ARCHCARE AND AFFILIATED ENTITIES POLICY

SUBJECT: Compliance and Ethics Program, Detecting and Preventing Fraud, Waste and Abuse, System-Wide

ORIGINATING DEPARTMENT: Corporate Compliance

EFFECTIVE DATE: October 1, 2010

BOARD AUDIT, RISK AND COMPLIANCE COMMITTEE APPROVAL DATE: 06/04/2026

LAST PERIODIC REVIEW DATE: 05/05/2026

PURPOSE: The purpose of this policy is to prevent, detect and address Fraud, Waste and Abuse (FWA) and to ensure compliance with applicable federal and state laws and regulations. ArchCare and its affiliated entities are committed to maintaining an effective Compliance Program, promoting ethical conduct, and educating workforce members on their responsibilities related to accurate reporting, claims submission, and the reporting of suspected misconduct.

ENTITIES AFFECTED: All ArchCare-sponsored entities

SCOPE: This policy applies to the workforce[1] of ArchCare and its affiliated entities. Specifically, ArchCare "[w]orkforce" includes, but is not limited to, care members (including chief executive and other senior administrators and managers), medical staff, volunteers, and students. The term "workforce" also applies to contractors, subcontractors, agents or independent contractors[2] who, on behalf of ArchCare, furnish, or otherwise authorize the furnishing of Medicare and/or Medicaid health care items or services, perform billing or coding functions, or are involved in monitoring of health care provided by ArchCare.

[1] This definition is aligned with the updated Part 521 of Title 18 of the Codes, Rules and Regulations of the State of New York which defines "[a]ffected [i]ndividuals as defined by the as all persons who are affected by the provider's risk areas, including employees, the chief executive and other senior administrators, managers, contractors, agents, subcontractors, independent contractors, and governing body and corporate officers."

[2] This policy applies to designated contractors who engage in the provision of quality healthcare service and/or who fall under the following risk areas of "billings, payments, ordered services, medical necessity, quality of care, governance, mandatory reporting, credentialing, contractor oversight, and other areas that should reasonably be identified by the provider through its organizational experience".

POLICY: ArchCare and its affiliated entities are committed to preventing and detecting fraud, waste and abuse in the organization. To this end, ArchCare maintains an effective Compliance Program and educates its workforce regarding the importance of submitting accurate claims and reports to federal and state governments, as well as the requirements, rights and remedies and whistleblower protections provided under federal and state false claims laws.

ArchCare prohibits the submission of false claims for payment to a federal or state health care program. Such conduct violates the federal False Claims Act and applicable state laws and may result in significant civil and/or criminal penalties.

To assist in meeting its legal and ethical obligations, ArchCare expects any workforce member who is aware of or reasonably suspects the preparation or submission of a false claim or report or any other potential fraud, waste, or abuse to report such information to their supervisor, the Compliance Liaison at the facility or program where they are employed, the ArchCare Corporate Compliance Officer of (646) 656-8724, or to call the Compliance & Corporate Ethics Hotline at (800) 443 0463 (which is available 24 hours a day, 7 days a week.) The reports can be submitted online as well at www.archcare.ethicspoint.com. Any workforce member who reports such information shall have the right and opportunity to do so anonymously and shall be protected against retaliation and intimidation for reporting such information, consistent with ArchCare's Compliance Program policies and procedures and applicable federal and state law. ArchCare and its affiliated entities prohibit retaliation against care members or others, in good faith report potentially unethical or illegal conduct. See Whistleblower Protection Policy (Compliance Program, Reporting Compliance Matters; Whistleblower/Non-Retaliation/Non-Intimidation Policy for Good Faith Participation in the Compliance Program, System-Wide).

ArchCare is committed to investigating any allegations of fraud, waste, or abuse promptly and requires all workforce members to assist in such investigations. Corrective action related to detected offenses will be promptly and thoroughly implemented, as necessary and appropriate. Failure to report or assist in an investigation or resolution of an allegation of fraud, waste or abuse is a breach of the workforce member's obligations to ArchCare and may result in disciplinary action, up to, and including termination of employment or affiliation with ArchCare.

ArchCare educates its workforce members on the importance of this policy on a periodic basis. See Compliance and Ethics Program, Compliance and Ethics Program Training & Education, System-Wide Policy

RELATED DOCUMENTS:
Other Compliance Program Policies are listed below:

Compliance Program, Code of Conduct
Compliance Program, Compliance Program Charter
Compliance Program, Compliance Program Files, System-Wide
Compliance Program, Conflict of Interest, System-Wide
Compliance, Conflicts of Interest in Compensation Decisions, System-Wide
Compliance Program, Reporting Compliance Matters; Whistleblower/Non-Retaliation/Non-Intimidation Policy for Good Faith Participation in the Compliance Program (System-Wide)
Compliance Program, Discipline Policy, System-Wide
Compliance Program, Employee Reviews, System-Wide,
Compliance and Ethics Program, Gifts, System-Wide
Compliance Program, Corrective Action and Response to Detected Offenses, System-Wide
Compliance Program, Risk Assessment, Monitoring and Reviewing, System-Wide
Compliance Program, Record Retention & Document Destruction, System-Wide
Compliance Program, Sanction Screening, System-Wide
Compliance Program, Vendor Deficit Reduction Compliance Education, System-Wide

REVISION HISTORY:

Date	Change/Note
05/05/2026	Annual review and update of the policies.
4/23/2025	Annual review and update of the policies.
5/1/2024	Annual review and update of the policies.
5/1/2023	Review and update to align with the new OMIG Guidance including redefining the term affected individual. In addition, made formatting changes.
08/2021	Revised definition of workforce; added language regarding anonymous reporting and investigations.
10/1/2010	New policy providing an overview and a roadmap to the other compliance program policies.

ARCHCARE AND AFFILIATED ENTITIES POLICY

SUBJECT: Compliance and Ethics Program, Discipline Policy, System-Wide

ORIGINATING DEPARTMENT: Corporate Compliance

EFFECTIVE DATE: September 9, 2007

BOARD AUDIT, RISK AND COMPLIANCE COMMITTEE APPROVAL DATE: 06/04/2026

MOST RECENT REVIEW/REVISION DATE: 05/05/26

PURPOSE: The purpose of this policy is to establish disciplinary standards for non-compliance with ArchCare' s Code of Conduct and Compliance Program policies and procedures, including those related to the detection, prevention, and remediation of fraud, waste and abuse.

ENTITIES AFFECTED: All ArchCare-sponsored entities.

SCOPE: This policy applies to care members of ArchCare and its affiliated entities. This policy applies to the workforce[1] of ArchCare and its affiliated entities. Specifically, ArchCare "workforce" includes, but is not limited to, employees (including chief executive and other senior administrators and managers), medical staff, volunteers, and students. The term "workforce" also applies to contractors, subcontractors, agents and independent contractors[2] who, on behalf of ArchCare, furnish, or otherwise authorize the furnishing of Medicare and/or Medicaid health care items or services, perform billing or coding functions, or are involved in monitoring of health care provided by ArchCare.

[1] This definition is aligned with the updated Part 521 of Title 18 of the Codes, Rules and Regulations of the State of New York which defines "[a]ffected [i]ndividuals as defined by the as all persons who are affected by the provider's risk areas, including employees, the chief executive and other senior administrators, managers, contractors, agents, subcontractors, independent contractors, and governing body and corporate officers."

[2] This policy applies to designated contractors who engage in the provision of quality healthcare service and/or who fall under the following risk areas of "billings, payments, ordered services, medical necessity, quality of care, governance, mandatory reporting, credentialing, contractor oversight, and other areas that should reasonably be identified by the provider through its organizational experience".

POLICY: All ArchCare workforce members are expected to comply with the Code of Conduct, the Compliance and Ethics Program, and applicable ArchCare compliance policies and procedures. If the Corporate Compliance Officer determines, following an appropriate investigation, that a violation has occurred, appropriate disciplinary action may be imposed by the SVP, Human Resources, as part of a corrective action plan. All ArchCare entities shall administer disciplinary action for compliance violations in a fair, equitable and timely manner, regardless of individual's title or position.

Disciplinary action may be imposed for actions including, but not limited to:

- failing to report suspected compliance concerns or violations
- authorizing, participating in, or otherwise engaging in non-compliant conduct;
- encouraging, directing, facilitating, permitting or failing to prevent non-compliant behavior whether actively or passively;
- refusing to cooperate in the investigation of a potential compliance violation;
- failure to assist in the identification or resolution of compliance-related issues; and/or
- intimidating, threatening, coercing or retaliating against any individual who, in good faith, reports a compliance concern or participates in the Compliance and Ethics Program.

PROCEDURE:

1. The Corporate Compliance Officer and the SVP, Human Resources are responsible for ensuring that disciplinary actions related to violations of applicable laws, regulations, the Compliance Program, and the Code of Conduct, are administered consistently and in alignment with actions taken in similar circumstances.

   The Corporate Compliance Officer is responsible for overseeing the compliance-related aspects of such matters, including ensuring that alleged violations are appropriately investigated and that corrective actions are implemented to prevent recurrence.

The SVP, Human Resources is responsible for overseeing the personnel related aspects of the disciplinary process and ensuring that disciplinary measures are applied

consistently in accordance with ArchCare' s policies, procedures and employment practices.

2. In recommending appropriate sanctions to the SVP, Human Resources, the Corporate Compliance Officer, or their designee, should consider as applicable:

   a. the nature and severity of the violation;
   b. the duration or time period during which the violation occurred;
   c. the nature and extent of any resulting government overpayment, if applicable;
   d. whether the violation was committed intentionally, recklessly, negligently, or inadvertently;
   e. whether the individual has a history of prior violations or misconduct;
   f. whether the individual voluntarily self-reported the misconduct;
   g. whether, and to what extent, the individual cooperated during the investigation of the misconduct;
   h. the actual or potential impact of the issue or incident on the quality of care provided to ArchCare residents or patients;
   i. the nature and extent of any potential criminal, civil or administrative liability for the individual and/or ArchCare;
   j. the individual's prior employment history or other affiliation with ArchCare;
   k. an entity's prior affiliation history with ArchCare, where applicable;
   l. whether the matter had previously been addressed through compliance training provided or required by ArchCare; and
   m. the extent to which the issue or incident reflects a systemic, operational or departmental failure to comply with the Compliance and Ethics Program.

   ArchCare shall apply progressive discipline in a manner that is proportionate to the nature and severity of the violation and consistent with applicable Human Resources policies and procedures. The nature of any disciplinary or corrective action will depend upon both the individual's or entity's relationship with ArchCare and the circumstances of the violation. Disciplinary or corrective actions may include, but are not limited to, the following:

   a. Workforce members may be subject to disciplinary action, including, verbal counseling, written warnings, suspension or other corrective measures;

   b. Employees may be subject to termination of employment;

c. interns, students, and volunteers may be subject to termination of their affiliation or placement with ArchCare;

d. contractors, vendors or other third parties may be subject to a termination of their contractual or business relationships with ArchCare;

e. members of the governing body may be subject to removal from, or termination of, their appointment to the applicable governing body;

f. licensed Clinicians or other billing providers may also be subject to suspension or restriction of billing for services rendered on behalf of ArchCare; and

g. ArchCare reserves the right to take any other corrective action, deemed appropriate under the circumstances and consistent with applicable laws and ArchCare policies.

3. Care members will be provided with an opportunity to review and respond to relevant information and evidence related to the allegation prior to the imposition of disciplinary action.

4. The SVP, Human Resources shall have responsibility for making the final determination regarding any disciplinary sanctions, taking into consideration the assessment and recommendations of the Corporate Compliance Officer regarding the nature, extent and severity of the compliance violation.

   If the Corporate Compliance Officer determines that the proposed sanctions for a compliance related violation are inconsistent with disciplinary actions imposed in similar instances of non-compliance, the Corporate Compliance Officer shall report such concerns to the President and Chief Executive Officer (CEO) and the Chair of the Audit, Risk, and Compliance Committee.

   In making a final determination, ArchCare may consider any applicable contractual, regulatory, credentialing, collective bargaining or other legal obligations affecting the individual or entity involved.

   Nothing in this Discipline Policy, the Compliance and Ethics Program, or any related policy, procedure, guidance or program documentation shall be construed to create, alter, or confer any contractual, employment, or other legal rights or

entitlements for any individual or entity employed by, affiliated with or retained by ArchCare.

5. The SVP, Human Resources, shall ensure that documentation of any disciplinary action imposed on an employee under the Compliance and Ethics Program is maintained in the care member's personnel file. The Corporate. Compliance Officer shall ensure that documentation relating to any disciplinary sanction imposed related to a compliance violation is maintained within the Compliance and Ethics Program records and files, in accordance with applicable compliance documentation and record retention requirements.

6. The individual responsible for provider credentialing for the applicable ArchCare entity shall ensure that documentation of any sanction imposed on a contractor or credentialed provider under the Compliance and Ethics Program is maintained in the appropriate Compliance and Ethics Program records and/or within the designated contractor or credentialing file, in accordance with applicable record retention requirements and credentialing procedures.

7. The head of the applicable program, department, or facility shall ensure that appropriate documentation is maintained regarding any disciplinary or corrective sanction imposed on a care member or other individual affiliated with ArchCare under the Compliance and Ethics Program. The head of the relevant program, department, or facility shall also ensure that such documentation is shared with the designated Compliance Officer or Compliance Liaison for that program or facility, as appropriate.

REVISION HISTORY:

Date	Note/Change
05/05/2026	Annual review and update of the policies.
4/23/2025	Revised responsibility of determining sanctions: responsibility of HR in consultation with Corporate Compliance Officer.
5/1/2024	Annual review and update of the policies.
5/1/2023	Review and update to align with the new OMIG Guidance including redefining the term affected individual. In addition, formatting was changed.
8/2022	Replaced Compliance Program with Compliance and Ethics Program throughout
8/2021	Reorganized document to include a "procedures" section. Defined care members consistent with charter. Added ArchCare's expectations as to care member's adherence to the Compliance Program; Expanded actions subject to discipline; expanded factors considered in determining disciplinary action;

	expanded potential disciplinary actions. Added that care members will be given an opportunity to review and respond to relevant evidence prior to any disciplinary action being taken.
11/2019	Clarified that sanctions will be imposed on all those affiliated with ArchCare, including ArchCare workforce, contractors, governing body members, etc.), not simply employees.
2/2018	Added second sentence to #4, incorporating ramifications should employee fail to satisfactorily implement a corrective action.
6/2016	Clarified that Chief Compliance Officer has an approval role in determining discipline for compliance infractions;
6/2014	Changes per OMIG evaluation tool: updated to note that sanctions will be imposed upon Designated Contractors in response to compliance violations;
1/2011	Changes per annual review, audit, and OMIG evaluation tool: clarified that discipline would be implemented regardless of title or position and that sanctions could include termination;
9/6/2007	New policy

ARCHCARE AND AFFILIATED ENTITIES POLICY

SUBJECT: Compliance and Ethics Program, Employee Reviews, System-Wide

ORIGINATING DEPARTMENT: Corporate Compliance

EFFECTIVE DATE: March 1, 2011

BOARD AUDIT, RISK AND COMPLIANCE COMMITTEE APPROVAL DATE: 06/04/2026

LAST PERIODIC REVIEW DATE: 05/05/26

PURPOSE: To promote accountability, ethical conduct, and compliance with applicable laws, regulations, and ArchCare policies by incorporating compliance and ethics standards into employee performance reviews and evaluations across the organization.

ENTITIES AFFECTED: All ArchCare-sponsored entities.

SCOPE: This policy applies to the workforce[1] of ArchCare and its affiliated entities. Specifically, for the purposes of this policy ArchCare "workforce" includes, but is not limited to, employees (including chief executive and other senior administrators and managers), medical staff, volunteers, and students.

POLICY: Employee performance evaluations shall include an assessment of each care member's awareness of, participation in, and adherence to the Compliance and Ethics Program, including, but not limited to, compliance with internal policies and procedures, the Code of Conduct, and all applicable laws, rules and regulations.

PROCEDURE:

1. Individuals conducting annual performance evaluations of ArchCare care members shall assess and discuss each care member's awareness of, participation

[1] This definition is aligned with the updated Part 521 of Title 18 of the Codes, Rules and Regulations of the State of New York which defines "[a]ffected [i]ndividuals as defined by the as all persons who are affected by the provider's risk areas, including employees, the chief executive and other senior administrators, managers, contractors, agents, subcontractors, independent contractors, and governing body and corporate officers."

in, and adherence to the Compliance and Ethics Program as part of the review process.

2. Care Member evaluations may include discussion of the care members understanding of and responsibilities under the Compliance and Ethics Program, including, but not limited to, ArchCare's expectation that care members:

    - report suspected compliance concerns or violations in good faith;
    - , cooperate fully with compliance reviews and investigations; and
    - assist in the resolution of compliance-related issues.

A care member's demonstrated adherence to the Compliance and Ethics Program may be documented in the care member's written performance evaluation.

3. Employee evaluations may also include discussion of any compliance-related concerns, incidents, or issues identified during the applicable review period involving the employee and, whether such matters resulted in, or warrant, disciplinary or corrective action, including, counseling, verbal/written warning, suspension, termination or other sanctions. Documentation of any sanction or corrective action imposed under the Compliance and Ethics Program shall be maintained in the Compliance and Ethics Program records and/or in the care member's personnel file and may be referenced in the employee's written performance evaluation, as appropriate.

4. Any supervisor or manager conducting a care member evaluation shall promptly report to the appropriate Corporate Compliance Officer, Entity Compliance Officer and/or Compliance Liaison any matters identified during the review process that may present potential compliance concern or require further review by the Compliance and Ethics Program.

REVISION HISTORY:

Date	Note/Change
05/05/26	Annual review and update of the policies.
4/23/25	Annual review and update of the policies.

5/1/2024	Annual review and update of the policies.
5/1/2023	Review and update to align with the new OMIG Guidance including redefining the term affected individual. In addition, made formatting changes.
8/2022	Replaced Compliance Program with Compliance and Ethics Program
1/2011	Changes per annual review
8/2011	Added to sections 1 and 2 language regarding assessment of the employee's awareness of the compliance program, as well as adherence.
9/6/2007	Original Policy

ARCHCARE AND AFFILIATED ENTITIES POLICY

SUBJECT: Compliance and Ethics Program, Compliance and Ethics Program Files, System-Wide

ORIGINATING DEPARTMENT: Corporate Compliance

EFFECTIVE DATE: February 15, 2011

BOARD AUDIT, RISK AND COMPLIANCE COMMITTEE APPROVAL DATE: 06/04/2026

MOST RECENT REVIEW/REVISION DATE: 05/05/26

PURPOSE: To establish a routine documentation system for compliance records.

ENTITIES AFFECTED: All ArchCare-sponsored entities.

SCOPE: This policy applies to the workforce[1] of ArchCare and its affiliated entities. Specifically, ArchCare "workforce" includes, but is not limited to, employees (including chief executive and other senior administrators and managers), medical staff, volunteers, and students. The term "workforce" also applies to contractors, subcontractors, agents and independent contractors[2] who, on behalf of ArchCare, furnish, or otherwise authorize the furnishing of Medicare and/or Medicaid health care items or services, perform billing or coding functions, or are involved in monitoring of health care provided by ArchCare.

POLICY: ArchCare shall maintain standardized and uniform systems for the creation, organization, retention, storage and disposal of compliance related records, documents and other materials generated or maintained in connection with the Compliance and Ethics Program.

[1] This definition is aligned with the updated Part 521 of Title 18 of the Codes, Rules and Regulations of the State of New York which defines "[a]ffected [i]ndividuals as defined by the as all persons who are affected by the provider's risk areas, including employees, the chief executive and other senior administrators, managers, contractors, agents, subcontractors, independent contractors, and governing body and corporate officers."

[2] This policy applies to designated contractors who engage in the provision of quality healthcare service and/or who fall under the following risk areas of "billings, payments, ordered services, medical necessity, quality of care, governance, mandatory reporting, credentialing, contractor oversight, and other areas that should reasonably be identified by the provider through its organizational experience".

All compliance-related records shall be maintained in accordance with ArchCare's, Compliance and Ethics Program, Record Retention and Document Destruction Policy, as well as all applicable federal, state, regulatory, accreditation, and legal requirements governing record retention, confidentiality, access and destruction.

PROCEDURE:

1. The designated Compliance Liaison shall establish and maintain or ensure that appropriate departments establish and maintain, standardized filing and documentation systems for compliance related records. Such records shall be maintained in secure locations with appropriate safeguards to protect confidentiality, integrity, and accessibility.

2. Any documents that the Compliance Liaison reasonably believes are subject to the attorney-client privilege and/or attorney client work product protection shall be maintained separately from non-privileged materials in a secure and restricted access location. Access to such records shall be limited to individuals who have a legitimate business need to know and are authorized to review such materials.

3. The Compliance Liaisons and/or appropriate department heads, supervisors and managers, or personnel responsible shall ensure the proper documentation, maintenance, and retention of the following records, as applicable:

    a. Corporate Compliance Education and/or Information Technology (IT) department shall maintain records evidencing completion of compliance orientation and reconciliation within the designated e-Learning management system.

    b. Corporate Compliance Education and/or the IT department shall maintain documentation related to compliance education and training activities, including, but not limited to:

        - training dates;
        - presenter(s);
        - training descriptions and subject matter;
        - presentation materials;
        - attendance records or electronic completion records; and
        - the annual Compliance Training Plan.

c. The Corporate Compliance Officer shall maintain documentation evidencing the appointment of Compliance Liaisons, as well as quarterly compliance reports submitted to the governing body or Board committees.

d. Human Resources shall maintain documentation related to:

- pre-employment background checks;
- monthly sanction and exclusion screenings;
- credential verification and screening of licensed professional staff; and
- any other required workforce screening activities

Documentation relating to see Sanction Screening Policy regarding documentation for monthly sanction screenings of agency staff, credentialed staff, vendors, and other non-employee entities.

e. Human Resources will retain documentation relating to disciplinary actions taken against employees resulting from violations of the Compliance and Ethics Program.

f. Corporate Compliance Officer and Compliance Liaisons shall retain Compliance Committee agendas and minutes.

g. The Corporate Compliance Officer shall retain the Code of Conduct, Compliance Program Charters and Compliance and Ethics Program policies and procedures, indicating dates approved, reviewed, revised and effective. The Corporate Compliance Officer shall maintain evidence of annual reviews and annual distribution to staff.

h. The Corporate Compliance Officer and/or Compliance Liaisons, depending upon the responsibilities in a particular case, shall maintain the following in subsections (h) through (l), including documentation of audit findings, reports or complaints made to the Compliance department, Compliance Officers/Liaisons or the Compliance and Ethics Hotline. Reports to management and corrective action plans prepared because of audit findings, reports or complaints made to the Compliance Liaisons also should be maintained in the Compliance Liaisons' files.

i. Documentation of annual compliance work plans and auditing and monitoring conducted in furtherance of the Compliance and Ethics Program.

j. Documentation of reports made to the Audit, Risk and Compliance Committee of the ArchCare Board of Trustees and/ or the Catholic Managed Long-Term Care, Inc. on compliance and regulatory updates.

k. Documents related to self-disclosures and/or overpayment reports to federal or state health care programs or oversight entities, including but not limited to the Office of the Inspector General (OIG), Office of the Medicaid Inspector General (OMIG), Medicare Administrative Contractors or other government or regulatory authorities.

4. All records related to the Compliance and Ethics Program shall be maintained for ten (10) years.

REVISION HISTORY:

Date	Change/Note
05/05/2026	Annual review and update of the policies.
4/23/2025	Annual review and update of the policies.
5/1/2024	Annual review and update of the policies.
5/1/2023	Review and update to align with the new OMIG Guidance including redefining the term affected individual. In addition, made formatting changes.
8/2022	Changes per annual review: replaced compliance program with compliance and ethics program
8/2021	Changes per annual review
1/2011	Changes per annual review

ARCHCARE AND AFFILIATED ENTITIES POLICY

SUBJECT: Compliance and Ethics Program, Conflicts of Interest and Related Party Transactions, System-Wide

ORIGINATING DEPARTMENT: Corporate Compliance

EFFECTIVE DATE: March 1, 2011

Most recent revision date: 05/26/2026

Board Audit, Risk, and Compliance Committee Approval Date: 06/04/2026

PURPOSE: The purposes of this Policy are to: (1) preserve the integrity of ArchCare's decision-making processes ; (2) prevent the intentional or inadvertent participation in decision-making by individuals with a conflict of interest; (3) promote fairness, transparency and accountability in the disclosure and management of conflicts of interest; (4) ensure compliance with applicable laws governing transactions involving conflicts of interest and (5) ensure that workforce members act in the best interests of ArchCare and in compliance with applicable legal and ethical requirements.

This Policy is intended to provide guidance for Personnel who may encounter situations in which personal interests could create, or appear to create, a conflict with the interests of ArchCare. All actual, potential, or perceived conflicts of interest must be disclosed and appropriately managed or avoided . Even the appearance of illegality, impropriety, or a conflict of interest may adversely affect ArchCare, and therefore should be avoided.

ENTITIES AFFECTED: All ArchCare-sponsored entities.

SCOPE: This Policy is applicable to Trustees, Officers and Key Persons (as those terms are defined below; hereinafter collectively referred to in this Policy as "**Personnel**") of Catholic Health Care System dba ArchCare and Affiliated Entities ("**ArchCare"**).

DEFINITIONS:

1. **Affiliate.** An entity controlled by Catholic Health Care System dba ArchCare or in control of Catholic Health Care System dba ArchCare.

2. **Disclosable Interests.** Personnel shall be deemed to have a Disclosable Interest if the individual, or a Relative:

    a. Has any financial interest in a Vendor (as defined below);

b. Serves as a member, owner, director, trustee, officer or partner of a Vendor;

c. Has a contractual, consulting or employment relationship with a Vendor;

d. Accepts gifts, entertainment, gratuities or other favors from a Vendor, competitor or any entity with which ArchCare does business, intends to conduct business or competes;

e. Represents ArchCare in any matter in which the individual has a personal, financial or other interest

f. Uses, or has the opportunity to use, confidential or proprietary knowledge regarding ArchCare for personal gain, profit or advantage;

g. Has any family or business relationship with another Trustee, Officer or Key Person. A business relationship includes circumstances in which: (i) one person is employed by the other in a sole proprietorship or by an organization with which the other is associated as a trustee, director, officer, or owner of more than thirty-five percent (35%) , including tax-exempt organizations; (ii) one person engages in business transactions with the other, directly or indirectly, outside the ordinary course of business on terms not generally available to the public, involving one or more contracts of sale, lease, license, loan, provision of services, or other transfer of cash or property valued in excess of $10,000 in the aggregate during ArchCare's tax year; or (iii) both individuals serve as directors, trustees, officers, or owner of more than 10% in the same business or investment entity, excluding service in the same tax-exempt organization;

h. Has a direct or indirect financial or other interest, including through a Relative, in an organization that provides grants to funding for research or other projects conducted in association with ArchCare; or

i. Engages in, or intends to engage in, a Related Party Transaction (as defined below).

Note, however, that *De Minimis* transactions and Ordinary Course of Business transactions (as defined herein), are not subject to this Policy. In such circumstances, however, the affected party shall not participate in, intervene in, or attempt to influence the individual responsible for reviewing, approving or making decisions regarding the transaction or matter. Likewise, the individual responsible for the review or decision-making process shall remain impartial and shall not consider, or be influenced by, the affected party's involvement in any decisions or matters that may affect the reviewer or decision-maker.

3. ***De Minimis* Transaction.** A "*De Minimis*" transaction for purposes of this Policy is a transaction that is immaterial or insignificant to ArchCare, taking into consideration all relevant factors, including but not limited to: (i) ArchCare's overall business or financial operations; (ii) any impact or potential impact the transaction may have on the quality of care, treatment or services provided to residents or patients, and/or (iii) the size, scope and nature of the transaction.

4. **Improperly Influence.** "Improperly Influence" means to coerce, manipulate, mislead, or fraudulently influencing the decision-making where a Trustee, Officer, or Key Person knew, or reasonably should have known that such actions, if successful, could result in an outcome on which the individual was prohibited from t deliberating or voting directly.

5. **Key Person.** A "Key Person" is an individual who is not an officer or director, whether or not employed by ArchCare, who: (i) has responsibilities or exercises powers or influence over ArchCare as a whole similar to those exercised by directors and officers; (ii) manages ArchCare, or a segment of ArchCare that represents a substantial portion of the organization's activities, assets, income or expenses or (iii) alone or together with others controls or determines a substantial portion of ArchCare's capital expenditures or operating budget.

   For purposes of this Policy, ArchCare Key Persons include: all individuals who report directly to the President & CEO of ArchCare and the Chief Information Officer. For the ArchCare affiliated entities, Key Persons are all individuals who report directly to the Administrator or Executive Director of the program or facility.

6. **Officer. "**Officer" means any individual designated as an officer in the By-Laws of ArchCare, as well as any individual otherwise appointed as an officer of ArchCare in accordance with the provisions of the By-Laws.

7. **Ordinary Course of Business Transaction.** An "Ordinary Course of Business Transaction" is a transaction consistent with either: (i) ArchCare' s consistently applied past practices in similar transactions; or (ii)common or accepted practices within the industry in which ArchCare operates.

8. **Related Party. A "Related Party" means:**

   a. any Trustee, Officer or Key Person of ArchCare;
   b. any Relative of such individual; or
   c. any entity in which such individual or Relative has a direct or indirect ownership, interest of beneficial interest of thirty-five (35%) or greater, or, in the

case of a partnership or professional corporation, a direct or indirect ownership interest exceeding of give percent (5%).

9. **Related Party Transactions.** A "Related Party Transaction" means any transaction, agreement or other arrangement in which a Related Party has a financial interest and in which ArchCare or any of its affiliated entities is a participant except where: (i) the transaction, or the Related Party's financial interest in the transaction is *De Minimis*; (ii) the transaction would not customarily be reviewed by the governing board of similar organizations in the ordinary course of business and is available to others on substantially similar terms, as determined by legal counsel and approved by the Audit, Risk, and Compliance Committee ("Committee") of the Board of Trustees; or (iii) the transaction constitutes a benefit provided to a related party solely as a member of a class of the beneficiaries that ArchCare intends to benefit as furtherance of its mission, provide that the benefit is available to all similarly situated members of the same class on substantially the same terms.

10. **Relative**. "Relative" means an individual's spouse or domestic partner (as defined in Section §2994-a of the NY Public Health Law); ancestors; siblings whether whole or half-blood; children, whether natural or adopted; grandchildren; great-grandchildren; and the spouses or domestic partners of the individual's siblings, children, grandchildren, great-grandchildren.

11. **Trustee. "**Trustee" means any member of the governing board of ArchCare, regardless of whether the individual is designated as a director, trustee, manager, governor, or by any other title.

12. **Vendor.** The term "Vendor" includes any vendor, supplier, consultant, contractor, service provider, or other third party, including, but not limited to pharmaceutical manufacturers, that is seeking to do business with, or is currently engaged in, business with, ArchCare or any of its affiliated entities.

POLICY:

All Personnel should conduct business and organizational activities in a manner that avoids any actual, potential or perceived favoritism or preference arising from personal interests or relationships.. Personnel are expected to exercise sound judgement, appropriate care, and their best professional efforts in furtherance of ArchCare' s interests and shall not permit personal considerations to influence the performance of their duties or responsibilities.

Any actual, potential, or perceived conflict of interest must be promptly disclosed in accordance with the procedures set forth in this Policy. Depending upon the nature of the conflict, the affected individual may be required to refrain from participating in the review, discussion, deliberation, recommendation, or decision-making process relating to the matter or transaction at issue.

All Personnel will be expected to read, understand, and periodically review this Policy in order to identify and appropriately address situations that may give rise to a conflict of interest. Conflicts shall be disclosed and managed in accordance with this Policy and, where applicable, disclosed publicly through IRS Form 990 reporting requirements. Failure to comply with this Policy may constitute a breach of the individual's s obligations to ArchCare, and may result in corrective or disciplinary action, up to and including termination of employment, appointment, affiliation, or contractual relationship, as applicable.

OVERSIGHT OF THIS POLICY

The adoption, implementation, and ongoing compliance with this Policy shall be overseen by the Audit, Risk, and Compliance Committee of the Board of Trustees ("Committee"). The Committee may, in its discretion, delegate certain administrative or operational responsibilities related to the implementation of and compliance with this Policy to one or more ArchCare employees, however, the Committee shall, retain ultimate oversight responsibility for all aspects of this Policy.

The Audit, Risk, and Compliance Committee has designated the ArchCare Corporate Compliance Officer to with assist with the administration and implementation of this Policy. Such responsibilities may include, but are not limited to: (1) collecting Conflict of Interest Disclosure Statements; (2) monitoring and tracking the timely completion and submission of the Disclosure Statements; (3) providing the Disclosure Statements to the Chair of the Audit, Risk, and Compliance Committee for each ArchCare entity, or, if the entity does not maintain such a Committee, directly to the Chair of the Board of the entity's Board; and (4) assisting the applicable Committees and/or Boards in organizing, reviewing and maintaining the Disclosure Statements and related documentation.

PROCEDURES

1. Disclosure Requirements.

All Personnel with a Disclosable Interest shall disclose the interest, and all material facts related thereto, in writing by completing a Conflict of Interest Disclosure Statement, as described below. If an individual is uncertain whether they have a Disclosable Interest

exists, the individual is expected to err on the side of disclosure and complete a Conflict of Interest Disclosure Statement.

a. Annual Conflict of Interest Disclosure Statements. All Trustees, Officers and Key Persons shall complete and submit a , written Conflict of Interest Disclosure Statement at least annually to the Corporate Compliance Officer, who shall provide copies of all completed Statements to the Chair of the appropriate Committee or Board.

   For Trustees, the Conflict of Interest Disclosure Statement shall specifically identify, to the best of the Trustee's knowledge: ,(i) any entity for which the Trustee serves as an officer, director, trustee, member, owner (including sole proprietor or partner), or employee, and with which ArchCare has a relationship, and (ii) any transaction or arrangement in which ArchCare is a participant and in which the Trustee may have a Disclosable Interest.

b. Continuing Obligation to Update Disclosure Statements. Each Trustee, Officer and Key Person has an ongoing affirmative obligation to update their Conflict of Interest Disclosure Statement whenever new or changed facts or give rise to a Disclosable Interest. Such disclosure shall be made (a) prior to voting on, deliberating upon, or otherwise participating in any matter involving the conflict that comes before the Board or a Committee; (b) prior to entering into any contract, transaction or arrangement involving ArchCare; and/or (c) as soon as reasonably practicable after becoming aware of a conflict of interest in any other context. All updated Disclosure Statements shall be submitted to the Corporate Compliance Officer, who shall provide copies to the Chair of the appropriate Committee or Board.

c. Prior to the Initial Election of a Trustee. Prior to the initial election or appointment of any Trustee, the proposed Trustee position shall complete, sign and submit a written Conflict of Interest Disclosure Statement to the Secretary of the Corporation, or Corporate Compliance Officer. The statement shall identify, to the best of the proposed Trustee's knowledge: (i) any entity for which the proposed Trustee serves as an officer, director, trustee, member, owner (including sole proprietor or partner), or employee, and with which ArchCare has a relationship, and (ii) any transaction or arrangement in which ArchCare is a participant and in which the proposed Trustee may have a Disclosable Interest. All such Statements shall be filed with the Corporate Compliance Officer who shall provide copies of each completed Statement to the Chair of the appropriate Committee or Board.

d. Additional Disclosure Requirements to the Board of Trustees. If, during the course of any Board or Committee meeting, discussion, or deliberation, an actual, potential or perceived conflict of interest becomes known to a Board member, the Board member shall promptly disclose such actual or potential conflict to the Board. If another Board member becomes aware of an actual, potential, or perceived conflict, involving a Board member who is absent or who has failed to disclose the conflict, the informed Board member shall disclose this matter to the Board or Committee. All such disclosures shall be documented in the official minutes or records of the applicable meeting.

2. Action Following Disclosure

The applicable Committee or Board shall conduct a thorough review of any matter involving an actual, potential or perceived conflict of interest. In conducting such review the Committee or Board shall:

a. consider all relevant facts and circumstances involved in the matter, including whether the proposed transaction or arrangement is fair, reasonable and in the best interests of ArchCare and the individuals it serves;

b. exclude the affected individual(s) from being participation in any deliberations, discussions, recommendations or voting related to the matter;

c. prohibit the affected individual(s) from attempting to Improperly Influence the deliberation, discussion, recommendation or voting process related to the matter; and

d. permit the affected individual(s), at the request of the Committee or Board, to factual background information or respond to questions concerning the matter prior to the commencement of deliberations or voting.

3. Additional Special Rules for Related Party Transactions. In addition to the general requirements and considerations set forth above, all Related Party Transactions shall be subject to the following additional requirements

a. ArchCare shall not enter into any Related Party Transaction unless the applicable Committee or the Board determines that the transaction is fair, reasonable and in best interest of ArchCare at the time such determination is made;

b. In reviewing a Related Party Transaction, the Committee or Board shall ensure that any Trustee, Officer or Key Person with an interest in the transaction has disclosed, in good faith, all material facts relating to such interest; and

c. No Related Party with an interest in the transaction shall participate in any discussion, deliberation, recommendations, or vote concerning the Related Party Transaction. However, the Committee or Board may request that the Related Party provide factual background information or respond to questions regarding the transaction prior to the commencement of deliberations or voting.

4. With respect to any Related Party Transaction involving ArchCare in which a Related Party has a substantial financial interest, the following shall apply**:**

(i) Prior to entering into the transaction, the applicable Committee or the Board shall consider, to the extent available, appropriate alternative transactions or arrangements;

(ii) The transaction must be approved by no less than a majority vote of the disinterested members present at the meeting; and

(iii) The Committee or Board shall contemporaneously document in the official meeting minutes the basis for its approval or disapproval of the transaction, including its consideration of any alternative transactions or arrangements.

A conflicted Trustee shall not be counted for purposes of establishing a quorum at any meeting of the Board or Committee, during which the Related Party Transaction is discussed, deliberated upon, or and voted upon.

5. Corrective Action. If the Committee determines that an actual, potential or perceived conflict of interest exists, appropriate action shall be taken to protect the best interests of ArchCare:

a. Fair and Reasonable Transactions. The Committee shall determine whether the proposed transaction or arrangement is fair, reasonable and in the best interests of ArchCare, and whether the transaction furthers ArchCare's charitable purposes without resulting in private inurement or an impermissible private benefit. If the Committee determines that ArchCare may proceed with a transaction involving a Vendor, Trustee, Officer, Key Person or other individual or entity presenting a conflict of interest, the Committee may take one or more of the following actions:

(i) Require that ArchCare's competitive bidding or procurement process be utilized without the participation or involvement of the conflicted individuals;

(ii) Obtain an independent appraisal, valuation, and other evaluation to assess the fair market value and reasonableness of the proposed transaction; and/or

(iii) Seek guidance from outside legal counsel or qualified advisors to ensure compliance with applicable federal, state and local laws, rules and regulations, including laws governing charitable organizations and applicable the IRS Form 990 disclosure requirements.

b. Approval by an Affiliate's Governing Board. With respect to any conflict of interest matter involving an ArchCare affiliated entity that is reviewed by the Committee or the Board shall report its findings, determination and recommendations to the applicable Affiliate's Governing Board. The Affiliate's Governing Board, acting through its disinterested members, shall review the matter and determine whether to approve, modify or disapprove the Committee's determination and recommendation.

6. Documentation.

The applicable Committee or Board shall contemporaneously document in writing, within the official minutes of any meeting at which the matter is discussed, deliberated upon or voted upon, all deliberations, disclosures, determinations and actions relating to the matter. Such documentation shall include, at a minimum: a description or summary of the matter under review, a summary of the discussions and deliberations conducted by the Committee or Board, consideration of any alternatives transactions, arrangements or courses of action, where applicable, the names of all individuals present during the discussions, deliberation and voting process, the results of any votes taken, including any recusals or abstentions and the basis for the determination and decision, including whether the transaction or arrangement was determined to be fair, reasonable, and in the best interests of ArchCare, and whether terms comparable to those available from unrelated parties could reasonably have been obtained by ArchCare under similar circumstances.

OTHER MATTERS PERTAINING TO CONFLICTS OF INTEREST:

1. Loans To Trustees and Officers: *Per Se* Conflicts of Interest.

Except through the purchase of bonds, debentures, or similar obligations customarily offered sold to the public, or through ordinary deposits of funds in a banking institution,

ArchCare shall not make loans to any Trustee or Officer, or to any other corporation, partnership, firm, association, or other entity in which one or more of its Trustees or Officers serve as trustees, directors or officers or hold a substantial financial interest.

Any such prohibited loan arrangement shall be considered a *per se* conflict of interest and shall not be permitted under any circumstances.

2. Ban on Private Inurement.

ArchCare shall not enter into any transaction or compensation arrangement with Trustee, Officer, or Key Person, senior staff member, or any other individual in a position to exercise substantial influence over the affairs of ArchCare if such arrangement provides an economic benefit that exceeds the value of the consideration, services or benefit received by ArchCare in return. All forms of compensation shall be considered in determining if an excess benefit has been conferred, including: salary or wages, consulting or professional fees, bonuses or incentive compensation, severance or separation payments, health, medical, dental or other insurance benefits, retirement, pension or deferred compensation benefits and any other financial or non-financial benefits provided by ArchCare.

All compensation arrangements must be reasonable, properly authorized, appropriately documented, and consistent with applicable federal and state laws governing charitable and tax-exempt organizations.

3. Conflicts of Interest in Compensation Decisions

No individual who directly or indirectly receives compensation from ArchCare or any of its affiliated entities shall participate in, be present for, or otherwise influence any deliberation, discussion, recommendation or vote concerning their compensation or benefits. Such individuals may, however, provide factual information, background, or responses to questions at the request of the Board or applicable Committee prior to the commencement of deliberations or voting on the matter.

4. Compliance with Gift and Fundraising Policies

All Personnel shall comply with all applicable ArchCare policies relating to gifts, gratuities, donations and fundraising activities. These policies strictly prohibit Personnel from soliciting any gift or benefit, either individually or on behalf of ArchCare, other than for official fundraising events. In addition, Personnel shall not offer, provide, solicit, accept or receive any gift, payment, gratuity, entertainment, or other benefit, directly or indirectly, to or from any individual or entity: (i) that refers, or may refer, patients or other health care business to ArchCare, (ii) to which ArchCare

refers, or may refer, patients or other health care business or (iii) with which ArchCare conducts business, under circumstances where the gift or benefit is offered, paid or received with a purpose of inducing or rewarding referrals of health care goods, items or services, or other business between the parties.

All Personnel are expected to conduct themselves in a manner consistent with applicable federal and state fraud and abuse laws, including anti-kickback and inducement prohibitions, as well as ArchCare's ethical standards and policies.

VIOLATIONS OF THE POLICY

If the Audit, Risk, and Compliance Committee or the Board has reasonable cause to believe that a Trustee, Officer or Key Person has failed to disclose an actual, potential or perceived conflict of interest, the individual shall be informed of the basis for such belief and provided with an opportunity to respond and explain the alleged failure to disclose.

If there is reasonable cause to believe that a member of the Board has violated this Policy, the affected Board member shall recuse them. If from any discussion, deliberation, or determination relating to the matter under review. If, after hearing the Personnel's response and making further investigation as warranted by the circumstances, the Committee or the Board determines that the Personnel has failed to disclose an actual or possible conflict of interest, it shall take appropriate disciplinary and corrective action.

The Corporate Compliance Officer, on behalf of the Secretary of the Corporation, will ensure that all Personnel file Conflict of Interest Disclosure Statements, or follow-up to make sure they do, in accordance with this Policy. Any failure to comply with the disclosure requirements of this Policy shall be reported to the Committee or Board, which may recommend or impose appropriate corrective or disciplinary action.

Failure to adequately disclose an actual, potential or perceived conflict of interest may constitute grounds for removal from the Board and/or any Committee, as applicable.

REVISION HISTORY:

Date	Change/Note
05/26/2026	Annual review and update of the policy.
4/23/2024	Annual review and update of the policy.
5/1/2024	Annual review and update of the policies.
5/1/2023	Review to align with the new OMIG Guidance. In addition, made formatting changes.
8/2022	Changed to Audit, Risk, and Compliance Committees Approval and replaced Compliance Program with Compliance and Ethics Program
8/2021	Expanded the Purpose, Definitions and Procedures sections, consistent with Not for Profit Corporation Law; added Scope, Policy and Oversight section.
11/2019	Changed definition of Key Person to match updates to Non-Profit Revitalization Act.
12/2017	In response to CSNP DFS audit, added footnote regarding electronic signatures
4/2014	Modified to comply with Non-Profit Revitalization Act.
3/2014	Clarified in a footnote that electronic signatures as well as "wet" signatures on conflict of interest statements are acceptable under this policy.
6/2013	Added role of Conflicts Management Committee to the end of paragraph 7. The Committee determines whether further steps must be taken to manage the potential conflicts disclosed. Also added responsibilities of compliance officers in collecting the conflict of interest statements.
1/2011	Changes per annual review
9/6/2007	New Document

ARCHCARE AND AFFILIATED ENTITIES POLICY

SUBJECT: Compliance and Ethics Program, Investigating Compliance Matters, System-Wide

ORIGINATING DEPARTMENT: Corporate Compliance

APPROVAL DATE: 09/21/2022

MOST RECENT REVIEW/REVISION DATE: 05/26/2026

AUDIT, RISK AND COMPLIANCE COMMITTEE APPROVAL DATE: 06/04/2026

PURPOSE/POLICY: To combat fraud, waste and abuse (FWA) and maintain an effective Compliance and Ethics Program, ArchCare has established procedures for promptly responding to and investigating compliance concerns. Potential compliance concerns identified through reviews, monitoring activities or self-evaluations are thoroughly reviewed, and corrective actions are implemented to address concerns, prevent reoccurrence and ensure ongoing compliance with federal and state health care programs requirements (*e.g.*, Medicare and Medicaid). Below are the procedures that ArchCare has adopted for conducting investigations. See Compliance and Ethics Program, Corrective Action and Response to Detected Offenses, System-Wide for information related to corrective actions.

ENTITIES AFFECTED All ArchCare-sponsored entities.

SCOPE: This policy applies to the workforce[1] of ArchCare and its affiliated entities. Specifically, ArchCare "workforce" includes, but is not limited to, care members (including chief executive and other senior administrators and managers), medical staff, volunteers, and students. The term "workforce" also applies to contractors, subcontractors, monitoring dependent contractors[2] who, on behalf of ArchCare, furnish, or otherwise authorize the furnishing of Medicare and/or Medicaid health care items or

[1] This definition is aligned with the updated Part 521 of Title 18 of the Codes, Rules and Regulations of the State of New York which defines "[a]ffected [i]ndividuals as defined by the as all persons who are affected by the provider's risk areas, including employees, the chief executive and other senior administrators, managers, contractors, agents, subcontractors, independent contractors, and governing body and corporate officers."

[2] This policy applies to designated contractors who engage in the provision of quality healthcare service and/or who fall under the following risk areas of "billings, payments, ordered services, medical necessity, quality of care, governance, mandatory reporting, credentialing, contractor oversight, and other areas that should reasonably be identified by the provider through its organizational experience".

services, perform billing or coding functions, or are involved in monitoring health care provided by ArchCare.

PROCEDURES:

1. Investigation - Generally.

A compliance concern may be reported to the Corporate Compliance Officer, Compliance Liaison or Compliance &Ethics Hotline, an internal compliance monitoring review, the review of a new regulation or governmental fraud alert, or from another source. Such matters may include any of the following: evidence that ArchCare is billing for services that were not performed or ordered; medical documentation does not adequately support the billing codes selected; or suspected financial relationships with other providers that may influence referrals to or from ArchCare.

Upon receiving a report or otherwise learning of a potential compliance concern, the Corporate Compliance Officer will bring such allegation to the attention of the applicable ArchCare Entity Compliance Officer/Compliance Liaison and the applicable operational Compliance Committee. Assisted by such personnel, the Corporate Compliance Officer or a designee(s) will promptly conduct an investigation and take all necessary and appropriate actions. Such investigations may be undertaken under the supervision and direction of internal or external legal counsel, as necessary and appropriate. Preliminary information may justify informing the President and CEO and Boards of Trustees of a potential compliance matter prior to (or during) investigation by the Compliance Officer.

All affected individuals are expected to cooperate in all compliance investigations. Failure to cooperate can result in disciplinary action, up to and including termination.

Depending on the nature of the potential compliance concern an investigation may include interviews with care members, documentation reviews and a root cause analysis. The objective of such an investigation will be to determine whether, first, a compliance issue exists or whether there has been a violation of the Compliance and Ethics Program (including ArchCare's Compliance policies and procedures, the Code of Conduct or applicable laws, regulations or other requirements. If an issue or violation does exist, then the investigation will attempt to determine its root cause so that appropriate and effective corrective action(s) may be instituted to help prevent reoccurrence.

2. Initial Assessment of Compliance Concerns.

The reported compliance concern will be assessed by the relevant Compliance Officer/Compliance Liaison and the Corporate Compliance Officer in consultation with

appropriate senior leadership to determine whether it is actionable and whether it should be referred to Human Resources, Quality or another department.

Examples of non-actionable reports include:

- Reports that do not provide enough information
- Reports that do not, as alleged, present compliance concerns
- Reports made in bad faith

Whenever possible, the Corporate Compliance Officer or the applicable Compliance Officer or Compliance Liaison shall provide the individual submitting a report that is non-actionable with information on why the report cannot be acted upon.[3]

Reports that will be referred are those for which there is a dedicated policy or procedure or complaints that are more appropriately handled through another process. For example:

- Reports involving allegations of patient abuse or neglect shall be referred to an independent reviewer who will review the allegation, conduct an investigation draft a report of the results of the investigation will be shared with the appropriate leadership and provided to the Corporate Compliance Officer, and create a corrective action plan, if necessary, for the facility or program to follow;
- Reports regarding customer service shall be referred to the appropriate facility or program;
- Reports alleging employee harassment or discrimination or compliance with personnel policies shall be referred to the Human Resources department

Programs or facilities, as applicable, and Human Resources shall provide the Corporate Compliance Officer with information on the disposition of reports that have been referred.

Within Ethics Point to consistently categorize calls, the case with be documented as follows, "first outcome" will be "referred"; "second outcome" will be substantiated,

[3] Compliance team will reach out to the reporter for additional information, if possible. If the reporter fails to respond or provide additional information, the matter will be closed.

unsubstantiated or partially substantiated. "Action taken" will be the action taken as the result of the investigation. If "unsubstantiated" "action taken" is "no action necessary."

Within Ethics Point, for non-actionable reports or reports for which the reporter is given information on the appropriate process to follow "primary outcome" will be changed to "insufficient information" and "Action Taken" will be "No Action Necessary" before the status is marked "closed."

3. Communicating with Reporters Who Identify Themselves.

The ArchCare Corporate Compliance Officer or the person to whom the compliance concern has been assigned will acknowledge receipt of the report by responding to the caller promptly through EthicsPoint after the report has been received and reviewed.

After the issue has been investigated, if applicable, and the non-compliance has been remedied or a corrective action plan has been created, the ArchCare Corporate Compliance Officer will respond to the reporter informing them the investigation has been completed.

4. Communicating with Reporters Who Do Not Identify Themselves (Anonymous Caller).

The ArchCare Corporate Compliance Officer will record: (a) acknowledgment of receipt of call and (b) resolution of investigation and corrective action in response to the call, if applicable, promptly and no later than the "follow up date" in the EthicsPoint system.

5. Investigations – Actionable Reports.

Actionable reports typically will be investigated by the Corporate Compliance Officer and other individuals selected by the Corporate Compliance Officer. Interim measures may be taken to prevent retaliation or to facilitate a thorough investigation.

The Compliance Office is authorized full, free and unrestricted access to ArchCare records, facilities, and care members pertinent to conduct any investigation.

a. <u>The purpose of the investigation</u> is to determine if there has been an occurrence or course of fraud, abuse or other systemic noncompliance, and if so:

   i. To determinate the nature, scope, frequency, duration and financial magnitude of fraud, abuse or other noncompliance;

   ii. To identify the individuals who may have knowingly or inadvertently been responsible for fraud, abuse or other noncompliance;

iii. To develop facts so that the ArchCare Entity may:

(a) Cease the problematic activity

(b) Determine whether it has a repayment obligation;

(c) Determine whether it has a self-disclosure obligation

(d) Develop and implement a corrective action plan;

(e) Take appropriate disciplinary steps against the persons responsible

(f) Make required or appropriate reports or referrals concerning the persons responsible, such as reports to licensing authorities;

(g) Take lawful and appropriate steps to minimize the jeopardy to ArchCare's mission, and protect itself from unwarranted civil and criminal liability; or

(h) Take other appropriate corrective actions.

b. The investigation process shall include, as applicable, but need not be limited to:

i. Interviewing the complainant and other persons who may have knowledge of alleged fraud, abuse or other noncompliance;

ii. Reviewing medical records, bills and other documents relevant to the alleged fraud, abuse or other noncompliance;

iii. Reviewing other representative bills or claims submitted to the relevant payor; and

iv. reviewing the applicable laws, regulations, internal policies and other documents regarding program requirements.

c. Timeliness of Compliance Investigations. Investigations must be concluded within a reasonable time period after the potential offense was detected. What is considered reasonable will depend upon the circumstances of the particular instance. Such investigations must be reported on periodically to the relevant operational committee and to the Board or Board Committee, no less than quarterly and the committee and the Board or Board Committee should evaluate whether the timeframe of the investigation is reasonable considering the facts and circumstances, and direct the investigation to be conducted by a third party or

referred to a regulatory or enforcement agency if internal resources are not sufficient to reach a conclusion within a reasonable timeframe.

d. Preliminary Actions. If the Corporate Compliance Officer believes that the presence of care members under investigation may jeopardize the integrity of an investigation, or that the allegations are of such a serious nature that, if true, the care members pose an immediate threat to the health and/or safety of ArchCare residents or personnel, the Corporate Compliance Officer, in consultation with the VP, Human Resources, may recommend to the President and CEO that the care members under investigation be temporarily suspended or temporarily reassigned to another work area (subject to any rights the investigated employee may have under applicable union contracts and rules).

6. No Findings of Fraud, Abuse or other Noncompliance

If at any time the Entity Compliance Officer or Compliance Liaison, in consultation with the Corporate Compliance Officer, legal counsel and/or the SVP, Human Resources, if appropriate, concludes, based on the investigation, that the reported conduct does not constitute fraud, abuse or other noncompliance, the Compliance Officer or Compliance Liaison shall document the outcome and support will be maintained by the Compliance department.

7. Reports to Management and Governing Bodies.

Compliance concerns/matters, including Compliance and Ethics Hotline calls will be made to the ArchCare Executive Compliance Steering Committee, the President and CEO of ArchCare, and/or the Executive Director of the relevant ArchCare Entity, depending upon the nature of the call. Summaries of significant actions resulting from Hotline calls (written to protect the identity of the reporting individual to the extent possible and/or appropriate) shall be included in reports to the ArchCare Audit, Risk and Compliance Committee of the Board and the appropriate governing body if there is no compliance committee by the Corporate Compliance Officer, the President and CEO, or the Executive Director of the Entity.

At the conclusion of the investigation, if the ArchCare Entity Compliance Officer or Compliance Liaison, in consultation with the Corporate Compliance Officer, legal counsel (if involved), and the VP, Human Resources, concludes that there has been fraud, abuse or other systemic noncompliance, the Compliance Officer shall prepare a report of findings that shall include, as applicable:

a. the reason for commencing the investigation;

b. the investigation process;

c. a description of the evidence of fraud, abuse or other systemic noncompliance;

d. findings ascertained regarding the nature, scope, frequency, duration and financial magnitude of the fraud, abuse or other systemic noncompliance;

e. the identity of person or persons who appear to have been responsible for the fraud, abuse or other systemic noncompliance, and a description of the evidence of their responsibility and intent; and

f. recommended responses.

Reports of all such investigations shall be reported to the relevant governing body, whether the Audit Risk & Compliance Committee of the Board of Trustees, or the Board of Managers, Catholic Managed Long-Term Care, Inc.

8. Retention of Records of Reports and Investigations.

The Compliance department will maintain a log of all reports, tracking their receipt, investigation and resolution. Sufficient documentation should be maintained by the Compliance Officer or Liaison on the EthicsPoint system to describe the nature, scope and outcome of any internal investigation that is undertaken. If the investigation was not initiated through the Compliance and Ethics hotline.

The Compliance department is accountable for safeguarding records and information and maintaining confidential investigation records.

9. Non-retaliation/Non-intimidation

No care member will be punished for reporting what he or she reasonably believed to be a compliance concern or potential violation of the Compliance and Ethics Program. Please refer to the following ArchCare Policy, Compliance and Ethics Program, Reporting Compliance Matters; Whistleblower/Non-retaliation/Non-Intimidation Policy for Good Faith Participation in the Compliance Program (System Wide).

10. Anonymity/Confidentiality.

Compliance reports may be made anonymously, if a person chooses. If not made anonymously, the confidentiality of individuals reporting compliance issues will be maintained, except when the matter is subject to a formal disciplinary proceeding, or when it is under investigation by regulatory bodies like MFCU, OMIG, or law enforcement, or when legal proceedings require disclosure. Compliance records shall be

maintained in a secure area to maintain appropriate confidentiality of reported information.

REVISION HISTORY:

Date	Change/Note
05/26/2026	Annual review and update of the policies.
4/23/2025	Annual review and update of the policy. Specified when confidentiality of complainant cannot be maintained, consistent with OMIG program guidance.
5/1/2024	Annual review and update of the policies.
5/1/2023	Review and update to align with the new OMIG Guidance including redefining the term affected individual. In addition, made formatting changes
8/29/2022	Annual review
8/2021	Expanded "Scope" of policy to "care members," consistent with definition in the Charter. Removed portion of "reporting" section and section on "anonymity" to Compliance Program, Reporting Compliance Matters; Non-Retaliation/Non-intimidation Policy, System-Wide Policy. Updated for compliance with Social Services Law 363-d. Incorporated sections regarding investigations from Compliance Program, Response to Detected Offenses, System-Wide Policy. Re-organization, other edits.
5/2021	Changed section 2 so that reports of patient abuse or neglect shall be referred to independent investigator who will conduct investigation and corrective action plan. Also changed how non-actionable reports are classified on Ethics Point system.
3/2020	Added sections 1- 3 adding procedural detail about referred and non-actionable reports.
2/2016	Changed "affected entities" to "scope" and "system compliance officer" to "Corporate Compliance officer" to reflect new format.

4/2011	Added a new Section 4 to policy specifying how and when to communicate to callers.
1/2011	Changes per annual review, audit and OMIG evaluation tool: clarified that hotline is for "individuals" use, not just care members, and clarified respective roles of ArchCare System Compliance Officer and Entity Compliance Officer in investigating calls.
10/25/2006	New document

ARCHCARE AND AFFILIATED ENTITIES POLICY

SUBJECT: Compliance and Ethics Program, Gifts, System-Wide

ORIGINATING DEPARTMENT: Corporate Compliance

Effective Date: 09/28/2021 (Original Effective Date: 9/6/2007)

BOARD AUDIT, RISK AND COMPLIANCE COMMITTEE APPROVAL DATE: 06/04/2026

MOST RECENT REVIEW/REVISION DATE: 05/21/2026

PURPOSE: To ensure that the ArchCare workforce remains within legal and ethical boundaries regarding the offering, acceptance or exchange of gifts with residents, patients, family members, vendors, contractors, potential referral sources and other individuals or entities doing business with or seeking to do business with ArchCare. This policy is intended to prevent conflicts of interest, maintain professional integrity, comply with applicable federal and state laws and regulations, and preserve trust in the organization's care and business practices.

ENTITIES AFFECTED All ArchCare-sponsored entities.

SCOPE: This policy applies to the workforce[1] of ArchCare and its affiliated entities. Specifically, ArchCare "workforce" includes, but is not limited to, employees (including chief executive and other senior administrators and managers), medical staff, volunteers, and students. The term "workforce" also applies to contractors, subcontractors, agents and independent contractors who, on behalf of ArchCare, furnish, or otherwise authorize the furnishing of Medicaid health care items or services, perform billing or coding functions, or are involved in monitoring of health care provided by ArchCare. In addition, this policy extends to the governing body and corporate officers.

[1] This definition is aligned with the updated Part 521 of Title 18 of the Codes, Rules and Regulations of the State of New York which defines "[a]ffected [i]ndividuals as defined by the as all persons who are affected by the provider's risk areas, including employees, the chief executive and other senior administrators, managers, contractors, agents, subcontractors, independent contractors, and governing body and corporate officers."

BACKGROUND: The exchange of gifts in the health care environment may implicate several statutes.[2] For example, the federal Anti-Kickback Statute makes it a crime to solicit or receive any item of value (remuneration) made directly or indirectly, in cash or in kind, in return for referring an individual to a person for the furnishing (or arranging for the furnishing) of any item or service for which payment may be made in whole or in part under a federal health care program (*e.g.*, Medicare or Medicaid).[3] New York State law similarly prohibits illegal remuneration related to Medicaid referrals or services.

In addition, the federal Civil Monetary Penalties Law prohibits offering remuneration to Medicare or Medicaid beneficiaries when the offeror knows or should know that the remuneration is likely to influence the beneficiary's selection of a particular provider, practitioner, or supplier for items or services reimbursable by a federal health care program..[4]

To ensure compliance with applicable legal and ethical standards, the acceptance or giving of gifts or business courtesies is strictly prohibited unless specifically permitted under this policy and approved in accordance with ArchCare procedures.

POLICY:

1. **Restrictions on gifts from those we serve or their families**: No member of the ArchCare workforce may solicit, accept, or receive any gift, gratuity or remuneration in any form from a resident/patient or their family member, regardless of its value. The following are acceptable expressions of gratitude and do not constitute inappropriate gifts, gratuities or remuneration:

    a. Letters of thanks and appreciation, including those which mention staff by name, directed to their supervisor, department head, or the President and CEO, etc.;
    b. Donations to ArchCare in honor of a member of the staff, or a department or unit of ArchCare; and
    c. Token gifts directed to departments or units (but not to specific individuals), such as flowers or fresh fruit baskets.

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[2] There are several exceptions to these statutes, however, they are complex and beyond the scope of this policy. If you have any questions, please contact the Compliance Officer/Liaison for your program or the Corporate Compliance Officer.

[3] Potential penalties for violating the federal anti-kickback statute include up to 10 years' imprisonment, or fines of up to $100,000, or both.

[4] The current penalty for violating the civil monetary penalties law by giving remuneration to improperly induce a beneficiary to choose a particular provider of Medicare or Medicaid services is $ 27,894 for each item or service for which payment may be made by Medicare or Medicaid. This amount is subject to annual adjustments.

2. **Restrictions on gifts to Medicare and Medicaid Beneficiaries:** ArchCare workforce members may not offer or provide Medicare or Medicaid beneficiaries with anything of monetary value intended to influence the beneficiary's selection of an ArchCare provider, practitioner, or service over any another provider. Prohibited conduct includes, but is not limited to, the routine waiver of copayments, coinsurance or deductibles[5] and the provision of items or services for less than fair market value, except as otherwise permitted by law. Inexpensive gifts of nominal value are permitted, however. For purposes of this policy, "nominal value" means items with a retail value of no more than fifteen dollars ($15) per individual item and no more than seventy-five dollars ($75) in the aggregate per patient or beneficiary on an annual basis.

3. **Restrictions on gifts to/from vendors and other individuals and entities with business relationships with ArchCare**: No member of the ArchCare workforce may solicit, accept, offer or give any gift or gratuity of more than **nominal value** (defined below) to or from potential referrals sources, and/or other individuals and entities with which an ArchCare Entity has an actual or potential business relationship, except for fundraising undertaken in accordance with the ArchCare Entity's fundraising policies and procedures to ensure appropriate solicitation practices. For more information, see the ArchCare Fundraising Policy.

   a. No member of the ArchCare workforce shall offer, pay, solicit or receive any commission, bonus, rebate, kickback, gratuity or any other remuneration in exchange for the referral of any resident, patient or health care business to ArchCare or its affiliated entities.

      This prohibition shall not preclude the provision of gifts of nominal value, as defined in Section 3(c) of this Policy, given in recognition of employees who facilitate transfers of individuals served between ArchCare entities, provided that all resident rights, including freedom of choice and informed decision-making, are fully preserved and honored.

   b. No member of the ArchCare workforce shall solicit, accept, or receive any remuneration, rebate, gift, benefit, favor, entertainment, or other item of value from any vendor, supplier, contractor, or other third party in connection with, or in exchange for, the purchase, lease, rental, recommendation, or procurement of equipment, supplies, goods, or services for ArchCare or its residents/patients.

[5] Non-routine, unadvertised waivers of copayments or deductible amounts based on individualized determinations of financial need or exhaustion of reasonable collection efforts may be permitted.

c. **Nominal Value**: Individual gifts valued above $50 and gifts given by one individual or entity to an individual over the course of a year valued above $100 in the aggregate are presumed to be of greater than nominal value. Also presumed to be of more than nominal value are gifts valued above $200 in the aggregate given at one time by a single individual or entity to more than one person, e.g., to several employees for a single social event or meal.

4. **No gifts as a precondition of admission or services or to influence use of services**: No member of the ArchCare workforce or contractor may charge, solicit, accept or receive, in addition to any amount otherwise required to be paid by third-party payors, including Medicare and Medicaid or other government or commercial insurer, any gift, money, donation or other consideration as a precondition of admission, expedited admission or continued stay in an ArchCare facility, except that arrangements for prepayment for basic services not exceeding three months are not precluded by this paragraph.

5. **No gifts to government employees**: No member of the ArchCare workforce may give any gift or gratuity to a government employee or official in connection with a business transaction or issue on behalf of ArchCare.

   All interactions with government officials and agencies must be conducted in compliance with applicable federal, state, and local laws, regulations, and ethical standards governing improper payments, gratuities, bribery, and conflicts of interest.

6. **Gifts or benefits to immediate family members of the workforce/ArchCare contractors are not permitted.** Gifts from vendors/referral sources/residents/ patients to immediate family members of the ArchCare workforce or contractors are prohibited. For purposes of this Policy, "Immediate Family Members" includes an individual's spouse; parent (whether biological, adoptive, or step-parent), child (whether biological, adoptive, or stepchild); siblings (including stepsiblings); parent-in-law, child-in-law, or sibling-in-law; grandparent; grandchild; and spouse of any grandparent or grandchild

7. While this Policy provides guidance for various common circumstances, it is not exhaustive. Questions regarding a particular relationship, gift, or business courtesy should be directed to the Corporate Compliance Officer, 646-656-8724.

8. Exceptions to this Policy must be disclosed to and approved by the Corporate Compliance Officer who shall retain information on the facts and circumstances of

the case and include a summary of such facts and circumstances in the next scheduled meeting of the Compliance Committee of the governing body.

RESPONSIBILITIES: The senior official or designated leader of each ArchCare facility, program, department and functional area is responsible for ensuring that operational practices and procedures comply with this policy and that staff are aware of this policy. Leadership is also responsible for communicating this policy to workforce members and ensuring appropriate education and oversight regarding compliance with gift and gratuity requirements.

All ArchCare workforce members, including employees, contractors, consultants, volunteers, temporary staff, and affiliated personnel, are responsible for understanding and adhering to this policy and for conducting themselves in a manner consistent with ArchCare's ethical and compliance standards. Workforce members must promptly report any actual or suspected violations of this policy in accordance with ArchCare compliance reporting procedures.

REVISION HISTORY:

Date	Change/Note
05/22/2026	Annual review and update of the policy.
4/23/2025	Annual review and update of the policy.
5/1/2024	Annual review and update of the policies and changed the annual value of penalties.
5/1/2023	Review and update to align with the new OMIG Guidance including redefining the term affected individual. In addition, made formatting changes
01/10/2023	Annual review.
8/2021	Expanded definitions of the statutes that are implicated; Added restriction on gifts to immediate family members; reorganized the policy.
8/2016	Simplified policy in accordance with compliance program assessment recommendation and removed section on fundraising into separate corporate policy.
7/2014	Added provision prohibiting VP, Support Services from communicating with

	vendors regarding fundraising event.
5/2011	Incorporated section on business courtesies and solicitation for fundraising.

ARCHCARE AND AFFILIATED ENTITIES POLICY

SUBJECT: Compliance and Ethics Program, Reporting Compliance Concerns; Whistleblower/Non-retaliation/Non-Intimidation Policy for Good Faith Participation in the Compliance Program (System Wide)

ORIGINATING DEPARTMENT: Corporate Compliance

EFFECTIVE DATE: July 16, 2012

MOST RECENT REVIEW/REVISION DATE: 05/05/2026

BOARD AUDIT, RISK, AND COMPLIANCE COMMITTEE APPROVAL DATE: 06/04/2026

PURPOSE: To encourage the prompt reporting of compliance matters and concerns, support good faith participation in the Compliance and Ethics Program, and protect individuals from retaliation, intimidation, or adverse action for reporting suspected misconduct or participating in compliance-related activities.

ENTITIES AFFECTED: All ArchCare-sponsored entities

SCOPE: This policy applies to the workforce[1] of ArchCare and its affiliated entities. Specifically, ArchCare "workforce" includes, but is not limited to, employees (including chief executive and other senior administrators and managers), medical staff, volunteers, and students. The term "workforce" also applies to contractors, subcontractors, agents and independent contractors[2] who, on behalf of ArchCare, furnish, or otherwise authorize the furnishing of Medicare and/or Medicaid health care items or services, perform billing or coding functions, or are involved in monitoring of health care provided by ArchCare.

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[1] This definition is aligned with the updated Part 521 of Title 18 of the Codes, Rules and Regulations of the State of New York which defines "[a]ffected [i]ndividuals as defined by the as all persons who are affected by the provider's risk areas, including employees, the chief executive and other senior administrators, managers, contractors, agents, subcontractors, independent contractors, and governing body and corporate officers."

[2] This policy applies to designated contractors who engage in the provision of quality healthcare service and/or who fall under the following risk areas of "billings, payments, ordered services, medical necessity, quality of care, governance, mandatory reporting, credentialing, contractor oversight, and other areas that should reasonably be identified by the provider through its organizational experience".

In addition, this policy applies to all individuals who report compliance concerns, including Medicaid recipients of services.

OVERSIGHT OF THIS POLICY: The adoption, implementation, and oversight of compliance with this Policy shall be the responsibility of each affiliated entity's designated Compliance Committee of the Board. The designated Compliance Committees may, at their discretion, authorize certain functions related to the implementation of, and compliance with, this Policy to be performed by one or more care members, officers or trustees., However, the designated Compliance Committees shall retain overall responsibility for oversight of all aspects of this Policy at all times. The Corporate Compliance Officer has been designated by the Boards to administer this Policy and to report to the Compliance Committees on concerns related to its implementation and compliance oversight.

POLICY: Care members are required to report unethical or illegal conduct, or instances of fraud, waste and abuse of which they become aware and must cooperate fully in any related investigation. ArchCare will not take disciplinary or retaliatory action against any care member for their good faith participation in the Compliance and Ethics Program, as defined below. Intimidation or retaliation of any kind by any individual associated with ArchCare is strictly prohibited and constitutes a serious violation of the Code of Conduct.

No affected individual, including but not limited to trustee, officer, key person,[3] care member or volunteer of ArchCare, who in good faith reports any actual or suspected action that is illegal, fraudulent, or in violation of any adopted ArchCare policy, shall be subject to intimidation, harassment, discrimination, retaliation, or in the case of care members, adverse employment consequences.

DEFINITIONS:

1. **<u>Compliance concerns</u>,** include, but are not limited to:

- Failure to comply with applicable federal, state, and local laws, regulations, official guidance or federal healthcare program standards (*e.g.,* Medicare or Medicaid requirements);

- Failure to comply with ArchCare's Code of Conduct, policies or procedures; and

- Conflicts of interest, fraud and other ethical breaches by affected

[3] These terms are defined in the Conflict-of-Interest Policy.

individuals or associates.

2. **"<u>Good faith participation in the Compliance and Ethics Program</u>"** includes, but is not limited to:

- reporting actual or potential issues or concerns, including but not limited to, any action or suspected action taken by or within ArchCare that is illegal, fraudulent or in violation of any adopted ArchCare policy;
- cooperating with or participating in the investigation of such concerns;
- assisting with or participating in self-evaluations, audits, and/or resolving compliance issues (remedial actions);
- reporting instances of intimidation or retaliation;
- reporting potential fraud, waste or abuse to appropriate State of Federal Entities; or reporting to appropriate regulatory officials as provided in New York Labor Law §§ 740 and 741.

3. **<u>Good faith report</u>:**

Any report of a compliance matter that is made without malice and with reasonable cause to believe that the information reported is true.

4. **<u>Report</u>:**

Any complaint, allegation, report, or concern of a compliance matter made under this procedure.

REPORTING PROCEDURE:

1. **Raising Compliance Concerns; Filing Reports.**

Affected individuals are encouraged to raise concerns regarding compliance concerns with their immediate supervisor. If the concern is regarding their immediate supervisor, they are encouraged to report to their local Compliance Officer or Compliance Liaison, the Corporate Compliance Officer, or Human Resources, as appropriate. Supervisors or other individuals receiving reports regarding compliance concerns should contact their local Compliance Officer or Compliance Liaison, the Corporate Compliance Officer, or Human Resources to determine next steps and should not investigate the matter themselves**.**

Affected individuals and others are always free to report compliance concerns to their local Compliance Officer or Compliance Liaison, or the Corporate Compliance Officer, regarding compliance concerns. They may also report to Human Resources with issues regarding compliance with personnel policies.

Reports for compliance related concerns may be made:

- by phone, email, regular mail or in person to the local Compliance Officer or Compliance Liaison or the Corporate Compliance Officer;
- to the Compliance Hotline (800) 443 0463 (which is toll free, operated by an outside vendor, and available 24 hours a day, 7 days a week. Calls to the Hotline may be made anonymously with the ability for the caller to receive reports and follow up questions. The number is posted within ArchCare Entities, on the website and included in the compliance education provided to the ArchCare workforce and to ArchCare vendors).
- via a secure report online to **www.archcare.ethicspoint.com**
- if the suspected misconduct being reported concerns the Corporate Compliance Officer or the Entity Compliance Officer or Compliance Liaison, the employee may report through the ArchCare Compliance and Corporate Ethics Hotline (in which case the information will be forwarded directly to the ArchCare Board of Trustees' Compliance Committee) or the Boards of Managers of ArchCare Senior Life directly. See Compliance Program, Corrective Action and Response to Detected Offenses, System-Wide Policy.

2. Anonymity/Confidentiality.

Compliance reports may be made anonymously, if a person chooses. If not made anonymously, the confidentiality of individuals reporting compliance issues will be maintained, except when the matter is subject to a formal disciplinary proceeding, or when it is under investigation by regulatory bodies like MFCU, OMIG, or law enforcement, or when legal proceedings require disclosure. Compliance files shall be

maintained in a secure area to ensure appropriate confidentiality of the reported information.

PROCEDURES FOR INVESTIGATING RETALIATION/INTIMIDATION COMPLAINTS

1. Non-intimidation and Non-retaliation

ArchCare and its Affiliated Entities strictly prohibit intimidation, retaliation, discrimination, harassment or any other adverse action by management or any other person or group, either directly or indirectly, against any individual or group who reports a potential violation in good faith under the reporting system described in this policy or for other good faith participation in the Compliance and Ethics Program. Anyone believing that he or she or an employee or other person has been subjected to retaliation or intimidation for making a good faith report or for other good faith participation in the Compliance and Ethics Program should report such matter to anyone designated to receive reports under this Policy.

2. Reporting to Compliance Personnel

Any complaint of retaliation or intimidation received by a supervisor shall be promptly reported to the Compliance Officer/ Liaison of the relevant program or to ArchCare's Corporate Compliance Officer. If an employee identifies themselves when making the complaint, the individual receiving the complaint will advise that employee of the results of its investigation and any related corrective action taken as a result.

3. Investigation and Corrective Action

All allegations of intimidation or retaliation resulting from good faith participation in the Compliance and Ethics Program will be fully investigated. The Corporate Compliance Officer, or a designee, will oversee any investigations and take all necessary and appropriate actions in connection with any investigation. The Corporate Compliance Officer, or a designee, will be assisted by internal staff and/or may solicit the support of external resources, as needed.

- All individuals who have relevant information will be promptly interviewed. At the outset of the interview process, the interviewee will be reminded that retaliation and intimidation is a violation of ArchCare's Code of Conduct and this Policy, and that under certain circumstance, may be unlawful as well. The interviewee will also be

reminded of ArchCare's disciplinary policy for failure to cooperate in a compliance-related investigation.

- All documentation related to the investigation will be kept confidential, consistent with the need to investigate the issue(s) raised. Investigative files will be kept secured in a central location under the control of the Corporate Compliance Officer or designated staff. Such investigative files will be kept separate from personnel files and will be maintained for no fewer than ten years from the date of the conclusion of the investigation, or the imposition of disciplinary sanctions or corrective actions resulting therefrom, or for such longer period of time as may be required by applicable law.

- If the Corporate Compliance Officer determines that an individual was improperly intimidated or retaliated against for good faith participation in the Compliance and Ethics Program, ArchCare will promptly take all appropriate corrective action as to the individual who was intimidated or retaliated against. The Audit, Risk & Compliance Committee of the Board will retain oversight of all such corrective action.

- ArchCare may terminate contracts and affiliations based on retaliation or intimidation for good faith participation in the Compliance and Ethics Program, subject to the oversight of the applicable designated Compliance Committee of the Board.

- To prevent retaliation or intimidation against care members who in good faith participate in the Compliance and Ethics Program, all terminations of employment must be approved by ArchCare's Human Resources Department prior to being effectuated. The Human Resources Department must be advised of the employee's participation in the Compliance and Ethics Program prior to the termination decision or other adverse employment action being made.

- A person that is subject of a whistleblower complaint may not be present at or participate in Board or Board-level committee deliberations or vote on the matter relating to such complaint. The Board or designated Committee, in its discretion, may request that a person who is subject of a whistleblower complaint present

information as background or answer questions at a Board or Committee meeting prior to the commencement of deliberations or related voting.

- Board members who are care members may not participate in any Board or Committee deliberations or voting relating to administration of the ArchCare Whistleblower Policy.

4. **Disciplinary Action for Reports Made Not in Good Faith**.

ArchCare and its Affiliated Entities may take appropriate disciplinary or legal action if an individual knowingly makes a false report, intentionally provides misleading information, or acts with reckless disregard for the truth in reporting suspected wrongdoing. Reports made in bad faith, including those intended to harm another individual or obtain personal benefit, are prohibited.

At the same time, ArchCare and its Affiliated Entities encourage all individuals to raise concerns in good faith without fear of retaliation. In addition, while self-reporting of misconduct may be considered a mitigating factor when determining appropriate corrective or disciplinary action, individuals remain accountable for their own conduct and may still be subject to disciplinary measures for violations of law, policy, or organizational standards.

DISTRIBUTION OF POLICY AND REPORTING REQUIREMENTS

1. **Policy Distribution**.

This Policy will be distributed to all directors, officers, key persons and employees of ArchCare, and to volunteers who provide substantial services to ArchCare. Distribution may be accomplished electronically, including posting the Policy on the ArchCare intranet. This policy is also available online at archcare.org/compliance.

2. **Reporting to the Governing Body**

The Corporate Compliance Officer will advise the Audit, Risk & Compliance Committees, as directed by the governing body, regarding any alleged acts of retaliation or intimidation in violation of this policy on an ongoing basis.

REVISION HISTORY:

Date	Change/Note

05/05/2026	Annual review and update of the policy.
4/23/2025	Annual review and update of the policy.
5/1/2024	Annual review and update of the policies.
5/1/2023	Review and update to align with the new OMIG Guidance including redefining the term affected individual. In addition, made formatting changes.
8/2022	Replaced "compliance program" with "compliance and ethics program". Replaced board compliance committee with board audit, risk, and compliance committee.
8/2018	Revised title to reflect expanded "reporting" section and reference good faith participation in the compliance program. Revised to comply with the Not for Profit Corporation Law §715-b, Social Services Law §363-d, 18 N.Y.C.R.R. § 518.3 and OMIG Guidance. Added definition of "good faith participation in the compliance program." Added "scope" and "oversight" sections. Added investigative procedures pertaining to retaliation/intimidation complaints.
4/2014	Revised to comply with the Nonprofit Revitalization Act.
1/2013	Clarified that intimidation of employees reporting unethical or illegal conduct is not tolerated either. Expanded reporting obligation to governing bodies and designated contractors as well as employees.
7/16/2012	Changes per annual review, amended to include Fraud, Waste and Abuse program.
1/2011	Changes per annual review.
9/6/2007	Original Policy

ARCHCARE AND AFFILIATED ENTITIES POLICY

SUBJECT: Compliance and Ethics Program, Risk Assessment, Monitoring and Reviewing, System-Wide

ORIGINATING DEPARTMENT: Corporate Compliance

EFFECTIVE DATE: March 1, 2011

MOST RECENT REVIEW/REVISION DATE: 05/22/26

BOARD AUDIT, RISK, AND COMPLIANCE COMMITTEE APPROVAL DATE: 06/04/2026

PURPOSE: To establish requirements for an ongoing risk assessment and monitoring program to designed to detect, prevent and address Fraud, Waste and Abuse.

ENTITIES AFFECTED: All ArchCare-sponsored Entities.

SCOPE:

POLICY: ArchCare will conduct on-going risk assessments through processes designed to continually monitor compliance with the Code of Conduct, Compliance and Ethics Program policies and procedures, and all applicable federal and state laws, rules and regulations. To support this effort, the Corporate Compliance Officer shall ensure the implementation and maintenance of an effective system for routine monitoring, auditing and identification of compliance risks.

The system shall include internal monitoring activities, as well as external reviews and audits when appropriate, to evaluate ArchCare's compliance with federal health care program requirements, including Medicare and Medicaid requirements, and to assess the overall effectiveness of the Compliance and Ethics Program. Risk assessment activities will be conducted on a periodic and ongoing basis to identify areas of potential Fraud, Waste, and Abuse and to support timely corrective action, education, and process improvement initiatives.

PROCEDURE:

NOTE: Risk assessment activities are also addressed in the Compliance Program Charter. In the event of a conflict between this policy and the Compliance Program Charter, the Compliance Program Charter shall govern.

1. **Compliance Monitoring Reviews**. The Corporate Compliance Officer will ensure compliance monitoring reviews are conducted in accordance with the following procedures and protocols. The Corporate Compliance Officer will work with the Compliance Officers/Liaisons in conjunction with the Compliance Committees, relevant Department Heads, and managers and supervisors, to arrange for the periodic review of various compliance matters, including, but not limited to, the following:

    a. Annual Self-Assessment of Risk. An internal risk assessment will be conducted to identify risk areas. These risk areas will be shared with the Corporate Compliance Officer and Compliance Committees. Periodic reports on the improvement in the risk areas identified will be required. The Compliance Committee will be responsible for monitoring such improvements and compliance with applicable laws and regulations.

    b. Billing Reviews. Periodic reviews will be performed as to how services are ordered, performed, billed and paid, utilizing external consultants and/or counsel, as necessary and appropriate. Such reviews will include the selection of a sample of medical records and corresponding bills to assess compliance with ArchCare's medical record and billing policies and with applicable legal requirements.

    Reviews may include targeted or probe "audits" of medical record documentation, coding billing, claims submission and other operational or compliance related activities, as appropriate. Significant variations from established benchmarks, regulatory requirements, internal policies, or expected performance standards shall be evaluated and addressed through appropriate corrective action measures, including but not limited to: education and training and follow-up reviews.

    c. Review of Billing Denials and Patient Complaints. Periodic reviews will be performed of denials from Medicare, Medicaid and other third-party payers in order to determine whether any patterns of improper billing exist that need correction. In addition, billing complaints from patients will also be tracked to determine whether such complaints reflect the existence of possible patterns of improper billing or other compliance issues.

d. Response to Third Party Audits. Following the resolution of audits conducted by third-party payers or external agencies, the results of such audits shall be reviewed by the Corporate Compliance Officer or designee, to determine whether the findings identify patterns, trends, , systemic deficiencies or other compliance concerns. The review shall include an assessment of potential noncompliance with applicable State or Federal laws, rules, regulations, contractual obligations, payer requirements and/or organizational policies and procedures.

When appropriate, identified issues shall be incorporated into the Compliance Department's risk assessment and monitoring activities. Corrective action plans, additional education and training, enhanced monitoring, policy revisions, repayment obligations, or follow-up audits may be implemented to address identified deficiencies and reduce the risk of future noncompliance.

e. Quality of Care/Medical Necessity Reviews. The Corporate Compliance Officer, or designee, will receive reports from the QA Committees which may include, but not be limited to the following quality-related issues: access to care; meeting recognized standards of care; preventing and addressing deficiencies in care; honoring patient rights; ensuring staff are qualified to provide care; and ensuring that pharmaceuticals and medical devices ordered are done so free from any conflicts of interest.

f. Contract Reviews (contractor, subcontractor, agent or independent contract oversight). ArchCare will assess whether contractual arrangements were executed in compliance with and otherwise conform to the requirements of the Compliance and Ethics Program and applicable contracts will be updated to address the requirement to comply with ArchCare Compliance Program (training and attestation);

g. Mandatory Reporting. The Corporate Compliance Officer will conduct reviews to ensure that all regulatory reporting obligations are met.

h. Credentialing. The SVP, Human Resources and Corporate Medical Officer will ensure that all clinical personnel are appropriately credentialed (*i.e.*, properly licensed/certified and registered) and that all affected individuals or entities (*e.g.*, staff, vendors, referring providers) are not listed on any federal or state exclusion list.

i. Governance. The Corporate Compliance Officer will regularly report to the Board of Trustees regarding the ongoing monitoring of ArchCare's compliance efforts. Follow-up reports with respect to identified areas of risk, or vulnerability, will be developed by the Corporate Compliance Officer and shared with the Board and the Audit, Risk & Compliance Committee. Moreover, the Corporate Compliance Officer will ensure that Trustees, Officers and Key Persons are educated regarding the Conflict-of-Interest Policy and that annual disclosure statements are completed and reviewed in accordance with the policy.

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

3. **Compliance and Ethics Program Reviews**. As part of ArchCare's compliance monitoring and oversight activities, the Corporate Compliance Officer shall work collaboratively with the Compliance Officers/Liaisons to periodically assess the effectiveness of the Compliance and Ethics Program, including whether:

   a. the anonymous reporting system is implemented and properly functioning;

   b. compliance reports, complaints, allegations, investigations and inquiries are appropriately documented, tracked, investigated, resolved and maintained in accordance with applicable policies and procedures;

   c. identified actual or suspected violations of applicable laws, regulations, policies, or standards or conduct have been appropriately investigated, corrected, remediated and addressed through corrective action and disciplinary measures, where warranted; and

   d. compliance risks, trends, audit findings, and issues identified through prior reviews, investigations, audits, or monitoring activities have been appropriately incorporated into training programs, compliance communications, policy updates, alerts and ongoing monitoring activities

Moreover, on at least an annual basis, the Corporate Compliance Officer, or designee shall conduct a formal review and evaluation of the overall effectiveness, implementation and operation of the Compliance and Ethics Program to determine revisions, enhancements, or corrective actions are necessary. Based upon the results of such reviews and evaluations, the Corporate Compliance Officer, or designee, shall recommend to the Audit, Risk & Compliance Committee any appropriate modifications, enhancements, or revisions to the Compliance and Ethics Program, including applicable compliance policies and procedures, the Code of Conduct, and the Compliance Program Charter.

In addition, they may conduct periodic surveys, assessments, interviews, or other feedback activities involving care members regarding various elements of the Compliance and Ethics Program, including awareness of reporting mechanisms, non-retaliation protections, training effectiveness, and overall compliance culture. The results of such surveys shall be shared with the appropriate Compliance Committee, senior leadership, and/or Audit, Risk and Compliance Committee as appropriate, and may be used to support ongoing program improvement efforts, including modifications or revisions to compliance policies, procedures, training initiatives, the Code of Conduct and the Compliance Program Charter.

4. **Response to Findings**. Findings and recommendations resulting from these reviews may be reported to senior leadership, the Compliance Committee, and/or the Board or applicable Board committee, as appropriate. In the event a violation of the Compliance and Ethics Program is discovered, appropriate remedial action will be taken in accordance with the Compliance and Ethics Program, Corrective Action and Response to Detected Offenses, System-wide Policy.

5. **Tracking New Developments.** On an ongoing basis, the Corporate Compliance Officer or designee, shall ensure that all new revised regulatory, legal, accreditation, contractual, and payer requirements issued by federal or state government agencies, oversight entities and commercial payers with which ArchCare conducts business are identified, reviewed and communicated to appropriate personnel. Such reviews may include, but are not limited to, the following:

   a. Reviewing all new and revised laws, regulations, rules coverage policies and guidance governing the coding, billing, documentation, reimbursement, and delivery of services provided by ArchCare;

   b. Receiving, monitoring and reviewing relevant Medicare bulletins, Medicaid updates, Local and National Coverage Determinations,

transmittals, payer manuals,, annual updates to the Current Procedural Terminology (CPT), HCPCS, ICD coding systems, other applicable regulatory or reimbursement guidance and policy changes;

c. Communicating and collaborating with the relevant professional associations, industry groups, accrediting organizations, and subject matter experts regarding emerging initiatives, regulatory, compliance risks, and best practices that may affect ArchCare operations, or support compliance with applicable requirements;

d. Reviewing (a) relevant Special Fraud Alerts, Advisory Opinions, Corporate Integrity Agreements, Compliance Program Guidance or other publications issued by the U.S. Department of Health and Human Services, Office of the Inspector General ("OIG"); (b) compliance alerts, guidance, audit protocols, and other publications issued by the New York State Office of the Medicaid Inspector General ("OMIG"); and (c) guidance, bulletins, manuals, contractual requirements, and policy updates issued by Medicare Administrative Contractors ("MACs"), Medicaid programs, managed care organizations, and other payers with which ArchCare conducts business; and

e. Reviewing applicable OIG and OMIG Work Plans, audit priorities, enforcement trends and identified areas of program integrity risk to assess potential impact on ArchCare operations and compliance activities.

Based on any relevant legal, regulatory, operational, audit, monitoring enforcement, or industry developments, the Corporate Compliance Officer, or designee, shall periodically review existing policies, procedures and compliance controls to ensure that ArchCare remains compliant with all applicable federal, state and local laws, regulations, payer requirements, accreditation standards and contractual obligations.

Where deficiencies, gaps, or areas requiring improvement are identified, ArchCare shall implement appropriate corrective actions, which may include policy revisions, enhanced monitoring, operational changes, additional training, disciplinary action, or other remedial measures deemed necessary to mitigate risk and support ongoing compliance.

REVISION HISTORY:

Date	Change/Note

05/22/2026	Annual review and revision of policy.
4/23/2025	Annual review and revision of policy.
5/1/2024	Annual review and update of the policies and including information regarding ongoing survey of the compliance program.
5/1/2023	Review to align with the new OMIG Guidance. In addition, made formatting changes.
8/2022	Replaced board compliance committee with board audit risk and compliance committee, replaced compliance program with compliance and ethics program
8/2021	Revised title of the policy; revised policy for compliance with Social Services Law 363-d; added risk areas, expanded the types of reviews that should be undertaken, added new sections regarding annual work plan and tracking new developments.
1/2011	Changes per annual review
9/2007	Original Policy

ARCHCARE AND AFFILIATED ENTITIES POLICY

SUBJECT: Compliance and Ethics Program, Record Retention & Document Destruction, System-Wide

ORIGINATING DEPARTMENT: Corporate Compliance

EFFECTIVE DATE: March 1, 2011

BOARD AUDIT, RISK, AND COMPLIANCE COMMITTEE APPROVAL DATE: 06/04/2026

MOST RECENT REVISION OR REVIEW DATE: 05/05/2026

PURPOSE: The purpose of this Policy is to establish record retention guidelines that outline the requirements of record management, retention, security disposal and archiving. This Policy provides for the systematic review, retention and destruction of documents received or created by ArchCare and its Affiliated Entities ("ArchCare") in connection with the transaction of its business. This Policy covers all records and documents, regardless of physical form, contains guidelines for how long certain documents should be kept and how records should be destroyed, and assigns responsibility for the enforcement of the policy within ArchCare.

SCOPE: This policy applies to all members of the ArchCare workforce including, but not limited to, employees, medical staff, volunteers, students, and contracted clinical and non-clinical staff performing work for or at ArchCare. "This policy applies to the workforce[1] of ArchCare and its affiliated entities. Specifically, ArchCare "workforce" includes, but is not limited to, employees (including chief executive and other senior administrators and managers), medical staff, volunteers, and students. The term "workforce" also applies to contractors, subcontractors, agents and independent contractors[2] who, on behalf of ArchCare, furnish, or otherwise authorize the furnishing

[1] This definition is aligned with the updated Part 521 of Title 18 of the Codes, Rules and Regulations of the State of New York which defines "[a]ffected [i]ndividuals as defined by the as all persons who are affected by the provider's risk areas, including employees, the chief executive and other senior administrators, managers, contractors, agents, subcontractors, independent contractors, and governing body and corporate officers."

[2] This policy applies to designated contractors who engage in the provision of quality healthcare service and/or who fall under the following risk areas of "billings, payments, ordered services, medical necessity, quality of care, governance, mandatory reporting, credentialing, contractor oversight, and other areas that should reasonably be identified by the provider through its organizational experience".

of Medicare and/or Medicaid health care items or services, perform billing or coding functions, or are involved in monitoring of health care provided by ArchCare.

POLICY: It is the policy of ArchCare that all of its entities retain Records, as defined below, in accordance with applicable: (1) Federal, State and/or local law and regulation; (2) statutes of limitation; and/or (3) contractual requirements.

All Records must be retained in accordance with the Record Retention Guidelines and schedules developed by the applicable ArchCare Entity.

Each ArchCare Entity is responsible for ensuring the security, privacy and confidentiality of medical records, as required by law and Entity-specific policies.

DEFINITIONS:

Non-Record. Preliminary materials and other materials that are not records and that do not reflect the position or business of the ArchCare Entity, including Transitory Records, blank forms, preliminary working papers, superseded drafts and word processing files used to produce original records. Non-Records are not subject to the Retention Schedule and should be discarded when no longer of use.

Record. An ArchCare Entity Record shall be defined as any memorandum, writing, entry, print, representation or combination thereof of any act, transaction, occurrence, or event made or received in the regular course of business. Generally, a Record contains information with operational, legal, fiscal or historic value. A Record is defined broadly as information and includes documents, books, statements, and analyses, whether on paper or contained on microfiche, microfilm, optical disk, laser disk, or other magnetic media. Records also include data in electronic format intended for use by a computer.

Record Retention Period. The time during which records must be maintained by a corporate entity because they are needed for operational, legal, fiscal, historical, or other purposes.

Transitory Record. A Transitory Record is a record that is intended to be an informal communication of information, and it is short lived. Examples of Transitory Records include voicemail messages, instant messages, telephone messages, post-it notes and e-mail messages when such messages are informal in nature and have short-lived or no administrative value.

RESPONSIBILITIES: Each ArchCare Entity, including ArchCare, must appoint a Records Coordinator who shall be responsible for the oversight of this Policy. All questions regarding the scope or meaning of the policy, as well as specific questions regarding the retention of a record should be addressed to the Records Coordinator.

Unless otherwise indicated, Department Heads within each ArchCare Entity are responsible for creating, and no less than annually, reviewing and revising, and complying with the record retention schedule of their department, including overseeing the off-site storage of records, if necessary, and the destruction of records in accordance with the record retention schedule.

The Records Coordinator shall be responsible for maintaining the Entity's record retention schedules.

At least annually, the Records Coordinator shall coordinate the destruction of all records stored at off-site storage facilities and records maintained onsite in accordance with the Entity's record retention schedules.

All employees have an affirmative obligation to inform the Records Coordinator of any audits, investigations or litigation that they are aware of regarding the ArchCare Entity or which are anticipated.

PROCEDURES:

1. R**ecord Management and Retention.** Each ArchCare Entity shall retain records for the period of their immediate or current use, unless longer retention is necessary for historical reference or to comply with contractual, legal, or regulatory requirements. Each ArchCare Entity shall establish and maintain record retention schedules, containing a list of records and prescribing the periods of authorized retention. Record retention guidelines for basic: (1) Business and Administrative Records; (2) Finance/Purchasing/Reimbursement Records; (3) Employment/Safety Records; and (4) Facility/Clinical Records (collectively "Basic Record Retention Guidelines") are attached to this Policy as a guide. Each ArchCare Entity shall retain records consistent with these guidelines and shall assure that their record retention schedules incorporate all the types of records required to be maintained by law or regulation. For types of records not addressed in the Basic Record Retention Guidelines, each ArchCare Entity shall retain the records for no less than the length of time required by federal or state law or regulation or to prove compliance with a law or regulation, and shall maintain a corresponding retention schedule.

2. **Electronic Documents and Records.** Electronic documents will be retained as if they were paper documents. Any electronic records that fall into one of the document types on the record retention schedule will be maintained for the appropriate amount of time. Non-record email not meeting the definition of record includes transitory email inboxes which are primarily generated for informal communication of information. All employees are

responsible for retaining those emails sent or received that constitute records in an appropriate file system in accordance with this record retention policy. Email inboxes and sent mailboxes do not constitute *de facto* filing system for emails that constitute records and are subject to a **180-day deletion policy**. Email folders may be created, however, to organize and classify email by message content and retention period that parallels an existing paper-based file plan.

3. **Off-Site Storage; Labeling and Marking**. Records that are stored off-site shall be labeled and marked with a disposal date equal to or beyond the period established for retention. Record storage containers and systems must be labeled in sufficient detail that permits prompt and accurate identification should retrieval of the medical records become necessary. The disposal date should always be December 31 of the last year for which the file must be retained. For example, a document dated May 23, 2014 with a ten-year retention period would be designated for destruction on December 31, 2024.

4. **Record Destruction/Annual Review.** Each ArchCare Entity will conduct a file review and purge process on at least an annual basis. This process consists of identifying and destroying unnecessary duplicate and multiple copies of documents, including drafts; reviewing and destroying documents which have exceeded their required retention period; and identifying, grouping and labeling documents which require retention and transferring these documents to the designated records storage site. Documents will be destroyed only in accordance with the Records Retention Schedule. Only Department Heads are permitted to authorize the destruction of Records. If there is any question as to how long a particular document should be retained, that document should not be destroyed until the question has been resolved.

   Confidential records, including records containing Protected Health Information, financial and personnel-related documents, and other records subject to confidentiality restrictions will be destroyed in a manner that ensures confidentiality, such as shredding, mutilation or incineration in accordance with the policy and procedure established by each ArchCare Entity.

5. **Record Destruction Suspension for Audit, Investigation or Litigation.** Document destruction will be suspended immediately if the ArchCare Entity knows such documents are (i) relevant to litigation, criminal and/or

civil investigations, audits, or needed for ongoing administrative proceedings, (ii) reasonably calculated to lead to the discovery of relevant records in a legal proceeding, (iii) reasonably likely to be requested during discovery in a legal proceeding, or (iv) subject to a pending discovery request in a legal proceeding. This includes, but is not limited to instances involving: (a) receipt of notice regarding the initiation of an audit or investigation by an outside agency (e.g., a Medicare or Medicaid audit); (b) receipt of service of legal process which involves an ArchCare Entity's records; or (c) receipt of a complaint that the ArchCare Entity determines may lead to a formal action or investigation.

The Records Coordinator will maintain a list of all such claims, investigations, audits, and litigations that will be reviewed by the Department Head or his/her designee prior to commencing any record destruction process in accordance with this Policy. Such list will be herein referred to as a "watch list."

Department Heads will evaluate the documents under consideration for destruction to determine if the documents (1) exceed the retention period on the Records Retention Schedule and (2) exceed contractual time frames applicable and are not on the "watch list."

Once the litigation, criminal and/or civil investigations and/or audits or proceeding are finalized, the relevant records may be destroyed in accordance with the applicable retention schedule and the requirements of this Policy.

6. Lost, Damaged or Destroyed Record

Medicaid Entities/Providers are required to prepare and maintain contemporaneous records demonstrating their right to receive payment under the medical assistance program and furnish the records, upon request.

If ArchCare becomes aware that records have been damaged, lost or destroyed they are required to report that information to the OMIG Self-Disclosure Program as soon as practicable, but no later than thirty (30) calendar days after discovery.

If ArchCare entity discovers a lost, damaged or destroyed record, it must contact the Corporate Compliance Officer, 646-656-8724 to prepare the

appropriate self-disclosure documentation to NYS Office of Medicaid Inspection General.

7. **Disciplinary Action.** Violations of this Policy will result in disciplinary action up to and including termination.

8. **Interpretation.** Any questions regarding the application of this Policy or retention requirements for specific types of records should be referred to the ArchCare Entity Compliance Officer of Compliance Liaison or to the Corporate Compliance Officer.

REVISION HISTORY:

Date	Change
05/26/26	Annual review and update.
4/23/2025	Annual review.
5/1/2024	Annual review and update of the policies incorporating requirements for self-disclosure of a lost, damaged or destroyed record.
5/1/2023	Review and update to align with the new OMIG Guidance including redefining the term affected individual. In addition, made formatting changes and added record retention for compliance program.
8/2022	Replaced "Board Compliance" with "Board Audit, Risk, and Compliance" and replace "compliance program" with "compliance and ethics program"
9/2021	Deleted reference to Sarbanes-Oxley which makes it a crime to alter, falsify, destroy, etc. any documents with the intent to impede, obstruct, influence a federal investigation; Reorganized Policy/Procedures Sections. Revised Record Destruction section and Definition of Record. Added reference to "Compliance Liaison" in Responsibilities section. Expanded Procedures Section. Added "Interpretations" section and recommendations for longer retention periods for certain Records.

11/2019	Corrected mistake in Section B. changed email inbox and sent mail box deletion period to 180 days.
4/2014	Changed reference to email inbox and sent mail box deletion period from 90 to 180 days.
9/2012	clarified employee responsibilities to maintain record system apart from email inbox. See Section B.
12/30/2008	Board Approved Policy
11/2011	Changes per annual review

SCHEDULE A: BUSINESS AND ADMINISTRATIVE RECORDS RETENTION GUIDELINES

DOCUMENT	RETENTION PERIOD
Articles of Incorporation	Permanent
Board Meeting and Committee Minutes	Permanent
Board Policies/Resolutions	Permanent
By-laws	Permanent
Construction Documents	Permanent
Fixed Asset Records	Permanent
IRS Application for Tax-Exempt Status	Permanent
IRS Determination Letter/Group Ruling	Permanent
Contracts (after expiration)	7 years
Correspondence (general)	3 years
Administrative Policies and Procedures	10 years
Corporate Compliance Documents	10 years
Donor Records and Acknowledgement Letters	7 years
Grant Applications and Contracts	5 years after completion
Insurance Policies	Permanent
Real Estate Documents	Permanent

SCHEDULE B: FINANCE/PURCHASING/REIMBURSEMENT RECORDS RETENTION GUIDELINES

DOCUMENT	RETENTION PERIOD
External Audit Reports	Current year + 15 years
Budget Work papers	Current year + 15 years
Financial Statements	Current year + 15 years
Collection Records	Current year + 15 years after audit
Purchase Orders/Supply Requisitions	Current year + 15 years
Financial Reports and Workpapers	Current year + 15 years
Cost Reports and Workpapers	Current year + 15 years except records relating to Base Year which should be maintained for as long as base year is used plus 2 years.

SCHEDULE C: EMPLOYMENT/SAFETY RECORDS RETENTION GUIDELINES

DOCUMENT	RETENTION PERIOD
Employment Testing, including any exams considered in connection with personnel action.	6 years from date of test.
Employment Contracts	Active + 6 years.
Personnel files including employee biographical data; employment contracts; records of additions to and deletions from pay; compensation rate changes; all records related to FMLA leave (excluding employee health records); all records related to Reasonable Accommodations; employment terminations, layoffs, promotions, demotions and transfers; tuition reimbursement records; W-4's; IT-2104's; training certificates.	7 years post termination
INS Form I-9 (retained separate from personnel file)	7 years post termination
Payroll and Compensation (Basic and Supplemental, such as wage rate tables, time sheets, earnings cards, docs indicating daily start/end times)	6 years
Earnings Records	6 years
Records of All Volunteers, Students, or Other Non-Compensated Personnel	6 years
EEO Recording/Reporting: 100 or more employees – EEO-1 Apprenticeships – EEO-2 Chronological apps Others for EEO-2	6 years
Employment Benefits/ Pensions/ Reporting Contributions Benefit Plans generally Plans or trusts that provide income including in "regular rate' of pay for FLSA	Active + 6 years

DOCUMENT	RETENTION PERIOD
ERISA filings and related records	
Worker's Compensation Records	18 years – for occupational injuries
Educational Assistance Financing	Current year + 6 years
Paid Time Off Records	Current year + 6 years
W-2 Forms	Tax return filing date + 15 years
W-9 Letters	Tax return filing date + 15 years
W-4 Forms	Tax return filing date + 15 years
Form 990	Tax return filing date + 15 years
Form 940 & 941	Tax return filing date + 15 years.
Form 1099	Tax return filing date + 15 years.
Employee Training Certification	Active + 6 years
Training Program Materials	Active + 6 years
Certificates of Completion of Infection Control & Barrier Precaution Training Courses	21 years
Nursing Records Training	Active + 6 years
FMLA Leave Records	6 years
Reasonable Accommodation	6 years

DOCUMENT	RETENTION PERIOD
Employee Medical Records	Active + 3 years (except to health insurance claims records maintained separately from the employer's medical program and its records; first aid records; medical records of employees who work for less than 1 year.)
OSHA Log (OSHA Form 300)	Active + 30 years
OSHA Form 300A (Summary of Work-Related Injuries and Illnesses	Active + 30 years
Health & Safety Illness/ Injury/ Accident Reports (OSHA Form 301)	Active + 30 years
Health & Safety Hazardous Employee Exposure	Active + 30 years
Health & Safety Noise Exposure Measurements	Active + 30 years
Health & Safety Audiometric Test Record	Active + 30 years
Health & Safety Emergency Action Plans (not specifically mentioned in regulations)	Active + 30 years
Material Safety Data Sheets	Active + 30 years
Fire Protection	6 years

SCHEDULE D: FACILITY AND CLINICAL RECORDS RETENTION GUIDELINES

DOCUMENT	RETENTION PERIOD
Patient Medical Records – Adult	Recommendation: 6 years from date of discharge
Patient Medical Records – Minor	Recommendation: 6 years from date of discharge or 2 years from age of majority, whichever is longer; or at least 6 years after the patient's death
Accident reports and related records	6 years
Census Record of Residents	10 years
Periodic reports, summaries, logs required by administrative policy	6 years
Disaster preparedness records	Permanent
Facility committee records	6 years
Fire Safety Records	6 years
HIPAA Mandated Records	6 years
Infection control and monitoring records	10 years
Internal investigations or non-fiscal audit records	Recommendation: 10 years
Quality assurance records	Recommendation: 10 years
Compliance Documents (documents supporting the adoption, implementation and operation of an effective Compliance Program)	6 years Recommended: 10 years

ARCHCARE AND AFFILIATED ENTITIES POLICY

SUBJECT: Compliance and Ethics Program, Report and Return of Overpayments, System-Wide

ORIGINATING DEPARTMENT: Corporate Compliance

ORIGINAL APPROVAL DATE: 10/14/2021

BOARD AUDIT, RISK & COMPLIANCE COMMITTEE APPROVAL DATE: 06/04/2026

MOST RECENT REVIEW/REVISION DATE: 05/26/2026

PURPOSE: The purpose of this policy is to establish the process for the timely identification, reporting, repayment and resolution of overpayments in accordance with Section 6402 of the Patient Protection and Affordable Care Act ("ACA"), federal regulations at 42 C.F.R. §401.305, New York Social Services Law §363-d and the Office of Medicaid Inspector General's ("OMIG") Self-Disclosure Program.

ENTITIES AFFECTED: All ArchCare-sponsored entities

POLICY: It is ArchCare's policy to neither retain nor knowingly fail to report or return any payment to which it is not entitled. ArchCare shall exercise reasonable diligence in the timely identification, investigation, and quantification, reporting, repayment and resolution of any actual or potential overpayments. Any identified overpayment shall be promptly reported, returned, and explained in writing to the appropriate governmental agency, contractor, payer, or oversight authority, including, but not limited to, the appropriate Medicare Administrative Contractor, the New York State Department of Health, the Office of the Medicaid Inspector General ("OMIG"), Medicaid Managed Care Organizations, commercial payers, or any other applicable federal or state agency, in accordance with applicable legal, regulatory, contractual, and program requirements and guidance.

Any potential **overpayments** discovered during routine monitoring, internal audits or investigations and confirmed as identified overpayments shall be reported, returned and explained as per this policy.

DEFINITIONS:

Overpayment is defined as any funds that a person receives or retains under title XVIII (Medicare) or title XIX (Medicaid) to which the person, after applicable reconciliation, is not entitled.

Overpayments include, but are not limited to, reimbursement received due to: upcoding, incorrect coding resulting in a higher level of reimbursement, insufficient or lack of documentation to support billed services, services billed under the wrong provider, lack of medical necessity, duplicate payments, payments to the incorrect payee, or any other finding that reflects an overpayment was received by an ArchCare Entity as a result of inaccurate or improper coding or reporting of health care items or services.

Identified an overpayment means the person has actual knowledge of the existence of the overpayment or acts in reckless disregard or deliberate ignorance of the overpayment. That is, the person has identified an overpayment when the person has, or should have through the exercise of reasonable diligence, determined that the person has received an overpayment and quantified the amount of the overpayment. A person should have determined that an overpayment was received and quantified if the person fails to exercise reasonable diligence and the person in fact received an overpayment.

Lookback period. An overpayment must be reported and returned if it is identified within six (6) years from the date the overpayment was received, in accordance with applicable federal and state laws and regulations

Reasonable diligence includes both proactive compliance activities conducted in good faith to monitor the receipt of overpayments, as well as investigations conducted in good faith and in a "timely manner" in response to obtaining credible information about a potential overpayment. Medicare considers a "timely manner" to be at most six (6) months from receipt of credible information, except in extraordinary circumstances.

PROCEDURE:

1. **All reports or other information indicating that an overpayment may have been received during the lookback period must be immediately brought to the attention of the entity's Compliance Officer/or Compliance Liaison or to the Corporate Compliance Officer.**

   The Compliance Officer/Compliance Liaison and/or the Corporate Compliance Officer must ensure that the entity exercises reasonable diligence to quantify any potential overpayments.

2. **Deadline for Reporting and Returning Identified Overpayments**

a. Medicare Part A and Part B. For identified overpayments received from Medicare Part A and/or Medicare Part B, the deadline for reporting and returning the overpayment is the later of either:

- 60 days from the date the overpayment is identified or
- the date any corresponding cost report is due, if applicable.

b. Medicare Advantage (Part C). For identified overpayments received from Medicare Part C, the deadline for reporting and returning the overpayment is no later than 60 days after the date the overpayment is identified, unless otherwise directed by CMS for purposes of risk adjustment data validation audit.[1]

c. Medicaid. The same deadline as defined above in 2.a is applicable to identified Medicaid overpayments. In addition, please refer to NYS OMIG Guidance of Self-Disclosure.

NYS OMIG's Self-Disclosure Program includes two pathways for Medicaid Entities/Providers to report, return and explain self-identified overpayments. Both the Full Self-Disclosure Process and the Abbreviated Self-Disclosure Process begin with the same steps. A Medicaid Entity/Provider discovers that they are in receipt of a Medicaid overpayment and investigates to identify and explain it.

The Corporate Compliance Officer shall be consulted to investigate and prepare the OMIG Self-Disclosure.

d. Other Third-party Payers. In the case of overpayments by commercial/other third-party payers, overpayments shall be reported and returned in accordance with any contractual obligation or if there is no specified deadline, the overpayment must be returned within 60 days from the date the overpayment is identified by the payer or the ArchCare Entity.

e. Program for All- Inclusive Care for the Elderly (PACE)
PACE as a Medicaid Managed Care Organization is required to establish Self-Disclosure Programs including policies and procedures for participating Providers and other subcontractors to report, return and explain Managed Care

[1] In 2018, the regulation governing Medicare Part C overpayments was found to be invalid by a Federal District Court. That ruling was overturned by the U.S. Court of Appeals for the District of Columbia Circuit on August 13, 2021 (See United Healthcare Insurance Company v. Becerra, 2021 WL 3573766).

overpayments within sixty (60) days of identification. Network Providers should self-disclose identified Managed Care overpayments to PACE in accordance with ArchCare's Network Provider Overpayment Self-Disclosure Policy and Procedure.

3. **Responsible Party for Processing Return of Identified Overpayments**

The Chief Financial Officer (CFO), in consultation with the Corporate Compliance Officer, shall be responsible for submitting the return of identified overpayments and any applicable report. For Part C overpayments, the CFO must certify (based on best knowledge, information, and belief) that the information provided for purposes of reporting and returning of overpayments is accurate, complete, and truthful.

4. **Process to Report and Return Identified Overpayments**
   a. Medicare Part A and Part B**.** With the limited exception described below, Medicare overpayments shall be returned to the Medicare Contractor that paid the claim, at the address provided by the Medicare Contractor using an applicable claims adjustment, credit balance, self-reported refund, or other reporting process as set forth by the Medicare Contractor.
   b. Medicare Part C. The Medicare Advantage (MA) organization must notify CMS of the amount and reason for the overpayment, using a notification process determined by CMS and return identified overpayments in a manner specified by CMS.
   c. Exception for Fraud. Identified Medicare overpayments that resulted from fraud shall be disclosed using the OIG's Self–Disclosure Protocol or the CMS Voluntary Self–Referral Disclosure Protocol, as applicable.

   d. Medicaid**.** Medicaid overpayments shall be reported and returned to the NYS Department of Health; a written explanation of the reason for the overpayment shall be provided to the NYS OMIG through its Self-Disclosure Program. Information regarding OMIG's Self-Disclosure Program is available here: https://omig.ny.gov/provider-resources/self-disclosure. A Self-Disclosure submission related to a Medicaid program overpayment requires completion of a Self-Disclosure Statement, Certification, and a Claims Data File of affected Medicaid claims, or Mixed Payer Calculation (MPC) form for Excluded provider disclosures. If the Medicaid program overpayment is not related to claim data or an excluded or non-enrolled provider, additional explanation to allow for the verification of the overpayment is required. Please refer to OMIG Self-Disclosure guidance for additional information**.**

REVISION HISTORY:

Date	Change/Note
05/26/2026	Annual review and update of policy.
4/23/2025	Annual review and update of policy.
5/1/2024	Annual review and update of the policies. Additional information related to self-disclosure was added.
5/1/2023	Review and update to align with the new OMIG Guidance on self-disclosure. In addition, made formatting changes.
07/25/2016	New policy

ARCHCARE AND AFFILIATED ENTITIES POLICY

SUBJECT: Compliance and Ethics Program, Corrective Action and Response to Detected Offenses, System-Wide

ORIGINATING DEPARTMENT: Corporate Compliance

ORIGINAL CREATION DATE: 9/2007

BOARD AUDIT, RISK, AND COMPLIANCE COMMITTEE APPROVAL DATE: 06/04/2026

MOST RECENT REVIEW/REVISION DATE: 05/26/26

PURPOSE: To ensure that detected compliance concerns are corrected promptly and thoroughly to reduce the potential for recurrence and ensure ongoing compliance with state and federal health care program requirements (*e.g.*, Medicare and Medicaid).

SCOPE:
This policy applies to the workforce[1] of ArchCare and its affiliated entities. Specifically, ArchCare "[w]orkforce" includes, but is not limited to, employees (including chief executive and other senior administrators and managers), medical staff, volunteers, and students. The term "workforce" also applies to contractors, subcontractors, agents or independent contractors[2] who, on behalf of ArchCare, furnish, or otherwise authorize the furnishing of Medicare and/or Medicaid health care items or services, perform billing or coding functions, or are involved in monitoring of health care provided by ArchCare.

POLICY: Whenever a compliance concern is reported/identified, regardless of the source, ArchCare and its Affiliated Entities will ensure that prompt, thorough, appropriate and effective corrective action is implemented. In discharging this responsibility, the entity Compliance Officer/ Compliance Liaison and/or the Corporate Compliance Officer may

[1] This definition is aligned with the updated Part 521 of Title 18 of the Codes, Rules and Regulations of the State of New York which defines "[a]ffected [i]ndividuals as defined by the as all persons who are affected by the provider's risk areas, including employees, the chief executive and other senior administrators, managers, contractors, agents, subcontractors, independent contractors, and governing body and corporate officers."

[2] This policy applies to designated contractors who engage in the provision of quality healthcare service and/or who fall under the following risk areas of "billings, payments, ordered services, medical necessity, quality of care, governance, mandatory reporting, credentialing, contractor oversight, and other areas that should reasonably be identified by the provider through its organizational experience".

work in consultation with outside legal counsel and others, as appropriate to address and correct the problem issue. All care members are expected to assist in the resolution of compliance concerns. Failure to cooperate could lead to disciplinary action, up to and including termination.

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

ENTITIES AFFECTED: All ArchCare-sponsored entities

PROCEDURE:

1. Upon conclusion of an investigation involving a compliance concern, and upon receipt of the Report of Findings, the President and CEO shall decide on an appropriate corrective action after consultation with the Corporate Compliance Officer, and, as applicable, the entity Compliance Officer/Compliance Liaison, legal counsel, the SVP, Human Resources, and other staff as appropriate and necessary.

2. Corrective actions may include, but are not limited to:

    a. Informing and discussing with the offending care member both the violation and how it may be avoided in the future;

    b. Providing remedial education (formal or informal) to ensure understanding of the applicable laws, rules, regulations, policies and/or requirements;

    c. Conducting a follow-up review, audit, or monitoring activity to ensure that the issue has been corrected and is not recurring;

    d. Requiring care members to complete one or more cycles of remedial education, focused audits or performance improvement activities;

    e. Suspending billing, in whole or in part, for services provided by a specific physician/practitioner, or care member pending corrective action review;

f. Implementing enhanced monitoring or pre-billing review processes for identified risk areas; (see the Compliance and Ethics Program, Report and Return of Overpayments, System-Wide Policy);

g. Promptly self-disclosing to an appropriate governmental agency or other payer, to the extent required or otherwise appropriate (including, but not limited to the federal DHHS' Office of Inspector General (OIG), the Centers for Medicare and Medicaid Services (CMS) or the New York State Department of Health, Office of the Medicaid Inspector General (OMIG) (consistent with ArchCare's self-disclosure policy);

h. Escalating matters for disciplinary action, up to and including termination of employment, contract, or privileges, where appropriate;

i. Developing and implementing corrective action plans with defined timelines, accountability measures, and ongoing oversight; and/or

j. Modifying or improving the Compliance and Ethics Program to better ensure continuing compliance with applicable federal and state laws, rules, regulations, federal health care program requirements and/or other contractual requirements.

3. If a Compliance Officer/Compliance Liaison or the Corporate Compliance Officer discovers credible evidence that criminal conduct may have occurred, ArchCare shall promptly investigate the matter to determine if specific corrective action and/or notification of appropriate governmental authorities is warranted under the circumstances. All instances in which credible evidence of a potential violation of any law (whether criminal, civil or administrative) is discovered will be promptly referred to legal counsel to evaluate the seriousness of the allegations and the necessity and timing of any disclosure to appropriate New York State and/or federal authorities.

4. If the President & CEO and the Corporate Compliance Officer cannot reach an agreement on the appropriate response to an issue, the issue shall be reported to the relevant governing body, whether the Audit, Risk & Compliance Committee

of the Board of Trustees, or the Board of Managers, Catholic Managed Long Term Care, Inc., for resolution.

5. In consultation with the President & CEO, the Corporate Compliance Officer may decide to refer potential fraud waste and abuse issues to the NBI MEDIC[3] and serious issues of program noncompliance to CMS, OIG or New York State DOH or OMIG. If the President & CEO and the Corporate Compliance Officer cannot reach agreement on whether or not to refer the issue to regulatory or enforcement agencies, the issues shall be escalated to the Audit, Risk & Compliance Committee of the Board of Catholic Health Care System for resolution.

REVISION HISTORY:

Date	Change/Note
05/26/2026	Annual review and update of the policy.
4/23/25	Annual review and update of the policy
5/1/2024	Annual review and update of the policies.
5/1/2023	Review and update to align with the new OMIG Guidance. In addition, made formatting changes.
8/2022	Annual review.
8/2021	Removed sections on investigations to the Compliance, Investigating Compliance Matters, System-wide policy. Added Purpose and Scope; expanded title of the policy, Policy section and possible corrective actions.
11/2018	Added #14 allowing Compliance Officer to refer serious compliance or potential fraud, waste, and abuse issues to NBI MEDIC, CMS, DOH or OMIG. Added to #13: while no time limit on investigations in general, each one should be concluded within reasonable timeframe given their facts and circumstances. Compliance Committees and Board should review investigations periodically and determine whether they should be referred to law enforcement or third party for conclusion.
2/2018	Added #13 requiring investigations to be concluded within reasonable time period after offense is detected.

[3] NBI MEDIC is the acronym for the National Benefit Integrity Medicare Drug Integrity Contractor. The purpose of the NBI MEDIC is to detect and prevent FWA in the Medicare Part C (Medicare Advantage) and Part D (Prescription Drug Coverage) programs.

6/2014	Added standardized Corrective Action Plan form to summarize findings and corrective action plan. Form will be approved by Administrator or Head of Program and appropriate Compliance Officer.
5/2012	Changes per annual review: add more detailed response and findings process. Changed title from "Internal Investigations of Compliance Issues"
1/2011	Changes per annual review
9/2007	Original Policy

ARCHCARE AND AFFILIATED ENTITIES POLICY

SUBJECT: Compliance and Ethics Program, Sanction Screening, System-Wide

ORIGINATING DEPARTMENT: Corporate Compliance

EFFECTIVE DATE: July 1, 2011

BOARD AUDIT, RISK, AND COMPLIANCE COMMITTEE APPROVAL DATE: 06/04/2026

MOST RECENT REVIEW/REVISION DATE: 05/27/2026

PURPOSE: To comply with requirements for screening employees, prospective employees, contractors, vendors and referral sources to determine whether they have been excluded or terminated from participation in federal and/or state health care programs.

ENTITIES AFFECTED: All ArchCare-sponsored Entities.

SCOPE: This policy applies to the workforce[1] of ArchCare and its affiliated entities. Specifically, ArchCare "workforce" includes, but is not limited to, employees (including chief executive and other senior administrators and managers), medical staff, volunteers, and students. The term "workforce" also applies to contractors, subcontractors, agents and independent contractors[2] who, on behalf of ArchCare, furnish, or otherwise authorize the furnishing of Medicare and/or Medicaid health care items or services, perform billing or coding functions, or are involved in monitoring of health care provided by ArchCare.

DEFINITIONS:

1. **Ineligible individual/entity**: Anyone who: 1) is currently excluded, debarred, or otherwise ineligible to participate in the federal and/or state healthcare programs,

[1] This definition is aligned with the updated Part 521 of Title 18 of the Codes, Rules and Regulations of the State of New York which defines "[a]ffected [i]ndividuals as defined by the as all persons who are affected by the provider's risk areas, including employees, the chief executive and other senior administrators, managers, contractors, agents, subcontractors, independent contractors, and governing body and corporate officers."

[2] This policy applies to designated contractors who engage in the provision of quality healthcare service and/or who fall under the following risk areas of "billings, payments, ordered services, medical necessity, quality of care, governance, mandatory reporting, credentialing, contractor oversight, and other areas that should reasonably be identified by the provider through its organizational experience".

or in federal procurement or non-procurement programs; 2) has been convicted of a criminal offense related to the provision of healthcare items or services but has not yet been excluded, debarred, or otherwise declared ineligible.

2. **Clinician**: A professional who provides care and/or treatment to an ArchCare patient, member, or participant, such as, but not limited to, a physician, a dentist, a nurse, or a therapist.

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

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

   - https://sam.gov/content/home (the General Service Administration's System for Award Management); and

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

   Other sources and lists may also be checked as ArchCare deems necessary and appropriate, including all other state jurisdictions for Medicaid exclusions. **Federal Health Care Program**: A "Federal health care program" is defined as any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government (other than the Federal Employees Health Benefits Program), or any State health care program.

POLICY: ArchCare is committed making good faith, reasonable efforts to avoid employing, contracting with, or otherwise doing business with individuals or entities that are excluded, debarred or suspended, or otherwise ineligible to participate in, federal and state health care programs or procurement or non-procurement programs. To support this commitment, ArchCare shall conduct monthly screenings to ensure it does not employ, retain, compensate, grant staff privileges to, or otherwise affiliate with excluded individuals or entities.

PROCEDURE:

A. RESPONSIBILITIES:

1. The **Senior Vice President, Human Resources**, ArchCare, shall be responsible for ensuring that **employees** of ArchCare and Affiliated Entities are screened in accordance with this policy.

2. The **Executive Directors** of ArchCare Entities or the Credentialing department are responsible for ensuring that **non-employed clinicians** are screened in accordance with this policy.

3. The **Vice President, Support Services, or designee** (for those contracts that are put through the contract review process) are responsible for ensuring that **individuals or entities entering into a business relationship with ArchCare** are screened in accordance with this policy.

4. The **Corporate Compliance Officer** is responsible for ensuring that **members appointed to any of the governing bodies** of ArchCare Entities are screened prior to appointment in accordance with this policy.

5. Any ArchCare executive entering into a business relationship on behalf of an ArchCare Entity is responsible for ensuring that such individual or entity is screened in accordance with this policy or notifying the applicable department.

6. ArchCare Executive Directors are responsible for ensuring that referral sources are screened in accordance with this policy.

B. SCREENING OF POTENTIAL AND CURRENT EMPLOYEES

1. **Pre-employment Screening.** Prior to employment, ArchCare Human Resources staff shall verify that any prospective employee of ArchCare and its Affiliated Entities has not been prohibited from participation in federal and/or state health care programs by doing a manual check of the Exclusion Lists within Kchecks.

2. **Monthly Screening of Employees.** Human Resources staff shall monthly upload new employees to the Kchecks database so that checks are conducted monthly thereafter.

3. **Upload and Monthly Screening of Employees who transfer from one ArchCare payroll to another:** At any time, if an employee is moved from one ArchCare payroll company to another, Human Resources staff (Corporate HR Operations Coordinator) shall upload that employee to the designated Kchecks database so that checks are conducted monthly thereafter.

C. SCREENING OF POTENTIAL AND CURRENT CLINICAL PROVIDERS

1. **Screening prior to credentialing.** Prior to a non-employed clinician furnishing services at or for ArchCare, an ArchCare Nursing Home, or an ArchCare Program, the Executive Directors or his/her designee must verify that s/he has not been prohibited from participation in federal and/or state health care programs by doing a manual check of the Exclusion Lists on Kchecks. The Executive Directors or their designee must upload the name on Kchecks and resolve potential matches, if necessary.

2. **Monthly Screening.** Kchecks will perform screening checks of the required Exclusion Lists monthly thereafter.

3. **Scope of Screening.** This screening shall include, but not be limited to, nurses referred from staffing agencies, non-employed therapists, and non-employed physicians.

D. SCREENING OF POTENTIAL AND CURRENT VOLUNTEERS, STUDENTS, CONSULTANTS

The Compliance Officer or Compliance Liaison (or a designee) of the relevant ArchCare Entity shall be responsible for entering into Kchecks and reviewing the Exclusion Lists for the names of consultants, students and volunteers.

E. SCREENING OF POTENTIAL AND CURRENT VENDORS AND CONTRACTORS

1. **Centrally reviewed Business Arrangements**

   For business relationships subject to the contract review process, the **Vice President, Support Services,** or designee shall verify that any prospective vendor, whether entity or individual, has not been prohibited from participation in federal and state health care programs by doing a manual check of the Exclusion Lists on KChecks.

   Once the relationship has been entered into, the VP, Support Service or a designee shall upload the name on KChecks on the ArchCare corporate account and resolve potential matches, if necessary. KChecks will perform screening checks of the Exclusion Lists monthly thereafter.

2. **Locally-negotiated Business Arrangements**

   For business relationships negotiated at the ArchCare Entity level, the Executive Director or a designee shall verify that any prospective vendor or contractor, whether entity or individual, has not been prohibited from participation in federal and state health care programs by performing a manual search of the Exclusion Lists on KChecks.

3. Once the relationship has been entered into, the Executive Director or a designee shall upload the name on KChecks and resolve potential matches, if necessary. KChecks will perform screening checks of the Exclusion Lists monthly thereafter.
4. If the vendor or contract is entered into the M System, the name will be uploaded on K Checks by the Purchasing department staff and potential matches will be resolved, if necessary.
5. If a check request is completed, the name of the payee will be loaded on KChecks by the Entity Compliance Officer or Compliance Liaison and potential matches will be resolved, if necessary. The Entity Compliance Officer or Compliance Liaison will print screen the result of the search for the individual completing the check request and that print screen will be attached to the check request and sent to Finance.
6. If applicable, screening for entities paid via credit card shall be addressed through ArchCare's purchasing, accounts payable, or other approved vendor review process.

F. SCREENING OF REFERRING PROVIDERS.

1. New Referring Providers. *Prior to* accepting referrals, filling orders or prescriptions from, or furnishing items or services at the medical direction of, a referring provider who is new to ArchCare, ArchCare will, at minimum, manually check the name of each such individual or entity against each of the Exclusion Lists on Kchecks.

2. Current Referring Providers. KChecks will perform screening checks of the Exclusion Lists monthly thereafter.

G. SCREENING OF POTENTIAL AND CURRENT MEMBERS OF GOVERNING BODIES

Prior to appointment, the applicant member of the governing bodies of ArchCare will be uploaded to the KChecks screening application by the Corporate Compliance Officer. KChecks will perform screening checks of the Exclusion Lists monthly thereafter.

H. RESULTS OF SCREENING

1. If screening of the Exclusion Lists reveals, or it is otherwise discovered, that a potential employee, a new referring provider or a potential contractor is found to be an excluded individual/entity ArchCare will not hire, contract, become affiliated with or do business with, the individual or entity, and will not accept referrals, orders, prescriptions or direction from, any such Referring Provider.

2. If screening of the Exclusion Lists reveals, or it is otherwise discovered, that a current employee or contractor or a current referring provider is an Ineligible individual/entity or is otherwise ineligible to continue to contract with an ArchCare entity, the name of the individual/entity and the reason for the ineligibility should be reported promptly to the appropriate Compliance Officer, Compliance Liaison or to the Corporate Compliance Officer. In any event, the Corporate Compliance Officer must be notified. ArchCare will take all appropriate corrective action.

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

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

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

I. COMPLIANCE OVERSIGHT

Each ArchCare Entity's Compliance Officer or Compliance Liaison will monthly monitor all KChecks sites to ensure that there are no new unresolved potential matches and to ensure that all those matches have been reconciled and if any can't be reconciled.

Each ArchCare Entity's Compliance Officer or Compliance Liaison will check to ensure that the number of new employees from Human Resources matches the total number of employees newly uploaded onto the KChecks system.

J. MAINTENANCE OF DOCUMENTATION

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

REVISION HISTORY:

Date	Change/Note

05/27/2026	Annual review and update of the policies.
4/23/2025	Removed exclusion screening for volunteers and students since providers and facilities aren't paying Medicare/Medicaid funds for these individuals.
5/1/2024	Annual review and update of the policies.
5/1/2023	Review and update to align with the new OMIG Guidance including redefining the term affected individual. In addition, made formatting changes. Clearly defined that that state exclusions are also reviewed.
8/2022	Replaced "compliance program" with "compliance and ethics program" and replaced Board Compliance Committee with Board Audit, Risk, and Compliance Committee
8/2021	Expanded Policy, Definitions and Results of Screening sections. Added requirement that referring providers be checked against the exclusion lists. Added Documentation section.
10/2019	Added Compliance Oversight provisions in section G and added to Section E that governing body members are screened by KChecks each month after they are uploaded.
4/2019	Added provision about agency staff/temporary staff/consulting staff
12/2018	Added provision for HR to re-enter employee in KChecks at any time that an employee transfers from one ArchCare payroll to another. (See Procedure A.3.)
9/2018	Added provision for SVP, Compliance to enter governing body members prior to approval by Providence
6/2011	Changes to incorporate new process of exclusion screening
1/2011	Changes per annual review
7/08/2008	Original Policy

ARCHCARE AND AFFILIATED ENTITIES POLICY

SUBJECT: Compliance and Ethics Program, Governing Body Members Education, System-Wide (System Wide)

ORIGINATING DEPARTMENT: Corporate Compliance

Effective Date: 09/15/2022

BOARD AUDIT, RISK, AND COMPLIANCE COMMITTEE APPROVAL DATE: 06/04/2026

MOST RECENT REVIEW/REVISION DATE: 05/05/2026

PURPOSE: To provide effective compliance program education and training to all members of ArchCare's governing bodies, who are considered affected individuals.[1]

ENTITIES AFFECTED: All ArchCare-sponsored entities

SCOPE: This policy applies to all ArchCare-sponsored Entities and their governing body members.

RESPONSIBILITY: The President and CEO, ArchCare, is responsible for notifying the Corporate Compliance Officer of the appointment of a new governing body member. The Corporate Compliance Officer is responsible for (i) ensuring that new governing body members receive compliance training and education upon their appointment; (ii) ensuring that all governing body members receive compliance training and education on an annual basis; and (iii) retaining records of such education.

POLICY: Within 30 days of appointment to an ArchCare governing body, a new member shall receive compliance training and education as part of orientation. Governing body members shall thereafter receive compliance, education and training on at least an annual basis.

[1] As noted by Part 521 of Title 18 of the Codes, Rules and Regulations of the State of New York which defines "[a]ffected [i]ndividuals as defined by the as all persons who are affected by the provider's risk areas, including employees, the chief executive and other senior administrators, managers, contractors, agents, subcontractors, independent contractors, and governing body and corporate officers."

Education and training topics may include, but are not limited to:

(i) the elements of an effective Compliance and Ethics Program; (ii) the structure and operation of the ArchCare Compliance and Ethics Program, including, but not limited to: reporting mechanisms, confidentiality, the investigation processes, corrective actions, disciplinary policies, non-retaliation/non-intimidation policies); (iii) ArchCare's expectations for care members to abide by the Code of Conduct, report issues and assist in their resolution; (iv) laws and regulations regarding fraud, waste, and abuse in Federal health care programs (including the False Claims Act and other federal and state laws prohibiting the filing of false claims); (v) compliance risk areas; and (vi) the governing body's role and responsibilities as to oversight of the Compliance and Ethics Program.

For governing body members with oversight responsibility for Catholic Managed Long Term Care Inc. d/b/a ArchCare Senior Life, such education and training shall also address applicable Medicare managed care compliance program requirements, including those reflected in Chapter 9 of the Medicare Prescription Drug Benefit Manual and Chapter 21 of the Medicare Managed Care Manual.

PROCEDURE:

1. The Corporate Compliance Officer shall ensure that governing body members receive compliance training and education either in person or virtually. New governing body members shall receive this training within 30 days of appointment. In addition, all governing body members shall receive compliance training annually, with proof of training completion maintained in accordance with the Compliance and Ethics Program requirements.

2. The Corporate Compliance Officer shall ensure the name of the new board member's name is uploaded into the exclusion screening database and retain a copy of the initial exclusion screening results in the Compliance and Ethics Program files.

3. The Corporate Compliance Officer shall periodically, and no less than annually, monitor, evaluate and assess the effectiveness of ArchCare's education and training programs, including verification and retention of proof of training completion, and shall revise such programs as necessary.

REVISION HISTORY:

Date	Change/Note
05/06/2026	Annual review and update of the policy.
4/23/2025	Annual review and update of the policy.
5/1/2024	Annual review and update of the policies.
5/1/2023	Review to align with the new OMIG Guidance. In addition, made formatting changes.
8/2022	Replaced "board compliance committee" with "board audit, risk, and compliance committee" and replaced "compliance program" with "compliance and ethics program"
8/2021	Expanded potential training topics. Revised the training schedule to within 30 days of appointment of a new member consistent with OMIG guidance. Emphasized the requirement for annual training. Added requirement to evaluate the training material.
10/03/2018	Policy implemented

ARCHCARE AND AFFILIATED ENTITIES POLICY

SUBJECT: Compliance and Ethics Program, Vendor Deficit Reduction Act Compliance Education, System-wide

ORIGINATING DEPARTMENT: Corporate Compliance

APPROVAL DATE: 09/15/2022

BOARD AUDIT, RISK & COMPLIANCE COMMITTEE APPROVAL DATE: 06/04/2026

MOST RECENT REVIEW/REVISION DATE: 05/26/2026

PURPOSE: To comply with Section 6032 of the Deficit Reduction Act of 2005 by providing information to designated contractors about ArchCare's policies and procedures and certain federal and state laws in preventing and detecting fraud, waste, and abuse in federal health care programs. This policy is extended by Part 521 of Title 18 of the Codes, Rules and Regulations of the State of New York.

ENTITIES AFFECTED: All ArchCare-sponsored entities

DEFINITIONS:

Designated Contractor: Any contractor, subcontractor, agent, or other person which or who on behalf of ArchCare or an ArchCare Affiliated Entity furnishes, or otherwise authorizes the furnishing of Medicaid health care items or services, performs billing or coding functions, or is involved in monitoring of health care provided by the relevant Entity. This policy applies to designated contractors who engage in the provision of quality healthcare service and/or who fall under the following risk areas of "billings, payments, ordered services, medical necessity, quality of care, governance, mandatory reporting, credentialing, contractor oversight, and other areas that should reasonably be identified by the provider through its organizational experience".

POLICY: It is the policy of ArchCare and its Affiliated Entities to provide health care services in a manner that complies with applicable federal and state law. To

further this and to comply with Section 6032 of the Deficit Reduction Act of 2005 and Part 521 of Title 18 of the Codes, Rules and Regulations of the State of New York with regard to ArchCare contractors with compliance responsibilities, ArchCare and its Affiliated Entities who are Medicaid providers require designated contractors to acknowledge receipt of and compliance with ArchCare's policies and procedures to prevent and detect fraud, waste, and abuse in federal health care programs.

Such acknowledgement may be accomplished through a contract provision, annual vendor communication, website posting, or other documentation evidencing Designated Contractors received or were directed to ArchCare's fraud, waste and abuse and compliance program materials.

RESPONSIBILITIES/PROCEDURE

A. The senior leader of each applicable ArchCare facility or program and senior ArchCare staff shall be jointly responsible for ensuring that operational procedures conform to this policy and that staff are aware of this policy and the Federal and State laws outlined in Appendix A.

B. The senior official of the applicable ArchCare facility or program shall be responsible for obtaining an executed DRA Certification if the vendor arrangement does not go through the contract review process.

C. ArchCare's agreement with a Designated Contractor should include provisions requiring the Designated Contractor to acknowledge ArchCare's Corporate Compliance Program and Code of Conduct, comply with applicable ArchCare compliance policies, and ensure that its personnel receive or have access to ArchCare's fraud, waste and abuse and compliance program materials. ArchCare may also provide or make available such materials through an annual vendor communication, website posting, contract attachment, certification, training, or other documented process. Designated Contractor must ensure that their employees and agents, receive education, on at least an annual basis, regarding the ArchCare Code of Conduct, and fraud, waste, and abuse issues including the False Claims Act and whistleblower protections unless such individuals complete ArchCare's own New Employee Orientation and Reorientation.

D. REVISION HISTORY:

Date	Change/Note

05/26/2026	Annual review and update.
4/23/2025	Annual review of policy.
5/1/2024	Annual review and update of the policies and update the 2024 Federal penalty amounts.
6/27/2023	Review and update the 2023 Federal penalty amounts.
5/1/2023	Review and update to align with the new OMIG Guidance including extending the policy. In addition, made formatting changes.
8/2022	Replaced "board compliance committee" with "board audit, risk, and compliance committee" and replaced "compliance program" with compliance and ethics program".
8/2021	Reorganized policy; Minor revisions.
4/2019	Revised responsibilities and procedure section to reflect current contract review process.
6/2014	Revised to note that education requirements for designated contractors must be met on at least an annual basis.
11/2011	Revised to replace Vendormate Registration requirement with requirement for vendors to certify receipt of vendor compliance package.
2/2011	Revised to require designated contractors to register with Vendormate to acknowledge receipt of Deficit Reduction Act Employee Education information and compliance with ArchCare's policies and procedures to prevent and detect fraud, waste, and abuse in federal health care programs.
2/22/2008	Revised to ensure compliance with Employee Education provisions of the Deficit Reduction Act
9/6/2007	New Document

APPENDIX A

FEDERAL & NEW YORK STATUTES RELATING TO FILING FALSE CLAIMS/WHISTLEBLOWER PROTECTIONS

I. FEDERAL LAWS

A. False Claims Act [**Title 31 United States Code §§ 3729 to 3733]**

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

> Any person who (1) knowingly presents, or causes to be presented, to an office or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval; (2) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; (3) conspires to defraud the Government by getting a false or fraudulent claim paid or approved by the Government;…or (7) knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government,

* * *

> is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000,[1] plus 3 times the amount of damages which the Government sustains because of the act of that person….
>
> For purposes of this section:
>
> (a) the term "claim"— means any request or demand, whether under a contract or otherwise, for money or property and whether or not the United States has title to the money or property, that—(i) is presented to an officer, employee, or agent of the United States; or (ii) is made to a contractor, grantee, or other recipient, if the money or property is to be spent or used on the Government's behalf or to advance a Government program or interest, and if the United States Government—
>
> - provides or has provided any portion of the money or property requested or demanded; or
>
> - will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded;

[1] Although the statutory provisions of the Federal False Claims Act authorizes a range of penalties of from between $5,000 and $10,000, those amounts have been adjusted for inflation. As of February 12, 2024, the minimum False Claims Act penalty will increase from $13,508 to $13,946 per claim, and the maximum penalty will increase from $27,018 to $27,894 per claim.

and

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

(b) The terms "knowing" and "knowingly mean that a person, with respect to information (i) has actual knowledge of the information; (ii) acts in deliberate ignorance of the truth or falsity of the information; or (iii) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.

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

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

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

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

In addition to its substantive provisions, the FCA provides that private

parties may bring an action on behalf of the United States. These private parties, known as "*qui tam* relators," may share in a percentage of the proceeds from an FCA action or settlement.

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

B. Administrative Remedies for False Claims [**Title 31 United States Code §§ 3801 to 3812]**

This statute allows for administrative recoveries by federal agencies. If a person submits a claim that the person knows is false or contains false information, or omits material information, then the agency receiving the claim may impose a penalty of up to $5,000 for each claim.[2] The agency may also recover twice the amount of the claim.

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

II. NEW YORK STATE LAWS

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

A. Civil and Administrative Laws

NY False Claims Act [State Finance Law §§187–194]

[2] Although the statutory provisions of the Federal False Claims Act authorizes a range of penalties of from between $5,000 and $10,000, those amounts have been adjusted for inflation. As of February 12, 2024, the minimum False Claims Act penalty will increase from $13,508 to $13,946 per claim, and the maximum penalty will increase from $27,018 to $27,894 per claim.

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

The Act allows private individuals to file lawsuits in state court, just as if they were state or local government parties. If the suit eventually concludes with payments back to the government, the person who started the case can recover up to 25-30% of the proceeds.

Social Services Law §145-b - False Statements

It is a violation to knowingly obtain or attempt to obtain payment for items or services furnished under any Social Services program, including Medicaid, by use of a false statement, deliberate concealment or other fraudulent scheme or device. The State or the local Social Services district may recover three times the amount incorrectly paid. In addition, the Department of Health may impose a civil penalty of up to $10,000 per violation. If repeat violations occur within 5 years, a penalty up to $ 30,000 per violation may be imposed if they involve more serious violations of Medicaid rules, billing for services not rendered or providing excessive services.

Social Services Law §145-c Sanctions

If any person applies for or receives public assistance, including Medicaid, by intentionally making a false or misleading statement, or intending to do so, the person's, the person's family's needs are not taken into account for six months if a first offense, 12 months if a second offense (or if benefits wrongfully received are at least one thousand dollars but not more than three thousand nine hundred dollars), for eighteen months if a third offense (or if benefits wrongfully received are in excess of three thousand nine hundred dollars), and five years for any subsequent occasion of any such offense.

B. Criminal Laws

Social Services Law §145 – Penalties

Any person who submits false statements or deliberately conceals material

information in order to receive public assistance, including Medicaid, is guilty of a misdemeanor.

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

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

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

Penal Law Article 155 - Larceny

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

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

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

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

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

Penal Law Article 175, False Written Statements

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

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

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

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

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

Penal Law Article 176, Insurance Fraud

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

a. Insurance fraud in the 5gh degree involves intentionally filing a health insurance claim knowing that it is false. It is a Class A misdemeanor.

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

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

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

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

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

Penal Law Article 177, Health Care Fraud

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

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

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

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

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

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

III. WHISTLEBLOWER PROTECTIONS

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

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

B. NY False Claim Act **[State Finance Law § 191—Remedies]**

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

C. New York Labor Law §740

An employer may not take any retaliatory action against an employee if the employee discloses information about the employer's policies, practices or activities to a regulatory, law enforcement or other similar agency or public official. Protected disclosures are those that assert that the employer is in violation of a law that creates a substantial and specific danger to the public health and safety or which constitutes health care fraud under Penal Law §177 (knowingly filing, with intent to defraud, a claim for payment that intentionally has false information or omissions). The employee's disclosure is protected only if the employee first brought up the matter with a supervisor and gave the employer a reasonable opportunity to correct the alleged violation. If an employer takes a

retaliatory action against the employee, the employee may sue in state court for reinstatement to the same, or an equivalent position, any lost back wages and benefits and attorneys' fees. If the employer is a health provider and the court finds that the employer's retaliatory action was in bad faith, it may impose a civil penalty of $10,000 on the employer.

D. New York Labor Law §741

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

ARCHCARE AND AFFILIATED ENTITIES POLICY

SUBJECT: Compliance and Ethics Program, Compliance and Ethics Program Training & Education, System-Wide

ORIGINATING DEPARTMENT: Corporate Compliance

Original Effective Date: March 1, 2011

Most Recent Review/Revision Date: 05/26/2026

Board Audit, Risk, and Compliance Committee Approval: 06/04/2026

PURPOSE: All ArchCare-sponsored entities will provide effective compliance training and education to all care members and associates to promote understanding of applicable laws, regulations, policies and standards.

ENTITIES AFFECTED: All ArchCare-Sponsored entities

SCOPE: This policy applies to the workforce[1] of ArchCare and its affiliated entities. Specifically, ArchCare "workforce" includes, but is not limited to, employees (including chief executive and other senior administrators and managers), medical staff, volunteers, and students. The term "workforce" also applies to contractors, subcontractors, agents and independent contractors who, on behalf of ArchCare, furnish, or otherwise authorize the furnishing of Medicare and/or Medicaid health care items or services, perform billing or coding functions, or are involved in monitoring of health care provided by ArchCare. In addition, this policy extends to the governing body and corporate officers.

POLICY:

1. ArchCare-sponsored Entities will provide compliance education and training to each workforce member, including the Compliance Officer and/or Compliance Liaison, the Chief Executive and other senior administrators and managers, as part

[1] This definition is aligned with the updated Part 521 of Title 18 of the Codes, Rules and Regulations of the State of New York which defines "[a]effected [i]ndividuals as defined by the as all persons who are affected by the provider's risk areas, including employees, the chief executive and other senior administrators, managers, contractors, agents, subcontractors, independent contractors, and governing body and corporate officers."

of the care member's orientation (within 30 days of hire) and annually thereafter in its New Employee Orientation (NEO) and REO eLearning.

2. The following affected individuals will either complete the Compliance New Employee Orientation and Annual Reorientation or receive an annual packet containing vendor training, links to the ArchCare Policies and Procedures, the Compliance Program Charter and any other relevant compliance documents. These individuals may be required to complete an attestation acknowledging review of the materials:

    a. Affiliated medical and allied professional staff,

    b. Students,

    c. Volunteers,

    d. Agency Staff,

    e. Temporary Staff, or

    f. Consultants.

3. ArchCare vendors who do not have patient contact and do not work inside an ArchCare facility but who: 1) furnish state and federal health care program (*e.g.*, Medicare or Medicaid) health care items or services; 2) perform billing or coding functions, 3) monitor healthcare provided by ArchCare; 4) perform other tasks on behalf of ArchCare necessitating compliance education as determined by the Corporate Compliance Officer; or 5) who have been identified as an "affected individuals" shall receive required compliance education containing the vendor training, links to the ArchCare Policies and Procedures, Compliance Program Charter and any other relevant compliance documents through contract provisions, annual vendor communications, website posting, or another documented process. They may be asked to complete an attestation acknowledging review of the documents. Entity Compliance Officers and/or Compliance Liaisons or their designees may periodically review documentation to ensure compliance with this requirement.

4. All training will be conducted in accordance with the Annual Training Plan.

5. ArchCare-sponsored programs or plans that administer Medicare Parts C & D benefits shall ensure that care members and First Tier, Downstream, and Affiliated Entities receive CMS Compliance and FWA or its equivalent. The requirement to

complete FWA is also extended to First Tier, Downstream, and Affiliated Entities of MLTC plans as required by law, contract or program guidance. Providers shall receive required compliance education through annual communications, website posting, training materials, contract provisions, certification, attestation, or another documented process. They may be asked to complete an attestation acknowledging review of the documents.

6. Potential education and training topics may include, but are not limited to: (i) the elements of an effective Compliance and Ethics Program; (ii) the structure and operation of the ArchCare Compliance and Ethics Program, including, how and to whom issues should be reported, confidentiality protections, investigation processes, corrective action procedures, disciplinary policies, non-retaliation/non-intimidation policies; (iii) ArchCare's expectations that comply with the Code of Conduct, report compliance concerns and assist in their resolution; (iv) applicable federal and state laws and regulations related to fraud, waste, and abuse in Federal health care programs, including the False Claims Act and other laws prohibiting the submission of false claims;[2] and (v) identified compliance risk areas.

7. Completion of annual compliance training and education is mandatory and is a condition of continued employment, association with or the conduct of business with ArchCare and its affiliated entities.

PROCEDURE

1. Registrations and completion records of New Employee Orientation and Annual Reorientation e-learning programs shall be maintained by the Human Resources department and/or Staff Development department and reported to the appropriate Compliance Committee.

2. The Corporate Compliance Officer, Compliance Liaisons, Compliance Officers and other appropriate officers, managers and supervisors shall be available on a continuing basis to respond to questions from care members seeking clarification regarding compliance-related matters.

[2] Attached to this Policy as Appendix A is an overview of the federal and state false claims laws, state criminal, civil and administrative penalties for filing false claims, and the whistleblower protections afforded by such laws.

3. Educational and training materials, including copies of all written materials, shall be retained for a period of no less than ten (10) years from the date the materials were last utilized.

4. The Corporate Compliance Officer shall periodically and no less than annually, monitor, evaluate and assess the effectiveness of ArchCare's education and training programs and revise such programs as necessary.

REVISION HISTORY

Date	Change/Note
05/26/2026	Annual review and update of policy
4/24/2025	Annual review and update of policy
5/1/2024	Annual review and update of the policies and update the 2024 Federal penalty amounts.
6/27/2023	Review and update the 2023 Federal penalty amounts.
5/1/2023	Review and update to align with the new OMIG Guidance including redefining the term affected individual. In addition, made formatting changes.
8/2022	replaced compliance with compliance and ethics
8/2021	expanded potential training topics; specified employees that must be trained in accordance with SSL 363-d and that training should take place with 30 days of hire; added procedure section, including requirement for retaining records and evaluating effectiveness of the training. Updated Appendix A, deleted reference to OMIG and privacy training.
4/2019	added Agency Staff, Temporary Staff, Consultant Staff to section 3 d;
11/2018	added temporary employees to "associates" and specified that compliance training must take place within 90 days of hire;
3/2017	clarified who is included in "associates";
1/2011	Changes per annual review;

9/6/2007	new policy

APPENDIX A

FEDERAL & NEW YORK STATUTES RELATING TO FILING FALSE CLAIMS/WHISTLEBLOWER PROTECTIONS

I. FEDERAL LAWS

A. False Claims Act [Title 31 United States Code §§ 3729 to 3733**]**

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

> Any person who (1) knowingly presents, or causes to be presented, to an office or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval; (2) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; (3) conspires to defraud the Government by getting a false or fraudulent claim paid or approved by the Government;…or (7) knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government,
>
> * * *
>
> is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000,[3] plus 3 times the amount of damages which the Government sustains because of the act of that person….
>
> For purposes of this section:
>
> (a) the term "claim"— means any request or demand, whether under a contract or otherwise, for money or property and whether or not the United States has title to the money or property, that—(i) is presented to an officer, employee, or agent of the United States; or (ii) is made to a contractor,

[3] Although the statutory provisions of the Federal False Claims Act authorizes a range of penalties of from between $5,000 and $10,000, those amounts have been adjusted for inflation. As of February 12, 2024, the minimum False Claims Act penalty will increase from $13,508 to $13,946 per claim, and the maximum penalty will increase from $27,018 to $27,894 per claim.

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

- provides or has provided any portion of the money or property requested or demanded; or
- will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded; and
- does not include requests or demands for money or property that the Government has paid to an individual as compensation for Federal employment or as an income subsidy with no restrictions on that individual's use of the money or property;

(b) The terms "knowing" and "knowingly mean that a person, with respect to information (i) has actual knowledge of the information; (ii) acts in deliberate ignorance of the truth or falsity of the information; or (iii) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.

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

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

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

In sum, the False Claims Act imposes liability on any person who submits a claim to the federal government that he or she knows (or should know) is false. An example may be a physician who submits a bill to Medicare for medical services she knows she has not provided. The False Claims Act also imposes liability on an individual who may knowingly submit a false record in order to obtain payment form the government. An example of this may include a government contractor who submits records that he knows (or should know) is false and that indicate compliance with certain contractual or

regulatory requirements. The third area of liability includes those instances in which someone may obtain money from the federal government to which he may not be entitled, and then uses false statements or records to retain the money. An example of this so-called "reverse false claim" may include a hospital who obtains interim payments from Medicare throughout the year, and then knowingly files a false cost report at the end of the year to avoid making a refund to the Medicare program.

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

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

B. Administrative Remedies for False Claims [or another documented process

This statute allows for administrative recoveries by federal agencies. If a person submits a claim that the person knows is false or contains false information, or omits material information, then the agency receiving the claim may impose a penalty of up to $5,000 for each claim.[4] The agency may also recover twice the amount of the claim.

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

II. NEW YORK STATE LAWS

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

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A. Civil and Administrative Laws

NY False Claims Act [State Finance Law §§187–194]

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

The Act allows private individuals to file lawsuits in state court, just as if they were state or local government parties. If the suit eventually concludes with payments back to the government, the person who started the case can recover up to 25-30% of the proceeds.

Social Services Law §145-b - False Statements

It is a violation to knowingly obtain or attempt to obtain payment for items or services furnished under any Social Services program, including Medicaid, by use of a false statement, deliberate concealment or other fraudulent scheme or device. The State or the local Social Services district may recover three times the amount incorrectly paid. In addition, the Department of Health may impose a civil penalty of up to $10,000 per violation. If repeat violations occur within 5 years, a penalty up to $ 30,000 per violation may be imposed if they involve more serious violations of Medicaid rules, billing for services not rendered or providing excessive services.

Social Services Law §145-c Sanctions

If any person applies for or receives public assistance, including Medicaid, by intentionally making a false or misleading statement, or intending to do so, the person's, the person's family's needs are not taken into account for six months if a first offense, 12 months if a second offense (or if benefits wrongfully received are at least one thousand dollars but not more than three thousand nine hundred dollars), for eighteen months if a third offense (or if benefits wrongfully received are in excess of three thousand nine hundred dollars), and five years for any subsequent occasion of any such offense.

B. Criminal Laws

Social Services Law §145 – Penalties

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

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

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

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

Penal Law Article 155 - Larceny

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

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

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

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

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

Penal Law Article 175, False Written Statements

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

g. §175.05, Falsifying business records involves entering false information, omitting material information or altering an enterprise's business records

with the intent to defraud. It is a Class A misdemeanor.

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

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

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

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m. Aggravated insurance fraud is committing insurance fraud more than once. It is a Class D felony.

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

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

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

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