CARDINAL HAYES HOME POLICY AND PROCEDURE	Date Issued 04/24/2023	Date Revised 08/14/2025	Date of Last Review 08/14/2025	Date Approved 08/20/2025	Section Number CC-01
	Subject Corporate Compliance				
	Topic Policy Development, Approval and Maintenance				

I. PURPOSE:

The Policy and Procedure provides clear direction for the process of developing and maintaining policies and establishes a process that promotes effective and timely policy development and review.

II. STATEMENT OF POLICY:

It is the policy of Cardinal Hayes Home for Children (sometimes referred to as "Cardinal Hayes Home") (CHH) to express policies in writing where appropriate. Policies explain how goals will be achieved and serve as guides that define the general scope of activities permissible for goal accomplishments.

Procedures, distinct from policies, are guides for action to be taken in the implementation of policies. When applicable, each CHH policy will include a prescribed procedure to be followed for proper implementation.

The Corporate Compliance Officer is responsible for the overall coordination and implementation of any new or revised policy. The Executive Director and the Executive Administration will be consulted as needed throughout the process of developing or revising any policy.

The CCO maintains the CHH policy manual, which is stored in the CHH Agency Shared Folder (policy & procedures). The CCO will also maintain a Policy Catalogue Database. The office is responsible for formulating statements of policy and for making recommendations as to implementation to the Executive Director. Prior to recommendations of approval to the Executive Administration, all policies will be referred to the Corporate Compliance Committee for review to ensure compliance with the legal and regulatory requirements and other Cardinal Hayes Policies and approval. When applicable, policies will also be forwarded to the Board of Directors for approval.

All policies and procedures must be reviewed annually by the Policy Owner or designee to update and incorporate changes in applicable laws, regulations and departmental processes as needed. If there are necessary revisions to the policy, the responsible person will follow the workflow provided below for approval.

All policies and accompanying procedures prepared will follow a standardized process for policy development, approval, revision, and implementation to promote high quality service and assist in improved decision-making.

All Cardinal Hayes Home policies will contain the required header information:

a) **Date Format:** 00/00/0000
b) **Subject:** Name of Department
c) **Topic:** Exact name of the policy.
d) **Section Number:** The prefix represents the department and is an alphabetical abbreviation of 2 or 3 letters. Next is a hyphen, followed by the 2-digit policy number. This Section Number must match what is on the CHH Policy Manual and Database. All Section Numbers will be issued by the CCO.
e) **Date Issued:** The date the policy was originally put into effect.
f) **Date Revised:** The date when any changes are made to the policy.
g) **Date of Last Review:** Date reviewed by Department Head.
h) **Date Approved**: Date when the policy is approved Corporate Compliance Committee or Bd of Directors (when applicable).

All **CARDINAL HAYES HOME** policies will include the following components:

a) Purpose – A brief description of why the Policy is being promulgated and/or what it seeks to accomplish.
b) Statement of Policy - A brief description of the policy.
c) Owner of Policy- The Policy Owner is the department/program administrator or individual responsible for the policy implementation and oversight. The Policy Owner shall be responsible for recommending the timely development, review, revision, and implementation of new and existing policies relating to their respective areas of accountability.
d) Scope- Affected departments or employees.
e) Procedure – Detailed procedure to be followed to implement the policy appropriately.
f) Sanction Statement- Non-compliance with this policy may result in disciplinary action, up to and including termination.
g) Compliance Statement
h) Record Retention Statement

III. POLICY OWNER

Corporate Compliance Officer or designee

IV. SCOPE

This policy applies to all operations at Cardinal Hayes Home for Children & Cardinal Hayes School for Special Children.

V. PROCEDURES

1. **Procedure for New Policy Initiation**

Responsible Staff	Actions Taken
Executive Director or Executive Administration	1. Requests that a policy be initiated in draft and assigns this task to a responsible person.
All Staff	1. Policies may be drafted by any CHH staff when such a statement seems appropriate and will serve a useful purpose.
Responsible Person for drafting the policy	1. Type the policy accessing the form via the template in the forms catalog in the agency shared folder (policy & procedures). 2. Using the format described in the policy statement, draft the policy and label it DRAFT. 3. Draft policy statements specific to the unit/department/disciplines are submitted to the appropriate Director or Policy Owner for review and consideration. 4. Create post-training test questions for policies related to the care of individuals. 5. Submit the draft policy to the Corporate Compliance Officer.
Corporate Compliance Office	1. Receives the draft policy statement for review. 2. The Corporate Compliance Officer in collaboration with the Compliance Committee will review new policies and provide feedback to the Policy Owner and/or appropriate administrator. 3. Incorporates the revisions and changes suggested by the CC into the policy. 4. Forwards all policies to the Executive Administration for final approval. When applicable, will send to Bd of Directors for their approval. 5. Once approved, remove all editing fonts, and assign a policy number. 6. Approved policies will be cataloged and posted in the CHH agency shared folder (policy & procedures). 7. The effective date of the policy shall be the date of final approval. 8. Notifies via email, the Board of Directors, the Executive Director, and all staff, and, if applicable, independent contractors and agents within 10 business days of final approval. 9. Updates the CHH Policy database.
Policy Owner	1. Within 10 days of posting in the agency shared folder (policy & procedures), the policy owner must inform all Affected Departments and Staff Development.
Staff Development	1. Must enroll all Affected staff for new policies in Relias.

2. **Procedure for Revision of Existing Policies**

Responsible Staff	Actions Taken
Responsible Person/Department or designee For Revising Policy	1. Policy owner or designee, as specified in the policy and procedure, must review the policy annually by the Review Date on the policy (request the Word version of existing policy from the Corporate Compliance Office). 2. Revise the policy and procedure as needed to include updates. 3. Using the Track Changes feature in Microsoft Word, edit the policy including the revision date. The policy should be marked DRAFT. 4. Submit the revised policy to the appropriate Director or Policy Owner for review and consideration. 5. Update post-training questions for policies related to the care of individuals as needed. 6. Submit the revised policy to the Corporate Compliance Officer.
Corporate Compliance Office	1. Receives the revised policy statement for review. 2. The Corporate Compliance Officer in collaboration with the Compliance Committee will review revised policies and provide feedback to the Policy Owner and/or appropriate administrator. 3. Incorporates the revisions and changes suggested by the CC into the policy. 4. Forwards all policies to the Executive Administration for final approval and Bd of Directors when applicable. 5. Once approved, remove all editing fonts. 6. Approved policies will be posted in the CHH agency shared folder (policy & procedures). 7. The effective date of the policy shall be the date final approval. 8. Notifies the Board of Directors, the Executive Director, and all staff, and, if applicable, independent contractors and agents within 10 business days of final approval, that revised/approved policies have been posted in the agency shared folder (policy & procedures). 9. Updates the CHH Policy database.
Staff Development	1. Must enroll all Affected staff for approved revised policies in Relias.

3. **Department Specific Standard Operating Procedures**

Responsible Staff	Actions Taken
Department Head or Discipline Head	1. Determine the need to establish a department or discipline specific standard operating procedures which are not based on any specific CHH policy. 2. Develops required department or discipline specific standard operating procedures. 3. Reviews all developed standard operating procedures on an on-going basis to assure review/revision as indicated and at least annually. 4. Department and Discipline Heads are responsible for distributing approved department or discipline standard operating procedures to all appropriate staff and for maintaining all such in a centrally maintained department or discipline operating manual.

VI. **SANCTION STATEMENT**

Non-compliance with this policy may result in disciplinary action, up to and including termination.

VII. **COMPLIANCE STATEMENT**

As part of its ongoing auditing and monitoring process in its Compliance Program, CHH will review this policy based on changes in the law or regulations, as CHH's practices change, and, at minimum, on an annual basis. Additionally, this policy will be tested for effectiveness on an annual basis or more frequently as identified in accordance with CHH's Compliance Program. Testing will include but is not limited to ensuring that the policy is appropriately followed; the policy is effective; the policy has been disseminated to all affected individuals, as well as notified of any updates or changes.

Tracking of the criteria above and results of this testing will be completed by the Compliance Officer, or designee. Additionally, results will be reported to the Compliance Committee and Governing Body on a regular basis.

VIII. RECORD RETENTION STATEMENT

CHH will retain this policy and all subsequent revisions, and any related documentation will be retained for a period of at minimum 10 years.

History:

Issued: 4/2023

Revised: 8/2025

CARDINAL HAYES HOME POLICY AND PROCEDURE	Date Issued 04/24/2023	Date Revised **08/14/2025**	Date of Last Review 08/14/2025	Date Approved 08/20/2025	Section Number CC-02
	Subject Corporate Compliance				
	Topic Compliance Plan				

I. PURPOSE:

Cardinal Hayes Home for Children (sometimes referred to as "Cardinal Hayes Home") (CHH) is committed to providing services of the highest quality and to being in full compliance with all federal, state, and local laws and regulations. As part of that commitment, CHH has adopted this Compliance Plan and the Standards of Conduct as the basis of its efforts in fostering an organizational culture that promotes responsible and honest conduct, transparency in all business transactions, and adherence to the laws and regulations of the government oversight agencies and funders.

For purposes of this Policy, the term "Affected Individuals" includes all persons who are affected by the required risk areas including all employees, the Executive Director and other senior administrators, supervisors, contractors, agents, interns, and the Board of Directors (hereafter referred to as "Affected Individuals").

II. STATEMENT OF POLICY:

It has been and continues to be the policy of CHH to comply with all applicable Federal, State, and local laws and regulations, and payer requirements. It is also the CHH's policy to facilitate the prevention of improper or illegal activities, to provide mechanisms to detect any violations of laws and regulations and work to prevent, detect, and investigate issues related to fraud, waste, and abuse. To ensure this, CHH has established a Compliance Plan and commits to maintaining an effective Compliance Program.

CHH is, and will remain, committed to our responsibility to conduct our business affairs with integrity based on sound ethical and moral standards. We will hold all Affected Individuals to these same standards.

CHH is committed to maintaining and measuring the effectiveness of our Compliance Program and Standards of Conduct through monitoring and auditing systems reasonably designed to detect noncompliance by Affected Individuals.

CHH is committed to the prevention of improper or illegal activities and to provide mechanisms to detect noncompliance, including but not limited to, any violations of laws and regulations, healthcare program requirements, the Standards of Conduct and CHH's policies and procedures. The CHH is committed to the prompt investigation and resolution of reported or detected noncompliance.

CHH is committed to the performance of regular, periodic compliance audits by internal and/or external auditors who have expertise in Federal and State healthcare statutes, regulations, and healthcare program requirements.

III. POLICY OWNER

Corporate Compliance Officer or designee

IV. SCOPE

This policy applies to all Affected individuals at Cardinal Hayes Home for Children & Cardinal Hayes School for Special Children.

V. POLICIES AND PROCEDURES AND STANDARDS OF CONDUCT

All Affected Individuals shall acknowledge that it is their responsibility to report any instances of suspected or known noncompliance to their immediate supervisor, the Executive Director, or the Compliance Officer without fear of retaliation, retribution, or intimidation.

CHH will communicate its compliance standards and policies through required training and communication initiatives and distribution of the Compliance Plan and the Standards of Conduct to all Affected Individuals.

- **Compliance Officer and Compliance Committee**

    - CHH has appointed a Compliance Officer who is responsible for the overall operation of the Compliance Program. A Compliance Committee works with the Compliance Officer to implement and maintain an effective Compliance Program.

- **Discipline/Enforcement**

    - The Compliance Plan will be consistently enforced through appropriate disciplinary mechanisms including, if appropriate, discipline of Affected Individuals responsible for failure to report known noncompliance or making reports that are not in good faith. Not reporting will be grounds for disciplinary action, up to and including termination of employment, contract, assignment, or appointment. Reports related to harassment or other workplace-oriented issues will be referred to Human Resources.

- **CHH Response**
    - Detected noncompliance, discovered through any mechanism, such as compliance auditing procedures and/or confidential reporting of noncompliance, will be responded to in an expedient manner. CHH is dedicated to the resolution of such matters and will take all reasonable steps to prevent further similar violations, including any necessary modifications to the Compliance Plan and policies and procedures.

- **Due Diligence**

    - CHH will, at all times, exercise due diligence with regard to background and professional license investigations for all Affected Individuals.

- **Non-Retaliation, Non-Intimidation, and Whistleblower Protections**

    - CHH will not take any retaliatory action against an Affected Individual who, in good faith, reports actual or suspected noncompliance or illegal activities or for good faith participation in the Compliance Program.

    - CHH will not take any retaliatory action against an employee if the employee discloses certain information about the CHH'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 CHH is in violation of a law that creates a substantial and specific danger to the public health and safety; or that constitute healthcare fraud under the law; or that assert that the employee, in good faith, believes constitutes improper quality of care.

VI. SANCTION STATEMENT

Non-compliance with this policy may result in disciplinary action, up to and including termination.

VII. COMPLIANCE STATEMENT

As part of its ongoing auditing and monitoring process in its Compliance Program, CHH will review this policy based on changes in the law or regulations, as CHH's practices change, and, at minimum, on an annual basis. Additionally, this policy will be tested for effectiveness on an annual basis or more frequently as identified in accordance with CHH's Compliance Program. Testing will include but is not limited to ensuring that the policy is appropriately followed; the policy is effective; the policy has been disseminated to all affected individuals, as well as notified of any updates or changes.
Tracking of the criteria above and results of this testing will be completed by the Compliance Officer, or designee. Additionally, results will be reported to the Compliance Committee and Governing Body on a regular basis.

VIII. RECORD RETENTION STATEMENT

CHH will retain this policy and all subsequent revisions, and any related documentation will be retained for a period of, at minimum, 10 years.

Issued: 4/2023
Revised 8/14/2025, Approved 8/20/2025

CARDINAL HAYES HOME POLICY AND PROCEDURE	Date Issued 12/14/2020	Date Revised 08/14/2025	Date of Last Review 08/14/2025	Date Approved 08/20/2025	Section Number CC-03
	Subject Corporate Compliance				
	Topic Roles and Responsibilities of the Compliance Committee				

I. PURPOSE:

Cardinal Hayes Home for Children (sometimes referred to as "Cardinal Hayes Home") (CHH) is committed to the operation of an effective Compliance Program. Therefore, CHH established the Compliance Committee to monitor results of the compliance functions and determine the CHH's strategy for promoting compliance.

For purposes of this Policy, the term "Affected Individuals" includes all persons who are affected by the required risk areas including all employees, the Executive Director and other senior administrators, supervisors, contractors, agents, interns, and the Board of Directors (hereafter referred to as "Affected Individuals").

II. STATEMENT OF POLICY:

It is the Policy of CHH to ensure that the organization maintains an effective Compliance Program in compliance with regulatory standards. This Policy defines the roles and responsibilities of the Compliance Committee and their duty to help ensure that CHH has an effective Compliance Program.

III. POLICY OWNER

Corporate Compliance Officer or designee

IV. SCOPE

This policy applies to all Affected individuals at Cardinal Hayes Home for Children & Cardinal Hayes School for Special Children

V. POLICIES AND PROCEDURES AND STANDARDS OF CONDUCT

1. The Compliance Committee is appointed by the President of the Board of Directors and Executive Director to advise and assist the Compliance Officer with the implementation of the Compliance Program. The Compliance Committee will report directly to the Executive Director and Board of Directors.

2. The Compliance Committee will be comprised of Senior Leadership, at minimum.

3. The Compliance Committee will meet on a regular and routine basis, but at minimum quarterly. Meeting minutes will be recorded. The Compliance Officer will maintain the minutes of all meetings.

4. The CHH will develop and implement a Compliance Committee Charter. The Charter will outline the Compliance Committee's duties and responsibilities, membership, designation of a chairperson, and frequency of meetings.

5. The Compliance Committee will review and update the Compliance Committee Charter at least annually.

6. Affected Individuals will be introduced to the role and responsibilities of the Compliance Committee as part of the Compliance Program education and training.

7. The Compliance Committee is responsible for the following:

    - Analyzing the regulatory environment where CHH does business, including legal requirements with which it must comply.

    - Reviewing and assessing existing policies and procedures that address risk areas for possible incorporation into the Compliance Program.

    - Reviewing and monitoring Compliance Program training and education to ensure that they are effective and completed in a timely manner.

    - Ensuring that the CHH has effective systems and processes in place to identify Compliance Program risks, overpayments, and other issues and has effective policies and procedures for correcting and reporting such issues.

    - Working with departments to develop standards and policies and procedures that address specific risk areas and to encourage compliance according to legal and ethical requirements.

    - Coordinating with the Compliance Officer to ensure that the written policies and procedures and Standards of Conduct are current, accurate, and complete.

    - Developing internal systems and controls to carry out compliance standards, Standards of Conduct, and policies and procedures.

    - Coordinating with the Compliance Officer to ensure communication and cooperation by Affected Individuals on compliance-related issues, internal or external audits, or any other function or activity.

    - Developing a process to solicit, evaluate, and respond to complaints and problems.

    - Monitoring internal and external audits to identify issues related to non-compliance.

    - Implementing corrective and preventative action plans and follow-up to determine effectiveness.

    - Ensuring the development and implementation of an annual Compliance Work Plan.

    - Advocating for sufficient funding, staff, and resources to be allocated to the Compliance Officer to carry out duties related to the Compliance Program.

    - Ensuring that the CHH has appropriate systems and policies in place that effectively identify risks, overpayments, and other areas of concerns including fraud, waste, and abuse.

    - Monitoring and evaluating the CHH's Compliance Program for effectiveness at least annually and making recommendations for necessary modifications to the Compliance Program as applicable.

    - Developing and implementing a Compliance Committee Charter. The Charter will outline the Compliance Committee's duties and responsibilities, membership, designation of a chairperson and frequency of meetings. The Charter will be reviewed and updated annually.

VI. SANCTION STATEMENT

Non-compliance with this policy may result in disciplinary action, up to and including termination.

VII. COMPLIANCE STATEMENT

As part of its ongoing auditing and monitoring process in its Compliance Program, CHH will review this policy based on changes in the law or regulations, as CHH's practices change, and, at minimum, on an annual basis. Additionally, this policy will be tested for effectiveness on an annual basis or more frequently as identified in accordance with CHH's Compliance Program. Testing will include but is not limited to ensuring that the policy is appropriately followed; the policy is effective; the policy has been disseminated to all affected individuals, as well as notified of any updates or changes.

Tracking of the criteria above and results of this testing will be completed by the Compliance Officer, or designee. Additionally, results will be reported to the Compliance Committee and Governing Body on a regular basis.

VIII. RECORD RETENTION STATEMENT

CHH will retain this policy and all subsequent revisions, and any related documentation will be retained for a period of, at minimum, 10 years.

12/14/2020 update: HVR; reviewed 4-1-2022,

Revised 3/20/2023, Revised-8/14/2025, Approved 8/20/2025

CARDINAL HAYES HOME POLICY AND PROCEDURE	Date Issued 12/31/2020	Date Revised 08/14/2025	Date of Last Review 08/14/2025	Date Approved 08/20/2025	Section Number CC-04
	Subject Corporate Compliance				
	Topic Compliance Education & Training				

I. PURPOSE:

The development and implementation of regular, effective education and training seminars is an integral part of the Compliance Program. Compliance education is divided into two general components. First, all Affected Individuals must receive an introduction to the Compliance Program. Second, those parties whose work is linked to identified risk areas should receive specialized compliance education pertaining to their function and responsibilities.

For purposes of this Policy, the term "Affected Individuals" includes all persons who are affected by the required risk areas including all employees, the Executive Director and other senior administrators, supervisors, contractors, agents, interns and the Board of Directors (hereafter referred to as "Affected Individuals").

II. STATEMENT OF POLICY:

It is the Policy of Cardinal Hayes Home for Children (sometimes referred to as "Cardinal Hayes Home") (CHH) to ensure that all Affected Individuals receive formal training relating to the Agency's Compliance Program. The Agency will ensure that all trainings are provided in a way that is accessible to all Affected Individuals and that they are in alignment with the required State and Federal laws, rules, and regulations.

It is the Policy of the Agency to ensure that Affected Individuals in identified risk areas, and members of the Board of Directors and Management, receive more detailed education related to their function and responsibilities.

This Policy applies to all Affected Individuals. Successful completion of the training sessions is mandatory and a condition of continued employment, contract, appointment, or assignment with the Agency.

III. POLICY OWNER

Corporate Compliance Officer or designee

IV. SCOPE

This policy applies to all Affected individuals at Cardinal Hayes Home for Children & Cardinal Hayes School for Special Children.

V. PROCEDURES

1. The Compliance Officer is responsible for developing the compliance education curriculum and monitoring and ensuring that compliance training and orientation meet the Policy standards on this subject.

2. Compliance education and training seminars must include an explanation of the structure and operation of the Compliance Program. They will introduce the Compliance Officer and the roles and responsibilities of the Compliance Committee to Affected Individuals.

3. Compliance education and training seminars will include, at a minimum, information on the following aspects of the Compliance Program:

   - CHH's Compliance Plan;
   - Standards of Conduct and other related written guidance;
   - Federal False Claims Act;
   - New York False Claims Act;
   - Whistleblower Protections;
   - Risk areas and organizational experience;
   - The role and responsibilities of the Compliance Officer and the Compliance Committee;
   - Communication channels (name of Compliance Officer, reporting mechanisms, anonymous reporting mechanism);
   - CHH's expectations for reporting known or suspected fraud, waste, and abuse; illegal or unethical acts; actual or suspected violations of Federal or State laws and regulations; actual or suspected violations of the Standards of Conduct, the Compliance Program, and CHH's policies and procedures; improper acts in the delivery or billing of services; and other wrongdoing (collectively referred to as "compliance concerns" for purposes of this Policy);
   - How the Agency responds to reports of compliance concerns, including the investigation process and corrective actions;
   - CHH's disciplinary policy and standards;
   - Prevention of fraud, waste, and abuse; and
   - Non-retaliation and non-intimidation policy.

   Specialized areas for education will include, but not be limited to, the following risk areas:

   - Improper or fraudulent billing for services;
   - Preparation of inaccurate or incorrect cost reports;
   - Misuse of CHH funds;
   - Payment or receipt of remuneration or gifts in return for referrals of service recipients or business contracts;
   - Medicaid requirements specific to CHH's services and programs;
   - Coding and billing requirements and best practices, if applicable;
   - Claim development and the submission process, if applicable;
   - Government and private payor reimbursement principles; and
   - Government initiatives related to the services provided by the Agency, if applicable.

4. Comprehensive education materials will be developed to facilitate the compliance sessions and ensure that a consistent message is delivered to all Affected Individuals. Education protocols and materials must be standardized, so as to evidence that everyone attending a seminar receives the same instruction.

5. As part of their initial orientation, each employee, including the Executive Director and other senior administrators, and Board members shall receive a training session within the first 30 days of employment or association with the Agency. Each party will receive an introduction to CHH's Compliance Program and objectives, and written copies of the Standards of Conduct and Compliance Plan and be provided access to Compliance Program policies and procedures. Each party will sign an acknowledgement form (attached to this Policy), or equivalent, that they are aware of and will abide by the Compliance Plan and Standards of Conduct.

6. All Affected Individuals will receive training and/or education at least once per year that includes a review of the existing Compliance Plan, the Standards of Conduct, and any applicable policies and procedures. The session will also focus on any changes in Federal or State laws and regulations.

7. All education and training relating to the Compliance Program will be verified by attendance and a signed acknowledgement of receipt of training. Training records will include the date, start and end time of the training, and the content of the material presented. The Compliance Officer will maintain records of attendance for all training sessions.

8. Only properly trained individuals will be used to provide compliance education and training seminars. Compliance Program trainers must be knowledgeable of the (a) Compliance Plan; (b) applicable Federal laws and regulations; (d) relevant CHH policies/procedures; (e) operations of the Compliance Program; and (f) content of the Standards of Conduct.

9. The Compliance Officer is responsible for coordinating with Management to ensure that specialized compliance education occurs in identified risk areas.

10. The Compliance Officer will ensure that all contractors and vendors meeting the criteria below are provided with a copy of the Compliance Plan and the False Claims Act and Whistleblower Protections Policy upon entering into a contractual agreement with CHH. For purposes of this Procedure, contractor and vendor are defined as:

    - Any independent contractor, contractor, subcontractor, or other person who, on behalf of the Agency, furnishes or otherwise authorizes the furnishing of Medicare, Medicaid, or other federally-funded healthcare items or services, or performs billing or coding functions; or
    - Any independent contractor, contractor, subcontractor, or other person who provides administrative or consultative services, goods, or services that are significant and material, are directly related to healthcare provision, and/or are included in or are a necessary component of providing items or services reimbursed by Medicare, Medicaid, or other federally funded healthcare program; or
    - Any independent, contractor, subcontractor, or other person who is involved in the monitoring of healthcare provided by the Agency.

11. CHH will ensure that the Compliance Officer has sufficient opportunities to receive training on compliance issues. Compliance training will be secured and made available to new Compliance Officers as part of the orientation to the role.

12. The Compliance Officer is responsible for submitting periodic reports to the Compliance Committee and Board of Directors on all education seminars related to the Compliance Program. This information will be trended and analyzed to evaluate and ensure that the Agency has an effective Compliance Program.

13. All education and/or training related to the Compliance Program will be incorporated into the Agency's training plan. The training plan shall, at a minimum, outline the subjects or topics for training and education, the timing and frequency of the training, which Affected Individuals are required to attend, how attendance will be tracked, and how the effectiveness of the training will be periodically evaluated. The training plan will be reviewed by the Compliance Officer and Compliance Committee and updated as needed, but at minimum on an annual basis.

VI. SANCTION STATEMENT

Non-compliance with this policy may result in disciplinary action, up to and including termination.

VII. COMPLIANCE STATEMENT

As part of its ongoing auditing and monitoring process in its Compliance Program, CHH will review this policy based on changes in the law or regulations, as CHH's practices change, and, at minimum, on an annual basis. Additionally, this policy will be tested for effectiveness on an annual basis or more frequently as identified in

accordance with CHH's Compliance Program. Testing will include but is not limited to ensuring that the policy is appropriately followed; the policy is effective; the policy has been disseminated to all affected individuals, as well as notified of any updates or changes.

Tracking of the criteria above and results of this testing will be completed by the Compliance Officer, or designee. Additionally, results will be reported to the Compliance Committee and Governing Body on a regular basis.

VIII. RECORD RETENTION STATEMENT

CARDINAL HAYES HOME will retain this policy and all subsequent revisions, and any related documentation will be retained for a period of, at minimum, 10 years.

History:
Issued 12/31/2020
Revised 3/31/2023
Reviewed 4/3/2023
Revised 8/14/2025
Approved 8/20/2025

Appendix A
CARDINAL HAYES
Attestation Form – Compliance Training and Education

Date of Training: _____ **Time of Training:** _____

Location: _____ **Instructor**: _____

Contents

- Cardinal Hayes Home's (CHH) Compliance Plan
- Standards of Conduct
- Prevention of Fraud, Waste, and Abuse
- Federal False Claims Act
- NY False Claims Act
- Whistleblower Protections
- Non-retaliation and Non-intimidation Policy
- The Role of the Compliance Officer and the Compliance Committee
- Reporting and Investigation of Compliance Concerns
- Disciplinary Standards
- Communication Channels (including name of Compliance Officer and methods to report)

- ✓ I acknowledge that I have attended Compliance training on this date. I have been provided with the opportunity to ask any questions that I may have.
- ✓ I acknowledge that I have received and read a copy of the Compliance Plan and the Standards of Conduct.
- ✓ I understand that I must comply with the Compliance Program, the Standards of Conduct, all laws, regulations, policies and procedures, and guidance provided.
- ✓ I understand that I must report any instances of known or suspected fraud, waste, and abuse; illegal or unethical acts; actual or suspected violations of Federal or State laws and regulations; actual or suspected violations of the Standards of Conduct, the Compliance Program, and CHH's policies and procedures; improper acts in the delivery or billing of services; and other wrongdoing (collectively referred to as "compliance concerns") to a member of Management or the Compliance Officer.
- ✓ I understand that CHH maintains a hotline (845-245-2417) for confidential or anonymous reporting of compliance concerns.
- ✓ I understand that my failure to comply with the Compliance Program, the Standards of Conduct, laws, regulations, and CHH's policies and procedures or to report possible violations may result in disciplinary action, up to and including termination of employment, contract, assignment or association with the Agency.

Print Name _____ Title _____

Signature _____ Date _____

Appendix B
CARDINAL HAYES
Compliance Training – Attendance

Date of Training: _____

Time of Training: Start: _____ End: _____

Location: _____

Instructor: _____

Contents

- Cardinal Hayes Home's Compliance Plan
- Standards of Conduct
- Prevention of Fraud, Waste, and Abuse
- False Claims Act
- NY False Claims Act
- Whistleblower Protections and Non-retaliation Policy
- The Role of the Compliance Officer and the Compliance Committee
- Reporting and Investigations of Compliance Concerns
- Disciplinary Standards
- Communication Channels (including name of Compliance Officer and methods to report)
- Questions and Answers

Attendance

Note: Each attendee/participant must also sign an acknowledgement of attendance.

Print Name Title Signature

_____
_____
_____
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CARDINAL HAYES HOME POLICY AND PROCEDURE	Date Issued 3/31/2021	Date Revised 08/14/2025	Date of Last Review 08/14/2025	Date Approved 08/20/2025	Section Number CC-05
	Subject Corporate Compliance				
	Topic Conflict of Interest				

I. PURPOSE:

All employees and Board members of Cardinal Hayes Home (CHH) have an obligation to conduct business within guidelines that prohibit actual or potential conflicts of interest. This policy is established to ensure that services and business activities are conducted in an objective manner and are not motivated by a desire for personal or financial gain. The Board of Directors is responsible for the implementation of the Conflict-of-Interest Policy.

For purposes of this Policy, the term "Affected Individuals" includes all persons who are affected by the required risk areas including all employees, the Executive Director and other senior administrators, supervisors, contractors, agents, interns, and the Board of Directors (hereafter referred to as "Affected Individuals").

II. STATEMENT OF POLICY:

It is the Policy of CHH to ensure that decisions about CHH's operations are made to benefit the organization when contemplating a transaction or arrangement that could benefit an officer, director, or employee.

1. Employees, officers, and Board members are required to disclose any actual or potential conflict of interest and seek guidance on how to handle the situation.

- *Conflict of Interest*: Any situation in which financial or other personal considerations may compromise or appear to compromise (1) an employee's or Board member's business judgment; (2) delivery of services; or (3) ability for an employee to do his or her job. An actual or potential conflict of interest occurs when an employee or Board member is in a position to influence a decision that may result in a personal gain for that employee, Board member, or for an immediate family member as a result of business dealings. For the purpose of this Policy, an immediate family member is any person who is related by blood or marriage, or whose relationship with the employee or Board member is similar to that of persons who are related by blood or marriage. An immediate family member of a person includes:

    - The person's spouse;
    - Natural or adoptive parent, child, or sibling;
    - Stepparent, stepchild, stepbrother, or stepsister;
    - Father-in-law, mother-in-law; son-in-law; daughter-in-law; brother-in-law; or sister-in-law;
    - Grandparent or grandchild; and
    - Spouse of a grandparent or grandchild.

Immediate family members will not be allowed to work together at the same program area on a permanent basis. In the case of a workplace crisis, special consideration may be given to staff to work together on a temporary basis. In addition, staff will not be allowed to directly supervise immediate family members or employees whose relationship is similar to that of persons who are related by blood or marriage. Immediate family members will recuse themselves when staff compensation is considered.

2. Business dealings with outside entities should not result in unusual gain for those entities, CHH, a Board member, or an employee. Unusual gain refers to gifts, bribes, product bonuses, special fringe benefits, unusual price breaks, and other windfalls designed to ultimately benefit the employer, the employee, or both or that would reasonably be determined to influence the employer, employee, or both.

3. The materials, products, designs, plans, ideas, and data are the property of the agency and should never be given to an outside firm or individual without appropriate prior authorization from the Executive Director. Any improper transfer of material or disclosure of information, even though it is not apparent that an employee has personally gained by such action, is prohibited.

4. CHH will not enter into a related party transaction unless the Board affirmatively determines that the transaction is fair, reasonable, and in the best interest of the agency. A related party transaction means any transaction, agreement, or arrangement in which a related party has a financial interest. A related party is defined as: (i) any director, officer, or key employee (e.g., members of senior leadership) of CHH or its related entities; (ii) any relative of any director, officer, or key employee of CHH or its related entities; or (iii) an entity in which any individual described in (i) or (ii) has a 35% or greater ownership or beneficial interest, or in the case of a partnership or professional corporation, a direct ownership interest in excess of 5%.

III. POLICY OWNER

Corporate Compliance Officer or designee

IV. SCOPE

This policy applies to all Affected individuals at Cardinal Hayes Home for Children & Cardinal Hayes School for Special Children.

V. PROCEDURES

1. Each employee will be provided with CHH's Conflict of Interest Policy as part of the new hire orientation process. Each employee shall sign a statement that affirms that the employee:
   - Has received a copy of the Conflict of Interest Policy,
   - Has read and understands the Policy, and
   - Has agreed to comply with the Policy.

2. Each Board member, officer, key employee, and member of a committee with Governing Board-delegated powers will be provided with CHH's Conflict of Interest Policy and shall sign a statement at the time of hire, assignment, and/or Board approval that affirms that such person:
   - Has received a copy of the Conflict of Interest Policy,
   - Has read and understands the Policy, and
   - Has agreed to comply with the Policy.

3. Employees must disclose any potential conflicts of interest upon hire and when a potential conflict arises. The Employee completes the Conflict of Interest Disclosure Statement form (attached to this Policy) to record an actual or potential conflict of interest upon hire and when a potential conflict arises. Completed forms are to be forwarded to and retained by the Compliance Officer.

4. Key employees (members of senior leadership), the Executive Director, officers, and Board members must complete a Conflict of Interest Disclosure Statement upon hire or prior to being seated (voted on for approval) and annually thereafter in order to report any actual or potential conflict of interest. Such annual statement shall not exempt any key employee, officer, or Board member from disclosing a potential conflict of interest pursuant to Procedure #11 below. The Compliance Officer

shall provide copies of all completed Conflict of Interest Disclosure Statements by key employees, the Executive Director, officers, and Board members to the President of the Board.

5. An employee or Board member with questions or concerns about a potential conflict of interest will promptly address the issue with appropriate Management staff and/or the Compliance Officer. Management staff will consult with the Compliance Officer before responding to a concern or question about a potential conflict of interest.

6. Board Members, Officers, the Executive Director, and Management personnel are expected to avoid actions that could be perceived or interpreted as being in conflict with the best interest of the agency .
7. Actual or potential conflicts of interest must be disclosed to appropriate management personnel and the Compliance Officer. Employees who may be involved in any CHH's business transaction in which there is an actual or potential conflict of interest will promptly notify their immediate supervisor and Compliance Officer; the Compliance Officer will promptly notify the Executive Director and the President of the Board.

8. The completed Conflict of Interest Disclosure Statements are reviewed by the Compliance Officer and Executive Director and, if necessary, appropriate actions and adjustments are made to avoid possible conflicts of interest. The Compliance Officer will report significant concerns regarding the Conflict of Interest Disclosure Statements to the Compliance Committee and the President of the Board.

9. The Compliance Officer will maintain a written record of any report of potential conflict of interest and of any adjustments made to avoid potential conflicts of interest.

10. The President of the Board, after receiving information about a potential conflict of interest, will take such action as is necessary to ensure that the transaction is completed in the best interest of CHH without the substantive involvement or influence of the person with the potential conflict of interest.

11. Key employees, officers, and Board members who have a direct or indirect interest in a related party transaction must disclose, in good faith, such interest to the Board or Committee considering the transaction and the material facts concerning such interest.

12. Key employees, officers, and Board members who have a direct or indirect interest in a related party transaction may not be present or otherwise participate in any Board or Committee deliberations or voting concerning the transaction; however, such individuals may present information concerning a related party transaction prior to the commencement of deliberations or voting.

13. Prior to entering into a related party transaction, the Board or Committee must consider alternatives, to the extent available, that would not be a related party transaction.

14. The Board or Committee must approve the related party transaction by not less than a majority vote of those present at the meeting.

15. The Board or Committee must contemporaneously document, in writing, the basis for its approval of the related party transaction, including its consideration of alternatives to the related party transaction.

16. Board members with conflicts will excuse themselves from the discussion/deliberation and vote on the item/circumstance that the Board member has identified as a conflict. The meeting minutes shall indicate when the member left the room, that the discussion and vote, if any, occurred, and then that the member was invited to return to the meeting. If any member with a conflict does not excuse themselves from the meeting, the President of the Board shall ask the member to leave the room. The existence and resolution of the conflict, if any, must be documented.

17. Board members are strictly prohibited from any attempt to influence the discussion, deliberations, or vote on any subject that relates to the member's conflict.

18. Employees must seek guidance and approval from appropriate Management personnel prior to pursuing any business or personal activity that may constitute a conflict of interest.

19. Outside employment may not interfere with the employee's ability to perform their job with CHH. In addition, CHH employees may not have any ownership interest in a competitor.

20. The Compliance Officer shall document the existence and resolution of any conflict in the agency's records, including putting in the minutes of any meeting at which a conflict was discussed and voted upon.

21. The Compliance Officer will investigate any violations of this Policy.

VI. Sanction Statement:

Non-compliance with this policy may result in disciplinary action, up to and including termination.

VII. Compliance Statement:

As part of its ongoing auditing and monitoring process in its Compliance Program, CHH will review this policy based on changes in the law or regulations, as CHH's practices change, and, at minimum, on an annual basis. Additionally, this policy will be tested for effectiveness on an annual basis or more frequently as identified in accordance with CHH's Compliance Program. Testing will include but is not limited to ensuring that the policy is appropriately followed; the policy is effective; the policy has been disseminated to all affected individuals, as well as notified of any updates or changes.

Tracking of the criteria above and results of this testing will be completed by the Compliance Officer, or designee. Additionally, results will be reported to the Compliance Committee and Governing Body on a regular basis.

VIII. Record Retention Statement:

CHH will retain this policy and all subsequent revisions, and any related documentation will be retained for a period of, at minimum, 10 years.

History
3.2021- updated
4.2022- reviewed
3.31.2023- revised, Approved 4.24.2023,
8.2025-revised and approved.

Appendix-A

CARDINAL HAYES HOME
Conflict of Interest Disclosure Statement

The Conflict-of-Interest Policy includes a provision that sets forth standards of conduct expected and requiring Board members, Management, and employees to disclose all interests that could result in an actual or potential conflict of interest.

In accordance with **Cardinal Hayes Home's** (CHH) Conflict of Interest Policy, a conflict of interest is defined as any situation in which financial or other personal considerations may compromise or appear to compromise (1) an employee's or Board member's business judgment; (2) delivery of services; or (3) ability for an employee to do their job. An actual or potential conflict of interest occurs when an employee or Board member is in a position to influence a decision that may result in a personal gain for that employee, Board member, or for an immediate family member as a result of business dealings.

Please complete and return this Conflict of Interest Disclosure Statement. Please be assured that the disclosure requirements are intended to provide the Board and Management with a systematic and ongoing method of disclosing and ethically resolving potential conflicts of interest. Although it is impossible to list every circumstance giving rise to a possible conflict of interest, the following will serve as a guide to the types of activities that might cause conflicts and that should be fully reported:

A. Outside Interests

a. To hold, directly or indirectly, a position or a financial interest in any outside concern from which the individual has reason to believe the agency secures goods or services (including the services of buying or selling stocks, bonds, or other securities), or that provides services that compete with the agency.

b. To compete, directly or indirectly, with the agency in the purchase or sale of property or property rights, interests, or services.

B. Outside Activities

To render directive, managerial, or consultative services to any outside concern that does business with the agency, or competes with the services of the agency, or to render other services in competition with the agency.

C. Inside Information

To disclose or use information relating to the agency's business for the personal profit or advantage of the individual or their immediate family.

D. Gifts, Gratuities, and Entertainment

To accept gifts, excessive entertainment, or other favors from any outside concern that does, or is seeking to do, business with, or is a competitor of, the CHH – under circumstances from which it might be inferred that such action was intended to influence or possibly would influence the individual in the performance of their duties.

- ✓ I have been provided with a copy of CHH's Conflict of Interest Policy.

- ✓ I hereby state that I, or members of my immediate family, have the following affiliations or interest and have taken part in the following transactions that, when considered in conjunction with the position with or relation to the agency, might possibly constitute a conflict of interest. (Check "None" where applicable)

1. Outside Interests

Identify any interests, other than investments, of yourself or your immediate family, as described in paragraph A (Outside Interests) above.

( ) None

2. Investments

   List and describe, with respect to yourself or your immediate family, all investments that might be within the category of "financial interest", as described in paragraph A (Outside Interests) above.

   ( ) None

3. Outside Activities

   Identify any outside activities, of yourself or your immediate family, as described in paragraph B (Outside Activities) above.

   ( ) None

4. Other

   List any other activities in which you or your immediate family are engaged that may be regarded as constituting a conflict of interest, giving particular attention to paragraphs B (Outside Activities) and C (Inside Information) above.

   ( ) None

5. I hereby certify that neither I nor any member of my immediate family have accepted gifts, gratuities, or entertainment that might influence my judgment or actions concerning the business of the agency, except as listed below:

   ( ) None

6. The following circumstances may possibly violate the Standards of Conduct:

   ( ) None

7. List any family members employed by **CHH** or serving as a member of **CHH**'s Board of Directors.

NAME	**RELATIONSHIP**

By signing below, I affirm that:

1. I have received and read a copy of **CHH's** Conflict of Interest Policy.

2. I agree to comply with the Policy.
3. I have no actual or potential conflicts as defined by the Policy or if I do, I have previously disclosed them as required by the Policy or am disclosing them on this form.
4. I hereby agree to report to Management or the Compliance Officer any future situation that may result in a conflict of interest.

Name (Printed or typed)	Title
Signature	Date

Reviewed by:

Name (Printed or typed)	Title
Signature	Date

CARDINAL HAYES HOME POLICY AND PROCEDURE	Date Issued 3/31/2021	Date Revised 08/14/2025	Date of Last Review 08/14/2025	Date Approved 08/20/2025	Section Number CC-07
	Subject Corporate Compliance				
	Topic Reporting and Investigation of Compliance Concerns				

I. PURPOSE:

Cardinal Hayes Home for Children (sometimes referred to as "Cardinal Hayes Home") (CHH) recognizes that a critical aspect of its Compliance Program is the establishment of a culture that promotes prevention, detection, and resolution of instances of conduct that do not conform to Federal and State requirements, the agency's ethical and business policies, and fraud, waste, and abuse prevention.

To promote this culture, CHH has established processes to encourage effective communication and the reporting of compliance questions, issues, concerns, or events that will result in a thorough investigation and appropriate remedial actions.

For purposes of this Policy, the term "Affected Individuals" includes all persons who are affected by the required risk areas including all employees, the Executive Director and other senior administrators, supervisors, contractors, agents, interns and the Board of Directors (hereafter referred to as "Affected Individuals").

II. STATEMENT OF POLICY:

It is the Policy of CHH to maintain a formal confidential and anonymous compliance reporting process to encourage the reporting of any known or suspected fraud, waste, and abuse; illegal or unethical acts; actual or suspected violations of Federal or State laws and regulations; actual or suspected violations of the Standards of Conduct, the Compliance Program, and CHH's policies and procedures; improper acts in the delivery or billing of services; and other wrongdoing (collectively referred to as "compliance concerns" for purposes of this Policy).

It is the Policy of CHH to fully and promptly investigate all reports of any compliance concerns and take appropriate remedial and/or disciplinary action upon completion of the investigation.

III. POLICY OWNER

Corporate Compliance Officer or designee

IV. SCOPE

This policy applies to all Affected individuals at Cardinal Hayes Home for Children & Cardinal Hayes School for Special Children.

V. PROCEDURES

<u>Reporting Process:</u>

1. All Affected Individuals have an affirmative duty and responsibility to promptly report any compliance concerns.

2. An "open-door policy" will be maintained at all levels of Management to encourage the reporting of problems and compliance concerns through normal business channels and appropriate levels of the agency for timely and effective resolution. The agency recognizes there may be situations where such reporting is impractical or inappropriate. In those instances, direct access to various levels of Management may be more appropriate.

3. CHH encourages all Affected Individuals, service recipients, vendors, and any party conducting business with it to promptly communicate questions, issues, or compliance concerns through any one of the following means:

    - Direct written or oral communication by fax, mail, email, telephone, or personal contact to the immediate supervisor, a member of Management, the Executive Director, a member of the Compliance Committee, or the Compliance Officer.
    - Confidentially or anonymously to the Compliance Officer through the Compliance Hotline. If the reporter elects to make the report anonymously to the Compliance Officer, no attempt will be made to trace the source of the report or identify the person making the report.

4. If the compliance concern is about the Compliance Officer, the Executive Director is to be notified.

5. If the Compliance Officer receives a concern related to the Executive Director, the Compliance Officer shall report such information to the President of the Board of Directors.

6. If a Board member has knowledge of a compliance concern as defined by this Policy, the Compliance Officer and the Executive Director are to be notified. If there is a concern about the Executive Director, the Compliance Officer and the President of the Board of Directors are to be notified.

7. Employees have the same obligations for reporting suspected compliance concerns committed by the agency's vendors or contractors.

8. Affected Individuals cannot exempt themselves from the consequences of their own misconduct by reporting the issue, although self-reporting may be considered in determining the appropriate course of action.

9. Strict confidentiality regarding the reporting of compliance concerns will be maintained unless the matter is subject to a disciplinary proceeding, referred to or under investigation by Federal, State, or local law enforcement, or should the disclosure be required during a legal proceeding. Those staff assigned to complete any investigation of a compliance concern shall treat the investigation as entirely confidential and shall reveal no details or discuss the content or status of the investigation with CHH staff or any other party except as may be directed by the Compliance Officer or legal counsel. Failure of staff to respect the confidentiality of any investigation of a compliance concern may be grounds for disciplinary action up to and including termination of employment.

10. The Compliance Officer will ensure that all reports of compliance concerns as defined by this Policy are recorded on the Compliance Concern Report Form (attached to this Policy) and tracked on the Compliance Concern and Investigation Log (attached to this Policy).

11. Any member of Management who receives a report of a compliance concern will immediately notify the Compliance Officer and complete a Compliance Concern Report Form. The completed Form will be promptly forwarded to the Compliance Officer.
12. Knowledge of a violation or potential violation of this Policy must be reported directly to the Compliance Officer or the Compliance Hotline.

13. Affected Individuals who report issues or concerns that are unrelated to the Compliance Program shall be redirected to the appropriate department or party. In instances where the Affected Individual seeks confidentiality or reports anonymously, the Compliance Officer shall redirect the report to the appropriate department or party while maintaining the request for confidentiality/anonymity.

14. CHH strictly prohibits its Management, employees, and Board members from engaging in any act, conduct, or behavior that results in, or is intended to result in, retribution, retaliation or intimidation (hereafter, collectively referred to as "retaliation") against any party for reporting compliance concerns as defined by this Policy.

15. If an Affected Individual believes in good faith that they have been retaliated against for reporting a compliance concern or for participating in any investigation of such a report, the retaliation should be immediately reported to the Compliance Officer or the Compliance Hotline. The report should include a thorough account of the incident(s) and should include the names, dates, specific events, the names of any witnesses, and the location or name of any document that supports the alleged retaliation.

16. The Compliance Officer will ensure that the means for reporting actual or suspected compliance concerns to the Compliance Officer are communicated to all Affected Individuals and service recipients. The Compliance Officer's contact information and Compliance Hotline number will be published on the agency's website and visibly posted in a manner consistent with employee notification in locations frequented by CHH employees.

17. The Compliance Officer's contact information and the Compliance Hotline number shall be provided to all Medicaid recipients of service.

Investigation and Resolution:

1. It is the responsibility of the Compliance Officer to conduct or oversee the conduction of all internal investigations involving compliance concerns and shall have the authority to engage legal counsel or other consultants, as needed. The Compliance Officer, in conjunction with the Executive Director and legal counsel, will consider whether the investigation should be conducted under attorney privilege.

2. Before conducting an investigation of any compliance concern as defined by this Policy, the Compliance Officer shall ensure a full understanding of the relevant laws, regulations, and government issuances. If a reported violation is related to improper billing, the Compliance Officer will consider the need for an audit of billing practices and determine the scope of interviews.

3. If deemed appropriate, the Compliance Officer will recommend the cessation of internal activities that may be the cause of, or contribute to, the alleged non-compliance.

4. The Compliance Officer will determine the scope of the reported compliance concern and make a determination regarding the course of action, including the investigation process and notifications to be made.

5. Upon report notice or discovery of an alleged compliance concern, the Compliance Officer will conduct an initial inquiry into the alleged situation. The purpose of the initial inquiry is to determine whether there is sufficient evidence of possible non-compliance to warrant further investigation. The initial inquiry

may include documentation review, interviews, audit, or other investigative techniques. The Compliance Officer should: (a) conduct a fair impartial review of all relevant facts; (b) restrict the inquiry to those necessary to resolve the issues; and (c) conduct the inquiry with as little visibility as possible while gathering pertinent facts relating to the issue.

6. If, during the initial inquiry, the Compliance Officer determines that there is sufficient evidence of possible noncompliance with any criminal, civil, or administrative law to warrant further investigation, the issue should be turned over to legal counsel. A memorandum to this effect should be directed to legal counsel with a copy to the Executive Director. The Compliance Officer or Executive Director will immediately make arrangements to retain legal counsel and no further internal discussion or investigative activity shall take place regarding the report except as directed by legal counsel. Once legal counsel is retained, it will be determined whether legal counsel or the Compliance Officer will be leading the investigation.

7. All documents produced during the investigation by or under legal counsel to be possibly protected from disclosure should include the notation: "Privileged and Confidential Document; Subject to Attorney-Client Privileges; Attorney Directed Work Product."

8. For investigations that do not involve legal counsel, the Compliance Officer will determine which personnel possess the requisite skills to examine the particular issue(s) and will assemble a team of investigators, as needed. The Compliance Officer shall work with the investigation team to develop a strategy for reviewing and examining the facts surrounding the possible violation. The Compliance Officer will also decide whether the agency has sufficient internal resources to conduct the investigation or whether external resources are necessary. If it is determined that additional resources are needed, the Compliance Officer will work with the Executive Director to secure such resources.

9. The Compliance Officer will be responsible for the investigation of and follow-up on any reported retaliation against a party for reporting a compliance concern or participating in the investigation of a compliance concern. The Compliance Officer will report the results of an investigation into suspected retaliation to the Executive Director, the Compliance Committee, and the Board of Directors.

10. If at any time, during an investigation, it is determined that the situation warrants the retention of legal counsel, the Compliance Officer will immediately suspend the investigation and follow the process in Procedure #6 (Investigations and Resolution) above.

11. The Compliance Officer, in consultation with the Compliance Committee and, where appropriate, the Board, may undertake measures during an investigation of a compliance concern to protect the integrity of the investigation, prevent the destruction of documents or other evidence relevant to the investigation, and respect the due process rights of involved parties. Measures may include, but are not limited to, reassignment or placement on administrative leave until the investigation is complete.

12. The Compliance Officer will track the investigation, responsible parties, and due dates. The resolution of the investigation will be recorded on the Compliance Concern and Investigation Log (attached to this Policy).

13. The Compliance Officer should ensure that the following objectives are accomplished for each investigation:
    - The complainant or reporter, if known, is fully debriefed;
    - Appropriate internal parties are notified;

- The cause of problem, desired outcome, affected parties, applicable guidelines, and possible regulatory or financial impact are identified;
- A complete list of findings and recommendations are provided;
- The necessary corrective action measures (e.g., policy changes, operational changes, system changes, personnel changes, discipline, training/education) are identified; and
- The investigation is documented.

14. Upon receipt of the results of the investigation, depending upon the scope and severity of the identified violations, the Compliance Officer may consult with legal counsel, the Executive Director, and/or the Compliance Committee to determine: (a) the results of the investigation and the adequacy of recommendations for corrective actions; (b) the completeness, objectivity, and adequacy of recommendations for corrective actions; and/or (c) further actions to be taken as necessary and appropriate.

15. Upon conclusion of the investigation, the Compliance Officer will organize the information in a manner that enables the agency to determine if an infraction did, in fact, occur. The Compliance Officer will maintain all notes of the interviews, all evidence and documents as part of the investigation file. The investigation file will be securely maintained by the Compliance Officer.

16. If the Compliance Officer, in consultation with legal counsel, identifies credible evidence or credibly believes that a State or Federal law, rule, or regulation has been violated, the Compliance Officer will promptly report such violation to the appropriate governmental entity, where such reporting is otherwise required by law, rule or regulation. The Compliance Officer will receive and maintain copies of any reports submitted to governmental entities.

17. The Compliance Officer, in consultation with legal counsel, the Executive Director, and the Compliance Committee, will evaluate any confirmed violation to determine if a voluntary self-disclosure of the violation is appropriate. In the event that voluntary disclosure is appropriate or required, the Compliance Officer will consult with legal counsel on the notification of appropriate government officials, private payors, or other entities. Notification shall be made within a reasonable time period from date of discovery and may include restitution of monies paid by the applicable Federal or State agency, payer, or other entity. The Compliance Officer will ensure that all overpayments are reported and refunded to the appropriate payer within 60 days of the identification of the overpayment and in accordance with the Billing Errors, Overpayments, and Self-Disclosure Policy and Procedure.

18. The Compliance Officer will be responsible for reporting the results of all investigations to the Executive Director, Compliance Committee, and the Board.

19. The Compliance Officer or appropriate member of Management will inform the reporter, if known, of the conclusion of the investigation and the outcome, if appropriate.

VI. Sanction Statement:

Non-compliance with this policy may result in disciplinary action, up to and including termination.

VII. Compliance Statement:

As part of its ongoing auditing and monitoring process in its Compliance Program, CHH will review this policy based on changes in the law or regulations, as CHH's practices change, and, at minimum, on an annual basis.

Additionally, this policy will be tested for effectiveness on an annual basis or more frequently as identified in accordance with CHH's Compliance Program. Testing will include but is not limited to ensuring that the policy is appropriately followed; the policy is effective; the policy has been disseminated to all affected individuals, as well as notified of any updates or changes.

Tracking of the criteria above and results of this testing will be completed by the Compliance Officer, or designee. Additionally, results will be reported to the Compliance Committee and Governing Body on a regular basis.

VIII. Record Retention Statement:

CHH will retain this policy and all subsequent revisions, and any related documentation will be retained for a period of, at minimum, 10 years.

History
3.2021- updated
4.2022- reviewed
4.13.2023- revised
8.14.2025- revised, Approved: 8.20.2025

Appendix-A
CARDINAL HAYES HOME
Compliance Concern Report Form

Today's date (date report filed): /_____/_____
Your name*:* _____ Title/Position:_____
Department/Program _____

Mode of Contact:

☐ Report to Supervisor ☐ Hotline ☐ Email
☐ Compliance Officer (Direct contact) ☐ Walk-In ☐ Organization phoneline

☐ Letter or Note ☐ Staff Meeting ☐ Other _____
☐Letter to Board or Executive Director ☐ Compliance Training

Source of Report:
☐ Employee, Independent Contractor ☐ Vendor/Subcontractor ☐ Board Member
☐ Service Recipient/Family Member ☐ Other Provider ☐ Other _____

Contact Confidentiality Status:
☐ Anonymous ☐ Confidential (Identified self) ☐ Name _____
Phone _____

Type of Report:
☐ Suspected Violation/Misconduct ☐ Regulatory Inquiry ☐ Organization P&P Inquiry ☐ Ethical Business Practice

Is this a question about the Compliance Program? Yes_____ No_____ If yes, indicate question here:

_____
_____
_____

Is this a suspected violation of the Compliance Program? Yes_____ No_____
If yes, answer the questions below: (***Attach additional sheets if necessary.)***
Please describe in as much detail as possible, the violation: (*Please be specific where the violation may have occurred)*_____
_____
_____
_____
_____

When did this occur?___/_____/_____ Were you directly involved?____
If yes, describe what you did:_____
_____

Who else was directly involved? (*Names and positions, if known):*
1. _____
2. _____
3. _____

Is there any documentation or other evidence of the alleged violation? *Please describe/list or attach:*
_____

Has the reporter discussed this issue with anyone else within the agency? *Please list by name and position:*
1. _____
2. _____
3. _____

Has the reporter discussed this with others outside the agency? *Please identify by name and relationship:*
_____

Completed by: _____ Title:_____
Signature: _____ Date:_____

Forward completed form to Compliance Officer

_____

For Use by Compliance Officer:
Follow Up:
Reported to Compliance Officer: _____ By: _____ Date: _____ Time: _____
Reported to Executive Director: _____ Date: _____
Reported to Compliance Committee: _____ Date: _____

Reported to Board: _____ Date: _____

Actions Taken:

☐ Immediate Response Provided
☐ Researched regulations
☐ Researched CHH P&P
☐ Responded to reporter; date _____
☐ Internal investigation initiated; assigned to: _____
☐ External investigation; Entity _____ Date _____
☐ Referred to legal counsel _____ Date: _____

Summary of Action Taken:

_____
_____
_____
_____

Final Disposition by Compliance Officer: _____
_____
_____
_____

Classification: _____

Compliance Report and Investigation Log Number: _____

Completed by:

_____ _____ _____

Compliance Officer Name Signature Date

Appendix-B
CARDINAL HAYES HOME
Compliance Concern and Investigation Log

Number	Date Received	Source	Type	Program/ Department	Summary	Date Investigation Completed	Disposition/Outcome	Date of Committee Review

Type of Report:
Question
Documentation Issue
Billing Issue
Violation of Standards of Conduct
Missing Funds/Misuse of Funds
Confidentiality/HIPAA
Human Resource Issue
Alleged Retaliation
Violation of Policy & Procedure
Other

Source:
Employee, Contractor (Direct to Compliance Officer)
Supervisor
Contractor, Vendor
Hotline
Other Provider
Service Recipient/Family
Anonymous letter
Other

CARDINAL HAYES HOME POLICY AND PROCEDURE	Date Issued 04/2021	Date Revised 08/14/2025	Date of Last Review 08/14/2025	Date Approved 08/20/2025	Section Number CC-13
	Subject Corporate Compliance				
	Topic Antikickback – Business Courtesies, Gifts, and Entertainment				

I. PURPOSE:

Cardinal Hayes Home for Children (sometimes referred to as "Cardinal Hayes Home") (CHH) recognizes that there are legitimate and lawful reasons to accept or provide reasonable business courtesies. However, in healthcare, business courtesies pose a risk for conflict of interest or fraud and/or abuse related to anti-kickback laws and regulations. The Federal Anti-Kickback law prohibits the offer of payment, solicitation, or receipt of anything of value to induce or reward the referral of Federal health care program recipients, such as Medicare and Medicaid recipients. The Federal Anti-Kickback statute also prohibits the payment or receipt of any remuneration that is intended to induce the purchasing, leasing, or ordering of any item or service that may be reimbursed, in whole or in part, under a federal health care program. It also prohibits the payment or receipt of any remuneration that is intended to induce the recommendation of the purchasing, leasing, or ordering of any such item or service.

The purpose of this policy is to assure that the agency complies with Federal Anti-Kickback laws. The policy provides guidance for providing business courtesies.

For the purpose of this policy, the following definitions apply:

- Affected Individuals: all persons who are affected by the required risk areas including all employees, the Executive Director and other senior administrators, supervisors, contractors, agents, interns and the Board of Directors (hereafter referred to as "Affected Individuals")
- Business Courtesies: A business courtesy is anything of value, a favor, or a benefit provided free of charge or at a charge less than fair market value in the context of a business relationship. The Policy applies to gifts, entertainment, and hospitality involving the agency's employees or Board members and its referral sources and business partners intended to enhance business relationships and/or further their mutual business interests. Examples include gifts, entertainment, or hospitality for the purposes of inducing:
    - Referrals for the agency's services or treatment;
    - The purchasing, leasing, or ordering of any item or service; or
    - The recommendation of the purchasing, leasing, or ordering of any such item or service.
- Immediate Family Member: For the purpose of this policy, an immediate family member is any person who is related by blood or marriage, or whose relationship with the employee or Board member is similar to that of persons who are related by blood or marriage. An immediate family member of a person includes:
    - The person's spouse;
    - Natural or adoptive parent, child, or sibling;
    - Stepparent, stepchild, stepbrother, or stepsister;
    - Father-in-law, mother-in-law; son-in-law; daughter-in-law; brother-in-law; or sister-in-law;
    - Grandparent or grandchild; and

- Spouse of a grandparent or grandchild.

- Nominal Value: CHH has determined that items with a value of $ 322.00 or less to be of nominal value
- Potential Referral Source: A potential referral source includes a physician, other healthcare provider, or party who could reasonably be a source of referral of individuals or patients to the agency for services or treatment.
- Remuneration: Any type of direct or indirect payment, bribe, rebate, or other type of inducement.

II. STATEMENT OF POLICY:

1. Any business courtesy intended to induce or reward referrals or result in the purchase of goods or services is strictly prohibited.

2. It is the policy of CHH that gifts, entertainment, and other benefits will not be provided to a potential referral source, except as permitted by this policy.

3. Any business courtesies involving physicians or other individuals or entities in a position to refer individuals or patients to CHH for services must strictly follow CHH's policies and be in conformance with all Federal and State laws, regulations, and rules regarding these practices.

III. POLICY OWNER

Corporate Compliance Officer or designee

IV. SCOPE

This policy applies to all Affected individuals at Cardinal Hayes Home for Children & Cardinal Hayes School for Special Children.

V. POLICIES AND PROCEDURES AND STANDARDS OF CONDUCT

1. CHH's employees and Board members may not offer a potential referral source business courtesy unless the following criteria are met:

   - The business courtesy is not based, directly or indirectly, on the volume or value of referrals or other business generated by the potential referral source;
   - The business courtesy is not solicited by the potential referral source or the referral source's employees;
   - The business courtesy does not consist of cash or the equivalent of cash; and
   - The business courtesy does not violate the Federal Anti-Kickback statute or any state or Federal law governing claims submission.

2. All employees and Board members must receive prior approval from the Compliance Officer before extending business courtesies to potential referral sources and business partners. The Compliance Officer will record any business courtesy extended to potential referral sources and business partners on the Gifts and Entertainment Recording Log attached to this Policy. The Compliance Officer will ensure that business courtesies are of nominal value.

3. Employees, Board members, and their Immediate Family Members are prohibited from receiving and/or accepting business courtesies from CHH's business partners or potential business partners as an inducement to purchase or lease goods or services.

4. Employees, Board members, and their Immediate Family Members shall not accept or solicit excessive gifts, meals, expensive entertainment, or other offers of goods or services that have more than a nominal value from vendors, suppliers, contractors, or other persons.

5. Employees and Board members may only retain gifts from vendors that have a nominal value. Gifts from vendors must be reported to the Compliance Officer and recorded on the Gifts and Entertainment Recording Log. If an employee or Board member has any concern as to whether a gift should be accepted, the Compliance Officer should be consulted. To the extent possible, these gifts should be shared with other individuals/employees at the agency.

VI. SANCTION STATEMENT

Non-compliance with this policy may result in disciplinary action, up to and including termination.

VII. COMPLIANCE STATEMENT

As part of its ongoing auditing and monitoring process in its Compliance Program, CHH will review this policy based on changes in the law or regulations, as CHH's practices change, and, at minimum, on an annual basis. Additionally, this policy will be tested for effectiveness on an annual basis or more frequently as identified in accordance with CHH's Compliance Program. Testing will include but is not limited to ensuring that the policy is appropriately followed; the policy is effective; the policy has been disseminated to all affected individuals, as well as notified of any updates or changes.

Tracking of the criteria above and results of this testing will be completed by the Compliance Officer, or designee. Additionally, results will be reported to the Compliance Committee and Governing Body on a regular basis.

VIII. RECORD RETENTION STATEMENT

CARDINAL HAYES HOME will retain this policy and all subsequent revisions, and any related documentation will be retained for a period of, at minimum, 10 years.

History
Implemented 4.2021
Reviewed 4.1.2022
Revised: 3.31.2023
Reviewed: 4.3.2023, Effective: 4.24.2023
Revised: 8.14.2025, Approved: 8.20.2025

Appendix A –
CARDINAL HAYES HOME
Gifts and Entertainment Recording Log

For the period 1/1/20__ to 12/31/20__

Potential Referral Source, Business Partner or Vendor	Authorized By	Date of Gift/ Entertainment	Type of Gift/ Entertainment	Gift/Entertainment Amount	Reason for Gift/ Entertainment

CARDINAL HAYES HOME & CARDINAL HAYES DAY SCHOOL POLICY AND PROCEDURE	Date Issued 04/2021	Date Revised 08/14/2025	Date of Last Review 08/14/2025	Date Approved 08/20/2025	Section Number CC-14
	Subject Corporate Compliance				
	Topic Auditing and Monitoring				

I. PURPOSE:

Cardinal Hayes Home for Children (sometimes referred to "Cardinal Hayes Home") (CHH) developed and implemented a Compliance Program in an effort to establish, in part, effective internal controls that promote adherence to applicable Federal and State laws and requirements. An important component of the Compliance Program is the use of audits and/or other evaluation techniques to monitor compliance and assist in the reduction of identified risk areas.

CHH recognizes the need for internal controls, but also realizes that resources are limited. Therefore, this policy focuses on the agency's resources to effectively and efficiently audit and monitor risk areas.

For purposes of this Policy, the term "Affected Individuals" includes all persons who are affected by the required risk areas including all employees, the Executive Director and other senior administrators, supervisors, contractors, agents, and the Board of Directors (hereafter referred to as "Affected Individuals").

II. STATEMENT OF POLICY:

It is the Policy of CHH to conduct ongoing auditing and monitoring of identified risk areas related to compliance including but not limited to billing, fiscal management, clinical operations, and service provision. It is the responsibility of the entire Management Team to ensure that ongoing auditing and monitoring is properly executed, documented, and evidenced.

It is the Policy of CHH to analyze and trend the results of all audits (both internal and external) on a regular basis to ensure that the agency's Compliance Program is effective.

III. POLICY OWNER

Chief Quality & Corporate Compliance Officer or designee.

IV. SCOPE

This policy applies to all Affected individuals at Cardinal Hayes Home for Children & Cardinal Hayes School for Special Children.

V. POLICIES AND PROCEDURES AND STANDARDS OF CONDUCT

1. On an annual basis, the Compliance Officer, in conjunction with the Executive Director, Senior Management, and Compliance Committee, will determine the scope and format of routine audits of **CHH**'s operations based on an organizational risk assessment. The Compliance Officer will include all scheduled audits on a work plan or audit plan that is shared with the Compliance Committee and the Board of Directors.

2. Each **CHH** program or department will conduct a review of its compliance with applicable regulations and quality measures on a[n] ***[quarterly/semiannual/annual]*** basis. Senior Management staff shall be responsible for identifying needs for internal auditing of specific issues under their oversight. This should occur at least annually as a part of the agency's risk assessment and for consideration into the annual work plan and audit plan.

3. The Compliance Officer will recommend and facilitate auditing and monitoring of the identified risk areas related to compliance with laws and regulations, as well as the agency's policies, procedures, and Standards of Conduct. (Risk areas

may be identified through the regular course of business, external alerts, external audits or reviews, or internal reporting channels.)

4. The Compliance Officer will be responsible for oversight of the agency's internal auditing system and is authorized to delegate auditing duties to other CHH personnel, accountants, consultants, and attorneys, as necessary and appropriate.

5. The Compliance Officer will conduct and/or oversee compliance audits and reviews with assistance from Management staff and/or Quality Assurance/Internal Audit staff with the requisite skills to carry out the audit. Whenever feasible, the Compliance Officer will seek to have audits conducted by **CHH** employees who are not involved in the delivery of services subject to the audit.

6. The Compliance Officer will facilitate all audits of financial processes or systems with the Chief Financial Officer. The audits will serve to ensure that internal controls are in place so that:

   - Generally Accepted Accounting Principles (GAAP) are followed; and
   - Federal, State, and local laws, regulations, and requirements are met.

7. The Compliance Officer will facilitate all audits of operational and programmatic issues with **CHH**'s Assistant Executive Director.

8. The ongoing auditing and monitoring will serve to evaluate, at minimum, the following risk areas:

   - Billings;
   - Payments;
   - Ordered services;
   - Medical necessity;
   - Quality of care;
   - Governance;
   - Mandatory reporting;
   - Credentialing;
   - Contractor, subcontractor, agent, or independent contract oversight;
   - Review of contracts and relationships with contractors, specifically those with substantive exposure to government enforcement actions;
   - Review of documentation and billing relating to claims made to Federal, State, and third party payers for reimbursement;
   - Compliance training and education;
   - Effectiveness of the Compliance Program; and
   - Other risk areas that are or should reasonably be identified by the agency through its organizational experience.

9. DEPARTMENT SPECIFIC PRACTICES OR PROCEDURES*****
   - <u>Fiscal/Business Office</u>
     i. An external audit of finances and business practices is conducted annually by a CPA firm hired by Cardinal Hayes Home.
   - <u>Human Resources</u>
     i. New employee checklists are completed for all new hires to verify all required documents and clearances are completed.
     ii. Required training is tracked via electronic training application, Relias, and is monitored by all supervisory and management staff for compliance.

   - <u>HCBS Residential Day Habilitation Services</u>
     i. Checklists are completed at least semi-annually to verify all required documents for billing and other regulations are accurate and filed in the case record.

ii. Billing / service documents are reviewed twice for accuracy before submission to Fiscal each month.
iii. Data collected via the Agency's electronic health record/data collection software is monitored by the Treatment Specialist as per policy.

- ICF Residential Services
    i. Attendance sheets for ICF billing are reviewed by the Residential Supervisor or Assistant before submission to Fiscal each Monday.
    ii. Data collected via Agency's electronic health record/data collection software is monitored by the Treatment Specialist as per policy.
- Medical Services
    i. The Director of Nursing and the residential nurses review the medical records as per the routine established in the respective policy.
- Quality Assurance Internal Program Audits
    i. Each residential facility will be audited by Quality Assurance at least annually to ensure compliance with 483 and 633 regulations and life safety code as per policy.
    ii. Human Resources will be audited at least annually to ensure all required background checks and other documents are filed.
    iii. Findings will be shared with all relevant program staff and the Corporate Compliance Officer and the Executive Director.
    iv. Corrective action will be recommended and supported by documentation.

10. The audits and reviews will examine the agency's compliance with specific rules and policies through on-site visits, personnel interviews, general questionnaires (submitted to employees and contractors), clinical record reviews to support claims for reimbursement, and documentation reviews.

11. The Compliance Officer will review and approve the sample size and sample criteria prior to each audit unless the detail is included in the annual audit plan or work plan.

12. All audit and review tools used will be standardized throughout the agency and approved by the Compliance Officer.

13. A written report of all internal audit and review results will be forwarded to the Compliance Officer and respective department or division director within seven (7) business days from the completion of the review or audit. Within 10 business days from the receipt of the written report of findings, the department or division director will submit a written Plan of Corrective Action to the Compliance Officer for review. The department head or director is responsible for ensuring that corrective measures are implemented and monitored for effectiveness.

14. The Compliance Officer will determine the timeframe for a post-audit review. The objective of the post-audit review is to ensure that corrective actions were completed and effective in preventing any recurrences of deficiencies.

15. The results of all internal auditing and monitoring activities, including records reviewed, audit results, and corrective actions, will be recorded and maintained by the Compliance Officer.

16. Should non-compliance be detected during routine internal monitoring and activities, the Compliance Officer will ensure a thorough investigation in accordance with the Reporting and Investigation of Compliance Concerns Policy.

17. Any correspondence from any regulatory agency charged with administering a federally- or state-funded program received by any department of the agency will be copied and promptly forwarded to the Compliance Officer for review and subsequent discussion by the Compliance Committee.

18. Program management will immediately notify the Compliance Officer of any visits, audits, investigations, or surveys by any regulatory agency or authority. Results (whether oral or written) of any visits, audits, investigations, or surveys will be forwarded to the Compliance Officer promptly upon receipt by agency personnel.

19. The Compliance Officer will be responsible for reporting to the Compliance Committee on the general status of all audits and reviews, the outcome of compliance auditing and monitoring, and the corrective actions taken. The reporting will occur at the first regularly scheduled Compliance meeting after the conclusion of the audit or review.

20. The Compliance Officer will be responsible for reporting the results of auditing and monitoring activities and corrective actions at least annually to the Board of Directors. The report will also include monitoring of trends, an assessment of any compliance risks to the agency, and an evaluation of the effectiveness of the agency's Compliance Program.

21. At least annually, the Compliance Officer will benchmark audit results and compare results of similar audits to determine whether improvement is occurring.

22. On an annual basis, the Compliance Officer, in collaboration with the Compliance Committee, will conduct a review to monitor the effectiveness of the Compliance Program, Compliance Program Policies and Procedures, and the Standards of Conduct to determine:

    a) Whether such written policies, procedures, and Standards of Conduct have been implemented;
    b) Whether Affected Individuals are following the policies, procedures, and Standards of Conduct;
    c) Whether such policies, procedures, and Standards of Conduct are effective; and
    d) Whether any updates are required.

    The Compliance Officer will provide a report of this review to the Compliance Committee and the Board of Directors.

VI. SANCTION STATEMENT

Non-compliance with this policy may result in disciplinary action, up to and including termination.

VII. COMPLIANCE STATEMENT

As part of its ongoing auditing and monitoring process in its Compliance Program, CHH will review this policy based on changes in the law or regulations, as agency practices change, and, at minimum, on an annual basis. Additionally, this policy will be tested for effectiveness on an annual basis or more frequently as identified in accordance with CHH's Compliance Program. Testing will include but is not limited to ensuring that the policy is appropriately followed; the policy is effective; the policy has been disseminated to all affected individuals, as well as notified of any updates or changes.

Tracking of the criteria above and results of this testing will be completed by the Compliance Officer, or designee. Additionally, results will be reported to the Compliance Committee and Governing Body on a regular basis.

VIII. RECORD RETENTION STATEMENT

CARDINAL HAYES HOME will retain this policy and all subsequent revisions, and any related documentation will be retained for a period of, at minimum, 10 years.

HISTORY

Applicability: Residential and Day Habilitation Programs; Fiscal Office, Human Resources
Topic: Internal Billing Audits
Regulatory References: OPWDD ADM-#2002-01; OMIG Audit Protocol for OPWDD IRA Residential Habilitation 8/26/16; OPWDD ADM-#2006-01; OMIG Audit Protocol for OPWDD Day Habilitation 8/26/17
Implemented: 3/16/18, rev. 4/8/2021; reviewed 4/2022
Revised 10/192023: Change title from 'Internal Billing Audit' to '**Auditing and Monitoring'**. The new policy incorporates all audits of potential risk areas under the Compliance Department.
Revised: 8/14/2025, Approved 8/20/2025

CARDINAL HAYES HOME & CARDINAL HAYES DAY SCHOOL POLICY AND PROCEDURE	Date Issued 03/16/2018	Date Revised 08/14/2025	Date of Last Review 08/14/2025	Date Approved 08/20/2025	Section Number CC-15
	Subject Corporate Compliance				
	Topic Billing Errors, Overpayments & Self Disclosure				

I. PURPOSE:

Cardinal Hayes Home for Children (sometimes referred to as "Cardinal Hayes Home") (CHH) is committed to adopting and implementing an effective Compliance Program that includes ensuring the ability to detect, correct, and resolve payment and billing errors as quickly and as efficiently as possible.

For purposes of this Policy, the term "Affected Individuals" includes all persons who are affected by the required risk areas including all employees, the Executive Director and other senior administrators, supervisors, contractors, agents, and the Board of Directors (hereafter referred to as "Affected Individuals").

II. STATEMENT OF POLICY:

It is the policy of CHH that any overpayments or inaccurate billing of claims be detected, reported, and returned in a timely manner following all rules, regulations, and laws.

CHH is committed to ensuring that in the event that the Agency has received an overpayment under the Medicaid Assistance Program (Medicaid), Medicare, or another third-party payer, the Agency shall report and return the overpayment, notify the appropriate payer, and comply with all Federal and State laws, regulations, guidelines, and policies.

III. POLICY OWNER

Chief Quality & Corporate Compliance Officer or designee.

IV. SCOPE

This policy applies to all Affected individuals at Cardinal Hayes Home for Children & Cardinal Hayes School for Special Children.

V. POLICIES AND PROCEDURES

A. Billing Practices

a) All employees and affected individuals will receive compliance training upon hire and annually thereafter on the Cardinal Hayes Home Compliance Program Plan and Standards of Conduct which includes, but is not limited to information on reimbursement practices, contemporaneous and accurate documentation of medically necessary services, reporting of compliance concerns and non-intimidation/retaliation protection, and enforcement of noncompliance.

b) All claims submitted to Fiscal for reimbursement submission will be reviewed and verified as per agency policies and practices. For the ICF programs, the attendance records will be submitted the Monday of each week. For HCBS residential and day habilitation programs, the service documents will be submitted twice during the month with the monthly note attached to the last submission for the month.

c) Internal monitoring and auditing will be conducted as per agency policies and procedures.

B. Identification of Billing Errors and Overpayments

a) The Compliance Officer must be promptly notified of all potential or actual billing errors and suspected overpayments. Examples of billing errors or reasons for overpayment may include, but are not limited to, the following:
   - Coding errors;
   - Errors in rate or unit;
   - Keying or inputting errors;
   - Provision of unauthorized services;
   - Services are not medically necessary, or necessity is not documented in the record;
   - Absence of one or more required elements of documentation;
   - Service was not rendered;
   - Falsification of service or billing documents;
   - Duplicate payments;
   - Fraudulent behavior by employees or others;
   - Discovery of an employee or contractor on the Federal or State exclusion lists; and
   - Damaged, lost, or destroyed records.

b) The Compliance Officer will notify the Executive Director and the Chief Financial Officer of potential billing issues and overpayments. The preliminary circumstances will be reviewed to determine if a suspension of billing is to be initiated.

c) The Compliance Officer or designee will investigate the issue; review any underlying facts; quantify and identify the amount of overpayment; ensure that any errors are corrected; and ensure that any refunds are made to the appropriate governmental agency or third-party payer. The investigation will be conducted in accordance with the Reporting and Investigation of Compliance Concerns Policy and Procedure. The Compliance Officer may engage outside legal counsel, auditors, or other consultants to help determine whether an overpayment has occurred and/or to quantify the overpayment.

d) An overpayment is deemed "identified" when it is determined or should have been determined through the exercise of reasonable diligence, that an overpayment was received, and the amount of the overpayment has been quantified.

e) The Compliance Officer is responsible for ensuring that the Agency properly discloses all overpayments to the appropriate payer and makes any reports and refunds that are necessary within the required timeframe for the payer.

f) Medicaid and Medicare overpayments must be reported and returned:
   - no later than 60 days after the date the overpayment was identified; or
   - by the date that any corresponding cost report is due, if applicable.

g) Medicaid overpayments must be reported and returned in accordance with the Office of Medicaid Inspector General's (OMIG) Self-Disclosure Protocol. The Protocol is available on OMIG's website at https://omig.ny.gov/. (For further information, refer to the Medicaid Self-Disclosure section below.)

h) Medicare overpayments are reported and refunded to the Medicare Administrative Contractor (MAC) or through the Office of Inspector General's Voluntary Self Disclosure program.

i) Overpayments to other third-party payers will be made in accordance with the contractual agreement.

j) Any overpayments retained by the Agency after the deadline for reporting and returning the overpayment may be subject to a monetary penalty.

k) The Compliance Officer must approve the overpayment and self-disclosure procedures and/or any revisions to procedures or forms before implementation.

l) Failure to report a potential reimbursement and billing issue or suspected overpayment will result in disciplinary action, up to and including termination of employment or contract.

m) The Compliance Officer will maintain a file for each overpayment and self-disclosure. All interview notes, evidence, claims data, and written communication to and from the government agency or third-party payer will be maintained in the file in a secure location.

n) The Compliance Officer will maintain a log of all overpayments that have been disclosed to governmental authorities and third-party payers. The following information will be recorded on the Overpayment and Disclosure Log (attached to this Policy):
   - The date that the overpayment was identified/quantified;
   - The date that the overpayment was disclosed;
   - The date that the overpayment was refunded;
   - The cause of the overpayment;
   - The department, program, or service;
   - The amount of the overpayment; and
   - The corrective action(s) to prevent the overpayment from recurring.

o) A report of overpayments, the results of investigations, and remedial actions will be reported to the Compliance Committee on a quarterly basis, and to the Board of Directors at least annually

C. Medicaid Self-Disclosure

a) **T**he Agency will participate in the OMIG's self-disclosure program under the following eligible conditions as required:
   - The Agency is not currently under audit, investigation, or review by the Medicaid Inspector General, unless the overpayment and the related conduct being disclosed does not relate to the OMIG audit, investigation, or review;
   - The Agency is disclosing an overpayment and related conduct that at the time is not being determined, calculated, researched, or identified by OMIG;
   - The overpayment and related conduct will be reported by the deadline previously specified, i.e., within 60 days of identification and the overpayment is quantified, or the date any corresponding cost report is due; and
   - The Agency is not a party to any criminal investigation being conducted by the deputy attorney general for the Medicaid Fraud Control Unit or any agency of the US government or any political subdivision thereof.

b) The Agency will pay the overpayment amount determined by OMIG within 15 days of OMIG notifying the Agency of the amount due, unless the OMIG permits the Agency to repay the overpayment and interest due in installments.

c) The Agency will enter into a self-disclosure compliance agreement with the Medicaid Inspector General that will be executed within 15 days of receiving said agreement from the Medicaid Inspector General or other time frame permitted by OMIG, but not less than 15 days.

d) Any false material information or omitted material information when submitting a self-disclosure, any attempts to evade an overpayment due, or any failure to comply with the terms of a self-disclosure and compliance agreement will not be tolerated and will be subject to disciplinary action up to and including termination.

VI. SANCTION STATEMENT

Non-compliance with this policy may result in disciplinary action, up to and including termination.

VII. COMPLIANCE STATEMENT

As part of its ongoing auditing and monitoring process in its Compliance Program, CHH will review this policy based on changes in the law or regulations, as CHH's practices change, and, at minimum, on an annual basis. Additionally, this policy will be tested for effectiveness on an annual basis or more frequently as identified in accordance with CHH's Compliance Program. Testing will include but is not limited to ensuring that the policy is appropriately followed; the policy is effective; the policy has been disseminated to all affected individuals, as well as notified of any updates or changes.

Tracking of the criteria above and results of this testing will be completed by the Compliance Officer, or designee. Additionally, results will be reported to the Compliance Committee and Governing Body on a regular basis.

VIII. RECORD RETENTION STATEMENT

CARDINAL HAYES HOME will retain this policy and all subsequent revisions, and any related documentation will be retained for a period of, at minimum, 10 years.

History

Implemented: 3/16/18, rev. 4/8/2021; reviewed 4/2022
Revised 10/2/2023: Changed title from 'Billing Practice & Billing Errors' to '**Billing Practice, Billing Errors, Overpayments & Self-Disclosure**.'
Revised: 8/14/2025, Approved 8/20/2025

CARDINAL HAYES HOME FOR CHILDREN

Overpayment and Disclosure Log

Date Overpayment Identified/ Quantified	Date Overpayment Disclosed	Date Overpayment Refunded	Cause of Overpayment	Amount of Overpayment	Department/ Program/ Service	Corrective Action(s)

CARDINAL HAYES HOME POLICY AND PROCEDURE	Date Issued 3/31/2021	Date Revised 10/30/2025	Date of Last Review 10/30/2025	Date Approved 11/13/2025	Section Number CC-16
	Subject Corporate Compliance				
	Topic Exclusion and Sanction Screening				

I. PURPOSE:

Cardinal Hayes Home for Children (sometimes referred to as "Cardinal Hayes Home") (CHHC) is committed to maintaining high quality care and service as well as integrity in its financial and business operations. Therefore, all necessary steps will be taken by CHHC to ensure that it does not employ, contract with, or conduct business with an individual or entity excluded from participation in federally funded healthcare programs, such as Medicare and Medicaid.

For purposes of this Policy, a "contractor" is defined as:

- Any independent contractor, contractor, subcontractor, or other person who, on behalf of the agency, furnishes or otherwise authorizes the furnishing of Medicare, Medicaid, or other federally funded healthcare items or services, or performs billing or coding functions; or
- Any independent contractor, contractor, subcontractor, or other person who provides administrative or consultative services, goods, or services that are significant and material, are related to healthcare provision, and/or are included in or are a necessary component of providing items or services of Medicare, Medicaid, or other federally funded healthcare programs; or
- Any independent contractor, subcontractor, or other person who is involved in the monitoring of healthcare provided by the agency.

II. STATEMENT OF POLICY:

1. It is the policy of CHHC not to employ, contract with, or conduct business with an individual or entity excluded from participation in federally funded healthcare programs, such as Medicare and Medicaid.

2. It is the policy of CHHC that CHHC employees including the Executive Director and senior leadership, interns, volunteers, contractors, vendors and Board members have an affirmative responsibility to notify the Compliance Officer promptly if charged with a criminal offense related to healthcare or proposed or found to be subject to exclusion from federal healthcare programs.

3. It is the policy of CHHC to conduct exclusion (sanction) screening of all current and proposed employees including the Executive Director and senior leadership, interns, volunteers, contractors, vendors and Board members.

4. It is the policy of CHHC to verify that contractors, as defined by this Policy, who provide and/or perform services for the agency have not been the subject of adverse governmental actions and/or excluded from the federal healthcare programs.

5. It is the policy of CHHC to verify that any physician or other healthcare practitioner ordering, authorizing, or prescribing goods or services under a federally funded healthcare program, such as Medicare or Medicaid, has not been excluded from participation from federal healthcare programs.

III. POLICY OWNER

Corporate Compliance Officer or designee

IV. SCOPE

This policy applies to all employees including the Executive Director and senior leadership, interns, volunteers, contractors, vendors and Board members at Cardinal Hayes Home for Children & Cardinal Hayes School for Special Children.

V. PROCEDURES

Applicable to Employees, Interns, Volunteers and Board Members:

1. CHHC will use a web-based exclusion screening system to conduct exclusion checks for all employees including the Executive Director and senior leadership, interns, volunteers, contractors, vendors and Board members to confirm that none have been excluded from federal healthcare programs. The exclusion check reviews, among other sources, the following databases to determine whether an individual's name appears on an exclusion list.

    - U. S. Department of Health and Human Services, Office of Inspector General's (OIG) List of Excluded Individuals and Entities (LEIE) available on the website at http://exclusions.oig.hhs.gov
    - The System for Award Management (SAM) available on the SAM website at https://www.sam.gov
    - ***For New York Agencies only:*** NYS Medicaid Fraud Database available on the NYS Office of Medicaid Inspector General (OMIG) website at https://omig.ny.gov/medicaid-fraud/medicaid-exclusions

2. An exclusion check will be performed on all applicants for employment as part of the initial pre-employment screening process. All names used by the applicant will be obtained by the Human Resources Department and utilized as part of the exclusion screening process. The Human Resources Department will submit all names for exclusion screening and will receive the screening results. Any findings indicating a potential exclusion will be reported to the Compliance Officer. If the exclusion check indicates that any individual has been excluded from federal healthcare programs, the applicant will not be offered employment.

3. An exclusion check will be performed on all interns and volunteers as part of the initial screening process. All names used by the applicant will be obtained by the Human Resources Department and utilized as part of the exclusion screening process. The Human Resources Department will submit all names for exclusion screening and will receive the screening results. Any findings indicating a potential exclusion will be reported to the Compliance Officer. If the exclusion check indicates that the intern or volunteer has been excluded from federal healthcare programs, the applicant will not be offered an internship or volunteer position.

4. An exclusion check will be performed for potential and current Board members as part of the initial screening process. All names used by the potential and Board member will be obtained by the Compliance Officer and utilized when conducting the exclusion screening. The Compliance Officer will submit all names for screening and will be the recipient of the finding of these screenings. Any findings indicating a potential exclusion will be reported to the Executive Director and the Chair of the Board of Directors or Board of Trustees (School). If the exclusion check indicates that a person has been excluded from federal healthcare programs, the Compliance Officer will inform the Executive Director, and the individual will not be considered for Board affiliation or removed from a position on the Board.

5. The Fiscal Department will maintain a Master List of Board members, vendors and independent contractors in an approved format and will make the list available to the Compliance Officer and other personnel responsible for exclusion screening of such parties.

6. The Human Resource Department will maintain a sub-list of employees, interns and volunteers, along with any known aliases, in an approved format and will make the list available to the Compliance Officer and other personnel responsible for exclusion screening of such parties.

7. The Compliance Officer will ensure that HR and Compliance are conducting ongoing exclusion screening for all employees, volunteers, interns, and Board members at least every 30 days thereafter using the exclusion screening vendor's web-based system. All names used by the parties will be utilized when the exclusion screening is conducted.

8. Any potential matches identified in the ongoing exclusion screening process for employees, interns, volunteers, and Board members will be reviewed and resolved by the Human Resource Department or the (Compliance Officer will review and resolve Board members). If there is an exclusion confirmed, the excluded party will be immediately relieved from duty and the Compliance Officer notified.

9. The exclusion will be reported as a violation of the Compliance Program and investigated and reported in accordance with the Reporting and Investigation of Compliance Concerns Policy and Procedure.

10. If any employee, intern, volunteer, contractor or Board member is charged with a criminal offense related to healthcare or is proposed or found to be subject to exclusion from federal healthcare programs, they must be removed from direct responsibility or involvement in any federally funded healthcare program while the matter is pending. If the matter results in conviction or exclusion, CHHC will immediately terminate the agency's relationship with the employee, intern, volunteer, contractor or Board member.

11. In addition to exclusion screening, the credentials of medical/healthcare and other professionals employed by CHHC will be verified with appropriate licensing and disciplining authorities, including any adverse actions taken against the individuals that might impair their performance of duties on behalf of the agency. The process is applicable to all employees for which license/certification is required for their duties. The verification will be conducted as part of the hiring process. Human Resources will track such credentials and run reports to ensure accuracy minimally semi-annually thereafter.

12. The Compliance Officer will consult with legal counsel if CHHC has been reimbursed for goods or services from the excluded individual or entity.

Applicable to Contractors:

1. CHHC will use a web-based exclusion screening system to conduct exclusion checks on current and potential vendors and independent contractors to confirm that none have been excluded from federal healthcare programs. This review shall be conducted prior to entering an agreement with a contractor, as defined by this Policy. An exclusion check reviews the following databases, among others, to confirm if an individual or entity's name appears as excluded.

- U. S. Department of Health and Human Services, Office of Inspector General's (OIG) List of Excluded Individuals and Entities (LEIE) available on the website at http://exclusions.oig.hhs.gov
- The System for Award Management (SAM) available on the SAM website at https://www.sam.gov
- ***For New York Agencies only:*** NYS Medicaid Fraud Database available on the NYS Office of Medicaid Inspector General (OMIG) website at https://omig.ny.gov/medicaid-fraud/medicaid-exclusions

2. An exclusion check will be performed on all current and potential vendors and independent contractors as part of the screening process. All names used by the potential vendor and independent contractor will be obtained and utilized as part of the exclusion screening process. The Fiscal Department will submit all names for screening and will be the recipient of the findings of these screenings. Any findings indicating a potential exclusion will be

reported to the Compliance Officer. If the exclusion check indicates that the vendor or contractor has been excluded from federal healthcare programs, the applicant will not be offered an internship or volunteer position or will be removed from service.

3. The Compliance Officer will ensure that all agency contracts include a certification stating that the contractor, its employees, and any subcontractors are not excluded by the federal or state government.

4. The Fiscal Department will maintain a Master List of Board members, vendors and independent contractors in an approved format and will make the list available to the Compliance Officer and other personnel responsible for exclusion screening of such parties.

5. The Compliance Officer will ensure that the Fiscal Department conducts ongoing exclusion screening for all vendors and contractors at least every 30 days thereafter using the exclusion screening vendor's web-based system . All names used by the parties will be utilized when the exclusion screening is conducted.

6. Any potential matches identified in the ongoing exclusion screening process for vendors and contractors will be reviewed and resolved by the Fiscal Department. If there is an exclusion confirmed, the excluded party will be immediately relieved from duty, and the Compliance Officer will be notified.

7. The indicated exclusion will be reported as a violation of the Compliance Program and investigated and reported in accordance with the Reporting and Investigation of Compliance Concerns Policy and Procedure.

8. The Compliance Officer will consult with legal counsel if the agency has been reimbursed for goods or services from the excluded individual or entity.

Applicable to Ordering/Prescribing Physicians and Other Healthcare Practitioners:

1. CHHC will use a web-based exclusion screening system to conduct exclusion checks on current and potential contracted physicians and healthcare practitioners who authorize, prescribes, or orders goods or services funded by Medicaid, Medicare, or other federally funded healthcare programs. An exclusion check reviews the following databases, among others, to confirm if an individual or entity's name appears as excluded.
    - U. S. Department of Health and Human Services, Office of Inspector General's (OIG) List of Excluded Individuals and Entities (LEIE) available on the website at http://exclusions.oig.hhs.gov
    - The System for Award Management (SAM) available on the SAM website at https://www.sam.gov
    - ***For New York Agencies only:*** NYS Medicaid Fraud Database available on the NYS Office of Medicaid Inspector General (OMIG) website at https://omig.ny.gov/medicaid-fraud/medicaid-exclusions

2. An exclusion check will be conducted on current and potential physicians or other healthcare practitioners who authorize, orders, or prescribes goods or services reimbursed by Medicaid, Medicare, or other federally funded healthcare programs. All names used by physicians or other healthcare practitioners will be obtained and utilized as part of the exclusion screening process. The Human Resources Department will submit all names for screening and will be the recipient of the findings of these screenings. Any findings indicating a potential exclusion will be reported to the Compliance Officer. If the exclusion check indicates that the healthcare practitioner has been excluded from federal healthcare programs, the practitioner will not be allowed to practice within the agency.

3. The Human Resources department will maintain an up-to-date list of contracted physicians and practitioners who authorize, order, or prescribe Medicaid, Medicare, or other federally funded healthcare program

services. The list will be maintained in an approved manner and be made available to the personnel responsible for the exclusion screening of such parties.

4. The Compliance Officer will ensure that the Human Resources Department conducts ongoing exclusion screening for all physicians and healthcare practitioners who authorize, order, or prescribe healthcare goods or services provided by the agency at least every 30 days thereafter using the vendor's web-based exclusion screening system . All names used by the parties will be utilized when the exclusion screening is conducted.

5. Any matches identified in the ongoing exclusion screening process for physicians and practitioners will be reviewed and resolved by the Human Resources Department. If the exclusion check indicates that a physician or practitioner has been excluded from federal healthcare programs, the services or goods will not be billed to Medicaid, Medicare, or other federally funded healthcare programs. The practitioner will not be allowed to practice withing the agency.

6. The indicated exclusion will be reported as a violation of the Compliance Program and investigated and reported in accordance with the Reporting and Investigation of Compliance Concerns Policy and Procedure.

7. The Compliance Officer will consult with legal counsel if the agency has been reimbursed for goods or services authorized, ordered, or prescribed by an excluded physician or practitioner.

Monitoring for Compliance with Policy:

1. The Compliance Officer will ensure the results of all exclusion checks are maintained for a period of at least 10 years.

2. The Compliance Officer is responsible for monitoring this Policy for compliance and reporting results quarterly to the Compliance Committee and the Board of Directors, along with any recommendations for remedial actions or improvements to the program.

VI. Sanction Statement:

Non-compliance with this policy may result in disciplinary action, up to and including termination.

VII. Compliance Statement:

As part of its ongoing auditing and monitoring process in its Compliance Program, CHHC will review this policy based on changes in the law or regulations, as CHHC's practices change, and, at minimum, on an annual basis. Additionally, this policy will be tested for effectiveness on an annual basis or more frequently as identified in accordance with CHHC's Compliance Program. Testing will include but is not limited to ensuring that the policy is appropriately followed; the policy is effective; the policy has been disseminated to all affected individuals, as well as notified of any updates or changes.

Tracking the criteria above and results of this testing will be completed by the Compliance Officer, or a designee. Additionally, results will be reported to the Compliance Committee and Governing Body on a regular basis.

VIII. Record Retention Statement:

CHHC will retain this policy and all subsequent revisions, and any related documentation will be retained for a period of, at minimum, 10 years.

CARDINAL HAYES HOME POLICY AND PROCEDURE	Date Issued 04/2021	Date Revised 08/14/2025	Date of Last Review 08/14/2025	Date Approved 08/20/2025	Section Number CC-17
	Subject Corporate Compliance				
	Topic False Claims Act and Whistleblower Protections				

I. PURPOSE:

Cardinal Hayes Home for Children (sometimes referred to as "Cardinal Hayes Home") (CHH) is committed to prompt, complete, and accurate billing of all services provided to service recipients. CHH and its employees and contractors shall not make or submit any false or misleading entries on any claim forms. No employee or contractor shall engage in any arrangement or participate in such arrangement at the direction of another person, including any supervisor or manager, that results in the submission of a false or misleading entry on claims forms or documentation of services that result in the submission of a false claim.

For purpose of this Policy, a contractor is defined as:

- Any independent contractor, contractor, subcontractor, or other person who, on behalf of the agency, furnishes or otherwise authorizes the furnishing of Medicare and/or Medicaid healthcare items or services, or performs billing or coding functions;
- Any independent contractor, contractor, subcontractor, or other person who provides administrative or consultative services, goods, or services that are significant and material, are directly related to healthcare provision, and/or are included in or are a necessary component of providing items or services reimbursed by Medicare, Medicaid, or another federally-funded healthcare program; or
- Any independent, contractor, subcontractor, or other person who is involved in the monitoring of healthcare provided by the agency.

II. STATEMENT OF POLICY:

It is the policy of CHH to detect and prevent fraud, waste, and abuse in Federal and State healthcare programs. This Policy explains the Federal False Claims Act, the Administrative Remedies For False Claims, the New York State False Claims Act, and other New York State laws concerning false statements or claims and employee protections against retaliation for reporting. This policy also sets forth the procedures that CHH has put into place to prevent any violations of Federal or New York State laws regarding fraud, waste, or abuse in its healthcare programs. (Refer to the appendix entitled "Overview of Relevant Laws" for further information.)

III. POLICY OWNER

Corporate Compliance Officer or designee

IV. SCOPE

This policy applies to all Affected individuals at Cardinal Hayes Home for Children & Cardinal Hayes School for Special Children.

V. POLICIES AND PROCEDURES AND STANDARDS OF CONDUCT

1. CHH will provide training and/or education in this policy and procedure to all Board members, all employees including Executive Director and senior leadership, and contractors, as defined by this Policy.
2. Training and/or education in this Policy will be provided to all employees as part of the new employee orientation.
3. Training and/or education in this Policy will be provided to all Board members and to new Board members as part of Board orientation.
4. The Compliance Officer will ensure that all Board members, all employees including Executive Director and senior leadership, and contractors receive training and/or education related to the contents of this Policy and the False Claims Act. The Compliance Officer will ensure that records are maintained to document the receipt of training.
5. The Compliance Officer will ensure that this Policy is attached to any contract with a contractor as defined by this Policy.
6. The prevention of fraud, waste and abuse, CHH requires compliance with the following requirements related to the provision of service(s) and claims for reimbursement:
    a. All service documentation, records, and reports are prepared timely, accurately, and honestly;
    b. All documentation supporting claims for service is complete and maintained in accordance with regulatory requirements and the agency's policies;
    c. All claims submitted to any government or private healthcare program are accurate and comply with all Federal and State laws and regulations and payer requirements;
    d. Claims are only submitted for medically necessary services provided by eligible providers;
    e. All claims are properly documented and accurately coded; and
    f. Billing errors are promptly identified, and any payments received in error are promptly returned to the payer.
7. Any employee or contractor who has any reason to believe that anyone is engaging in false billing practices, false documentation of services, and other non-compliance related to service provision and billing is expected to report the practice to the Compliance Officer in accordance with the Reporting and Investigation of Compliance Concerns Policy.
8. Any form of retribution, intimidation, and/or retaliation against any party who reports, in good faith, a perceived problem or concern regarding the provision or billing of services is strictly prohibited.
9. Any employee or contractor who commits or condones any form of retribution, intimidation, or retaliation will be subject to discipline up to, and including, termination of employment or contract.
10. CHH will perform billing activities in a manner consistent with the regulations and requirements of third-party payers, including Medicaid, Medicare, and other Federal healthcare programs.
11. CHH will conduct regular auditing and monitoring procedures as part of its efforts to ensure compliance with applicable regulations.
12. CHH will report and refund all overpayments to Medicaid and Medicare within 60 days of identification of the overpayment in accordance with the Billing Errors, Overpayments, and Self-Disclosure Policy.

VI. SANCTION STATEMENT

Non-compliance with this policy may result in disciplinary action, up to and including termination.

VII. COMPLIANCE STATEMENT

As part of its ongoing auditing and monitoring process in its Compliance Program, CHH will review this policy based on changes in the law or regulations, as CHH's practices change, and, at minimum, on an annual basis. Additionally, this policy will be tested for effectiveness on an annual basis or more frequently as identified in accordance with CHH's Compliance Program. Testing will include but is not limited to ensuring that the policy is appropriately followed; the policy is effective; the policy has been disseminated to all affected individuals, as well as notified of any updates or changes.

Tracking of the criteria above and results of this testing will be completed by the Compliance Officer, or designee. Additionally, results will be reported to the Compliance Committee and Governing Body on a regular basis.

VIII. RECORD RETENTION STATEMENT

CARDINAL HAYES HOME will retain this policy and all subsequent revisions, and any related documentation will be retained for a period of, at minimum, 10 years.

History
Implemented 4.2021
Reviewed 4.2022
Revised: 3.31.2023, Approved 4.24.2023
Revised: 8.14.2025, Approved: 8.20.2025

Appendix A –
Overview of Relevant Laws

The False Claims Act (31 USC Chapter 37, §§ 3729-3733)

The False Claims Act is a Federal law designed to prevent and detect fraud, waste, and abuse in Federal healthcare programs, including Medicaid and Medicare. Under the False Claims Act, anyone who "knowingly" submits false claims to the Federal Government is liable for damages up to three times the amount of the erroneous payment plus mandatory penalties of approximately $12,000 to $25,000[1] for each false claim submitted.

The law was revised in 1986 to expand the definition of "knowingly" to include a person who:

- Has actual knowledge of falsity of information in the claim;
- Acts in deliberate ignorance of the truth or falsity of the information in the claim; and
- Acts in reckless disregard of the truth or falsity of the information in a claim.

False Claims suits can be brought against individuals and entities. The False Claims Act does not require proof of a specific intent to defraud the Government. Providers can be prosecuted for a wide variety of conduct that leads to the submission of a false claim.

Examples include, but are not limited to, the following:

- Knowingly making false statements;
- Falsifying records;
- Submitting claims for services never performed or items never furnished;
- Double-billing for items or services;
- Upcoding;
- Using false records or statements to avoid paying the Government;
- Falsifying time records used to bill Medicaid; or
- Otherwise causing a false claim to be submitted.

Whistleblower or "Qui Tam" Protections

In order to encourage individuals to come forward and report misconduct involving false claims, the False Claims Act contains a "Qui Tam" or whistleblower protection.

The United States Government, or an individual citizen acting on behalf of the United States Government, can bring actions under the False Claims Act. An individual citizen, referred to as a whistleblower or "Relator," who has actual knowledge of allegedly false claims may file a lawsuit on behalf of the United States Government. If the lawsuit is successful, and provided certain legal requirements are met, the whistleblower may receive an award ranging from 15% - 30% of the amount recovered.

[1] The penalties are updated regularly; the provider should refer to the Federal False Claims Act for current amounts.

Employee Protections

The False Claims Act prohibits discrimination by an organization against any employee for taking lawful actions under the False Claims Act. Any employee who is discharged, demoted, harassed, or otherwise discriminated against because of lawful acts by the employee in False Claims actions is entitled to all relief necessary to make the employee whole. Such relief may include reinstatement, double back pay, and compensation for any special damages, including litigation costs and reasonable attorney fees.

Administrative Remedies for False Claims (31 USC Chapter 38, §§3801-3812)

The Federal False Claims Act allows for administrative recoveries by Federal agencies including the Department of Health and Human Services, which operates the Medicare and Medicaid Programs. The law prohibits the submission of a claim or written statement that the person knows or has reason to know is false, contains false information, or omits material information. The Federal agency receiving the claim may impose a monetary penalty of up to $5,500 per claim and damages of twice the amount of the original claim.

Unlike the False Claims Act, a violation of this law occurs when a false claim is submitted, not when it is paid.

New York State Laws

A. Civil and Administrative Laws

New York State False Claims Act (State Finance Law §§187-194)

The New York State False Claims Act closely tracks the Federal False Claims Act. It imposes fines on individuals and entities that file false or fraudulent claims for payment from any State or local government, including healthcare programs such as Medicaid. The penalty for filing a false claim is $6,000 - $12,000[2] per claim and the recoverable damages are between two and three times the value of the amount falsely received. In addition, the false claim filer may be responsible for the government's legal fees.

The New York State Government, or an individual citizen acting on behalf of the Government (a "Relator"), can bring actions under the New York State False Claims Act. If the suit eventually concludes with payments back to the government, the party who initiated the case can recover 15% - 30% of the proceeds, depending upon whether the government participated in the suit.

The New York State False Claims Act prohibits discrimination against an employee for taking lawful actions in furtherance of an action under the False Claims Act. Any employee who is discharged, demoted, harassed, or otherwise discriminated against because of lawful acts by the employee in furtherance of an action under the False Claims Act is entitled to all relief necessary to make the employee whole.

Social Service 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 up to three times the amount of the incorrectly paid claim. In the case of non-monetary false statements, the local Social Service district or State may recover three times the amount incorrectly paid. In addition, the Department of Health may impose a civil penalty of up to $2,000 per violation. If repeat violations occur within five years, a penalty up to $7,500 may be imposed if they involve more serious violations of the Medicaid rules, billing for services not rendered, or providing excessive services.

[2] The penalties are updated regularly; the provider should refer to the Federal False Claims Act for current amounts.

Social Service 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 and the person's family needs are not taken into account for a period of six months to five years, depending upon the number of offenses.

B. Criminal Laws

Social Service 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 Service Law § 366-b, Penalties for Fraudulent Practices

Any person who, with intent to defraud, presents for payment any false or fraudulent claim for furnishing services or merchandise, knowingly submits false information for the purpose of obtaining Medicaid compensation greater than that to which they are legally entitled to, or knowingly submits false information in order to obtain authorization to provide items or services shall be guilty of a Class A misdemeanor.

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.

Penal Law Article 155, Larceny

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

Penal Law Article 175, Written False 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 organization'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 E felony.

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 Medicaid (or other health plans, including non-governmental plans), they knowingly provide false information or omits material information for the purpose of requesting payment for a healthcare item or service and, as a result of the false information or omission, receives such a payment in an amount to which they are not entitled. Prosecution under Health Care Fraud is determined by the amount of payment inappropriately received.

New York Labor Law §740

An employer may not take any retaliatory personnel 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.

This law offers protection to an employee who:

- Discloses, or threatens to disclose, to a supervisor or to a public body an activity, policy, or practice of the employer that is in violation of law, rule, or regulation that presents a substantial and specific danger to the public health or safety;
- Provides information to, or testifies before, any public body conducting an investigation, hearing, or inquiry into any such violation of a law, rule, or regulation by the employer; or
- Objects to, or refuses to participate in, any such activity, policy, or practice in violation of a law, rule, or regulation.

The employee's disclosure is protected under this law only if the employee first brought up the matter with a supervisor and gave the employer a reasonable opportunity to correct the alleged violation, with certain exceptions. The law allows employees who are the subject of a retaliatory action to bring a suit in State court for reinstatement to the same, or an equivalent position, any lost back wages and benefits and attorneys' fees.

<u>New York Labor Law §741</u>

Under this law, a healthcare 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 or improper quality of workplace safety.

This law offers protection to an employee who:

- Discloses or threatens to disclose to a supervisor, to a public body, to a news media outlet, or to a social media forum available to the public at large, an activity, policy, or practice of the employer or agent that the employee, in good faith, reasonably believes constitutes improper quality of patient care or improper quality of workplace safety; or
- Objects to, or refuses to participate in any activity, policy, or practice of the employer or agent that the employee, in good faith, reasonably believes constitutes improper quality of patient care or improper quality of workplace safety.

The employee's disclosure is protected under this law only of 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. Certain exceptions apply. If the 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 healthcare 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.

CARDINAL HAYES HOME POLICY AND PROCEDURE	Date Issued 04/2021	Date Revised 08/14/2025	Date of Last Review 08/14/2025	Date Approved 08/20/2025	Section Number CC-18
	Subject Corporate Compliance				
	Topic Whistleblowers Protection & Non-Retaliation				

I. PURPOSE:

Cardinal Hayes Home for Children (sometimes referred to as "Cardinal Hayes Home") (CHH) is committed to promoting an environment where concerns regarding known or suspected fraud, waste, and abuse; illegal or unethical acts; actual or suspected violations of Federal or State laws and regulations; actual or suspected violations of the Standards of Conduct, the Compliance Program, and CHH's policies and procedures; improper acts in the delivery or billing of services; and other wrongdoing (collectively referred to as "compliance concerns" for purposes of this Policy) are reported and addressed without fear of retaliation, intimidation, retribution or harassment for good faith reporting of such concerns. To reinforce this commitment, CHH maintains a policy of non-intimidation and non-retaliation for good faith participation in the Compliance Program, including but not limited to reporting potential issues and compliance concerns, investigating issues, self-evaluations, audits and remedial actions, and reporting to appropriate officials as provided in the Labor Law.

For purposes of this Policy, the term "Affected Individuals" includes all persons who are affected by the required risk areas including all employees, the Executive Director and other senior administrators, supervisors, contractors, agents, interns, and the Board of Directors (hereafter referred to as "Affected Individuals").

II. STATEMENT OF POLICY:

It is the policy of CHH to strictly prohibit any form of retaliation or intimidation against Affected Individuals or entities, for reporting compliance concerns.

CHH strictly prohibits Affected Individuals from engaging in any act, conduct, or behavior that results in, or is intended to result in, retribution, intimidation, or retaliation against any individual or entity for reporting compliance concerns to the agency or government agency.

No CHH supervisor, manager, or employee is permitted to discharge, demote, suspend, threaten, harass, or in any other manner discriminate against an employee, vendor, contractor, or other individual or CHH (all such activity collectively referred to as "retaliation") who in good faith participates in the Compliance Program, including but not limited to reporting potential compliance concerns, investigating or participating in an investigation, self-evaluations, audits, and reporting to the appropriate officials.

III. POLICY OWNER

Corporate Compliance Officer or designee

IV. SCOPE

This policy applies to all Board members, all employees including Executive Director and senior leadership, and contractors.

V. POLICIES AND PROCEDURES AND STANDARDS OF CONDUCT

1. If an Affected Individual, vendor, or service recipient believes in good faith that they have been retaliated against for reporting a compliance concern or for participating in any investigation of such a report, the retaliation should be immediately reported to the Compliance Officer or the Compliance Hotline. The report should include a thorough account of the incident(s) and should include the names, dates, specific events, the names of any witnesses, and the location or name of any document that supports the alleged retaliation.

2. Knowledge of a violation or potential violation of this Policy must be reported directly to the Compliance Officer or the Compliance Hotline.
3. Any employee who believes they are subjected to retaliation, intimidation, harassment, discrimination, or an adverse employment consequence must immediately report the actions to the Compliance Officer or Human Resource Director.

4. The Compliance Officer will implement this Policy and take appropriate actions in response to the whistleblower's complaint of retaliation based on the nature of the report. Legal counsel will be consulted, if appropriate.

5. The Compliance Officer will investigate all reports of retaliation in accordance with the Reporting and Investigation of Compliance Concerns Policy and report results to the Director of Human Resources and the Executive Director.

6. The Executive Director or designee will investigate any report that the Compliance Officer is engaging in intimidation or retaliation.

7. The Compliance Officer will provide information on each report of retaliation and any actions taken to the Compliance Committee and the Board of Directors.

8. The right of the reporter to protection against retaliation does not include immunity for any personal wrongdoing that is alleged and investigated.

9. Any Affected Individual who commits or condones any form of retaliation will be subject to discipline up to, and including, termination.

10. The Compliance Officer will ensure this Policy is disseminated to all Affected Individuals and that these individuals have received relevant training in accordance with the agency's training plan.

Further Information Regarding Employee Protections

New York Labor Law §740

An employer may not take any retaliatory personnel 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.

This law offers protection to an employee who:

- Discloses, or threatens to disclose, to a supervisor or to a public body an activity, policy, or practice of the employer that is in violation of law, rule, or regulation that presents a substantial and specific danger to the public health or safety;
- Provides information to, or testifies before, any public body conducting an investigation, hearing, or inquiry into any such violation of a law, rule, or regulation by the employer; or
- Objects to, or refuses to participate in, any such activity, policy, or practice in violation of a law, rule, or regulation.

The employee's disclosure is protected under this law only if the employee first brought up the matter with a supervisor and gave the employer a reasonable opportunity to correct the alleged violation, with certain exceptions. The law allows employees who are the subject of a retaliatory action to bring a suit in State court for reinstatement to the same, or an equivalent position, any lost back wages and benefits and attorneys' fees.

More information can be found at http://public.leginfo.state.ny.us/lawssrch.cgi?NVLWO%20: under LAB-Labor.

New York Labor Law §741

Under this law, a healthcare 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 or improper quality of workplace safety.

This law offers protection to an employee who:

- Discloses or threatens to disclose to a supervisor, to a public body, to a news media outlet, or to a social media forum available to the public at large, an activity, policy, or practice of the employer or agent that the employee, in good faith, reasonably believes constitutes improper quality of patient care or improper quality of workplace safety; or

- Objects to or refuses to participate in any activity, policy, or practice of the employer or agent that the employee, in good faith, reasonably believes constitutes improper quality of patient care or improper quality of workplace safety.

The employee's disclosure is protected under this law 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. Certain exceptions apply. If the 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 healthcare 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.

More information can be found at: http://public.leginfo.state.ny.us/lawssrch.cgi?NVLWO%20: under LAB-Labor.

VI. SANCTION STATEMENT

Non-compliance with this policy may result in disciplinary action, up to and including termination.

VII. COMPLIANCE STATEMENT

As part of its ongoing auditing and monitoring process in its Compliance Program, CHH will review this policy based on changes in the law or regulations, as CHH's practices change, and, at minimum, on an annual basis. Additionally, this policy will be tested for effectiveness on an annual basis or more frequently as identified in accordance with CHH's Compliance Program. Testing will include but is not limited to ensuring that the policy is appropriately followed; the policy is effective; the policy has been disseminated to all affected individuals, as well as notified of any updates or changes.

Tracking of the criteria above and results of this testing will be completed by the Compliance Officer, or designee. Additionally, results will be reported to the Compliance Committee and Governing Body on a regular basis.

VIII. RECORD RETENTION STATEMENT

CARDINAL HAYES HOME will retain this policy and all subsequent revisions, and any related documentation will be retained for a period of, at minimum, 10 years.

History
Implemented 4.2021
Reviewed 4.2022
Revised: 3.31.2023
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