WORKMEN'S CIRCLE MULTICARE CENTER
ADMISSION AGREEMENT

Agreement dated _____, 20___ (hereinafter the "Agreement") between Workmen's Circle Multicare Center located at 3155 Grace Avenue, Bronx, New York 10469 (hereinafter "Facility") and _____ (hereinafter referred to as "Resident"), whose community residence is located at _____ and _____ (hereinafter "Resident Representative") residing at _____

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

I. ADMISSION AND CONSENT

The undersigned hereby agrees, subject to federal and state laws, rules and regulations, that the Resident will be admitted to the Facility only upon the order of a New York State licensed physician and upon a determination that the Resident satisfies the admission assessment criteria set by the New York State Department of Health ("DOH") and by the Facility. The Resident and/or Resident Representative hereby consent to such routine care and treatment as may be provided by the Facility and/or ancillary providers in accordance with the Resident's plan of care, including but not limited to, transfer to an acute care hospital when necessary, dental, medical and/or surgical consultation, examination by medical and nursing staff, telemedicine services, routine diagnostic tests and procedures, nursing services, and medication administration. The Resident and Resident 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 hereby understands and agrees that admission to the Facility is conditioned upon the review and execution of this Agreement and related documents as more fully set forth herein.**

The Facility will arrange for the transfer of the Resident to a hospital or other health care facility when any such transfer is ordered by the attending physician or a substitute physician. The Facility is not responsible for payment for care and services rendered to the Resident by any hospital or any other health care facility.

II. MUTUAL CONSIDERATION OF THE PARTIES

The Facility agrees to provide all basic (routine) services to the Resident, as well as either provide or arrange for available ancillary services, that the Resident may require. 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 included in your admission package.

By entering into this Agreement, the Resident and/or the Resident Representative on the Resident's behalf, understand and agree to the following Resident payment obligations. The Resident agrees to pay for, or arrange to have paid for by Medicaid, Medicare or other insurers, all services provided under this Agreement, and agrees to pay any required third-party deductibles, coinsurance or monthly income budgeted by the Medicaid program. The Resident accepts the responsibility to ensure continuity of payment, including the obligation to arrange for timely Medicaid coverage, if Medicaid coverage becomes necessary.

The Resident and Resident Representative understand and agree that the Facility's acceptance of the Resident is based on the representation that the Resident has financial resources, third party insurance coverage and/or is eligible for government benefits (including Medicare and/or Medicaid) to cover the cost of care at the Facility. The Resident and Resident Representative to the extent that the Resident Representative has access to this information may be required to make full and complete disclosure to the Facility of all income including, but not limited to, Social Security and pension(s), assets, insurance coverage and any other resources available to the Resident that could be available to pay for the cost of care.

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

III. ANTICIPATED SERVICES

Generally, residents are admitted to the Facility for one of the following reasons: sub-acute care*; long term care, or hospice care.

* Workmen's Circle Multicare Center defines sub-acute care as goal oriented, comprehensive, inpatient care designed for an individual who has an acute illness, injury, or exacerbation of a disease process. Generally, sub-acute care is rendered at the Facility immediately after, or instead of, acute hospitalization. Sub-acute care lasts for a limited time or until a condition is stabilized or a predetermined treatment course is completed.

Residents, who are admitted for sub-acute care, are admitted with the expectation that they will be discharged once short-term services are no longer required, unless continued placement in the Facility is medically appropriate. It is the mutual goal of the Resident and the Facility that the Resident returns to his/her home or a less restrictive setting, if appropriate. The Resident and/or Resident Representative 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. The Resident's failure to cooperate with discharge constitutes a waiver of any limitation that might otherwise apply to private collection.

Residents admitted for sub-acute care are responsible for applicable copayments, deductibles, and/or coinsurance, and for any charges that may accrue after termination of their third-party coverage if they remain in the Facility for any reason. Residents covered by Medicare Part A are responsible for a daily coinsurance amount for days 21 to 100 of a Part A covered stay.

If the Resident is admitted for sub-acute services and thereafter remains in the Facility for long term care, an intra-facility room change or transfer to a more appropriate setting may be necessary. Any such room change will be conducted in accordance with applicable law and the Facility's policies and procedures.

IV. FINANCIAL ARRANGEMENTS

(a) Obligations of Resident and/or Resident Representative

i. **Resident:** The Resident agrees to pay, or arrange for payment of, any portion or all of the applicable private pay room and board rate and the ancillary charges incurred for services not covered by third party payors and/or required third party deductibles and/or coinsurance including the monthly income contribution (NAMI) budgeted by the Medicaid program. If the Resident has no third-party coverage, or if the Resident remains in the Facility after any such coverage terminates because covered services are deemed no longer "medically necessary" or for any other reason consistent with applicable law, the Resident agrees to pay or arrange for payment at the private pay rate for room and board and the ancillary charges incurred until discharge or until another source of coverage becomes available. The Resident agrees to take the necessary steps to ensure that the Facility and its ancillary providers receive payment from all third-party payors, including the timely disclosure of available insurance coverage, timely appeal of insurance coverage denials, and production of information and documentation needed to meet the eligibility criteria of the Medicaid program (e.g., proof of income, resources, residency, citizenship, and explanation of past financial transactions). The Resident hereby agrees to indemnify and hold the Facility harmless from any loss, damage or expense the Facility may suffer or incur as a result of a breach of the foregoing obligations.

ii. **Resident Representative.** The Resident Representative is the individual designated, by either a Court of law, the Resident or a family member or other party(ies) having an interest in the well-being of the resident, including but not limited to the Resident Representative's self-designation by signing this Agreement, to receive information and assist and/or act on behalf of the Resident to the extent permitted by State law. By signing this Agreement, the Resident Representative hereby agrees (i) to the extent he/she has legal access to the Resident's funds, to access and use the Resident's funds to pay for the Resident's care at the Facility; and (ii) to the extent that the Resident Representative has access, to cooperate with the Facility and timely provide information and documentation requested by the Facility or a third party payor including, but not limited to, insurance and/or Medicaid (e.g., a request for documentation needed to complete a Medicaid application or insurance policy information); and regarding such matters as the Resident's financial resources, citizenship or immigration status and third party insurance coverage.

iii. ***Resident and/or Resident Representative.*** The Resident and Resident Representative understand that the Facility is available to assist with securing third party coverage (including but not limited to Medicaid), but it is ultimately the responsibility of the Resident and, to the extent he/she has legal access, the Resident Representative l to take all necessary steps to apply for, and qualify for, such coverage in a timely manner. Care provided to a Resident

who does not meet the eligibility criteria for coverage by third party payors will be billed to the Resident at the Facility's private pay room and board rate.

The Resident and, to the extent he/she has access, the Resident Representative agree to provide the Facility with all relevant information and documentation regarding potential third-party payors, including insurance and managed care plans, and to promptly notify the Facility of any changes in insurance status or coverage. Additional charges, such as co-insurance, deductibles, and co-payments, may apply based on the insurance coverage, managed care plan, or any written agreement with the Facility. Prior authorization from an insurance carrier or managed care plan does not guarantee coverage or reimbursement. If a third-party payor denies payment, benefits are exhausted, or coverage is terminated, the Resident is responsible for payment to the Facility. Additionally, the Resident must immediately inform the Facility of any notice of discontinued payment (coverage) from a third-party payor.

The Resident Representative's execution of this Agreement and agreement to undertake the obligations of the Resident Representative as specifically set forth in this Agreement shall not be deemed an agreement by the Resident Representative to pay for the Resident's stay and care at the Facility from the Resident Representative's personal funds. The Resident Representative is not a guarantor of payment and is not obligated to pay for the cost of the Resident's stay and care at the Facility from his/her own funds.

Nothing herein relieves the Resident Representative of his/her obligations set forth in the Agreement nor restricts or otherwise limits the remedies legally available to the Facility in the event the Resident Representative fails to comply with his/her agreements and/or obligations set forth in this Agreement.

(b) Private Payment

If the Resident does not have a third-party payment source in place 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, his/her care will be billed at private pay rates. The private pay room and board rate ("Daily Basic Rate") is **$ 720** per day for a private room and $**695** per day for a semi-private room. In addition, New York State Health Facility Cash Assessment Program (HFCAP) imposes an additional six and eight tenths (6.8%) percent, which is added to the Daily Basic Rate. Ancillary services are not included in the Daily Basic Rate. Ancillary services, such as physician services, rehabilitation therapies, oxygen, dental and diagnostic services, laboratory, x-ray, podiatry, optometry, pharmacy services, urinary care supplies, trach and ostomy supplies, surgical supplies, parenteral and enteral feeding supplies, transportation services, and extraordinary rehabilitative devices, are provided by independent service providers who contract with the Facility and will be billed separately according to the Facility's and/or the service providers' charge schedules. Rates of payment to the Facility may differ for individuals with additional sources of payment such as third-party coverage. A copy of the Facility charge schedule for ancillary services is attached to this Agreement and included in your admission package. In addition, certain items and services, such as beauty/barber services; personal telephone, newspaper delivery etc. (see Attachment "A" - Non-Clinical Services) are not covered in the Daily Basic Rate or by health insurance plans and the Resident is responsible to pay for such services. Room and board charges are billed monthly on a one-month advance basis. Ancillary charges are billed in the month following the month that the services were provided. Bills are generated at the end of each month and cover the next month of room and board charges ("Monthly Advance Payment") and the previous month's ancillary charges. All payments are due upon receipt of the monthly bill. The Daily Basic Rate and charges for ancillary and/or additional services are subject to increase upon thirty (30) days' written notice to the Resident and/or Resident Representative.

(c) Prepaid Deposits/Advance Payment

Unless otherwise specified prior to admission herein and/or restricted by law, the Facility requires an advance payment in cash or certified check equal to three (3) months of services at the Facility's Daily Basic Rate from private pay residents. Such sum represents a two (2) month prepaid security deposit ("Prepaid Deposit") and the Monthly Advance Payment for the first month stay at the Facility. The Prepaid Deposit, including any interest accrued, shall continue to be the property of the depositor. However, the Facility shall have the right to apply, at its sole discretion, the Prepaid Deposit toward payment for services provided under this Agreement. The Resident agrees to deposit additional funds with the Facility to replenish the Prepaid Deposit to a sum equivalent to two (2) months of the current Daily Basic Rate within ten (10) days of written notice to the Resident. To the extent that the Resident Representative has legal access to the Resident's funds, the Resident Representative shall take all steps necessary to assist the Resident in fulfilling the foregoing obligation. The Facility may deduct a fee of one percent (1%) per year from Prepaid Deposit amounts to cover administrative costs in accordance with applicable law. Upon Resident's discharge from the Facility, the balance of the prepaid amount in excess of outstanding bills will be refunded in accordance with Facility's policy within thirty (30) days of the discharge. However, if a private paying Resident leaves the Facility for reasons within the Resident's control without giving five (5) days' prior notice, the Facility will retain an additional amount not to exceed one (1) day's Daily Basic Rate.

Prepaid deposits/advance payment are not required upon admission from individuals eligible for Medicare, Medicaid and/or Veterans Administration benefits. However, immediately upon the ineligibility of a Resident and/or the expiration or discontinuation of coverage for services at the Facility by such government programs, a Prepaid Deposit and Monthly Advance Payment will be required in accordance with the above-mentioned Prepaid Deposit policies of the Facility.

(d) Late Charges

Interest at the rate of fifteen (15%) percent per annum [1¼ % per month] or the maximum allowed by State law will be assessed on all accounts more than thirty (30) days overdue.

(e) Collection Costs, Including Reasonable Attorneys' Fees and Related Expenses

In the event of any arbitration or litigation arising from this Agreement, the Facility, if it prevails, shall be entitled to reasonable attorneys' fees. The Resident shall be responsible for the expenses related to collecting damages hereunder, including but not limited to reasonable attorneys' fees and other collection-related costs and disbursements, in addition to the late charges imposed on any overdue payments.

(f) 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 will be according to the rates for coverage of skilled nursing facility benefits agreed upon by such plan and the Facility. Residents who are members of a managed care benefit plan that has a contract with the Facility to provide specified services to plan members will have such services covered as long as the Resident meets the eligibility requirements of the managed care benefit plan. To the extent the Resident meets the eligibility requirements of the managed care benefit plan, he or she will be financially responsible only for payment for those services not covered under his or her plan and for applicable copayments, coinsurance and/or deductibles.

If the Resident is covered by a private insurance plan or managed care benefit plan that **does not** have a contract with the Facility, and where the private insurance or managed care plan reimbursement is insufficient to cover the cost of care, the Resident will be responsible for any difference in accordance with federal and State laws and regulations. The Facility will bill the Resident for any such difference on a monthly basis as described in the "Private Payment" section above. The coverage requirements for nursing home care vary depending on the terms of the insurance or managed care plan. Questions regarding private insurance and managed care coverage should be directed to the social work staff and/or the Resident's insurance or managed care plan, carrier or agent. The Resident and/or Resident Representative shall notify the Facility immediately of any change in Resident's insurance status or coverage including, but not limited to, ineligibility, termination, discontinuation of coverage, and/or any decrease or increase in benefits.

If the 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 nonparticipating provider with the understanding that there may be additional charges to the Resident for using such nonparticipating providers.

Alternate Physician or Professional Provider of Service: The Resident and/or Designated Representative agree that if the physician or any other professional provider of service designated by the Resident and/or Designated Representative is not available to serve the Resident, fails to serve the Resident, or fails to comply with any applicable provision of federal or state law, the Facility is authorized to obtain the services of a substitute physician or professional provider of service. Payment for such services will be made in accordance with this Agreement.

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, the Resident's coverage may be subject to co-insurance, deductibles and/or co-payments which will be the Resident's responsibility and billed according to the terms for private payment stated above.

In the event of denial of payment by a third-party payor, exhaustion of benefits and/or termination of coverage, the Resident and/or Designated Representative shall be responsible (in accordance with the terms and provisions of this Agreement) for payment to the Facility as described in the "Private Pay" section above and in accordance with applicable law.

(g) Medicare

Medicare Part A: 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 guidelines. If the Resident continues to be eligible, Medicare may provide coverage of up to 100 days of care. The first 20 days of covered services are fully paid for by Medicare and the next 80 days (days 21 through 100) of the covered services are paid in part by Medicare and subject to a daily coinsurance amount for which the Resident is responsible.

Medicare Part B and/or Part D coverage. If a Resident exhausts his/her Part A coverage or no longer needs a skilled level of care under Part A, the Resident may still be eligible for coverage of certain services under Medicare Part B and/or Part D. The Resident will be responsible for all deductible and copayments associated with Part B and Part D services. Any charges for services that Medicare Part B, Part D, or other third-party payers do not cover will also be the Resident's responsibility.

Medicare will terminate coverage for therapy services (physical, occupational and/or speech therapy) if the beneficiary does not receive therapy for three (3) consecutive days, whether planned or unplanned, for any reason, including illness or refusals, doctor appointments or religious holidays. If such therapy was the basis for Medicare Part A coverage, the Resident would be responsible for the cost of his/her stay, unless another payor source is available.

If Medicare denies coverage and denies further payment and/or recoups any payment made to the Facility, the Resident hereby agrees to pay 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. Such amounts shall be calculated in accordance with the Facility's applicable prevailing private rates and charges for all basic and additional services provided to the Resident.

MEDICARE PART A, MANAGED CARE, AND THIRD-PARTY INSURANCE

Except for specifically excluded services, most nursing home services are covered under the consolidated billing requirements for Medicare Part A beneficiaries or under an all-inclusive rate for other third-party insurers and managed care organizations (MCOs). Under these requirements, the Facility is responsible for furnishing directly, or arranging for, the services for its residents covered by Medicare Part A and MCOs. When not directly providing services, the Facility is required to enter into arrangements with outside providers and must exercise professional responsibility and control over the arranged-for services. All services that the Resident requires must be provided by the Facility or an outside provider approved by the Facility. Before obtaining any services outside of the Facility, the Resident must consult the Facility.

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

(h) Medicaid

If and when the Resident's assets/funds have fallen below the Medicaid eligibility levels, and the Resident otherwise satisfies the Medicaid eligibility requirements and is not entitled to any other third-party coverage, the Resident may be eligible for Medicaid (often referred to as the "payor of last resort"). **THE RESIDENT AND, TO THE EXTENT HE/SHE HAS LEGAL ACCESS, THE RESIDENT REPRESENTATIVE AGREE TO NOTIFY THE FACILITY AT LEAST THREE (3) MONTHS PRIOR TO THE EXHAUSTION OF THE RESIDENT'S FUNDS (APPROXIMATELY $50,000) AND/OR INSURANCE COVERAGE TO CONFIRM THAT A MEDICAID APPLICATION HAS OR WILL BE SUBMITTED TIMELY AND ENSURE THAT ALL ELIGIBILITY REQUIREMENTS HAVE BEEN MET. THE RESIDENT AND RESIDENT REPRESENTATIVE AGREE TO PREPARE AND FILE AN APPLICATION FOR MEDICAID BENEFITS PRIOR TO THE EXHAUSTION OF THE RESIDENT'S RESOURCES.** Services reimbursed under Medicaid are outlined in Attachment "A" to this Agreement.

Once a Medicaid application has been submitted on the Resident's behalf, the Resident and Resident Representative to the extent that he/she has legal access to the Resident's funds, agree to pay to the Facility the Resident's monthly income, which will be owed to the Facility under the Resident's Medicaid budget. Medicaid recipients are required to pay their Net Available Monthly Income ("NAMI") to the Facility on a monthly basis as a co-payment obligation as part of the Medicaid rate. A Resident's NAMI equals his or her income (e.g., Social Security, pension, etc.), less allowed deductions. The Facility has no control over the determination of NAMI amounts, and it is the obligation of the Resident and/or Resident Representative to appeal any disputed NAMI calculation with the appropriate government agency. Once Medicaid eligibility is established, the Resident and/or Resident Representative to the extent he/she has legal access agree to pay NAMI to the Facility or to arrange to have the income redirected by direct deposit to the Facility and to ensure timely Medicaid recertification. The Resident and Resident Representative agree to provide the Facility with copies of any notices (such as requests for information, budget letters, recertification, denials, etc.) received from the Department of Social Services related to the Resident's Medicaid coverage.

Until Medicaid is approved, the Facility may bill the Resident's account as private pay and the Resident will be responsible for the Facility's private pay rate. If Medicaid denies coverage, the Resident or the Resident's authorized representative can appeal such denial; however, payment for any uncovered services will be owed to the Facility at the private pay rate pending the appeal determination. If Medicaid eligibility is established and retroactively covers any period for which private payment has been made, the Facility agrees to refund or credit any amount in excess of the NAMI owed during the covered period.

Direct Deposit

All long-term residents and all short-term residents transferred to long-term care may have their Net Available Monthly Income or NAMI (Social Security, pension benefits, etc.) deposited in the Facility's account and/or their "personal income allowance" 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 directly deposited into the Facility's account as Representative Payee.

_____ I wish to have my/the Resident's **Pension** Income directly deposited into the Resident's PNA account at the Facility and, if my/the Resident's pension check cannot be directly deposited, then I wish to change the address so that such income check is physically sent to the Resident c/o the Facility's address.

(Specify Name of Pension benefit organization): _____.

_____ I wish to have my/the Resident's income directly deposited into the Resident's PNA account at the Facility and, if my/the Resident's income check cannot be directly deposited, then I wish to change the address so that such income check is physically sent to the Resident c/o the Facility's address.

(Specify Name of the income source): _____.

I understand that the Facility will apply any income received towards my/the Resident's NAMI obligation in accordance with applicable Social Services Law and regulations and/or towards my/the Resident's anticipated NAMI obligation and that the Facility will deposit my/the Resident's "personal income allowance" in my/the Resident's personal account at the Facility.

I understand that during the pendency of my/the Resident's Medicaid application that the Resident's "estimated" NAMI should be turned over to the Facility to be applied on the Resident's account either via direct deposit as indicated above or by submitting a check for such income or by turning over such income checks on a monthly basis on or before the 5th day of the month. I understand that the Resident's NAMI is determined by the applicable Department of Social Services and that the amount of such NAMI is subject to change upon the issuance of a budget. I understand that the Resident is responsible for any differences between the "estimated" NAMI and the actual budgeted NAMI. Similarly, credit balances, if any, resulting from such "estimated" NAMI payments made to the Facility during the pendency of the Resident's Medicaid application will be refunded less any payments, monies, or balance due to the Facility for the services rendered to the Resident pursuant to terms of this Agreement.

V. AUTHORIZATIONS AND ASSIGNMENTS FROM RESIDENT TO THE FACILITY

(a) Authorization to Release Information

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

(b) Authorization to Obtain Records, Statements and Documents

By execution of this Agreement, the Resident and Resident Representative authorize the Facility, its agents, representatives, successors and assigns to obtain from financial institutions, including, but not limited to, banks, insurance companies, broker and credit unions, and government agencies, such as the Social Security Administration and Department of Social Services, records, statements, correspondence and other documents pertaining to the Resident for the purposes of payment to the Facility and/or securing Medicaid coverage.

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

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

(d) Designation and Authorization for External Appeal of Medical Necessity Denials

Except where a designee is appointed, only a Resident may request an "external" or independent appeal of benefit denials based on lack of medical necessity. The Resident and/or Resident Representative appoints the Facility as designee authorizing it to request an external appeal of a health plan denial or limitation of coverage because of medical necessity and agrees to sign any form needed to effectuate such appointment.

(e) Authorization to Represent Resident Regarding Medicaid

By execution of this Agreement, the Facility, its agents, representatives, successors and assigns 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 and Article 78 judicial appeals. The Facility will appeal a Medicaid determination only if it deems an appeal has merit and is necessary and prudent.

(f) Authorization to Take Resident's Photograph

By execution of this Agreement, the Resident and/or Resident Representative authorize the Facility to photograph the Resident for identification purposes and to photograph any part of the Resident to document certain physical conditions, e.g., wounds or skin discolorations, for treatment purposes. I understand that the Facility retains ownership rights to

these photographs but that the Resident will be allowed access to view them or obtain copies.

(g) Authorization to Take Resident's Photograph for Public Relations Purposes

By execution of this Agreement, the Facility shall be authorized to take and use photographs of the Resident during the normal routine of activities and/or events at the Facility, which photographs may be used for the purpose of marketing, publicity, social media, and advertising, including but not limited to web content, Instagram and Facebook. By execution of this Agreement, the Resident and/or Designated Representative understand that there will be no remuneration or compensation for any such use. All such photographs, images and stories regarding such activities and/or events will be used and displayed with discretion by the Facility carefully respecting the Resident's rights.

(h) Authorization to Search Resident's Room

By execution of this Agreement, the Resident and/or Designated Representative hereby authorize the Facility to enter and search the Resident's room as it deems necessary. Facility staff may enter resident rooms to respond to health or safety concerns, enforce facility policies and procedures, to respond to a complaint, or to ensure that state and federal laws, rules and regulations are not being violated. Facility staff may repair any situation that is considered necessary by Facility staff.

(i) Authorization for Emailed Invoices

The Resident and/or Designated Representative do hereby consent to the Facility sending any and all invoices for services rendered hereunder via email to the Resident and/or Designated Representative, as applicable.

VI. TEMPORARY ABSENCE (also referred to as "bed hold" or "bed reservation")

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

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

(a) Private Pay Residents who elect to retain a bed in the Facility during a period of hospitalization or therapeutic leave may do so by notifying the Admission Department and signing a bed hold reservation form with the Admission Department stating their intent to hold, and pay for the bed at the Facility's private pay rate, and continuing payment at the private pay rate. The bed hold will be in effect until the Facility received written notice of discontinuance by the Resident/Designated Representative or payment if discontinued.

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

(c) Medicaid Recipients: Medicaid regulations provide that when a Medicaid recipient has been a resident in the Facility for a minimum of thirty (30) days and the Facility's vacancy rate is less than five (5%) percent, the Resident's bed will be reserved for: (1) Residents under 21 years of age for temporary hospitalization and therapeutic leave; (2) Residents 21 and over who are receiving hospice services for temporary hospitalization. The Medicaid bed hold is limited for fourteen (14) days in any twelve (12) month period; (3) Residents 21 and over for non-hospitalization therapeutic leaves of absence ("Therapeutic Leave"). The Medicaid bed hold for Therapeutic Leave is limited to ten (10) days in a twelve (12) month period.

There is no Medicaid paid bed hold for a Resident 21 years of age or older who is temporarily hospitalized unless such Resident is receiving hospice services within the Facility.

Medicaid recipients who do not meet the bed hold eligibility requirements, who do not have a paid bed hold, whose bed hold has expired or has been terminated, may elect to reserve/hold the same bed in the Facility by notifying the Admission Department and signing a bed hold reservation form with the Admission Department stating their intent to hold, and pay for, the bed at the Facility's private pay rate.

In the absence of a bed hold, a Medicaid resident, has the right to, and will be given priority for readmission when an appropriate bed in a semi-private room becomes available if the Resident requires the services provided by the Facility and is eligible for Medicaid nursing home services, unless there are special circumstances which would preclude the Resident's return.

For additional information, please contact our Admissions Department, Monday through Friday from 9 am to 5pm.

VII. DISCHARGE, TRANSFER AND INTRA-FACILITY ROOM CHANGES

(a) Involuntary Discharge for Non-Payment

To the extent authorized by applicable law, the Facility reserves the right to discharge the Resident if the Resident fails to pay for, or secure third-party coverage of the Resident's care at the Facility, including failing to pay applicable co-insurance and/or NAMI.

(b) Involuntary Discharge for Non-Financial Matters

The Facility may transfer or discharge the Resident if the transfer or discharge is necessary for the Resident's welfare and the Resident's needs cannot be met in the Facility; the Resident's health has improved sufficiently so the Resident no longer needs the services provided by the Facility; the health or safety of individuals in the Facility would otherwise be endangered; or the Resident has failed to pay for (or have paid under Medicare, Medicaid, or third-party insurance) a stay at the Facility, or for any other reason permitted by applicable law.

(c) Voluntary Discharge

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

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

(d) Intra-facility Room Change

The Facility reserves the right to transfer the Resident to a new room on an as-needed basis, consistent with applicable law. Residents who 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. If the Resident occupies a private room, the Resident understands and agrees that when he/she no longer pays the private rate or upon Medicaid coverage, he/she may be moved to a semi-private room unless the private room is medically necessary. The Facility may also initiate a room change for medical, social and/or other reason consistent with applicable law and the Resident's rights.

VIII. RESIDENT'S PERSONAL PROPERTY

Each Resident may request a locked drawer in his/her room for the storage of personal property. It is not recommended that valuable personal property (such as jewelry, money, or other valuable items, etc.) be kept in the Resident's room. In the event of lost personal property, the Facility will conduct an investigation to determine the cause of the loss. Liability for the loss shall be borne by the party found responsible at the conclusion of the investigation. Further, it is the responsibility of the Resident and/or Resident Representative to arrange for disposition of the Resident's property upon discharge or death of the Resident. Property left in the Facility for more than thirty (30) days after discharge will be disposed of at the discretion of the Facility.

IX. SMOKING AND VAPING POLICY

The Facility is committed to maintaining a smoke-free and vape-free environment. The Resident agrees that under no circumstances will he/she and/or his/her visitors smoke or vape anywhere on the grounds or in the buildings of the Facility, nor will he/she maintain or store any smoking or vaping material, electronic nicotine delivery systems or devices, oils, paraphernalia or other flammable, spark, smoke or vape producing device(s) in his/her room at the Facility. The use of spark producing devices is strictly prohibited in all areas of the Facility. The Resident agrees to comply with the Facility's non-smoking and non-vaping policy.

X. FACILITY SECURITY

In order to safeguard the safety and security of our residents and staff, the facility has implemented 24-hour video surveillance of the facility grounds and/or public/common areas in the facility, including the lobby, unit corridors, dining/day rooms and exit areas. The cameras do not record audio. All video recordings remain in the possession of the facility until erased or otherwise destroyed and will only be released in accordance with applicable State and federal laws and regulations. By executing this Agreement, you consent to the video surveillance system.

XI. MEDICAL AID IN DYING (MAID)

The Facility is committed to providing compassionate, resident-centered end-of-life care while respecting the rights of Residents under New York State Public Health Law Article 28-F (Medical Aid in Dying or "MAID"). The Facility has elected not to participate in MAID, including the prescribing, dispensing, ordering or self-administering of medications intended to end a Resident's life based upon sincerely held ethical and moral convictions. If an eligible Resident requests MAID, the Facility shall promptly facilitate transfer to a reasonably accessible health care provider that is willing to evaluate and participate in MAID in accordance with New York State law. The Facility shall provide the receiving provider with relevant medical records upon appropriate request and authorization to ensure continuity of care. This approach is consistent with the New York State Department of Health guidance, which permits facilities to decline participation while requiring prompt transfer assistance and expressly prohibits staff from administering the medication. Facility staff shall not administer, assist in administering, or otherwise participate in the administration of medication prescribed for MAID under any circumstances. The Facility shall continue to provide medically appropriate treatment, comfort care, pain management, palliative care, hospice services, or any other care required by applicable law.

XII. GENERAL PROVISIONS

(a) Governing Law

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

(b) Assignment

This Agreement may not be assigned by either party without the prior written consent of the other party. Notwithstanding the foregoing, this Agreement may be assigned by Facility in connection with the transfer of Facility operations to a new operator. Upon such assignment, Facility is relieved of further duties and obligations under the Agreement.

(c) Binding Effect

Notwithstanding the foregoing, all covenants, conditions, and obligations contained herein shall be binding upon, and shall inure to the benefit of the parties and their respective heirs, executors, administrators, successors and assigns.

(d) Continuation of This Agreement

Temporary transfer of the Resident to another health care facility for medical or surgical treatment, or the Resident's authorized temporary absence from the Facility for any other purpose, where such transfer or absence does not exceed a period of sixty (60) days, shall not terminate this Agreement. Upon the Resident's return and re-admission in accordance with the admission assessment criteria set by the DOH and by the Facility, this Agreement shall continue in full force and effect.

(e) Entire Agreement

This Agreement and addenda, which are incorporated herein, contain the entire understanding between the Resident and/or Resident Representative and the Facility. This Agreement cannot be modified orally, and any changes must be in writing, signed by the parties to this Agreement.

(f) Severability

Any provision in this Agreement determined to be inconsistent with applicable law or to be unenforceable 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.

(g) Waiver

The failure of any party to enforce any term of this Agreement or the waiver by any party of a breach of this Agreement will not prevent the subsequent enforcement of such term, and no party will be deemed to have waived subsequent enforcement.

(h) 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 and facsimile and electronic signatures shall be accepted and deemed to be original signatures and shall be binding on the parties upon signing.

(i) Relationship between Parties

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

(j) 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.

(k) Representations

The Resident and Resident Representative warrant and represent that the information (both written and oral) provided during the admission process is complete and accurate, and acknowledge that the Facility has relied upon such information in entering into this Agreement and admitting the Resident.

(l) Attachments

Attachments “A” and “B”, as cited and referenced in this Admission Agreement, are intended to be informational only; they are not otherwise incorporated into the Admission Agreement, and they confer no legal rights or obligations.

(m) Non-Discrimination

IN ACCORDANCE WITH FEDERAL AND NEW YORK STATE LAW AND REGULATIONS, INCLUDING THE PROVISIONS OF TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, THE AGE DISCRIMINATION ACT OF 1975, AND THE REGULATIONS OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ISSUED PURSUANT TO THE ACTS, TITLE 45 CODE OF FEDERAL REGULATIONS PART 80, 84, AND 91, NO PERSON SHALL, ON THE GROUNDS OF RACE, COLOR, NATIONAL ORIGIN, SEX, AGE, SEXUAL ORIENTATION, GENDER IDENTITY, RELIGION, CREED, DISABILITY, MARITAL STATUS, BLINDNESS, SOURCE OF PAYMENT OR SPONSORSHIP, BE EXCLUDED FROM PARTICIPATION IN, BE DENIED THE BENEFITS OF, OR BE OTHERWISE SUBJECTED TO DISCRIMINATION UNDER ANY PROGRAM OR ACTIVITY PROVIDED BY THE FACILITY, INCLUDING BUT NOT LIMITED TO, THE ADMISSION, CARE, AND RETENTION OF RESIDENTS

THE FACILITY DOES NOT DISCRIMINATE AND DOES NOT PERMIT DISCRIMINATION, INCLUDING, BUT NOT LIMITED TO, BULLYING, ABUSE, HARASSMENT, OR DIFFERENTIAL TREATMENT ON THE BASIS OF ACTUAL OR PERCEIVED SEXUAL ORIENTATION, GENDER IDENTITY OR EXPRESSION, OR HIV STATUS, OR BASED ON ASSOCIATION WITH ANOTHER INDIVIDUAL ON ACCOUNT OF THAT INDIVIDUAL'S ACTUAL OR PERCEIVED SEXUAL ORIENTATION, GENDER IDENTITY OR EXPRESSION, OR HIV STATUS. YOU MAY FILE A COMPLAINT WITH THE OFFICE OF THE NEW YORK STATE LONG-TERM CARE OMBUDSMAN PROGRAM IF YOU BELIEVE THAT YOU HAVE EXPERIENCED THIS KIND OF DISCRIMINATION.

THE REMAINDER OF THIS PAGE IS LEFT BLANK INTENTIONALLY.

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

1. Schedule of Coverage and Fees for Ancillary Services (Attachment A)
2. Medicare and Medicaid Information (Attachment B)
3. Voluntary Arbitration Agreement
4. Statement of Resident's Rights and Responsibilities; Facility Rules and Regulations
5. Contact information for the Resident's Attending Physician (name, address, and telephone number); and information and contact information for filing grievances, including the name, business address, email address, and phone number of the Facility's grievance official; the telephone numbers for the DOH "Hot Line" and the NYS Office of Aging Ombudsman Program; and a list of legal service agencies and community resources providing resident advocacy services.
6. Information about advance directives including: A summary of the Facility's policy and DOH pamphlets: *Deciding about Health Care: A Guide for Patients and Families; Health Care Proxy: Appointing your Health Care Agent in New York; and Do Not Resuscitate Orders - A Guide for Patients and Families.*
7. State-required disclosures: CMS and DOH websites access information, and common/familial ownership of any entity or individual providing services to the facility.
8. Statement regarding the use of the Medicare Minimum Data Set (MDS) and the Privacy Act of 1974.
9. Notice of Privacy Practices for Protected Health Information
10. Veterans Information
11. Addenda:
    - I. Assignment of benefits form (Signature on File form)
    - II. Acknowledgment of receipt of the Notice of Privacy Practices
    - III. Authorization for Release of Information
    - IV. Designation and authorization for external appeal of medical necessity denials
    - V. Authorizations for Medicaid
    - VI. Request for facility to maintain personal fund account

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

ACCEPTED AND AGREED:

_____ _____ _____

Date Signature (or Mark*) of RESIDENT Print Name

*If Mark, signature of two witnesses: _____ _____

_____ _____ _____

Date Signature of RESIDENT REPRESENTATIVE Print Name

WORKMEN'S CIRCLE MULTICARE CENTER

_____ By: _____ _____

Date Print Name and Title

ATTACHMENT "A"

BASIC SERVICES

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

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

** If these items or services are necessary for other than routine treatment, they may not be included in the basic Medicaid and Private Pay room and board rate and may be billable to the Resident, Medicare Part B or other third-party insurance. (see chart below)

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

ADDITIONAL CLINICAL SERVICES

THE FOLLOWING ADDITIONAL 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 Services	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 (4)	Covered	Medicare Fee Schedule
Speech Therapy Maintenance	Covered	Not Covered	Covered	Medicare Fee Schedule
Ophthalmology Services	Varies (5)	Varies (5)	Varies (5)	Billed Direct to Patient
Optometry/Optician Services	Not covered	Not covered	Varies (5)	Provider Bills Patient
Audiology Services	Varies (5)	Varies (5)	Varies (5)	Audiologist Bills Patient
Dental	Not covered	Not Covered	Covered	Included
Pharmaceuticals	Covered	Not Covered	Covered	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 2026 are $217.00 per day for days 21 through 100.

** It is the responsibility of the Resident and/or Representative to verify co-insurance coverage by secondary insurance with the Business Office at _____..

If you are covered by Medicare Part B, for 2026:

- Annual Medicare Part B Deductible is $283.00.
- Co-Insurance payments are 20% of the approved Medicare Part B charge for all Part B covered services.
- Physical and speech therapy benefits (combined) are capped at $2,480.00, and occupational therapy benefits are capped at $2,480.00 per year (including co-insurance).
- Beneficiary may qualify for Therapy Cap Exception Process. However, if your request for additional services (over the cap) 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 to DMERC or Intermediary
(2) Billed by Facility.
(3) Billed direct by Provider or Vendor.
(4) Patient/Resident responsible for co-insurance and deductible.
(5) Coverage depends on services provided.

ADDITIONAL NON-CLINICAL SERVICES

THE FOLLOWING ADDITIONAL NON-CLINICAL SERVICES ARE NOT INCLUDED IN THE DAILY BASIC RATE AND ARE NOT PAID FOR BY MEDICARE AND/OR MEDICAID OR OTHER INSURANCE. IF REQUESTED, THE CHARGES FOR SUCH ITEMS WILL BE THE RESPONSIBILITY OF THE RESIDENT.

- Telephone, including a cellular phone
- Television/radio, personal computer or other electronic devices for personal use
- Personal comfort items, notions and novelties, and confections
- Cosmetic and grooming items and services, in excess of those for which payment is made under Medicaid, Medicare, or other insurance programs
- Beauty shop / barber services
- Personal clothing
- Dry cleaning
- Newspapers and other personal reading matter
- Items/gifts purchased on behalf of a Resident
- Flowers and plants
- Social events, special meals, and entertainment offered off the premises and outside the scope of the activities program provided by the Facility
- Non-covered special care services, such as privately hired nurses, aides, or companions
- Specially prepared or alternative food (other than Kosher food or food required by a therapeutic or modified diet prescribed by a physician)
- Private room (except when therapeutically required, such as for isolation for infection control)

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

ATTACHMENT "B"

SPECIAL RULES REGARDING SELECTED PAYORS

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

MEDICARE PART A PAYMENT

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

Where these five criteria are met, Medicare may provide coverage of up to 100 days of care in a skilled nursing facility (SNF): the first 20 days of covered services are fully paid for; and the next 80 days (days 21 through 100), of the covered services are paid for by Medicare subject to a daily coinsurance amount for which the Resident is responsible. For 2026, the Medicare Part A co-insurance amount is $217.00 per day.

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

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

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

If a Resident meets the eligibility requirements for Skilled Nursing Facility benefits under the Medicare Part A Hospital Insurance Program, Facility will bill Medicare directly for all Part A services provided to the Resident. Medicare will reimburse Facility a fixed *per diem* or daily fee based on the Resident's classification within the Medicare guidelines. These guidelines are a measure of the type of care the Resident requires and the costs to provide that care. Members of our professional staff will evaluate the Residents health condition based on a standardized assessment form (called the MDS 3.0) provided by the Centers for Medicare and Medicaid Services (CMS). Medicare uses the MDS 3.0 information to assign a case-mix classification for the Resident.

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 received a covered level of care in a skilled nursing facility for at least 60 days, returns to the hospital for another three-day stay, and then re-enters the SNF. A SNF may not request private payment until the Resident has received an official initial determination from Medicare that "skilled nursing" benefits are no longer available. While a SNF may make a determination of non-coverage, beneficiaries have a right to request an official Medicare determination of coverage (called a "Demand Bill"), which can be appealed.

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 Facility. Medicare Part B pays for a wide range of additional services beyond Part A coverage. Part B may cover some of a Resident's 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 outpatient and clinical laboratory services. However, Part B benefits have limitations. For example, for 2026, there is an annual $283.00 deductible applicable to Medicare Part B benefits. Additionally, physical therapy (including speech-language pathology services) and occupational therapy are each subject to an annual limitation, which are indexed by the Medicare Economic Index (MEI) each year. For 2026, this indexed amount is $2,480.00 including co-insurance. Beneficiaries may be eligible for the Therapy Cap Exception Process. 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 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.

In addition, Medicare Advantage programs and other alternatives may increase available Medicare benefits. To receive additional information about Medicare and Medicare Advantage programs, call the Social Security Administration at 800-772-1213 or the Centers for Medicare and Medicaid Services at 1-800-MEDICARE.

MEDICARE PART D - PRESCRIPTION DRUG COVERAGE

Individuals eligible for Medicare Part A or enrolled in Medicare Part B and who do not have prescription drug coverage from a privately operated health plan or a Medicare Advantage-PD plan are eligible to enroll in Medicare Part D for prescription drug coverage. Medicare Part D through the selected PDP will provide reimbursement for prescription drugs listed in the PDP's formulary subject to applicable premiums, deductibles and co-payments. Eligible individuals interested in obtaining prescription drug coverage through Medicare Part D must enroll in a PDP approved in the region. Upon admission to a skilled nursing home, individuals enrolled in a PDP in the community are permitted to continue with, or switch to a different PDP in the region.

Dual eligible Medicare/Medicaid beneficiaries are automatically enrolled in and assigned to an approved benchmark prescription drug plan ("PDP") in the region. Medicaid does not pay for prescription drug cost for dual eligible individuals. Dual eligible residents in nursing homes will receive prescription drug coverage through Medicare Part D for the drugs listed on the selected PDP's formulary. As long as dual eligible residents are enrolled in benchmark plans in their region, they will not be responsible for premiums, deductibles and cost sharing obligations.

Please call 800-633-4227 or contact www.medicare.gov/pdphome.asp to obtain enrollment information.

MANAGED CARE

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

PRIVATE INSURANCE

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

MEDICAID

Medicaid is a publicly-funded assistance program that may cover nursing home residents who can demonstrate financial need. To qualify for Medicaid, an individual may have only limited assets (subject to annual increases); For example, in 2026, the individual resource limit is $32,532.00 plus any funds held in an "irrevocable burial trust" arrangement or up to $1,500.00 in a revocable burial account. Generally, most of the Resident's monthly income must be paid to the Facility, except for a $50 monthly "personal needs allowance" and the monthly cost of retaining a private health insurance policy. This monthly income obligation, called the Net Available Monthly Income (NAMI), is determined by the Medicaid agency. If the Resident has a spouse in the community, the spouse may be entitled to a contribution from the Resident's monthly income. During 2026, the "community spouse" is entitled to a minimum monthly income of $4,066.50 and resources in an amount equal to the greater of $74,820.00 or one-half the couple's resources as of the date of institutionalization to a maximum of $162,660.00. These figures are subject to increase each calendar year. Increases beyond these spousal allowances may be secured via a Department of Social Services Fair Hearing or Family Court support proceeding. The Resident's home may be exempt for Medicaid eligibility purposes if the equity value is less than $1,130,000.00 for 2026 or if the spouse or a disabled or minor child resides there. Upon application, Medicaid looks back at financial transactions made within sixty (60) months from the date on which the person was institutionalized and applied for Medicaid coverage. A Resident or spouse who makes a transfer within this "look-back" period may create a period of Medicaid ineligibility. Private-pay Residents should apply for Medicaid about three months before their funds are depleted as Medicaid will only provide coverage, if the Resident is eligible, up to three months prior to the date of application. A Medicaid application must include proof of the Resident's identity, U.S. citizenship or legal alien status, and past and present financial status (see required documentation list at page iv). Medicaid recipients are required to recertify eligibility each year in order to retain benefits. Medicaid is a complex program, and a knowledgeable professional can advise Residents and their families as to their rights under the Medicaid program. To receive information about Medicaid, individuals can call their local Department of Social Services in the county in which the Resident resides.

WORKERS' COMPENSATION

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

NO-FAULT INSURANCE

No-fault insurance coverage must be maintained by all automobile owners in New York State. When a driver or passenger suffers "serious injury" in an automobile accident, regardless of fault, the injured party is entitled to compensation under the 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 90 days during the 180 days immediately following the accident. By statute, the "basic economic loss" recoverable under a no-fault policy is limited to medical expenses and lost earnings up to $50,000. The injured party ordinarily assigns to the nursing home his or her benefits under the no-fault policy. It is advisable to consult with an experienced attorney when pursuing a no-fault claim. For further information, contact your automobile insurance carrier.

VETERANS' BENEFITS

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

VOLUNTARY BINDING ARBITRATION AGREEMENT

The parties (the "Parties") to this binding arbitration agreement (the "Arbitration Agreement") are the "Resident" or "Resident's Designated Representative" (collectively, the "Resident") and Workmen's Circle Multicare Center and its individual owners (collectively, the "Facility").

The Parties believe that it is in their mutual interest to provide for a faster, less costly, and more confidential solution to disputes that may arise between them. Accordingly, the Parties agree as follows:

All disputes and disagreements between the Facility and the Patient/Resident and between the Facility and the Designated Representative (as those Parties are indicated below) (or their respective successors, assigns, agents or representatives) arising out of or relating to the Admission Agreement or its enforcement or interpretation or to the services provided by Facility to the Patient/Resident, including, without limitation, any claim for payment (exceeding the jurisdiction of the small claims court), nonpayment or refund for services rendered to the Resident by the Facility, violations of any right granted to the Resident by statute, common law, or by the Admission Agreement, breach of contract, fraud, deceptive trade practices, misrepresentation, negligence, gross negligence, malpractice, wrongful death, and any other claim, whether sounding in tort, contract, or otherwise shall be submitted to binding arbitration in accordance with the Rules of the American Health Law Association then in effect. The arbitration shall take place in a venue that is convenient to both the Facility and the Resident and/or Designated Representative. In the event the parties cannot select a mutually convenient venue, then venue shall be selected by the arbitrator. The arbitrator shall be neutral and agreed upon by both the Facility and the Resident, and/or Designated Representative and shall have the authority to issue any appropriate relief, including interlocutory and final injunctive relief. If the parties cannot select a mutually agreeable arbitrator, then the parties shall agree to select one (1) arbitrator from NAMS, JAMS, or Resolute and if the parties cannot agree on a single arbitrator, they can be given a list from the company and strike out those arbitrators who are objectionable. If either party declines and/or does not participate in the process of selecting an arbitrator or arbitrators on a timely basis, then the selection(s) by the participating party will stand. The arbitrator's award shall be binding on the Parties and conclusive and may be entered as a judgment in a court of competent jurisdiction, subject to each party's right to submit motions for reconsideration and/or appeal, as authorized by the arbitration group. Each Party shall undertake to keep confidential all awards and orders in the arbitration, as well as all information and materials in the arbitration proceedings not otherwise in the public domain, unless disclosure is required by law or is necessary for the enforcement of a Party's legal rights. While an arbitration proceeding is ongoing, the Facility, Resident and/or Designated Representative shall continue to perform their respective obligations under the Admission Agreement for so long as the Resident resides at the Facility. Notwithstanding anything herein to the contrary, a panel of three (3) arbitrators shall be selected for all claims related to neglect, abuse, malpractice and negligence.

The Parties agree that no arbitration proceeding hereunder shall be certified as a class action or proceed as a class action. The Parties further agree that the arbitrator shall not be permitted to award or consider punitive damages or attorney fees except to the extent permitted by applicable state law, if any.

The Parties agree to split all fees relative to the arbitration process.

The Resident and/or Designated Representative is not prohibited or discouraged from communicating with federal, state, or local officials, including federal or state surveyors, other federal or state health department employees or representatives of the Office of the State Long Term Care Ombudsman.

The arbitrator shall have exclusive authority to resolve any dispute relating to the interpretation, applicability, enforceability, or formation of this Arbitration Agreement, including, but not limited to, any claim that all or any part of this agreement is void or voidable. If any provision of this Arbitration Agreement is determined to be invalid or unenforceable, in whole or in part, the remaining provisions remain in full force and effect.

The Resident and/or Designated Representative have the right to opt out or rescind this agreement to arbitrate by providing written notice of his or her intention to do so to the Facility within thirty (30) calendar days of the execution of the Arbitration Agreement by the Resident and/or the Designated Representative. The Resident and/or Designated Representative do not need to sign this Arbitration Agreement as a condition of admission to, or as a requirement to continue to receive care at the Facility. In the event that the Parties opt for arbitration, the Facility will retain copies of the signed Arbitration Agreement for binding arbitration and the arbitrator's final decision for five years after the resolution of any dispute resolved through arbitration and make the documents available or inspection upon request by CMS or its designee.

This Arbitration Agreement does not constitute a waiver of any immunities provided to the Facility by operation of law, including but not limited to New York Public Health Law Section 3082.

The Resident and/or the Designated Representative reserve the right not to sign this Arbitration Agreement and understand that this Arbitration Agreement is not a requirement as a condition of the Resident's admission to the Facility or for the Resident to continue to receive care at the Facility.

By opting to participate in binding Arbitration, the undersigned acknowledge that he/she/they are waiving the right to a trial by jury or a judge in a court of law, except for small claims court matters.

BY SIGNING BELOW, THE UNDERSIGNED ACCEPT, AGREE, AND ACKNOWLEDGE THEIR UNDERSTANDING OF THIS AGREEMENT TO ARBITRATE AND CONFIRM THAT THIS AGREEMENT TO ARBITRATE WAS EXPLAINED TO THE RESIDENT AND/OR DESIGNATED REPRESENTATIVE IN A FORM AND MANNER THAT HE OR SHE UNDERSTANDS, INCLUDING IN A LANGUAGE THAT HE OR SHE UNDERSTANDS, AND THAT THE RESIDENT AND/ORDESIGNATED REPRESENTATIVE ACKNOWLEDGES THAT HE OR SHE UNDERSTANDS THIS ABITRATION AGREEMENT.

_____ _____ _____
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 Translator Print Name

_____ Initial if Translator Not Needed

WORKMEN'S CIRCLE MULTICARE CENTER

_____ _____ _____
Date Signature of FACILITY'S REPRESENTATIVE Print Name and Title

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EXHIBIT 3

REQUIRED DISCLOSURE PURSUANT TO NEW YORK STATE PUBLIC HEALTH LAW SECTION 2803-X

NOTICE OF COMMON OR FAMILIAL OWNERSHIP TO THE FACILITY

Please be advised that the following entities have common ownership or familial ownership to the Facility and provide services to the Facility:

3155 Management
Lighthouse Indemnity
ALPA Laundry Services, LLC
Cassena Care, LLC
Northview Risk Management, LLC
LI Script, LLC
Theradynamics Rehab. Management, LLC
Healthpro Nursing Solutions, LLC d/b/a Perfect Choice Staffing
Medd Max LLC
Smartlinx Solutions, LLC
Agewell, LLC

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WORKMEN'S CIRCLE MULTICARE CENTER

3155 Grace Avenue
Bronx New York 10469

October 20, 2021

This directive is intended to heighten awareness among residents and their families as to the availability of certain compliance information maintained by the NYS Department of Health (NYSDOH) and the Centers for Medicare and Medicare Services (CMS) with regards to residential health facilities.

Both the NYSDOH and CMS maintain information on nursing homes that includes performance on quality measures, complaints, inspection results, and citations and enforcement actions, as well as any penalties imposed on the nursing home. CMS has created a tool called Care Compare to help consumers search for and select nursing homes and other health care providers and the NYS DOH maintains a web site called Nursing Home Profiles.

According to CMS, the information it maintains on nursing homes should be used with other information you gather about providers and facilities in your area. In addition to reviewing the Care Compare information, you should talk to your doctor, social worker, or other health care providers when choosing a provider. Additional tips for selecting a nursing home can be found in CMS's guide to selecting a nursing home: https://www.medicare.gov/care-compare/en/assets/resources/nursing-home/02174-nursing-home-other-long-term-services.pdf?redirect=true.

The New York State Nursing Home Profiles website maintained by the New York State Department of Health can be accessed below:

- https://profiles.health.ny.gov/nursing_home/#5.79/42.868/-76.809

  On the NYSDOH site, select the nursing home by name after selecting the appropriate Region/County from the dropdown menu, and open the Inspections tab to view any Complaints, Inspection results including any citations, and any enforcement actions against the nursing home.

The Nursing Home Compare website maintained by the U.S. Department of Health and Human Services can be accessed below:

- https://www.medicare.gov/care-compare/?providerType=NursingHome&redirect=true

  On the CMS Care Compare site, enter the name of the nursing home in the search box. Click on the name of the nursing home to view Inspection results as well as any penalties that have been imposed.

AUTHORIZATION TO APPLY FOR MEDICAID ON MY BEHALF

I. Facility and Consumer Information

A. Consumer Information

Consumer Name: _____ Admission Date:_____ SSN: XXX-XX-_____

Date of Birth:_____ Sex: M F Telephone Number:_____

Community Address:_____

_____

B. Facility Information

Facility Name: Workmen's Circle Multicare Center

Facility Contact Person: _____ Position/Title:_____

Address:_____

_____

II. Reason for Submission

_____, hereby authorizes Workmen's Circle Multicare Center and/or its representatives, agents, successors, and assigns, (collectively referred to herein as the "Facility"), to represent, _____ (the "Consumer"), with regard to his/her Medicaid benefits, including but not limited to submitting documentation to, and obtaining documentation and information from, the Department of Social Services and Office of Temporary and Disability Assistance, and appearing at any local conference, New York State Fair Hearing, and/or Article 78 proceeding. I hereby authorize the Department of Social Services and the Office of Temporary and Disability Assistance to recognize this appointment of representative, and provide any documentation and/or information with regard to the Consumer's Medicaid benefits requested by the Facility. By accepting this appointment, the Facility is not obligated to undertake the handling of the Consumer's Medicaid application/appeal and the Facility does not waive any rights otherwise available to them to pursue collection of the cost of the Consumer's nursing home care.

Dated: _____

_____ _____

Consumer or Authorized Representative

Legal Authority, if applicable
(e.g., guardian, power of attorney)

Resident Fund Management Service

AUTHORIZATION AND AGREEMENT TO HANDLE RESIDENT FUNDS

*** * PLEASE TYPE OR PRINT * ***

ACCOUNT NUMBER
2185

DIRECT DEPOSIT NUMBER

Resident Name _____ Taxpayer ID NO. _____
First Last Resident's own Social Security No

Facility Name WORKMEN'S CIRCLE MULTICARE CT Facility Resident ID _____
Optional Data - Max 12 Characters

StatementAddress , _____
Only if different than Facility address.

CHECK ACCOUNT TYPE

1. RESIDENT FUND ACCOUNT
   - ____ NON-TRANSFERRING ACCOUNT (No automatic transfer of deposits to pay for care cost.)
   - ____ TRANSFERRING ACCOUNT (Automatic transfer of care cost payments due the facility.) with $_____ MONTHLY ALLOWANCE AMOUNT.
2. BURIAL ACCOUNT (Deposit only account - monies to be used for burial expenses only.)
   - _____ Revocable (May be closed prior to death.)
   - _____ Irrevocable (To be closed after death or if resident transfers from facility or if transferred to another burial account.)
   - _____ Non-interest bearing burial account (Interest will be paid if this item is NOT checked.)

DIRECT DEPOSIT – Please enroll my indicated recurring benefit payments for direct deposit.

____ Social Security ____ Supplemental Security Income ____ _____
____ Veterans Administration ____ Civil Service ____ _____
____ Railroad Retirement ____ Miners Benefit/Black Lung ____ _____

*** **Note** – Enter the direct deposit information in the RFMS software, or complete the appropriate pension direct deposit form. If you are enrolling for any of the federal government agencies listed above and the resident has a representative payee, the representative payee MUST sign this form.

By my signature below, I hereby authorize the facility named above to establish and manage an FDIC insured interest bearing resident fund or burial account with the options as specified above. I understand, I may have my recurring checks direct deposited to my resident fund account, I may make deposits to and withdrawals from my resident fund account at the facility, and I will receive a statement of any account I have at least quarterly.

In the event that I elect to have a resident fund transferring account, I direct that the amount stipulated by me or required or permitted under federal, state or local law from time to time in effect, be withheld monthly for my personal use and that the remainder be transferred to the facility for the payment of my care costs. I hereby authorize the facility administrator and/or his/her designated staff, to from time to time adjust my personal allowance amount to comply with governing laws as they apply to me.

In the event of my death, I direct that any funds owed or advanced to me by the facility prior to my death are to be paid to the facility with any remaining balance in my resident fund account to become part of my estate.

By signing this form, I under penalties of perjury, certify that (1) the number shown on this form is my correct taxpayer identification number, and (2) I am not subject to backup withholding because (a) I have not been notified that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (b) the Internal Revenue Service (IRS) has notified me that I am no longer subject to backup withholding. [If the signer has been notified by the IRS that he/she is subject to backup withholding, cross out the language in (2) above.]

* * RESIDENT'S ILLEGIBLE SIGNATURE OR MARK (X) REQUIRES TWO WITNESS SIGNATURES * *

Witness_____ RESIDENT * _____
Signature or Mark (X)

Witness _____ Date _____

* ANYONE SIGNING FOR THE RESIDENT MUST SIGN THE CERTIFICATION BELOW

I, the undersigned, certify that I am the legal representative as stated below for the above named resident and agree to all the terms stated above and will provide valid legal supporting documentation of my legal capacity and authority upon the facility's request.

_____ _____
PRINTED NAME OF REPRESENTATIVE SIGNATURE OF LEGAL REPRESENTATIVE

_____ LEGAL TITLE _____
DATE REP PAYEE; GUARDIAN; CONSERVATOR; TRUSTEE; POA

*AP*****

Workmen's Circle
MultiCare Center

Resident: _____

I _____ (the Resident/Guardian/Representative) understand and accept that I/the Resident am/is at risk of developing pressure injuries because of my/their medical condition(s), medical treatment, and/or expected medical treatment.

_____
(Resident/Guardian/Representative initials)

I understand and accept that a pressure injury is not always avoidable despite measures and interventions being utilized to reduce the likelihood of them developing, and nothing any of my/the Resident's health care providers can do, or not do, in their judgment, can guarantee that I/the Resident will remain free from a pressure injury.

_____
(Resident/Guardian/Representative initials)

I, the Resident/Guardian/Representative understand that I/the Resident am/is at risk for a fall and understand that falls cannot always be prevented. I understand that my/the Resident's healthcare providers will implement a care plan to reduce the likelihood of a fall or a serious injury as a result of a fall.

I, the Resident/Guardian/Representative understand that I/the Resident am/is to request assistance to get out of bed or wheelchair, and to ambulate. I understand that if I/the Resident gets up without obtaining assistance that I/they increase the likelihood that I/they will fall and suffer an injury.

_____
(Resident/Guardian/Representative initials)

The above was explained to the Resident and family in detail and I/we understand the explanation. I/we had the opportunity to ask questions, and any questions I/we had were answered to my/our satisfaction.

_____
(Resident/Guardian/Representative initials)

_____ Date: _____
Signature of Resident/Guardian/Representative

_____ Date: _____
Signature of Facility Staff Member

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WORKMEN'S CIRCLE MULTICARE CENTER

HIPAA Authorization Form

Consent for the Use or Disclosure of Health Information For Treatment, Payment or Health Care Operations

I understand that as part of my health care, the Facility and the physician(s) who care for me originate and maintain health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as a basis for planning my care and treatment, to arrange for the billing and payment of my care and to carry out routine health care operations, such as assessing quality.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the Facility reserves the right to change its notice and practices, and that prior to implementation of those changes will mail a copy of the revised notice to me. I have been informed that if I refuse to sign this consent for the use and disclosure of my health information, then the Facility may refuse to admit me or treat me in any manner.

I understand that I have the right to:

- Object to the use of my health information for directory purposes.
- Request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations, and that the Facility is not required to agree to the restrictions requested. If the Facility agrees to any restrictions, then it is bound by those restrictions.
- Revoke this consent in writing, except to the extent that the Facility has already taken action in reliance thereon. I understand that if I revoke my consent, then the Facility will no longer be able to treat me, and that I will need to be discharged from the Facility.

I consent to the use and disclosure by the Facility and its agents or representatives, and the physicians who care for me, of all my health information for treatment, payment and health care operations (as more fully articulated in the Notice of Information Practices).

I have read and understood this consent form. I have had the opportunity to ask questions, and have had all of my questions answered to my full satisfaction.

_____ _____
Signature Date

_____
Print Name

_____ _____ _____
Resident's Name Room # File #

DocuSign Envelope ID: DD8F0F78-03CB-4A90-B0B5-7B83B4EBF934

Workmen's Circle MultiCare Center

Effective Date: November, 2013

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT FORM

I, _____, the Resident, acknowledge and agree that I have received a copy of Workmen's Circle MultiCare Center's Notice of Privacy Practices.

_____ _____
Resident Signature Date

_____ _____
Print Name of Resident's Legal/Designated Representative Relationship to Resident

_____ _____
Signature of Resident's Legal/Designated Representative (If applicable) Date

_____ _____
Witness Date

FOR WORKMEN'S CIRCLE MULTICARE CENTER USE ONLY:

INSTRUCTIONS: *(1) If the Resident has a Legal/Designated Representative with authority to make health care decisions on his/her behalf, then the Notice of Privacy Practices must be given to and an acknowledgment obtained from the Resident's Legal/Designated Representative. If the Resident or the Legal/Designated Representative did not sign above, then proceed to #2 below.*

(2) Identify below the efforts that were made to obtain the Resident or the Legal/Designated Representative's written acknowledgment, including the reason(s) (if known) why the written acknowledgment was not obtained from such individual.

Workmen's Circle MultiCare Center made the following good faith efforts to obtain the above referenced individual's written acknowledgment of receipt of the Notice of Privacy Practices:

_____
_____
_____
_____

_____ _____
Workmen's Circle MultiCare Center Representative Signature Date

ASSIGNMENT OF BENEFITS

PROVIDER INFORMATION		
L.I. SCRIPT, LLC		
333 CROSSWAYS PARK DRIVE		
Phone: (631) 321– 3850	**Fax: (866) 626-7525**	**Email: billing@liscript.com**

Resident Information			
Name:		**Phone No.**	
Address:	**City:**	**State:**	**Zip Code:**
Social Security Number:		**Date of Birth:**	

The Resident, Designated Representative and/or Sponsor understand that the fees for pharmacy services provided by LI Script, LLC may not be covered by or may exceed the Resident's third-party insurance plan benefits. The Resident, Designated Representative and/or Sponsor understand that the Resident, Designated Representative and/or Sponsor is financially responsible to LI Script, LLC for the costs associated with the services it provides that are not covered by a third-party payer. The Resident, Designated Representative and/or Sponsor hereby assigns my benefits payable for these services to LI Script, LLC and authorize payment directly to LI Script, LLC.

The Resident, Designated Representative and/or Sponsor hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medically related facility, pre-payment organization, insurance company, third party administrator, plan sponsor, employer, government agency, investigative or security agency or any other person or organization having any records, knowledge or information about me as it may relate to a claim for such services to release such information to insurance company / third-party payer and to exchange such information with any of the named parties where such exchange is necessary for the proper adjudication and processing of the claim. A photocopy of this signed authorization shall be as valid as the original.

Signature: _____ Date: _____

Print Name: _____ Date: _____

Witness: _____ Date: _____

Notice of Privacy Practice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
Provided in compliance with 45C.F.R. § 164.520

LI Script LLC health information about you for treatment, to obtain payment for treatment, to evaluate the quality of care you receive, and for other administrative and operational purposes. Your health information is contained in a medical record that is the
physical property and responsibility of LI Script LLC.

Your Health Information Rights:
You have the following rights with respect to health information about you.
Right to Copy of Notice of Privacy Practices. You have the right to a paper copy of our Notice of Privacy Practices at any time. To obtain a copy of our current Notice of Privacy Practices, please contact LI Script LLC at the address or phone listed below.
Right to Inspect and Copy. You have the right to inspect and/or obtain a copy of the health information about you that we maintain in certain groups of records that are used to make decisions about your care. Your request must be in writing. If you request a copy of your health information, we will charge you a fee to cover the costs of copying and mailing the information. In certain very limited circumstances, we may deny your request to inspect and copy your health information. If you are denied access to your health information, we will explain our reasons in writing. You have the right to request that another person at LI Script LLC review the decision . We will comply with the outcome of the review. For information about this right, see 45C.F.R. § 164.524.
Right to Amend. If you feel that health information about you that we maintain in certain groups of records is inaccurate or incomplete, you have the right to request that we amend the information. You have the right to request an amendment as long as we maintain the information. Depending on the nature of your request, we may ask that you submit it in writing and include a reason supporting the request. In certain circumstances, we may deny your request to amend your health information. If your request for an amendment is denied, we will explain our reasons in writing. You have the right to submit a statement explaining why you disagree with our decision to deny your amendment request. We will share your statement when we disclose health information about you that we maintain in certain groups of records. For more information about this right, see 45 C.F.R. § 164.526.
Right to an Accounting of Disclosures. You have the right to request an accounting or detailed listing of certain disclosures of your health information. The time period covered by the accounting is limited. Your request must be in writing. If you request an accounting more often than once every twelve (12) months, we may charge you a fee to cover the costs of preparing the accounting. For more information about this right, see 45 C.F.R. § 164.528.
Right to Request Restrictions. You have the right to request a restriction or limitation on the health information about you that we use or disclose. Your request must be in writing. Please be aware that we are not required to agree to your request for restrictions. If we agree to your request for a restriction, we will comply with it unless the information is needed for emergency treatment. For more information about this right, see 45 C.F.R. § 164.522.
Right to Revoke Authorization. You have the right to revoke your authorization to use or disclose health information, except to the extent that action has been taken in reliance upon your authorization. Your request must be in writing.
Right to Request Alternative Method of Contact. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. Your request must be in writing. We will agree to the request to the extent that it is reasonable for us to do so. For example, you may request that we use an alternative address for billing purposes. For more information about this right, see 45 C.F.R. § 164.522(b).
Complaints
If you believe your privacy rights have been violated, you may complain to LI Script LLC and to the Department of Health and Human Services. You may make a complaint to us by contacting LI Script LLC at the address or phone listed below. You will not be retaliated against for filing a complaint.
LI Script LLC's Obligations
LI Script LLC is required to:
- maintain the privacy of protected health information;
- provide you with this Notice of our legal duties and privacy practices with respect to your health information;
- abide by the terms of the Notice of Privacy Practices currently in effect;
- notify you if we are unable to agree to a requested restriction on how your health information is used or disclosed;
- accommodate reasonable requests you may make to communicate health information by alternative means or at alternative locations;
- obtain your written authorization to use or disclose your health information for reasons other than those identified in this Notice and permitted by law; and
- comply with your state's laws if they provide you with greater rights over your health information or provide for more restrictions on the use or disclosure of your health information.

LI Script LLC reserves the right to change the terms of this Notice, our privacy practices, and to make the new provisions effective for all protected health information we maintain. You may contact LI Script LLC at the address or phone listed below to obtain a revised Notice of Privacy Practices.
Uses or Disclosures of Your Health Information
Treatment. We may use and disclose health information about you to provide you with pharmaceutical care or other medical treatment or services. To this end, we may communicate with other health care providers regarding your treatment and coordinate and manage your health care with others. For example, information related to your treatment may be obtained by a health care provider, such as a pharmacist, nurse, respiratory therapist, or other person providing health services to you, and will be recorded in your medical record. This information is necessary for health care providers to determine what treatment you should receive. Health care providers also may record actions taken by them in the course of your treatment and note how you responded to the actions.

Under the Federal HIPAA Privacy Rule, we are required to give you our Notice of Privacy Practices and make a good faith effort, before providing services, to get your:
Acknowledgement of Receipt of Notice of Privacy Practices

_____ _____
Name of Patient (*print*) **Facility of Organization**
By signing this form, I acknowledge that I have been provided with a copy of the Notice of Privacy Practices for LI Script LLC.

_____ _____
Signature (*patient, parent, or legal representative*) Date

_____
Name and Relationship to Patient (*if signed by someone other than patient*)
PLEASE FAX This document to your LI Script LLC products or service provider Immediately

Uses or Disclosures of Your Health Information (cont..)

Payment. We may use and disclose health information about you to others for purposes of receiving payment for treatment and services that you receive. For example, a bill may be sent to you or a third-party payor, such as Medicare, an insurance company, or a health plan. The information on the bill may include information that identifies you, your diagnosis, and treatment or supplies used in the course of your treatment. In some instances, we may disclose health information about you to an insurance plan before you receive certain health care products or services, to determine whether the insurance plan will pay for the particular product or service.

Health Care Operations. We may use and disclose health information about you for administrative and operational purposes. Members of the risk management or quality improvement teams may use health information about you to assess the care and outcomes in your case and others like it. The results will be used internally to continually improve the quality of care for all patients. For example, we may combine medical information about many patients to evaluate the need for new products, services, or treatments. We may disclose information to health care professionals, students, and other personnel for review and training purposes. We also may combine health information we have with other sources to see where we can make improvements. We may remove information that identifies you from this set of health information to protect your privacy and to allow others to use the information to study health care without learning the identity of the specific patients.

We may also use and disclose medical information to:

- evaluate the performance of our staff and your satisfaction with our services;
- learn how to improve our facilities and services;
- determine how to continually improve the quality and effectiveness of the health care we provide; and
- conduct training programs or review competence of health care professionals.

Organized Health Care Arrangement. An organized health care arrangement is a clinically integrated care setting in which individuals typically receive health care from more than one health care provider. We may participate in organized health care arrangements with long-term care facilities, hospice, or other health care facilities in connection with the services we furnish to patients in such settings. Health information may be shared between the participants in the organized health care arrangement for the health care operations of the arrangement.

Individuals Involved in Your Care or Payment for Your Care. We may release health information about you to a family member or friend who is involved in your medical care. We also may give information about you to someone who helps pay for your care. If you do not specifically inform us of individuals who are to be excluded from involvement in your care or payment for your care, we will assume that we have your permission to release health information about you to family and friends as provided above. In addition, we may disclose health information about you to an entity assisting in a disaster relief effort (such as the Red Cross) so that your family can be notified about your condition, status, and location

Business Associates. We provide some services through contracts with business associates, such as accountants, consultants, and attorneys. When such services are contracted, we may disclose health information about you to our business associates so that they can perform the tasks that we have assigned to them. To protect your health information, we require the business associate to appropriately safeguard health information about you.

Appointment Reminders. We may use health information about you to provide appointment or prescription reminders.

Alternative Treatments. We may use health information about you to provide you with information about alternative treatments or other health-related benefits and services that may be of interest to you.

Future Communications. We may communicate with you via newsletters, mailings, or other means regarding treatment options, health-related information, disease-management programs, wellness programs, or other community-based initiatives or activities in which we are participating.

Required by Law. We may use and disclose health information about you as required by federal, state, or local law. For example, we may disclose health information for the following purposes:

- for judicial or administrative proceedings pursuant to legal authority;
- to report information related to victims of abuse, neglect, or domestic violence; and
- to assist law enforcement officials in their law enforcement duties.

***Public Health*:** We may use or disclose health information about you for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability, or for other health oversight activities.

Research. We may use or disclose health information about you for research purposes under certain circumstances. For example, we may disclose health information about you to a research organization if an institutional review board or privacy board has reviewed and approved the research proposal, after establishing protocols to ensure the privacy of your health information.

Health and Safety. We may use or disclose health information about you to avert a serious threat to your health or safety or any other person pursuant to applicable law.

Medical Examiners and Others. We may use or disclose health information about you to medical examiners, coroners, or funeral directors to allow them to perform their lawful duties. If you are an organ or tissue donor, we may use or disclose health information about you to organizations that help with organ, eye, and tissue donation and transplantation.

Food and Drug Administration (FDA). We may use or disclose health information for purposes of notifying the FDA of adverse events with respect to food, supplements, product, and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacements.

Information Not Personally Identifiable. We may use or disclose health information about you in ways that do not personally identify you or reveal who you are.

Government Functions. We may use or disclose health information about you for specialized government functions, such as protection of public officials, national security and intelligence activities, or reporting to various branches of the armed services.

Workers Compensation. We may use or disclose health information about you to comply with laws and regulations related to workers compensation.

Correctional Institutions. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may use or disclosure health information about you. Such information will be disclosed to the correctional institution or law enforcement official when necessary for the institution to provide you with health care and to protect the health and safety of others.

Affiliated Covered Entity. We are part of an affiliated covered entity with other entities that are under common ownership or control. The affiliated covered entity treats itself as a single entity for purposes of using and disclosing health information about you.

Contact Information

If you have any questions, requests, or concerns about your LI Script LLC.-related health information rights or our use and disclosure of health information, please contact: LI Script LLC., 333 Crossways Park Drive, Woodbury, NY 11797
Phone: 631-321-3850

Inability to Obtain Acknowledgement: If the patient refuses to sign this form or it is otherwise not possible to obtain an acknowledgement of receipt of the Notice of Privacy Practices, please identify the good faith efforts made to obtain the patient's acknowledgement and the reasons why the acknowledgement was not obtained:

- Patient/representative refused to sign.
- Patient/representative unable to sign Acknowledgement.
- Other (*explain*):

_____

_____ _____

Signature (*person who attempted to obtain acknowledgement*) Date

_____

Patient Name (*print*) Organization

PLEASE FAX : The correct side of this document to your LI Script LLC products or service provider Immediately

333 CROSSWAYS PARK DRIVE ✷ WOODBURY, NY 11797 ✷ Tel: (631) 321-3850 ✷ Fax: (866) 626-7525

RESIDENT/DESIGNATED REPRESENTATIVE AGREEMENT

I,_____ ("Resident"), hereby agree to the following terms:

- If Resident is deemed a "PRIVATE PAY" resident by the facility, then RESIDENT and/or his/her Designated Representative as set forth herein, SHALL BE PERSONALLY RESPONSIBLE TO PAY LI SCRIPT ("Pharmacy") for all pharmacy services rendered, using Resident's own funds.
- Invoices will be sent from the Pharmacy monthly to the Resident and/or the Designated Representative and are DUE AND PAYABLE UPON RECEIPT.
- If Resident has prescription plan coverage, a copy of the card (both sides) must be forwarded to the Pharmacy immediately. If no card is provided within **14 days of Resident's admission**, Resident or Designated Representative must pay the Pharmacy in full and seek reimbursement directly from Resident's insurance provider.
- If a Resident becomes eligible for Medicaid, Resident shall be responsible to pay the Pharmacy with Resident's own funds for all medications dispensed prior to the eligibility date.
- If a Resident leaves the facility, Resident or Designated Representative, as applicable, shall be responsible for any amounts owed to the Pharmacy due to its provision of medications and services to Resident while at the facility.
- If at any time there is a CHANGE OF Designated Representative (or any change in Designated Representative's contact information), Resident and/or the Designated Representative shall CONTACT THE PHARMACY IMMEDIATELY with any new information regarding the Designated Representative r, so that a new agreement can be signed.
- Resident or his/her Designated Representative shall be responsible for all co-pays and non formulary charges for medications provided by the Pharmacy under Medicare Part D prescription drug plans and private insurance plans.
- This Agreement may be immediately enforced by the Pharmacy upon any failure by Resident to pay any sums due to the Pharmacy.

Please provide all requested information, and fax (or mail) this Agreement to our Billing Department at (866) 626-7525.

DESIGNATED REPRESENTATIVE: By signing as the Designated Representative for the Resident, the undersigned hereby represents that he/she has access and/or control of the Resident's income and resources. As such, the Designated Representative is responsible for providing payment from the Resident's income and resources to the extent he/she has access to same without the Designated Representative incurring personal financial liability. By signing this Agreement, the Designated Representative guarantees a continuity of payment from the Resident's funds to which he/she has access or control and agrees to arrange for third-party payment, if necessary, to pay for the Resident's Pharmacy costs.

Obligations of the Designated Representative

1. Without incurring the obligation to pay for the cost of the Resident's pharmacy costs from the Designated Representatives own funds, the Designated Representative personally agrees to use his/her access to the Resident's income, assets and resources to aid the Resident in paying for the Resident's pharmacy costs.
2. The Designated Representative personally agrees to use his/her access to the Resident's income, assets or resources to ensure continued satisfaction of the Resident's payment obligations to the Pharmacy and agrees not to use the Resident's income, assets or resources in such a way as to place the Pharmacy in a position where it cannot receive payment from either the Resident's funds or a third party payor.

I, _____/_____ READ AND AGREE TO THE ABOVE TERMS AS OF _____

Resident/Designated Representative Date

Resident Signature: _____

Designated Representative Signature: _____Relationship to Resident: _____

Designated Representative's Address: _____

E-mail Address: _____

Home/Work #: _____ Cell Phone #: _____

333 CROSSWAYS PARK DRIVE ✷ WOODBURY, NY 11797 ✷ Tel: (631) 321-3850 ✷ Fax: (866) 626-7525

The documents accompanying this transmission contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation and is required to destroy the information after its stated need has been fulfilled. In addition, the facility noted above is hereby given permission to have and retain a copy of this document in their files. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.

Dear _____ Resident, Designated Representative and/or Sponsor,

Welcome to_____ LI Script, LLC will be the pharmacy providing medications during your stay at _____. We are here to service you and make sure that you get the best possible care. LI Script, LLC will be sending a separate bill from the pharmacy every month with the copayments for your medication prescriptions. The copayments are the indicated amount provided by the prescription insurance company that are your responsibility.

Credit cards can be accepted over the phone or if making a payment by check, please make checks payable to LI Script, LLC. If you have any further questions or concerns, please feel free to contact us. Our hours of operation are Monday through Friday 8:00 am to 5:00 pm. If we are not available, please leave a message and we will return your call as soon as possible.

Thank you,

Private Billing Department

LI Script, LLC

333 Crossways Park Drive

Woodbury, NY 11797

631-321-3850 (press option 6 then option 2)

DocuSign Envelope ID: DD8F0F78-03CB-4A90-B0B5-7B83B4EBF934

Workmen's Circle Multicare Center

EMERGENCY & DISASTER PREPAREDNESS FORM

In accordance with New York State Law and New York State Department of Health Regulations, Workmen's Circle Multicare Center has developed an Emergency and Disaster Preparedness Plan.

As part of this Plan, the Facility is required to have an updated list of Residents whose families have indicated that they would accept them temporarily in the event of an emergency.

Please check below as applicable:

□ I would be able to accept the Resident temporarily in the event of a disaster or emergency.

□ I would not be able to accept the Resident temporarily in the event of a disaster or emergency.

_____
Signature

_____
Relationship to Resident

_____
Date