Methodist Home for Nursing and Rehabilitation
4499 Manhattan College Parkway
Bronx, New York 10471

ADMISSION AGREEMENT

Agreement dated ____________________, 2022 between the **Methodist Home for Nursing and Rehabilitation, 4499 Manhattan College Parkway, Bronx, New York 10471** (hereinafter the "Facility" or "Home") and ____ (hereinafter referred to as a Resident), whose residence is located at____ and/or ____ (hereinafter the "Designated Representative") residing at: ____and Resident's spouse (if not listed as a Designated Representative) residing at: ____.

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

1. ADMISSION AND CONSENT

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, Resident's Spouse, Financial Sponsor and Designated Representative hereby consent to such routine care and treatment as may be provided by the Facility and/or the Facility's affiliated and ancillary providers in accordance with the Resident's plan of care. The Resident, Resident's Spouse, Financial Sponsor 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, Resident's Spouse, Financial Sponsor and Designated Representative hereby understand and jointly and severally 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.

2. MUTUAL CONSIDERATION OF PARTIES

The Facility agrees to provide all basic (routine) services to the Resident, as well as available ancillary services, which 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 admissions package.

The Resident, Resident's Spouse, Financial Sponsor and Designated Representative understand and agree that the Facility's acceptance of the Resident is based on the Resident's, Resident's Spouse, Financial Sponsor and Designated Representative's representation that the Resident has sufficient funds/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, Resident's Spouse, Financial Sponsor and Designated Representative agree to take all necessary steps to ensure that the Facility receives payment from these and/or other available funds/resources and sources consistent with this Agreement. The Resident, Resident's Spouse, Financial Sponsor and Designated Representative 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 funds/resources available to the Resident that could be available to pay for the cost of care.

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

3. 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 need change, such change will be noted in the Resident's medical record):

☐ Post-Acute Care/Short-Term Rehabilitative Services:
Methodist Home for Nursing and Rehabilitation defines post-acute 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. Post-Acute care lasts for a limited time or until a condition is stabilized or a predetermined treatment course is completed.

☐ Long Term Care:

☐ Other: ____

☐ Medicare Part A may provide and is generally limited to coverage of up to the first 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 Resident is responsible for payment to the Facility of any co-insurance and/or deductible obligations under the Medicare Part A program unless Resident has approved Medicaid coverage. For beneficiaries in skilled nursing facilities the daily Medicare Part A co-insurance amount for days 21 through 100 of extended care services in a benefit period is currently **$194.50 PER DAY**. When Resident's Medicare Part A coverage expires, unless Resident has approved Medicaid coverage, Resident will be responsible for payment of the **Facility's private pay basic daily rate**.

Please sign here: X ______________________________________

Admissions for Post-Acute Services/Short-Term Rehabilitative Services:

Residents admitted for post-acute care services are admitted with the expectation that, unless continued placement in the Facility is medically appropriate, they will be discharged once post-acute 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. Residents and their 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 Post-Acute services and subsequently, by virtue of his or her health condition, requires long term care placement, 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. The obligations and responsibilities of the Resident, Resident's Spouse, Financial Sponsor and Designated Representative as set forth in this Admission Agreement and any documents referred to herein shall apply regardless of the anticipated services, the initial level of care or any change in the initial or any subsequent level of care.

4. FINANCIAL ARRANGEMENTS

Obligation of Resident and Designated Representative
The Resident, Resident's Spouse, Financial Sponsor and Designated Representative shall pay the Facility on a private pay basis, and/or 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. The Designated Representative is responsible to provide payment from the Resident's income and resources to the extent he/she has access to such income and resources without the Designated Representative incurring personal

financial liability. The Resident, Resident's Spouse, Financial Sponsor and Designated Representative jointly and severally agree to provide payment from the Resident's income, assets, funds and resources 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. Payment to the Facility shall be made on a monthly basis, as billed. The Designated Representative is the person signing this Agreement who agrees to be responsible to assist the Resident in meeting his or her obligations under this Agreement. The Designated Representative agrees to make all reasonable efforts to assist the Facility in meeting the Resident's responsibility to obtain payment for care in the Facility. The Designated Representative does agree to use his or her personal resources if he or she breaches his or her obligations, duties or responsibilities arising out of or in connection with this Agreement, or fails to comply with the provisions of this Agreement, including but not limited to, e.g., the obligation to provide truthful information and to assist the Resident in the use of his/her income, assets, funds and resources to be applied toward the cost of care and to duly and timely apply for, pursue, maintain and renew government benefits for the Resident (to include Medicaid nursing home care coverage and benefits). If the Designated Representative is the spouse, parent, legal guardian, agent or attorney-in-fact of the Resident, such Designated Representative may also be required to use his or her resources for the Resident's necessities solely to the extent that such Designated Representative is obligated to do so under the laws of the State of New York.

If the Resident has no third party coverage, or if the Resident remains in the Facility after any such coverage terminates because it is deemed no longer "medically necessary", or for any other reason consistent with applicable law, the Resident, Resident's Spouse, Financial Sponsor and Designated Representative jointly and severally agree to provide payment, from the Resident's income, assets, funds and resources, for the private pay room and board rate and the ancillary charges incurred until discharge or until another source of coverage becomes available. The Facility will promptly notify the Resident, Resident's Spouse, Financial Sponsor and/or Designated Representative of a third party payor's discontinuation of payment (coverage).

NOTE: The execution of this Agreement by the Financial Sponsor/Designated Representative cannot and shall not serve as a third party guarantee of payment in violation of applicable law and regulations. Notwithstanding the foregoing, the Financial Sponsor/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 income, assets, resources and/or funds to pay for the Resident's care at the Facility when the Financial Sponsor/Designated Representative has access to or control over the Resident's income, assets, resources and/or funds including but not limited to by way of Power of Attorney, access to joint accounts and/or the like;**

(ii) **misappropriating or misuse of the Resident's income, assets, resources and/or funds;**

(iii) **failing to duly and timely remit the Resident's social security, pension and/or other income to the Facility, including but not limited to the Resident's monthly contribution or Net Available Monthly Income (NAMI);**

(iv) **failing to duly and timely provide requested information and/or documentation to the Facility or third party payor, such as an insurer or local department of social services (e.g. Medicaid); and/or**

(v) **providing false, misleading or incomplete information and/or documentation, regarding matters including, but not limited to, the Resident's financial resources, citizenship or immigration status, government or other benefits and/or third party insurance coverage.**

In addition to the foregoing, any failure of the Financial Sponsor/Designated Representative to use the Resident's income, assets, resources and funds in accordance with the Agreement to include the failure to use such for the Resident's care at the Facility will also constitute a breach of this Agreement on the part of the Financial Sponsor/Designated Representative.

Anticipated Payor

The Resident, Resident's Spouse, Financial Sponsor and the Designated Representative represents 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 that apply, including both primary and secondary payors):

☐ Medicare ☐ Medicaid ☐ Veteran's Administration Benefit

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

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

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

☐ Other (Please Specify): ____

THE RESIDENT, RESIDENT'S SPOUSE, FINANCIAL SPONSOR AND DESIGNATED REPRESENTATIVE ARE RESPONSIBLE FOR TIMELY ADVISING THE FACILITY OF ANY CHANGE IN THE RESIDENT'S THIRD PARTY PAYOR, i.e., A CHANGE FROM TRADITIONAL MEDICARE TO A MEDICARE HMO, A CHANGE FROM ONE HMO TO ANOTHER, etc.

NOTE: The Resident, Resident's Spouse, Financial Sponsor and Designated Representative jointly and severally agree to provide the Facility with all relevant information and documentation regarding all potential third party payors. The Resident, Resident's Spouse, Financial Sponsor and Designated Representative understand that if the anticipated payor does not pay the cost of care, then the Resident, Resident's Spouse, Financial Sponsor and/or Designated Representative will be responsible to pay for the cost of care through the Resident's income, assets, resources and/or funds and/or by duly and timely 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, Resident's Spouse, Financial Sponsor and Designated Representative understand that, although the Facility will be available to assist the Resident, Resident's Spouse, Financial Sponsor and/or Designated Representative to apply for third party coverage, it is the responsibility of the Resident, Resident's Spouse, Financial Sponsor and Designated Representative to duly and timely apply for and meet the requirements of third party payors (including, but not limited to governmental benefits such as Medicaid nursing home care coverage and benefits). A Resident who does not meet the eligibility criteria that govern payment by third party payors will be billed at the Facility's private pay room and board rate.

The obligations and responsibilities of the Resident, Resident's Spouse, Financial Sponsor and Designated Representative as set forth in this Admission Agreement and any documents referred to herein shall apply regardless of the anticipated payor(s), payor source(s) or any change in the anticipated payor(s) or payor source(s).

X ____
Signature / Date

Private Payment

If the Resident is paying privately for the cost of his or her care, and part or all of said payment is not covered by a third party payor, the private room rate for room and board is currently $480.60 per day, **also referred to as the Facility's private pay or daily basic rate**. Rehabilitation services and ancillary services are provided for an additional charge and will be billed to the Resident according to the Facility's and/or the provider of services charge schedules. Ancillary services include but are not limited to, urinary care supplies, trach and ostomy supplies, surgical supplies, parenteral and enteral feeding supplies, and pharmacy supplies. Rehabilitation services include physical, occupational, and speech and language therapy. However, rates of payment to the 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 rehabilitation and ancillary services is available upon request. Payment must be made to the Facility by the first (1st) day of the month following receipt of the bill by the Resident, Resident's Spouse, Financial Sponsor and/or Designated Representative. The private pay or daily basic rate to include the private pay room and board rate and additional service charges are subject to increase upon sixty (60) days' written notice to, as applicable, the Resident, Resident's Spouse, Financial Sponsor and/or Designated Representative.

Private Pay Billing Policy

The Facility bills private pay individuals for the private pay or daily basic rate to include the private pay room and board charges on a one month advance basis. Bills for rehabilitation and ancillary charges are generated in the month following the month the services were rendered. All bills are generated by the twentieth (20th) of the month and cover the next month of room and board charges and the previous month's rehabilitation and ancillary charges. All payments are due upon receipt of the bill by the Resident, Resident's Spouse, Financial Sponsor and/or Designated Representative.

Security Deposits

Unless otherwise noted prior to admission and/or restricted by law, the Facility requires a security deposit in cash or certified check for each Resident, equal to two (2) months (of services at the Facility's private pay or daily basic rate. This money will be deposited by the Facility in an interest-bearing bank account. The Facility shall have the sole discretion as to the type and nature of account in which the security deposit is held. Subject to the provisions of this Agreement and/or applicable law, 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 private pay or daily basic rate to include the daily basic rate increases, the Facility will notify the Resident, Resident's Spouse, Financial Sponsor and/or the Designated Representative and, within ten (10) days' of receipt of the notice, additional security must be deposited so that the total security equals two (2) months of services at the Facility's daily basic rate. Pursuant to Section 2805-f of the New York Public Health Law, the Facility is entitled to an annual administrative fee of 1% of the amount of the security deposit; and the Facility may deduct such a fee from security deposit amounts to cover administrative costs and consistent with applicable law.

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

Late Charges

A late charge at the rate of fifteen (15%) percent per annum [1.25 % per month] will be assessed on all accounts more than thirty (30) days' overdue.

Collection Costs, Including Attorney and Court Fees

If the Resident, Resident's Spouse, Financial Sponsor and/or the Designated Representative fail to make payments within thirty (30) days of the date payment is due, or in case of nonpayment of any sum due under the terms of this Agreement, or the failure to comply with or breach of any term of this Agreement, the Resident, Resident's Spouse, Financial Sponsor and/or the Designated Representative shall be responsible for and 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, reasonable attorneys' fees, court costs and related disbursements. In addition, the Resident, Resident's Spouse, Financial Sponsor and/or Designated Representative shall be responsible for and shall pay all late charges as noted above.

Refunds to Residents

The facility will refund amounts to the Resident in accordance with the following terms:

If the Resident leaves and does not return to Methodist Home, the Facility shall refund to the Resident, within thirty (30) days of the Resident's departure, the balance, if any, remaining of any security deposit, personal funds retained by the Facility, or any other charges already paid, plus accrued interest, less the Facility's private pay or daily basic per diem rate, for the days the Resident actually resided, reserved or retained a bed in the Facility or any other amount due from the Resident shall be refunded to the Resident, along with a final accounting of these funds.

Upon death of a Resident, the Facility will convey the balance, if any, remaining of any security deposit personal funds retained by the Facility, or any other amount due from the Resident, and a final accounting of those funds to the individual or probate jurisdiction administering the Resident's estate within thirty (30) days of the date the Facility is furnished with evidence of the identity of the fiduciary or probate jurisdiction to whom the funds may be legally disbursed.

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 receive those services with full coverage 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 (and/or the Resident's Spouse, Financial Sponsor and/or Designated Representative, as applicable) 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 coinsurance 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 (and/or the Resident's Spouse, Financial Sponsor and/or Designated Representative, as applicable) will be responsible for any difference. The Facility will bill the Resident (and/or the Resident's Spouse, Financial Sponsor and/or Designated Representative, as applicable) 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 business office staff 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 (and/or the Resident's Spouse, Financial Sponsor and/or Designated Representative, as applicable) for using such non-participating providers.

NOTE: The Resident is responsible for timely advising the Facility of 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 (and/or the Resident's Spouse, Financial Sponsor and/or Designated Representative, as applicable) responsibility and billed according to the terms for private payment stated above.

Medicaid

If and when the Resident's funds/assets have fallen below the Medicaid eligibility levels, and the Resident otherwise satisfies the Medicaid eligibility requirements, and the Resident 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, Resident's Spouse, Financial Sponsor and Designated Representative JOINTLY AND SEVERALLY 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 THE RESIDENT AND/OR DESIGNATED REPRESENTATIVE HAS OR WILL SUBMIT A TIMELY MEDICAID APPLICATION AND ENSURE THAT ALL ELIGIBILITY REQUIREMENTS HAVE BEEN MET**. Services reimbursed under Medicaid are outlined in Attachment "A" to this Agreement.

If the Resident's care is covered by Medicaid, the Resident, Resident's Spouse, Financial Sponsor and Designated Representative jointly and severally agree to remit to the Facility the Resident's Net Available Monthly Income ("NAMI") on a timely basis, pursuant to the Resident's Medicaid budget (see Attachment "B"). The Resident's Medicaid budget and the NAMI amount will be determined by Medicaid. The Facility has no control over the determination of NAMI amounts. The Resident, Resident's Spouse, Financial Sponsor and Designated Representative is obligated to pay the private pay or daily basic rate up to the time the Resident is determined eligible for and receives coverage for Medicaid for nursing home services by a local, state or federal agency. In the event of retroactive payment by Medicaid, the Facility agrees to reimburse the Resident the private pay or daily basic rate paid to the Facility from the date established for commencement of Medicaid eligibility and receipt of coverage to the date of the Medicaid determination, less NAMI monies required to be paid to the Facility. To the extent the Resident's assets are exhausted or unavailable to pay the full daily basic rate pending the processing of the Medicaid application, the Resident, Resident's Spouse, Financial Sponsor and Designated Representative jointly and severally agree to pay the Resident's monthly income as partial payment of the daily basic rate until Medicaid eligibility is established, subject to the Facility's obligation to refund any excess amounts received based on the Medicaid determination and the establishment of the Resident's NAMI contribution.

Where the Resident is awaiting the issuance of a Medicaid budget, the Resident, Resident's Spouse, Financial Sponsor and Designated Representative shall remit to the Facility the anticipated NAMI in a timely manner.

In the event the Medicaid application or Medicaid recertification is denied due to a transfer of assets within the applicable Medicaid "look-back" period or due to an equity interest in the Resident's home that exceeds the current equity interest limitation, the Resident and the Resident's Spouse, Financial Sponsor and Designated Representative jointly and severally agree to take one or more of the following actions, as appropriate, to qualify for or to continue eligibility for Medicaid:

a. undertake, to the Resident's, Resident's Spouse's, Financial Sponsor's and Designated Representative's best efforts, all reasonable actions necessary to have the transferred assets returned to the Resident or

to obtain the fair market value for the assets transferred;

b. designate the state in any annuity purchased by or on behalf of the Resident or the Resident's spouse as the remainder beneficiary in either the first or second position, as appropriate, under applicable Medicaid laws and regulations and restructure any such annuity as necessary, including, but not limited to, the removal or elimination of any deferral or balloon payments, the provision for payments in equal amounts during the term of the annuity, ensuring that the annuity is actuarially sound, ensuring the annuity is irrevocable and non-assignable; or

c. with respect to home equity interest in excess of the Medicaid limit, sell the home at fair market value or secure a reverse mortgage or home equity loan to reduce the equity interest in the home to below the Medicaid limit.

In addition, the Resident, Resident's Spouse, Financial Sponsor and Designated Representative jointly and severally agree to forego the purchase of a promissory note, loan, mortgage or life estate, unless such purchase will not adversely affect the Resident's eligibility or continued eligibility for Medicaid.

If due to a transfer of assets or due to an equity interest in the Resident's home in excess of the Medicaid limit, the Resident's Medicaid application or Medicaid renewal/recertification is denied, the Resident, Resident's Spouse, Financial Sponsor and Designated Representative hereby jointly and severally agree to timely request and prosecute a hardship waiver application with the appropriate County Department of Social Services. Alternatively, the Resident, Resident's Spouse, Financial Sponsor and Designated Representative jointly and severally agree to consent to Facility requesting and prosecuting a hardship waiver application and will agree to sign an appropriate authorization when and if the need arises.

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

Medicare

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 or other applicable guidelines. If the Resident meets the eligibility criteria, Medicare may provide coverage. Generally, if you are admitted to a hospital for three consecutive days, you may be entitled to a period of up to 100 days of care in post-hospitalization benefits under Part A. The Medicare Part A program imposes a co-insurance and/or deductible obligation upon the Resident. The Resident (and/or the Resident's Spouse, Financial Sponsor and/or Designated Representative, as applicable) is responsible for payment to the Facility of any co-insurance and/or deductible obligations under the Medicare Part A program unless Resident has approved Medicaid coverage. The Facility will invoice the co-insurance and/or deductible obligation on a monthly basis and Resident (and/or the Resident's Spouse, Financial Sponsor and/or Designated Representative, as applicable) will be responsible to pay such invoice within ten (10) days. Currently, under the Medicare Part A post-hospitalization benefits, the first twenty (20) days of covered services may be fully paid for by Medicare and the next eighty (80) days (days 21 through 100) of the covered services may be paid for by Medicare subject to the daily coinsurance and/or deductible obligation for which the Resident (and/or the Resident's Spouse, Financial Sponsor and/or Designated Representative, as applicable) 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 be eligible to receive coverage for certain Part B services (previously included in the Part A payment to the Facility). During the 100-day period, there are a series of complicated rules which require that most of the services included in the care plan we develop jointly with you and your representative, be furnished to you by our Facility either directly or "under arrangements". For example, if you need laboratory testing or radiological examinations during your 100-day benefit period, we will arrange to have our contract laboratory or contract radiological group provide for such needs. All you pay during this period is the co-insurance authorized by Medicare Part A. This is called "consolidated billing". However, not all services are consolidated into your Part A benefit

period. Some services such as physician services, outpatient dialysis and emergency room services (just to name a few) are not consolidated. This means that your physician will bill Medicare Part B for his or her service to you and will then bill you, Medicaid or your insurance company for the co-insurance amount.

The Resident, Resident's Spouse, Financial Sponsor and/or Designated Representative, jointly and severally agree, during the Resident's Part A stay, to keep the Facility informed and aware of any outside health care providers who the Resident may see while outside of the Facility. For example, if the Resident should visit a personal physician during the Resident's Part A stay and he or she orders diagnostic testing or provides certain technical services, the Resident may be financially responsible for the cost of such testing or services if the Resident is not pre-approved and coordinated by your care planning team and your attending physician here at the Facility.

We provide the services required by the resident's plan of care either directly through staff or pursuant to written arrangements with other health care providers. As part of your admission, you are consenting and agree to receive services required by the plan of care as may be arranged under our auspices. If you go outside of these arrangements, you and/or your Designated Representative will be solely and absolutely responsible for the cost of any medical, diagnostic or other health service or item which is privately arranged. In the event that you and/or your Designated Representative and/or family privately arranges for any such medical, diagnostic or other health services or items, please advise the outside provider of such services that they may **NOT** be able to bill Medicare or the Facility. As noted, under these circumstances, you and/or your Designated Representative, other representative and/or family are solely responsible for the cost of such services.

NOTE: If Medicare denies coverage, the Resident, Resident's Spouse, Financial Sponsor and Designated Representative hereby jointly and severally agree to remit to the Facility any outstanding amounts for unpaid services not covered by other third party payers subject to applicable federal and state laws and regulations. Said amounts shall be calculated in accordance with the Facility's applicable prevailing private pay rates, the daily basic rate and charges for all basic and additional services provided to the Resident. For further information on third party payor sources, please refer to Attachments A and B.

5. AUTHORIZATIONS AND ASSIGNMENTS FROM RESIDENT TO THE FACILITY

Authorization to Release Information

By execution of this Agreement, the Resident, Resident's Spouse, Financial Sponsor and Designated Representative jointly and severally 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 make copies of all records relating to such care.

Assignment of Benefits and Authorization to Pursue Third Party Payment

By execution of this Agreement, the Resident, Resident's Spouse, Financial Sponsor and Designated Representative jointly and severally authorizes the Facility to seek and obtain all information and documentation necessary for the processing of any third party claim.

Authorization to Obtain Records, Statements and Documents

By execution of this Agreement, the Resident, Resident's Spouse, Financial Sponsor and Designated Representative jointly and severally 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, the Human Resources Administration of the City of New York or appropriate County Department of Social Services), records, statements, correspondence and other documents pertaining to the Resident. Nothing contained herein shall be deemed or construed as any requirement or obligation on the part of the Facility to do so.

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. Nothing contained herein shall be deemed or construed as any requirement or obligation on the part of the Facility to do so.

Authorization to Take Resident's Photograph

By execution of this Agreement, the Resident, Resident's Spouse, Financial Sponsor and Designated Representative shall jointly and severally allow the Facility to photograph the Resident upon admission and in furtherance of identification, treatment and/or administrative functions of the Facility. All such photographs shall become part of the Resident's medical record at the Facility. The Resident and Designated Representative authorize the taking of photographs of the Resident for identification purposes. Such photographs will become part of the Resident's confidential record.

Authorization to Disclose Resident's Presence in Facility

Do you wish to disclose that you reside at the Facility (temporarily or permanently) when an inquiry is made by telephone? [ ] Yes [ ] No By visitor(s)? [ ] Yes [ ] No Family member(s)

Authorization to Release Protected Health Information

By execution of this Agreement, the Facility is authorized to release confidential information, to include medical and Protected Health Information, of a Resident to third parties in accordance with applicable law to include, third parties involved with, or in furtherance of, payment to the Facility for the services furnished to the Resident.

Authorization to Admit or Bar Visitors to See Resident

By execution of this Agreement, the Resident, Resident's Spouse, Financial Sponsor and/or Designated Representative shall allow or disallow visitation rights of any individual(s). Do you wish to bar any specific individual(s) from visiting you? [ ] Yes [ ] No

If "Yes" please supply name(s): ____

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

If the Resident leaves the Facility due to a hospitalization or therapeutic leave, subject to and pursuant to applicable law the Facility may 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", the terms of which are incorporated herein. The Resident and/or Resident's Spouse, Financial Sponsor and/or Designated Representative acknowledge receipt of the Facility's "Bed Hold Reservation Policy and Procedure", and agree to pay any and all bed hold charges incurred by the Resident.

,

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

Private Pay Residents (and/or the Resident's Spouse, Financial Sponsor and/or Designated Representative, as applicable) who elect to retain a bed in the Facility during a period of hospitalization or therapeutic leave may do so by:

1. Notifying the Admissions Department via telephone;

2. Signing a bed guarantee letter with the Admissions Department stating their intent to hold the Resident's bed at the Facility's private pay or daily basic rate; and
3. Continuing payment at the private pay or daily basic rate.

Private Pay Residents (and/or the Resident's Spouse, Financial Sponsor and/or Designated Representative, as applicable) 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 I/the Resident are hospitalized. By initialing this section I have agreed to ensure prompt payment, from my/the Resident's funds, of the Facility's private pay or daily basic 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 I/the Resident are hospitalized. However, should I/the Resident be hospitalized, I/the Resident will be consulted at that time as to whether or not I/the Resident choose to hold the bed.

Medicare Residents are not entitled to reimbursement for Bed Hold or Therapeutic Leave under the Medicare Program. However, Medicare Residents may elect to retain a bed in the Facility by following the Private Pay Resident Bed Reservation policy above.

Effective May 29, 2019, with very limited exception, Medicaid generally no longer pays to reserve a bed for a recipient in a nursing home who is temporarily hospitalized unless the recipient is receiving hospice services at the Facility. The Facility is not required to hold a bed for days where no Medicaid payment is available. A Medicaid Recipient has the option to reserve the bed at the Facility's prevailing private pay or daily basic rate. A Medicaid Recipient is eligible for overnight visits for therapeutic leave which must be documented by the Medical/Nursing Staff. Family or Resident must advise the Facility (Social Services) of his/her intention to leave the facility at least two (2) days prior to a planned departure. For a Medicaid resident aged 21 years and older who is on a non-hospital therapeutic leave of absence, under certain circumstances, Medicaid will reimburse the facility for bed reservations for such therapeutic leaves of absences for up to a combined aggregate total of 10 days per 12 month period for therapeutic leaves of absence occurring within the given 12-month period.

7. TRANSFER AND DISCHARGE

Voluntary Discharge

If the Resident no longer requires the services provided by the Facility, or voluntarily wishes to be discharged, the Resident, Resident's Spouse, Financial Sponsor and/or Designated Representative and Facility will work cooperatively to develop and implement a safe, appropriate, and timely discharge plan.

Involuntary Discharge for Non-Payment

To the extent authorized by applicable law, the Facility reserves the right to discharge the Resident if the Resident, Resident's Spouse, Financial Sponsor and/or Designated Representative have failed to pay for, or secure third party coverage of the Resident's care at the Facility. Non-payment also occurs when the applicable Resident NAMI is not delivered to the Facility. The Resident may be discharged for non-payment only if the charge is owed and is not in dispute or funds are actually available or would be available to the Resident and the Resident and/or the Resident's Spouse, Financial Sponsor and/or Designated Representative refuse to cooperate with the Facility in obtaining such funds or there is no appeal of a denial of benefits pending Non-payment applies if the Resident or the Resident's Spouse, Financial Sponsor and/or Designated Representative does not submit necessary paperwork for third party payment, including but not limited to Medicaid payment, or after the third party, including but not limited to Medicaid, denies the claim and the Resident or the Resident's Spouse, Financial Sponsor and/or Designated Representative refuses to pay for the Resident's stay at the Facility. Such discharge will comply with Federal rules as contained in 42 CFR 483.15 and New York rules pursuant to 10 N.Y.C.R.R. Section 415.3, as same currently exist or as hereinafter amended or modified.

Involuntary Discharge for Non-Financial Matters

The Facility may transfer or discharge the Resident in accordance with the Facility's Transfer and Discharge policy and procedures to include if: 1) 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; 2) the Resident's health has improved sufficiently and the resident no longer needs the services provided by the Facility; 3) the safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; 4) the health of the individuals in the facility would otherwise be endangered; and 5) for any other reason permitted by applicable law to include in accordance with federal rules/regulations as contained in 42 CFR 483.15 and New York State rules as contained in 10 N.Y.C.R.R. Section 415.3, as same currently exist or as hereinafter amended or modified. The Facility will, in accordance with applicable law and as medically appropriate, attempt reasonable alternatives prior to transfer or discharge of a resident.

NOTE: The Resident will be informed of his or her rights in the event that the Facility initiates an involuntary transfer or discharge and may appeal the Facility's determination in accordance with applicable federal and state rules/regulations.

Infectious or Communicable Diseases

Pursuant to 10 NYCRR § 415.26(i)(1)(viii), the Facility is prohibited from admitting or retaining individuals as residents where such individuals suffer from a communicable disease, unless a physician certifies in writing that transmissibility is negligible, and poses no danger to other residents, or the Facility is staffed and equipped to manage such cases without endangering the health of other residents. Accordingly, in the event that the Resident becomes infected with a communicable disease, the Resident may be discharged or transferred to an appropriate facility, unless the Resident's attending physician has made the appropriate written certification. The Facility will provide to the Resident and his/her Designated Representative, notice as required by law (and as set forth in this Section 7). In any event, the Facility shall have no liability of any kind arising from such transfer or discharge.

Intra-Facility Room Change

The Facility does not guarantee permanent placement on any units or floors. The Facility reserves the right to transfer the Resident to a new room within the Facility on an as-needed basis, upon prior written notice to the Resident and the Resident's Designated Representative, which shall include a reason for the change, and consultation with the Resident and/or the Resident's Designated Representative, 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. The Facility may also initiate a room change for medical or social reasons consistent with applicable law and the Resident's rights. Such notice and consultation will not be required under the following circumstances: 1. the Resident has requested the change; 2. the medical condition of the Resident requires a more immediate change; or 3. an emergency situation develops. Under such circumstances, the Facility will endeavor to give the Resident and/or the Resident's Designated Representative prior notice of such change.

8. TREATMENT DECISIONS

Resident shall be provided with adequate and appropriate medical care, and will be fully informed by a physician of his or her total health status, including but not limited to, his or her medical condition including diagnosis, prognosis and treatment plan options. Resident will be fully informed and provided with all information concerning his or her rights, when permitted by applicable law and regulations, to consent to or refuse treatment, and/or to execute an advance directive such as a living will, Health Care Proxy, or Do Not Resuscitate (DNR) Order.

9. COMPREHENSIVE CARE PLAN MEETINGS

Comprehensive Care Plan (CCP) Meetings are held by the Facility for all Residents on a regularly scheduled basis. Resident and family members and/or Designated Representatives are encouraged to attend these meetings to better understand the care being provided. The CCP meeting is composed of members of the Interdisciplinary Team.

Resident's physical and psychosocial needs are assessed by the Interdisciplinary Care Team. Based on these assessments the Facility will identify needs, establish goals, and a plan of care will be developed. This plan will be re-evaluated every three months, annually or as needs require including a significant change in the resident's physical or mental condition or as otherwise required by law.

Resident and family members and/or Designated Representatives are requested to attend the CCP meetings for the Resident. The Facility shall facilitate the inclusion of the Resident and/or family members and/or Designated Representatives in the care planning process. Resident, family members, and/or Designated Representatives agree to inform the nursing department if they plan on attending the CCP meetings.

10. RESIDENT'S PERSONAL PROPERTY

The Facility will not be liable for the loss of personal property during the term of resident's stay unless the loss is caused by the negligence or wrongdoing of the Facility, its employees or staff, or where the loss is caused by a violation by the Facility of New York's Public Health Law. Lost/damaged items must be reported at time of occurrence to the Facility's Social Service Department. The Resident has the option to keep valuable personal property (such as jewelry, money and clothing) in a locked drawer in his or her room, or to request the Facility hold said property for safekeeping. Further, it is the responsibility of the Resident, Resident's Spouse, Financial Sponsor and/or Designated Representative to arrange for the disposition of the Resident's property upon discharge. Property left in the Facility for more than fourteen (14) days after discharge will be disposed of at the discretion of the Facility. Resident is encouraged to obtain renter's insurance at resident's expense.

X ____
Signature of Resident/Designated Representative

11. RESIDENT'S PERSONAL BANK ACCOUNT

If the Resident, Resident's Spouse, Financial Sponsor and/or Designated Representative request the Facility to retain the Resident's personal funds, all funds over $100 ($50.00 for Medicaid Recipients) shall be kept in an interest-bearing bank account separate from the Facility's operating account. The Resident, Resident's Spouse, Financial Sponsor and/or Designated Representative will receive account statements on a quarterly basis, and all inquiries will be addressed in a timely fashion. Upon the discharge of the Resident, with a personal fund deposited with the Facility, the Facility will refund within 30 days the resident's funds after any outstanding payments are made to the Facility, and a final accounting of those funds, to the Resident or Designated Representative. In the event of death of the Resident, such refund shall be made to the individual or probate jurisdiction administering the Resident's estate in accordance with applicable state law, or otherwise in accordance with Facility policy and applicable law.

Please initial one of the lines below.

_________ **I wish** to have the Facility retain my/the Resident's personal funds.

_________ **I do not wish** to have the Facility retain my/the Resident's personal funds.

(Please Note: The Financial Sponsor and/or Designated Representative must have legal authorization to handle the Resident's funds should they choose to receive the funds directly. If not, the Financial Sponsor and/or Designated Representative may purchase items on behalf of the Resident and be reimbursed upon presentation of adequate documentation to the Facility's Business Office.)

____

Signature / Date

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** direct deposited into my/the Resident's personal account at the Facility.

__________ **I wish** to have my/the Resident's **Pension Income** direct deposited into my/the Resident's personal account at the Facility. (Specify Name of Pension benefit organization): ____

__________ **I wish** to have my/the **Resident's Income** direct deposited into my/the Resident's personal account at the Facility. (Specify Name of income source): ____

12. SMOKING POLICY

The Facility is a "smoke-free" facility, and the Facility reserves the right to enforce its smoking policies and procedures with respect to safety and compliance with utilization or designated smoking areas, to include as required by New York City's local law – Smoke Free Act. The Resident agrees that under no circumstances will he/she and/or his/her visitors smoke anywhere in the Facility.

13. GENERAL PROVISIONS

a) **Governing Law**

This Agreement shall be governed by and construed in accordance with the laws of the State of New York. 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 Bronx 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 shall not terminate this Agreement. Upon the Resident's return and/or 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. For discharged residents returning to the Facility within one year, the admissions agreement will continue to remain in effect.

d) **Entire Agreement**

This Agreement contains the entire understanding between the Resident and/or the Resident's Spouse, Financial Sponsor and/or Designated Representative 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) **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.

h) **Medications**

All prescribed medications will be in accordance with the Facility's drug formulary.

i) **Physicians**

The Resident may use the services of medical physicians engaged by the Facility or may, at the Resident's personal expense, retain his/her own physician, provided the latter (or his designee, in the absence of said physician) meets the requirements of Facility medical staff (to include granting of physician privileges, as applicable) and agrees to abide by the rules and regulations of the Facility medical staff, and agrees to abide by all federal and State laws and regulations regarding the provision of physician services to residents of nursing facilities.

j) **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, SEXUAL PREFERENCE, 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.

k) Acknowledgment

We have been informed of and given copies of the Resident's Handbook, "Your Rights as a Nursing Home Resident in New York State", Resident Bill of Rights, information on advance directives, grievances and Notice of Privacy Practices. Your signature acknowledges your understanding and agreement to comply with the terms, conditions and requirements of this Agreement along with your acceptance of the rights and responsibilities (under separate cover) as a resident of the Home, and your acknowledgment of receipt of the above referenced documents, the forms, documents

and information referred to below and the executed copy of this Agreement.

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

Authorization Forms

1. Consent to Photography
2. Pharmacy Billing Letter / Signature on file
3. Appointing your Health Care Agent: New York State's Health Care Proxy
4. Do Not Resuscitate Orders: A Guide for Patients and Families
5. HIPAA Policies and Procedures / Notice of Privacy Practices
6. Hospital Request Form
7. Bed Reservation Policy
8. Medicare Benefits Payment Authorization Form
9. Pneumonia Vaccine (PPV)
10. Funeral Arrangements
11. Request for Personal Allowance Account Consent Form
12. Notification of R. U. G. S. Category
13. Visitors' Rules and Regulations
14. Notice of Discharge/Transfer
15. Assignment of Benefits Form

Medicaid Process / Private Forms

16. Financial Questionnaire/MAP-3043 and MAP-3044
17. Appointment of Authorized Representative & Consent to Release Information
18. Change of Address
19. Bank Direct Deposit
20. Medicaid Applicant Documentation List (no family signature required)
21. NAMI Calculation form (no family signature required)

General information

22. MCH Staff Services (Nursing Services)
23. Interdisciplinary Team Care Plan Meetings
24. Family Council Meetings
25. Clothing List for New Residents
26. Personal Belongings
27. Beauty Parlor and Barber Price List
28. Veteran Affairs & Local Veterans offices

Policies and Procedures of Facility

29. Resident Complaint, Suggestion Grievance Process (family signature required)
30. Statement of Resident's Rights
31. Advance Directives
32. Patient Abuse and Neglect
33. Planning in Advance for your Medical Treatment
34. Smoking Policy
35. Statement regarding the use of the Medicare Minimum Data Set (MDS) and the Privacy Act of 1974
36. Schedule of Charges for Ancillary Services (Attachment A)
37. Information about Medicare and Medicaid eligibility (Attachment B)
38. Information about risk/benefits of immunization (Pneumovax, Flu)
39. Policy granting of physician privileges

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

ACCEPTED:

____________________	______________________________	____________________
Date	Signature of Resident	Print Name
____________________	______________________________	____________________
Date	Signature of Witness	Print Name

* If Resident is unable to sign due to physical limitations, Resident should affix an "X" in the presence of a witness.

____________________	______________________________	____________________
Date	Signature of DESIGNATED REPRESENTATIVE	Print Name
____________________	______________________________	____________________
Date	Signature of SPOUSE	Print Name
____________________	______________________________	____________________
Date	Signature of FINANCIAL SPONSOR	Print Name
____________________	______________________________	____________________
Date	Signature of FACILITY'S REPRESENTATIVE	Print Name

ADDITIONAL CLINICAL SERVICES

THE FOLLOWING ADDITONAL CLINICAL SERVICES ARE AVAILABLE TO ALL RESIDENTS. THE CHART BELOW DESCRIBES MEDICARE, MEDICAID AND PRIVATE RATE COVERAGE OF THESE SERVICES.

Services	Medicare Part A	Medicare Part B	Medicaid	Private Pay (When Not Covered by Medicare or Medicaid)
Attending Physician	Not Covered	Covered	Covered	Physician Bills Patient
Physical Therapy Restorative	Covered	Covered (4)	Covered	Medicare Fee Schedule
Physical Therapy Maintenance	Covered	Not Covered	Covered	Medicare Fee Schedule
Occupational Therapy Restorative	Covered	Covered (4)	Covered	Medicare Fee Schedule
Occupational Therapy Maintenance	Covered	Not Covered	Covered	Medicare Fee Schedule
Speech Therapy Restorative	Covered	Covered	Covered	Medicare Fee Schedule
Speech Therapy Maintenance	Covered	Not Covered	Covered	Medicare Fee Schedule
Opthamalmology Services	Varies (5)	Varies (5)	Varies (5)	Billed Direct to Patient
Audiology Services	Varies (5)	Varies (5)	Varies (5)	Audiologist Bills Patient
Dental	Not Covered	Not Covered	Covered	Not Included
Pharmaceuticals	Covered	Not Covered	Covered	Not Included
Oxygen	Covered	Not Covered	Covered	Included
Oxygen Supplies	Covered	Not Covered	Covered	Included
Enteral Nutrition - Supplements	Not Covered	Covered (1,4)	Covered	Medicare Fee Schedule (2)
Enteral and Parenteral Supplies	Covered	Covered (1,4)	Covered	Medicare Fee Schedule (2)
Primary Surgical Dressings	Covered	Covered (1,4)	Covered	Medicare Fee Schedule (2)
Urological Supplies	Covered	Covered (1,4)	Covered	Medicare Fee Schedule (2)
Tracheostomy Supplies	Covered	Covered (1,4)	Covered	Medicare Fee Schedule (2)
Ostomy Supplies	Covered	Covered (1,4)	Covered	Medicare Fee Schedule (2)
Prosthetics and Orthotics	Covered	Covered (1,4)	Covered	Medicare Fee Schedule (2)
Laboratory	Covered	Covered (1,4)	Covered	Medicare Fee Schedule (3)
X-Ray	Covered	Covered (1,4)	Covered	Medicare Fee Schedule (3)
EKG	Covered	Covered (1,4)	Covered	Medicare Fee Schedule (3)
EEG	Covered	Covered (1,4)	Covered	Medicare Fee Schedule (3)
Ambulance	Covered	Covered (1,4)	Covered (1)	Medicare Fee Schedule (3)
Ambulette	Not Covered	Not Covered	Varies (5)	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 are met and benefits are still available.
- Co-insurance payments for 2022 are $194.50 per day for day 21 to day 100.

**It is the responsibility of the Resident, Resident's Spouse, Financial Sponsor and/or Designated Representative to verify co-insurance coverage of any secondary insurance by contacting the insurance carrier and notifying Desiree at (718) 732-7126

If you are covered by Medicare Part B, for 2022:

- Annual Medicare Part B Deductible is $233.00.
- The average 2022 Medicare Part B Premium for those "held harmless" from any increase in premiums is $170.10. Beneficiaries not subject to the "hold harmless" provision pay less. Medicare Part B beneficiaries not subject to the "hold harmless" provision are those not collecting Social Security benefits, those who enroll in Part B for the first time in 2017, dual eligible beneficiaries who have their premiums paid by Medicaid and beneficiaries who pay an additional income-related premium.
- Co-Insurance payments are 20% of the approved Medicare Part B Charge for all Part B covered services.
- Occupational therapy benefits are capped at a total of $**2,150.00** per year (including co-insurance).
- Physical and speech therapy benefits (combined) are capped at a total of **$2,150.00** per year (including co-insurance).
- Beneficiary may qualify for the Therapy Cap Exception Process. However, if your request for additional services above the therapy is denied, you will be responsible for 100% of the Medicare Approved Charge once the cap is reached.

(1) May be billed by outside vendor 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;
- Lodging; a clean, healthful, sheltered environment, properly outfitted;
- 24-hours-per-day nursing care;
- Use of all equipment, medical supplies and modalities for everyday care, notwithstanding the quantity usually used in the everyday care of nursing home residents, including but not limited to catheters, dressings*, pads, hypodermic syringes and needles, irrigation outfits, and so forth
- Fresh bed linen, as required, changed at least twice weekly, including sufficient quantities of necessary bed linen or appropriate substitutes changed 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, elects to furnish them; and laundry services for these and other launderable personal clothing items;
- General household medicine cabinet supplies, including but not limited to non-prescription medications, materials for routine skin care, oral hygiene, care of hair, and so forth, except when specific items are medically indicated and prescribed 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 concerned with resident care;
- Use of customarily stocked equipment, including but not limited to crutches, walkers, wheelchairs or other supportive equipment, including training in their use when necessary, unless such items are prescribed for exceptional use for 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;
- Arrangements for opportunities for religious worship and counseling for Residents requesting such services; and
- Kosher food or food products prepared in accordance with the Hebrew Orthodox religion requirements when the resident, as a manner of religious belief, desire to observe Jewish dietary law.

*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.

IF YOU HAVE ANY QUESTIONS REGARDING CHARGES AND BILLING, PLEASE FEEL FREE TO

CONTACT THE ACCOUNTS RECEIVABLE OFFICE.

The Basic Private Daily Rate does not include:

a. Ambulance or transportation services;

b. Physician services and consultation fees;

c. Prescription Medication;

d. Physical therapy, occupational therapy, speech therapy, audiology services;

e. Podiatry and ophthalmology;

f. Electrocardiograph, X-ray, or laboratory tests or professional fees for same;

g. Denture, eyeglasses, contact lenses, hearing aids, or similar personal items;

h. Special nursing or personal care supplies not considered routine;

i. Supportive equipment such as walkers, canes and wheelchairs when these are prescribed by a physician for the regular and sole use by the specific Resident;

j. Dental services, including oral hygiene care and routine and twenty-four (24) hour emergency dental care;

k. Oxygen;

l. General household medicine cabinet supplies, including but not limited to non-prescription medications, materials for routine skin care, oral hygiene, care of hair, etc. when medically indicated and prescribed for an exception use;

m. ; and

n. Those items and services listed as additional non-clinical services.

MEDICARE COVERED SERVICES

1.1. The Federal Medicare program is divided between payment for (1) post-hospitalization skilled nursing facility care, generally referred to as Part A; (2) supplemental medical and health benefits, generally referred to as Part B; (3) Medicare Advantage Plans generally known as Part C; and (4) prescription drug benefit plans known as Part D. However, if you meet the criteria for coverage under Medicare Part A, payment for basic and certain ancillary services will be made by the Medicare program for additional services less any co-insurance or deductible obligations.

1.2 The Home accepts Medicare Part A benefits and applicable co-insurance and deductible as payment in full: (1) for all the items listed under Basic Services described above; (2) except as set forth in 1.3 below and (3) any other

items or services required by the Resident's care plan excluding those items or services set forth below regarding Additional Non-Clinical Services. Certain ancillary items are also covered in full under the Medicare Part A benefit. These items include:

(a) physical therapy;
(b) occupational therapy;
(c) speech therapy;
(d) audiology services;
(e) prescription medication;
(f) oxygen;
(g) support equipment and general medicine cabinet supplies; and
(h) electrocardiograph, radiology (technical only) and laboratory tests.

1.3. Any ancillary or charge-based services or items provided by the Home <u>which are not covered or payable under the Medicare Part A benefit</u> will be charged to the Resident or billed to Medicare Part B or Third-party insurer as applicable.

Items not covered or paid by Medicare Part A are:

a. the professional component of physician services;

b. services of a physician's assistant working under a physician's supervision;

c. services of nurse practitioners and clinical nurse specialists working in collaboration with a physician;

d. services of a qualified psychologist;

e. hospice services provided by a certified hospice pursuant to a contract with the Home;

f. home dialysis supplies and equipment, self-care home dialysis support services and institutional dialysis services and supplies;

g. erythropoietin;

h. ambulance services not provided in conjunction with the Resident's stay at the Home, i.e., ambulance trips that occur at either the beginning or end of the Resident's stay;

i. The following drugs and biologicals:

    1. vaccinations for pneumococcal pneumonia;

    2. vaccination for hepatitis B;

    3. vaccination for influenza;

j. dental services;

k. Ambulance services furnished in conjunction with renal dialysis;

l. Certain chemotherapy items and chemotherapy administration services;

m. Certain radioisotope services; and

n. Certain customized prosthetic devices.

Descriptions of these items will be provided upon request.

1.4 Items listed above (not covered as part of the private pay or daily basic rate) which are not covered under the Medicare Part A benefit will be charged to the Resident or billed to Medicare Part B (where covered) or to other third party insurance (where such coverage is available to the Resident).

1.5 Medicare Part A coverage is generally limited to the first one hundred (100) days of your stay at the Home. The Medicare Part A program imposes a co-insurance and/or deductible obligation on you. You are responsible for payment to the Home of any co-insurance and/or deductible obligations under the Medicare Part A program. The Home will invoice the co-insurance and/or deductible obligation on a monthly basis and you will be responsible to pay such invoice within ten (10) days.

1.6. Medicare Part A Residents shall assure that the Home is kept aware of any outside health care providers whom the Resident may see outside of the Home. For example, if the Resident visits a personal physician during his or her Part A stay where diagnostic testing is ordered certain technical services are provided, the **Resident may be financially responsible for the cost of such testing or services if they are not pre-approved and coordinated by your care planning team and your attending physician here at the Home**.

The Home provides the services required by the Resident's plan of care either directly through staff or pursuant to written arrangements with other health care providers. As part of Resident's admission, he or she consents and agrees to receive those services required by the plan of care as may be arranged under the Home's auspices. Accordingly, if the Resident goes outside of these arrangements, the Resident and/or his or her Designated Representative will be solely and absolutely responsible for the cost of any medical, diagnostic or other health service or item which are privately arranged. In the event that Resident or his or her Designated Representative and/or family privately arranges for any such medical, diagnostic or other health services or items, please advise the outside provider of such services that they may NOT be able to bill Medicare or the Home. As noted, under these circumstances, the Resident/ Designated Representative and family are solely responsible for the cost of such services.

1.7 Medicare Part D Eligible Residents. The Home arranges for prescription drugs included within the care plan for all Residents through a specific vendor pharmacy as required and allowed for by law. A Resident who is eligible for Medicare Part D coverage agrees to enroll in a Medicare Part D prescription drug plan (PDP) which has a contract with the Home's vendor pharmacy ("Vendor Pharmacy PDP") on the following time frames:

a. at or prior to the time of admission, (if eligible at such time), or

b. during the month the Resident first becomes eligible for Medicare Part D coverage, if such eligibility occurs after the date of admission.

1.8 The Resident and/or the Resident's Designated Representative agree to fully cooperate In the enrollment process, including, but not limited to: (1) disenrolling from the Medicare Part D PDP in which the Resident may be enrolled at the time of admission, to the extent such PDP does not have a contact with the Home's vendor pharmacy; (2) requesting any required disenrollment/enrollment forms from a Medicare Part D prescription drug plan; and (3) timely completing and submitting an enrollment form with a Vendor Pharmacy PDP. To the extent permitted by applicable law, the Home will provide assistance to the Resident and/or the Designated Representative in the Medicare Part D enrollment process.

1.9 The Resident and/or the Designated Representative will ensure that the Resident maintains continuous coverage under Medicare Part D with a Vendor Pharmacy PDP for the duration of the Resident's stay at the Home, including, but not limited to, payment of any required Medicare Part D premium.

1.10 The following terms will apply with regard to the Resident's payor status as private pay, Medicare and Medicaid:

a. Private Pay Resident Eligible for Medicare Part D Coverage. The Resident and/or the Designated Representative is liable and responsible for all required prescription medication costs and payments under the Medicare Part D program, including, but not limited to, co-payments, deductibles and prescription medication costs that standard beneficiaries are required to pay once the initial coverage limit of is reached (currently $**4,020.00**). The

Resident and/or Designated Representative is liable and responsible for the cost of any and all prescription medications not covered by the Resident's Vendor Pharmacy PDP, to the extent not otherwise covered under the Medicare Part D program.

If a Resident fails to enroll in a Vendor Pharmacy PDP or disenrolls or is disenrolled from such a Vendor Pharmacy PDP, the Resident will be liable and responsible for prescription medication costs to the same extent as a Private Pay Resident without Medicare Part D coverage (See subsection b. below). Home has no financial liability for prescription medication costs incurred on behalf of the Resident and, to the extent Home incurs financial liability for such costs, the Resident and/or Designated Representative agree to reimburse and indemnify the Home for all such costs.

b. Private Pay Resident without Medicare Part D Coverage. The Resident and/or the Designated Representative is fully liable and responsible for all prescription medication costs incurred on behalf of the Resident, including, but not limited to, any required third-party insurance co-payments, deductibles, or co-insurance amounts. Home has no financial liability for prescription medication costs incurred on behalf of the Resident and, to the extent the Home incurs financial liability for such costs, the Resident and/or Designated Representative agree to reimburse and indemnify the Home for all such costs.

c. Medicare Part A Resident. Prescription medication costs are included in Home's Medicare Part A rate. When Medicare Part A coverage ceases, the Resident and/or Designated Representative will be responsible for prescription medication costs to the extent required by the Resident's status under subsections a, b, d, or e.

d. Medicaid Only Resident. A Medicaid only Resident is a Resident who is eligible for Medicaid but not eligible for Medicare Part D coverage. Prescription medication costs incurred on behalf of the Resident are included in Home's Medicaid rate or, to the extent not so included, are paid for by Medicaid.

e. Medicaid Resident Eligible for Medicare Part D Coverage. Prescription medication costs covered by the Vendor Pharmacy PDP are fully covered under the Medicare Part D program. However, to the extent that the Resident or the Designated Representative incur costs not covered by the Vendor Pharmacy PDP and which are in excess of what Medicaid will cover, the Home has no financial liability for prescription costs covered by the Vendor Pharmacy PDP. The Resident and Designated Representative are liable for the costs of prescription medication not covered by the Vendor Pharmacy PDP, to the extent not otherwise paid for by Medicaid.

1.11 It is important that we provide notice of your status here at the Home to our Vendor Pharmacy to assure continued and uninterrupted prescription drug coverage. This will include the provision of your Part D enrollment information, your status under Medicaid and periods during your stay which may be covered by Medicare's post hospitalization benefit under Part A. You agree to provide information concerning your PDP enrollment and such other information as required by our Vendor Pharmacy in order to assure proper payment for prescription drugs furnished to you at the Home.

MEDICAID COVERED SERVICES

2.1 If you meet the criteria for eligibility under the New York State Medical Assistance Program (Medicaid), the State Medicaid program will pay for most services provided to you at the Home. This section will describe such services and will outline your personal payment responsibilities.

2.2 The Home accepts Medicaid as payment in full for the basic services items as set forth above, as well as the following Ancillary services:

a. Oral hygiene care and routine and twenty-four (24) hour emergency dental care;

b. Pharmaceutical services when not covered by Medicare Part D or other plans;

c. Physical therapy services, as prescribed by a physician, administered by or under the direct supervision of a qualified physical therapist;

d. Occupational therapy services, as prescribed by a physician, administered by or under the direct supervision of a qualified occupational therapist;

e. Speech pathology services, as prescribed by a physician, administered by or under the direct supervision of a qualified speech pathologist.

2.3 Residents who are not eligible for a Medicare Part A stay or determined to be eligible for Medicaid benefits, agree to pay the designated private pay or daily basic rate for as long as personal funds allow. This is known as a “Spend Down” period. It is essential that Residents and their Designated Representatives (who manage or control the Resident’s funds) provide financial information to the Home as necessary to assure that a proper source of payment exists for the Resident’s care at the Home. The Resident and Designated Representative agree to provide such information upon request using the forms provided by the Home periodically during the Resident’s stay.

2.4 The Home must be notified at least three months prior to the Resident's personal funds becoming exhausted. The Resident or his/her Designated Representative will duly and timely apply for medical assistance. In the event medical assistance coverage is denied, the Resident is obligated to pay the basic Private Rate up to the time the Resident is determined eligible for medical assistance by the local, state or federal agency.

2.5 Where a Designated Representative or other individual has control of Resident income, assets, resources or funds, that individual agrees to remit such income, assets, resources and funds (as well as all funds required under any spend down period) to the Home.

2.6 Medicare Part B covered items to the extent not covered in the Medicaid rate will be billed to the third party payor or insurance carrier by the Home or the vendor providing the service.

ADDITIONAL NON-CLINICAL SERVICES

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

- Telephone, including cellular phone;
- Television/radio, personal computer or other electronic device for personal use, including cable services;
- Personal comfort items including smoking materials, 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;
- Costs to participate in social events, special meals and entertainment offered off the premises and outside the scope of the Activities program provided by the Home required under applicable Department of Health Regulations, as well as any related transportation services;
- Non-covered special care services, such as private duty nurses and/or aides;
- Specially prepared or alternative food requested instead of the food generally prepared by the Facility and the requested food costs more than the food prepared for other residents, except, (i) for Medicare Part A and Medicaid residents only, special foods and meals, including medically prescribed dietary supplements, ordered by the Resident's attending physician or nurse practitioner; and (ii) menu items that reflect the religious, ethnic and cultural population at the Facility, such as Kosher foods;
- Personal dry cleaning;
- Specialized cleaning of Resident furniture or personal items when the use of outside services are required;
- Newspapers and periodicals;
- Non-routine Beauty/Barber Parlor services not provided by staff of Home.
- Any other services which are in excess of what is covered under Medicaid or paid for during a Medicare Part A stay.

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

ATTACHMENT "B"

SPECIAL RULES REGARDING SELECTED PAYORS

PAYMENT FOR IN-PATIENT LONG TERM CARE SERVICES CAN BE 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.

PRIVATE INSURANCE

Residents who are covered by a private insurance plan that does not have a contract with the Home 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 (and/or the Resident's Spouse, Financial Sponsor and/or Designated Representative, as applicable) 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 January 2022 generally no more than $16,800 (subject to annual increases).. Generally, for a resident who is receiving Medicaid, most of the Resident's monthly income must be paid to the Home, except for a $50 monthly "personal needs allowance" and the monthly cost of retaining a private health insurance policy. The monthly income obligation, called the income contribution or 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 2022, the "community spouse" is-entitled-to a Minimum Monthly Maintenance Needs Allowance (MMMNA) of $3,435 and with respect to resources the Maximum Federal Community Spouse Resource Allowance is $137,400 and the Minimum State Community Spouse Resource Allowance is $74,820 (these figures are subject to change each calendar year); increases beyond these amounts are possible, but a Fair Hearing (conducted by the Human Resources Administration of the City of New York or appropriate County Department of Social Services) or a 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. A Resident or spouse who transfers cash and/or property within five (5) years of applying for Medicaid nursing home benefits can create a period of Medicaid ineligibility. Private pay Residents should apply for Medicaid about three months before their funds are depleted. A Medicaid application will require the provision of certain information and documentation, including but not necessarily limited to, 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 the Human Resources Administration of the City of New York or their local Department of Social Services in the county in which the Resident resides. *

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 Home within 30 days after leaving the hospital; 4) The Resident is admitted to the Home 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 Home for five (5) days per week, due to staffing levels at the Home. Additionally, there may be a one to two day break if the Resident's needs require suspension of the services.

Where these five criteria are met, Medicare may provide coverage of up to one hundred (100) days of care in a skilled nursing facility (SNF): the first twenty (20) days of covered services are fully paid for; and the next eighty (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 $194.50 per day.

Additionally, Medicare Residents requesting a leave of absence from the Home 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 Home 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, and does not return by twelve (12) midnight, will be an uncovered day.

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 in order to be eligible for SNF coverage. A Resident may leave the Home past twelve (12) midnight, however, this will be considered a discharge and they may be readmitted to the SNF if they return within the thirty (30) day time limit and meet the skilled care requirements.

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 diem or daily fee based on the Resident's classification within the Medicare RUG-IV 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 Resident's health condition based on a standardized assessment form (called the MDS 3.0) provided by the Health Care Financing Administration (HCFA). Information from the MDS 3.0 form will be used by Medicare to assign the Resident a RUG-IV 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 sixty (60) days, returns to the hospital for another three-day stay, and then re-enters the SNF. While a SNF may make a determination of non-coverage, beneficiaries have a right to request an official Medicare determination of

coverage (called a "Demand Bill"), which can be appealed. SNF will not bill for private pay payment during the appeal of the Demand Bill.

MEDICARE PART B PAYMENT

Individuals who pay monthly premiums to enroll in Medicare Part B will be charged according to Facility's or the service providers' stated charge schedule for services they receive at the 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 are 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 out-patient and clinical laboratory services. However, Part B benefits have limitations. For example, for 2022, there is an annual $233.00 deductible applicable to Medicare Part B benefits. Additionally, physical therapy (including speech-language pathology services) and occupational therapy are each subject to annual limitation. The therapy financial limitations or "caps" are indexed by the Medicare Economic Index (MEI) each year. For 2022, the therapy threshold for physical therapy including (speech-language pathology services) and occupational therapy are $ **2150.00** each, including co-insurance. Both therapy limitations are still subject to the 80% - 20% coverage limitation in that the individual will be responsible for the 20% co-insurance payments. **The Resident (and/or the Resident's Spouse, Financial Sponsor and/or Designated Representative, as applicable) is responsible for private payment of all 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 health care 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-Choice 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.

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 owner's 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 ninety (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.

MANAGED CARE

Residents who are members of a managed care benefit plan that is under a contract with the Home 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 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 care benefit plan are advised to contact their social worker and/or managed care benefit plan.

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) is 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.

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.