Bridge View Nursing Home

Compliance Program - Code of Conduct

A. Introduction

Bridge View Nursing Home, Inc. ("Bridge View") has adopted a corporate compliance program ("Compliance Program") as an embodiment of its commitment to conducting its business in compliance with all applicable laws, rules, regulations and other directives of the federal, state, and local governments and agencies. An expression of this commitment is the code of conduct ("Code of Conduct") described herein which is applicable to all individuals, including, as applicable, Bridge View's Directors, Officers, corporate officers, administrators, employees, agents, physicians, volunteers, contractors, subcontractors and independent contractors working for or providing services for Bridge View ("Associates").

The Code of Conduct is intended to provide general guidelines to assist Associates to understand and appreciate the manner in which Bridge View wishes to conduct business. This Code of Conduct also includes the information required by the Deficit Reduction Act (DRA), including a summary of Federal and State False Claims Acts, State health care fraud laws, applicable State and Federal whistleblower protections, and applicable policies for detecting fraud, waste, and abuse ("DRA Summary of Fraud and Abuse Laws and Policies"). It is the duty of every Associate to adhere to the principles set forth herein.

The Code of Conduct shall be distributed and available to all Associates. Associates are responsible for ensuring that their behavior and activities are consistent with the standards embodied in this Code of Conduct.

B. Compliance with Laws and Regulations

Bridge View and its Associates shall comply with all applicable federal, state, and local laws, rules, regulations, and standards ("laws and regulations"). Each individual must be aware of the legal requirements and restrictions applicable to his or her respective position and duties.

While the duty remains the individual's responsibility, Bridge View shall implement programs necessary to foster further awareness of applicable laws and regulations and to monitor and promote compliance with such laws and regulations. Any questions about the legality or propriety of any actions undertaken by or on behalf of Bridge View should be referred immediately to an individual's supervisor, the Administrator, or the Compliance Officer.

C. Fraud and Abuse

Bridge View expects its Associates to refrain from any conduct that may violate applicable federal and state laws and regulations, with special emphasis on those related to fraud, waste, and abuse.

These laws generally prohibit: (1) the transfer of anything of value in order to induce the referral of patients or any government program business (i.e., Medicare, Medicaid and other federal or state health care programs); and (2) the making of false representations or the submission of false, fraudulent or misleading claims to any government entity or third party payor, including claims for services not rendered, claims which characterize the service differently than the service actually rendered, or claims which do not otherwise comply with applicable program or contractual requirements.

More specific guidance with respect to laws and regulations applicable to fraud and abuse can be found in Bridge View's Compliance Manual.

D. Professional and Ethical Standards

All Associates have a duty to promote Bridge View's goals to provide quality health care services that respond to the needs of our residents. The services provided must be reasonable and necessary for

the care of each resident. Resident care shall be provided by appropriately qualified individuals and properly documented as required by law and regulation, payor requirements and professional standards.

Bridge View and its Associates shall conduct all activities in accordance with the highest ethical standards and in a manner which shall uphold Bridge View's reputation and standing in the community to which we serve.

E. Confidentiality and HIPAA Compliance

Bridge View and its Associates are in possession of, or have access to, a wide variety of confidential and sensitive information. Bridge View and its Associates shall maintain the confidentiality of patient medical records and personal information, as well as client information, by actively protecting and safeguarding such information in a manner designed to prevent its unauthorized use or disclosure. Bridge View and its Associates shall comply with applicable federal and state laws and regulations concerning confidentiality of health care records including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder, the Health Insurance Technology for Economic and Clinical Health Act, Title XIII of the American Recovery and Reinvestment Act of 2009, and the Omnibus Rule enacted in 2013 (collectively referred to as "HIPAA"). Any questions or concerns relating to the use or disclosure of information should be referred to the Compliance Officer or Privacy Officer.

F. Business Practices

Bridge View's business practices will be conducted honestly, with integrity, and in a manner that upholds Bridge View's reputation with residents, payors, vendors, competitors, and the community. Bridge View expects its Associates to be loyal to Bridge View's interests. Associates should not use their positions to profit personally or to assist others in profiting in any way at the expense of Bridge View. Associates must refrain from activities that create conflicts of interest with Bridge View or give the appearance of impropriety.

Associates involved in business transactions on behalf of Bridge View shall not offer or pay, or solicit or receive any gifts, favors or other improper inducements in exchange for influence or assistance in a transaction or the referral of business. Associates are required to disclose any conflicts of interest or concerns about the propriety of specific arrangements, conduct, or activities to the Compliance Officer.

G. Employment Practices.

Bridge View is committed to providing equal employment opportunities for all persons in accordance with federal and New York State Law and Regulations including, but not limited to, the provisions of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and the Regulations of the U.S. Department of Health and Human Services (HHS) issued pursuant to the Acts, Title 45 Code of Federal Regulations Part 80, 84, and 91, in that no person shall, on the grounds of race, color, national origin, sex, age, sexual orientation, gender identity, religion, creed, disability, marital status, blindness, or source of payment or sponsorship, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program, service or activity provided by the facility. Bridge View is committed to providing resident care and a workplace environment that emphasizes the dignity and respect of every individual. In that regard, harassment, retaliation, violence, and/or any prohibited discrimination in any form or context will not be tolerated.

Bridge View is committed to providing a healthy and safe workplace. Bridge View and its Associates will comply with federal, state, and local laws and regulations that promote the protection of health and safety. Workplace injuries or any situation presenting a danger of injury should be reported immediately.

H. Reimbursement

Bridge View and its Associates are responsible for complying with the laws and regulations governing the submission of billing claims and related statements. A detailed description of the Federal False Claims Act, the Federal Program Fraud Civil Remedies Act, New York State civil and criminal laws pertaining to false claims and the whistleblower protections is contained herein.

All claims for reimbursement for services must be supported by adequate documentation, which justifies that the service is reasonable and necessary, provided by properly qualified persons, and coded correctly. Such documentation must conform to legal, professional, and ethical standards.

Claims for reimbursement must be truthful and accurate and conform to all applicable laws and regulations. Bridge View and its Associates are prohibited from knowingly presenting or causing to be presented claims for payment that are false, fictitious, fraudulent, or otherwise not in compliance with applicable laws and regulations.

I. Summary of Federal and New York State False Claims Acts and New York State Health Care Fraud Laws & Applicable Policies pursuant to the Deficit Reduction Act of 2005 ("DRA Summary of Fraud and Abuse Laws and Policies")[1]

Bridge View expects its employees, agents, and contractors to refrain from conduct that may violate federal and state laws, rules and regulations relating to the provision of and payment for health care items and services. It is our ethical and legal obligation to ensure that all billing and claims reimbursement activities are based on materially accurate and complete information and that we only receive payment and reimbursement for which we are entitled. Our conduct must be consistent at all times with accepted and sound fiscal, business, and medical practices. Clinical and medical personnel must provide services that meet professionally recognized standards of care and all personnel involved in coding, billing and claims submissions must maintain high ethical standards and must become familiar with all rules and laws applicable to such activities.

Federal False Claims Act

The Federal Civil False Claims Act (31 USC §§ 3729 through 3733) makes it illegal for any person to (i) knowingly present, or cause to be presented a false or fraudulent claim for payment or approval; (ii) knowingly make, use, or cause to be made or used, a false record or statement material to a false or fraudulent claim; (iii) conspire to commit a violation of any provision of this Act; (iv) has possession, custody, or control of property or money used, or to be used, by the government and knowingly delivers, or causes to be delivered, less than all of that money or property; or (v) knowingly make, use, or cause to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the government, or knowingly conceal or knowingly and improperly avoid or decrease an obligation to pay or transmit money or property to the government. "Knowingly" means that the person has actual knowledge of the information, acts in deliberate ignorance of the truth or falsity of the information, or acts in reckless disregard of the truth or falsity of the information and requires no proof of specific intent to defraud. Liability under the act is for a civil penalty of not less than $13,508 and no more than $27,018[1] plus three (3) times the amount of damages that the government sustains as a result of the fraudulent act. However, the court may assess a lesser amount not less than double the damages, under certain circumstances. To qualify for reduced damages, the facility must report the false claim to the Government within 30 days after the date on which the facility first obtained the information about the violation and before the commencement of any criminal prosecution, civil action, or administrative action with respect to the false claim and the facility did not have actual knowledge of the existence of an investigation into such violation. In addition, the facility must fully cooperate with any Government investigation. Under the Act, private parties may bring a qui tam action on behalf of the federal government and may share in a percentage of the proceeds from a False Claims Act action or settlement. A person violating this Act will also be liable for the U.S. government's costs of a civil action brought to recover any such penalty or damages.

[1] The civil money penalty listed is adjusted annually for inflation based on the Consumer Price Index (CPI).

Federal Program Fraud Civil Remedies Act

Under the Federal Program Fraud Civil Remedies Act (31 USC Chapter 38), any person who makes, presents, or submits (or causes to be made, presented, or submitted) a claim that the person knows, or has reason to know, (i) is false, fictitious, or fraudulent; (ii) includes or is supported by any written statement which asserts a material fact which is false, fictitious, or fraudulent, or that omits a material fact (which the person has a duty to include and the statement is false, fictitious, or fraudulent as a result of such omission); or (iii) is for payment for the provision of property or services which the person has not provided as claimed may be subject to, in addition to any other remedy, a civil penalty of not more than $13,508[2] for each claim or statement. The violator may also be subject to an assessment of two times the amount of such claim. In addition, any person who makes, presents, or submits (or causes to be made, presented, or submitted) a written statement that (i) the person knows, or has reason to know (a) asserts a material fact which is false, fictitious, or fraudulent, or (b) omits a material fact (which the person has a duty to include) and the statement is false, fictitious, or fraudulent as a result of such omission; and (ii) contains or is accompanied by an express certification or affirmation of the truthfulness and accuracy of the contents of the statement shall be subject to the civil penalty.

New York State False Claims Act

The New York False Claims Act (NYS Finance Law §§ 187 through 194) makes it illegal for any person to (i) knowingly present, or cause to be presented a false or fraudulent claim for payment or approval; (ii) knowingly make, use, or cause to be made or used, a false record or statement material to a false or fraudulent claim; (iii) conspire to commit a violation of any provision of this Act; (iv) has possession, custody, or control of property or money used, or to be used, by the government and knowingly delivers, or causes to be delivered, less than all of that money or property; or (v) knowingly make, use, or cause to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the government, or knowingly conceal or knowingly and improperly avoid or decrease an obligation to pay or transmit money or property to the government. "Knowingly" means that the person has actual knowledge of the claim or information, acts in deliberate ignorance of the truth or falsity of the claim or information, or acts in reckless disregard of the truth or falsity of the claim or information. The civil penalty for filing a false claim is equal to the civil penalty allowed under the Federal False Claims Act, as amended, as adjusted for inflation by the Federal Civil Penalties Inflation Adjustment Act of 1990, as amended, plus three (3) times the amount of all damages sustained by the state or local government. However, the court may assess a lesser amount of not more than double the damages, under certain circumstances. To qualify for the "not more than double damages" provision, the provider must report the false claim to the Government within 30 days after the date on which the provider first obtained the information about the violation and before the commencement of any criminal prosecution, civil action, or administrative action with respect to the false claim. In addition, the provider must fully cooperate with any Government investigation. Under the Act, private parties may bring an action on behalf of the state or local government and may share in a percentage of the proceeds from a False Claims Act action or settlement. The violator is also liable for costs, including attorney's fees, of a civil action brought to recover any such penalty.

New York State Social Services Law § 145, Penalties

Any person who by means of a false statement or representation, or by deliberate concealment of any material fact, or my impersonation or other fraudulent device, obtains or attempts to obtain, or aids or abets any person to obtain public assistance or care to which he is not entitled, or does any willful act designed to interfere with the proper administration of public assistance and care, shall be guilty of a misdemeanor, unless such act constitutes a violation of penal law, in which case he or she shall be punished in accordance with penalties of such law. Failure to notify social services official granting receipt of money or property or income from employment or any other source whatsoever, shall, upon the cashing of public assistance check by or on behalf of such person constitutes presumptive evidence of deliberate concealment of a material fact.

[2] Ibid.

New York State Social Services Law § 145-b, False statements, actions for treble damages

It is unlawful to knowingly obtain or attempt to obtain payment for items or services furnished under any Social Services programs, including Medicaid, by means of a false representation, statement, deliberate concealment or other fraudulent scheme or device. The state or local Social Services district may recover three times the amount incorrectly paid, the amount by which any figure is falsely overstated, or in the case of nonmonetary false statements, three times the amount of damages which sustained by the state or $5,000, whichever is greater. In addition, the Department of Health may impose a civil penalty of up to $10,000 to $30,000 per violation. If deemed appropriate, the matter may be referred to appropriate law enforcement officials. Any person who submits false statements or deliberately conceals material information in order to receive public assistance, including Medicaid, is guilty of a misdemeanor.

New York State Social Services Law §145-c, Sanctions

Any member who applies for or receives public assistance and is found by a federal, state or local criminal, civil or other court to have intentionally (a) made a false or misleading statement or misrepresented, concealed, or withheld facts, or (b) committed any act intended to mislead, misrepresent, conceal or withhold facts or propound a falsity, for the purpose of establishing or maintaining the eligibility of the individual or of the individual's family for aid or of increasing (or preventing reduction in) the amount of such aid, then the needs of such individual shall not be taken into account in determining his or her need or that of his or her family (i) for six months upon first occasion of any offense, (ii) for 12 months upon second occasion of such offense or upon an offense which resulted in the wrongful receipt of benefits between $1,000 to $3,900, (iii) for eighteen months upon the third occasion of such offense or upon offense which resulted in wrongful receipt of benefits in excess of $3,900, and (iv) five years for any subsequent offense. These sanctions are in addition to, and not substitution for, any other sanctions provided by law.

New York State Social Services Law §363-d, Provider compliance program

Section 363-d of New York's Social Services Law obligates certain Medicaid providers to adopt and implement an effective compliance program, which shall include measures that prevent, detect, and correct fraud waste, and abuse, as well as non-compliance with the Medicaid requirements, and must incorporate the elements set forth in the statute. The compliance program shall meet the requirements of SSL §363-d as a condition of payment from the Medicaid program. Regulations promulgated pursuant to the statute require the provider to certify, upon enrollment in the Medical Assistance Program, and during the month of December annually thereafter, that an effective compliance program is in place (18 N.Y.C.R.R. § 521.3). Failure to adopt and implement a compliance program which satisfactorily meets the SSL 363-d requirements may result in monetary penalties of $5,000 per calendar month (for a maximum of 12 calendar months). For repeat offenders (penalty imposed within the prior 5 years), the penalties increase to up to $10,000 per month (for a maximum of 12 calendar months).

New York State Social Services Law §366-b, Penalties for fraudulent practices

Any person who, with intent to defraud, presents for allowance or payment any false or fraudulent claim for furnishing services or supplies, knowingly submits false information for the purpose of obtaining greater compensation than that to which he is legally entitled, or knowingly submits false information for the purpose of obtaining authorization for furnishing services or supplies under the medical assistance program, or 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.

New York State 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. The crime of larceny has been applied to Medicaid fraud cases. Charges may range from a Class A misdemeanor for petit larceny, to Class E felony for grand larceny in the fourth degree, to a Class B felony for grand larceny in the first degree.

New York State Penal Law Article 175, False written statements

There are four crimes in this Article that relate to filing false information or claims. Actions include falsifying business records, entering false information, omitting material information, altering an agency's business records, or providing a written instrument (including a claim for payment) knowing that it contains false information. Depending upon the action and the intent, a person may be guilty of a Class A misdemeanor or a Class E felony.

New York State Penal Law Article 176, Insurance fraud

This Article applies to claims for insurance payment, including Medicaid or other health insurance. The six crimes in this Article involve intentionally filing a false insurance claim. Under this article, a person may be guilty of a felony for false claims in excess of $1,000. Four crimes in this Article relate to filing false information or claims and have been applied in Medicaid fraud prosecutions. Criminal charges may range from a Class A misdemeanor to a Class B felony.

New York State Penal Law Article 177, Health care fraud

This Article establishes the crime of Health Care Fraud. A person commits such a crime when, with the intent to defraud any publicly or privately funded health insurance or managed care plan, including Medicaid, he/she knowingly provides false information or omits material information for the purpose of requesting payment for a health care item or service and, as a result of the false information or omission, receives such a payment in an amount to which he/she is not entitled. Violators may be subject to fines, imprisonment, or both. Charges under Penal Law Article 177 may range from a Class A misdemeanor to a Class B felony.

Federal and New York State Whistleblower Protection

The Federal and State False Claims Acts 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 False Claims Act (31 U.S.C. § 3730(h); NYS Finance Law § 191). Remedies include injunction to restrain continued discrimination, reinstatement with a comparable position as the *qui tam* relator would have had but for the discrimination, two times any back pay with interest, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees.

New York State 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 the 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.

New York State Labor Law §741

A health care employer 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. Protected disclosures are those that assert that, in good faith, the employee believes constitute improper quality of patient care. 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 or patient 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.

Detecting and Preventing Fraud, Waste and Abuse:

In accordance with the requirements of relevant false claims laws, and to further ensure the accuracy and appropriateness of claims submitted, the facility has adopted the following rules that its Associates must strictly follow:

- *Detect and prevent the filing of claims for services not rendered.* All documentation must be reviewed and checked for accuracy by clinical staff prior to submission. Furthermore, billing staff must review the completeness and check for inconsistencies in the documentation supporting the bill prior to submitting a claim;
- *Detect and prevent the filing of claims for services rendered that were not medically necessary.* Documentation submitted by the clinical departments must be consistent with medical necessity requirements ("reasonable and necessary" in the context of Medicare). All clinical and billing staff shall communicate effectively to ensure that documentation is accurate and consistent;
- *Detect and prevent the submission of any claim that contains false information.* All claim forms must be reviewed for accuracy prior to presentation for payment;
- *Detect and prevent any claim for inadequate or substandard services.* Clinicians must review services rendered and supporting documentation to determine that the level of services provided is adequate to support a claim for payment.

The clinical and billing staff, in coordination with the Compliance Officer or other designated party, will conduct periodic reviews to ensure that documentation is accurate and supports the claims for reimbursement.

The facility has adopted policies and procedures for preventing and detecting fraud, waste, and abuse of the federal health care programs, including Medicare and Medicaid. All employees, agents and contractors must comply with these policies. These policies and procedures are available for review upon request. To review these policies and procedures, contact the Compliance Officer. The following represents a summary of the relevant policies.

Policy: **Designation and Responsibilities of the Compliance Officer**

It is the policy of facility to ensure that it conducts itself in compliance with all applicable laws, rules, regulations and other directives of the federal, state, and local governments, departments, and agencies. In furtherance of this policy, the facility shall have at all times an individual designated as a Compliance Officer to oversee and monitor its Compliance Program.

Coordination and communication are the key functions of the Compliance Officer with regard to planning, implementing, maintaining, and monitoring the facility's Compliance Program and evaluating its effectiveness. The Compliance Officer shall develop and assist the facility in putting appropriate compliance processes in place to implement and ensure the effectiveness of the Compliance Program. Examples of these activities and processes include, but are not limited to, the following:

- serve as a trusted source of guidance for Associates with regard to compliance related matters;
- test the billing and claims reimbursement staff on their knowledge of applicable program requirements and claims and billing criteria;
- conduct or oversee unannounced audits of claims and billing information;
- assess contractual relationships with contractors, consultants, and potential referral sources;
- determine whether individuals who previously have been reprimanded for compliance issues are now conforming to policies;
- Assisting in the development of methods to improve efficiency and quality of services and reducing vulnerability to fraud, waste, and abuse;
- develop, coordinate, and participate in compliance educational and training programs; and
- coordinate internal compliance review and monitoring activities, including annual or periodic

reviews and oversee any resulting corrective action; and

- designing and coordinating internal investigations of any matters related to the compliance program and coordinating any resulting corrective action.

Policy: **Retention of Records**

It is the policy of the facility that all employees, agents, contracted health professionals and vendors maintain and preserve all documents, including compliance, business, and medical records, and secure them against loss, destruction, unauthorized access, unauthorized reproduction, corruption, or damage. Compliance with regulations concerning document retention periods is required.

The primary components of the facility's record maintenance, access and retention policies and procedures include, but are not limited to, the following:

- Records will only be accessible by authorized personnel on a need-to-know basis or legally authorized individuals, and in strict conformance with applicable federal, state, and local laws and regulations, including those relating to privacy and confidentiality.
- Medical records may only be accessed by authorized individuals and personnel. Questions as to whether medical records should be released and/or distributed should be directed to the facility's Privacy Officer and/or the Administrator where appropriate.
- Records will be stored in a systemized manner that preserves confidentiality and takes into consideration environmental elements.
- Security of electronic records shall comply with HIPAA regulations.

Policy: **Individuals Excluded from Federal and State Health Care Benefit Programs**

It is the policy of the facility not to enter into employment, contractual or business arrangements, in any capacity, with individuals or entities that are barred or excluded from participating in federal or state health care benefit programs. This shall be accomplished through screening programs, including review of the U.S. Office of Inspector General's (OIG) List of Excluded Individuals/Entities (LEIE), the New York Office of Medicaid Inspector General (OMIG) Exclusion List, and other applicable data sources prior to hiring, engaging or otherwise transacting business with any person or entity, and at least every thirty days thereafter.

Policy: **Conflicts of Interest**

It is the policy of the facility that all personnel avoid any and all activities that conflict with their responsibilities and obligations to the facility. The policies and procedures relating to conflicts of interest include, but are not limited to, the following:

- Employees or agents must not have an interest in or serve as director, officer, manager, or member of any entity in competition with the facility without permission.
- Any employee and agent who perform work or render services for any competitor of the facility or for any organization that does business with or seeks to do business with the facility outside of the normal course of his or her employment shall notify the Administrator.
- Business with any vendor, supplier, contractor, or agency, or any of their officers or employees that is not conducted on behalf of the facility is prohibited, unless previously authorized by the Administrator.
- Employees and agents shall not permit their names to be used in any fashion that would tend to indicate a business connection with any organization that does business with or seeks to do business with the facility without the prior approval of the Administrator.
- The facility shall not be represented by an employee or agent in any transaction in which he or she or an immediate family member has a personal financial interest.
- Confidential information should not be discussed with anyone outside of the facility. This confidential information includes, but is not limited to, personnel data, patient lists, clinical information, financial data, research data, strategic plans, potential mergers and acquisitions, marketing strategies, processes, techniques, computer software, any information with a copyright,

financial results, or other business dealings.

- Employees and agents shall not accept any gifts, favors, or things of value, including discounts, from prospective or current suppliers and/or contractors.
- Employees and agents shall not engage in any activities or outside interests that influence their ability to make objective decisions in the course of their job responsibilities.
- Potential conflicts of interest involving Associates or their immediate family members (spouse, parents, brothers, sisters, and children) are required to be reported to the Administrator using the facility's "Conflict of Interest Disclosure Statement" form.

Policy: **Billing and Claims Reimbursement**

It is the policy of the facility to comply with all relevant billing and claim reimbursement requirements. All personnel involved in coding, billing and claims submissions must maintain high ethical standards and must know and adhere to all requirements for the health care industry, including all rules and regulations pertaining to coding, billing, claims submission and reimbursement, including, among others, Medicare, and Medicaid regulations. All billing personnel are expected to attend training and education sessions. Billing personnel will be regularly monitored to ensure that they are not engaging in any activity that may be fraudulent or abusive under the Medicare and Medicaid regulations.

Personnel are required to report promptly all known or suspected violations of billing policies to their immediate supervisor, Administrator, Compliance Officer, or other designated party, in accordance with the facility's policy and procedures for internal reporting.

Policy: **Compliance Training and Education**

It is the policy of the facility as part of its continued commitment to compliance with legal requirements, to ensure that its affected employees and persons associated with the facility including governing body members and administration receive training and education on the compliance program, compliance issues and expectations.

Participation in a minimum of one (1) hour of basic compliance training and education is required as part of the facility's orientation program and annually. Individuals involved in specialty fields such as coding, claims development and billing will require additional compliance training and education addressing documentation, claims, billing, and fraud and abuse issues. Additional training attendance may be required as part of a performance improvement measure or action plan. Attendance at educational and training sessions is the responsibility of each individual and will be documented. In addition to periodic training and in-service programs, relevant new compliance information will be disseminated to affected personnel.

Policy: **Employee Screening**

It is the policy of the facility to ensure that its employees, agents, and independent contractors are properly screened in accordance with facility procedures and in compliance with applicable laws and regulations prior to employment or engagement and periodically during their tenure with the facility. Offers of employment or engagement, as well as continued employment and engagement, shall be contingent upon satisfactory screening.

Policy: **Monitoring and Auditing**

It is the policy of the facility to ensure that the facility, its employees, contractors, and agents conduct business and activities in compliance with all applicable laws, rules, regulations and other directives of the federal, state, and local governments, departments and agencies. In this regard, and in furtherance of this policy, the facility shall conduct periodic audits designed to address relevant compliance issues. Internal or external auditors will conduct periodic audits, which will be overseen by the Compliance Officer.

Policy: **Internal Reporting of Compliance Related Matters**

It is the policy of Bridge View to maintain an internal reporting mechanism for all employees, agents, and contractors to report actual or perceived violations of the facility's Code of Conduct, Compliance Program, policies and procedures and applicable laws and regulations.

Anyone with current knowledge of an event, occurrence, or activity that appears to violate applicable laws and regulations, the facility's Code of Conduct or any of its policies or procedures should promptly communicate the actual or perceived violation to their immediate supervisor, the Administrator, Compliance Officer, or other designated party. Personnel who act in supervisory, managerial, or other administrative roles have an obligation to promptly report any potential violation reported to them by subordinates or others to the Compliance Officer for appropriate action and follow-up. If the individual reporting prefers not to report the matter to a supervisor or the Administrator, he/she should call the facility's Compliance Hotline. Callers to the hotline will remain anonymous.

Policy: **No Retaliation**

There will be no intimidation or retaliation taken against employees or agents who participate in the Compliance Program in good faith. Intimidation, retaliation or any form of reprisal based upon an employee's or agent's good faith reporting of potential unethical or illegal activity is strictly prohibited and will not be permitted or tolerated by Bridge View. Employees and agents are expected to report any possible instances of intimidation or retaliatory action immediately to the Administrator and/or Compliance Officer. Bridge View strives to promote integrity, support objectivity and foster trust in compliance with this Code of Conduct.

Policy: **Investigations of Compliance Reports and Corrective Action**

It is the policy of Bridge View to make reasonable inquiry into any report concerning activity that may be contrary to applicable laws and/or regulations. Upon receipt of a report that suggests that improper conduct has occurred, an investigation will be commenced under the direction of the Compliance Officer. The Compliance Officer may seek legal counsel to assist with any legal issues that may arise during the investigation. The investigative techniques used shall be implemented in order to facilitate the correction of any practices not in compliance with applicable laws and/or regulations and to promote, where necessary, the development and implementation of policies and procedures to ensure future compliance.

J. Administration and Application of this Code of Conduct

Bridge View expects that the Code of Conduct will be a part of the daily activities of all who provide services on behalf of the facility. The Code of Conduct is in addition to and does not limit specific policies and procedures of Bridge View. Associates must perform their duties in accordance with all such policies and procedures as well as laws and regulations.

Associates are responsible for promoting the standards set forth in this Code of Conduct and for reporting potential violations in accordance with the reporting procedures outlined in the Compliance Manual. All reports of unethical or illegal conduct will be investigated by persons designated by, and pursuant to procedures established by, Bridge View. All reports will be held in the strictest confidence possible, unless the matter is turned over to law enforcement or disclosure is required during a legal proceeding.

Failure to abide by the Code of Conduct and compliance standards of Bridge View, including failing to report suspected problems, participating in non-compliant behavior, or encouraging, directing, facilitating, or permitting either actively or passively non-compliant behavior, will result in disciplinary action. In addition, facility personnel are expected to cooperate with compliance investigations and audits and assist in the resolution of compliance issues. Disciplinary action will be fairly and firmly enforced on a case-by-case basis and, at Bridge View's discretion, may range from a warning to termination. If Bridge View determines that a violation has included criminal violations of law or regulation, Bridge View will cooperate with law enforcement authorities in connection with the investigation and prosecution of the offender.

If you have any questions or concerns regarding the compliance program or the Code of Conduct, you can seek clarification from the Compliance Officer at any time.

It is an explicit violation of Bridge View's policy to intimidate or retaliate against an individual who reports in good faith an actual or potential violation of applicable laws, regulations, rules, or the Code of Conduct or who participates in the compliance program, including but not limited to investigating compliance issues, audits, self-evaluation, remedial actions, reporting intimidation or retaliation, and reporting fraud, waste, or abuse to appropriate officials.

How to Report a Violation of the Code

Associates should report any violation of the Code of Conduct to your immediate supervisor, the Administrator and/or the Compliance Officer. If you prefer not to report such matter to a supervisor or the Administrator because you believe they may be involved in the actual or perceived violation, if you otherwise have a legitimate reason to be concerned about intimidation or retaliation, if your previous reports have not been acted upon, or for any other reason, you should contact Bridge View's Compliance Officer by telephone or in writing, or call the Compliance Hotline. The Compliance Officer's contact information and the Hotline number are listed below. While hotline calls may be made anonymously, supplying your name and contact information may assist in the investigation. Bridge View will maintain the confidentiality of the identity of an individual who reports possible violations unless the matter is turned over to law enforcement or a federal or state regulatory agency or disclosure is required during a legal proceeding.

Compliance Officer: Carlton Williams
Bridge View Nursing Home
143-10 20th Avenue, Whitestone, New York 11357
Telephone: (718) 961-1212, Ext. 1505
Fax: (718) 461-9484
Email: cwilliams@bridgeviewnh.com
Compliance Hotline: (888) 215-6592

This Code of Conduct is not intended to and shall not be construed as providing any additional employment or contract right to Associates or other persons.

Bridge View will attempt to communicate changes to the Code of Conduct prior to the implementation of such changes. However, Bridge View reserves the right to modify, amend, or alter the Code of Conduct and its policies and procedures without prior notice to any person.

[1] These policies are deemed to be incorporated into the facility's Employee Handbook, if applicable.

Bridge View Nursing Home

Compliance Program

Certification of Receipt of Code of Conduct and DRA Summary of Fraud and Abuse Laws and Policies

I, the undersigned, hereby certify that I have received and read the Code of Conduct, which includes the DRA Summary of Fraud and Abuse Laws and Policies ("DRA Summary"), of Bridge View Nursing Home, Inc. ("Bridge View"). I understand that the Code of Conduct and the DRA Summary reflect Bridge View's earnest commitment to integrity and compliance with all applicable federal, state, and local laws, regulations and rules.

I fully understand the requirements set forth in the Code of Conduct and DRA Summary. I hereby agree to abide by the principles and standards set forth in the Code of Conduct and DRA Summary and to conduct myself during my employment or association with Bridge View in full compliance with the Code of Conduct, federal and state fraud and abuse laws and regulations, the policies of Bridge View, and the highest ethical standards.

Acknowledged and Agreed:

Signature: _____

Print Name: _____

Title / Department: _____

Company (if applicable): _____

Date: _____