WHITE GLOVE COMMUNITY CARE, INC.

MEDICAID COMPLIANCE PLAN AND POLICIES

Adopted February 2nd, 2024
Revised January 1st, 2025
Revised December 1st, 2026

INTRODUCTION AND STATEMENT FROM THE GOVERNING AUTHORITY

White Glove Community Care, Inc. (the “Company”), including its board of directors (the “Governing Authority”), and the members of its senior management team, are committed to conducting themselves in accordance with the highest level of business and ethical standards and in compliance with all applicable Federal, State and local laws, regulations, and rules. The Company believes the best method to ensure consistency and compliance with applicable laws, rules and regulations, and to avoid fraud, waste and abuse, is through the establishment and implementation of a robust and effective compliance program (the “Compliance Program”).

The Company will designate an individual to serve as the Chief Compliance Officer ("CCO"). The CCO will be the focal point for the Company’s Compliance Program and is responsible for the day-to-day operations of the Compliance Program. If you have any questions regarding the Compliance Program, please contact the CCO.

The purpose of the Compliance Program is to assist all persons who are affected by the Company’s Risk Areas (defined below) including the Company’s employees, the chief executive and other senior administrators, managers, contractors, agents, subcontractors, independent contractors, members of the Governing Authority and corporate officers (collectively, the “Affected Individuals”), in maintaining compliance with applicable laws, rules, regulations and program requirements through the development and implementation of internal controls, policies, and procedures that promote compliance.

The Compliance Program is intended to: (a) prevent both inadvertent and intentional noncompliance with applicable statutory, regulatory and other requirements; (b) promote the detection of noncompliance if it occurs; (c) discipline offenders when appropriate; and (d) educate Affected Individuals on the importance of compliance and the Company’s compliance policies and procedures. The Compliance Program is designed to be an integral part of all aspects of the Company’s operations, including billing; payments; ordered services; medical necessity; quality of care; governance; mandatory reporting; credentialing; contractor, subcontractor, agent or independent contract oversight; and other risk areas identified by the Company through its organizational experience (collectively, "Risk Areas").

The Compliance Program applies to all services the Company bills to the New York State Medicaid program, directly or through Medicaid managed care plans.

I. WRITTEN POLICIES AND PROCEDURES

The Company maintains written policies and procedures that articulate the Company's (a) commitment and obligation to: comply with all applicable Federal and State laws, regulations, rules and standards applicable to the Company's Risk Areas; (b) describe compliance expectations as embodied in Standards of Conduct; (c) document and outline the implementation and ongoing operation of the compliance program; (d) provide guidance to Affected Individuals on dealing with potential compliance issues; (e) identify the methods and procedures for communicating compliance issues to the appropriate compliance personnel; (f) describe how potential compliance issues are investigated and resolved; and (g) describe the

procedures for documenting the investigation of compliance issues and the resolution or outcome. Copies of policies and procedures referenced in this Section I may be obtained from the CCO at any time. Copies of the Compliance Plan, and applicable policies and procedures, will be provided to all Affected Individuals upon orientation and in the event they are subsequently modified.

Governing Laws. The Company identifies the laws, regulations, and Medicaid program policies that apply to its Risk Areas, including Social Services Law § 363-d; 18 NYCRR Parts 504, 515, 517, 518, 521, and 540; 10 NYCRR Part 766; the New York State Medicaid Program provider manuals for the services the Company bills; Public Health Law § 3614-c (home care worker wage parity); federal electronic visit verification requirements (42 U.S.C. § 1396b(l)); and the terms of its Medicaid managed care plan contracts. The CCO maintains this list and updates it as laws and program requirements change.

A. The Compliance Plan.

The core elements of the Compliance Program and its functions, policies, and procedures are described in this Compliance Plan and Policies (the “Compliance Plan”). The Compliance Plan is intended to reflect the commitment of the Company and its Governing Authority to comply with all Federal, State and local laws, rules, regulations and standards, including 18 NYCRR SubPart 521-1 (“OMIG Compliance Regulations”). All Affected Individuals are required, as a condition of employment (or contracting), to comply with and actively participate in the Company’s Compliance Program. Affected Individuals are expected to review this Compliance Plan in detail upon hire and periodically thereafter. As a condition of employment or contracting, all Affected Individuals assume responsibilities for carrying out the functions of this Compliance Plan. All employees, from senior management to front-line staff, shall be required to certify that they have received, read, understand, and agree to abide by the Compliance Plan upon hire and as part of annual compliance training thereafter.

Development, Revision, and Approval of Policies. The CCO drafts new compliance policies and revisions to existing policies, with input from the managers responsible for the affected Risk Areas and, as needed, legal counsel. The Compliance Committee reviews each draft and recommends it for approval. The Governing Authority approves this Compliance Plan, the Standards of Conduct, and any material change to them. Each policy shows its effective date and the date of each review or revision. The CCO keeps the current version of all compliance policies in a central location accessible to all Affected Individuals, provides copies on request, and keeps prior versions in accordance with Section I(C)(2)(B).

This Compliance Plan is applicable to the Company’s contractors, agents, subcontractors, and independent contractors (collectively, "Contractors") to the extent the services provided by such Contractors relate to one or more Risk Area(s). All such Contractors shall be provided with a copy of this Compliance Plan and any Company policies related to the Risk Area(s) relevant to the Contractor's performance of its contractual obligations. All Contractors are required to acknowledge annually that they have received, read, understand, and agree to comply with this Compliance Plan. Contractors may satisfy this requirement by implementing a compliance plan within their own organization that satisfies the requirements of New York’s Social Services Law

§ 363-d, provided that the Company shall have the right to audit the Contractor's compliance plan operations and performance, and that the Contractor is required to timely notify the Company of any instances of non-compliance, and any identified overpayments, that relate to or implicate the Contractor's relationship with the Company. These requirements shall be set forth in the written contract or agreement with such Contractor. Provisions relating to the foregoing shall be incorporated in new contracts, and shall be incorporated in existing contracts upon renewal or in the event of amendment. Contracts shall also require Contractors to check their own Affected Individuals against the exclusion lists in Section I(D)(1) at least every thirty (30) days and to give the Company a written attestation of those checks each month, and shall permit the Company to terminate the contract if the Contractor fails to meet these requirements. The CCO maintains a list of all Contractors subject to this Compliance Plan.

This Compliance Plan and its policies and procedures will be reviewed by the CCO, the Compliance Committee, and the Governing Authority, at least annually to determine (a) if such written policies and procedures have been implemented; (b) whether Affected Individuals are adhering to such policies and procedures; (c) whether such policies and procedures are effective; and (d) whether any updates to such policies and procedures are required. This Compliance Plan and the Company's policies and procedures shall be updated as needed upon completion of this review. The annual review is documented in a written Annual Policy Review that addresses each of the four determinations above. It is presented at the Compliance Committee’s fourth-quarter meeting and reported to the Governing Authority, and both sets of minutes record the review. Each policy shows the date of its most recent review.

B. Standards of Conduct.

It is the Company's policy to maintain the highest level of professional and ethical standards in the conduct of its business, which is embodied in formal Standards of Conduct adopted by the Governing Authority of the Company. The Company places the highest importance upon its reputation for honesty, integrity and high ethical standards. A copy of the Company’s Standards of Conduct is attached hereto as Exhibit A.

The Standards of Conduct will be distributed to all Affected Individuals. Affected Individuals other than Contractors are required to certify, upon hiring and on an annual basis thereafter, that they have read, understand, and agree to adhere to the Standards of Conduct. Contractors subject to this Compliance Program are required to certify, upon execution of any contract or agreement with the Company, that they either (1) have internal standards of conduct that protect against fraud, waste and abuse, with an emphasis on compliance, or (2) agree to adhere to the Company's Standards of Conduct in their performance of their contract with the Company throughout its term.

The Standards of Conduct will be reviewed by the CCO, the Compliance Committee, and the Governing Authority, at least annually to determine (a) if the Standards of Conduct have been implemented; (b) whether Affected Individuals are adhering to the standards set forth therein; (c) whether such standards are effective; and (d) whether any updates to the Standards of Conduct are required. The Standards of Conduct shall be updated as needed upon review to ensure that the Company maintains the highest possible standards of compliance. Any changes

to the Standards of Conduct will be approved by the Governing Authority and distributed to Affected Individuals.

C. Operating Policies and Procedures Related to Billing and Payment Integrity.

1. Claims Submission, Billing and Payments Policies. It shall be the policy of the Company to: (i) provide for sufficient and timely documentation of all services, including subcontracted services, prior to billing to ensure that only accurate and properly documented services are billed; (ii) submit claims only when appropriate documentation is maintained, appropriately organized in legible form, and available for audit and review; (iii) compensate billing department personnel and billing consultants only in a manner that does not offer any financial incentive to submit claims regardless of whether they meet applicable coverage criteria for reimbursement or accurately represent the services rendered; and (iv) establish and maintain a process for pre and post submission review of claims to ensure that claims submitted for reimbursement accurately represent medically necessary services actually provided, supported by sufficient documentation, and in conformity with any applicable coverage criteria for reimbursement (including without limitation 18 NYCRR Subchapter E, as applicable, and 10 NYCRR Part 766). In anticipation of claims being made to Medicaid, services should be evaluated for appropriateness and must be consistent with the patient's plan of care.

Any inconsistencies in documentation or reports of impropriety with regard to claim development and submission will be investigated by the CCO. If errors or impropriety in claim development and submission are substantiated, necessary restitution will be made by the Company and the individual or individuals responsible will face disciplinary action with consequences ranging from re-training to dismissal.

Authorized Services. Claims should only be submitted for services for which the Company has documentation of authorization by a physician or other authorized clinician, as required by applicable law, and which are consistent with the patient's treatment plan (10 NYCRR Part 766).

All services for which reimbursement is sought must be performed and documented in accordance with New York State Department of Health ("DOH") regulations (10 NYCRR Part 766.12).

Plan of Care. The Company must take all responsible steps to ensure that a plan of care is developed in accordance with the authorization. The plan of care must be dated and signed, and reviewed and updated as required by applicable law. (10 NYCRR Part 766.3).

Electronic Visit Verification. Personal care, home health aide, and other services subject to electronic visit verification (EVV) must be verified through the Company's EVV system before they are billed. Visits with missing EVV data or manual edits are reviewed and corrected before claims are submitted, and EVV compliance is monitored monthly.

2. Record Retention Policy. The Company will retain all records and related documentation in the following manner:

A. General Record Retention Policy.

The Company has implemented a general record retention policy to ensure all medical records and other related records are retained in accordance with applicable Federal and State laws, rules and regulations. In the event the Company is subject to an audit or investigation by a governmental agency having jurisdiction over the Company, the Company shall continue to preserve and maintain relevant records until the later of the applicable statutory record retention period or the completion of such audit or investigation, including any appeals.

B. Compliance Record Retention Policy.

It shall be the policy of the Company to maintain all records related to the adoption and implementation of the Compliance Program, including without limitation all adopted versions of this Compliance Plan and related policies and procedures, audit and investigation materials, corrective actions, training documentation, meeting minutes, compliance work plans and audit work plans, and any other documentation required to be maintained by this Compliance Plan or applicable Federal or State laws, rules or regulations, including without limitation the OMIG Compliance Regulations, for a period of not less than six (6) years from the date that such record was created. This requirement shall be interpreted to require the maintenance of copies of the Compliance Plan and all policies and procedures that were in effect for the preceding six (6) year period, even if the Plan or such policies and procedures were adopted prior to such six year period.

3. Reporting and Return of Overpayments. It shall be the policy of the Company to identify, investigate, report and return overpayments in accordance with the following overpayments policy:

A. Purpose.

To establish a process to report, return, and explain any overpayments of Medicaid funds within sixty (60) days of identification, or by the date any corresponding cost report is due, whichever is later, in accordance with Federal and State law. An overpayment includes any amount not authorized to be paid under the Medicaid program, whether paid as the result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, or abuse. Overpayments may include, without limitation:

- Duplicate payments
- Payments for incorrect dates of service
- Incorrect payment amounts
- Incorrect Payer Responsibility/Coordination of Benefits (COB)
- A simple billing error or mistake
- A violation of the False Claims Act, Stark or Anti-Kickback Laws, or Civil Monetary Penalties Statute, or
- Other reasons the Company may not be entitled to payment.

B. Responsibility.

All Affected Individuals are required to promptly report potential or actual instances of non-compliance, including those that may give rise to overpayments, to the CCO as soon as the overpayment or potential overpayment is identified. The CCO is responsible for conducting or overseeing an appropriate investigation and ensuring compliance with this policy and all ACA (defined below) and OMIG overpayment reporting requirements (18 NYCRR SubPart 521-3).

C. Procedures.

All overpayments of Medicaid funds discovered by the Company must be reported, returned, and explained in writing within sixty (60) days of the date they are identified as required by section 6402(a) of the Affordable Care Act of 2010 ("ACA") and applicable Federal, state and local laws and regulations (see, e.g., OMIG Regulations at Part 521-3). Failure to exercise reasonable diligence in identifying an overpayment can result in an inference of knowledge and sanctions under Federal and State law. Failure to timely report and return any Medicaid overpayment can have severe consequences, including potential liability under the State and Federal False Claims Act, as well as the imposition of civil monetary penalties and exclusion from the Medicaid program.

All potential Medicaid overpayments will be investigated by the CCO in conjunction with appropriate staff. If an overpayment is identified, the CCO will ensure that the overpayment is reported, returned, and explained to Medicaid in accordance with applicable self-disclosure processes or other permissible processes, within sixty (60) days of identification. The CCO shall confer with outside legal counsel prior to making a determination whether the overpayment requires self-disclosure.

Methods of Reporting. Overpayments are reported, returned, and explained as follows: (a) fee-for-service Medicaid overpayments are reported through OMIG's Self-Disclosure Program, using the Abbreviated Self-Disclosure process (claim void or adjustment within sixty days, listed on OMIG's Self-Disclosure Abbreviated Statement) where the overpayment qualifies, or the Full Self-Disclosure process where it does not; and (b) Medicaid managed care overpayments are reported and returned to the Medicaid managed care plan in accordance with the plan's self-disclosure process.

Monthly Review. Each month, the billing manager reviews all voids, adjustments, and credit balances and gives the results to the CCO. The CCO determines whether any item is an overpayment that must be reported, maintains a monthly void and adjustment log, and reports the results to the Compliance Committee quarterly.

All records related to the Company's compliance with this policy will be maintained by the CCO in compliance with the Company's records retention policy, but in no case for a period of less than six (6) years.

4. Third-Party Liability. It shall be the policy of the Company that all reasonable measures shall be taken to ascertain the legal liability of third parties, for the purpose of, as consistent with Section 1902 of the Social Security Act, ensuring Medicaid is the payor of last resort.

A. Responsibility.

The policy is applicable to all Affected Individuals responsible for billing Medicaid.

B. Procedures.

The Company shall implement the following procedures in accordance with this Policy:

- Disclosure of potential third party resources will be required on all Medicaid claim forms.
- Investigation will be conducted by the billing personnel to determine the existence of potential third parties that may be legally responsible to pay for the services to be billed, prior to actually billing Medicaid.
- Any payment and/or reimbursement shall be sought from all potential third party payors prior to submitting the claim to Medicaid.
- In the event the Company receives payment and/or reimbursement from a liable third party, Affected Individuals responsible for billing shall either: (a) apply such payment to reduce any Medicaid claim; or (b) repay the Medicaid program within thirty (30) days after the third party reimbursement is received, if the claim was submitted before the third party's liability was ascertained.

Relevant citations: 42 USC 1396a(a)(25); 18 NYCRR § 540.6.

D. Employee and Business Relationship Integrity.

The policies and procedures of the Company are designed to maintain employee and business relationship integrity. These policies are described below.

1. Excluded Providers. In accordance with the requirements of applicable Federal and State law, including relevant OMIG Compliance Regulations (see 18 NYCRR Section 521-1.4(g)(3)), the Company will confirm the identity and determine the exclusion status of all Affected Individuals.

The Company will review the following Federal and State databases at least every thirty (30) days to determine the exclusion status of all Affected Individuals, including members of the Governing Authority, and will check each new Affected Individual before hire, appointment, or contract execution:

- New York State Office of the Medicaid Inspector General Restricted and Excluded Providers database; and
- Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities; and
- System for Award Management (SAM.gov) exclusion records. (The Excluded Parties List System was retired and incorporated into SAM.gov.)

The Company requires Contractors to comply with the provisions of this Policy by completing required exclusion checks, at least every thirty (30) days, for all persons employed or contracted with the Contractor. Contractors shall give the Company a written attestation each month confirming that the required checks were completed and identifying any excluded individuals. The CCO tracks receipt of each attestation, follows up on any attestation not received, and

reports the results to the Compliance Committee quarterly. Potential matches for Company and Contractor personnel are researched and resolved, and the resolution is documented.

2. Screening Policies and Procedures. The Company has implemented the following screening policies in accordance with industry best practices, applicable OMIG Compliance Regulations, and other applicable Federal and State law.

- It is the policy of the Company that all employees, prospective employees, and other Affected Individuals, as applicable, are subject to exclusion screening on a monthly basis in accordance with the Company's exclusion policy set forth above. The Company will prohibit the employment of individuals that are ineligible for participation in federal health programs or the Medicaid program. The purpose of this policy is to preclude: (a) payment by the Medicaid program for medical care, services or supplies ordered or prescribed by any person who is excluded from participation in the federal health care programs; and (b) involvement by such excluded persons in activities related to the furnishing of such medical care, services or supplies. This screening policy is conducted in the manner set forth under Section I(D)(1) of this Compliance Plan.
- It is the policy of the Company that new or prospective employees be subject to initial screening to determine engagement in illegal activities or other conduct inconsistent with the Company's Standards of Conduct and the goals of this Compliance Plan, to the extent permitted by applicable Federal, State or Local law. The initial screening shall include a criminal history record check in accordance with applicable DOH Regulations and Company policy. Such initial screening shall demonstrate the Company’s use of reasonable efforts to ensure this Compliance Plan remains effective.
- For all new employees with discretionary authority to make compliance decisions or with compliance oversight, the Company will conduct a reasonable and prudent review of the information obtained during the application process, including a reference check as part of evaluating candidates for employment by the Company.
- The Company will prohibit the employment of individuals that do not meet all statutory or regulatory requirements for providing services to federal health programs or the Medicaid Program. Prior to employment and at regular intervals thereafter, the Company will verify that an individual has all required licenses, certifications and other required credentials, and has received all required training.

3. Stark and Anti-Kickback Statutes. The Company has in place appropriate policies and procedures for compliance with Federal and State anti-kickback statutes, as well as the Stark physician self-referral law, and the New York State anti-self-referral laws and regulations, both within the Company and among its contractors. 42 U.S.C. § 1320a-7b(b); 42 USC § 1395nn; N.Y. Public Health Law § 238-a. These policies provide that:

- All of the Company's contracts and arrangements with actual or potential referral services are reviewed by counsel and comply with applicable statutes and regulations;
- The Company does not submit or cause to be submitted to Federal health care programs claims for patients who were referred to the Company pursuant to contracts or

financial arrangements that violate the anti-kickback statute, Stark physician self-referral law or similar Federal or State statutes and regulations; and

- The Company does not offer or provide gifts, free services, or other incentives to patients, relatives of patients, physicians, hospitals, contractors, other home care providers, or other potential referral sources, for the purpose of inducing referrals.

4. Compliance as an Element of Performance Evaluations. It is the policy of the Company that adherence to this Compliance Plan is a factor in evaluating the performance of all employees (including officers, senior management and line-staff).

5. Conflicts of Interest. The Company has in place policies and procedures to ensure that the outside financial and other personal interests of all employees, officers, senior managers and members of the governing body do not compete with the interests of the Company or influence decisions or actions taken on behalf of the Company.

6. Deficit Reduction Act. The OMIG Compliance Regulations require the Company to comply with the federal Deficit Reduction Act. The federal Deficit Reduction Act requires recipients of federal health care program funds to include in its policies and procedures detailed information regarding the federal False Claims Act, the Federal Program Fraud Civil Remedies Act, applicable state civil and criminal laws intended to prevent and detect fraud, waste, and abuse in federal health care programs, and whistleblower protections afforded under such laws. A copy of the Company's Deficit Reduction Act policy is attached as Exhibit B. If you have questions regarding any of the laws discussed in Exhibit B, please contact the CCO. The information in Exhibit B is included in each employee handbook in use and is distributed to all employees, Contractors, and agents.

E. Prohibition against Retaliation and Intimidation.

No Affected Individual who in good faith reports a suspected compliance problem shall suffer harassment, retaliation, intimidation, or adverse employment consequence. Any person who retaliates against or intimidates a person for (a) reporting potential compliance issues to appropriate personnel; (b) participating in the investigation of potential compliance issues; (c) participating in self-evaluations; (d) participating in audits; (e) participating in remedial actions; (f) reporting instances of intimidation or retaliation; or (g) reporting potential fraud, waste or abuse to the appropriate State or Federal entities, will be subject to discipline. Disciplinary action for violations of this policy may include termination of employment or contract, or any other action pursuant to the disciplinary policy set forth in this Compliance Plan.

The Company enforces this policy against retaliation and intimidation fairly and consistently among all Affected Individuals, regardless of their position within the Company. The Company posts the notice of employee whistleblower rights required by Labor Law § 740.

II. DESIGNATION OF A CHIEF COMPLIANCE OFFICER

A. Chief Compliance Officer.

The Company will, at all times, designate an individual to serve as the CCO. The CCO will be the focal point for the Company's Compliance Program and is responsible for the day-to-day operations of the Compliance Plan. Any questions or concerns relating to any compliance related matter should be immediately referred to the CCO.

The CCO is designated by resolution of the Governing Authority. The CCO can be reached directly by telephone (1-718-828-2666, ext. 4007) or e-mail (complianceofficer@whiteglovecare.net). The CCO's contact information and the anonymous Compliance Hotline number appear on compliance postings and the Company's website.

In addition, anonymous reports to the CCO can be made by calling White Glove's anonymous Compliance Hotline (929-468-9080).

The primary responsibilities of the Company's CCO shall include the following:

- Overseeing and monitoring the adoption, implementation and maintenance of the Compliance Plan and evaluating its effectiveness;
- Drafting, implementing, and updating no less frequently than annually or, as otherwise necessary, to conform to changes to Federal and State laws, rules, regulations, policies and standards, a compliance work plan which shall outline the Company's proposed strategy for meeting its compliance program obligations for the upcoming year, with a specific emphasis on (a) written policies and procedures; (b) training and education; (c) auditing and monitoring; and (d) responding to compliance issues;
- Reviewing and revising the (a) Compliance Plan; (b) written policies and procedures; and (c) Standards of Conduct, to incorporate changes based on the Company's organizational experience and changes to Federal and State laws, rules, regulations, policies and standards;
- Reporting directly, on a regular basis, but no less frequently than quarterly, to the Company's Governing Authority, chief executive, and Compliance Committee, hereinafter defined, on the progress of adopting, implementing, and maintaining the Compliance Plan, through written reports recorded in Compliance Committee and Governing Authority minutes;
- Assisting the Company in establishing methods to improve the Company's efficiency and quality of services, and reducing the Company's vulnerability to fraud, waste and abuse;
- Investigating and independently acting on matters related to the Compliance Plan, including designing and coordinating internal investigations, as well as documenting, reporting, coordinating, and pursuing any resulting corrective action internally, as well as with Contractors and the State;
- Ensuring that all of Affected Individuals have read and understood this Compliance Plan, and obtain a signed acknowledgment from Affected Individuals;

- Ensuring that Affected Individuals have read, understood and agree to abide by the Company's Standards of Conduct (or with respect to Contractors, have adopted standards of conduct that satisfy the OMIG Compliance Regulations);
- Ensuring that exclusion checks are conducted in accordance with this Compliance Plan;
- Fostering a "culture of compliance" within the Company by regularly communicating compliance expectations, and publicizing the anonymous Compliance Hotline and other ways of communicating with the CCO (such as through compliance posters);
- Conducting an annual review of the Company's compliance efforts to be provided to the Governing Authority;
- Regularly monitoring the Compliance Plan and Compliance Program to improve its effectiveness;
- Monitoring proposed and enacted changes in laws, rules, regulations and program guidelines applicable to the Company and ensuring that any such changes are adopted and implemented, including updating the Company's policies and procedures, providing training as appropriate, and using the Compliance Program's auditing and monitoring processes to ensure such changes have been effective in practice;
- Developing, coordinating and participating in compliance education and training programs and ensuring that staff are properly educated and trained concerning compliance, and attending annual compliance training as a participant;
- Receiving, responding to, and investigating complaints and concerns submitted through the anonymous Compliance Hotline and other lines of communication to the CCO;
- Maintaining a log of all compliance complaints and concerns, including the source of the complaint, the issue, the status of the investigation, and the resolution;
- Maintaining a compliance discipline log of disciplinary actions taken for compliance-related violations, including electronic visit verification and scheduling-conflict violations;
- Ensuring that disciplinary policies for non-compliant behavior, participation in non-compliant behavior, and the encouragement, direction, facilitation or allowance of noncompliant behavior, is firmly and fairly enforced;
- Conducting or overseeing ongoing internal and external audits and reviews to assess the Company's compliance with applicable laws, rules and regulations;
- Ensuring that policies, procedures and processes found to be ineffective or outdated are revised;
- Monitoring and identifying Risk Areas that should be the focus of the Company's annual audit plan and preparing and implementing the Company's annual audit plan;
- Investigating, responding to, correcting and preventing compliance issues;
- Developing and overseeing the implementation of corrective action plans, and ensuring that the implementation of corrective action plans are effective in preventing further non-compliance;
- Reporting and returning overpayments identified through the Compliance Program in accordance with the Company's overpayments policy;

- Enforcing the Company's policy against retaliation and intimidation; and
- Taking actions the CCO deems necessary to ensure that Contractors are familiar with the Compliance Program, receive compliance training, and abide by the Compliance Plan.

The CCO shall report directly to and be accountable to the Company's chief executive or another senior manager whom the chief executive may designate for reporting purposes provided, however, such designation does not hinder the CCO's ability to carry out their primary responsibilities and to access the chief executive and Governing Authority.

The primary responsibilities of the CCO set forth above may be the sole duties of the CCO, or the CCO may be assigned additional duties, depending on the size, complexity, resources, and culture of the Company and the complexity of the duties in question, provided that such additional duties do not hinder the CCO in carrying out their compliance responsibilities. When the CCO is assigned other duties, the chief executive documents a written assessment, at designation, annually, and whenever the duties change, confirming that the other duties do not hinder the CCO in carrying out compliance responsibilities.

The Company will ensure that the CCO is allocated sufficient staff and resources to satisfactorily perform their primary responsibilities for the day-to-day operation of the Compliance Program based on the Company's Risk Areas. The Company shall further ensure that the CCO and appropriate compliance personnel have access to all records, documents, information, facilities and Affected Individuals that are relevant to carrying out their primary responsibilities under this Compliance Plan. The chief executive documents an annual assessment of the CCO's staffing and resources, and the Company confirms the CCO's access in writing at designation and annually.

B. Compliance Committee.

The Company has established a compliance committee ("Compliance Committee") to work with the CCO in pursuit of the Company's compliance-related goals, to manage risk, and to continuously improve organizational performance. The Compliance Committee assists the CCO with implementation of the Compliance Program and ensuring the Company is conducting its business in an ethical and responsible manner, consistent with this Compliance Plan. The Compliance Committee provides a mechanism to coordinate and integrate compliance activities across all Risk Areas.

Membership in the Compliance Committee shall be comprised of senior managers that represent functions that impact the Risk Areas. The Compliance Committee shall report directly and be accountable to the Company's chief executive and Governing Authority. The members of the Compliance Committee and the Committee chair are listed in the Committee membership roster, which is updated whenever membership changes.

The Compliance Committee shall meet no less frequently than quarterly. Compliance Committee meetings may be held in conjunction with other Company committee meetings, such as a quality assurance committee. Minutes of each meeting record attendance, the matters reviewed, and approval of the minutes of the prior meeting.

The Compliance Committee shall be governed by a written compliance committee charter (the "Charter"). The Charter sets out the Committee's duties and responsibilities, membership, designation of a chair, and frequency of meetings. The responsibilities of the Compliance Committee shall be set forth in the Charter and shall include:

- Coordinating with the CCO to ensure written policies, procedures, and Standards of Conduct are current, accurate and complete, and that training required by this Compliance Plan is timely completed;
- Coordinating with the CCO to ensure communication and cooperation by Affected Individuals on compliance related issues, internal or external audits, or any other function or activity required by this Compliance Plan;
- Advocating for the allocation of sufficient funding, resources and staff for the CCO to fully perform their responsibilities;
- Ensuring the Company has effective systems and processes in place to identify compliance program risks, overpayments and other related issues, and effective policies and procedures for correcting and reporting such issues;
- Advocating for adoption and implementation of required modifications to this Compliance Plan;
- Propose revisions to the Compliance Plan as warranted;
- Establish compliance policies and procedures across the organization deriving from the Compliance Plan;
- Implement compliance initiatives and measure their effectiveness based upon an approved audit methodology;
- Redesign compliance initiatives, policies and procedures as necessary;
- Review compliance investigations and assist the CCO in conducting such investigations, as necessary;
- Recommend and enforce action for actual compliance violations;
- Assist in the collection, review and analysis of data from compliance audits, and reporting its findings to the Governing Authority; and
- Serve as a risk management body with an emphasis on prevention of compliance issues, particularly fraud, abuse and waste.

The Charter shall be reviewed no less frequently than annually and updated as necessary. Annual reviews and revisions shall be appropriately documented. The Compliance Committee reviews the Charter at its fourth-quarter meeting each year. The review and any revisions are recorded in the meeting minutes, and the Charter shows the date of each review.

III. TRAINING AND EDUCATION

A. General Compliance Training.

The Company has established and implemented an effective compliance training and education program for its CCO and all Affected Individuals. Compliance training and education will emphasize the importance of compliance practices which are essential to the operation of the Company, and the Company's commitment to detecting and preventing fraud, waste and abuse. In addition, the compliance training and will highlight key compliance issues and Risk Areas. The Standards of Conduct will be described during the compliance training and education, and copies of the same will be distributed.

The Company's compliance training has two essential objectives: (1) to train all Affected Individuals to perform their jobs in accordance with this Compliance Plan; and (2) to convey to all Affected Individuals that adherence to proper compliance practices is a condition of continued employment. The Company's compliance training and education program shall include, at a minimum, the following topics:

- The Company's Risk Areas;
- The Company's written policies and procedures set forth in this Compliance Plan;
- The role of the CCO and the Compliance Committee;
- Means for Affected Individuals to ask questions and report potential compliance-related issues to the CCO and senior management, including the obligation of Affected Individuals to report suspected illegal or improper conduct and the procedures for submitting such reports, and the protection from intimidation and retaliation for good faith participation in the Compliance Program;
- Disciplinary standards, specifically such standards related to this Compliance Plan and prevention of fraud, waste and abuse;
- The manner in which the Company responds to compliance issues and implements corrective action plans;
- Requirements specific to the Medicaid program and the services and treatments provided by the Company;
- Coding and billing requirements and best practices; and
- The Company's process for claim development and submission.

The CCO and all Affected Individuals shall complete the compliance training program required by Section III of this Compliance Plan no less frequently than annually. Contractors may satisfy these requirements by providing training directly to their personnel in accordance with their own compliance program, provided that such training satisfies the requirements of the OMIG Compliance Regulations and addresses the above elements, as applicable. The training and education required by this Section III shall be made a part of the orientation of new Affected Individuals and shall occur promptly upon hiring. The CCO maintains a training log for each Affected Individual showing the type of Affected Individual, the training completed, the method, the date of hire, and the date completed.

Training and education shall be provided in a form and format accessible and understandable to all Affected Individuals, consistent with Federal and State language and other access laws, rules or policies. Training and written materials are provided in English and Spanish, and in other languages as needed. All training under this Section III will be reflective of the skills and experience of participants, utilize a variety of teaching methods, and include a post-evaluation for effectiveness. The Company will utilize appropriate training methods which may include distribution of written compliance materials (provided adequate systems exist for verification of completion, including without limitation, dated memos documenting distribution to all Affected Individuals), in-house training and outside seminars. The CCO maintains a written training plan, reviewed and updated at least annually. The training plan will, at a minimum, (a) outline the abovementioned subjects or topics for training and education; (b) the timing and frequency of the training; (c) how attendance will be tracked; and (d) how the effectiveness of the training will be periodically evaluated.

New employees responsible for complicated tasks that involve potential legal exposure will be monitored closely until all required training is completed. For all Affected Individuals, participation in the mandatory training programs is a condition of continued employment (or contracting), and failure to comply with the training requirements will result in disciplinary action.

B. Specialized Training

The Company will provide more in-depth training on specific compliance issues to Affected Individuals whose job responsibilities implicate such specific compliance issues. Additional training will be provided as deemed necessary to address Risk Areas, implement corrective action, ensure the adoption of new or modified policies and procedures, or that are otherwise deemed necessary or appropriate by the CCO or the Compliance Committee.

IV. EFFECTIVE LINES OF COMMUNICATION

Open lines of communication between the CCO, Compliance Committee, Governing Authority, Medicaid patients, and all Affected Individuals, which protect the confidentiality of persons reporting compliance issues, is essential to the proper implementation of this Compliance Plan. All Affected Individuals and Medicaid patients, have access to such lines of communication and are encouraged to discuss compliance-related matters with their supervisors and/or the CCO. The Company designed the lines of communication to:

- Be accessible to all Affected Individuals and Medicaid recipients and provide forum for questions regarding compliance issues and manner to report such compliance issues.
- If the Company has a website, the Company will publish information about its Compliance Plan, including how to report compliance issues and contact the CCO, along with a copy of its Standards of Conduct, on its website. The website information is checked at least annually and whenever the CCO changes, and a dated screenshot is kept.
- Be publicized to Medicaid recipients through the patient admission (start-of-care) packet, which lists the Compliance Hotline and how to contact the CCO, and to Affected

Individuals through compliance posters displayed in each office, the employee handbooks, and orientation.

- Protect of the confidentiality of persons reporting compliance issues, and maintain such confidentiality unless the matter is subject to disciplinary proceedings, referred to, or under investigation by the Medicaid Fraud Control Unit (MFCU), OMIG, or applicable State, Federal, or Local law enforcement, or if disclosure is required during a legal proceeding.
- Protect any such persons reporting compliance issues under the Company's non-intimidation and retaliation policy.

In addition, all Affected Individuals are advised:

- They must report conduct which a reasonable person would, in good faith, believe to be non-compliant, fraudulent or erroneous.
- They must refuse to participate in unethical or illegal conduct.
- The Company maintains several means through which Affected Individuals can report conduct they believe to be non-compliant, fraudulent, erroneous, wasteful, or abusive, including:
    - Anonymously through the Company's anonymous Compliance Hotline (929-468-9080) for reports of problems, non-compliance and suggestions to improve the Compliance Program;
    - Telephone the CCO at 1-718-828-2666, ext. 4007;
    - E-mail the CCO at complianceofficer@whiteglovecare.net; or
    - Report the activity to a supervisor or to the CCO in person.
- To knowingly fail or refuse to report non-compliant, fraudulent, or erroneous conduct is a violation of this Compliance Plan and can result in disciplinary action.

Assistance with identifying potential compliance issues, as well as any compliance related questions and concerns for Affected Individuals will be promptly addressed by the CCO.

The CCO will be responsible for promptly investigating and resolving all reports of fraudulent, erroneous or non-compliant conduct, including implementing appropriate corrective action. The confidentiality of all individuals who report fraudulent, erroneous or non-compliant conduct will be maintained by the CCO and Compliance Committee, unless the matter is subject to disciplinary proceedings, referred to, or under investigation by the Medicaid Fraud Control Unit (MFCU), OMIG, or applicable State, Federal, or Local law enforcement, or if disclosure is required during a legal proceeding.

The Compliance Hotline (929-468-9080) is the Company's only compliance hotline number. The CCO tests the hotline at least quarterly to confirm it is working and allows anonymous reporting, documents each test, and keeps a confidential log of all hotline calls and other compliance reports.

V. DISCIPLINARY POLICY

All Affected Individuals are subject to the Company's disciplinary policy. All Affected Individuals who fail to comply with the written policies and procedures, Standards of Conduct, or State and Federal laws, rules and regulations, as set forth in this Compliance Plan will be subject to discipline. Disciplinary action in response to non-compliance or violations of this Compliance Plan is subject to escalation based on the severity of behavior, with intentional or reckless acts or repeated acts of non-compliance resulting in more severe disciplinary action. The Company's disciplinary policy embodies the expectation that all Affected Individuals (a) act in accordance with the Standards of Conduct and (b) must refuse to participate in unethical or illegal conduct. Discipline applies to Affected Individuals who fail to comply, who fail to report suspected problems, who participate in non-compliant behavior, or who encourage, direct, facilitate, or permit non-compliant behavior.

The Company's disciplinary policy will be fairly enforced. Disciplinary actions may be taken against, and sanctions imposed upon, any Affected Individual, regardless of an individual's position within the Company. Discipline may include the following:

- Warnings (oral)
- Warnings (written)
- Reprimands (written)
- Probation
- Demotion
- Temporary suspension
- Discharge from employment, removal from the Governing Authority and/or removal as an officer, as applicable
- Referral for appropriate sanctioning by regulatory agencies and/or criminal prosecution
- Termination of contract or agreement, for cause, for Contractors.

Disciplinary Procedures. When a compliance violation is substantiated, the CCO consults with the Director of Human Resources (and, for Contractors, the chief executive) to determine the appropriate action, considering the severity of the conduct, whether it was intentional or reckless, and any prior violations. Discipline is applied in accordance with any applicable collective bargaining agreement. The action taken is documented in the individual's file and recorded in the compliance discipline log. The Compliance Committee reviews the discipline log quarterly to confirm that discipline is applied fairly and consistently at all levels of the Company.

Publication. The disciplinary standards are published in the employee handbooks and Contractor agreements and are distributed to all Affected Individuals, including members of the Governing Authority.

VI. AUDITING AND MONITORING

The Company has established and will implement an effective system for the routine monitoring and identification of compliance risks. The system includes internal monitoring and audits, as well as external audits, as appropriate, to evaluate the Company's compliance with the requirements of the Medicaid program and the overall effectiveness of this Compliance Plan. The CCO is responsible for overseeing the auditing and monitoring activities set forth in this Section VI. All Affected Individuals are required to participate in and assist the CCO as requested in the implementation of these auditing and monitoring activities.

The Company's auditing and monitoring program is described below:

A. Timely Identification and Implementation of Changes in Laws, Regulations and Program Requirements.

The CCO will be responsible for staying abreast of changes to all laws, regulations and program guidelines applicable to the Company. The CCO will monitor Medicaid Updates, DOH guidance, OMIG Compliance Alerts, and other state and federal advisories, bulletins and publications that impact the Company for potential changes in the laws, regulations and program guidelines applicable to the Company.

The CCO shall also be responsible for implementing required changes to the Company's internal policies and procedures necessary to comply with changes to the laws, regulations and program guidelines applicable to the Company. The CCO will provide or arrange for additional training necessary or appropriate to explain changes to the laws, regulations and program guidelines to applicable Affected Individuals, and to ensure that such Affected Individuals understand the new requirements, policies and/or procedures.

B. Auditing and Monitoring of Risk Areas.

The Company will perform routine audits conducted by internal or external auditors who have expertise in state and federal Medicaid program requirements and applicable laws, rules and regulations, or have expertise in the subject area of the audit, in accordance with this subsection. The CCO shall be responsible for: (a) monitoring and evaluating potential areas of vulnerability for noncompliance within the Company; (b) implementing a process for auditing such high risk areas; and (c) implementing preventative and corrective action to ensure compliance with respect to such high risk areas. Audits conducted by government agencies do not count as the Company's routine internal or external audits.

The CCO and the Compliance Committee shall be responsible for developing an annual audit plan for auditing and reviewing the internal operations of the Company. Annual audits shall be focused on Risk Areas and, in particular, those Risk Areas that the CCO deems to be areas of particular vulnerability for non-compliance. The annual audit plan may include audits focused on: (a) ongoing compliance with applicable laws, rules and regulations; (b) effectiveness of internal changes to policies and procedures to respond to changes in the law; and (c) high risk areas for noncompliance. The annual audit plan is part of the annual compliance work plan and

addresses each Risk Area listed in the Introduction. Sources from which the CCO may identify annual audit work plan topics may include:

- OMIG/OIG Annual Work Plans;
- OMIG and OIG Corporate Integrity Agreements;
- OMIG compliance alerts and webinars;
- Applicable OMIG Audit Protocol(s);
- Audit findings of other providers of the same provider type;
- Special Fraud Alerts,
- Advisory Opinions;
- Compliance issues identified through compliance program activities (e.g. anonymous complaints);
- Compliance issues identified through internal audits and reviews; and
- Compliance issues identified through external audits, surveys and reviews (including those conducted by governmental agencies).

The CCO will prioritize potential areas of audit and prepare and present a draft audit plan for auditing such prioritized areas to the Compliance Committee for review and to the Governing Authority (or a committee of the Governing Authority) for review and approval.

Upon approval by the Governing Authority, the CCO, in conjunction with the Compliance Committee, shall oversee the completion of audits in accordance with the approved audit plan. Audit methodology may include, among other things:

- Visits and interviews with patients;
- Analysis of patient records and supporting materials and documentation;
- Testing of billing staff regarding claims submission requirements and official coding guidelines;
- Assessment of existing relationships with physicians, hospitals and other potential referral sources;
- Examination of the Company’s complaint logs;
- Reviewing the personnel records of individuals with past compliance reprimands and monitoring their current compliance performance;
- Interviews with Affected Individuals involved in management, operations, claims development and submission, patient care, and other related activities;
- Reviews of clinical documentation, financial records, and other source documents that support claims for reimbursement;
- Validation of credentials of physicians and clinicians who authorize services provided by the Company; and
- Review of employee files.

The design, implementation, and results of any internal or external audits will be documented, and the results shared with the Compliance Committee and Governing Authority.

The results of all internal or external audits, as well as audits conducted by State or Federal governmental agencies, will be reviewed by the CCO for potential corrective actions that are needed to prevent recurrence of any findings. Required corrective actions will be incorporated in the Company's compliance work plan and the CCO will oversee the prompt implementation of corrective action, such as through training, policy revisions, and/or disciplinary action to prevent recurrence. In addition, any Medicaid program overpayments that are identified as a result of routine audits will be reported, returned and explained in accordance with applicable OMIG Compliance Regulations and Company policy.

C. Annual Compliance Program Review.

The CCO and Compliance Committee will undertake a process for reviewing, at least annually, its compliance with applicable OMIG Compliance Regulations to determine whether its compliance policies and procedures are effective, current and complete, and are preventing fraud, waste and abuse in the Company’s day-to-day operations. Whenever the policies and procedures are found to be ineffective or outdated, they will be revised as appropriate. The purpose of such reviews shall be to determine the effectiveness of the Compliance Program, and whether any revisions, additions, improvements or corrective actions are required.

These compliance program reviews may be carried out by the CCO, Compliance Committee, external auditors, or other staff designated by the CCO, provided, however, that such other staff have the necessary knowledge and expertise to evaluate the effectiveness of the components of the Compliance Plan they are reviewing and are independent from the functions being reviewed. The reviews may include on-site visits, interviews with Affected Individuals, review of records, surveys, or any other comparable method the CCO deems appropriate, provided that such method does not compromise the independence or integrity of the review.

The CCO will document the design, implementation and results of its compliance program review, and any corrective actions that are identified as a result. Implementation of such corrective actions shall be documented by the CCO. The results of the compliance program review, including any required corrective actions identified, will be shared with the chief executive, senior management, Compliance Committee and the Governing Authority. The review is documented in a written Annual Compliance Program Effectiveness Report, supported by OMIG’s Compliance Program Self-Assessment form.

D. Annual Certification.

The Company certifies to the Department of Health, upon enrollment and annually, that it has an effective compliance program, using the Certification Statement for Provider Billing Medicaid for each Provider ID. The Company also gives each Medicaid managed care plan in which it participates a copy of its certification when it enters into the participating provider agreement and annually thereafter, in the manner described on the plan’s website. Copies are kept in the compliance records.

VII. RESPONDING TO COMPLIANCE ISSUES AND DEVELOPING CORRECTIVE ACTION PLANS

The Company has established and will implement procedures and systems for: (a) promptly responding to compliance issues as they are raised; (b) investigating potential compliance problems as identified in the course of the internal auditing and monitoring conducted pursuant to the Company's auditing and monitoring program set forth in Section VI of this Compliance Plan; (c) correcting such problems promptly and thoroughly to reduce the potential for recurrence; and (d) ensuring ongoing compliance with Federal and State laws, rules and regulations, and requirements of the Medicaid program.

Upon the detection of potential compliance risks and compliance issues, whether through reports received, or as a result of the auditing and monitoring activities conducted pursuant to the Company's auditing and monitoring program set forth in Section VI of this Compliance Plan, the CCO will take prompt action to investigate the conduct in question, make a determination as to whether any non-compliance occurred, and evaluate what, if any, corrective action is required. The CCO may retain outside experts, auditors, or counsel to assist with the investigation where appropriate.

The CCO will thoroughly document all compliance related investigations, including (a) documenting the nature of any alleged violation and a description of the investigative process used to investigate the alleged violation, and (b) written interview notes and other documents demonstrating the completion of a thorough investigation of the issue. For each compliance investigation, the CCO will promptly document his or her findings as to the following: Each report and investigation is recorded in the compliance issue and investigation log, which tracks the source, issue, Risk Area, status, findings, and corrective action through closure.

- Whether, in fact, there is noncompliance;
- What parties are responsible for such noncompliance;
- What corrective action plan is appropriate (e.g., re-training, disciplinary actions, the formulation of procedures to prevent future noncompliance and other actions to improve the Compliance Plan); and
- After consultation with legal counsel, whether a particular violation is reportable under applicable Federal or State law, and whether any overpayments exist that must be reported and returned in accordance with the Company's overpayment policy.

Corrective action will be designed to ensure not only that the specific problem is addressed, but also to ensure similar problems are not occurring in the same or other departments. If systemic violations are identified (such as several violations occurring in the same department by more than one individual), corrective action may require policy and procedure changes, additional training, disciplinary action, and follow up audits.

The CCO will be responsible for taking steps, as necessary, to ensure that any implemented corrective action is effective in preventing the recurrence of the compliance issue in question. The CCO will document any disciplinary action taken and any corrective action implemented.

If the Company identifies credible evidence of, or credibly believes that, a Federal or State law, rule or regulation has been violated, the Company will promptly report such violation to the appropriate governmental entity, where such reporting is otherwise required by law, rule or regulation. The CCO will retain copies of any reports or information submitted to governmental authorities in connection with this requirement.

VIII. ADOPTION BY GOVERNING AUTHORITY

This Compliance Plan and Policies was adopted by the Governing Authority effective as of the 2nd of February 2024. This Compliance Plan and Policies, as revised, was reviewed by the Compliance Committee on _____ and approved by the Governing Authority on _____, effective _____. The Compliance Program will be reviewed, and as applicable, revised annually hereafter.

EXHIBIT A
STANDARDS OF CONDUCT

PURPOSE:

The purpose of these Standards of Conduct is to foster and maintain the highest level of professional and ethical standards in the conduct of the business of White Glove Community Care, Inc. (the "Company"). The Company places the highest importance upon its reputation for honesty, integrity and high ethical standards. The Standards of Conduct contain standards of ethical behavior and practices for the Company and Affected Individuals (as defined below) that impact all dealings with colleagues, patients, the community and society as a whole, as well as standards governing personal behavior relating directly to the role and identity of the Company. The Standards of Conduct are intended to serve as notice to Affected Individuals, local, state and federal government officials, and the community at large, that the Company expects and requires all persons associated with the Company to abide by all applicable laws and regulations, prevent, to assist in the Company's efforts to detect and deter fraud, waste and abuse, and to adhere to the standards set forth in these Standards of Conduct.

APPLICABILITY:

These standards can only be achieved and sustained through the actions and conduct of all persons whose job responsibilities impact or affect the Company's Risk Areas (as defined in the Compliance Plan), including the Company's employees, the chief executive and other senior administrators, managers, contractors, agents, subcontractors, independent contractors, members of the Governing Authority and corporate officers (collectively, "Affected Individuals"). Every Affected Individual is obligated to conduct himself/herself in a manner to ensure maintenance of these standards. The actions and conduct of Affected Individuals and their compliance with these Standards of Conduct will be important factors in evaluating an Affected Individual's judgment and competence, and an important component of all performance evaluations and contract renewal decisions.

POLICY:

Ethics and Compliance

The Company has an ethical responsibility to the patients and the community it serves, and fulfills this responsibility through ethical care, treatment, services and business practices. All Affected Individuals are expected to uphold the values, ethics and mission of the Company. The mission of the Company, the Company's policies and procedures, and the Company's business practices, shall be consistent in the support and protection of the rights of patients in all aspects of care, treatment and services provided.

All Affected Individuals shall conduct all personal and professional activities with honesty, integrity, respect, fairness and good faith in a manner that will reflect positively upon the Company and in the best interest of the patient population and community served. Affected Individuals must be cognizant of and comply with all applicable federal and state laws and regulations that apply to and impact the Company in the provision of services, documentation,

billing, and the day to day activities of the Company and its employees and agents. This includes requirements regarding confidentiality of personal health information. Each Affected Individual who is materially involved in the provision of services, documentation, coding or billing has an obligation to familiarize himself or herself with all applicable laws and regulations, as well as the Company's internal policies and procedures related to such functions, and to adhere at all times to the requirements thereof. Where any question or uncertainty regarding these requirements exists, it is incumbent upon, and the obligation of, each Affected Individual to seek guidance from a knowledgeable officer of the Company, such as the Chief Compliance Officer. It is the responsibility of every Affected Individual to be familiar with the requirements of applicable federal and state laws, rules and regulations, and to report any situations that may violate such requirements pursuant to the Compliance Program. Claims of ignorance, good intentions and bad advice are not acceptable as excuses for non-compliance or failing to report non-compliance. Those in supervisory positions have the additional responsibility to verify that supervised personnel understand and comply with the standards of professional and business conduct set forth in these Standards of Conduct.

Patient Care and Company Practices Related to Provision of Services

All Affected Individuals shall maintain competency and proficiency in healthcare industry and general business standards, as applicable. Contracted providers of healthcare services must meet and adhere to the quality and ethical standards of the Company, as well as the requirements of New York's Social Services Law § 363-d. Marketing materials shall accurately represent the Company to the public as to the types or quality of care, treatment and services the Company can provide, directly or indirectly by contractual arrangement. Should a patient require or request care, treatment or services not available or inconsistent with the Company's mission, an offer to refer/transfer the patient to an organization that can fulfill this need will be made and, if in agreement, the patient will be referred/transferred appropriately. The Company shall not receive, accept or offer any remuneration for referrals or transfers of patients in violation of the Anti-Kickback Law.

Whenever possible, patients, families and legal guardians shall be included in decisions about patient care, treatment and services, including ethical issues, subject to all applicable privacy and confidentiality laws. The effectiveness and safety of care, treatment and services provided by the Company shall be consistent for all patients and is not dependent on the patient's ability to pay. The Company shall implement and maintain a process to evaluate the quality of care or services rendered.

Billing and Claims

The Company bills only for services that are actually ordered, coded accurately, verified, medically necessary, and adequately and accurately documented. Billing practices of the Company shall adhere to and be compliant with federal, state and local regulations, and applicable program requirements, including all requirements under Medicaid and/or Office of the Medicaid Inspector General (OMIG) and Department of Health (DOH) directives. The Company shall maintain all documentation required to support claims and payments for at least six years, or longer if required by applicable laws, rules or regulations, program requirements, or contractual requirements, or the Company's record keeping policies. Unpaid accounts will be

reviewed prior to referral to a collection agency. Should a patient continue to require home health assistance although he/she financially can no longer continue services, efforts will be made to assist the patient/family to obtain alternate financial resources.

Business Practices

Affected Individuals are prohibited from exploiting their professional relationships for personal gain, and shall maintain the confidentiality of the Company's business and financial information and practices. Affected Individuals shall refrain from participating in any endorsement or publicity that demeans the credibility and dignity of the Company and the profession. Affected Individuals shall not allow any outside financial interest or competing personal interest to influence their decisions or actions taken on behalf of the Company. Affected Individuals must avoid any situation where a conflict of interest exists or might appear to exist between their personal interests and those of the Company. All Affected Individuals must disclose any situation where a conflict of interest exists, or might appear to exist, between personal interests and those of the Company. Affected Individuals may not engage in activities in which an actual or potential conflict of interest may exist unless such actual or potential conflict of interest has been disclosed to and approved by the Chief Compliance Officer and/or the governing authority of the Company.

The Company shall strive to continuously improve business management processes, functions and services. Practicing or facilitating discrimination in any form is strictly prohibited. The Company shall institute safeguards to prevent discriminatory practices. Affected Individuals shall adhere at all times to the prohibition against discrimination, and shall adhere at all times to policies and safeguards adopted by the Company to prevent discrimination.

Patient and Community Responsibilities

Healthcare services shall be provided consistent with available resources and a resource allocation process that considers ethical ramifications. Competitive and cooperative activities shall be conducted in a way that improves community healthcare services. The Company's business activities and service provision shall be carried out in a manner that respects the customs and practices of those served, consistent with the Company's philosophy. Affected Individuals shall be truthful in all forms of communication, and avoid communications that would create unreasonable expectations. The Company shall strive to enhance the dignity and image of the Company through marketing, public relations and education programs, without undermining the reputation of competitive businesses.

VIOLATIONS:

Affected Individuals who ignore or disregard the principles of these Standards of Conduct will be subject to appropriate disciplinary actions, up to and including restitution and employment termination (or contract termination, in the case of contractors). Questions or concerns about these Standards of Conduct may be directed to the CCO at 1-718-828-2666, ext. 4007, or complianceofficer@whiteglovecare.net, or reported anonymously to the Compliance Hotline (929-468-9080).

CERTIFICATION:

I hereby certify that I have received a copy of the Company's Standards of Conduct and have read, understand and agree to abide by the Standards of Conduct. I further agree to fulfill my obligations to assist the Company in ensuring its compliance with applicable laws, rules and regulations, and preventing, detecting and deterring fraud, waste and abuse.

Name: _____

Signature: _____

Date: _____

EXHIBIT B
DEFICIT REDUCTION ACT POLICY

PURPOSE:

The Deficit Reduction Act of 2005 instituted a requirement for health care entities which receive or make $5.0 million or more in Medicaid payments during a federal fiscal year to establish written policies and procedures informing and educating their employees, contractors and agents about federal and state false claim acts and whistleblower protections. In addition, the OMIG Compliance Regulations require all Medicaid providers subject to the OMIG Compliance Regulations to comply with the Deficit Reduction Act. In compliance with this requirement, set forth below is a detailed description of the Federal False Claims Act, the Federal Program Fraud Civil Remedies Act, New York State civil and criminal laws pertaining to false claims, and the whistleblower protections afforded under such laws. In addition, this policy provides a description of the Company's policies and procedures for detecting, preventing and deterring fraud, waste and abuse.

POLICY:

I. FEDERAL LAWS

1) Federal False Claims Act (31 USC §§3729-3733)

(a) Liability for certain acts.--

(1) In general.--Subject to paragraph (2), any person who--

(A) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;

(B) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim;

(C) conspires to commit a violation of subparagraph (A), (B), (D), (E), (F), or (G);

(D) has possession, custody, or control of property or money used, or to be used, by the Government and knowingly delivers, or causes to be delivered, less than all of that money or property;

(E) is authorized to make or deliver a document certifying receipt of property used, or to be used, by the Government and, intending to defraud the Government, makes or delivers the receipt without completely knowing that the information on the receipt is true;

(F) knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the Government, or a member of the Armed Forces, who lawfully may not sell or pledge property; or (G) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government, is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C. 2461 note; Public Law

104-4101), plus 3 times the amount of damages which the Government sustains because of the act of that person.

(2) Reduced damages.--If the court finds that--

(A) the person committing the violation of this subsection furnished officials of the United States responsible for investigating false claims violations with all information known to such person about the violation within 30 days after the date on which the defendant first obtained the information;

(B) such person fully cooperated with any Government investigation of such violation; and

(C) at the time such person furnished the United States with the information about the violation, no criminal prosecution, civil action, or administrative action had commenced under this title with respect to such violation, and the person did not have actual knowledge of the existence of an investigation into such violation, the court may assess not less than 2 times the amount of damages which the Government sustains because of the act of that person.

(3) Costs of civil actions.--A person violating this subsection shall also be liable to the United States Government for the costs of a civil action brought to recover any such penalty or damages.

(b) Definitions.--For purposes of this section--

(1) the terms “knowing” and “knowingly” --

(A) mean that a person, with respect to information--

(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 of the truth or falsity of the information; and

(B) require no proof of specific intent to defraud;

(2) the term “claim”--

(A) means any request or demand, whether under a contract or otherwise, for money or property and whether or not the United States has title to the money or property, that--

(i) is presented to an officer, employee, or agent of the United States; or

(ii) is made to a contractor, grantee, or other recipient, if the money or property is to be spent or used on the Government's behalf or to advance a Government program or interest, and if the United States Government--

(I) provides or has provided any portion of the money or property requested or demanded; or

(II) will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded; and (B) does not include requests or demands for money or property that the Government has paid to an individual as compensation for Federal employment or as an income subsidy with no restrictions on that individual's use of the money or property;

(3) the term “obligation” means an established duty, whether or not fixed, arising from an express or implied contractual, grantor-grantee, or licensor-licensee relationship, from a fee-based or similar relationship, from statute or regulation, or from the retention of any overpayment; and (4) the term “material” means having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property.

(c) Exemption from disclosure.--Any information furnished pursuant to subsection (a)(2) shall be exempt from disclosure under section 552 of title 5.

> (d) Exclusion.--This section does not apply to claims, records, or statements made under the Internal Revenue Code of 1986.

While the False Claims Act imposes liability only when the claimant acts “knowingly,” it does not require that the person submitting the claim have actual knowledge that the claim is false. A person who acts in reckless disregard or in deliberate ignorance of the truth or falsity of the information, also can be found liable under the Act. 31 U.S.C. 3729(b).

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

A violation of the Federal False Claims Act results in a civil penalty for each false claim submitted (as adjusted for inflation, $14,308 to $28,619 per claim as of 2025), plus up to three times the amount of the damages sustained by the Government because of the violation. In addition, the United States Department of Health and Human Services (HHS) Office of the Inspector General (OIG) may exclude the violator from participation in Federal health care programs.

In addition to its substantive provisions, the FCA provides that private parties may bring an action on behalf of the United States. 31 U.S.C. 3730 (b). These private parties, known as “qui tam relators,” may share in a percentage of the proceeds from an FCA action or settlement.

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

2) Administrative Remedies for False Claims (31 USC Chapter 38. §§ 3801 – 3812)

This statute allows for administrative recoveries by federal agencies. If a person submits a claim that the person knows is false or contains false information, or omits material information, the agency receiving the claim may impose a penalty of up to $14,308 (as adjusted for inflation as of 2025) for each claim. The agency may also recover twice the amount of the claim.

Unlike the False Claims Act, a violation of this law occurs when a false claim is submitted rather than when it is paid. Also unlike the False Claims Act, the determination of whether a claim is

false, and the imposition of fines and penalties is made by the administrative agency, not by prosecution in the federal court system.

II. NEW YORK STATE LAWS

New York State False Claim Laws fall under the jurisdiction of both New York's civil and administrative laws as well as its criminal laws. Some apply to recipient false claims and some apply to provider false claims. The majority of these statutes are specific to healthcare or Medicaid. Yet some of the "common law" crimes apply to areas of interaction with the government and so are applicable to health care fraud and will be listed in this section.

A. CIVIL AND ADMINISTRATIVE LAWS

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

The New York False Claims Act is similar to the Federal False Claims Act. It imposes penalties and fines upon individuals and entities who knowingly file false or fraudulent claims for payment from any state or local government, including health care programs such as Medicaid. It also has a provision regarding reverse false claims similar to the federal FCA such that a person or entity will be liable in those instances in which the person obtains money from a state or local government to which he may not be entitled, and then uses false statements or records in order to retain the money.

The penalty for filing a false claim is six to twelve thousand dollars per claim (as adjusted to be equal to the civil penalties available under the federal false claims act) plus three times the amount of the damages which the state or local government sustains because of the act of that person. In addition, a person who violates this act is liable for costs, including attorneys' fees, of a civil action brought to recover any such penalty.

The Act allows private individuals to file lawsuits in state court, just as if they were state or local government parties, subject to various possible limitations imposed by the NYS Attorney General or a local government. If the suit eventually concludes with payments back to the government, the person who started the case can recover twenty-five to thirty percent of the proceeds if the government did not participate in the suit, or fifteen to twenty-five percent if the government did participate in the suit.

2) Social Services Law, Section 145-b - False Statements

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

3) Social Services Law, Section 145-c - Sanctions

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

B. CRIMINAL LAWS

1) Social Services Law, Section 145 - Penalties

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

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

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

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

3) Penal Law Article 155 - Larceny

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

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

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

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

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

4) Penal Law Article 175 - False Written Statements

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

a. §175.05 - Falsifying business records involves entering false information, omitting material information or altering an enterprise’s business records with the intent to defraud. It is a class A misdemeanor.

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

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

d. §175.35 - Offering a false instrument for filing in the first degree includes the elements of the second degree offense and must include an intent to defraud the state or a political subdivision. It is a class E felony.

5) Penal Law Article 176 - Insurance Fraud

This law applies to claims for insurance payments, including Medicaid or other health insurance, and contains six crimes

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

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

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

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

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

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

6) Penal Law Article 177 - Health Care Fraud

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

This law primarily applies to claims by providers for insurance payment, including Medicaid payment, and it includes six crimes.

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

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

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

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

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

III. WHISTLEBLOWER PROTECTION

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

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

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

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

3) New York State Labor Law, Section 740

An employer may not take any retaliatory action against an employee, including a former employee or an independent contractor, because the employee discloses, or threatens to disclose, to a supervisor or to a public body an activity, policy, or practice of the employer that the employee reasonably believes violates a law, rule, or regulation or poses a substantial and specific danger to the public health or safety; provides information to, or testifies before, a public body conducting an investigation, hearing, or inquiry into such activity; or objects to or refuses to participate in such activity. Before disclosing to a public body, the employee must make a good

faith effort to notify the employer by bringing the matter to the attention of a supervisor and allowing a reasonable opportunity to correct it, except in circumstances defined in the law, such as an imminent and serious danger to public health or safety. An employee who is retaliated against may sue within two years for reinstatement, lost wages and benefits, and attorneys' fees, and, where the violation was willful, malicious, or wanton, punitive damages; the court may also impose a civil penalty of up to $10,000. Employers must post a notice of employee rights under this law.

4) New York State Labor Law, Section 741

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

POLICIES AND PROCEDURES FOR DETECTING AND PREVENTING FRAUD, WASTE, AND ABUSE

The Company has put in place written policies and procedures that describe compliance expectations, as embodied in Standards of Conduct; describe the operation of its compliance program; provide guidance to employees and others on dealing with potential compliance issues; identify how to communicate compliance issues to appropriate personnel; and describe how potential compliance problems are investigated and resolved. These policies and procedures are set forth in the Company's Compliance Plan.

The Company has designated a Chief Compliance Officer who is responsible for the day-to-day operation and oversight of the compliance program. We encourage all personnel and others associated with us to communicate with us about compliance questions and issues as they arise by calling the Chief Compliance Officer, at 1-718-828-2666, ext. 4007, email the Chief Compliance Officer at complianceofficer@whiteglovecare.net, or call the anonymous Compliance Hotline (929-468-9080).

We conduct training and education for employees and others associated with us on compliance issues, expectations and the compliance program operation and on subjects within the scope of their responsibilities. We require all persons associated with the Company to participate in good faith in the compliance program, to report suspected compliance issues as they arise, and to assist in their resolution. We maintain disciplinary policies to encourage good faith participation

in the compliance program, and we maintain a policy of non-intimidation and non-retaliation for such participation.

We have developed a system for the routine identification of compliance risk areas specific to the Company and for self-evaluating risk areas, through internal and, as appropriate, external audits and reviews. We conduct reference checks on prospective employees, criminal background checks (in accordance with state law requirements) on non-licensed prospective employees, and exclusion reviews, upon hire and on a monthly basis thereafter, on employees and others with whom we do business.

We respond to compliance issues as they arise by conducting investigations as needed, responding to compliance issues identified in the course of self-evaluations and audits, correcting compliance issues, including reporting and repayment where necessary, and implementing mechanisms to reduce the potential for recurrence. We provide education on Federal and state false claims acts and other federal and state civil and criminal laws on false claims, and the whistleblower protections afforded under such laws and on our policies and procedures for detecting and preventing fraud, waste, and abuse.