ATTACHMENT A

CORPORATE COMPLIANCE AND ETHICS PROGRAM

I. INTRODUCTION

The Friendly Home (the "Home") provides nursing care, rehabilitation and related services that enhance the quality of life for older adults, and is committed to being the provider and employer of choice, continuing a tradition of not-for-profit service to the community. We recognize the complexities associated with the financing and delivery of our services and, as such, have established this Corporate Compliance and Ethics Program (Program), which includes the Standards of Conduct and Corporate Compliance and Ethics Plan, to assist in meeting the needs of those we serve in a fashion that complies with our own philosophy and values as well as laws, rules and regulations applicable to the provision of residential long and short term care services.

Our Program reflects the organization's commitment to honest and ethical behavior in all aspects of service to our Residents and our relations with third-party payors, employees, independent contractors and vendors. The Program is designed to provide guidance to everyone to which the Program applies, including our corporate officers, senior administrators, managers, employees, medical staff members, volunteers, contractors, agents, subcontractors, and independent contractors (collectively, Affected Individuals), and to prevent fraud, waste and abuse while providing high quality care to our Residents.

We acknowledge that the Program is not fool proof and that it may not detect all intentional or unintentional instances of noncompliance. However, we believe that by following all of these guidelines, we have an effective Program that will uphold our standards and enable us to utilize internal controls to efficiently strive for assurance to our standards, and the laws and regulations that govern us.

A copy of this Program document is available in the Administrative, Finance, Human Resources, and Nursing Administration offices and may be reviewed at any time upon request by any Affected Individual. We recognize that ongoing monitoring, evaluation and revision to the Program may be necessary to achieve our objective of compliance with our standards.

Following initial training, there will be ongoing communication and training to maintain an appropriate level of awareness and understanding of the Program, its components and any additions or modifications.

The Board of Directors of the Home has adopted this Corporate Compliance and Ethics Program and has acknowledged its commitment to compliance and our ongoing process of implementation, monitoring and modification.

The success of any of our programs and services is dependent upon an open and collaborative relationship between our Board of Directors, staff, medical professionals, and outside relationships. I appreciate everyone's commitment to quality and to honest and ethical behavior as we work to carry out our mission of service to older adults.

Glen Cooper

President/Chief Executive Officer

II. PURPOSE STATEMENT

The Friendly Home is committed to maintaining a Corporate Compliance and Ethics Program that supports our priority of providing high quality care to our Residents. Our compliance efforts are designed to prevent, detect, and resolve conduct that does not conform to the Home's ethical and business practices; Federal and State law; or Federal, State and private payor health care program requirements. Our Program includes standards of conduct, provides a structure for Corporate Compliance and Ethics training, requires internal audits, and facilitates communication regarding overall compliance.

The Program includes not only the policies and standards described in this document, but also those established by Federal and State laws and regulations, and other policies and procedures of the Home, including, but not limited to policies on internal control, employment, Residents' rights, patient abuse and neglect, sexual harassment, and billing.

We are committed to conducting our business affairs with integrity based on sound ethical and moral standards. We will not tolerate fraud, waste, or abuse and will strive to always deliver medically necessary services in the most efficient and prudent manner, while providing compassionate and high quality care. We hold our employees, medical professionals, independent contractors and vendors, and others that we conduct business with to these same standards.

To ensure effective compliance and ethics throughout the Home, we will provide timely and ongoing education for our employees and medical professionals. We promote self-monitoring of our activities and provide oversight to reach the goal of compliance with our standards. We seek to provide an atmosphere that is safe, encourages open discussion of compliance and ethics matters without fear of retribution, and provides prompt identification and resolution of issues.

All Affected Individuals shall report compliance or ethics concerns to the Home Corporate Compliance and Ethics Officer. Failure to report suspected problems, assisting or participating in fraud, waste abuse or other non-compliant behavior, or encouraging, directing, permitting or facilitating such activities whether actively or passively will result in disciplinary action in accordance with the Home's Progressive Disciplinary Action Policy, which may include termination.

Neither the Friendly Home nor any Affected Individual will penalize, discriminate, or retaliate against anyone who, in good faith:

1. Reports a practice that the person believes in good faith may constitute fraud, waste or abuse, improper healthcare billing or payment, or any other practice or concern that may violate any law, regulation, or program requirement, or may raise a quality of patient care or workplace safety issue (collectively, a "Concern"). Protected disclosures include those made to a supervisor, a regulatory agency, a public official, to the news media or in a social media forum (provided required patient confidentiality is preserved);

2. Initiates, cooperates or participates in any self-evaluation, audit, investigation or corrective action;

3. Objects to or refuses to participate in any activity, policy or practice that the person believes in good faith may be a Concern;

4. Reports any harassment, intimidation or retaliation related to any of the protected activity described in (1) to (3) above.

Prohibited Retaliation includes (a) actions or threats to discharge, suspend or demote an Affected Individual, (b) actions or threats to adversely affect an Affected Individual's current or future employment, (c) threats to contact the United States immigration authorities or to otherwise report or threaten to report the suspected citizenship or immigration status of an Affected Individual or member of the Affected Individual's family or household.

Before publicly disclosing any Concern as described in (1), an Affected Individual must file a complaint with the Corporate Compliance Officer or Executive Director and allow the Home a reasonable opportunity to address the Concern, unless there is an imminent and serious threat to public health or safety, or a delay could endanger the welfare of a minor or result in physical harm to a person.

The objectives of this Corporate Compliance and Ethics Program are to:

1. Demonstrate our commitment to provide high quality of care in an honest and ethical manner, in conformance with applicable laws and regulations and our organization's standards;
2. Prevent, detect, resolve, and respond to accidental and intentional noncompliance and/or problems;
3. Reinforce standards of conduct through education and training;
4. Identify oversight responsibility for compliance and ethics;
5. Provide a structure for educating all Affected Individuals, regarding compliance and ethics standards;
6. Encourage open communication without fear of retribution;
7. Establish a reporting and response system for problems and suspected noncompliance;
8. Provide for progressive discipline of those involved in non-compliant behavior including termination;
9. Provide guidelines for auditing and monitoring compliance.

III. STANDARDS OF CONDUCT

These Standards of Conduct are divided into seven sections and reflect general policies of the Home. We recognize that they are not all-inclusive and may supplement or overlap policies already in place. The information below is a summary for each section.

All Affected Individuals associated with The Friendly Home are required to comply with the following Standards of Conduct. Violations of these Standards of Conduct or other policies and procedures of the Home will result in necessary corrective and disciplinary actions in accordance with the Progressive Disciplinary Policy, up to and including termination.

A. General – For All Affected Individuals

1. Notify the Corporate Compliance and Ethics Officer, supervisor, or, if necessary, President/CEO or Board member, of any questions, problems, or suspected instance of noncompliance.

2. Maintain high standards of business and ethical conduct in accordance with the Home's standards and applicable Federal, State, and local laws and regulations, including the laws and regulations described in the DRA Notice (Attachment C).

3. Deal honestly with all persons associated with the Home and in all business transactions.

4. Not offer, pay, solicit, or accept payments or anything else of value (kickbacks) in exchange for a referral for healthcare services covered by Medicare or Medicaid.

5. Ensure that all financial relationships with physicians are documented in writing and reviewed by legal counsel before they are implemented.

6. Prohibit discrimination because of age, race, creed, religion, sex, gender, color, familial or marital status, pregnancy, disability, predisposing genetic characteristics, sexual orientation, gender identity or expression, military status, national origin, status as a victim of domestic violence, or sponsor.

7. Be a prudent purchaser and user of services and supplies that avoid waste.

8. Comply with Federal and State laws concerning antitrust and unfair competition including price fixing, collusion with competitors, rigging of bids, boycotts, and unfair trade and business practices.

9. Not engage in Prohibited Retaliation against anyone for reporting Concerns.

B. Quality of Care

1. Accept and retain only those individuals to whom the Home can provide adequate care.

2. Prepare a comprehensive, accurate assessment of each resident's functional capacity and a comprehensive care plan that includes measurable objectives to meet the resident's medical, mental, and psychosocial needs.

3. Provide care to our Residents necessary to attain and maintain their highest practicable physical, mental, and psychosocial well-being.

4. Respond promptly to survey deficiencies, provide corrective action when necessary, and incorporate the corrective procedure into the Home's policies and educational programs as appropriate.

5. Provide appropriate and sufficient treatment and services to address Residents' clinical conditions in accordance with their plans of care and professional standards of practice.

6. Take proactive measures to identify, anticipate, and respond to quality of care risk areas.

7. Provide a clean, safe environment and an adequate and sufficiently trained staff to provide medical, nursing, and related services to the Residents.

8. Ensure that a physician supervises the medical care of each Resident.

9. Properly prescribe, administer, and monitor the Residents' drug medication usage. Ensure that medication records are complete and readily accessible.

10. Provide Residents with appropriate therapy services and provide assistance with activities of daily living such as feeding, dressing, bathing, etc.

11. Promptly report incidents of mistreatment, neglect, or abuse of Residents to the administrator or Corporate Compliance and Ethics Officer and to other officials as required by law.

12. Prepare and maintain adequate records and documentation in compliance with relevant laws, regulations, rules, professional standards of practice and applicable policies, including the Records Management Policy. The documentation shall support medical necessity of items and services ordered and provided. It shall reflect the clinical condition of the Resident and appropriate follow-up as defined by current professional standards of practice.

C. Residents' Rights

1. Adhere to the standards defined in the Home's Bill of Resident Rights.

2. Refrain from verbal, mental, or physical abuse of any Resident. If mistreatment or abuse is suspected, the administrator or designee, or the Corporate Compliance and Ethics Officer, shall be notified immediately and investigation shall be conducted promptly.

3. Practice non-discriminatory admission policies by offering to care for any potential Resident that is eligible in accordance with Federal and State laws governing admissions.

4. Maintain non-discriminatory identical policies for transfer, discharge, and provision of services for all Residents, regardless of payment source.

5. Properly safeguard the Residents' financial affairs. Residents shall have the right to choose to manage their own financial affairs or permit the facility to manage personal funds. The Home shall ensure that Residents' personal funds are not used to pay for items or services paid for by Medicare or Medicaid.

6. Residents shall have the right to access their personal records upon request. The facility shall preserve the confidentiality of those records and make no unauthorized disclosures.

7. Residents shall have the right to privacy in personal communications including the right to receive mail that is unopened and to use the telephone in private.

8. Residents shall have the right to participate in their care and treatment decisions, including the right to choose a personal physician and the right to refuse treatment, unless adjudged incompetent or incapacitated. The Home shall ensure that Residents are fully informed of their health status and that they and their designated representatives receive information regarding diagnosis, treatment, prognosis, and treatment options in a language they can understand. There shall be no inappropriate use of physical or chemical restraints.

9. Residents will be treated with dignity and respect and have freedom of choice, self-determination, and reasonable accommodation of individual needs.

D. Billing and Financial Activities

The standards of conduct contained in this section apply to Affected Individuals who work in the financial and clinical departments of the Home.

1. Ensure completeness, accuracy and uniformity in the billing of services regardless of source of payment.

2. Remit timely bills to Residents and third-party payors for reasonable and medically necessary services and items provided in accordance with billing procedures and medical record documentation. Ensure that genuinely signed orders exist where appropriate before submitting claims for reimbursement.

3. Address and resolve billing questions from Residents or third-party payors expeditiously and courteously.

4. Respond promptly to situations that result in inaccurate billing, including refunds for duplicate or overbilling.

5. Identify and resolve credit balances, providing refunds when appropriate.

6. Confirm Residents' eligibility for Medicare Part A coverage for claims submitted to Medicare Part A.

7. Ensure that care provided to Residents is adequate and not substandard, before submitting claims for reimbursement.

8. Provide accurate information about a Resident's medical condition on the Minimum Data Set (MDS) to ensure a proper reimbursement.

9. Select the appropriate billing code that accurately describes the service, item, or condition to prevent upcoding.

10. Do not bill separately for items or services that are included in the per diem rate or may not be unbundled.

11. Do not bill Residents for items or services that are included in the per diem rate or otherwise covered by a third-party payor.

12. Ensure that cost reports are prepared as accurately as possible, documentation exists to support reported information, non-allowable costs are appropriately identified and removed, and related party transactions are treated properly.

13. Do not routinely waive coinsurance or deductible amounts without good faith effort to collect or to determine that the Resident is in financial need (waivers based on documented financial need may be permitted).

14. Perform purchasing and vendor selection functions independently of fundraising activities.

15. Adhere to compliance requirements regarding billing, coding, claim submission, and cost reporting.

E. Employee and Independent Contractor/Vendor Screening

1. Affected Individuals shall immediately notify their administrative contact who shall the notify the Corporate Compliance and Ethics Officer if subjected to an investigation, convicted of a crime, subjected to civil penalties, excluded from Federal health care programs, or if their license, certification or registration is revoked, suspended, curtailed, or is otherwise no longer in good standing.

2. Regarding employment and contracting, the Home shall:

   - Require that applicants disclose criminal convictions and exclusions from participation in Federal health care programs.
   - Upon initial hire or engagement, conduct background investigations on Affected Individuals.
   - Upon initial hire or engagement and monthly thereafter, screen Affected Individuals upon hire or engagement and monthly thereafter using the Office of Inspector General's List of Excluded Individuals/Entities (LEIE), the General Service Administration's System for Award

Management (SAM) exclusion database and the Office of Medicaid Inspector General's (OMIG) Medicaid Exclusion List (the Exclusion Databases) to confirm those individuals have not been excluded or debarred from participation in federal health care programs or the New York State Medicaid program, or debarred from participation in federal contracts. programs or grants (collectively, Excluded).

- Require contractors who provide services related to the Risk Areas listed in the next sentence to screen their employees and subcontractors using the Exclusion Databases to ensure they have not been Excluded and to promptly notify the Corporate Compliance Officer if any employee or subcontractor Excluded. The Risk Areas are billing, payment, ordered services, medical necessity, quality of care, governance, mandatory reporting, credentialing and direct patient care.
- Evaluate and periodically re-evaluate the credentials of employees and medical professionals to verify that requisite licenses, certifications and registrations exist.
- Prohibit employment of and execution of contracts with individuals or companies that have been convicted of a criminal offense related to health care, convicted of resident abuse, or are Excluded or otherwise ineligible from participation in Federal health care programs. Require contracts with individuals or companies who will be engaged in activities related to the Home's Risk Areas to include the Home's Compliance Addendum or Amendment. (See Exhibit L).

F. Conflicts of Interest

A conflict of interest may exist when an action or activity results in personal gain or advantage or has an adverse effect on The Friendly Home, its Residents and/or staff. The Home's Board of Directors has adopted a resolution concerning conflicts of interest. The resolution is contained in the Administrative Policy manual. In addition to it, all staff shall adhere to the following:

1. Report actual or potential conflicts of interest to the Corporate Compliance Officer.

2. Comply with the anti-kickback statute, which states that it is illegal to knowingly offer, pay, solicit, or receive bribes, kickbacks, or other remuneration in order to induce business reimbursable by Federal health care programs.

3. Comply with the Stark physician self-referral law, which generally prohibits a physician from making a referral for health services to an entity with which the physician or any member of his immediate family has a financial relationship.

4. Avoid inducement, solicitation of referrals, or other similar arrangements to other health care providers, suppliers, and Residents.

5. Do not disclose or use confidential and/or privileged information relating to the Home.

G. Records Retention

The Friendly Home will retain records per the Records Management Policy and governmental guidelines for records retention including:

1. Maintain appropriate and thorough medical records for each resident. Ensure that documentation supports medical necessity issues and clinical condition of the Residents.

2. Maintain records and documentation required for participation in Federal, State, and private health care programs and other governmental institutions, including the resident assessment instruments, comprehensive care plans, and survey information.

3. Maintain records, documentation, and audit data that support and explain financial activity, cost reports, and internal and external compliance monitoring activities.

4. Maintain records necessary to demonstrate that the Home has an effective Corporate Compliance and Ethics Plan including acknowledgement forms, Corporate Compliance and Ethics training materials, Corporate Compliance and Ethics report logs, results of investigations, audit results, corrective actions, and disciplinary actions.

5. Maintain correspondence files between the Home and, Medicare Administrative Contractors, Medicare, Medicaid, private payor insurers, other carriers, CMS, and State survey and certification agencies.

6. Maintain a log of oral inquiries between the Home and third parties that will document efforts to ensure compliance.

7. Ensure that all informational systems are secure, in working order, and can access Federal and State databases.

8. Prohibit falsification and backdating of records.

9. Limit appropriate access to information and documents to help avoid accidental or intentional fabrication or destruction of records.

ATTACHMENT C

The Friendly Home ("TFH") is committed to preventing and detecting fraud, waste and abuse. In support of this commitment, TFH has established a Corporate Compliance and Ethics Program. The purpose of the Corporate Compliance and Ethics Program is to establish appropriate controls that will help ensure consistent compliance with the federal and state laws which govern our activities, and to detect and address violations of the law by employees and others affiliated with TFH. The program applies to the Board of Directors, the Chief Executive Officer and all corporate officers, senior administrators, managers, employees, medical staff members, volunteers, contractors, agents, subcontractors, and independent contractors that work for, and do business with, or serve on the Board of Directors of the Home (Affected Individuals).

Elements of TFH's Corporate Compliance and Ethics Program include:

- A Corporate Compliance and Ethics Officer who is responsible for the day-to-day operations of the Corporate Compliance and Ethics Program.
- Written standards of conduct, policies and procedures that describe compliance and ethics expectations and promote TFH's commitment to compliance and ethics for all Affected Individuals.
- A Corporate Compliance and Ethics Committee that operates and monitors the Corporate Compliance and Ethics Program and initiates the necessary actions to correct any compliance problems.
- Regular, effective education and training programs for all Affected Individuals whose job descriptions include activities that are subject to the Corporate Compliance and Ethics Program.
- Procedures to encourage everyone to bring to the Corporate Compliance and Ethics Committee's attention any situation that may be a violation of law or the Corporate Compliance and Ethics Program without fear of threats, retaliation or punishment.
- A system that allows for confidential and anonymous reporting of compliance issues or concerns.
- A system to respond to allegations of improper or illegal activities and the enforcement of appropriate disciplinary action against Affected Individuals who have violated the Corporate Compliance and Ethics policies.
- Compliance audits and/or other evaluation techniques to monitor compliance and assist in the reduction of potential problem areas.

A goal of the Corporate Compliance and Ethics Program is to educate appropriate employees with respect to federal and State laws and regulations with which they must comply. In this regard, the federal Deficit Reduction Act ("DRA") requires TFH to provide all employees with "detailed information" about:

- The federal and state Civil False Claims Acts
- The federal administrative remedies associated with the False Claims Act
- New York State laws pertaining to civil or criminal penalties for false claims and statements
- Whistleblower protections provided under federal and state laws
- The role of federal and state laws in preventing and detecting fraud, waste and abuse

This letter provides you with the information required by the DRA.

Federal and New York Statutes

Filing False Claims

Numerous federal and State laws prohibit health care providers from submitting "false" or "fraudulent" claims to Medicare and Medicaid and other federally-funded health care programs. Presented below is a listing and description of various federal and State statutes related to the filing of false Medicare and Medicaid claims.

Federal Laws

1. False Claims Act, 31 U.S.C. 3729-3733.

   The federal False Claims Act imposes penalties and fines on individuals and entities that file false or fraudulent claims for payment from Medicare, Medicaid, or other federal health programs. The penalty for filing a false claim is $14,308-28,619 per claim and the recoverable damages are between two and three times the value of the amount falsely received. In addition, the false claims filer may have to pay the government's legal fees.

   The False Claims Act allows private individuals to file lawsuits in federal court, just as if they were federal prosecutors. If the suit eventually concludes with payments back to the government, the person who started the case can recover 25-30% of the proceeds if the government did not participate in the suit, or 15-25% if the government did participate in the suit.

2. Administrative Remedies for False Claims, 31 U.S.C. 3801-3812.

   This statute allows for administrative recoveries by federal agencies. If a person submits a claim that the person knows is false, or contains false information, or omits material information, then the agency receiving the claim may impose a penalty of up to $14,308for each claim. The agency may also recover twice the amount of the claim.

   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.

New York State Laws

New York false claims laws fall into two categories: administrative and civil laws; and criminal laws. Many of the laws overlap. Some apply to recipient false claims, and some apply to provider false claims.

A. Administrative and Civil Laws

1. New York False Claims Act (State Finance Law 187-194). The New York False Claims Act is similar to the federal False Claims Act. It imposes penalties and fines on individuals and entities that knowingly file false or fraudulent claims for payment from Medicaid or other State or local health care programs. The potential penalty for knowingly filing a false claim is (1) $6,000 - $12,000 per claim, (2) payment of three times the State's damages, (3) payment of three times the damages sustained by any local government, and (4) payment of the State's legal fees.

   The New York False Claims Act allows private individuals to file lawsuits in State court. If the suit eventually concludes with payments back to the State, the person who started the case can recover a percentage of the proceeds based on whether the State did or did not participate in the suit.

2. Social Services Laws 145-c. 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 needs or the person's family's needs are not taken into account for six months if a first offense, 12 months if a second offense (or a single offense if the benefits received are $1,000 - $3,900), 18 months if a third offense (or a single offense if the benefits received are over $3,900) and five years for four or more offenses.

3. Social Services Law 145-b False Statements. It is a violation to knowingly obtain or attempt to obtain payment for items or services furnished under any Social Services program, including Medicaid, by use of a false statement, deliberate concealment or other fraudulent scheme or device.

   The State or the local Social Services district may recover three times the amount incorrectly paid. In addition, the Department of Health may impose a civil penalty of up to $10,000 per violation if they involve more serious violations of Medicaid rules, billing for services not rendered, or providing excessive services. If repeat violations occur within five years, a penalty up to $30,000 per violation may be imposed.

B. Criminal Laws

1. Social Services Law 145, Penalties. Any person who submits false statements or deliberately conceals material information to receive public assistance, including Medicaid, is guilty of a misdemeanor.

2. Social Services Law 366-b, Penalties for Fraudulent Practices.

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

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

3. Penal Law Article 155, Larceny. The crime of larceny applies to a person who, with intent to deprive another of his property, obtains, takes or withholds the property by means of trick, embezzlement, false pretense, false promise, including a scheme to defraud, or other similar behavior. It has been applied to Medicaid fraud cases.

   a. Fifth degree petit larceny involves property of any amount. It is a Class A misdemeanor.

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

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

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

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

4. Penal Law Article 175, False Written Statements. Four crimes in this Article relate to filing false information or claims that have been applied in Medicaid fraud prosecutions.

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

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

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

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

5. Penal Law Article 176, Insurance Fraud. Article 176 applies to claims for insurance payment, including Medicaid or other health insurance, and contains six crimes.

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

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

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

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

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

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

6. Penal Law Article 177, Health Care Fraud. Article 177 applies to claims for health insurance payment, including Medicaid, and contains five crimes.

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

b. Health care fraud in the 4th degree is filing false claims for health care items or services and receiving over $3,000 in aggregate within a year from a health plan. It is a Class E felony.

c. Health care fraud in the 3rd degree is filing false claims for health care items or services and receiving over $10,000 in aggregate within a year from a health plan. It is a Class D felony.

d. Health care fraud in the 2nd degree is filing false claims for health care items or services and receiving over $50,000 in aggregate within a year from a health plan. It is a Class C felony.

e. Health care fraud in the 1st degree is filing false claims for health care items or services and receiving over $1 million in aggregate within a year from a health plan. It is a Class B felony.

Whistleblower Protection

1. New York Labor Law 740. An employer may not take any retaliatory action against an employee (including a former employee or an independent contractor) if the employee objects to, refuses to participate in, or discloses information about an employer's policies, practices or activities that the employee reasonably believes to be (1) in violation of a law or (2) to create a substantial and specific danger to public health or safety. Protected disclosures are those made to a supervisor, regulatory agency, law enforcement agency or a public official (including testimony before a public body conducting an investigation). In limited circumstances, 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 equivalent position, any lost back wages and benefits and attorneys' fees, a civil penalty of $10,000 on the employer, plus punitive damages if the violation was willful, malicious or wanton.

2. New York Labor Law 741. A health care employer may not take any retaliatory action against an employee if the employee objects to, refuses to participate in, or discloses certain information about the employer's policies, practices or activities to a supervisor, regulatory agency, law enforcement agency, public official, news media outlet or public social media forum. Protected disclosures are those that assert that, in good faith, the employee believes constitute improper quality of patient care or improper quality of workplace safety. The employee's disclosure is protected only if the employee first brought up the matter with a supervisor and gave the employer a reasonable opportunity to correct the alleged violation, unless the danger is imminent to the public 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 equivalent position, any lost back wages and benefits and attorneys' fees, a civil penalty of $10,000 on the employer, plus punitive damages if the violation was willful, malicious or wanton.

3. Federal False Claims Act (31 U.S.C. 3730(h)) and New York False Claims Act (State Finance Law 191). An employee who is "discharged, demoted, suspended, threatened, harassed or in any manner discriminated against" because of the employee's lawful acts under the federal or New York False Claims Act is entitled to reinstatement, double back pay with interest, special damages, and litigation costs and attorneys' fees.

   If you become aware of any compliance and/or ethical issues or have any questions regarding the information contained in this letter, please contact Michael Perrotta, TFH's Corporate Compliance and Ethics Officer, at (585) 789-3352.