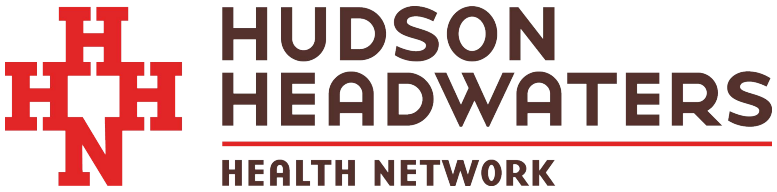

Ethics & Compliance Plan
2018

Ethics and Compliance Plan 2018

Table of Contents

Ethics and Compliance Plan 2018

Definition of Ethics & Compliance

Hudson Headwaters Health Network (Network) strives to maintain a reputation for conducting all fiscal and operational activities in accordance with the highest level of business and community ethics. As a healthcare provider, the Network is committed to operating under the highest ethical and moral standards, and ensures that the Network, in all of its activities, complies with applicable federal, state and local laws, regulations and guidelines.

The Network Ethics & Compliance program begins with our organizational Mission, our quality Vision and our core Values. All compliance-related activities are designed to detect and prevent accidental and intentional noncompliance with applicable laws, throughout the organization. The plan contains organizational conduct requirements that are intended to address pertinent compliance issues and the overall scope of conduct, however, are not to be considered all-inclusive.

Purpose

The purpose of the Hudson Headwaters Health Network Ethics & Compliance Program is to:

1. Implement measures for detecting, correcting, and preventing, fraud, waste and abuse
2. Create a culture of non-retaliation and non-intimidation for reporting potential compliance and privacy breaches
3. Ensure patient rights confidentiality of protected health information
4. Facilitate compliance with regulatory, legal, and accrediting agency requirements
5. Protect human and intangible resources (e.g., reputation).

Scope of the Program

The scope of the program is comprehensive and includes all clinical and administrative departments and activities that have a direct or indirect influence on the quality and outcome of care delivered to all Hudson Headwaters Health Network patients. This scope includes primary care, specialty care, behavioral health, dental, and imaging.

We will perform all necessary "due diligence" for services provided to Hudson Headwaters Health Network patients through written agreement (specialists, radiology, etc.). Through this mechanism, the Network will ensure that patients receive acceptable quality of care in these external settings.

Revised 06/08, 06/09, 09/09, 12/10, 10/12, 1/2014, 3/2015, 5/2016, 4/2017, 3/2018

Program Accountabilities and Responsibilities

Accountability

Hudson Headwaters Health Network' Board of Directors is ultimately accountable for the Ethics and Compliance program at Hudson Headwaters Health Network. The Board holds the Chief Executive Officer accountable for the efficient and effective functioning of the Hudson Headwaters Health Network Health Network and its Ethics & Compliance program.

Responsible Individuals

A. The ***Chief Executive Officer*** is accountable to the Board of Directors and holds ultimate responsibility for the implementation of the Ethics & Compliance Program.
B. The ***VP, Medical Staff Operations (Quality)*** chairs the Network Quality, Risk & Compliance Committee and has oversight responsibility for all aspects of quality, risk management, patient safety and compliance from a clinical perspective. This position reports to the Chief Executive Officer and represents the committee at the Performance Improvement Committee of the Board of Directors meetings.
C. The Network's ***Risk and Compliance Officer*** has oversight responsibility for the Compliance, Privacy & Security, and Risk Management and Safety programs. This position report to the President, Chief Administrative Officer and the Board of Directors.
D. The ***Vice President of Population Health Management*** has oversight responsibility for the Clinical Quality Management and Patient Satisfaction programs. This position reports to the President, Chief Administrative Officer
E. The Network's ***President, Chief Administrative Officer*** has oversight responsibility for Operations, 340B, Population Health, Risk and Compliance, Information Systems and Human Resources. This position reports to the Chief Executive Officer.
F. The Network's ***Vice President of Finance/Chief Financial Officer*** has oversight responsibility for all finance, billing and coding programs, and facilities management. This position reports to the Chief Executive Officer.

Organizational Structure

Board of Directors

The Board of Directors will take an active role in the continual improvement of Hudson Headwaters Health Network. The Board reviews and approves the overall Ethics and Compliance program annually; receives and acts upon reports presented to it by the Risk & Compliance Officer; and ensures the availability of resources and systems to support all Ethics and Compliance activates.

Audit & Compliance Committee of the Board

The Audit & Compliance Committee is a standing committee of the Board of Directors that provides oversight and monitoring of the integrity of the financial statements of the corporation, the independence and the performance of the corporation's internal financial systems and reporting, and the performance of the independent auditors. It is staffed by

the Vice President of Finance/Chief Financial Officer, Controller, and the Risk & Compliance Officer. The Audit and Compliance Committee is chaired by a Board member and consists of at least five Directors who are appointed by the Chair of the Board. This committee meets at least quarterly and reports to the full Board of Directors at least quarterly.

Performance Improvement Committee

The Performance Improvement Committee is a standing committee of the Board of Directors whose purposes are to develop and monitor the organization's clinical quality, risk management, operations, human resources, medical staff, finance and administrative performance improvement programs. It is staffed by the Vice President, Medical Staff Operations; Risk & Compliance Officer; VP of Health Center Operations; and VP of Population Health. The Performance Improvement Committee is chaired by a Board member and consists of at least four Directors who are appointed by the Chair of the Board. This committee meets at least quarterly and reports to the full Board of Directors at least quarterly.

Network Quality, Risk & Compliance Committee (NQRC)

The Network Quality, Risk & Compliance Committee has the responsibility to oversee all of the Quality Assessment and Quality Improvement, Compliance, Risk Management and Safety activities at Hudson Headwaters. This Committee also addresses all Network-wide issues that relate to quality, risk and compliance, including environmental center audits, patient/family/staff complaints, safety drills and incidents, clinical measures, customer service and overall unusual occurrences. The NQRC reports its activities and findings to the CEO and the Performance Improvement Committee of the Board.

The NQRC meets at least quarterly and is chaired by the Network Risk and Compliance Officer and VP, Medical Staff Operations (Quality). Hudson Headwaters recognizes the important role of leadership in its quality program. Accordingly, the Network Quality, Risk & Compliance Committee is comprised of the VP, Medical Staff Operations (Quality), President/CAO, Risk and Compliance Officer, VP of Health Center Operations, VP of Human Resources, and the VP of Population Health. Other staff may be requested to attend the NQRC Committee Meeting depending on the material being discussed.

Security and Safety Committee

Overseen by the Risk and Compliance Officer and the Executive VP of Finance/ CFO the Security and Safety Committee is responsible for the overall privacy, safety and security throughout the Network; both cyber security and physical plant/staff safety and security. The Security and Safety Committee is comprised of the President/Chief Administrative Officer, Director of Information Services, Director of Athena Support, VP for Health Center Operations, Director of Revenue Cycle, the Network Safety Officer and

when appropriate the Network's Legal Counsel. Other staff may be requested to attend the Safety and Security Committee meeting depending on the material being discussed.

Project-specific Workgroups

Multi-disciplinary ad-hoc workgroups that are convened as new Network-wide initiatives are introduced and implemented. The groups meet at frequencies and for durations deemed necessary, depending on the complexity of the specific initiative.

Integration and Coordination

Hudson Headwaters Health Network' Ethics and Compliance program is fully integrated into the Network's ongoing operations through participation of all departments, disciplines, and cross-functional groups/teams.

The Chief Executive Officer is responsible for the Program with active assistance from the Risk & Compliance Officer, the Network Quality, Risk & Compliance and the Board of Directors.

Essential Components

Annual Compliance Plan, Written Policies and Procedures

The Network has established compliance policies, procedures and code of conduct to be followed by its employees and agents that are reasonably capable of reducing the prospect of criminal conduct. The Ethics and Compliance Plan and related policies and procedures are specific to the mission and vision, organization history, lines of business and corporate culture of Hudson Headwaters Health Network.

The Ethics and Compliance plan and related policies and procedures are developed in a collaborative fashion, incorporating all legal requirements with the business methodology embraced by Hudson Headwaters Health Network. The plan and related policies and procedures are reviewed and approved by Network leadership and the Board of Directors.

Copies of the Ethics and Compliance Plan, policies and procedures are available in the organizational policy and procedure manual, located on the Network's Intranet site. Policies and procedures will address specific areas of potential fraud, such as billing and claims processing. Any new or revised corporate compliance policies and procedures will be disseminated to all staff members by the Risk & Compliance Officer.

Designation of a Compliance Officer

The Risk & Compliance Officer has the responsibility to administer and manage all tasks related to establishing, monitoring and updating the ethics and compliance program, with

oversight from the Chief Executive Officer, the Board of Directors and legal counsel. Specifically, the Risk & Compliance Officer has the responsibility to:

- Oversee the completion of a compliance risk analysis to identify areas of risk specific to the Network.
- Supervise the implementation and maintenance of the corporate compliance program plan, coordinate existing compliance policies and procedures, develop new compliance policies and procedures and assure all revisions and new policies and procedures are disseminated as outlined in this plan. Facilitate the review and revision, as necessary, the Code of Conduct for all Network employees.
- Provide oversight for, and evaluate monitoring and auditing procedures related to compliance standards. Establish methods, such as periodic audits, to improve the Network's efficiency and quality of services, and to reduce the Network's vulnerability to fraud and abuse.
- Monitor that personnel receive training and education in the basic principles of corporate compliance and ethical business practices.
- Implement and maintain a means for anonymous communication for reporting noncompliance issues, and/or receiving help and assistance regarding potential violations and general information about corporate compliance.
- Establish and maintain open lines of communication with all departments, including the billing department and organizational personnel and agents to ensure effective and efficient compliance policies and procedures.
- Investigate any report or allegation concerning possible unethical or improper business practices, and monitor subsequent corrective action and/or compliance.
- Work closely with regulatory body auditors where appropriate, and be available as needed during annual facility audits.
- Prepare and forward compliance reports as required by the Ethics & Compliance Committee, but no less than on a semi-annual basis. An annual summary and evaluation report is to be submitted to the CEO, Network leadership and the Board of Directors.

All questions and concerns regarding compliance with any of the directives set forth within this plan are to be directed to the Risk & Compliance Officer. All personnel and agents are required to fully cooperate with and assist the Chief Compliance Officer as outlined in the performance of his/her duties. Any uncertainty regarding compliance issues on behalf of personnel or agents should be brought to the attention of the Risk & Compliance Officer for assistance and direction.

Effective Education & Training

The Network ensures that ethics and compliance standards and procedures are effectively communicated all personnel. Education is provided through mandatory training programs and by disseminating publications that explain, in a practical manner, the

requirements of the ethics and compliance plan. All employees will receive training on how to perform their jobs in compliance with the standards of the Network and any applicable regulations; and each employee will understand that compliance is a condition of continued employment.

Coders, billers and coding managers are educated regularly on the following topics: Medicare reimbursement principles, billing Medicare and Medicaid for services not rendered, misrepresenting the nature of services rendered, alterations of medical records, billing in violation of the Medicare/Medicaid bundling regulations, medical necessity of services provided, contracts/conflict of interest, credit balance, failure to refund, patient's freedom of choice.

Both initial and annual training in compliance will be conducted, both with respect to the compliance plan itself and applicable statues and regulations. This training is a component of Board Member, provider and staff orientation. Items to be included in compliance training include: operation and importance of the compliance plan; consequences of violating the standards and procedures set forth in the plan; and role of each employee in the operation of the compliance plan.

Training is provided in an understandable manner to assure all staff is aware and know the Network's code of conduct and steps to alert management and the Risk & Compliance Officer to concerns or problems. Training is modified to reflect the level of risk a staff member or agent possesses, or may encounter, with additional training for providers, managers, supervisors, Board members and those individuals working with billing and accounting processes.

Evaluation of directors'/managers'/supervisors' promotion and adherence to the corporate compliance program plan and any other compliance issues will be a component of the individual's annual performance appraisal. Attendance records of personnel orientation and annual update education will be maintained, with annual performance appraisals based, in part, on receipt of compliance information as offered by the Network.

Fraud, Waste & Abuse Program

Hudson Headwaters Health Network employees or agents (via written or verbal contract and/or statement or representation of material fact in agreement), shall not knowingly and willfully make or cause to be made, any false any claim or application for benefits under any federal, state or other healthcare program. Network personnel and agents shall not, with knowledge and fraudulent intent, retain federal, state or other healthcare benefit program funds, which have not been properly paid. The ethics and compliance program includes activities to detect, correct and prevent fraud waste and abuse.

Fraud: The intentional deception or false misrepresentation that an individual knows to be false or does not believe to be true; knowing that deception could result in some unauthorized benefit.

Waste: Acting with gross negligence or reckless disregard for the truth in a manner resulting in any unnecessary cost or consumption of health care resources.

Abuse: Those incidents inconsistent with accepted medical or business practices, improper or excessive.

Examples of Fraud, Waste & Abuse

1. Provider
   - Billing for Medicaid/Medicare services that were not provided
   - Giving out, or billing for, unnecessary services
   - Selling prescriptions
   - Ordering unnecessary tests
   - Giving money or presents to consumers in return for agreeing to get medical care from someone
2. Enrollee
   - Lending a Medicaid Identification card to another person;
   - Forging or altering a prescription or fiscal order;
   - Using multiple Medicaid ID cards;
   - Intentionally receiving duplicative, excessive, contraindicated, or conflicting health care services or supplies; and
   - Re-selling items provided by the Medicaid program

Effective Lines of Communication

Expected standards of conduct are included in the terms and conditions of employment as well as in the annual performance reviews of each officer, provider and staff member of the Network. Should staff, physicians or others question the integrity of any individual or department of the Network, they are expected to report their concerns, anonymously if so desired, through the compliance 'hotline' without fear of retribution.

Individuals leaving an anonymous message are encouraged to provide as many details as possible in order for HHHN to conduct a proper investigation. Individuals who report problems or concerns in good faith will be protected from retaliation, retribution or harassment. Employees who engage in retribution, harassment or any other type of retaliatory action will be subject to disciplinary action up to and including termination of employment.

Anonymous Compliance 'Hotline' Posters are posted in employee break rooms throughout the Network and on the Intranet with Compliance Policies & Procedures.

Internal Monitoring and Auditing

Hudson Headwaters Health Network has taken reasonable steps to achieve compliance with its standards, i.e., by utilizing monitoring and auditing systems designed to detect actual or potential compliance issues by Network personnel or agents, and by having in place and publicizing a reporting system whereby staff and agents can report compliance issues without fear of retribution. The purpose of the ongoing auditing process is to identify actual or potential issues in a timely manner so that systemic checks and balances can be imposed quickly to prevent future recurrences.

Exclusions

- All current and prospective Network providers, employees, vendors, suppliers, contractors or any Business Associates will be verified against the HHS/OIG Cumulative Sanctions List of excluded persons, the Systems for Award Management (SAM) database and the NYS Office of the Medicaid Inspector General.

- Exclusion Monitoring is conducted monthly and reports are provided to the Network Quality & Compliance Committee quarterly.

Auditing

- Coding and billing audits are conducted as outlined in the Corporate Compliance Work plan. The Work plan will be evaluated at least annually.
- Assessments and changes must be documented clearly. Documentation must be consistent, timely, and authenticated.
- Should instances of potentially improper code assignments be identified, all pertinent policies/procedures, including official coding guidelines and billing manuals are reviewed with the individual who coded the encounter.
- A statistically valid, random sample of cases is reviewed to determine whether the problem is: an isolated case, occurred during an isolated time period or a widespread, ongoing problem
- Staff will be interviewed to obtain more information on how the particular billing or coding practice in question was started. A trend analysis is conducted, and re-training is conducted as needs are identified.
- An annual financial audit is conducted to check for violations or possible violations of laws or regulations, such as those related to the Medicare and Medicaid antifraud and abuse statutes, including but not limited to the Medicare and Medicaid Anti-Kickback Statute, Limitations on Certain Physician Referrals (the Stark law), and the False Claims Act, in any jurisdiction whose effects should be considered for disclosure in the financial statements or as a basis for recording a loss contingency [other than those disclosed or accrued in the financial statements].

Monitoring

- Monitoring provides an ongoing system of internal coding and billing review. Monitoring is conducted on a regular basis, and focuses on compliance to the program and performance measures. The purpose of monitoring is to assure that policies and procedures have been properly followed.
- Monitoring techniques include, but are not limited to: health center visits, interviewing staff members, interviewing management, review of operations, billing and related functions and trend analysis studies.

Prompt Response to Detected Offenses

The Network encourages prompt reporting, at the earliest reasonable opportunity, by employees, board members, independent contractors and vendors of any activity or conduct in violation of any HHHN compliance policy or any federal, state or local laws or regulations pertaining to compliance related matters.

The Risk & Compliance Officer shall promptly investigate any reports of potential violations or non-compliance and when necessary and/or appropriate available evidence will be reviewed with the relevant Supervisor, Manager, Director or Senior Management and the Board of Directors.

Enforcement of Standards & Discipline

Through its systematic reporting, monitoring and auditing systems, Hudson Headwaters Health Network will investigate and remediate identified systematic and personnel problems. Discipline of individuals responsible for the failure to detect a violation and/or individuals who commit a violation will be conducted. Upon determination that a personnel member has violated the conduct requirements as set forth in this plan, the individual case will be handled per the Network's disciplinary processes.

Management personnel are made aware of their responsibility for compliance training and for the misconduct of subordinates.

- All personnel are informed that adherence to the compliance program will be an element of annual performance evaluations and that willful violation or failure to comply with organizational policies/procedures and the corporate compliance program plan will be grounds for immediate termination.
- All disciplinary actions will be conducted in such a manner that affords the personnel member confidentiality and due process.
- Self-disclosure of misconduct is encouraged and personnel are advised that while self-reporting will not result in immunity from discipline, it will be considered as a strong mitigating factor when corrective action is required.
- No individual who has engaged in illegal or unethical behavior and/or who has been convicted of healthcare related crimes will be allowed to occupy any position within the Network which involves the exercise of discretionary authority.

- Any individual applying for a position of discretionary authority will have a background evaluation performed prior to hire. Upon discovery of any state or federal sanctions, the potential staff member will no longer be considered for hire.
- Any personnel in a position of discretionary authority, displaying evidence that he/she is unwilling to comply with the corporate compliance program plan will be removed from that position.

Any personnel member who has been under federal or state sanctioning will be immediately terminated.

Regulatory Compliance

The Network's definition and resulting application of compliance, will at all times remain consistent with the Office of Inspector General (OIG), Office of Medicaid Inspector General (OMIG), Bureau of Primary Health Care (BPHC) Program Expectations, appropriate guidelines of the Federal Tort Claims Act (FTCA), all applicable accrediting entities and Federal and State laws, rules and regulations.

Federal Regulations

The False Claims Act

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. The False Claims Act imposes liability on any person who submits a claim to the federal government that he or she knows (or should know) is false

The Anti-Kickback Statute

The Anti-Kickback Statute is a criminal statute that prohibits the exchange (or offer to exchange), of anything of value, in an effort to induce (or reward) the referral of federal health care program business.

The Physician Self-Referral Law (Stark Law)

The Stark Law Prohibits a physician from making referrals for certain designated health services (DHS) payable by Medicare to an entity with which he or she (or an immediate family member) has a financial relationship (ownership, investment, or compensation), unless an exception applies. The Stark Law also prohibits the entity from presenting or causing to be presented claims to Medicare (or billing another individual, entity, or third party payer) for those referred services.

The Exclusion Authorities

The effect of an OIG exclusion from Federal health care programs is that no Federal health care program payment may be made for any items or services (1) furnished by an excluded

individual or entity, or (2) directed or prescribed by an excluded physician. This payment ban applies to all methods of Federal program reimbursement, whether payment results from itemized claims, cost reports, fee schedules or a prospective payment system (PPS). Any items and services furnished by an excluded individual or entity are not reimbursable under Federal health care programs. In addition, any items and services furnished at the medical direction or prescription of an excluded physician are not reimbursable when the individual or entity furnishing the services either knows or should know of the exclusion. This prohibition applies even when the Federal payment itself is made to another provider, practitioner or supplier that is not excluded.

The Civil Monetary Penalties Law

The Civil Monetary Penalties Law authorizes the imposition of substantial civil money penalties against an entity that engages in activities including, but not limited to: (1) knowingly presenting or causing to be presented, a claim for services not provided as claimed or which is otherwise false or fraudulent in any way; (2) knowingly giving or causing to be given false or misleading information reasonably expected to influence the decision to discharge a patient; (3) offering or giving remuneration to any beneficiary of a federal health care program likely to influence the receipt of reimbursable items or services; (4) arranging for reimbursable services with an entity which is excluded from participation from a federal health care program; (5) knowingly or willfully soliciting or receiving remuneration for a referral of a federal health care program beneficiary; or (6) using a payment intended for a federal health care program beneficiary for another use.

Criminal Health Care Fraud Statute

The Criminal Health Care Fraud Statute prohibits knowingly and willfully executing, or attempting to execute, a scheme or artifice in connection with the delivery of or payment for health care benefits, items, or services to defraud any health care benefit program; or obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program.

HIPAA Requirements

Patient Rights

- The Network is committed to ensuring patient rights and responsibilities by educating staff and providers. The Network's Patient Rights are available to every patient of the Network through the following channels:
- A printed version of the Patient Rights are framed and hung in a visible location within each Network location;
- The Patient Rights are listed on the Network website
- The patient's registration sheet informs the patient as to the availability of the Patient Rights upon request.

Privacy & Security

- The Network restricts access to all patient protected health information (PHI), including electronic information to individuals who have a need to know and permission for access. Confidentiality must be safeguarded by the restrictive use of (PHI) obtained from and about a patient. Information from the patient's medical record shall be secured by departmental policies regarding authorized users and authorized release of patient and clinical data. PHI will not be allowed off the premises unless in an encrypted electronic form.

- The Network has established a Privacy & Security Officer as required by HIPAA. The Director of Risk Management is the designated Privacy & Security Officer for the Network and has the responsibility to oversee all ongoing activities related to the development, implementation, and maintenance of the Network privacy & security policies in accordance with applicable federal and state laws.

Employee Whistleblower Protections

Hudson Headwaters Health Network is prohibited from discharging, demoting, or otherwise discriminating against an employee as a reprisal for disclosing, to government entities information that the employee reasonably believes is evidence of gross mismanagement of a Federal contract, a gross waste of Federal funds, an abuse of authority relating to a Federal contract, a substantial and specific danger to public health or safety, or a violation of law, rule, or regulation related to a Federal contract (including the competition for or negotiation of a contract). A reprisal is prohibited even if it is undertaken at the request of an executive branch official, unless the request takes the form of a non-discretionary directive and is within the authority of the executive branch official making the request.

An employee who believes that he or she has been discharged, demoted, or otherwise discriminated against contrary to the policy in 3.908–3 of this section may submit a complaint with the Inspector General of the agency concerned. Procedures for submitting fraud, waste, abuse, and whistleblower complaints are generally accessible on agency Office of Inspector General Hotline or Whistleblower Internet sites.

New York State Regulations

New York Social Services Law

Every provider of medical assistance program items and services that is subject to subdivision four of this section shall adopt and implement a compliance program. Such program shall at a minimum be applicable to billings to and payments from the medical assistance program but need not be confined to such matters. The compliance program required may be a component of more comprehensive compliance activities by the medical assistance provider so long as the requirements of this section are met. A compliance program shall include the following elements: written policies & procedures; training &

education; designated employee(s); communication lines; disciplinary actions; system for routine identification; system for responding; and a policy of non-intimidation & non-retaliation.

New York Labor Law

An employer shall not take any retaliatory personnel action against an employee because such employee does any of the following: (a) discloses, or threatens to disclose to a supervisor or to a public body an activity, policy or practice of the employer that is in violation of law, rule or regulation which violation creates and presents a substantial and specific danger to the public health or safety, or which constitutes health care fraud; (b) provides information to, or testifies before, any public body conducting an investigation, hearing or inquiry into any such violation of a law, rule or regulation by such employer; or (c) objects to, or refuses to participate in any such activity, policy or practice in violation of a law, rule or regulation.

Health Information Management

Hudson Headwaters will achieve continued excellence with respect to its medical records. These records will be maintained in a manner that is current, detailed, secure, and enabling of effective, confidential patient care and quality review. Medical records will reflect all aspects of care and will be complete, accurate, systematically organized, legible, authenticated, and readily available to all appropriate health care practitioners and other necessary parties, in strict accordance with HIPAA guidelines.

Release of Information

Adherence to all governing rules and regulations in relation to the release and disclosure of medical records while ensuring continuity of care and patient confidentiality is maintained. Medical records are secure when the Network is responding to requests for release of confidential information.

Conflict of Interest and Code of Conduct

It is the policy of the Network to outline the standard of conduct expected of all management employees, officers, and Directors, and members of committees with Board of Directors-delegated powers of, as well as others who are in a position to influence or make business decisions on behalf of Network ("Covered Individuals"). It is expected that during the performance of duties on behalf of Network, Conflicts of Interest will be avoided. In the event that a Covered Individual is involved in a Conflict of Interest, it is expected that the conflict will be disclosed so that resolution of the conflict may occur.

Board members, employees, contractors, agents, consultants, volunteers, and others who act on Hudson Headwaters' behalf ("Staff") have a responsibility to Hudson Headwaters patients, Federal and State Governments, other Hudson Headwaters funders and the communities served by Hudson Headwaters to conduct themselves prudently, responsibly, in furtherance of, and consistent with, Hudson Headwaters charitable purposes and non-profit, tax-exempt status, and in the best interests of Hudson Headwaters' patients.

The Ethics and Compliance program will be conducted in such a manner as to ensure organizational compliance with appropriate policies concerning Confidentiality and Conflict of Interest, as well as with all HIPAA requirements concerning patient/staff confidentiality and privacy issues.

Record Creation and Retention

A permanent written record of any communication (verbal, written or electronic) reporting a real or potential noncompliance issue, will be generated.

All records regarding corporate compliance and any of the issues outlined in this plan will be kept in a locked file cabinet. Records must be available upon request for any state or federal official requesting review.

Reports, as outlined earlier in this plan, will be forwarded to the Board of Directors. The Risk and Compliance Officer, as stated above, will keep an original copy of any and all reports. All copies of reports disseminated for review will be collected and disposed of in a confidential manner.

All documentation related to the corporate compliance issues as outlined in this plan will be retained for a period of seven years, (or as required by state and federal mandates).

HUDSON HEADWATERS HEALTH NETWORK

Ethics and Compliance Plan 2018

Signature Page

Chair, Board of Directors T. Robert Wolgin — 3/22/18 Date Approved

T. Shuryland MD CEO
Chief Executive Officer — 3/22/18 Date Approved

Kimberly Chaffee, MHA
Risk & Compliance Officer — 3/22/18 Date Approved