

**Confidential and Proprietary**

**LAKE SHORE BEHAVIORAL HEALTH, INC.**

**COMPLIANCE PROGRAM PLAN**

May 20, 2016

# LAKE SHORE BEHAVIORAL HEALTH, INC.

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## **I. INTRODUCTION.**

In furtherance of its vision and mission, Lake Shore Behavioral Health, Inc., (hereafter “LSBH”) has established a Compliance Program that promotes an organizational culture that encourages truthfulness, ethical conduct and a commitment to compliance with federal and state laws, rules and regulations, payor program requirements and LSBH’s business practices governing its operations. LSBH believes that infusing clinical, business, and compliance expectations throughout all aspects of the organization creates an environment that encourages everyone to become part of the compliance process and results in accountability at every level of service. This document describes LSBH’s Compliance Program, which consists of a combination of this Compliance Plan together with all of LSBH’s operational policies and procedures designed to ensure compliance with laws and regulations.

LSBH provides a full continuum of comprehensive Mental Health and substance abuse treatment and rehabilitation services. LSBH is subject to numerous laws, rules and regulations governing areas such as access to services; consent for services; record retention, access and confidentiality; consumer's rights; and service delivery. LSBH is also subject to federal and state labor laws, discrimination laws, consumer protection laws, tax laws and general and professional liability laws.

The Corporate Compliance Program is designed to provide guidance to all LSBH colleagues and assists employees in carrying out daily activities within appropriate ethical, professional, and legal standards. These obligations apply to our relationships with clients, affiliated providers, third-party payors, independent contractors, and fellow employees. All persons associated with LSBH, including LSBH Board members, employees, affiliated providers, and independent contractors, are expected to read and become familiar with the contents of this plan and sign an attestation statement to verify they have done so.

### **A. Vision, Mission and Beliefs.**

It is LSBH’s vision that all residents of Western New York will have easy access to a full continuum of high quality behavioral health treatment and recovery services, which they can utilize without fear of stigma or discrimination.

LSBH’s Mission is that Lake Shore Behavioral Health, Inc. promotes self-sufficiency, wellness and recovery, and an enhanced quality of life for all individuals with mental illnesses and addictive disorders by providing effective, accessible and culturally sensitive services.

LSBH’s beliefs are:

- Mental illness and addictive disorders are treatable disorders from which individuals can recover;
- Persons with mental illnesses and addictive disorders can have a high quality of life, with proper rehabilitation and supports;
- Quality behavioral healthcare is person-centered and holistic;

- Public advocacy is necessary to combat the stigma of mental illness and addictive disorders;
- Inclusion of peers, families and significant others in services promotes successful outcomes;
- Partnerships must be established with all who have a stake in an individual's recovery;
- Services must be culturally relevant and sensitive;
- Services must be delivered in an effective and cost-efficient manner;
- Services must be integrated into the community to be effective;
- Our staff is our most important asset;
- New and innovative programs must be explored to achieve improved outcomes in the future;
- Integration of health care and behavioral health services is necessary; and
- Collaborative efforts offer opportunities to improve services and achieve greater efficiencies.

## **B. Overview of Compliance Efforts.**

LSBH's Compliance Program integrates various systems of operations with an emphasis on internal and external audits, reviews, benchmarks and trend analysis. It is based on effective and open communications, and relies on measurements to assure sustainability and success. The Program applies to: (1) billing; (2) payment; (3) medical necessity and quality of care; (4) governance; (5) mandatory reporting; (6) credentialing; and (7) other risk areas identified by LSBH. LSBH's Compliance Program incorporates operations and individual departmental program policies and procedures, all of which reinforce LSBH's commitment to high standards of performance and quality of services.

LSBH's Compliance Program applies to **all**: (1) individuals employed by LSBH; (2) individuals and entities providing services and supplies to LSBH; (3) affiliated providers, consulting physicians and independent contractors; and (4) administrators, directors, supervisors and members of the Board of Directors (all of the preceding collectively referred to as "Personnel"). All Personnel are expected to read, understand and comply with the Compliance Program (including the Code of Conduct) and attend required trainings on the Program. In addition, all Personnel are expected to report to their administrator, director, supervisor or to LSBH's Vice President of Corporate Compliance/Quality Improvement (hereafter "Compliance Officer"), President or the Compliance Report Line or Suggestion Box, any conduct that may violate this Program, LSBH's policies, or applicable laws and regulations.

Federal and state government agencies have intensified their efforts to audit, investigate and prosecute Medicare and Medicaid fraud, waste and abuse. Civil and criminal audits and investigations of the health care and human services industry are occurring at an unprecedented rate and resulting in large fines and criminal convictions. Even if the outcome of an audit or investigation is positive, a lengthy audit or investigation can be extremely intrusive and disrupt the ability of LSBH to provide care and services. An effective Compliance Program, such as this one, can substantially reduce potential liability for LSBH and its Personnel in the event of such an audit or investigation.

The Compliance Program is meant to elaborate upon and supplement, but not replace, any obligations that otherwise exist under law or regulation that govern LSBH's practices, as well as the policies and procedures of applicable governmental agencies.

**C. The Program's Elements.** LSBH's Compliance Program consists of the following eight (8) elements as follows:

- (1) Written overview of compliance principles and compliance-related policies and procedures, including a Code of Conduct;
- (2) Appointment of a: (i) Compliance Officer, who is responsible for the oversight of the Compliance Program and the day-to-day operation of the Compliance Program; and (ii) a Compliance Committee to work with the Compliance Officer;
- (3) Training and education of all affected Personnel about the Compliance Program;
- (4) Mechanisms to report compliance concerns;
- (5) Disciplinary policies to encourage good faith participation in the Compliance Program;
- (6) Systems for identifying compliance risk areas, including self-monitoring and internal auditing;
- (7) Systems for responding to, investigating, and correcting compliance issues; and
- (8) A policy of non-intimidation and non-retaliation for good faith participation in the Program.

LSBH's development and implementation of these eight (8) elements requires the full cooperation and participation of all Personnel. Such cooperation and participation ensures that LSBH maintains a high level of honest and ethical behavior in the delivery of its services.

## **II. CODE OF CONDUCT AND PHILOSOPHY.**

It is the philosophy of LSBH that a well articulated Code of Conduct provides the necessary context within which all members of the organization should function -- a context that

reflects the duties each individual owes to LSBH, and to the adults, children and families LSBH serves. This Code of Conduct “Code” has been adopted by Board of Directors of LSBH to provide guidance to all LSBH Personnel and to assist us in carrying out our daily activities and responsibilities according to appropriate ethical and legal standards. This Code is a critical component of LSBH’s overall Compliance Program.

The Code applies to all Personnel. It is a formal statement of LSBH’s commitment to ethical and honest conduct in its business dealings. This Code lays out general rules of conduct with more specific details provided in training sessions, policies and procedures (including applicable regulations and guidance) and job-specific duties and responsibilities.

LSBH strives to ensure that all aspects of client care and the business conduct of its Personnel are performed in compliance with its mission and vision statements, policies and procedures, professional standards, applicable governmental laws, rules and regulations, and other payer standards. LSBH expects every person who provides services to its clients to adhere to the highest ethical standards and to promote ethical behavior. Any person whose behavior is found to violate ethical standards will be subject to appropriate discipline.

#### **A. General Standards.**

- Honesty and Lawful Conduct. Personnel must be honest and truthful in all of their dealings. Personnel must avoid doing anything that is, or might be, against the law and must be knowledgeable about and comply with all applicable laws and regulations. Any Personnel who are unsure whether an action is lawful, are required, prior to action, to review it with the appropriate administrator, director, supervisor or the Compliance Officer.
- Respect for Individuals Served. Personnel must fully respect the rights of the individuals served, including their rights to privacy, respect, dignified existence, self determination, participation in their own care and treatment, freedom of choice, ability to voice grievances, and reasonable accommodation of client needs. All LSBH clients shall be provided a Notice of their rights upon admission to any LSBH program.
- Confidentiality. Personnel must keep all information concerning the individuals they serve in strict confidence in keeping with all confidentiality laws and regulations including HIPAA, the HITECH Act, federal laws covering substance abuse treatment records and LSBH's confidentiality policies and procedures. Such information shall not be disclosed to anyone unless authorized by the individual or his/her representative, or otherwise as permitted or required by law. Open and closed records, in both electronic and paper formats, must be handled as confidential by the standards cited above. All personnel are expected to maintain the integrity all service records. All questions about these policies and procedures should be directed to the Compliance Officer.
- Business Information. Personnel may not disclose or release any confidential information relating to LSBH’s operations, pending or

contemplated business transactions including: acquisitions, divestitures, affiliations, mergers, financial data, strategic plans, marketing strategies, proprietary techniques, employee lists, confidential personal information, data maintained by the organization, and/or trade secrets without the prior authorization of the appropriate administrator, director or supervisor. All confidential information is to be used for the benefit of LSBH and the individuals it serves, and is not to be used for the personal benefit of Personnel, their families, or friends.

- LSBH's Assets. All of LSBH's assets shall be used solely for the benefit and purpose of LSBH. Personal use of LSBH's assets is prohibited unless following established procedure or disclosed to and approved by a member of the Senior Management Team. Personnel with access to cash must adhere to internal control procedures at all times and refrain from misappropriating LSBH's funds.
- Non-Discrimination. Personnel shall not discriminate based on the recipient's gender, race, sexual orientation, gender expression, religion, creed, military status, national origin, marital status, disability, status as a victim of domestic violence, source of payment or sponsorship, or other protected classes.

## **B. Billing For Services.**

- Accurate and Truthful Claims and Reports. All claims submitted for payment must be accurate and truthful, and reflect only those services and supplies that were properly ordered and provided. Expense reports, cost reports, reimbursement requests, and financial statements must be prepared as accurately as possible, and adequate documentation must exist to support information provided in the reports. No individual shall willfully or purposefully misrepresent any financial data, reports or reimbursement requests. Non-allowable costs must be appropriately identified and removed, and related party transactions must be treated consistent with applicable laws and regulations. Suspected errors in coding or billing should be reported to the administrator, director, supervisor or the Compliance Officer.
- Coding. Coding of services shall accurately reflect the services rendered. Personnel who perform coding and billing shall receive training regarding current regulations and codes annually or more frequently as needed. Such training will be provided internally or externally to affected employees, as appropriate. The training is intended to incorporate compliance concepts and updates of regulatory information needed to ensure that employees are current in their knowledge.
- Ordered Services. All services ordered, provided, and billed must be appropriate to the quantity and type of service provided. All services ordered, provided, and billed must be believed by LSBH's Personnel in

good faith to be reasonable, medically necessary, and in compliance with regulations.

- Verification of Coverage/Copays. To the best of Personnel's ability, insurance coverage and benefits shall be verified. Any changes in coverage, or changes in benefits, learned from a source other than the individual receiving service, shall be promptly communicated to the individual and/or the individual's family. Personnel shall comply with the requirement that Medicaid is a payor of last resort, shall ascertain that other payors are not primary before billing Medicaid deductibles and that copays have been paid.
- Adequate Documentation & Records. Billing of services must be based on complete, accurate and contemporaneous documentation in the associated records to support the services provided, in accordance with applicable laws and regulations and third party payor requirements. The term "records" includes all documents, both written and electronic, relating to services provided by LSBH. All documentation must be completed by Personnel in a timely manner. Records must reflect the actual service provided. LSBH has oversight systems to verify that clinical documentation accurately reflects services provided. All corrections or additions to records must reflect the date of the addition or correction, the name, signature, and title of the person making the correction or addition, and the reason for the correction or addition if not apparent. No person shall ever sign the name of another person to any document. Electronic signatures are accepted. Signature stamps shall not be used. Backdating and predating documents is unacceptable and will lead to discipline up to and including termination of employment.
- Inadequate or Substandard Care or Services. Claims for payment shall not be knowingly submitted for inadequate, substandard or unsubstantiated care or services.
- Excluded Providers. Claims for items or services furnished by an individual or entity that has been excluded from participation in a federal or state health care program shall not knowingly be submitted for payment.
- Record Maintenance and Retention. Personnel must record and report all agency, client and financial information fully, accurately and honestly. All identifying and demographic information will be accurately entered into the chart and supported by a photo ID of the client. Records include, but are not limited to, progress notes and other documentation for the individuals LSBH serves, accounting books, billing records, timesheets, expense reports, vouchers, bills, payroll, correspondence and others. All relevant information must be included in a format that complies with all applicable LSBH policies and procedures, and laws and regulations, and no relevant information shall be concealed or omitted. Records that

contain confidential health information will be kept according to federal and state regulations addressing such records, particularly CFR 42, Part 2, 45 CFR, Parts 160 and 164 and NYCRR Parts 819.2, 819.5, 833.2, 822.5, 587.7 and 63 (HIV). Under no circumstances will a record be tampered with, altered, or destroyed to gain any perceived advantage for LSBH. Closed cases will be archived in accordance with regulations. Records that demonstrate the right to receive payment, including medical records, must be retained for ten (10) years. LSBH will keep all closed charts for 10 years and all Discharge Summaries for 25 years. Records slated for destruction will be shredded in accordance with HIPAA regulations.

### **C. Improper Payment or Gifts.**

- Credit Balances. A “credit balance” is an excess or improper payment as a result of billing or claims processing errors. If a department or program knows that it has received payments from a government agency or unit, private payor, or recipient of service for which it was not entitled, such payments shall be promptly refunded to the appropriate payor or recipient.
- Receipt of Payments and Gifts. Personnel may not accept any gifts, gratuities or tips from any individual (or his/her family) served by LSBH or from any individual or entity outside of LSBH, such as contractors and vendors, that are intended, or could be construed as intending, to influence the staff member’s actions and decisions.
- Compensation for Services to Others. Personnel may not accept compensation received for services provided to other individuals/organizations during normal work time at LSBH. All compensation should be paid directly to LSBH.
- Outside Employment. All staff will be expected to sign an attestation statement at the time of hire, and annually thereafter, that states they are not engaged in outside employment that could be perceived as a conflict of interest.
- Honoraria. During work time or when functioning as a representative of LSBH, personnel may not accept any personal honoraria or compensation while participating as faculty, speaker at educational programs or in development of publications.
- Payment of Items or Gifts. Personnel may not give anything of value, including gratuities, bribes, kickbacks, or payoffs, in any form, to any government representative, fiscal intermediary, carrier, contractor, vendor, or any other person in a position to benefit LSBH in any way.
- Exception for Nominal Value. Personnel may provide or receive ordinary and reasonable business entertainment and gifts of nominal value, if those gifts are not given for the purpose of influencing the business behavior or

clinical evaluation of the recipient. “Nominal value” is defined by the federal Office of the Inspector General as no more than \$10.00 per gift or \$50.00 per year per person.

**D. Medical Necessity and Quality of Care and Services.**

- Delivery of Care and Services. All clients served by LSBH will be afforded the care and services necessary to attain or maintain the highest possible physical, mental, and psycho-social well-being. All clinical staff will be trained to evaluate and provide appropriate services and are encouraged to seek guidance from management or other senior staff members regarding any areas of question or concern. An individual’s identified needs and goals will drive any decisions related to the provision of services. In cases where there is a question of medical necessity and/or medical efficacy, the clinician, the Program Director, the Vice President of Clinical Operations, or a member of the Utilization Review Team may ask that the Utilization Review Level III team review the case.
- Ability to Provide. LSBH will refer individuals and their families to other appropriate providers when it cannot provide for the individual’s identified needs and goals.
- Medical and/or Educational Necessity. Medical care and clinical services shall be based on medical necessity and professionally recognized standards of care. Non-medical services shall be based on the programmatic requirements for those services.
- Appropriate Treatment and Service. LSBH shall provide appropriate and sufficient treatment and services to address individuals’ clinical conditions in accordance with their plans of care and professional standards of practice. All Personnel shall be informed of, and protect and preserve, the basic rights of individuals served by LSBH. Personnel must interact with all individuals in an honest and ethical manner. Personnel shall provide services respectfully to an individual and his/her cultural, religious, or ethics background, and shall strive to continuously improve their understanding of all cultures. Care should be taken that intentions of staff using interventions designed to be supportive, such as hugging or handholding, are clearly understood by the client.
- Continuous Quality Improvement. LSBH shall establish processes to measure and improve the quality of its care and services, and safety of the individuals served. To the extent possible, LSBH’s quality assessment and improvement processes shall be coordinated with its Compliance Program.
- Accountability. Personnel shall be responsible for being knowledgeable, balancing individual needs, allowable benefits, and limited resources in providing services, supervision, and case management.

- Audit and Regulatory Review Performance. Personnel shall strive for deficiency-free audits and regulatory reviews. Any deficiencies identified by state, federal or national agencies may reflect noncompliance with applicable laws and regulations or required standards. Therefore, current and past audits and reviews should be periodically reviewed in order to identify specific risk areas, and where appropriate, incorporate corrective action into the program's policies, procedures, training and monitoring.

**E. Professional Practices.**

- Behavior of Personnel. Personnel shall seek to model appropriate and acceptable behavior to the individuals served and shall maintain professional boundaries with all such individuals, both in and out of the office. Personnel shall not share their personal information with LSBH's clients, including phone numbers and addresses.
- Operation Within Scope of Practice. All licensed staff will be expected to work within their license's scope of practice and adhere to the license's Code of Conduct and Ethical Requirements.
- Prohibited Activities. Personnel shall not engage in any activity that constitutes abuse or neglect and shall refrain from working under the influence of alcohol, illegal substances, or prescription/non-prescription medications that cause the appearance of being impaired (e.g., significant odor, impaired speech or judgment). Personnel are prohibited from possessing a firearm or weapon of any type at any LSBH location or satellite site. Personnel are also prohibited from selling or distributing drugs (prescription or otherwise), alcohol, or other illegal substances to any individual receiving services from LSBH. LSBH will not tolerate harassment by anyone based on the diverse characteristics or cultural backgrounds of those with whom we work. Any verbal or physical conduct including cursing, obscene and insulting language or conduct of a sexual nature creates an intimidating, hostile, or offensive work environment and will not be tolerated.
- Solicitation. Solicitation by one employee of another employee is prohibited while either individual is on working time, with the exception of activities related to raising funds for "Staff Appreciation" functions. The distribution of material of any kind is prohibited on working time, and is also prohibited in working areas at any time. This includes distribution through office mail or electronically. For purposes of this rule, break room areas are not considered work areas. Non-employees are prohibited from soliciting or distributing to employees for any purpose at any time on LSBH property, with the exception of individuals associated with the United Way annual campaign.

- Abusive Practices. Personnel shall not intentionally prescribe or administer improper medications, or have any intentional personal physical contact with, or engage in psychological abuse of, an individual that causes or has the potential to cause harm. Personnel must also refrain from any activity that could constitute sexual harassment, and may not engage in sexual contact or allow or encourage sexual contact with any individual receiving services from LSBH.

**F. Governance.**

- Board Oversight. The Board of Directors and its Compliance Committee shall exercise reasonable oversight over the implementation of the Compliance Program and ensure that it receives appropriate information in a timely manner as is necessary and appropriate. The Board of Directors duty of “reasonable oversight” includes the duty to make reasonable inquiry when presented with extraordinary facts or circumstances of a material nature (i.e. indications of financial improprieties, self-dealing, or fraud) or a major governmental investigation.

**G. Conflict of Interest.**

- Conflict of Interest. Personnel must disclose any actual or potential conflict of interest to ensure that the integrity of LSBH’s operations is not compromised. All Personnel must disclose to the Compliance Officer any financial interest that they or a member of their family have in any entity that does business or competes with LSBH in any manner in accordance with LSBH’s Conflict of Interest Policy.
- Performing Work or Providing Services for Competitor or Colleague. All personnel are advised to be especially sensitive to the potential for a conflict of interest or a violation of this Code of Conduct in performing work or providing services for any competitor or colleague organization of LSBH. Personnel are strongly reminded of their personal and professional responsibilities to adhere to this Code of Conduct and should immediately discuss any concerns or questions about a conflict of interest with the Compliance Officer.

**H. Tax Exempt Status.**

- Maintaining Tax Exempt Status. LSBH is a not-for-profit corporation that has been granted exemption from federal and state income tax. In order for LSBH to maintain its tax exempt status, LSBH and its Personnel shall not engage in any activity, including use of funds and/or resources (e.g., staff time), for political activities or fundraising, or other activities that violate the requirements for tax exempt corporations.

## **I. Mandatory Reporting.**

- Abuse, Neglect, Mistreatment. Individuals receiving services will be free from abuse, neglect and mistreatment. Any allegations of abuse, neglect or mistreatment must be immediately reported to the appropriate administrator, director or supervisor, and other officials as required by law, and investigated in accordance with applicable policies, rules, and regulations.

## **J. Credentialing.**

- Background Checks. LSBH, through its Human Resources Department, shall screen prospective personnel prior to engaging their services, against websites which provide information on excluded individuals and entities, criminal backgrounds, and professional licensure and certification<sup>1</sup>. Screening shall be done periodically to ensure that such individuals and entities have not been excluded, convicted of a disqualifying criminal offense, or had their licensure or certification suspended, revoked or terminated since the initial screening.
- Fingerprinting. In accordance with Part 575 of the NYS Laws of 2004, all persons hired to work in an OMH-licensed program, who will have regular and substantial unsupervised contact with clients must consent to background fingerprinting. These fingerprints will be taken by an OMH-designated site, who will submit them to Department of Criminal Justice Services (“DCJS”). DCJS will advise the provider whether or not the applicant has a criminal history that precludes employment. In cases where a person is denied employment because of this information, the applicant has a right to explain, in writing, why they should not be denied employment. If OMH maintains its determination that the applicant should not be employed, the applicant will be notified that employment is denied because of the information obtained in the criminal background history. The applicant has the right to obtain, review, and seek correction if such information in accordance with DCJS regulations.
- Driver Checks. Staff hired to drive clients, whether in an agency or personal vehicle, will consent to a driver’s license background check through the NYS Department of Motor Vehicles, prior to the time of hire. In addition, LSBH will contract with an outside vendor who will monitor state DMV records and report to LSBH when an employee is identified as having a driving infraction. In cases where LSBH is notified that an employee has received a driving infraction, continued employment will be based on the nature and severity of the infraction. Staff hired or contracted to drive in the LSBH Transportation Department and the

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<sup>1</sup> Licensure will be verified with the NYS Department of Education, OASAS and the CRC database. In addition, all personnel shall be screened to ensure they are not excluded individuals/entities and all personnel providing direct care to individuals receiving services from LSBH shall undergo criminal background checks.

designated drivers at the Lighthouse Residence for Women will be randomly drug tested in accordance with DOT regulations.

- NYS Statewide Central Register of Child Abuse and Maltreatment: All direct care staff in both OMH and OASAS licensed programs will be checked at the time of hire against the NYS Central Registry List, as indicated.
- Physicians. For physicians and other healthcare practitioners, LSBH shall also consult the National Practitioner Data Bank: <http://www.npdb.hipdb.com>, and verify the physician's license.
- Other Personnel. For all applicable employees and contractors, LSBH shall consult the Lists of Excluded Individuals/Entities at: (1) U.S. Office of Inspector General <http://www.oig.hhs.gov/fraud/exclusions/index.asp>; (2) Government Services Agency [www.EPLS.gov](http://www.EPLS.gov); and (3) the NYS Office of the Medicaid Inspector General [www.omig.state.ny.us/data/content/view/72/52/](http://www.omig.state.ny.us/data/content/view/72/52/).
- Director, Employee, and Contractor Certifications. LSBH shall require all potential directors, employees, and contractors to certify that they have not been arrested for or convicted of any criminal offense and that they have not been excluded from participation in any federal or state health care program. LSBH shall require all employees, Directors, and contractors to report to LSBH if, subsequent to their employment or commencement of Board of Director service or a contractual relationship, they are convicted of a criminal offense or that they have been excluded from participation in any federal or state health care program.

#### **K. Business Practices.**

- Improper and Illegal Means. LSBH will forego any business transaction or opportunity that can only be obtained by improper or illegal means, and will not make any unethical or illegal payments to anyone to induce the use of LSBH's services. No employee will collude with a client to present false or misleading information to another party.
- Business Records. Business and financial records must be complete, accurate and truthful, with no material omissions. LSBH's assets and liabilities must be accounted for properly in compliance with all tax and financial reporting requirements. LSBH's external and internal financial statements must be prepared in accordance with Generally Accepted Accounting Principles and annually subject to an external audit by independent Certified Public Accountants.
- Computer Resources and Internet Use. All Personnel who use LSBH's computer server and information systems assume the responsibility for using these resources in an appropriate manner and in accordance with

LSBH's Electronic Communications and Data Storage Policy and all employees will be required to sign an Employee Network Security Agreement. LSBH owns all information communicated or stored via computer. The computers are agency tools and are to be used only for agency business.

Employees may not access the Internet at work to post, store, transmit, download, or distribute any threatening; knowingly, recklessly, or maliciously false; or obscene materials including anything constituting or encouraging a criminal offense, giving rise to civil liability, or otherwise violating any laws. Additionally, this channel of communication may not be used to send chain letters, personal broadcast messages, or copyrighted documents that are not authorized for reproduction; nor are they to be used to conduct a job search or open misaddressed mail. Employees who abuse our communications systems may lose these privileges and be subject to disciplinary action. Employees using the Agency's electronic and telephonic communications systems have no expectation of privacy in such use. Employees using the Agency's electronic and telephonic communications systems for personal purposes are responsible for the costs of such use (*e.g.*, phone charges, fax line charges, etc.).

Employees are not permitted to use a code, access a file, or retrieve any communication stored on the Agency systems unless they have received prior permission to do so from the administration. Employees are prohibited from running a personal business on the Agency system. Employees also may not send, save, view, or access offensive material, including but not limited to sexual or racial jokes, comments or images, or any other jokes, comments or images that would offend someone based upon their race, color, religion, sex, age, national origin, marital status, disability or other status protected by law. Employees who violate this policy will be subject to disciplinary action, up to and including termination.

Employees are not allowed to share any issued password or code for any system (computer, phone, security, etc.). Any employee that shares their password or code with any other individual may be subject to disciplinary action.

Authorized representatives of the Agency may monitor and access use of these systems from time to time. This may include, but is not limited to, monitoring Internet usage and e-mail and voicemail messages entering, leaving, or stored on the Agency system.

- Portable Electronic Device Security. LSBH employees may use Portable Electronic Devices and personal computers (collectively, "Devices") to access, store, and transmit Electronic Protected Health Information (EPHI) and confidential business information when such Devices are properly safeguarded to prevent unauthorized use and disclosure of the information. LSBH policies on confidentiality and security of information apply

regardless of how the information is captured or stored and regardless of the ownership of the Device. All LSBH employees must protect all EPHI and confidential business information contained on their Devices. Federal regulations governing Confidentiality and Drug Abuse Patient Records (42 CFR Part 2) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its Security and Privacy Rules (45 CFR Parts 160 and 164) require LSBH and its employees to safeguard the confidentiality, integrity, and availability of EPHI that they create, receive, maintain, and transmit on their Devices in accordance with LSBH's Portable Electronic Device Security Policy.

- Loans. Appropriate LSBH Personnel shall maintain familiarity with all terms, conditions, and covenants contained in any loan/financing agreement, and shall refrain from any activity in direct conflict or breach of the terms, conditions, or covenants. Financial loans to or from any individual or business (other than recognized financial institutions and foundations) that furnish or receive supplies or services to or from LSBH are prohibited.
- Purchasing. Purchasing decisions must be made with the purpose of obtaining the highest quality product or service for LSBH at the most reasonable price. No purchasing decision may be based on considerations that Personnel, or their family member or friend, will benefit.
- Marketing and Referrals. All Personnel must refrain from improper or high pressure individual solicitation or marketing. Personnel must be truthful in the representations they make with respect to LSBH's services, and never agree to offer anything of value in return for new business or referrals.
- Relationships with Other Providers. Contracts, leases, and other financial relationships with hospitals, physicians, hospices, other medical providers and suppliers who have a referral relationship with LSBH will be based on the fair market value of the services or items being provided or exchanged, and not on the basis of the volume or value of referrals of Medicare or Medicaid business between the parties. Free or discounted services or items shall not be accepted or provided in return for referrals.

**L. Scope and Application of Standards to Personnel.**

- Responsibility of All Personnel. All Personnel are expected to be familiar with, and comply with, all federal and state laws, regulations, and rules that govern the duties covered in their job descriptions. Personnel are also expected to comply with LSBH's Compliance Program (including the Code of Conduct) and any applicable departmental and other compliance-related policies and procedures. Strict compliance with such standards is a condition of employment, and violation of any of these standards will result in discipline, up to and including termination of employment.

- Administrators, Directors and Supervisors. All administrators, directors and supervisors have the responsibility to help create and maintain a work environment in which ethical concerns can be raised and openly discussed. They are also responsible to ensure that the employees they supervise understand the importance of the Compliance Program (including the Code of Conduct). The failure of administrators, directors and supervisors to so instruct their subordinates or to take reasonable measures to detect non-compliance by their subordinates will result in discipline, up to and including termination of employment.
- Departmental Compliance Policies and Procedures. In addition to the Compliance Program, many of the departments have specific compliance policies and procedures. These additional policies and procedures are an integral part of the Compliance Program and are designed to complement and augment the standards set forth in this Compliance Plan.

### **III. COMPLIANCE PROGRAM STRUCTURE AND OVERSIGHT.**

LSBH has adopted a structure to establish oversight authority for the Compliance Program. This structure includes establishment of a Compliance Committee. The members of the Compliance Committee include: the Compliance Officer, the President, the Chief Financial Officer, the Vice Presidents of Clinical Operations and Community-Based Treatments and Supports, the Accounts Receivable Manager, the Manager of the IT Department and two members of the Board of Directors. All of these individuals or groups are firmly committed to supporting each employee in meeting the standards set forth in the Compliance Program.

The Compliance Program is structured to provide a direct reporting line to LSBH's President, or the Board of Directors.

#### **A. Compliance Officer.**

1. Authority and Duties. LSBH's Compliance Officer is a key member of the Senior Management Team, who is responsible for the day-to-day operation of the Compliance Program, for receiving, investigating and responding to all reports, complaints, and questions about compliance issues, and for oversight of regulatory compliance for all services provided by LSBH's Personnel. The Compliance Officer maintains regulatory resources, oversees implementation of the Compliance Program, responds to and acts on issues of potential non-compliance, and functions as a liaison to the Board of Directors.

The Compliance Officer shall possess the experience, training and integrity necessary to fulfill the responsibilities of the position. Such training and experience shall be in areas such as compliance and operations, including the business process of compliance, and shall reflect an understanding of the laws, regulations and standards applicable to the programs and services offered by LSBH. If any other work duties of the Compliance Officer create any conflict with his/her ability to function as Compliance Officer, whether due to a conflict of interest or as a result of time limitations, or otherwise, the Compliance Officer shall simultaneously report same to both LSBH's President and the Chair of LSBH's Board of Directors. The Compliance Officer

shall have direct access to both the President and the Board. LSBH's Compliance Officer is the Vice President of Corporate Compliance/Quality Improvement.

The Compliance Officer shall, with the assistance of other Personnel, as appropriate:

- Develop and supervise the implementation of policies, procedures, and practices designed to ensure compliance with the Corporate Compliance Program and HIPAA Privacy Program policies, and all applicable laws and regulations;
- Promote compliance with, and adherence to, LSBH's Code of Conduct, policies and procedures and applicable laws, rules, and regulations;
- Facilitate communication and activities on compliance matters throughout the organization;
- Develop and coordinate educational and training programs and materials for all Personnel;
- Monitor federal and state agency websites (e.g., OIG, OMIG, DOH, OMH, and OASAS) for guidance, reports, and other publications to prevent potential areas of weakness in compliance;
- Access resources within and without LSBH to effectively recommend revision of, and implement and monitor, the Compliance Program and HIPAA Privacy Program. The Compliance Program, and all future revisions thereof, shall include information about the organization and operation of LSBH and its programs to best assess compliance and to identify areas of weakness. Accordingly, the Compliance Officer shall have access to all relevant documents, systems and records necessary to fulfill his/her obligations and duties;
- Secure support from the President and Board of Directors for compliance initiatives including incentivizing the reporting of compliance concerns and assuring that no retaliation for such reporting activities occurs;
- Conduct and facilitate internal audits to evaluate compliance and assess internal controls;
- Develop and ensure the effective implementation of a confidential system through which LSBH's Personnel may express compliance concerns, and ensure that those concerns are appropriately addressed;
- Investigate compliance inquiries, Report Line and Suggestion Box complaints and, if appropriate, develop corrective action plans, including self disclosure reporting, if appropriate;

- Ensure that the Human Resources Department screens prospective personnel including regular background checks of employees, board members, vendors and consultants against all available databases listing excluded parties under state and federal fraud and false claim legislation in accordance with this Compliance Plan;
- Ensure that clinicians, independent contractors, suppliers, and other agents who furnish medical, nursing, or other care or services to LSBH's clients are aware of the Compliance Program's requirements;
- Disseminate information on LSBH's Compliance Program to independent contractors of LSBH;
- Work with the President and the Board of Directors in periodically reviewing and modifying the Compliance Program, including the Code of Conduct and the HIPAA Privacy Program, to reflect the evolving nature of applicable laws and regulations, and the priorities of LSBH;
- Access outside counsel and consultants where necessary and appropriate;
- Assist management in review of LSBH's contracts for compliance with applicable laws and regulations, and in confirming the qualified status of contractors, including review by counsel as appropriate;
- Coordinate and oversee the: (1) compliance initiatives of LSBH's Departments; (2) audits and investigations conducted by government agencies; and (3) Compliance-related Corrective Action Plans and Preventive Action Plans.
- Maintain documentation of the following: internal and external audit and investigation results, logs of Report Line calls and their resolution, corrective action plans, due diligence efforts with regard to business transactions, records of compliance training, and modification and distribution of policies and procedures; and
- Attend conferences, meetings or seminars designed to enhance understanding of the effective development and implementation of the Compliance Program and identification and management of risk areas.

The Compliance Officer's ultimate scope of authority and duties shall be determined by the President and the Board of Directors in accordance with Compliance Program requirements.

2. Distributing Responsibility. The successful implementation of the Compliance Program requires the distribution of compliance responsibilities throughout LSBH. As such, the Compliance Officer may seek the assistance of the Compliance Committee, President, general counsel or others in discharging such responsibilities, develop a system that distributes the responsibilities, and establishes accountability for performing such responsibilities.

Compliance issues are to be reported to LSBH's Compliance Officer. Depending upon the findings, issues will be brought to the attention of the President, the Compliance Committee and/or the Board of Directors.

3. Reporting. The Compliance Officer shall regularly report on LSBH's compliance activities to the President, Compliance Committee and to the Board of Directors at a minimum of once a year.

## **B. Corporate Compliance Committee.**

1. Appointment and Authority. The Board of Directors has appointed a Corporate Compliance Committee to advise the Compliance Officer and provide oversight in the implementation of the Compliance Program. The Corporate Compliance Committee ("Compliance Committee") consists of the Compliance Officer, the President, the Chief Financial Officer, the Vice Presidents of Clinical Operations and Community-Based Treatments and Supports, the Accounts Receivable Manager, the Manager of the IT Department and two members of the Board of Directors. LSBH's Compliance Officer reports directly to the President and to the Board of Directors. Through the Compliance Officer, the Compliance Committee shall report to the Board of Directors, as appropriate, and at minimum, on an annual basis.

2. Authority and Duties. The scope of the Compliance Committee's authority and duties shall be determined by the Board of Directors in accordance with the Compliance Program and the Bylaws of the Corporation, and modified from time to time as the Compliance Program is evaluated. Under the direction of the Compliance Officer, the Compliance Committee's primary duties are:

- Assessing existing policies and procedures that address identified risk areas and modifying the policies and procedures as needed;
- Working with the Compliance Officer to develop or modify standards of conduct, and policies and procedures that address specific risk areas to promote compliance with legal and ethical requirements;
- Establishment of annual agency-wide and program specific Quality Improvement activities;
- Under the direction of the Compliance Officer, advising and monitoring appropriate departments relative to compliance matters;
- Developing internal systems and controls to carry out compliance initiatives to ensure implementation of compliance standards and policies;
- Recommending and monitoring internal and external audits to identify potential non-compliant issues;

- Participating in developing a process to evaluate and respond to compliance-related complaints and problems;
- Receiving, reviewing, and recommending appropriate responses to reports of actual or potential non-compliance with applicable laws, regulations, Code of Conduct, and policies and procedures in coordination with the Compliance Officer and with the assistance of counsel as necessary; and
- Regular consultation with the Compliance Officer.

3. Meetings. The Compliance Committee shall meet quarterly or as deemed necessary and appropriate by the President or the Compliance Officer to review the status of the Compliance Program, assist in identifying risk areas, present and discuss potential compliance concerns and issues and recommend changes to the Compliance Program.

4. Record of Proceedings. The Compliance Committee shall record the proceedings of the Compliance Committee and issue written minutes. Minutes of the Compliance Committee shall be distributed to the Compliance Committee and the Board.

5. Coordination of Enforcement Efforts. The Compliance Committee shall have the responsibility to ensure that enforcement of the Code of Conduct and the applicable policies and procedures of LSBH as expressed in this Compliance Plan is achieved consistent with the due process rights afforded to individuals pursuant to applicable laws, regulations, and Bylaws.

6. Corrective Action Plans. Senior Management Team, under the direction of the Compliance Officer, the President and General Counsel as needed, will develop corrective action plans to address any instances of non-compliance. Such corrective actions plans must adhere to the compliance policies as set forth in this Compliance Plan and adhere to laws and regulations applicable to the subject matter of the plan. A summary of compliance activities—including the general subject matter and timetable—will be presented to the Compliance Committee at every meeting.

7. Departmental Coordination. The Compliance Committee shall be responsible for coordinating compliance efforts among LSBH's employees, including the following:

- (i) identifying existing and future compliance initiatives;
- (ii) coordinating such initiatives with LSBH's Compliance Program and ensuring conformity of all such initiatives with the policies and procedures set forth in LSBH's Compliance Program;
- (iii) approving by resolution such departmental initiatives, with such modifications as the Compliance Committee deems appropriate; and

- (iv) providing assistance to the Compliance Officer.

#### **IV. COMPLIANCE TRAINING AND EDUCATION.**

All Personnel shall receive training on LSBH's policies and procedures, including the Compliance Program, the expectations of LSBH's management with respect to compliance, and such other compliance matters. LSBH believes all employees should have the educational tools necessary to perform their jobs in a compliant and quality-driven manner. The Compliance Officer, in coordination with Senior Management, is responsible for setting the annual Employee Training Calendar. Using audit and monitoring feedback, the trainings are customized to the organization and tailored to the educational backgrounds of the targeted employees. Trainings will use a variety of presentation methods, including web-based, didactic, interactive, and group programs.

Training shall be provided by qualified individuals and shall be delivered in accordance with the following:

**A. Applicability.** All affected Personnel shall participate in training and education on the Compliance Program. Training programs should include sessions summarizing the Code of Conduct, LSBH's Compliance Program requirements, fraud and abuse laws, federal and state health care program and private payor requirements, clinical best practices, and agency policies and procedures. Any employee may suggest a topic for training and education by contacting the Compliance Officer. Attendance at compliance training sessions shall be mandatory and a condition of continued employment.

**B. Frequency.** Compliance Program training shall be made a part of the orientation for new employees and members of the Board of Directors and shall thereafter occur periodically. All new employees will be required to attend New Employee training given by a Human Resources representative within the first two weeks of hire. Site-specific orientation will be done at the program level by the Program Director or their designee. Twice a year, LSBH will conduct a day-long New Employee Orientation that reinforces compliance, regulatory, and clinical expectations.

All staff members will participate in training at the time of hire and annually thereafter. Training should also be set up for all Personnel to address changes in applicable laws, regulations, policies and initiatives. Additional training information or materials will also be disseminated at regular staff meetings or through other means. Personnel will be notified via email and/or flyers of all required and elective trainings and will be required to sign an attendance sheet. Such additional training is mandatory.

Adherence to the requirements of continuing education and training will be considered in the overall evaluation of the performance for each individual associated with LSBH. Failure to participate may result in disciplinary action which may consist of a written warning, up to and including possible termination of employment, subject to due process, and legal and contractual rights, if any, applicable to such individual.

**C. Targeted Training.** In addition to general compliance training and education, face-to-face training and targeted compliance training that is tailored to particular individuals and departments covering identified risk areas will be provided. Such training is mandatory.

**D. Training for Agents and Contractors.** LSBH mandates that all organizations acting as agents on its behalf, such as consultants and independent contractors, will comply with the Compliance Program. Consultants and independent contractors shall be furnished with a copy of the Code of Conduct, and have access to the Compliance Manual, policies and procedures and are expected to perform their duties in compliance with all Compliance Program requirements.

**E. Records of Training.** The Compliance Officer or his/her delegate shall ensure that records are maintained, including copies of training materials, the types of training program provided, dates scheduled, and the individuals in attendance at each training session (as evidenced by signed attendance sheets), for a period of ten (10) years from the date of training. Records of all trainings attended will be kept in the employee's individual Personnel File. The Compliance Officer shall provide the Compliance Committee access to records pertaining to continuing education and training programs. Records shall also include documentation of additional or corrective education and training given to LSBH Personnel who, based on competency reviews, audits or other available information, did not demonstrate knowledge sufficient to substantially adhere to applicable laws and regulations and LSBH's policies.

**F. Periodic Review of Training.** The Compliance Officer and Compliance Committee shall periodically monitor, evaluate and assess the effectiveness of LSBH's training and education programs and shall revise such programs as necessary to reflect internal and external audits, investigations or other compliance findings.

**G. Distribution of Compliance Information.** In addition to periodic training and in-service programs, the Compliance Officer will distribute any relevant new compliance information to affected Personnel. Such information may include fraud alerts, advisory opinions, newsletters, notices, posters, FAQs, bulletins and intranet site or email alerts.

**H. Distribution and Certification of Compliance Manual.** This Compliance Manual will be made accessible to Personnel in whatever format is deemed appropriate, including posting on LSBH's website. Personnel will be required to examine the Compliance Manual and certify their examination within sixty (60) days of receipt of access to the Manual. New Personnel must certify their receipt of and examination of the documents in the Manual within sixty (60) days after the commencement date of their employment. Subsequent to the initial certification, each officer, employee or member of the Board of Directors shall annually repeat the procedure of examining the documents in the Manual and certifying that he or she has examined its contents. The certifications will be distributed by, and returned to, the Compliance Officer or his/her delegate. In addition, all employees will be required to acknowledge, in writing, that adherence to LSBH's Compliance Program, and policies and procedures, is a condition of employment.

## **V. REPORTING COMPLIANCE ISSUES.**

**A. Required Reporting.** LSBH has established a compliance reporting system that includes an anonymous voicemail Report Line number and Suggestion Box. Suggestions boxes are located at every LSBH site, prominently wall mounted in common areas, to allow staff, clients, and others to submit suggestions, concerns, and/or complaints anonymously. Submissions are collected and returned to the Compliance Officer. Results are reported to the

site, via email, to maintain the anonymity of the submitter. Any action taken as a result of these suggestions is reported back to the Compliance Committee.

If any Personnel believe in good faith that fraud, waste, abuse or other improper conduct has occurred in violation of laws, regulations, guidelines or the Compliance Program, the individual is required to report such information internally to the Compliance Officer, or as set forth below. The Compliance Program encourages individual responsibility for reporting any activity by any colleague, clinician, independent contractor, or vendor or others that reasonably appears to violate laws, regulations or Compliance Program requirements. Individuals who report such conduct in good faith shall not be subjected to retaliation or intimidated for making such a report. LSBH shall maintain the confidentiality of reports to the extent feasible and permitted by law. Individuals may report a concern to:

An administrator, director or supervisor; or

- The Compliance Officer, (Vice President of Corporate Compliance/Quality Improvement) can be reached at 716-842-0440, ext. 131 or by email at [compliance@lake-shore.org](mailto:compliance@lake-shore.org).
- The Compliance Committee, to any member orally or in writing.
- The Board of Directors; to any member of the Board orally or in writing.
- The Confidential Compliance Report Line; Callers may make anonymous reports to the Report Line at 716-842-0440,ext.131; or [compliance@lake-shore.org](mailto:compliance@lake-shore.org).
- In Writing, anonymously via written letter sent directly to the Suggestion Box located in common areas at every LSBH site or to the Compliance Officer.
- U.S. OIG or NYS OMIG Compliance Hotlines. Personnel and contractors may also contact the U.S. Office of Inspector General hotline at 1-800-447-8477 or the New York State Office of the Medicaid Inspector General hotline at 1-877-873-7283 if he/she wishes.

While LSBH requires Personnel to report fraud, waste, abuse or other improper conduct directly to LSBH, certain laws provide that individuals may also bring their concerns directly to the government (as further set forth above).

**B. Confidentiality.** Any individual who reports a compliance concern in good faith will have the right to do so anonymously if he/she requests anonymity. The information provided by the individual will be treated as confidential and privileged to the extent feasible and permitted by applicable laws. However, individuals who report compliance concerns are encouraged to identify themselves when making such reports so that an investigation can be conducted with a full factual background and without any delay.

**C. Non-Retaliation and Non-Intimidation.** Any individual who reports a compliance concern in good faith will be protected against retaliation and intimidation. In such

an instance, retaliation is itself a violation of the Code of Conduct and is unlawful. Retaliation and/or intimidation will not be tolerated. However, if the individual who reports a compliance issue has participated in a violation of law, the Code of Conduct or a LSBH policy, LSBH retains the right to take appropriate disciplinary or other action, including termination of employment or service on the Board of Directors, or in the case of a contractor, termination of the applicable contract.

**D. Role of Outside Counsel.** Outside legal counsel shall assist the Board, Committees of the Board, the Senior Management Team, the President, the Compliance Officer, and the Compliance Committee as needed, to identify and interpret federal and state laws and regulations applicable to the Compliance Program, assist in the periodic revision and maintenance of the Program, and with respect to any aspect of the Compliance Program.

Counsel may be notified at the discretion of the Compliance Officer or the President of incidents that have a reasonable chance of revealing non-compliance, at which time the Compliance Officer will be responsible for facilitating an investigation of the facts of the reported incident, at the direction of legal counsel. The results of the investigation will be used by legal counsel to provide legal advice to the Compliance Officer, the President, and the Compliance Committee. At the recommendation of the Compliance Officer, Compliance Committee has adopted an organizational Response and Reporting Procedure that outlines the process that LSBH will follow in responding to incidents of potential non-compliance detected through its reporting system.

## **VI. RESPONDING TO COMPLIANCE PROBLEMS.**

**A. Investigation of Reports.** Upon receiving a credible report of suspected or actual fraud, waste, abuse or other improper conduct, or upon the identification of a potential or actual compliance concern in the course of self-evaluation and audits, the Compliance Officer will investigate such report or concern through an internal compliance process. The internal compliance process will include consultation with the President, Compliance Committee, outside counsel, auditors, or other experts who may assist in an investigation, and will be used as appropriate and necessary. LSBH requires that all Personnel fully cooperate in any such investigation. The investigative file should contain documentation of the alleged violation, a description of the investigative process, copies of interview notes and key documents, a log of the witnesses interviewed and documents reviewed, the results of the investigation, and any disciplinary actions taken and/or corrective action plan established. The Compliance Officer shall report all investigations to the President and the Compliance Committee.

**B. Corrective Action.** After appropriate investigation, if the Compliance Officer determines that there has been an occurrence(s) of fraud, waste, abuse, improper conduct or violation(s) of the Compliance Program, LSBH's policies and procedures, and/or any applicable laws or regulations, the Compliance Officer, or his/her designee, in coordination with the President and, if appropriate, the Compliance Committee, shall institute corrective action. Any problems identified shall be corrected promptly and thoroughly, and procedures, policies, and systems shall be implemented as necessary to reduce the potential for reoccurrence. Such action may include (without limitation): (1) additional training for Personnel; (2) modification or improvement of LSBH's business practices; (3) modification or improvement of the Compliance Program itself to better ensure continuing compliance with applicable federal and state laws and

regulations; (4) disclosure to appropriate government agencies and/or third party payors; and (5) repayment of any funds that were improperly paid to LSBH.

**C. Disciplinary Action.** Lake Shore Behavioral Health, Inc. is committed to providing staff with the tools and education they need to be successful in their job and expects all staff to conduct themselves in an ethical and law-abiding manner. LSBH has established rules and procedures that are reasonably capable of reducing criminal conduct and must be followed by all employees and agents of the organization. These rules and procedures are embedded within this Corporate Compliance Manual. Any employee who has questions or needs further clarification is expected to contact their supervisor or the Compliance Officer at 716-842-0440, ext. 131 or by email at [compliance@lake-shore.org](mailto:compliance@lake-shore.org).

If after appropriate investigation, the Compliance Officer determines that there has been an occurrence(s) of fraud, waste, abuse, improper conduct or violation(s) of the Compliance Program, or LSBH's policies and procedures, and any applicable laws or regulations, the Compliance Officer, in conjunction with the President or his/her designee, shall impose sanctions against those individuals involved. Sanctions shall be imposed against any Personnel for: (1) failing to report suspected compliance problems; (2) participating in non-compliant activity; and (3) encouraging, directing, facilitating or permitting non-compliant behavior.

Sanctions will also be imposed against administrators, directors and supervisors for failure to adequately instruct their staff on the importance of the detection of noncompliance with applicable polices and legal requirements, where reasonable due diligence would have led to the earlier discovery of a violation and opportunity to correct the problem. Sanctions shall be imposed, subject to the due process requirements of any applicable employment contracts, organizational Bylaws, or contracts or agreements. Sanctions shall be fairly and consistently applied and enforced in accordance with any written standards of disciplinary action as follows:

- Employee sanctions according to LSBH's Progressive Discipline includes:
  - a verbal warning;
  - a written warning;
  - suspension; and
  - termination of employment.
- Board Member sanctions can range from written admonition to, in the most extreme cases, removal from the Board of Directors, in accordance with applicable Bylaws, policies, laws and/or regulations.
- Contractor sanctions shall range from written admonition, financial penalties, and in the most extreme cases, termination of the contractor's relationship with LSBH.

## VII. MONITORING AND AUDITING.

**A. System for Identifying Risks.** The Compliance Officer and the Compliance Committee has developed a system for routine identification and evaluation of compliance risk areas. Such a monitoring and auditing system shall include the performance of regular, periodic compliance audits by internal or external auditors and department heads or other designated employees. Such audits will include reviews of LSBH's business and billing practices, including pre-billing audits, and measures to identify, anticipate, and respond to quality of care risk areas. In addition, such system shall include a periodic review of the Compliance Program and include onsite visits, Personnel interviews, questionnaires (submitted to employees and contractors) and client record documentation reviews to determine whether the elements of the Compliance Program have been satisfied. More specifically these audits shall include but are not limited to:

- Chart audits prior to the resolution of any billed date of service
- Weekly report of unresolved visits
- Monthly retrospective billing audits
- Establishment of annual Quality Indicators
- Utilization Review of a pre-determined sample of clinical records<sup>2</sup>
- Monthly Utilization Review Level III meetings to discuss cases with identified questions of medical efficacy and/or medical necessity
- Quarterly Corporate Compliance Meetings with LSBH Board representation
- Monthly Incident Review Meetings with LSBH Board representation
- Monthly review of fiscal, clinical, productivity, and other data by Senior Management
- Periodic employee satisfaction surveys, performed by internal and external survey teams

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<sup>2</sup> LSBH has developed a team of cross-trained peer-reviewers, composed of Program Directors and senior clinicians, who conduct ongoing reviews of a sample of case records at each program that provides billable services. The LSBH Utilization Review Schedule is set annually and is calculated to ensure statistically significant samples of charts from all billable programs are audited. Cases are selected randomly, with attention given to length of stay, diagnoses, and past performance of the clinician in an audit. Reviews are performed using a program-specific audit tool to help ensure audit consistency. Charts are reviewed for compliance with all applicable rules and regulations, accuracy in documentation, and clinical excellence. All results are reported to the Compliance Officer. In cases where there are questions of medical necessity and/or medical efficacy, the case will be reviewed by the Utilization Review Level III Committee. This committee is composed of all direct service Program Directors, Senior Clinical Administrative staff, and a rotating selection of clinical line staff. The results of these case reviews are communicated, in writing, to the Director of Services, the Program Director, and the responsible clinician. The determination of the UR III Committee is final.

- Exit interviews conducted with all employees voluntarily leaving the agency
- Background and license checks on all employees at the time of hire and regularly thereafter
- Regular monitoring of the federal and state exclusion lists
- Customer Satisfaction Surveys: Clients are asked, at least twice a year, to provide feedback about the services they receive and the program they attend. Using a standardized, program-specific, questionnaire, all clients who receive services during a given week are surveyed and the completed forms are returned to the Compliance Officer. Results are collated and reported to the LSBH Board, the Senior Management Team, and the respective Program Directors.
- Stakeholder Surveys: Referral sources, and other stakeholders are surveyed periodically. Using a standardized survey tool, areas of access, customer service, reimbursement, and clinical services are assessed. The results are returned to the Compliance Officer, collated, trended, and reported to the LSBH Board and the Senior Management Team.
- Retrospective billing audits: Senior staff from the Accounts Receivable Department will conduct periodic billing audits in all programs that bill for services. Using a sample of paid claims, staff will audit for documentation and coding accuracy. Findings of these audits will be reported to Senior Management, the respective Program Director, and the site's Senior Secretary.
- Consumer Advisory Committee (CAC): This committee is chaired by the President or other member of the Senior Management Team and includes consumer representatives from each of LSBH's programs. Representatives are nominated to represent program by the respective Program Director and serve a term of one year. The Committee solicits feedback from consumers of the various programs and brings the information back to the committee. Feedback may consist of complaints, concerns or suggestions for program improvement. Representatives from the Board of Directors attend the CAC meetings twice yearly at minimum in order to listen to consumer concerns and issues, thus allowing the Board of Directors to be informed.

The Compliance Officer shall establish and implement standard operating procedures for conducting internal reviews in compliance with regulations governing LSBH's programs. These procedures shall establish specific schedules for the frequency of each type of review activity and the percentage of records and/or claims reviewed for each audit. Sampling shall be conducted in a manner consistent with generally accepted statistical standards. The results of such reviews shall be documented on a standardized form and retained for a minimum of ten (10) years. Any compliance operation that identifies a significant risk identified that rises to the level of an investigation shall be brought to the attention of the Board of Directors.

In addition, LSBH shall have an annual financial audit conducted by Certified Public Accountants to examine on a test basis, evidence supporting the proper handling and reporting of amounts, and disclosures relating to the financial activity of LSBH. LSBH shall also conduct annual reviews of business and contractual agreements and relationships, as well as billing

practices, to ensure that all activities are in compliance with its Code of Conduct, standards, and procedures. LSBH shall maintain a disclosure listing of all individuals associated with LSBH who have identified outside party interests that represent potential conflicts of interest.

**B. Corrective Action Plans.** The Compliance Officer and the Compliance Committee shall review the results of such reviews, develop a corrective action plan to remedy any deficiencies identified in the results, with the assistance of counsel if necessary, and provide the corrective action plan to those individuals who will be charged with the responsibility of implementing it. If periodic review and monitoring activities identify substantial deviation from acceptable norms, the Compliance Officer, Compliance Committee, and Board of Directors shall take prompt steps to address such deviations. Where additional investigation of such deviations is appropriate, the Compliance Officer, in consultation with the Compliance Committee, shall retain the services of such independent advisors as shall be necessary to address such deviations.

**C. Documentation of Agency Consultations.** All Personnel who, with advice from legal counsel as appropriate, in their efforts to comply with a particular law or regulation, request advice from an employee of a federal, state, or local government agency, or a fiscal intermediary, carrier, or third party payor, such person shall document the consultation in writing. Documentation should include the name and title of the party consulted, the date and time of the consultation, the subject matter of the consultation, the questions asked, and the advice received. Copies of consultations should be provided to the Compliance Officer for retention. Written documentation of agency guidance is critical to demonstrating the good faith reliance and due diligence efforts of LSBH and its Personnel.

**D. Government Inquiries.** If contacted by a government official, all Personnel are required to obtain the official's identification and immediately inform his/her supervisor, director and the Compliance Officer of the contact. Personnel are strongly encouraged that before they speak to such officials, they first contact their supervisor, director and the Compliance Officer. Their supervisor, director and/or the Compliance Officer will attempt to obtain additional information from the government official that will assist LSBH in deciding how to respond to the official's request.

In no event, however, may any Personnel respond to a request to disclose LSBH's documents or records of any kind without first speaking with their supervisor, director and/or the Compliance Officer, and receiving his/her/their approval to release documents. If appropriate, the supervisor, director and/or Compliance Officer shall seek advice from legal counsel prior to the release of any documents to government officials. If it is appropriate to give a response to a request for information, the response given must be accurate and complete.

## **VIII. COMPLIANCE CONTACTS AND NUMBERS.**

Any Personnel may contact his/her administrator, director, supervisor, the Compliance Officer, a Compliance Committee member, the Compliance Report Line or Suggestion Box with any compliance question or concern. The contact information is as follows:

- The Compliance Officer, (Vice President of Corporate Compliance/Quality Improvement) can be reached at 716-842-0440, ext. 131 or by email at [compliance@lake-shore.org](mailto:compliance@lake-shore.org).

- The Compliance Committee, to any member orally or in writing.
- The Board of Directors, to any member of the Board orally or in writing.
- The Confidential Compliance Report Line, callers may make anonymous reports to the Report Line at 716-842-0440-131; or compliance@lake-shore.org
- In Writing, anonymously via written letter sent directly to the Suggestion Box located in common areas at every LSBH site or to the Compliance Officer.
- U.S. OIG or NYS OMIG Compliance Hotlines, Personnel and contractors may also contact the U.S. Office of Inspector General hotline at 1-800-447-8477 or the New York State Office of the Medicaid Inspector General hotline at 1-877-873-7283 if he/she wishes.

## **IX. LAWS REGARDING THE PREVENTION OF FRAUD, WASTE AND ABUSE.**

### **A. Federal Laws.**

1. Federal False Claims Act. The federal False Claims Act (the “Federal Act”) provides sanction in connection with the submission of a false claim. A civil lawsuit can be brought by the United States government against any person who knowingly presents a false claim, record or statement to the government for payment. A lawsuit can also be brought against any person who conspires to defraud the government by facilitating the allowance or payment of a false or fraudulent claim. “Knowingly” means that the person: (i) has actual knowledge of the information; (ii) acts in deliberate ignorance of the truth or falsity of the information; or (iii) acts in reckless disregard for the truth or falsity of the information. To make a case, the government does not have to prove that the person specifically meant to defraud the government. Examples of fraud include (but are not limited to), falsifying records, double billing, submitting bills for services that were never performed. The person guilty of submitting a false claim can be held responsible for damages for up to three times the amount of each false claim, record or statement submitted, plus mandatory penalties ranging from \$5,500 to \$11,000.

The Federal Act allows “qui tam” actions. These lawsuits are brought by a private individual who knows about the fraud on behalf of the government. The individual sues as an individual and on behalf of the government. The individual who brings the lawsuit is called a “qui tam relator” or “whistleblower”.

The government may choose whether or not it wishes to join the lawsuit. If the government joins in the lawsuit and the lawsuit is successful, the individual whistleblower may receive between 15% and 25% of the proceeds of the lawsuit. If the government does not join in the lawsuit and

the lawsuit is successful, the individual may receive between 25% and 30% of the proceeds. However, if the action has no merit and/or is for the purpose of harassing LSBH, the individual filing the suit may have to pay LSBH for its legal fees and costs in addition to his/her own fees and costs.

2. Administrative Remedies for False Claims and Statements. Another false claims statute that works together with the Federal Act is the Program Fraud and Civil Remedies Act (the “PFCR”). This statutory provision expands damages so that a person who knowingly submits a false claim is liable for a civil penalty of up to \$5,000 for each false claim submitted, and may also be subject to an “assessment” of up to twice the amount of each such claim. The United States Attorney General’s office is responsible for investigating allegations of false claims submission, issuing subpoenas, filing the action, holding hearings before an administrative law judge (“ALJ”), and collecting the penalties assessed.
3. Federal Anti-Kickback Law. Individuals/entities are prohibited from knowingly offering, paying, soliciting, or receiving remuneration in exchange for referring, furnishing, purchasing, leasing or ordering a service or item paid for by Medicare, Medicaid, or other federal health care program. Criminal or civil penalties include repayment of damages, fines, imprisonment, and exclusion from participation in federal programs.

## **B. State Laws.**

New York has enacted laws that are similar to the federal laws listed above. These include the New York False Claims Act, False Statements Law, Anti-Kickback Law, Self Referral Prohibition Law, Health Care and Insurance Fraud Penal Law. Individuals may be entitled to bring an action under the False Claims Act, and share in a percentage of any recovery. However, if the action has no merit and/or is for the purpose of harassing LSBH, the individual may be required to pay LSBH for its legal fees and costs, in addition to his/her own costs and fees.

## **C. Whistleblower Protections.**

1. Federal Whistleblower Protection. An employee who is discharged, demoted, suspended, threatened, harassed, or discriminated against because of his/her lawful acts conducted in furtherance of a False Claims Act action may bring an action against the employer. However, if the employee’s action has no basis in law or fact or is primarily for harassment, the employee may have to pay the employer its fees and costs.
2. New York State Whistleblower Protection. Employees who, in good faith, report a false claim are protected against discharge, demotion, suspension, threats, harassment, and other discrimination by their employer. Remedies include reinstatement, two times back pay plus interest, and litigation costs and attorneys’ fees.

*\*These are brief summaries of very complex laws. The Compliance Officer can provide more information about these laws, or their application to any situation personnel may encounter. These laws all serve the important function of protecting Federal and State health care programs from fraud, waste, and abuse, and facilitate funds that would otherwise have been spent for non-program reasons to protect the beneficiaries of these programs. LSBH supports the goals of these laws and requires all employees, contractors and agents to comply with these laws as part of our mission of providing services to individuals.*

## **X. PROGRAM EVALUATION.**

The Compliance Officer will oversee an annual review of the Compliance Program. The Compliance Officer will randomly survey staff as to their knowledge and understanding of the Program. The Compliance Officer will report to the Board of Directors at least annually on the activities and the effectiveness of the Compliance Program. In addition, the Compliance Officer shall examine any certifications of compliance required by law to be filed with government regulatory agencies. To the extent that completion and filing of such certifications are necessary and appropriate, the Compliance Officer shall be responsible for their completion and filing with the applicable government regulatory agency.

## **XI. CONCLUSION.**

LSBH is proud of its reputation for consistently practicing the values of professionalism, service quality, personal service, and trust. As a values-driven organization, LSBH is committed to complying with all applicable laws and regulations.

**Lake Shore Behavioral Health, Inc.**

**Conflict of Interest Policy: Board and Senior Staff**

**Purpose.** The purpose of this Policy is to protect the Corporation’s interests in transactions involving directors, officers, and other related parties while also providing clear guidance to directors, officers, and related parties. This Policy applies to “conflict of interest” transactions by the Corporation, where a director or officer of this Corporation either is a director or officer of, or has a substantial financial interest in, the other party to the transaction, and “related party” transactions by the Corporation, where a director, officer, or key employee of the Corporation, or a relative, stands to gain personal financial benefit from the transaction, all as more fully defined and provided below.

**Generally.**

The Board of Directors shall review all Conflict of Interest Transactions and Related Party Transactions and determine whether they are fair, reasonable, and in the Corporation’s best interest in accordance with this Policy and applicable law.

Each director, officer, and Key Employee shall promptly disclose in good faith to the Board of Directors all material facts he or she is aware of concerning any actual or potential Conflict of Interest Transaction and Related Party Transaction involving such director, officer, or Key Employee or any of his or her Relatives.

Each director shall, prior to election and annually thereafter, submit a written statement in the form of that attached to and made part of this Policy. The Secretary of the Corporation shall provide a copy off all completed statements to the chair of the committee that oversees this Policy or, if there is no such committee, to the chair of the Board.

Prior to a determination by the Board with respect to potential Conflict of Interest Transactions and Related Party Transactions, no inference shall be drawn from the use of such terms that the transaction, agreement or other arrangement is a Conflict of Interest Transaction or Related Party Transaction.

The Board’s authority under this Policy may be delegated to and exercised by a Board committee. Independent Directors shall oversee the implementation of and compliance with this Policy. Only Independent Directors may participate in Board or committee deliberations or voting with respect to such matters.

All information obtained pursuant to this Policy, including but not limited to disclosures made to the Corporation pursuant to this Policy, and proceedings conducted under this Policy shall be kept confidential except to the extent necessary to administer the Policy and pursuant to applicable law.

Capitalized terms in the Policy are used as defined in Section 6 of this Policy, subject to applicable law. The provisions of this Policy are in addition to, and not in replacement of, any applicable law, including without limitation any applicable confidentiality law and, if the Corporation is a “private foundation,” the applicable provisions of the Internal Revenue Code.

**Review of Conflict of Interest Transactions.**

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The Board shall review all available material facts and circumstances concerning each actual or potential Conflict of Interest Transaction disclosed or know to it, conduct such investigation as it deems appropriate or necessary, determine whether a potential Conflict of Interest Transaction is an actual Conflict of Interest Transaction, and with respect to an actual Conflict of Interest Transaction, (i) whether it is fair, reasonable, and in the Corporation's best interest, or (if entered into earlier) was fair, reasonable, and in the Corporation's best interest at the time it was entered into and (ii) what action, if any, to take pursuant to Section 5 of this Policy.

In conduction such review and determinations, the Board may, in its sole discretion, consider such matters, collect such information, and take such actions as it deems appropriate in light of the purposes of this Policy, including but not limited to the matters in Section 4(c).

### Review of Related Party Transactions.

The Board shall review all available material facts and circumstances concerning each actual or potential Related Party Transaction disclosed or know to it, conduct such investigation as it deems appropriate or necessary, determine whether a potential Related Party Transaction is an actual Related Party Transaction, (i) whether it is fair, reasonable, and in the Corporation's best interest, or (if entered into earlier) was fair, reasonable, and in the Corporation's best interest at the time it was entered into and (ii) what action, if any, to take pursuant to Section 5 of this Policy.

If a Related Party has a Substantial Financial Interest in a Related Party Transaction, the Board shall also review alternative transactions, to the extent available, and contemporaneously document the basis for its decision on t he Related Party Transaction, including the consideration of alternative transactions.

In conducting such review and determinations, the Board may, in its sole discretion, consider such facts and circumstances and take such actions as it deems reasonable and appropriate in light of the purposes of this Policy, including without limitation the facts, circumstances and actions described below.

The Board should endeavor to establish the "rebuttable presumption" that the benefit to the Related Party from the Related Party Transaction is not more than is reasonable under Section 4958 of the Internal Revenue Code of 1986, or any successor section, and the regulations promulgated under each statute.

Factors other than the price or cost of the Related Party Transaction may affect the best interests of the Corporation with respect to the Related Party Transaction.

The extent to which the Related Party Transaction is or was in the normal course of operations and on terms and conditions that are the same as the terms and conditions available to the general public may affect the reasonableness of the Related Party Transaction.

The Board may review and approve, as a group, multiple Related Party Transactions with the same parties and substantially similar major terms and conditions, including but not limited to price, subject matter, and duration. If such Related Party Transactions are expected to occur

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repeatedly over time, the Board shall re-review such Related Party Transactions as often as is reasonable in the circumstances (but not less frequently than annually) and also whenever any of the major terms and conditions change in any material way.

The Related Party in a Related Party Transaction shall be notified of the review under this Policy and, at the request of the Board, shall be permitted to present information concerning the Related Party Transaction. Notwithstanding the preceding sentence, the Related Party (i) may not otherwise be present at or participate in the deliberations or voting on the Related Party Transaction and (ii) may not improperly influence such deliberation or voting.

### Action after review.

If the Conflict of Interest Transaction or Related Party Transaction is approved, no further action is necessary.

If the Conflict of Interest Transaction or Related Party Transaction is not approved, then the Corporation may not enter into it or, if it was already entered into, the Corporation (i) may pursue such legal remedies as may be available with respect to the Related Party Transaction or the Related Party and (ii) without limiting the foregoing or any applicable law, without being deemed to have elected its remedies, and notwithstanding anything to the contrary in the Corporation's By-Laws, may remove the Related Party from his or her position in the Corporation.

### Definitions.

"Affiliate" means any entity controlled by, in control of, or under common control with, the Corporation. For the purpose of the preceding sentence, "control" means the power to elect or appoint a majority of the directors or officers of the entity or other persons with similar authority over the entity.

"Conflict of Interest Transaction" means a transaction, agreement or other arrangement between the Corporation and any other corporation, firm, association or other entity (other than an Affiliate of the Corporation) in which a director or officer of the Corporation is a director or officer or has a Substantial Financial Interest.

"Financial Interest": A "Financial Interest" of a Related Party means an agreement, instrument, or other binding promise or arrangement that entitles the Related Party to receive payment, compensation or other financial or economic benefit, whether or not in connection with the provision of goods or services by the Related Party, including but not limited to ownership and beneficial interests.

"Key Employee" means any person who is in a position to exercise substantial influence over the affairs of the corporation, as referenced in Section 2958(f)(1)(A) of the Internal Revenue Code of 1986 and further specified in Section 53.4958-3(c), (d) and (e) of the United States Treasury Regulations, or succeeding provisions to either thereof.

"Independent Director" means a director who:

Is not, and has not been within the last three years, an employee of the Corporation or an Affiliate of the Corporation, and does not have a Relative who is, or has been within the last three years, a Key Employee of the Corporation or an Affiliate of the Corporation;

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Has not receive, and does not have a Relative who has received, in any of the last three fiscal years, more than then thousand dollars in direct compensation from the Corporation (other than reimbursement for expenses reasonably incurred as a director or reasonable compensation for service as a director as permitted by applicable law; and

Is not a current employee of or does not have a Substantial Financial Interest in, and does not have a Relative who is a current officer of or has a Substantial Financial Interest in, any entity that has made payment to, or received payments from, the Corporation or an Affiliate of the corporation for property or services in an amount which, in any of the last three fiscal years, exceeds the lesser of twenty-five thousand dollars or two percent of such entity's consolidated gross revenues. For purposes of this paragraph, "payment" does not include (A) contributions or grants or (B) fees, dues, or assessments in the nature of contributions or grants.

"Substantial Financial Interest" means a Financial Interest that is of significant size, importance, or value.

"Related Party" means (i) any director, officer or Key Employee of the Corporation; (ii) any Relative of any such person; or (iii) any entity in which any such person or Relative has a thirty-five percent or greater ownership or beneficial interest or, in the case of a partnership of professional corporation, a direct or indirect ownership interest in excess of five percent.

"Related Party Transaction" means any transaction, agreement or any other arrangement in which (i) a Related Party has a Financial Interest and (ii) the Corporation or any Affiliate of the Corporation is a participant. Without limiting the foregoing:

A donor does not necessarily have a Financial Interest in contributions or grants to the Corporation or an Affiliate;

A Related Party who has a Financial Interest in a third party does not necessarily have a Financial Interest in any transaction, agreement or other arrangement that such third party may have with the Corporation or an Affiliate; and

An "excess benefit transaction," as defined in Section 53.4958-4 of the United States Treasury Regulations or any successor regulation, may be deemed to be a Related Party Transaction.

- i. "Relative" of an individual means the individual's (i) spouse, ancestors, brothers and sisters (whether whole or half-blood), children (whether natural or adopted), grandchildren, and great-grandchildren; or (ii) domestic partner as defined in Section 2994-a of the New York Public Health Law or any successor statute.

**Annual Certification  
under  
Conflict of Interest Policy  
of  
Lake Shore Behavioral Health, Inc.**

The undersigned director of the Corporation hereby certifies that the undersigned director (a) has received a copy of the Corporation's Conflict of Interest Policy, (b) has read and understands the Policy, (c) agrees to comply with the Policy, (d) understands that the Corporation is a charitable organization and that in order to acquire and maintain its federal tax exemption, it must engage primarily in activities that accomplish one or more of its charitable purposes, (e) agrees to disclose any actual or potential Conflict of Interest Transaction or Related Party Transaction whenever he or she becomes aware of it, and (f) to his or her knowledge, does not have any actual or potential Conflict of Interest Transaction or Related Party Transaction under this Policy except as follows (attach additional pages if necessary):

Dated: \_\_\_\_\_

Signed: \_\_\_\_\_

Name (printed): \_\_\_\_\_

Title: \_\_\_\_\_