUCT

III. RESIDENT RIGHTS

It is our responsibility to protect the rights of our residents and obey the laws concerning resident rights. We are each individually required to promptly report any incident of abuse, neglect or mistreatment. All Workforce members, including employees, contractors and vendors are expected to ensure that:

> Residents are protected from verbal, physical, emotional or sexual abuse or neglect.

> Residents are treated with courtesy, respect and dignity.

> Residents can participate in their healthcare decisions.

> Residents are not improperly denied care.

IV. PROPER SUBMISSION OF CLAIMS

To ensure compliance with the federal False Claims Act and similar state regulations, we have policies and procedures in place to detect, prevent, and report instances of fraud, waste, and abuse. The Centers for Medicare & Medicaid Services (CMS) defines fraud, waste and abuse as follows:

> Fraud is committed when a person submits a false statement or makes a misrepresentation to obtain government funds when he/she knows it is false. Fraud also occurs when a person solicits, pays or receives payment to induce or obtain referrals for items or services reimbursed by a government program.

^ ***Examples:***

- ***Billing for a service that was not rendered.***
- ***Making a false statement in a claim for payment.***
- ***Falsifying clinical or coding information.***
- ***Double billing or submitting duplicate claims.***

18 NYCRR Section 515.1(b)(7) defines fraud as, "an intentional deception or misrepresentation made with the knowledge that the deception could result in an unauthorized benefit to the provider or another person and includes the acts prohibited by section 366-b of the Social Services Law."

CODE OF CONDUCT

> **Waste** is committed when a person overuses services or other practices that (directly or indirectly) results in unnecessary costs to a government program.

^ ***Example: Billing for an unnecessarily repeated service due to a system inefficiency.***

> **Abuse** is committed when a person submits a claim to a government program for items or services provided, but were not medically necessary. Here, the provider has not knowingly or intentionally misrepresented the facts.

^ ***Example: Billing for a service that was provided to a resident, but was not medically necessary.***

18 NYCRR Section 515.1(b)(1) defines abuse as, "practices that are inconsistent with sound fiscal, business, medical or professional practices and which result in unnecessary costs to the medical assistance program, payments for services which were not medically necessary, or payments for services which fail to meet recognized standards for health care."

A. False Claims Act

I. THE FEDERAL FALSE CLAIMS ACTS

a. FEDERAL CIVIL FALSE CLAIMS ACT - Under the Federal False Claims Act ("FCA") (31 U.S.C. §3729 et seq.) it is a violation to:
- Knowingly present, or cause to be submitted, a false or fraudulent claim, record or statement for payment or approval;
- Knowingly use a false record or statement to avoid or decrease an obligation to pay the Government;
- Engage in a conspiracy to defraud the government by the improper submission of a false claim for payment; or
- Other fraudulent acts enumerated in the statute.

i. The FCA defines "knowingly" as actual knowledge of, deliberate ignorance of, or reckless disregard of the truth or falsity of the information. This standard does not require specific intent to defraud.
ii. "Claim" includes any request or demand for money or property if the United States Government provides any portion of the money requested or demanded.

b. THE PROGRAM FRAUD CIVIL REMEDIES ACT
i. The Program Fraud Civil Remedies Act of 1986 provides for administrative remedies against any person who makes, or causes to be made, a false claim or written statement to certain federal agencies, including the Department of Health and Human Services. The Program Fraud Civil Remedies Act addresses lower dollar fraud and generally applies to claims of $150,000 or less.

c. Examples of false claims include:
i. Making false statements regarding a claim for payment;
ii. Falsifying information in the medical record;
iii. Double-billing for items or services;
iv. Billing for services or items not performed or never furnished.

d. Reporting violations - In the event that you discover any violation under the federal or state false claims acts, you should follow the steps in the Compliance Program, including:
    i. Informing your supervisor;
    ii. Informing the Administrator;
    iii. Contacting the Compliance hotline by phone 516-433-0697 or email (Corporatecompliance@central-island.com); or anonymously by navigating to the FACILITY website (www.centralislandhealthcare.com).
    iv. An employee is not required to first notify the FACILITY in which he/she works. The Facility would like to be apprised of any issues because it allows for an opportunity to quickly address potential issues. Thus, Facility encourages employees to consider first reporting suspected false claims to the employee's supervisor, Administrator/Corporate Compliance Officer (CCO), but the choice is up to the employee.

e. Non-Retaliation
    i. Under no circumstances will Facility retaliate against any employee for informing the Facility's management or the federal or state government of a possible FCA violation.

II. FEDERAL ADMINISTRATIVE REMEDIES FOR FALSE CLAIMS

a. 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.
b. Violations under the FCA may result in civil penalties of not less than $5,500 and not more than $11,000 per violation, plus treble damages, and the costs of any civil action brought to recovery such penalties or damages.

III. ACTIONS BY PRIVATE PERSONS (QUI *TAM)*

Private Persons (qui tam lawsuits) can bring a civil action in the name of the government for a violation of the False Claims Act. Generally, the action may not be brought more than six years after the violation, but in no event more than ten. 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' fees and costs. 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 to the plaintiff.

An employee who is discharged, demoted, suspended, threatened, harassed, or discriminated against in the employee's 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.

CODE OF CONDUCT

B. Billing

We are committed to ethical and honest billing practices and will not tolerate any purposely false billing. Workforce members are expected to:

- Submit accurate and truthful claims;
- Ensure that there is adequate documentation to substantiate claims;
- Refund overpayments;
- Accurately report financial transactions;
- Alert the supervisor or Administrator/Corporate Compliance Officer if the member becomes aware of a false or questionable claim, without fear of retaliation.

C. Self-Disclosure Requirements

The retention of identified overpayments from Federal health care programs (e.g. Medicare and Medicaid) is a potential liability under both federal and state law including the False Claims Act. Related laws are intended to prevent fraud.

An overpayment is a payment that the federal and/or state government or program did not authorize and that exceeds the amount due and payable according to existing law and regulations. An overpayment may include payments resulting from inaccurate or improper cost reporting, improper claiming, unacceptable practice, fraud, abuse or mistake.

Once a provider identifies an overpayment, it must be self-disclosed to the appropriate state and/or federal office or department within 60 days after the date it was identified or, if applicable, the date that a corresponding cost report is due. State and/or federal law or regulations will have information about the specific process to follow when submitting a self-disclosure, which will include, among other things, what information to submit and how. Information to be disclosed will include the circumstances of the overpayment, calculation of overpayment(s) and corrective action.

There is no threshold for reporting. Examples of what should be self-disclosed include, but are not limited to, a billing error, fraudulent behavior, discovery of an employee on the Excluded Provider List, documentation errors that resulted in overpayments or overpayments caused by other means such as changing billing systems.

Failure to comply with self-disclosure requirements and/or to issue a repayment may lead to the imposition of criminal and/or civil monetary penalties, imprisonment and/or exclusion from participation in Federal health care programs.

CODE OF CONDUCT

Under federal law, filing false claims may lead to fines of up to three times the programs' loss plus $11,000 per claim filed, and there may be criminal fine and/or imprisonment as well. Federal civil monetary penalties range from $10,000 to $50,000 per violation. Similar state penalties may apply as well.

V. BUSINESS PRACTICES

A. Kickbacks

Kickbacks are any items or services of value including cash, goods, gifts, or freebies (also known as "remuneration") that are received in return for the incentive or acceptance of referrals.

Examples:

> ***Acceptance of gifts, free goods or services from vendors in exchange for their business; or***

> ***Asking vendors for gifts, money or favors from of value in exchange for business.***

Kickbacks are illegal. A person who accepts or gives a kickback may be subject to prison time, large fines and program exclusion which may prohibit you from working any place that accepts government support. Workforce members may never ask for, accept, offer or give kickbacks of any kind and must never:

> Offer or pay for anything of value to influence or reward someone for referrals;

> Ask for or accept anything of value in order to refer residents to other providers; or

> Ask for or accept from vendors anything of value in exchange for our business.

We will only pay for services provided and supplies or goods received. Contracts and arrangements must comply with ethical business practices and applicable laws such as the Anti-Kickback Statute.

B. Conflicts of Interest

A conflict of interest is when one's personal interests interferes or seems to interfere with the interests of the facility. Workforce members must identify any action where a conflict of interest could affect an ability to do one's job honestly. Workforce members are particularly cautioned to avoid:

> Accepting personal gifts, money or favors from residents or their families;

> Accepting personal gifts, money or favors from vendors;

> Entering into relationships with vendors that would cause the placing of one's personal interests ahead of the Facility; or

> Making decisions for the facility that result in personal gain.

C. Responsible Use of Property and Supplies

Workforce members are expected to use facility resources for authorized purposes only. Workforce members are responsible for protecting supplies, equipment and property from loss, theft, damage or misuse. Workforce members are prohibited from using facility resources for personal use.

VI. PROFESSIONAL STANDARDS

Only qualified personnel may provide resident care. All employees are screened prior to employment to verify educational, professional, clinical and criminal background; and to ensure that employees are not excluded or disqualified from participating in any federal or state healthcare program. Workforce members are expected to perform their job with honesty and integrity and must maintain their professional and clinical licenses throughout their employment. Managers are responsible for maintaining a positive work environment.

If a workforce member is charged with any criminal offense, the member must notify the member's supervisor or manager.

VII. TRAINING AND ATTESTATION

Compliance training will be provided as required. All new employees will receive compliance training as part of the orientation process or within 30 days. Training will also be providedat least annually.

All vendors, independent contractors, and those who conduct business for, or on behalf of the facility shall have access to a copy of the Code and shall comply with the Code and policies and procedures.

Affected individuals will also be trained to the extent required by New York law and/or regulation.

An acknowledgement that the training was completed will be signed, which will also indicate that the person signing agrees to abide by the Code of Conduct. A quiz and/or survey may be completed as well in some circumstances.

VIII. MANAGEMENT

Management staff must provide an open door policy and guidance relating to the Code and applicable laws and regulations. Management is required to:

> Ensure all employees receive annual compliance training in general and area-specific topics;

> Maintain a positive work environment;

> Prevent, detect and respond to compliance concerns; and

> Enforce disciplinary standards in the event non-compliance is found.

>

IX. COMMUNICATION

Where a Workforce member requires help or guidance on any issue that may affect their ability to comply with the Code, related policies and procedures, laws or regulations, the member must contact the supervisor, Administrator/Corporate Compliance Officer. Contractors or vendors should contact the Administrator/Corporate Compliance Officer. Workforce members may also call the toll-free Compliance Hotline (516-433-0697) at any time for assistance.

X. REPORTING

All Workforce members are responsible for preventing fraud, waste and abuse and acting ethically and legally. Any Workforce member who discovers, knows or suspects that anyone has violated any state or federal laws, including the False Claims Act, or this Code of Conduct ***must*** report the violation by doing any one of the following:

> Reporting the known or suspected violation to a supervisor, Administrator/Corporate Compliance Officer;

> Calling the Compliance Hotline (516-433-0697) at any time;

> Sending an email to Corporatecompliance@central-island.com:

> Making an anonymous report on the facility website by clicking on the “Compliance” tab and thereafter clicking on “Report a Compliance Concern”; or,

Anyone may call the hotline confidentially, or report through the website confidentially. Reporting concerns or non-compliance does not replace our policies for reporting resident abuse, mistreatment or neglect.

XI. NON-RETALIATION AND NON-INTIMIDATION

Workforce members are strictly prohibited from subjecting another to intimidation, retaliation or discipline for good faith reporting actual or suspected violations of any state of federal law, including the False Claims Act, or this Code of Conduct, including reports made to external officials.

> ***Retaliation*** is the discharge, threat, suspension, demotion, denial of promotion, discrimination, or other adverse employment action following a good faith report of a compliance complaint.

> ***Intimidation*** is bullying, coercion or threatening behavior directed to an employee for a good faith report of a complaint.

> ***Good faith*** refers to an honest desire or intent to comply with the Code of Conduct.

If you feel your position is threatened as a result of your actual or potential reporting a compliance concern, please immediately contact the Administrator/Corporate Compliance Officer at 516-433-0697.

XII. PRIVACY AND CONFIDENTIALITY

We are committed to protecting resident information. The Health Insurance Portability and Accountability Act (HIPAA) requires that we safeguard and protect protected health information ("PHI") which in an electronic format is referred to as electronic PHI ("ePHI").

Protected Health Information

PHI can include any information which identifies a resident, including but not limited to name, address, location in the facility, health insurance information, social security number and date of birth. Workforce members must:

- Only share the minimum information necessary to staff who are authorized to have such information to do one's job;
- Only share PHI with the people designated by the resident to receive such information;
- Only share PHI with authorized staff who have a need to know the information;
- Not disclose PHI outside the facility, unless required by law to do so
- Ensure a Business Associate Agreement is in place for arrangements with contractors, vendors, and those who will use, disclose, and transmit resident PHI.

Electronic Protected Health Information (ePHI)

ePHI must be secure and protected from loss, damage or unauthorized access or use. Only certain employees are granted access to computer systems. Employees with access are responsible for protecting ePHI and must do the following:

- Keep user and log-in information and passwords confidential;
- Access only the ePHI necessary for work; and
- Log off from computer terminals whenever stepping away (even if for a few minutes).

XIII. ACCURATE RECORDS

Workforce members must document care rendered accurately and timely. Documentation must support the services provided. It is never appropriate to make improper changes or forge documents or signatures.

CODE OF CONDUCT

XIV. RECORD RETENTION

We are required to maintain medical and business records for a specified period of time. Failure to properly retain these records could result in serious penalties. Each of us is expected to comply with our record retention policy.

XV. NON-DISCRIMINATION

It is strictly prohibited to discriminate on the basis of race, color, national origin, disability, past/present history of mental disorder, or age in admission or access to treatment or employment in programs and activities as required by Title VI of the Civil Rights act of 1964, Section 504 of the Rehabilitation Act of 1973 and the Age Discrimination Act of 1975. Other agency guidelines prohibit discrimination on the basis of creed, marital status and sex (including gender identity and sexual orientation).

XVI. DISCIPLINE

Compliance with the Code and applicable policies and procedures, laws and regulations is a required condition of employment and/or contractual relationship. Without regard to title or job function, violators shall be subject to disciplinary action and/or sanctions..

Sanctions may include oral or written warnings, suspension, and/or termination and must conform with collective bargaining agreements when applicable.

Any intentional or reckless behavior shall be subject to more significant sanctions.

Violators may also be subject to criminal and/or civil monetary penalties.

Everyone including all levels of personnel shall be subject to the same options for disciplinary action. Disciplinary action shall be enforced fairly and equally.

CODE OF CONDUCT

NEW YORK FALSE CLAIMS ACT

Knowing(ly) means that a person with respect to information: a) Has actual knowledge of the information; b) acts in deliberate ignorance of the truth or falsity of the information; or, c) acts in reckless disregard of the truth or falsity of the information, without regard to whether the person intends to defraud

> It is prohibited to:

^ **Knowingly present, or cause to be presented, a false or fraudulent claim for payment or approval;**

^ **Knowingly make, use or cause to be made or used a false record or statement to get payment for a false or fraudulent claim.**

^ **Conspire to defraud by getting a false or fraudulent claim allowed or paid;**

^ **Knowingly make, use, or cause to be made or used, a false record or statement to get a false or fraudulent claim paid or approved, or to avoid or decrease an obligation;**

^ **Have possession, custody, or control of property or money used, or to be used, intending to defraud or willfully to conceal the property, delivers, or causes to be delivered, less property than the amount for which the person receives a certificate or receipt.**

> **Penalties** include:

^ Three (3) times damages; and

^ Up to $12,000 per claim or up to $7,500 per claim for Social services fraud.

^ However, if the violator reports the violation within 30 days after obtaining the information; the person fully cooperates with any state investigation; and the report precedes any civil, administrative or criminal action, the court may assess costs in the amount of not less than 2 times the amount of damages

> Whistleblower

^ Anyone with evidence of false claims can sue to recover the funds and receive a share of the funds recovered and expenses.

^ Anyone who is fired, suspended, threatened or retaliated against for reporting false claims is protected. In the event of retaliation, the employee is entitled to reinstatement of their job, benefits and double back pay and other fees.

CODE OF CONDUCT

> Labor Law - Employers may not retaliate against employees if they report information about ^ (1)

public health safety;

^ (2) improper quality of care; or ^ (3) false claims to a

public official or law enforcement.

^ The employee is protected only if they first brought the information to a supervisor and gave reasonable time to correct the allegation. If retaliated against, the employee may sue for reinstatement and other benefits.