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KINGS HARBOR MULTICARE CENTER

ADMISSION AGREEMENT

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Kings Harbor Multicare Center

ADMISSION AGREEMENT

Kings Harbor Multicare Center
2000 East Gun Hill Road
Bronx, New York 10469
(718) 320-0400

ADMISSION AGREEMENT

Agreement dated _____, 20___ between **Bronx Harbor Care Complex, Inc. d/b/a Kings Harbor Multicare Center** located at 2000 East Gun Hill Road, Bronx, New York 10469 (hereinafter "Facility") and _____ (hereinafter referred to as "Resident"), whose residence is located at _____
and _____ (hereinafter "Designated Representative") residing at _____
and _____ Resident's spouse (if not listed as "Designated Representative") residing at _____ _____
and _____ Resident's sponsor (hereinafter "Sponsor") residing at _____.

The Facility accepts the Resident for admission subject to the following terms and conditions:

I. ADMISSION AND CONSENT

The undersigned hereby agrees, subject to both federal and state laws, rules and regulations, that the Resident will be admitted to the Facility only upon the order of a New York State licensed physician and upon a determination that the Resident satisfies the admission assessment criteria set by the New York State Department of Health and by the Facility. The Resident and/or Designated Representative hereby consent to such routine care and treatment as may be provided by the Facility and/or ancillary providers in accordance with the Resident's plan of care, including but not limited to, transfer to an acute care hospital when necessary, dental, medical and/or surgical consultation, examination by staff, routine diagnostic tests and procedures, and the administration of pharmaceuticals. The Resident and/or Designated Representative shall have the right to participate in the development of the plan of care and shall be provided with information concerning his or her rights, to consent or refuse treatment at any time to the extent allowable under applicable law. **The Resident and/or Designated Representative hereby understand and agree that Admission to the Facility is conditioned upon the review and execution of this Agreement and related documents as more fully set forth herein.**

II. MUTUAL CONSIDERATION OF PARTIES

The Facility agrees to provide all basic (routine) services to the Resident, as well as either provide or arrange for available ancillary services, that the Resident requires. Attachment "A" lists the routine, ancillary and additional services provided and/or arranged for by the Facility. A list of private pay charges for certain ancillary and other available services is attached to this Agreement and included in your admission package.

The Resident, Designated Representative and Sponsor understand and agree that the Facility's acceptance of the Resident is based on the Resident's, Designated Representative's, and/or Sponsor's representation that the Resident has resources, insurance coverage and/or is eligible for government benefits (including Medicare and/or Medicaid) to cover the cost of care at the Facility. Furthermore, the Resident, Designated Representative and Sponsor agree to take all necessary steps to ensure that the Facility and its associated providers receive payment from these and/or other available sources consistent with this Agreement. The Resident, Designated Representative and/or Sponsor may be required to make full and complete disclosure to the Facility of all income (including Social Security, pension and other periodic receipts), assets, insurance coverage and any other resources available to the Resident that could be available to pay for the cost of care.

Kings Harbor Multicare Center

TELEPHONE HOOKUP

There will be a $2.50 per day, $75.00 per month charge for unlimited local calls.

Telephone service hookup is being requested for 30 days; expiration date will be _____ or date of discharge. Payment of one month on account in advance will activate telephone service. **There will be no exceptions.**

To obtain telephone service call the nursing home and ask for extension 124. At least one day notice is to be given to Telecommunications before discharge date or discontinuance of service. You will be charged from date of service to date of discharge/discontinuance of service. Any refund due to you vill be mailed to you within 30 days following your discharge from the facility or 30 days after you request shut off of service.

To extend telephone service beyond the expiration date noted above, please send an additional check or money order to Telecommunications indicating that you wish to continue telephone service for an additional period of time.

Phone services and equipment are on a rental basis only and any stolen equipment will be charged to the resident's account.

Resident's Name:_____Room # _____

Date of Activation:_____

Resident/Family Member Approval:_____

Billing/Mailinq Address:_____

_____

_____

_____

Visa, Master Card, Check, Cash or Money Order accepted

Please make payable to:

Kings Harbor Multicare Center

The Resident, Designated Representative and Sponsor agree to comply with all applicable policies, procedures, regulations and rules of the Facility.

III. ANTICIPATED SERVICES

It is anticipated that the Resident will initially require the following level of care (should the Resident's condition and level of care needs change, such change will be noted in the Resident's medical record):

☐ **Short Term Specialty Care***: check one of the following: ☐ **Medically Complex** ☐ **Rehabilitation**
☐ **Long Term Care**
☐ **Hospice Care**
☐ **Other** _____

***Kings Harbor Multicare Center** defines short term specialty care as goal oriented, comprehensive, inpatient care designed for an individual who has an acute illness, injury, or exacerbation of a disease process. It is generally rendered at the Facility immediately after, or instead of, acute hospitalization. Short term care lasts for a limited time or until a condition is stabilized or a predetermined treatment course is completed.

Residents admitted for short term specialty care services are admitted with the expectation that, unless continued placement in the Facility is medically appropriate, they will be discharged once short term services are no longer required. It is the mutual objective of the Resident and the Facility that the Resident returns to his/her home or a less restrictive setting, if appropriate. The Resident and his/her Designated Representatives agree to facilitate discharge as soon as medically appropriate, and hereby represent and agree that they will work with the Facility staff to secure an appropriate and timely discharge.

NOTE: In the event Resident is admitted for Short Term Specialty Care services and thereafter no longer requires such care due to his/her condition, an intra-facility room change or transfer to a more appropriate setting may be necessary. Any such room change shall be carried out in accordance with applicable law and the Facility's policies and procedures.

IV. FINANCIAL ARRANGEMENTS

(a) Obligations of Resident, Designated Representative and/or Sponsor

The Resident, Designated Representative and Sponsor shall ensure that resident has a payment source and/or pay the Facility on a private pay basis, with private insurance, and/or by means of a third party government payor, such as Medicare or Medicaid. A Resident's obligation to guarantee payment is personal and limited to the extent of his/her finances, and, where consistent with applicable laws, rules and regulations, to the extent of his/her spouse's income and resources as well. A Sponsor, usually the Resident's spouse, is defined pursuant to 10 NYCRR §415.2, as "the entity or the person or persons, other than the resident, responsible in whole or in part for the financial support of the Resident, including the costs of care in the Facility." Accordingly, the Sponsor is personally responsible for paying for the costs of the Resident's care in the Facility. The Designated Representative is defined as the individual designated by a court of law when the designation of a guardian has been sought, by the resident, or by family members and other parties who have an interest in the well-being of the resident who, after discussion with the facility, identify the individual most personally involved in the resident's care, if the resident lacks the capacity to make such designation to receive information and to assist and /or act in behalf of the resident to the extent permitted by State law. Unless the Designated Representative is also the Resident's spouse or Sponsor, the Designated Representative is not obligated to pay for the cost of the Resident's care from his/her own funds, except to the extent of his/her breach of this Agreement. By signing this Agreement, however, the Designated Representative personally guarantees continuity of payment from the Resident's funds to which he or she has access or control and agrees to arrange for third-party payment if necessary to meet the Resident's cost of care. The Resident, Designated Representative and/or Sponsor agree to provide or arrange for payment for any portion or all of the applicable private pay room and board rate and the ancillary charges incurred for services not covered by third party payors and/or required third

party deductibles, deductibles or the monthly income budgeted by the Medicaid program (NAMI). Payment to the Facility shall be made on a monthly basis as billed.

If the Resident has no third party coverage or if the Resident remains in the Facility after any such coverage terminates because covered services are deemed no longer "medically necessary" or for any other reason consistent with applicable law, the Resident, Designated Representative and/or Sponsor agree to pay or arrange payment at the private pay rate for the room and board rate and the ancillary charges incurred until discharge or until another source of coverage becomes available in accordance with federal and state laws and regulations. The Facility will promptly notify the Resident, Designated Representative and/or Sponsor of a third party payor's discontinuation of payment (coverage).

By entering this Agreement, the Resident, Designated Representative and/or Sponsor understand and agree to the payment obligations set forth in this Agreement.

NOTE: The execution of this Agreement by the Designated Representative cannot, and shall not, serve as a third party guarantee of payment in violation of applicable law and regulation. Notwithstanding the foregoing, the Designated Representative will be held personally responsible and liable if his/her actions or omissions have caused and/or contributed to non-payment of the Facility's fees. Such actions or omissions include, but are not limited to the following: (I) failing to utilize the Resident's funds to pay for the Resident's care at the Facility when the Designated Representative has control over the Resident's funds through a Power of Attorney, access to joint accounts and/or the like; (ii) misappropriation of the Resident's funds; (iii) failure to remit the Resident's social security and/or pension income to the Facility; (iv) failure to provide requested information and/or documentation to the Facility or third party payor, such as an insurer or Medicaid, and/or (v) provision of false, misleading or incomplete information and/or documentation, regarding matters including, but not limited to, the Resident's financial resources, citizenship or immigration status, and/or third party insurance coverage, to the extent that the Facility relies on such information and/or documentation to its detriment. Any failure of the Designated Representative to use the Resident's funds in accordance with the Agreement will constitute a breach of contract on the part of the Designated Representative.

(b) Anticipated Payor

The Resident, Designated Representative and/or Sponsor represent to the Facility that it is anticipated that the cost of the Resident's care will be paid in whole or in part by (check all applicable categories, including both primary and secondary payors):

☐ Medicare ☐ Medicaid ☐ Veteran's Administration Benefits

☐ Managed Care Organization: (Specify Name of Organization): _____

☐ Other private insurance: (Specify Name of Insurance Company): _____

☐ Private Payment ☐ No Fault Insurance Benefits ☐ Worker's Compensation Benefits

☐ Other (Please specify): _____

NOTE: The Resident, Designated Representative and Sponsor agree to provide the Facility with all relevant information and documentation regarding all potential third party payors. The Resident, Designated Representative and Sponsor understand that if the anticipated payor does not pay the cost of care, then the Resident, Designated Representative and Sponsor will be responsible for paying for the cost of care through the funds legally available to the Resident

AUTHORIZATION FOR RELEASE HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name	Date of Birth
Patient Address	

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV* RELATED INFORMATION only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release, or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary and I may refuse to sign this authorization. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.

6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE PERSON(S) SPECIFIED IN ITEM 9(b).**

7. Name and address of health provider or entity to release this information.	
8. Name and address of person(s) or category of person to whom this information will be sent:	
9(a) Specific Information to be released: ☐ Medical Record from (insert dates) _____ to _____. ☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent by other health care providers. ☐ Other: _____ **Include**: (Indicate by initialing) _____ Alcohol/Drug treatment,_____ Mental Health information, _____ HIV-related information	
9(b) **Authorization to discuss health care information:** ☐ By initialing here _____, I authorize _____to discuss my health information with the person(s) listed here: _____.	
10. Reason for release of information: ☐ At request of individual. ☐ Other: _____	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ _____

Signature of resident or resident's legal representative Date

*** Human Immunodeficiency Virus that cause AIDS. NYS Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

Kings Harbor Multicare Center

ASSIGNMENT OF BENEFITS FORM
SIGNATURE ON FILE (SOF)

Date:_____

Name of Resident:_____Date of Admission:_____

Medicare #:_____
Medicaid #:_____
SS #:_____

The Resident, or the Undersigned on the Resident's behalf, assigns the benefits due to the Resident for services rendered by Kings Multicare Center (hereinafter "Facility") (or any person or company that is subcontracted or acts on behalf of Kings Harbor) to provide service to the Facility. The Resident or Undersigned authorizes any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services and its agents any information necessary to claim and receive such payment on the Resident's behalf.

Resident

Resident's Representative

Relationship to Resident

and/or by securing coverage through another third party payor. This provision will be applied consistent with any agreement the Facility may have with a third party payor.

The Resident, Designated Representative and Sponsor understand that, although the Facility will be available to assist the Resident, Designated Representative and Sponsor for third party coverage, it is ultimately the responsibility of the Resident, Designated Representative and/or Sponsor to timely apply for and meet the requirements of third party payors (including, but not limited to Medicaid). A Resident who does not meet the eligibility criteria for coverage by third party payors will be billed at the Facility's private pay room and board rate.

(c) Private Payment

If the Resident is paying privately for the cost of his or her care, and part or all of such payment is not covered by a third party payor, the rate for room and board is $260 per day. In addition, the Resident will be billed for ancillary services including, but not limited to, urinary care supplies, trach and ostomy supplies, surgical supplies, parenteral and enteral feeding supplies, occupational, speech and physical therapy, physician services, prescription medications, laboratory tests, x-rays and other diagnostic services, ambulance/ambulette services, beauty and barber services; personal telephone and newspaper delivery and extraordinary rehabilitative devices according to the Facility's and/or the service providers' charge schedules. However, rates of payment to Facility may differ for individuals with additional sources of payment such as Medicare, Medicaid and third party insurance. A copy of the Facility charge schedule for ancillary services is attached to this Agreement and included in your admission package. Bills are issued monthly and payable on receipt. The private pay room and board rate and additional services charges are subject to increase upon thirty (30) days written notice to the Resident, Designated Representative and/or Sponsor.

(d) Private Pay Billing Policy and Security Deposits

Unless otherwise noted prior to admission and/or restricted by law, the Facility requires a security deposit in cash or certified check equal to two (2) months of services at the Facility's daily basic rate. This money will be deposited by the Facility in an interest-bearing bank account. This security deposit, including any interest accrued, shall continue to be the property of the depositor. However, the Facility shall have the right to apply any or all of the security deposit toward the payment of any unpaid amounts due under this Agreement. If any or all of the security deposit is so applied, or if the Facility's daily basic rate increases, the Facility will notify the Resident, Designated Representative and/or Sponsor and, within ten (10) days of receipt of the notice, additional security must be deposited so that the total security deposit equals two (2) months of services at the Facility's daily basic rate. The Facility may deduct a fee of 1% per year from security deposit amounts to cover administrative costs in accordance with applicable law. Additionally, if private paying Residents leave the facility for reasons within the Resident's control without giving five (5) days prior notice, the Facility will retain an additional amount not to exceed one (1) day's daily basic rate.

The Facility bills private pay individuals for the room and board charges on a one month advance basis. Bills for ancillary charges are generated in the month following the month the services were rendered. All bills are generated at the end of each month and cover the next month of room and board charges and the previous month's ancillary charges. All payments are due upon receipt of the monthly bill.

NOTE: Security Deposits or advance payments are not required upon admission from individuals eligible for Medicare/Medicaid/Veterans Administration benefits. However, immediately upon the ineligibility of a Resident and/or the expiration or discontinuation of coverage for services at the Facility by Medicare, Medicaid or the Veterans Administration, the Resident will be required to remit a security deposit and advance payment at the Facility's basic room and board rate and in accordance with the above-mentioned policies of the Facility.

(e) Late Charges

Interest at the rate of fifteen (15%) percent per annum [1 1/4% per month] will be assessed on all accounts more than thirty (30) days overdue.

(f) Collection Costs, Including Attorney and Court Fees

If the Resident, Designated Representative and/or Sponsor fails to make payments within thirty (30) days of the date payment is due, the Resident shall pay all expenses incurred by the Facility, in connection with its attempts to collect the outstanding payment. Such collection costs will include, but may not be limited to, attorneys' fees, court costs and related disbursements. In addition, the Resident, Designated Representative and/or Sponsor shall pay all late charges as noted above.

(g) Third Party Private Insurance and Managed Care

If the Resident is covered by a private insurance plan or under a managed care benefit plan that has a contract with the Facility, payment of his or her care will be according to the rates for coverage of skilled nursing facility benefits set forth in the written financial agreement with the Facility and the third party insurer or managed care payor. Residents who are members of a managed care benefit plan that is under a contract with the Facility to provide specified services to plan members will have such services covered as long as the Resident meets the eligibility requirements of the managed care benefit plan. To the extent the Resident meets the eligibility requirements of the managed care benefit plan, he or she will be financially responsible only for those services that are not included in the list of covered services under his or her plan and applicable co-pays and deductibles.

If Resident is covered by a private insurance plan or under a managed care benefit plan that does not have a contract with the Facility, and where the insurance proceeds under the private plan are insufficient to cover the cost of care, the Resident will be responsible for any difference. The Facility will bill the Resident for any such difference on a monthly basis as described in the "Private Payment" section above. The coverage requirements for nursing home care vary depending on the terms of the insurance or managed care plan. Questions regarding private insurance and managed care coverage should be directed to the case management staff, the business office and/or the Resident's insurance or managed care plan, carrier or agent.

If Resident is covered by a private insurance plan or under a managed care benefit plan for either all or a portion of the Facility's charges pursuant to the terms of the Resident's plan, by execution of this Agreement the Resident hereby authorizes the Facility to utilize participating physicians and providers of ancillary services or supplies, if required by the plan for full benefit coverage, unless the Resident specifically requests a non-participating provider with the understanding that there may be additional charges to the Resident for using such non-participating providers.

NOTE: The Resident is responsible for timely advising the Facility what benefits, if any, may be available from his or her private insurance and/or managed care plan. Charges may be assessed above the covered benefit for skilled nursing facility care depending on the insurance coverage, managed care plan and/or written agreement with the Facility. Furthermore, Resident's coverage may be subject to co-insurance, deductibles and/or co-payments which will be the Resident's responsibility and billed according to the terms for private payment stated above. In the event of denial of payment by a third party payor, exhaustion of benefits and/or termination of coverage, the Resident shall be responsible for payment to the Facility as described in the "Private Payment" section above and in accordance with applicable law.

(h) Medicaid

If and when the Resident's assets/funds have fallen below the Medicaid eligibility levels, and the Resident otherwise satisfies the Medicaid eligibility requirements and is not entitled to any other third party coverage, the Resident should be eligible for Medicaid (see Attachment "B"), often referred to as the "payor of last resort." **THE RESIDENT, DESIGNATED REPRESENTATIVE AND SPONSOR AGREE TO NOTIFY THE FACILITY AT LEAST THREE (3) MONTHS PRIOR TO THE EXHAUSTION OF THE RESIDENT'S FUNDS AND/OR INSURANCE COVERAGE TO CONFIRM THAT A MEDICAID APPLICATION HAS OR WILL BE SUBMITTED TIMELY AND ENSURE THAT ALL ELIGIBILITY REQUIREMENTS HAVE BEEN MET. MOREOVER, THE RESIDENT, DESIGNATED REPRESENTATIVE AND SPONSOR AGREE TO APPLY FOR MEDICAID BENEFITS PRIOR TO THE EXHAUSTION OF THE RESIDENT'S RESOURCES.** Services reimbursed under Medicaid are outlined in Attachment "A" to this Agreement.

WORKERS' COMPENSATION

Workers' Compensation benefits are available for an employee's work-related injuries. Benefits, including direct payments to a health care provider, are paid by the employer's insurance carrier. Workers' Compensation will provide primary coverage of nursing home care, as long as it is established that the nursing home care is necessitated solely by the Workers' Compensation injury. Claim forms must be submitted to the local Workers' Compensation Board Office within two years of the date of injury. It is advisable to consult with an attorney practicing in the Workers' Compensation area when pursuing a claim. For further information, you can contact your local Workers' Compensation Board office.

NO-FAULT INSURANCE

No-fault insurance coverage must be maintained by all automobile owners in New York State. When a driver or passenger suffers "serious injury" in an automobile accident, regardless of fault, the injured party is entitled to compensation under the owners no-fault policy for "basic economic loss." Under the New York State Insurance Law, 'serious injury" includes permanent limitation of use of a body part or body function, or a non-permanent injury which prevents an individual from performing "substantially all of the material acts which constitute such person's usual and customary daily activities" for at least 90 days during the 180 days immediately following the accident. By statute, the "basic economic loss" recoverable under a no-fault policy is limited to medical expenses and lost earnings up to $50,000. The injured party ordinarily assigns to the nursing home his or her benefits under the no-fault policy. It is advisable to consult with an experienced attorney when pursuing a no-fault claim. For further information, contact your automobile insurance carrier.

VETERANS' BENEFITS

Veterans with certain service-related conditions, former prisoners of war, Medicaid-eligible veterans, or veterans receiving pension benefits may be eligible to receive Veterans' Administration (VA) nursing home benefits. VA nursing home benefits are available for Residents in private non-VA facilities if. (i) the veteran requires nursing care for a service-connected disability following a stay at a VA hospital; (ii) the Resident is an Armed Services member who requires an extended period of nursing care and who will become a veteran upon discharge; (iii) a veteran who requires nursing home care for a service-connected disability, even where no hospital stay is first required; and (iv) a veteran who had been discharged from a VA hospital and is receiving VA hospital-based home health services. Generally, the VA will not authorize nursing home benefits for more than six months, except for veterans requiring care for a service-related disability. This six-month period can in some cases be extended when the veteran is: (i) awaiting Medicaid payment; (ii) planning to pay privately but there are obstacles to arranging the private payments; or (iii) terminally ill and expected to expire within six months. For further information, contact the Department of Veterans' Affairs at (212) 807-7229 or 1 - 800-827-1000

MEDICARE PART B PAYMENT

Individuals who pay monthly premiums to enroll in Medicare Part B will be charged according to Facility's or the provider of services' stated charge schedule for services they receive at Facility. Medicare Part B pays for a wide range of additional services beyond Part A coverage. Part B may cover some of a Residents care regardless of whether they am eligible for Part A benefits. Part B covers eighty (80%) percent of the Medicare approved charge for a specific service and the individual is responsible for the additional twenty (20%) percent. In general, Part B covers medical services and supplies. Part B covers such services as: physical, occupational and speech therapy, physician services, durable medical equipment, ambulance services and certain outpatient and clinical laboratory services. However, Part B benefits have limitations. For example, there is an annual $155.00 deductible applicable to Medicare Part B benefits. **The Resident is responsible for private payment of therapy charges and any other ancillary charges above the Medicare Part B coverage limitations.** The Facility can bill and receive payment if the Resident fills out a Medicare assignment of benefits form. If the Resident completes an assignment of benefits form, a healthcare provider cannot charge the Resident above the Medicare approved charge. In order to determine the Resident's Part B coverage you should contact the Social Security Administration.

As a result of recent legislation, Medicare Advantage and other alternatives now exist which may increase available Medicare benefits. To receive additional information about Medicare coverage, call the Social Security Administration at 800-772-1213.

MANAGED CARE

Residents who are members of a managed care benefit plan that is under a contract with the Facility to provide specified services to plan members will receive those services with full coverage so long as the Resident meets the eligibility requirements of the managed care benefit plan. To the extent the Resident meets the eligibility requirements of the managed care benefit plan, he or she will be financially responsible only for the required deductibles and co-insurance and for those services that are not included in the list of covered services. Residents who have not received a list of covered services and eligibility requirements from their managed cam benefit plan are advised to contact their social worker and/or managed care benefit plan.

PRIVATE INSURANCE

Residents who are covered by a private insurance plan that does not have a contract with the Facility must exhaust all available insurance coverage before seeking Medicare or Medicaid coverage. Where the insurance proceeds under the private plan are insufficient to cover the cost of care, the Resident will be responsible for any difference. The coverage requirements for nursing home care vary depending on the terms of the insurance policy. Questions regarding private insurance coverage should be directed to the social work staff and/or the Resident's insurance carrier or agent.

MEDICAID

Medicaid is a publicly-funded program of assistance that covers nursing home Residents who can demonstrate financial need. To qualify for Medicaid, an individual may have only limited assets. For example, in 2010, no more than $13,800 (subject to annual increases); plus any funds held in an "irrevocable burial trust" arrangement or up to $1,500 under a revocable burial account. Generally, most of the Resident's monthly income must be paid to the Facility, except for a $50 monthly "personal needs allowance" and the monthly cost of retaining a private health insurance policy. This monthly income obligation, called the NAMI (Net Available Monthly Income), is determined by the Medicaid agency. If the Resident has a spouse in the community, the spouse might be entitled to a contribution from the Resident's monthly income. During 2010, the "community spouse" is entitled to a minimum monthly income of $2,739 and resources of $74,820 or one-half the couple's resources as of the date of institutionalization to a maximum of $109,560 (these figures are subject to increase each calendar year); increases beyond these amounts are possible, but a Department of Social Services Fair Hearing or Family Court support proceeding may be required. The Resident's home may be exempt for Medicaid eligibility purposes if the spouse or other specified family members reside there. Medicaid has a sixty (60) months look back period (five (5) years) for transfers cash and/or property and a sixty (60) months look back period (five (5) years) for trust transfers. A Resident or spouse who makes a transfer within those periods may create a period of Medicaid ineligibility. Private pay Residents should apply for Medicaid about three months before their funds are depleted. A Medicaid application must include proof of the Resident's identity, U.S. citizenship or legal alien status, and past and present financial status. Medicaid recipients are required to recertify eligibility each year in order to retain benefits. Medicaid is a complex program and a knowledgeable professional can advise Residents and their families as to their rights under the Medicaid program. To receive information about Medicaid, individuals can call their local Department of Social Services in the county in which the Resident resides.

If the Resident's care is covered by Medicaid, the Resident, Designated Representative and Sponsor agree to remit to the Facility the Resident's Net Available Monthly Income or "NAMI" on a timely basis, pursuant to the Resident's Medicaid budget (see Attachment "B"). A Resident's NAMI equals his or her income (for example Social Security income, pension income, etc.) which is available to offset the cost of care after all deductions have been made and is determined by Medicaid. The Facility has no control over the determination of NAMI amounts. When the Resident is awaiting the issuance of a Medicaid budget, the Resident, Designated Representative and/or Sponsor shall remit the anticipated NAMI to the Facility in a timely manner.

NOTE: If Medicaid denies coverage, the Resident, Designated Representative and Sponsor hereby agree to remit to the Facility any outstanding amounts for unpaid services not covered by other third party payors subject to applicable federal and state laws and regulations. Such amounts shall be calculated in accordance with the Facility's applicable prevailing private rates and charges for all basic and additional services provided to the Resident.

(I) <u>Medicare</u>

If the Resident meets the eligibility requirements for Skilled Nursing Facility benefits under the Medicare Part A Hospital Insurance Program, the Facility will bill Medicare directly for Part A services provided to the Resident. Medicare will reimburse the Facility a fixed per diem or daily fee based on the Resident's classification within the Medicare RUGS III guidelines. If the Resident meets the eligibility criteria, Medicare **may** provide coverage of up to 100 days of care. The first 20 days of covered services are fully paid for and the next 80 days (days 21 through 100), of the covered services are paid for by Medicare subject to a daily coinsurance amount for which the Resident is responsible. Please note, an individual who is a Medicare beneficiary under both the Part A and Part B programs, and who subsequently exhausts their coverage under Part A or is no longer in need of a covered level of skilled care under Part A, may still be eligible to receive coverage for certain Part B services (previously included in the Part A payment to the Facility) after they are no longer eligible for coverage under Part A.

NOTE: If Medicare denies coverage, the Resident and/or the Designated Representative hereby agree to remit any outstanding amounts for unpaid services not covered by other third party payers to the Facility, subject to applicable federal and state laws and regulations. Such amounts shall be calculated in accordance with the Facility's applicable prevailing private rates and charges for all basic and additional services provided to the Resident.

Further information on third party payor sources, please refer to Attachment "B."

<u>MEDICARE PART A BENEFICIARIES</u>

Except for specifically excluded services, nursing home services provided to Medicare Part A beneficiaries are covered under the consolidated billing requirements. Pursuant to the consolidated billing requirements, the Facility is responsible for furnishing directly, or arranging for, the services for its residents covered by Medicare Part A. In arranging for the provision of such services, the Facility is required to enter into arrangements with outside providers. Further, in entering into such an arrangement, the Facility must exercise professional responsibility and control over the arranged-for services. In that regard, all services that are required by the Resident must be provided by the Facility or an outside provider approved by the Facility. Prior to obtaining any services outside of the Facility, the Resident must consult the Facility.

While the Resident has the right to choose a health care provider, the Resident understands that by selecting the Facility, the Resident has effectively exercised his/her right of free choice with respect to the entire package of services for which the Facility is responsible under the consolidated billing requirements. The Resident understands and agrees that he/she will not arrange for the provision of ancillary services unless the Resident has obtained prior approval of the Facility.

V. AUTHORIZATIONS AND ASSIGNMENTS FROM RESIDENT TO THE FACILITY

(a) Authorization to Release Information

By execution of this Agreement, the Resident, Designated Representative and Sponsor authorizes the Facility to release to government agencies, insurance carriers or others who could be financially liable for any medical care provided to the Resident, all information needed to secure and substantiate payment for such medical care and to permit representatives thereof to examine and copy all records relating to such care.

(b) Assignment of Benefits and Authorization to Pursue Third Party Payment

By execution of this Agreement, the Resident, the Resident, Designated Representative and Sponsor hereby assign to the Facility any and all applicable insurance benefits and other third party payment sources to the extent required by the Facility to secure reimbursement for the care provided to the Resident. The Resident, Designated Representative and Sponsor authorize the Facility to seek and obtain all information and documentation necessary for the processing of any third party claim.

(c) Authorization to Obtain Records, Statements and Documents

By execution of this Agreement, the Resident, Designated Representative and Sponsor authorizes the Facility to obtain from financial institutions, including, but not limited to, banks, insurance companies, broker and credit unions, and government agencies, such as the Social Security Administration and Department of Social Services, records, statements, correspondence and other documents pertaining to the Resident for the purposes of payment to the Facility.

(d) Authorization to Represent Resident Regarding Medicaid

By execution of this Agreement, the Facility shall be authorized to have access to the Resident's Medicaid file, and, if the Facility so elects, to act on behalf of the Resident in connection with any and all matters involving Medicaid, including, but not limited to, representation of the Resident at Administrative Fair Hearings.

(e) Authorization to Take Resident's Photograph

By execution of this Agreement, the Resident, Designated Representative and/or Sponsor authorize the Facility to take and keep a photograph of the Resident for identification and to photograph any part of the Resident which has wounds and/or discoloration for treatment purposes.

VII. TEMPORARY ABSENCE (also referred to as "bed hold" or "bed leave")

If the Resident leaves the Facility due to hospitalization or therapeutic leave, the Facility shall NOT be obligated to hold the Resident's bed available until his or her return, unless prior arrangements have been made for a bed hold pursuant to the Facility's "Bed Hold Reservation Policy and Procedure" and pursuant to applicable law. In the absence of a bed hold, the Resident may be placed in any appropriate bed available in the Facility at the time of his or her return from hospitalization or therapeutic leave.

Before a Resident is transferred to a hospital the attending physician or a Facility designee will inform the Designated Representative or responsible family member accordingly, except in an extreme emergency, when the Facility staff has tried but has been unable to reach the Designated Representative or family member. In that circumstance, the Designated Representative or family member will be forwarded a letter restating when and here the Resident was transferred and restating the Facility's bed hold policy and procedure.

(a) **Private Pay Residents** who elect to retain a bed in the Facility during a period of hospitalization or therapeutic leave may do so by:

1. Notifying the Admission Department via telephone,
2. Signing a bed guarantee letter with the Admission Department stating their intent to hold the bed at the Facility's private pay rate; and
3. Continuing payment at the private pay rate.

ATTACHMENT "B"

SPECIAL RULES REGARDING SELECTED PAYORS

PAYMENT FOR IN-PATIENT LONG TERM CARE SERVICES IS AN EXPENSIVE AND COMPLICATED PROCESS. THIS SUMMARY PROVIDES OUR RESIDENTS AND THEIR FAMILIES WITH BASIC INFORMATION WHICH SHOULD SIMPLIFY THE PROCESS. NOTHING HEREIN SHOULD BE CONSIDERED TO BE LEGAL ADVICE. WE URGE YOU TO CONSULT WITH AN INSURANCE AGENT, ATTORNEY AND/OR OTHER KNOWLEDGEABLE PROFESSIONAL(S) IN ORDER TO HELP MAXIMIZE AVAILABLE COVERAGE. FURTHER, AS THE INFORMATION PROVIDED BELOW IS BASED UPON STATUTE AND REGULATIONS, IT IS SUBJECT TO CHANGE WITHOUT NOTICE.

MEDICARE PART A PAYMENT

Medicare part A Hospital Insurance Skilled Nursing Facility coverage is generally available to qualified individuals 65 years of age or older, and individuals under age 65 who have been disabled for at least twenty-four months, who meet the following five requirements: 1) The Resident requires daily skilled nursing or rehabilitation services that can be provided only in a skilled nursing facility,- 2) The Resident was hospitalized for at least three consecutive days, not counting the day of discharge, before entering the skilled nursing facility; 3) The Resident was admitted to the facility within 30 days after leaving the hospital; 4) The Resident is admitted to the facility to receive treatment for the same condition(s) for which he or she was treated in the hospital; and 5) A medical professional certifies that the Resident requires skilled nursing care on a "daily basis." A Resident requires skilled nursing or skilled rehabilitation services on a daily basis when services are medically necessary and provided seven (7) days a week. There is an exception if they are only provided by the facility for five (5) days per week, due to staffing levels at the facility. Additionally, there may be a one to two day break if the Residents needs require suspension of the services.

Where these five criteria are met, Medicare may provide coverage of up to 100 days of care in a skilled nursing facility (SNF): the first 20 days of covered services are fully paid for; and the next 80 days (days 21 through 100), of the covered services are paid for by Medicare subject to a daily coinsurance amount for which the Resident is responsible. The Medicare Part A co-insurance amount is currently $137.50 per day.

Additionally, Medicare Residents requesting a leave of absence from the facility should be aware of the Medicare rules regarding leave of absence and transfer within thirty (30) days. Medicare treats a leave of absence where a Resident leaves the facility on a particular day and does not return by twelve (12) midnight that day, as an uncovered day. Additionally, the day in which a Resident begins a leave of absence (i.e., hospitalization), where the resident is absent for more than 24 hours, is treated as a day of discharge.

Except for specifically excluded services, nursing home services provided to Medicare Part A beneficiaries are covered under the consolidated billing requirements. Residents must consult with the Facility before obtaining any services outside of the Facility.

Medicare also has a thirty (30) day transfer requirement. A Resident must be transferred from a hospital or other SNF within thirty (30) days of discharge and meet the skilled care requirements in order to be eligible for SNF coverage.

If a Resident meets the eligibility requirements for Skilled Nursing Facility benefits under the Medicare Part A Hospital Insurance Program, Facility will bill Medicare directly for all Part A services provided to the Resident Medicare will reimburse Facility a fixed per them or daily fee based on the Resident's classification within the Medicare RUGS III guidelines. RUGS is an acronym for Resource-based Utilization Groups. These guidelines are a measure of what type of care the Resident requires and what it costs health care providers to provide that care to a Resident. Members of our professional staff will evaluate the Residents health condition based on a standardized assessment form (called the MDS 2.0) provided by the Centers for Medicare and Medicaid Services (CMS). Information from the MDS 2.0 form will be used by Medicare to assign the Resident a RUGS III category.

The Resident will be responsible for the daily co-insurance amount determined by Medicare. This amount is subject to increase each calendar year. With limited exceptions, a Resident who requires more than 100 days of SNF care in a benefit period will be responsible for private payment of all charges beginning with the 101st day. A new benefit period may begin when the Resident has either not been in a facility or has not been receiving a covered level of care in a skilled nursing facility for at least 60 days, returns to the hospital for another three-day stay, and then re-enters the SNF. A SNF may not request private payment until the Resident has received an official initial determination from Medicare that "skilled nursing" benefits are no longer available. While a SNF may make a determination of non-coverage, beneficiaries have a right to request an official Medicare determination of ,overage (called a "Demand Bill"), which can be appealed.

ADDITIONAL NON-CLINICAL SERVICES

THE FOLLOWING ADDITIONAL NON- CLINICAL SERVICES ARE AVAILABLE TO ALL RESIDENTS AND IF REQUESTED BY THE RESIDENT AND/OR DESIGNATED REPRESENTATIVE, WILL BE CHARGED TO THE RESIDENT:

- Telephone
- Television/radio for Resident's personal use
- Personal comfort items, notions and novelties, and confections
- Cosmetic and grooming items and services, in excess of those for which payment is made under Medicaid, Medicare, or other insurance programs
- Personal clothing
- Personal reading matter
- Gifts purchased on behalf of a Resident
- Flowers and plants
- Social events, special meals, and entertainment offered off the premises and outside the scope of the Activities program provided by the Facility
- Non-covered special care services, such as private duty nurses
- Specially prepared or alternative food (other than Kosher food or food required by a therapeutic or modified diet prescribed by a physician)
- Private room (except when therapeutically required, such as for isolation for infection control).

IF YOU HAVE ANY QUESTIONS REGARDING CHARGES AND BILLING, PLEASE FEEL FREE TO CONTACT THE RESIDENTS' ACCOUNTS OFFICE.

Private Pay Residents may also authorize a bed hold (if the resident is hospitalized) in advance for a period of at least three days by signing below:

_____I **wish** to have the Facility retain my/the Resident's bed for a period of three days if hospitalized. By initialing this section I have agreed to ensure prompt payment, fro. my/the Resident's funds, of the Facility's private pay daily rate for the three-day bed hold period.

_____I **do not wish** to authorize the Facility at this time to retain my/the Resident's bed if hospitalized. However, should hospitalization be required, I will be consulted at that time as to whether or not I would choose to hold the bed.

(b) **Medicare Residents** are not entitled to reimbursement for any Leave of Absence from the Facility (Bed Hold for hospitalization or therapeutic leave) under the Medicare Program. Medicare Residents who are absent from the Facility past twelve (12) midnight on any given day are deemed to be on Leave of Absence. However, Medicare Residents- may elect to retain a bed in the Facility by following the Private Pay Resident Bed Reservation policy above.

(c) **Medicaid Recipients** may be eligible for a bed hold due to hospitalization for a maximum of 14 days for hospital stay in a 12 month period or a maximum of 10 days in a 12 month period for therapeutic leave of absence. In order to be eligible, Residents must meet a thirty (30) day residency requirement and the Facility must satisfy a vacancy requirement. Medicaid recipients who are ineligible for a Medicaid bed hold or whose Medicaid bed hold has expired or has been terminated, may elect to secure the same bed in the Facility by:

1 . Notifying the Admission Department via telephone;
2. Signing a bed guarantee letter with the Admission Department stating their intent to hold their bed at the Facility's private pay rate.

If the Resident/Designated Representative/Sponsor does not choose to hold the bed privately, a Medicaid Resident temporarily hospitalized or on therapeutic leave will be given priority for readmission when an appropriate bed becomes available, unless there are special circumstances which would preclude a Resident's return.

Please Note: Medicaid Residents who are not entitled to Bed-Hold or Therapeutic Leave and who choose to leave the Facility (i.e., a family member chooses to take resident home for the week-end/holiday) may only secure their bed by following the Private Pay bed hold procedure stated above and paying the Facility at the Private Pay rate.

VII. DISCHARGE, TRANSFER AND INTRA-FACILITY ROOM CHANGES

(a) Involuntary Discharge for Non-Payment

To the extent authorized by applicable law, the Facility reserves the right to discharge the Resident if the Resident, Designated Representative and/or Sponsor fails to pay for, or secure third party coverage of the Resident's care at the Facility.

(b) Involuntary Discharge for Non-Financial Matters

The Facility may transfer or discharge the Resident if the transfer or discharge is necessary for the Resident's welfare and the Resident's needs cannot be met after reasonable attempts at accommodation in the Facility; the Resident's health has improved sufficiently so the Resident no longer needs the services provided by the Facility; the health or safety of individuals in the Facility would otherwise be endangered and all reasonable alternatives to transfer or discharge have been explored and have failed to safely address the problem; and for any other reason permitted by applicable law.

(c) Voluntary Discharge

If the Resident no longer requires the services provided by the Facility, or voluntarily wishes to be discharged, the Resident, Designated Representative and Facility will cooperate in the development and implementation of a safe, appropriate, and timely discharge plan.

NOTE: The Resident will be informed of his or her due process rights in the event that the Facility initiates a transfer or discharge and may appeal the Facility's determination in accordance with applicable regulations.

(d) Intra-Facility Room Change

The Facility reserves the right to transfer the Resident to a new room on an as-needed basis, consistent with applicable law. Residents that are admitted as short term Residents who subsequently become long-term Residents, will be the subject of an intra-facility transfer to rooms that are better suited for long term Residents. By execution of this Agreement the Resident understands and agrees that if he/she, or any third party payor, no longer pays the private rate covering the private room or upon Medicaid coverage, he/she will move to a semiprivate room if requested by the Facility unless the provision of a private room is medically necessary. The Facility may also initiate a room change for medical or social reasons consistent with applicable law and the Resident's rights.

VIII. RESIDENT'S PERSONAL PROPERTY

The Resident has the option of securing personal property (such as jewelry, money, credit cards and personnel identification) in the facility safe. Personal property storage envelopes are available at time of admission. To secure property during you stay, please contact the unit social worker or the facility security officer. A locked drawer will be provided upon request for storage of spending money and small personal items. Residents are strongly encouraged to store valuable items in the facility safe or arrange for family members to hold items at home. The Facility will not be liable for the loss of the Resident's property that is kept in Residents room. Further, it is the responsibility of the Resident and/or Designated Representative to arrange for the disposition of the Resident's property upon discharge. Property left in the Facility for more than thirty (30) days after discharge will be disposed of at the discretion of the Facility.

IX. RESIDENT'S PERSONAL BANK ACCOUNT

The Resident and/or Designated Representative has the option to request that the Facility retain the Resident's personal funds. All funds more than $50.00 shall be kept in an interest-bearing account by Facility. The Resident and/or Designated Representative will receive account statements on a quarterly basis, and all inquiries will be addressed in a timely fashion. The Resident and/or Designated Representative hereby agree to and acknowledge that upon the discharge of the Resident, and after any outstanding payments are made to the Facility, the account balance, if any, will be distributed to the Resident, Designated Representative, Resident's estate and/or the Department of Social Services, as permitted by law. **Please initial one of the lines below.**

_____ I **wish** to have the Facility retain my/the Residents personal funds.

_____ I **do not wish** to have the Facility retain my/the Resident's personal funds. (**Please Note:** The Designated Representative must have legal authorization to handle the Residents funds should he/she choose to receive the funds directly. If not, the Designated Representative may purchase items on behalf of the Resident and be reimbursed upon presentation of adequate documentation to the Facility's Finance Department.)

Direct Deposit

Residents who choose to do so may have income such as Social Security, pension benefits, etc. deposited in their personal account via electronic direct deposit. If you would like the facility to assist you/the Resident in obtaining direct deposit of these income sources, **please initial all that apply below.** By initialing below you are agreeing to allow the facility to become representative payee for direct deposit purposes.

_____ **I wish** to have my/the Resident's Social Security Income, Pension Income, and any other income direct deposited into my/the Resident's personal account at the facility.

ADDITIONAL CLINICAL SERVICES

THE FOLLOWING ADDITIONAL CLINICAL SERVICES ARE AVAILABLE TO ALL RESIDENTS. THE CHART BELOW DESCRIBES THE BASIC GUIDELINES FOR MEDICARE, MEDICAID AND PRIVATE RATE COVERAGE OF THESE SERVIC-

Services	Medicare Part A	Medicare Part B	Medicaid	Private Pay (When Not Covered by Medicare or Medicaid)
Physical Therapy Restorative	Covered	Covered (4) (5)	Covered	Based on Medicare Fee Schedule (2) or (3)
Physical Therapy Maintenance	Covered	Not Covered	Covered	Based on Medicare Fee Schedule (2) or (3)
Occupational Therapy Restorative	Covered	Covered (4) (5)	Covered	Based on Medicare Fee Schedule (2) or (3)
Occupational Therapy Maintenance	Covered	Not Covered	Covered	Based on Medicare Fee Schedule (2) or (3)
Speech Therapy Restorative	Covered	Covered (4) (5)	Covered	Based on Medicare Fee Schedule (2) or (3)
Speech Therapy Maintenance	Covered	Not Covered	Covered	Based on Medicare Fee Schedule (2) or (3)
Ophthalmology Services	Varies (3) (5)	Varies (3) (5)	Varies (3) (5)	Fee Basis (2) or (3)
Audiology Services	Varies (5)	Varies (5)	Varies (5)	Fee Basis (2) or (3)
Dental	Not Covered	Not Covered	Covered (5)	Fee Basis (2) or (3)
Pharmaceuticals	Covered	Not Covered	Covered	Fee Basis (2) or (3)
Oxygen	Covered	Not Covered	Covered	Included
Oxygen Supplies	Covered	Not Covered	Covered	Included
Enteral Nutrition - Supplements	Not Covered	Covered (1) (4)	Covered	Based on Medicare Fee Schedule (2) or (3)
Enteral and Parenteral Supplies	Covered	Covered (1) (4)	Covered	Based on Medicare Fee Schedule (2) or (3)
Primary Surgical Dressings	Covered	Covered (1) (4)	Covered	Based on Medicare Fee Schedule (2) or (3)
Urological Supplies	Covered	Covered (1) (4)	Covered	Based on Medicare Fee Schedule (2) or (3)
Tracheostomy Supplies	Covered	Covered (1) (4)	Covered	Based on Medicare Fee Schedule (2) or (3)
Ostomy Supplies	Covered	Covered (1) (4)	Covered	Based on Medicare Fee Schedule (2) or (3)
Prosthetics and Orthotics	Covered	Covered (1) (4)	Covered	Based on Medicare Fee Schedule (2) or (3)
Laboratory	Covered	Covered (1) (4)	Covered	Based on Medicare Fee Schedule (2) or (3)
X-Ray	Covered	Covered (1) (4)	Covered	Based on Medicare Fee Schedule (2) or (3)
EKG	Covered	Covered (1) (4)	Covered	Based on Medicare Fee Schedule (2) or (3)
EEG	Covered	Covered (1) (4)	Covered	Based on Medicare Fee Schedule (2) or (3)
Ambulance	Covered (1) (5)	Covered (1) (4) (5)	Covered (1) (3)	Based on Medicare Fee Schedule (3)
Ambulette	Not Covered	Not Covered	Varies (3)	Fee Basis (3)

If your stay is covered under Medicare Part A:
- Medicare will pay up to 100 days for your stay (assuming eligibility criteria am met and benefits are still available).
- Co-Insurance payments for 2010 are $137.50 per day for day 21 through 100.

If you are covered by Medicare Part B:
- Annual Medicare Part B Deductible is $155.00 for 2010.
- Co-Insurance payments are 20% of the approved Medicare Part B charge for all Part B covered services.

(1) May be billed by outside vendor to DMERC or Intermediary.
(2) Billed by Facility.
(3) Billed directly by Provider or Vendor.
(4) Patient/Resident responsible for co-insurance and deductible.
(5) Coverage depends on services provided.

ATTACHMENT "A"

BASIC SERVICES

THE FOLLOWING ITEMS AND SERVICES ARE AVAILABLE TO ALL RESIDENTS AND ARE INCLUDED IN THE MEDICARE PART A, BASIC MEDICAID, AND THE PRIVATE PAY ROOM AND BOARD RATE:

- Board, including therapeutic or modified diets as prescribed by a physician (excluding enteral and parenteral feeding), and including Kosher food provided upon the request of a Resident who as a matter of religious belief wishes to follow Jewish dietary laws
- Lodging; a clean, healthful, sheltered environment, properly outfitted
- 24-hours-per-day professional nursing care
- Use of all equipment, medical supplies and modalities for everyday care, such as catheters*, dressings*, pads, etc.
- Fresh bed linen, changed at least twice weekly, or as often as required for incontinent Residents
- Hospital gowns or pajamas as required by the Resident's clinical condition, unless the Resident, next of kin or sponsor elect to furnish them; and laundry services for these and other launderable personal clothing items
- General household medicine cabinet supplies, such as non-prescription medications; routine hair and skin care materials; oral hygiene materials; except for specific items that are medically indicated and needed for exceptional use for a specific Resident
- Assistance and/or supervision, when required, with activities of daily living, including but not limited to toileting, bathing, feeding, and ambulation assistance
- Services, in the daily performance of their assigned duties, by Facility staff members responsible for Resident care
- Use of customarily stocked equipment, including crutches, walkers, wheelchairs or other supportive equipment, including training in their use when necessary, unless such items are prescribed by a physician for regular and sole use by a specific Resident. "Customarily stocked equipment" excludes prosthetics
- Therapeutic recreation (Activities) program, including but not limited to a planned schedule of recreational, motivational, social and other activities; together with the necessary materials and supplies to make the Resident's life more meaningful
- Social Services as needed
- Complete dental examination upon admission and annually thereafter
- If these items or services are necessary for other than routine treatment, they may not be included in the basic Medicaid and Private Pay room and board rate and may be billable to the Resident, Medicare Part B or other third party insurance. (see chart below)

IF YOU HAVE ANY QUESTIONS REGARDING CHARGES AND BILLING, PLEASE FEEL FREE TO CONTACT THE RESIDENTS' ACCOUNTS OFFICE.

X. SMOKING POLICY

Smoking by Residents is allowed in designated areas of the Facility only. Smoking and/or the use of spark producing devices is prohibited in all other areas of the Facility. Specific information regarding the Facility's smoking policy is included in your admission package. Room assignment may be based upon resident's desire to smoke. The Resident agrees to comply with the Facility's smoking policy.

XI. GENERAL PROVISIONS

(a) Governing Law

This Agreement shall be governed by and construed in accordance with the laws of the State of New York without giving effect to conflict of law provisions. Any and all actions arising out of or related to this Agreement shall be brought in, and the parties agree to exclusive jurisdiction of, the New York State Supreme Court, located in Westchester County, New York.

(b) Binding Effect

This Agreement shall be binding on the parties, their heirs, administrators, distributees, successors and assignees.

(c) Continuation of This Agreement

Temporary transfer of the Resident to another health care facility for medical or surgical treatment, or the Resident's authorized temporary absence from the Facility for any other purpose, where such transfer or absence does not exceed a period of thirty (30) days, shall not terminate this Agreement. Upon the Resident's return and re-admission in accordance with the admission assessment criteria set by the New York State Department of Health and by the Facility, this Agreement shall continue in full force and effect.

(d) Entire Agreement

This Agreement contains the entire understanding between the Resident, Designated Representative and/or Sponsor and the Facility. This Agreement cannot be modified orally and any changes must be in writing, signed by the parties to this Agreement.

(e) Severability

Should any provision in this Agreement be determined to be inconsistent with any applicable law or to be unenforceable, such provision will be deemed amended so as to render it legal and enforceable and to give effect to the intent of the provision; however, if any provision cannot be so amended, it shall be deemed deleted from this Agreement without affecting or impairing any other part of this Agreement.

(f) Counterparts

For the convenience of the parties hereto, this Agreement may be executed in counterparts and all such counterparts shall together constitute the same agreement.

(g) Relationship between Parties

Execution of this Agreement is not intended, nor shall it be deemed, to create a landlord-tenant relationship between the Facility and the Resident.

(h) Section Headings

The section headings used herein are for convenience of reference only and shall not limit or otherwise affect any of the terms or provisions hereof.

(i) Non-Discrimination

IN ACCORDANCE WITH STATE AND FEDERAL LAW, THE FACILITY SHALL ENSURE THAT NO PERSON IN THE UNITED STATES OF AMERICA SHALL, ON GROUNDS OF RACE, COLOR, CREED, NATIONAL ORIGIN, SEX OR SEXUAL ORIENTATION, RELIGION, HANDICAP OR DISABILITY, AGE, MARITAL STATUS,

BLINDNESS, SOURCE OF PAYMENT OR SPONSORSHIP, BE EXCLUDED FROM PARTICIPATION IN, BE DENIED THE BENEFITS OF, OR BE OTHERWISE SUBJECTED TO DISCRIMINATION UNDER ANY PROGRAM OR ACTIVITY PROVIDED BY THE FACILITY, INCLUDING BUT NOT LIMITED TO, THE ADMISSION, CARE AND RETENTION OF RESIDENTS.

THE REMAINDER OF THIS PAGE IS LEFT BLANK INTENTIONALLY.

By execution of this Agreement, Resident, Designated Representative and/or Sponsor acknowledge receipt of the following documents and information:

- **Schedule of Coverage and Fees for Ancillary Services (Attachment A)**
- **Medicare and Medicaid Information. (Attachment B)**
- **Assignment of Benefits Form.**
- **HIPAA Authorization Form.**
- **Personal Telephone Hook up Form.**
- **Medical Transportation Authorization.**
- **Facility Policy and Procedures, Resident and Visitor Rules and Regulations, Statement of Resident's Rights and the addresses and telephone numbers for New York State Department of Health and the State Office for the Aging Ombudsman Program.**
- **Facility Information Sheet: Attending Physician's Name, Address, and Telephone Number; Social Worker's Name and Telephone Number; Nurse Manager's Name and Telephone Number.**
- **Statement regarding the use of the Medicare Minimum Data Set (MDS) and the Privacy Act of 1974.**
- **Notice of Privacy Practices for Protected Health Information.**
- **Veterans Information.**
- **Advance Directives: Planning in Advance for Your Medical Treatment, Do Not Resuscitate Orders: A Guide for Residents and Families, Appointing Your Health Care Agent: New York State's Health Care Proxy Law and the Facility's Policies on Advance Directives.**

THE UNDERSIGNED HAVE READ, UNDERSTAND AND AGREE TO BE LEGALLY BOUND BY THE TERMS AND CONDITIONS AS SET FORTH HEREIN, AND IN ALL ADDENDA TO THIS AGREEMENT.

ACCEPTED AND AGREED:

Date	**Signature (or Mark) of RESIDENT**	**Print Name**
Date	**Signature of DESIGNATED REPRESENTATIVE**	**Print Name**
Date	**Signature of SPOUSE (if not Designated Representative)**	**Print Name**
Date	**Signature of SPONSOR (if other than the Resident's spouse)**	**Print Name**
Date	**Signature of FACILITY'S REPRESENTATIVE**	**Print Name and Title**