WOMEN'S LEAGUE COMMUNITY RESIDENCES, INC.

CORPORATE COMPLIANCE PLAN

INTRODUCTION

Women's League Community Residences, Inc. (WLCR) is a professional organization committed to the philosophy that every person, regardless of his/her personal handicaps or developmental level must be treated with the utmost dignity and respect for privacy accorded to all human beings. It is our belief that every person with developmental disabilities should be afforded the opportunity to maximize his/her functional, social and intellectual potential through appropriate individualized programming, by living in as normal a home environment as possible, and by living in an atmosphere of acceptance, warmth, understanding, and security which upholds the rights of each individual and provides developmental opportunities on both individual and group bases.

WLCR provides the following services to the members of our community:

Medicaid Service Coordination (MSC) and Plan of Care Support Services (PCCS)
Individualized Residential Alternative (IRA) Residential Habilitation
Community Habilitation
Intermediate Care Facilities
Individualized Support Services (ISS)
Group Day Habilitation
Supportive Employment Program
Jumpstart Early Intervention Program

WLCR is committed to adhering to all federal, state and city laws, regulations and directives which address detecting and preventing fraud, waste and abuse in federal, New York State and New York City healthcare programs. Every effort must be extended to assure that all billings for services are prompt, complete and accurate. The purpose of this policy is to detect and correct billing errors both from accidental mistakes and from fraud. Systems will be put into place to ensure that all billings are made timely and accurately.

The policies enumerated in this plan apply to billings, payments, determinations of medical necessity and quality of care, governance, mandatory reporting, credential and license verification, and any other risk areas that are identified by WLCR.

All employees are expected to live up to WLCR's code of conduct as enumerated in this Plan. This plan applies to all employees of WLCR including management and supervisory staff, as well as the Board of Directors, volunteers, contractors and agents. It applies to all programs operated by WLCR.

The policies enumerated in this Plan will be enforced by the Agency's Corporate Compliance Officer. He/she will also be responsible for reviewing these policies periodically and revising them as necessary.

This plan also enumerates policies which protect an employee's right to disclose improper practices of the Agency without fear of retaliation.

APPLICABILITY

These policies are applicable to all employees of Women's League Community Residences, Inc., the Board of Directors, volunteers and contractors.

STATUTORY BASIS

There are various federal laws, ranging from the law originally passed during the Civil War and updated by various laws ending with the Deficit Reduction Act of 2007. These laws are designed to prevent and detect fraud, waste and abuse in federal healthcare programs. Anyone who knowingly submits false claims to the Government is liable for damages and penalties. In addition, there are protections for employees who come forward and report misconduct involving false claims; however, these protections apply 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.

There are also several New York State Civil, Administrative and Criminal laws which parallel the federal laws and, in some instances, expand upon them.

Fraud is an intentional act to deceive, meaning that someone intended to misrepresent, omit or hide information which results in an incorrect payment of funds. It is a crime to knowingly cause a false claim to be submitted.

A summary of the various laws follows:

FEDERAL & NEW YORK STATUTES RELATING TO FILING FALSE CLAIMS

Federal False Claims Act

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

While the False Claims Act imposes liability only when the claimant acts "knowingly," it does not require that the person submitting the claim have actual knowledge that the claim is false. A person who acts in reckless disregard or in deliberate ignorance of the truth or falsity of the information also can be found liable. In addition to its substantive provisions, the FCA provides that private parties may bring an action

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

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

The current FCA can be found in the United States Code, Title 31, Sections 3729 through 3733:

US Code Title 31 Chapter 37

Background

The FCA dates back to the Civil War. During the Civil War, some defense contractors defrauded the Union government, and Congress enacted the FCA in response to these scandals.

Who is Liable?

The FCA makes anyone who submits (or causes someone else to submit) a false or misleading claim liable for penalties and fines.

What is a claim?

A claim is simply some demand for money or property, where the federal government provides any portion of the money or property requested. Because the federal government funds part of New York's Medicaid program, the FCA covers claims or bills to Medicaid in New York, including claims or bills for Medicaid-funded services or goods provided by OPWDD or provided by OPWDD-funded agencies or persons.

How Does This Work?

If a Medicaid claim or bill is untrue (or "false"), it will bring liability upon the person who said it was true. The penalties and fines under the FCA will vary for each claim and can include the government's costs in pursuing a lawsuit against the person. Some of the things included in the FCA are falsifying billing records, billing for services not rendered, billing for goods not provided, billing for a more expensive service than the one actually provided (often called "upcoding") and duplicating billing to obtain double payment. No proof of specific intent to defraud the government is required to be held liable under the FCA. All that is required is that the person has actual knowledge, or has acted with deliberate ignorance or reckless disregard of the truth or falsity of his or her claim. Basically, the defense of "I didn't know it was illegal" does not work.

The FCA also has incentives for employees to come forward and report misconduct. Generally, a person who knows about the false claims (the whistleblower) may sue on behalf of the government for a violation of the FCA. After the whistleblower files a lawsuit, the government can pursue the suit on its

own, or decline and allow the whistleblower to continue. The government may elect to move forward with the suit as is, change it to a criminal or administrative case, settle it, or request a dismissal. The whistleblower can participate in the lawsuit along with the government, but the judge can limit who the whistleblower calls as witnesses, how long they testify and how much the whistleblower can cross examine witnesses if the whistleblower is just harassing the defendant or is interfering with or duplicating the government's case.

Depending on the outcome of the case and the whistleblower's involvement in the prosecution of the case, the whistleblower can receive a percent of the proceeds of the action or settlement. The whistleblower only gets this money if the government recovers money from the defendant as a result of the FCA lawsuit. The whistleblower's award may be reduced if the judge decides that the whistleblower planned and initiated the violation. A whistleblower who files a frivolous lawsuit can be forced to reimburse the defendant for all the costs of defending the lawsuit, including attorneys' fees.

Is there a Statute of Limitations?

Yes. A lawsuit to enforce the FCA must be brought within six years of the violation, or, if the government brings the suit, within three years of when the government knew or should have known the facts about the violation. A suit can never be brought later than ten years after the date the violation was committed.

Administrative Remedies for False Claims

This federal statute allows for administrative recoveries by federal agencies. If a person submits a claim that the person knows is false or contains false information, or omits material information, then the agency receiving the claim may impose a penalty and additional amounts for the claim.

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

For reference purposes, the full code may be accessed in the United States Code, Title 31 Chapter 38 Sections 3801-3812: Administrative Remedies for False Claims and Statements.

New York False Claims Act

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

The NYS False Claims Act closely tracks the Federal False Claims Act. It imposes penalties and fines on individuals and entities that file false or fraudulent claims for payment from any state or local government, including health care programs such as Medicaid. It also has a provision regarding reverse false claims similar to the federal FCA such that a person or entity will be liable in those instances in which the person obtains money from a state or local government to which he may not be entitled, and

then uses false statements or records in order to retain the money.

There are penalties of at least $6,000 per claim and damages of three times the loss the government sustains because of the false claim. In addition, the false claim filer may have to pay the government's legal fees.

The Act allows private individuals to file lawsuits in state court, just as if they were state or local government parties, subject to some limitations imposed by the State Attorney General or a local government. If the suit eventually concludes with payments back to the government, the person who started the case can recover a percentage of the proceeds, amounts of which are dependent upon whether the government did or did not participate in the suit. (25% - 30% if the government did not participate in the suit, and 15% - 25% is the government did participate in the suit). For reference purposes, the full state law may be found in Article XIII: New York False Claims Act, Sections 187-194: State Finance Law §§187-194

New York Social Services Law

In addition to New York's False Claims Act, there are other state laws which address false claims. These laws fall into two categories: civil and administrative; and criminal laws. Some apply to recipient false claims and some apply to provider false claims, and while most are specific to healthcare or Medicaid, some of the "common law" crimes apply to areas of interaction with the government. Specifics relating to false claims in the NYS Social Services Laws may be found in Article 5, Title 1.

Civil and Administrative Laws:

Social Services Law §145-b False Statements

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

Social Services Law §145-c Sanctions

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

Criminal Laws

Social Services Law §145 Penalties

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

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

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

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

New York Penal Law

The following references are from the NYS Penal Laws: NYS PENAL LAW Articles 155, 175, 176, 177

Penal Law Article 155, Larceny.

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

Penal Law Article 175, False Written Statements.

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

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

b. § 175.10 - Falsifying business records in the first degree - includes the elements of §175.05 and the intent to commit another crime or conceal its commission.

c. §175.30 - Offering a false instrument for filing in the second degree - involves presenting a written instrument, including a claim for payment, to a public office knowing that it contains false information.

d. §175.35 - Offering a false instrument for filing in the first degree - includes the elements of §175.30 and an intent to defraud the state or a political subdivision.

Penal Law Article 176, Insurance Fraud

Applies to claims for insurance payment, including Medicaid or other health insurance and contains six crimes involving filing false insurance claims and committing insurance fraud.

Penal Law Article 177, Health Care Fraud.

This statute, enacted in 2006, applies to health care fraud crimes. It was designed to address the specific conduct by health care providers who defraud the system including any publicly or privately funded health insurance or managed care plan or contract, under which any health care item or service is provided. Medicaid is considered to be a single health plan under this statute. This law primarily applies to claims by providers for insurance payment, including Medicaid payment, and it includes six crimes.

a. Health care fraud in the 5th degree - a person is guilty of this crime when, with intent to defraud a health plan, he or she knowingly and willfully provides materially false information or omits material information for the purpose of requesting payment from a health plan.

b. Health care fraud in the 4th degree - a person is guilty of this crime upon filing such false claims on more than one occasion and annually receives more than three thousand dollars.

c. Health care fraud in the 3rd degree - a person is guilty of this crime upon filing such false claims on more than one occasion and annually receiving over ten thousand dollars.

d. Health care fraud in the 2nd degree - a person is guilty of this crime upon filing such false claims on more than one occasion and annually receiving over fifty thousand dollars.

e. Health care fraud in the 1st degree - a person is guilty of this crime upon filing such false claims on more than one occasion and annually receiving over one million dollars.

Whistleblower Protections

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

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

New York State False Claim Act (State Finance Law §191)

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

New York State Labor Law, Article 20-C

In addition to New York's False Claims Act, there are other state laws which address false claims and provide employees with protection against retaliation. The following references are from the NYS Labor Law which can be found in the Consolidated Laws of the State of New York, Labor (LAB): Consolidated Laws of the State of New York, Labor (LAB)

New York State Labor Law, Section 740

An employer may not take any retaliatory action against an employee if the employee discloses information about the employer's policies, practices or activities to a regulatory, law enforcement or other similar agency or public official. Protected disclosures are those that assert that the employer is in violation of a law that creates a substantial and specific danger to the public health and safety or which constitutes health care fraud under Penal Law §177 (knowingly filing, with intent to defraud, a claim for payment that intentionally has false information or omissions). The employee's disclosure is protected only if the employee first brought up the matter with a supervisor and gave the employer a reasonable opportunity to correct the alleged violation. If an employer takes a retaliatory action against the employee, the employee may sue in state court for reinstatement to the same, or an equivalent position, any lost back wages and benefits and attorneys' fees. If the employer is a health provider and the court finds that the employer's retaliatory action was in bad faith, it may impose a civil penalty of $10,000 on the employer.

New York State Labor Law, Section 741

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

CODE OF ETHICS

Everyone employed by the Agency shall maintain the highest level of honesty and integrity in all his/her actions performed on behalf of the Agency. The following list (which is not all inclusive) lists the expected behavior of the Agency's staff or representatives:

1. Maintaining the confidentiality of all Agency records. These include individual records of the service participants, WLCR reports, financial records and personnel records.

2. Avoid unauthorized use of WLCR assets including property, supplies and equipment.

3. Maintain the public image of WLCR. All staff members should conduct themselves in a manner which reflects positively on the Agency's image both internally and externally. Everyone should deal fairly and appropriately with WLCR's service participants, other employees, consultants and vendors.

4. Each staff member is expected to perform his/her job responsibly. He/she is expected to know what is required of his/her position and that these requirements are performed at the highest level possible.

5. Each employee has a primary responsibility to WLCR and is expected to avoid any activity that may interfere or have the appearance of interfering with the performance of his/her job responsibilities.

6. WLCR staff shall not engage in any activities that constitute abuse of persons receiving services as defined in the regulations of the Commissioner of OPWDD. Failure to exercise one's duty to intercede or report any activity which may be considered abuse will constitute abuse.

7. All staff must maintain a professional relationship with the service participants he/she serves. There should be no financial transactions between staff and service participants. All staff are expected to maintain a professional demeanor with the service participants. All staff are expected to model appropriate and acceptable behavior while in the presence of the service participants.

8. As a tax-exempt, non-profit agency, there are several guidelines which must be adhered to. Some of them are:

    A. WLCR's sales tax exemption may be used only for legitimate Agency business and service transactions

    B. All appropriate withholding taxes must be applied to staff wages.

9. All time and attendance records must be accurately entered and recorded. Staff should not be conducting personal business while on the clock. All activities done to justify billing must be accomplished accurately, on a timely basis. Staff should never certify performing services that have not been performed. In addition, he/she should not misrepresent the services which were performed.

10. Each employee has a primary business responsibility to WLCR and is expected to avoid any activity that may interfere or have the appearance of interfering with his/her performance. A conflict of interest exists if an employee's outside business or other interests may affect adversely, or have the potential to affect adversely, his or her motivation, objectivity, loyalty or performance. In addition, a potential conflict of interest occurs when an individual's personal or private interests might lead an independent observer to reasonably question whether the individual's professional

actions or decisions are influenced by significant personal interest, financial or otherwise.

If a relative of a member of the Board of Directors or a key employee such as the Executive Director wants to be hired by WLCR, this could be a conflict of interest. Precautions have to be taken to ensure that this person is the most qualified person for the position and his/her salary is commensurate with what others in the same position are receiving. In addition, the member of the Board of Directors or the key employee must recuse himself/herself from any decision to hire or any decision in the future to promote the relative.

CORPORATE COMPLIANCE PROGRAM OVERVIEW

All programs are required to adhere to Medicaid and WLCR rules prior to billing for services provided. The Accounting and Bookkeeping Department has an Accounting Manual which prescribes how to bill for the various programs. Bookkeeping must make sure to keep this manual current so that it covers all programs. In addition, there are Administrative Memoranda and the New York State Regulations issued by OPWDD for all of the various programs which prescribe the documentation needed to bill for each program.

Women's League's internal compliance controls, to ensure that there are no erroneous or inappropriate billings, include routine reviews of documentation in support of billing by Waiver program managers and the Agency's Quality Assurance Department. OPWDD memoranda and regulations delineate which documentation supports billing.

Waiver program managers / supervisors review, on a monthly basis, Waiver Habilitation documentation to ensure that staff have recorded service provision accurately.

The Bookkeeping Department reviews all billing rosters received from managers to check for irregularities and other potential issues.

For ICFs, the managers will notify the Bookkeeping Department, in writing, of any hospitalization of any of their service participants.

A person designated by the Bookkeeping Department reviews, on a monthly basis, IRA Res Hab service checklists to ensure that staff have recorded service provision accurately.

QA conducts centralized, in-office reviews of waiver and MSC billing documentation, as it is produced. In addition, QA will conduct on-site, programmatic reviews of the MSC program and each Waiver program annually.

In the course of any of the reviews described in this plan, the scope of the review could be expanded to make sure that all potential issues are identified and that corrective procedures are put in place to prevent any recurrence.

Upon notification of a potential billing documentation error or concern, the Corporate Compliance

Officer will determine the appropriate course of action.

In the Early Intervention (EI) Program, all service coordinator notes are reviewed by management prior to billing. All evaluations are reviewed by an evaluation coordinator prior to billing. All therapists' documentation of their service provision is reviewed for content quality and accuracy by two staff members. Women's League EI billing system is programmed to reject all duplicate billings. Prior to any billing being transmitted to the City, i.e., service coordinator notes, evaluations or therapists billings, a cross check is done by someone other than the person doing the data input.

Additionally, the EI Program QA staff randomly reviews files during the year for billing and quality accuracy.

All candidates for employment who have regular and substantial contact with the service participants are required to undergo a Criminal Background Check (CBC) prior to working unsupervised, one on one with the service participants. Each month, a list of new hires is sent to QA along with the CBC approval notice. These are reviewed for completeness. If there are any questions, they are clarified with the Personnel Department prior to approval of the monthly list.

If a position requires a certain educational background or license, the Personnel Department will verify with the school and/or state the validity of the diploma and/or license.

The Personnel Department will make the required checks with the State Central Registry as well as the Justice Center (SEL and Section 1834) prior to allowing the potential employee to work unsupervised with the individuals.

The personnel department will also verify that any candidate for employment is not on the state or federal 'excluded provider' lists. In addition, all employees and contractors of the Agency will be screened against both 'excluded provider' lists once a month.

Use of Agency Funds and Resources:

Controls must be established to ensure that Agency funds are not spent for items or services unrelated to Agency business. All agency vehicles have mileage logs which are regularly reviewed to ensure that they are not used for personal business. The personal allowance funds are audited quarterly by the QA department to make sure they are used for the benefit of the service participants and are used for permissible purposes. Staff in bookkeeping review all requests for reimbursement of travel expenses to make sure they were used for Agency business.

Purchasing/Competitive Bidding:

All purchases must be prudent, reasonable and related to the care of the service participants and/or to the operations of the Agency. Purchase orders are required for all major purchases. The Agency has procedures in place for managerial approval of all vouchers which are used to make purchases from Agency-approved vendors. For all purchases over $5,000.00, competitive bids must be obtained from, at least, three vendors. No bid may be opened until after the

deadline for submitting bids has passed. Written records of the competitive bidding process must be maintained. Note: for purchases between $5,000.00 and $15,000.00, bids may be obtained orally but a written record of each oral solicitation must be kept.

It is the stated policy of WLCR to comply with the provisions of N.Y.S. Executive Law Article 15-A and 5NYCRR § 140 - 143, which pertains to the Minority/Women Business Enterprises - Disabilities Equal Employment Opportunity (MWBE-EEO) Program, as further clarified by the guidelines and goals expressed by OPWDD in its Guidance Bulletins.

Medical Necessity/Quality of Care

All individuals receiving services must have a medical necessity for them. This will usually be established through completion/annual certification of the ICF/MR - LEVEL OF CARE ELIGIBILITY DETERMINATION FORM. The QA Department, as part of the Agency's self-survey process, assures that all requirements for entitlement to services have been met and continue to be met.

All staff are required to adhere to the standards of care required by OPWDD regulations, all other governmental regulations and Agency requirements. This will also be assessed during the Agency's self survey process (as well as during any ad hoc visits to ensure that a high quality of service is maintained.

All individuals hired by the Agency will be given the necessary training in order to properly perform his/her duties. He/she will be given follow up training periodically both as refresher training and to train them on new policies and procedures.

GOVERNANCE

1. The Board of Directors will receive training and orientation and understand its role thereby.

2. The Board of Directors must review and approve WLCR's finances. This includes revenue and expenditures, assets and liabilities and annual budgets. A Finance and Audit Committee has been established.

3. The Board of Directors is responsible, through the senior staff of WLCR, for seeing that all programmatic and administrative policies and procedures are developed, reviewed, approved, implemented and updated, as needed. An Executive Committee has been established.

DUTIES OF THE BOARD OF DIRECTORS

1. The Board of Directors must undertake reasonable efforts to ensure that compliance programs are in place and are effective.

2. The Board of Directors must follow up on system**ic** failures. This should be accomplished through proper interaction with the senior staff member responsible for the particular area in question.

EXECUTIVE COMPENSATION: BOARD OF DIRECTOR'S RESPONSIBILITY

1. The Board of Directors must ensure the reasonableness of the compensation packages of the Executives of WLCR as determined by a market value survey from comparable organizations or its equivalence.

2. The above data should be reviewed and recommended by the Board of Director's Audit Committee and discussed at a Board meeting and documented in the Board minutes.

3. The full compensation package should be included in the evaluation and in discussions with the Executive (e.g., deferred compensation, expense allowances, etc.). This should be, preferably, reduced to writing.

4. The Board of Directors must vote on the above compensation package. At least 2/3's of the Board must be present for the vote.

MANDATORY REPORTING

WLCR is responsible for certain mandatory reports.

These reports must be accurate and submitted on time.

Mandatory reports include: CFRs, financial statements, Form 990, other tax forms, e.g., payroll, unemployment, etc.. Responsibility for ensuring that these reports are accurate and filed timely rests primarily with the CFO, and in turn, with the CEO/Executive Director to whom he reports.

CORPORATE COMPLIANCE OFFICER

The Corporate Compliance Officer is responsible for the oversight of the Agency's corporate compliance program. If any allegations of impropriety are made, he/she will investigate the allegation, institute any corrective actions as appropriate, and insure that any improperly received monies are refunded. The Corporate Compliance officer will be responsible for ensuring that all staff are periodically trained on corporate compliance. This includes volunteers and the Board of Directors. He/she will be responsible for reporting any issues or concerns to the CEO/Executive Director and the Board of Directors. Staff will be made available to him/her to assist with any reviews and/or investigations which are needed.

TRAINING AND EDUCATION

All employees, both paid and volunteers, and including the Board of Directors will be trained on his/her rights and responsibilities under corporate compliance.

All new employees will receive initial training on corporate compliance as part of his/her initial orientation during the hiring process. During the following six months he/she will attend a mandatory training session on Corporate Compliance. Subsequent to that, there will be periodic training sessions to refresh the staff's knowledge of the Agency's Corporate Compliance Policies and to train them on any

changes which occur as a result of federal or state policy changes or which occur because of self-monitoring audits or audits by regulatory agencies. All training will be documented by sign-in sheets.

Independent contractors will be given the latest copy of the Agency's Corporate Compliance Plan as part of his/her contract.

OPEN LINES OF COMMUNICATION

All employees have the responsibility to report if something improper is happening. The success of the Corporate Compliance Plan is contingent on employees being able to report what they see as a violation of the plan without fear of retaliation as long he/she is reporting in good faith. It is an expected good practice, when one is comfortable with it and thinks it is appropriate under the circumstances, for concerns to be raised first with a supervisor. If this is not comfortable or not a viable option, employees are encouraged to contact the Corporate Compliance Officer directly at 347-390-1330. There is also a confidential hotline at 718-670-3258. This latter number only takes messages. Although such reports may be made anonymously, callers are urged to leave detailed information so that a full investigation can be made.

The Corporate Compliance Officer can also be contacted to ask questions regarding any compliance issue. If the caller leaves his/her name and telephone number, he/she will receive a response within no more than ten business days.

If an employee has a concern about the CEO/Executive Director, this should be reported directly to the Corporate Compliance Officer. If the concern is about the Corporate Compliance Officer, this should be reported to the CEO/Executive Director.

Questions or concerns about any ethical or legal issue may be raised without concern for disciplinary or retaliatory action as long as they are made in good faith. Employees will not be subject to reprisals or retaliatory actions for reporting or supplying information about potential violations, except in cases where those employees are responsible for the violation or when deliberate false reporting has occurred. All staff are required to assist in the resolution of any and all compliance issues. Failure to do so may result in disciplinary action.

DISCIPLINARY POLICIES AND PROCEDURES

WLCR will make every effort to ensure that its billings for medicaid services are as accurate as humanly possible. Erroneous billings can be classed into two broad categories: fraudulent billings and erroneous billings.

INCORRECT BILLINGS DUE TO FRAUDULENT ACTIONS

A decision as to the appropriate discipline for fraudulent actions will be made after consultation between the Corporate Compliance Officer, the CEO/Executive Director, the Program Director and the Program Manager/Supervisor. Depending upon the egregiousness of a first offense, the discipline may be either a two week suspension without pay or termination of employment. All second offenses will result in

termination of employment. Some examples of fraudulent actions include: certifying performance of actions which were not done; certifying actions done by someone other than the certifier; falsifying dates of certification of services; falsifying dates monthly notes prepared; duplicate billings for the same services; unqualified personnel performing services; persons performing services who are on the 'excluded provider' lists; upcoding - billing for a higher payment than the service warrants; billing for a Supervised IRA Residential Habilitation day when a service "was performed" but the individual was not present in the IRA; always billing for Supportive IRA Residential Habilitation for a full month for all individuals without verification and documentation; billing for a full month of Supportive IRA Residential Habilitation when there are less than 22 billable days; and billing for MSC, billing at the transition level for longer than warranted.

Regardless of the punishment, all erroneous billings will be voided or adjusted.

ERRONEOUS BILLINGS

Billing errors resulting from oversight, carelessness or lack of knowledge will be addressed depending on the circumstances of the errors. Corrective action may consist of remedial training, internal reviews, or any type of discipline ranging from counseling, verbal warnings, written warnings, removal from a position or termination of employment. All decisions will be made by management in consultation with the Corporate Compliance Officer in order to maintain consistency.

In all cases, all erroneous billings will be voided or adjusted.

CAUSING/PERMITTING IMPROPER ACTIVITIES

Anyone who encourages, directs, facilitates or permits improper activities, whether or not they ultimately result in erroneous billings will be subject to discipline depending on the egregiousness of the activity. See section on Incorrect Billings Due to Fraudulent Actions for sequence of discipline.

SYSTEMIC AND ROUTINE IDENTIFICATION OF COMPLIANCE RISK AREAS

The Corporate Compliance Officer will be responsible for ascertaining any risk areas which need oversight, internal reviews or periodic spot checks. He/she will keep abreast of potential issues through use of the following:

State and Federal Audits
Internal/external audits and reviews such as the semi-annual fiscal inventories done by the QA Dept., the programmatic self-surveys done by the QA Dept., the Limited Fiscal Reviews, the triennial Social Security Onsite Review
Areas of risk uncovered in prior reviews and/or audits
Areas brought up at OPWDD meetings as well as at provider association (IAC, NYSACRA) meetings and releases from these groups

SYSTEM FOR RESPONDING TO COMPLIANCE ISSUES AS THEY ARE RAISED

As any compliance issues are raised, the Corporate Compliance Officer, together with any assigned staff, will take any or all of the following steps:

1. If the health and/or safety of anyone is affected, they will take all necessary steps to protect them.

2. A thorough investigation of the issues raised will be undertaken. All evidence will be secured and all appropriate parties will be interviewed.

3. All investigations will be handled as expeditiously as possible.

4. All employees are required to cooperate with any staff assisting the Corporate Compliance Officer in an investigation.

5. A final report will be issued to the CEO/Executive Director and the Board of Directors summing up the process and the results. If corrective action is appropriate, the Corporate Compliance Officer will follow up to ensure that it takes place.

6. The Corporate Compliance Officer will ensure that any erroneous billings are voided or adjusted.

7. The Corporate Compliance Officer, together with the administrative, management and supervisory staff, will ensure that there is no retaliation against any employee who, in good faith, reports fraudulent or incorrect activities on the part of any of the staff.

NON-INTIMIDATION AND NON-RETALIATION POLICIES FOR REPORTING

Any form of discipline or retaliation against **any** employee who reports a perceived problem or concern in good faith is strictly prohibited. **Any** employee who commits or condones **any** form of intimidation or retaliation will be subject to discipline up to, and including, termination.

SELF-DISCLOSURE

The Office of the Medicaid Inspector General (OMIG) has set up a protocol for self-disclosure of improper or fraudulent billings. Self-disclosure is proper in the following situations:

Substantial routine errors
Systematic errors
Patterns of errors
Potential violation of fraud and abuse laws

If such a situation occurs, the Corporate Compliance Officer will conduct a full investigation covering all

areas outlined in the OMIG's Self-Disclosure Guidance. The officer will then contact the director of OPWDD's Division of Quality Management and proceed further as per his instructions.

OTHER IMPORTANT POLICIES AND PROCEDURES

1. The Agency's independent audit firm should not provide non-auditing services on a regular basis (e.g., bookkeeping, legal services, etc.) to avoid a conflict of interest.

2. Form 990, which is publicly available, should be understood by the CEO/Executive Director, the CFO and the members of the Board of Directors. The Corporate Compliance Officer of WLCR, who serves as the Agency's Internal Auditor as well, will provide the necessary assistance to accomplish this practice.

3. Clear policies and procedures will be established concerning any loans made to employees of the Agency. Loans may not be made to members of the Board of Directors or to executives of the organization.

4. It is a clear policy that Corporate Compliance is a mainstay of WLCR, and as such this message will be disseminated from the top, i.e., the CEO/Executive Director and the Board of Directors.

To report a Compliance Concern, contact:

MR. DAVID SINGER, CORPORATE COMPLIANCE OFFICER:

718-853-0900 ext. 330 or 347-390-1330

or

CONFIDENTIAL HOTLINE: 718-670-3258