NAME: «${resident.first_name}» «${resident.last_name}»

ADMISSION AGREEMENT

Please sign pages:

Thank you

1529 Nye Road
Lyons, New York 14489-9106

Phone (315) 946-5673
Fax (315) 946-5671
website: www.waynecountynursinghome.org

Revised November 2005 & July 2007, August 2010, June 2011, January 2013, February 2016, February 20, 2020, August 3rd, 2021, 7/2022, 3/2023, 1/2024
6/11 ADT-01, ADT-02
P/P&P/Forms 2010/291

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EXHIBITS

ADDENDA

THIS FACILITY DOES NOT DISCRIMINATE IN ADMISSION OR RETENTION OR CARE OF ITS RESIDENTS BECAUSE OF RACE, CREED, COLOR, NATIONAL ORIGIN, SEX, DISABILITY, AGE, SOURCE OF PAYMENT, MARITAL STATUS OR SEXUAL PREFERENCE.

ADMISSION AGREEMENT

Agreement entered on «${census.admission.date}» by Wayne County Nursing Home & Rehab Center
and «${resident.first_name}» «${resident.last_name}» residing at «${resident.address1}» «${resident.city}»
(Resident/Patient)
and _____ residing at _____
(Responsible Party/Spouse or Sponsor)

In consideration of the mutual covenants contained in this Agreement, the Facility admits the Patient/Resident ("the Resident") subject to the following terms and conditions.

1. **THE RESIDENT'S AGENTS**

A. THE "RESPONSIBLE PARTY" is the person chosen by the Resident who agrees to be primarily responsible to assist the Resident meet his/her obligations under this Agreement. Unless the Responsible Party is also the Resident's spouse, the Responsible Party is not obligated to pay for the cost of the Resident's care from his/her own funds.

By signing this Agreement, however, the Responsible Party personally guarantees 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 meet the Resident's cost of care.

To assure the Resident's payment and insurance obligations under this Agreement if the Resident were to lack capability, the Responsible Party must have sufficient access to the Resident's funds and financial information. This access, usually granted through a Durable Power of Attorney, may be limited solely to meeting the payment and insurance obligations under this Agreement and may be limited to take effect in the future only if necessary to fulfill the Resident's obligations under this Agreement.

B. **THE SPOUSE OR "SPONSOR"** is the person, usually the Resident's spouse, responsible in part or in whole to pay for the Resident's cost of care. A Spouse may also serve as the Resident's Responsible Party. The Spouse's personal financial duty may be limited by the amount of his/her assets if the Resident becomes Medicaid-covered.

C. A "FINANCIAL AGENT" is an individual who has access to or control over some or all of the Resident's assets. A Financial Agent who does not sign this Agreement as the Responsible Party or Spouse (herein the "Undersigned" or the "Undersigned Agents") is not primarily responsible to assist the Resident meet the payment and/or insurance obligations under this Agreement.

Because the cooperation of a Financial Agent other than the Undersigned often becomes necessary, the Facility requests other Financial Agents to agree to help meet the Resident's obligations (1) if requested, and (2) to the extent permitted by their access to or control of the Resident's assets and financial information. This agreement is at Addendum VI.

The Resident and the Undersigned Agents confirm that they have provided the Facility a complete list of the Resident's current Financial Agents, and all Powers of Attorney, Guardianship Commissions or other documents authorizing an agent to act for the Resident or to have access to or control of any Resident's assets, *e.g.*, access to or joint ownership of bank accounts, stocks, or social security. They agree to inform the Facility of future appointments or revocations.

D. THE RESIDENT'S DIRECTION TO ALL AGENTS

The Resident, or the Undersigned legal representatives on behalf of the Resident, hereby directs all of the Resident's Agents, including future appointees and the Undersigned, (1) to meet all payment obligations under this Agreement from the Resident's assets and/or from insurance coverage; (2) to cooperate in obtaining Medicaid coverage if needed; and (3) to manage the Resident's assets responsibly so that the Facility is not in a position where it is denied payment for the cost of care from the Resident's funds and from Medicaid.

2. SERVICES PROVIDED BY THE FACILITY

A. SERVICES INCLUDED UNDER THE DAILY BASIC RATE

The services provided for the daily basic rate are listed at Exhibit A.

B. SHORT-TERM SERVICES

Rehab or other short term services are those aimed at enabling the Residents to reach a specific performance goal so that continued recovery can take place at home or at a lower level of care. The duration of such services is determined by the Resident's continued need for and/or continued improvement from them. Where an insurer or health benefit plan ("health plan" or "third party payor") manages the stay and covers only "medically necessary" services, the initial anticipated length of stay is determined by such health plan. This anticipated length of stay in the subacute bed is set forth in the Resident's discharge plan and notice of discharge attached at Addendum VII.

Discontinuance of Short-Term Services. The Resident and the Undersigned have accepted and agreed to the initial discharge notice and the discharge plan at Addendum VII subject to subsequent adjustments as the Resident's needs, choices and post-discharge options are better evaluated. They also agree to cooperate in securing adequate aftercare services, if needed. Upon discontinuance of short-term services, if the Resident is not discharged, he or she agrees to transfer to another room or unit after appropriate notice.

C. PHYSICIAN AND ANCILLARY SERVICES

Physician services, including physician extenders such as nurse practitioners or physician assistants, and the following physician-ordered services (collectively "ancillary services") are available through duly licensed, registered, and/or certified practitioners or entities.

1. Pharmacy Services
2. Physical Therapy
3. Audiology Services
4. Occupational Therapy
5. Speech Therapy
6. Podiatry Services
7. Psychiatric or Psychological Treatment
8. Optometric Services
9. Laboratory Services
10. X-ray Services
11. Special Nurse or Companion on Order of Physician
12. Oxygen Therapy
13. Dental Services
14. Transportation Services

Ancillary Charges. Physician, physician extender and ancillary services are not included in the private pay basic rate. Charges for such services may be billed by the Facility or by the service provider. Current private charges for ancillary services are provided at admission and are available upon request.

Ancillary services are generally covered by Medicaid and Medicare Part A or Part B. Other third party payors who have negotiated a rate with the Facility may cover all or some of these services but may require the use of plan participating physicians and providers.

Participating Providers. To obtain full coverage from "managed" benefit plans beneficiaries must use plan participating physicians and ancillary service providers. The Resident agrees to use plan participating providers unless the Facility is notified to the contrary, and agrees to pay privately for requested non-covered non-participating providers' services.

3. AGREEMENT TO PAY OR TO ARRANGE FOR PAYMENT

By entering this Agreement, the Resident, the Resident's spouse and/or the Undersigned Agents 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 (called the "NAMI" amount). The Undersigned Agents accept the duty to ensure continuity of payment. This includes the duty to arrange for timely Medicaid coverage, if Medicaid coverage becomes necessary.

A. PRIVATE PAY STATUS.

The privately paying Resident agrees to pay the applicable daily basic room rate ("private pay rate") (and pharmacy charge) after any Medicare Part A or other plan coverage has been applied or exhausted, unless and until the Resident is determined to be Medicaid eligible for chronic care. **The private pay rate is owed while a Medicaid application is pending and if the Medicaid application is denied unless other insurance covers the rate. See ¶ E. below.**

Specifically, the Resident agrees to pay, or arrange for payment of, (1) the daily basic rate of the room occupied: $625.00(suite), $430.00 (private room), or $400.00 (semi-private room) or $ N/A, $ N/A [*Short-term bed or unit rates*]; (2) physician and ancillary medical services as set forth above; (3) any applicable deductibles or coinsurance, and (4) individual purchases and "extras" described below. The Resident's currently assigned room rate is $_____. Payment for all services is due by the *[10th]* of each month. Monthly statements include the New York State Gross Receipt Tax at the New York stated mandated rate (6.8%).

(Suite with tax $667.50 Private with tax $459.24 Semi with tax $427.20)

B. ITEMS/SERVICES NOT INCLUDED IN THE BASIC RATE

Certain items and services, such as those below, are not covered by the daily rate or by health plans. They may be paid for directly or charged against the Resident's personal account.

1. Barber/Beauty Parlor
2. Private telephone including installation, maintenance and fees
3. Private TV including installation, maintenance and cable fees
4. Newspapers, sundries
5. Specially prepared catered or alternate meals apart from the regular meal service
6. Dry cleaning
7. Special transportation for personal use and ambulance
8. Personal Clothing and Shoes

The Undersigned agree to assist the Resident obtain needed clothing and requested personal items.

Requests for "Extras". When the Resident requests items that are more expensive than or in excess of items provided under the rate or applicable health plan, the Resident will be charged. Except for the items described above, the Facility will provide notice of the extra charge prior to providing the requested items.

C. PREPAID AMOUNTS AND SECURITY DEPOSITS

If the Resident is not qualified for Medicare Part A, Medicaid, VA or HMO coverage or upon termination of such coverage, the Resident agrees to prepay a security deposit of $_____. After the daily rate for the initial month *[and* _____ *month]* is applied from this prepayment, the balance will be held for amounts owed. Prepaid funds held more than 61 days will be kept in an interest-bearing account. If the Facility uses the security deposit to cover delinquent charges, the Resident agrees to replenish the security deposit to the original amount.

Refund of Deposit. Upon discharge, the deposit will be applied to cover amounts owed. The rest will be refunded promptly to the Resident. If the Resident is deceased, refunds will be paid to the person or probate jurisdiction administering the estate, or by a New York "small estate" affidavit, or as otherwise required by law.

D. ADDITIONAL CHARGES AND RATE INCREASES

No additional charges beyond the daily rate will be assessed except: (1) upon express written orders of the treating physician for specific services and supplies not included in the daily rate; or (2) where a health emergency requires the furnishing of special services or supplies.

The Facility agrees not to increase the daily basic rate except: (1) due to the increased cost of operations and after 30 days' prior written notice to the Resident, the Designated Representative and/or the Undersigned; or (2) upon express written authority of the Resident, the Designated Representative, or the Undersigned.

E. DUTY TO PAY PRIVATE RATE UNTIL MEDICAID COVERED

Except where Medicare or other insurance covers the daily rate, the Resident agrees to pay the private pay rate unless and until Medicaid coverage is obtained. The private rate applies while a Medicaid application is pending and/or if Medicaid coverage is denied. Medicaid can only cover up to three months' care prior to the month the Medicaid application is filed. If Medicaid ultimately covers a retroactive period paid for privately, the Facility will refund or credit any excess over the amount owed by the Resident.

If the Resident's liquid assets are exhausted or unavailable prior to Medicaid coverage, the Resident agrees to pay his/her monthly income as partial payment of the daily basic rate until the Medicaid eligibility is established.

F. THIRD PARTY COVERAGE

The Resident and Undersigned Agents each separately acknowledge the Facility has relied on the financial and insurance information they submitted for admission. Each warrant that the information contains no known material omissions, and is true in all material respects.

The Facility accepts as payment in full rates which it has negotiated with a Resident's health plan and, as applicable, the Medicaid, Medicare, or VA rate plus any deductibles, coinsurance or the Medicaid budgeted income payments.

If the Facility has no agreement with the Resident's indemnity (non-HMO) health insurance plan to accept a negotiated rate, the Resident agrees to pay any portion of or all of the applicable private rate and ancillary charges which the plan does not cover. All health plan benefits are assigned to the Facility.

Assignment of Benefits. The Resident, or the Undersigned Agents on the Resident's behalf, assigns the benefits due to the Resident to the Facility and requests the Facility to claim payment from Medicare or other insurance for covered services or supplies provided by the Facility. The Resident authorizes release of information necessary for the Facility to claim and receive such payments on the Resident's behalf. A separate assignment of benefits will be signed and attached to this Agreement at Addendum I.

Managed Care and Benefit Denials. Residents/patients with coverage for all or part of the Facility's charges by a "managed" health plan understand that although the Facility relies on the plan's verification of eligibility, payment for covered services is not guaranteed. Continued coverage may be subject to specific additional preauthorization requirements, to modification by the plan, and to the plan's determination that recommended services continue to be or are "medically necessary" as well as covered.

The Facility is not responsible for benefit denials or cut-offs by insurers. The Facility will, however, use its best efforts (1) to present information to support the medical necessity of recommended treatment; and (2) to notify the Patient and/or Responsible Party as soon as it is informed that coverage will cease or decrease.

External Appeals. The Facility cannot request an "external" or independent appeal of benefit denials based on lack of medical necessity unless it is appointed a "designee" to file such appeal. The Facility, therefore, requests appointment of the Facility Administrator as designee to request an external appeal of a health plan denial or limitation of coverage because of medical necessity. This appointment can be made at Addendum VIII.

Termination of Coverage. If the Resident remains in the Facility after coverage terminates or after the insurer deems that otherwise-covered services are no longer "medically necessary," the Resident agrees to pay the applicable private rate and charges for requested non-covered services and supplies until Medicaid covers such services.

Cooperation Securing Insurance Benefits. Medicare and Medicaid reimbursement is contingent on having sought payment from all other liable third parties. The Undersigned verify that they have disclosed all sources of third party coverage, and have (i) provided proof of eligibility for coverage or (ii) provided the information and authorization necessary to verify third party coverage.

The Resident, the Responsible Party, and Spouse further agree:

(1) To keep any insurance coverage premiums current and to notify the Facility if required premiums have not been or cannot be made;

(2) To notify the Facility of any denial of benefits or termination of coverage;

(3) To assist with appeals of denials of payment; and

(4) Upon request, to provide the Facility updated insurance information, including

copies of the summary of benefits or policy riders or amendments.

Authorization to Submit Claims For Payment. The Resident or the Undersigned Agents authorize the Facility: (1) to submit claims and receive payment of health plan benefits for services rendered under this Agreement; and (2) to release confidential information required by the insurer for reimbursement to the Facility.

Deductibles and Co-insurance. The Resident agrees to pay any deductibles and/or co-insurance required by Medicare or other health plans, including any budgeted income amounts required under Medicaid.

G. DUTY TO ARRANGE FOR TIMELY MEDICAID APPLICATION

The Resident and the Undersigned agree to monitor the Resident's resources and assure uninterrupted payment to the Facility by making timely and complete application to Medicaid (and/or other payors), if necessary, and to notify the Facility (i) when the Resident's resources are expected to reach the Medicaid resource level, and (ii) when the Medicaid application will be and is filed.

Release of Medicaid Information to the Facility. To facilitate the Medicaid application and annual recertification, the Facility requests access to the Resident's Department of Social Services ("DSS") Medicaid application and recertification file. This authorization is at Addendum III.

Authorization to Act on Resident's Behalf. The Facility requests the authority to file and participate in an appeal of a Medicaid denial if it deems appropriate and if the Resident or Undersigned are unable or unavailable to appeal. Authorization for Facility participation in an appeal is at Addendum IV. The Undersigned agree to cooperate in any such appeal and to provide timely financial and other required documentation.

H. MONTHLY INCOME PAYMENTS UNDER MEDICAID

The Resident understands that, upon Medicaid eligibility, DSS will require most monthly income (the "Net Available Monthly Income" or "NAMI") to be paid to the Facility as part of the Medicaid rate. If DSS sets a NAMI, the Resident agrees (1) to pay the NAMI by the *[10th]* of each month, or to require the monthly income to be sent directly to the Facility (Addendum II); and (2) if the Resident disputes the NAMI amount, to place the disputed portion in an escrow account, and pay the undisputed portion to the Facility by the *[10th]* of each month. The Parties agree that funds held in escrow will be released according to the determination of the entity adjudicating the NAMI dispute.

4. THE PERSONAL AND INDEPENDENT OBLIGATIONS OF THE RESPONSIBLE PARTY AND SPONSOR

In consideration of the fact that the Undersigned Agents cannot otherwise provide adequate nursing care to the Resident and wish to facilitate his/her admission to the Facility, and to the extent of their access to or control over the Residents' assets, the Undersigned *personally and independently* agree to assure continuity of payment for services by delivering payments from such assets and/or by arranging for benefit coverage as described below. Unless the Undersigned Agents are legally obligated to pay for the Resident's care, as a Spouse may be, they are not required to use their personal funds to pay for such care. The Undersigned nevertheless *personally* agree to pay damages resulting from a breach of the following *personal and independent* promises to the Facility.

A. TIMELY PAYMENT FROM RESIDENT'S FUNDS

Private Rate, Deductibles and Coinsurance. If necessary to meet the Resident's payment obligations to the Facility, the Undersigned *personally agree to* pay any deductibles, coinsurance or co-pays and the daily basic rate and pharmacy charge from the Resident's funds to which he/she has access or control (where Medicare Part A or other negotiated rate coverage is not available) until Medicaid covers such charges.

Monthly Income As Partial Payment of Private Rate. To the extent of the Undersigned Agents' access to or control over the Resident's income, if the Resident's resources are depleted or unavailable while a Medicaid application is pending, the Undersigned Agents *personally agree* to pay the Resident's monthly income as partial payment for the private pay rate owed, unless DSS has budgeted such income to the Resident's spouse.

Payment of Medicaid NAMIs. If Medicaid eligibility is established, the Undersigned Agents either (i) *personally agree to* pay the Resident's monthly NAMI or (ii) agree to arrange to have such income deposited directly with the Facility pursuant to Addendum II. If the NAMI amount is disputed, the Undersigned *personally agree* to place the disputed amount in escrow and pay the undisputed amount pursuant to Section 3 above.

B. TRANSFERS OF ASSETS

The Undersigned Agents *personally* agree to use his/her access to the Resident's funds to ensure continuity of payment under this Agreement, and agree not to use the Resident's funds in a manner which places the Facility in a position where it cannot receive payment from either the Resident's funds or from Medicaid. If the Undersigned Agents receive a transfer of assets from the Resident which causes such nonpayment, the Undersigned Agents agree to use such assets or an amount equal to such assets to assure continuity of payment until Medicaid covers such costs.

C. MEDICAID OBLIGATIONS

The Undersigned Agents *personally agree* to cooperate in obtaining timely and continued Medicaid coverage, either with the Facility staff's assistance or independently, as follows:

(1) By timely filing the Resident's Medicaid application to ensure uninterrupted payments to

the Facility and by notifying the Facility of the filing date;

(2) By providing the requested application information and documentation to Medicaid within the specified time frame or by requesting an extension in writing prior to the deadline and notifying DSS that the time frame cannot be met and why; and

(3) By providing annual Medicaid recertification information timely to DSS upon request.

D. TRUTHFULNESS OF INFORMATION PROVIDED

The RESIDENT represents that the financial information they have submitted to the FACILITY is true, accurate and complete in all material aspects and that there are no material omissions and that they understand that the FACILITY will rely on such information submitted.

5. LATE PAYMENTS AND NONPAYMENT

A. LATE CHARGES, COLLECTION COSTS, AND ATTORNEY FEES

A 16% per annum fee or the maximum amount allowed by law, whichever is less, will be assessed on accounts owed by the Resident which are overdue more than 30 days. If non-payment is caused by a breach of this Agreement, the Resident agrees to pay reasonable collection costs and attorney's fees incurred by the Facility.

B. DISCHARGE FOR NONPAYMENT

The Resident may be discharged for nonpayment in breach of this Agreement, including nonpayment of the Medicaid NAMI income. *See* Section 6 below.

C. DAMAGES DUE FROM THE RESPONSIBLE PARTY, FINANCIAL AGENTS OR SPONSOR

The Undersigned Agents agree to use their personal resources if necessary to pay damages to the Facility resulting from a breach of their *personal and independent obligations* to the Facility promised at Section 4 above. Such damages include collection costs and attorney fees.

Damages resulting from a breach of a Financial Agent Agreement (Addendum VI) will also be due hereunder if the Financial Agent (1) refuses to pay amounts due from the Resident's funds upon request when delivery of such funds is feasible and necessary to meet the Resident's obligations; and/or (2) transfers Resident assets which prevents the Facility from receiving payment for services.

6. RETENTION AND DISCHARGE

A. NOTICE TO FACILITY OF NON-EMERGENCY DISCHARGE

If the Resident wishes to leave the Facility for reasons within his/her control, the Resident and/or Undersigned agree to give the Facility [7] calendar days written advance notice. **Privately paying Residents agree to pay one day's basic rate beyond the discharge date if such notice**

is not given.

B. INVOLUNTARY DISCHARGE

Discharge for Nonpayment. The Resident may be discharged for nonpayment upon appropriate prior notice with appeal rights. Nonpayment includes a failure to pay privately after reasonable notice or to have Facility services paid for by Medicare, Medicaid or other third party coverage. Nonpayment for a Medicaid-covered Resident occurs if the budgeted monthly NAMI is not paid and the amount is not in dispute, or funds are actually available or would be available and the Resident, or the Undersigned with access to or control over the NAMI, refuses to pay the NAMI.

Other Bases for Involuntary Discharge. Upon appropriate prior notice, the Facility also may transfer or discharge the Resident involuntarily:

(1) when the interdisciplinary care team, in consultation with the Resident or the Resident's Designated Representative determines that the transfer or discharge is necessary for the Resident's welfare and the Resident's needs cannot be met after reasonable attempts at accommodation in the facility;
(2) because the Resident's health has improved and he/she no longer needs nursing facility services;
(3) if the health or safety of individuals in the facility would otherwise be endangered, the risk to others is more than theoretical and all reasonable alternatives to transfer or discharge have been explored and have failed to safely address the problem; or
(4) the Facility closes.

7. CONSENTS

A. ROUTINE SERVICES

Subject to the Resident's right to refuse specific medical treatment, the Resident (or the Undersigned Agents for the Resident) consents to receive routine nursing facility services, routine medical assessments, dental examinations and comprehensive assessments required by Medicare.

B. PHYSICIAN VISITS

A physician and/or a physician extender, if applicable, is authorized to visit the Resident at least once every 30 days for the first 90 days and at least once every 60 days thereafter, and as often as necessary to address the Resident's medical condition. If the Resident's attending, alternate or staff physician is not available as required or as medically necessary, the Facility may arrange for a different physician to visit the Resident.

C. IDENTIFIABLE HEALTH INFORMATION

Subject to specific federal or state law limitations, the Facility may use and disclose the Resident's personally identifiable health, insurance and financial information for treatment,

payment and health care operations, or as permitted or required by law.
Wayne County Nursing Home does not publish a facility directory containing protected health information.
Residents may opt-out of receiving communications related to fundraising and marketing for the nursing home.
If a resident does "opt-out" of fundraising/marketing communications, social workers must be notified.

D. RESIDENT PHOTOGRAPH

The Resident's facial photograph may be taken to use as identification, and photographs of specific injuries or conditions, as medically necessary. These photographs will be kept confidential.

E. ROOM TRANSFERS

Upon request, the Resident who occupies a private room and who does not pay the private room rate agrees to move to a semi-private room unless a private room is medically necessary. **The Resident occupying a Short-term/rehabilitation bed agrees to be transferred to a non-specialized unit or bed after Short-term care terminates.**

8. TEMPORARY ABSENCES AND BED RESERVATIONS

Beds may be reserved privately during temporary absences if the Resident's payments are not overdue upon written agreement to pay the private rate. Medicaid and some health plans pay for bed reservations under some circumstances. Please review the Resident's health plan and the bed reservation policies at Exhibit B.

9. PERSONAL PROPERTY

Facility procedures provide reasonable security for Resident personal property. Locked storage in each room is available upon request. Because of the number of people at the Facility and the diminishing capacity of many residents to safeguard their own property, the Facility can only insure against the loss of valuable items (such as jewelry or money) if they are deposited with the management or placed in locked storage when not in use. Facility reserves the right to pack up personal property in the absence of authorized representative at time of death, discharge, transfer, or room changes. Resident property left more than 30 days after discharge will be disposed of at the Facility's discretion.

10. RESIDENT PERSONAL ACCOUNTS

The Facility offers to provide personal accounts with quarterly statements for incidental expenses. Amounts over $50 or as required by law are deposited in an interest bearing bank account.

Refunds for the balance in the personal account, less amounts owed to the Facility, will be made to the Resident after discharge. Following a Resident's death, refunds will be made to the person or probate jurisdiction administering the Resident's estate or by use of a New York "small estate"

affidavit unless the funds are otherwise properly claimed by DSS to recoup Medicaid payments.

The Resident, and/or the Undersigned Resident Agents, consent to the Facility's withdrawal of amounts owed to the Facility from the personal account prior to return of the balance. [*If this account is in a bank solely in the Resident's name, please sign Addendum V.*]

11. FACILITY RULES

The Resident and the Undersigned agree to abide by the Facility's rules and regulations, and to respect the dignity, personal rights and property of residents, visitors, and staff (located in the Resident Handbook).

12. GENERAL PROVISIONS ABOUT THE AGREEMENT

WHO IS COVERED. In addition to the parties signing this Agreement, the Agreement shall be binding on the heirs, executors, administrators, distributors, successors, and assigns of said parties.

DURATION. This Agreement remains in effect if the Resident is readmitted to the Facility after a hospitalization or temporary absence.

MODIFICATIONS. This Agreement may not be amended or modified except in writing signed by the Facility and the Resident and/or the Undersigned Agents except for: (1) increases in charges according to this Agreement and (2) modifications required by changes in the law, which are deemed to become part of this Agreement.

WAIVER OF RIGHTS. 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 of this Agreement.

SEVERABILITY OF CERTAIN PROVISIONS. If any provision in this Agreement is determined to be illegal or unenforceable, it will be deemed amended to render it legal and enforceable and to give effect to its intent. If any such provision cannot be amended, it shall be deemed deleted without affecting or impairing any other part of this Agreement.

ENTIRE AGREEMENT. This Agreement with its Exhibits and all executed Addenda are incorporated herein and contain the entire agreement between the parties.

GOVERNING LAW AND JURISDICTION. This Agreement is governed by New York State law. Any action arising out of or related to a dispute under this Agreement shall be brought in the State or District court located in Wayne County, New York. The parties agree to such Court's jurisdiction. If the matter is brought in Federal court, the parties agree to the venue of the Western District of New York.

WE THE RESIDENT AND UNDERSIGNED HAVE READ, BEEN ADVISED OF, UNDERSTAND AND AGREE TO BE LEGALLY BOUND BY THE TERMS AND

CONDITIONS OF THIS AGREEMENT. WE ALSO CERTIFY TO RECEIVING THE FOLLOWING.

The Statement of Residents' Rights
Physician's Name, Address And Telephone Number
New York State Department Of Health "Hot Line" Telephone Number
New York State Office Of The Aging Ombudsman Program Telephone
The Facility Policy On Advanced Directives and CPR policy
The Facility Rules And Regulations
Information About Medicaid and Medicare Eligibility
Statement on The Minimum Data Set And The Privacy Act
Organ Donor Gift Of Life Program Information.
The Notice of Privacy Practices

ACCEPTED ON «${census.admission.date}» (DATE)

SIGNATURE (OR MARK) OF RESIDENT/RESPONSIBLE PARTY/ SPOUSE OR SPONSOR	**Tanisha Whitfield** **SIGNATURE FOR FACILITY**

WAYNE COUNTY NURSING HOME AND REHAB CENTER

RE-ENTRY REVIEW OF ADMISSION AGREEMENT

In consideration of the mutual covenants of the Admission Agreement entered into and accepted on _____ the Wayne County Nursing Home re-admits the Patient/Resident ("the Resident") subject to the terms and conditions of the previous Admission Agreement.
We have reviewed the Admission Agreement and accept it. We have reviewed and updated any addendums as needed which are attached to this document. Addendums to the previous Admission Agreement that were not updated remain in effect.

Accepted on: _____

_____
Signature (or Mark) of Resident/Responsible Party/Spouse or Sponsor

_____
Signature for Wayne County Nursing Home and Rehab Center

EXHIBIT A

BASIC SERVICES INCLUDED UNDER THE DAILY RATE

1. Lodging;

2. Board, including therapeutic or modified diets as prescribed by a physician; Kosher food will be provided upon request of the patient who, as a matter of religious belief, wishes to follow Jewish dietary laws;

3. Twenty-four hour per day nursing care;

4. Fresh bed linens;

5. Hospital gowns or pajamas as required by the clinical condition of the Resident, unless the Resident, next of kin and/or sponsor elects to furnish them, and regular non-dry cleaning laundry services for these and other launderable personal clothing items;

6. General household medicine cabinet supplies, including, but not limited to, non-prescription medications, material for routine skin care, oral hygiene, care of hair, and so forth, except for specific items that are medically indicated and needed for exceptional use for a specific resident;

7. Assistance and/or supervision when required with activities of daily living, including, but not limited to, toileting, bathing, feeding and ambulation assistance;

8. Services of members of the Facility staff performing their daily assigned patient care duties;

9. The use of customarily stocked equipment, including, but not limited to, crutches, walkers, wheelchairs, or other supportive equipment, and training in their use when necessary, unless such item is prescribed by a physician for the regular and sole use by a specific resident;

10. The use of all equipment, medical supplies and modalities, notwithstanding the quantity usually used in the everyday care of the Resident including, but not limited to catheters, hypodermic syringes and needles, irrigation outfits, dressings and pads, and so forth;

11. An activities program, including, but not limited to, a planned schedule for recreational, motivational, social and other activities, together with the necessary materials and supplies to make the Resident's life more meaningful;

12. Social services as needed.

EXHIBIT B

BED RESERVATIONS FOR TEMPORARY ABSENCES

PRIVATELY PAYING AND MEDICARE PART A COVERED RESIDENTS.

Upon agreement to pay the private daily rate, private paying residents including those covered by Medicare Part A or another private health plan (or their sponsors and agents) may hold a resident's bed available if the Resident is expected to return to the Facility *and* providing the Resident's accounts are not in arrears. During the Resident's absence, the daily rate under this Agreement is owed unless the Facility is notified to cancel the bed-hold.

BED RESERVATIONS FOR MEDICAID-COVERED RESIDENTS.

Medicaid will pay for a bed reservation only under the following conditions:

- The resident is receiving hospice services from the Facility and is temporarily hospitalized. In this circumstance, Medicaid will pay for a bed hold of up to fourteen (14) days in a twelve (12) month period; or
- The resident is on a therapeutic leave of absence. In this circumstance, Medicaid will pay for a bed hold of up to ten (10) days in a twelve-month period.

If a resident's circumstances do not meet the above conditions but the resident still wishes to reserve the bed, the resident has the option to pay privately.

When a resident with no bed hold wishes to return to the Facility, the Facility will offer the resident "priority readmission", meaning the Resident is entitled to the first available semi-private room.

BED RESERVATION THROUGH THE VETERANS ADMINISTRATION

During hospitalization or leave of absence, the Facility will reserve the bed for the number of days during which the Veterans Administration ("VA") agrees to pay the VA contract charges. If the VA-covered bed-hold expires, the bed may be reserved for the prevailing private daily rate so long as the Resident's payments for care are not in arrears.

ADDENDUM I

ASSIGNMENT OF BENEFITS
TO
WAYNE COUNTY NURSING HOME

RESIDENT: **«${resident.first_name}» «${resident.last_name}»**
INSURANCE ID: «${insurance_second.policy_number}»
MEDICARE NO.: «${resident.medicare_no}»
MEDICAID NO.: «${resident.medicaid_no}»

The Resident, or the Undersigned on the Resident's behalf, assigns the benefits due to the Resident for services rendered by Wayne County Nursing Home and/or Scott Schabel, M.D.; Arif Choudhury, MD; Arun Nagpaul, M.D.

To: Wayne County Nursing Home & Rehab Center

Attn: Administrator.

The Resident or Undersigned also authorizes the Facility to claim payment from Medicare or other insurance for covered services or supplies received during the Resident's stay at the Facility. The Resident consents to the release of information by the Facility, which is necessary to claim and receive such payments on the Resident's behalf.

DATE: «${census.admission.date}»

_____
Resident or Representative

_____
Relationship to Resident

_____
Legal Authorization or Designation

ADDENDUM II

AGREEMENT TO ARRANGE DIRECT PAYMENT OF MONTHLY INCOME TO THE FACILITY

The Resident, and/or the Undersigned on the Resident's behalf, agrees to arrange for direct payment of the Resident's monthly income to the Facility. This monthly income (less any applicable personal allowance deposited in the Resident's personal account) will be applied by the Facility as part of the monthly Medicaid payment, or the full amount will be applied as partial payment of the private pay amounts owed, as applicable.

I hereby agree to have direct payment of the Resident's monthly income checks to Wayne County Nursing Home to apply the amount owed to the Facility with any remainder deposited in the Resident's personal account.

_____ _____

Resident/Sponsor (Spouse)/Responsible Party Date

[Use in the Alternative only if No Direct Payment of Income Is Arranged]

ADDENDUM II-A

AGREEMENT TO CHANGE THE RESIDENT'S ADDRESS

Because the Resident's monthly income is not sent directly to the Facility, to facilitate payment obligations under the Facility Admission Agreement, the Resident and the Undersigned Agents agree to notify payors of monthly income of the Resident's address change and to direct them to send the Resident's monthly income to the Resident at the Facility.

_____ _____

Resident/Sponsor (Spouse)/Responsible Party Date

ADDENDUM III
AUTHORIZATION FOR
RELEASE OF MEDICAID INFORMATION TO FACILITY

I, «${resident.first_name}» «${resident.last_name}», hereby authorize the_____ (Local Department of Social Services) to release information about «${resident.first_name}» «${resident.last_name}» Medicaid case to: the Administrator of Wayne County Nursing Home located at 1529 Nye Road, Lyons, NY 14489. Telephone: (315) 946-5673.

This Medicaid file information to be released is that which enables the Facility to assist the Resident obtain Medicaid eligibility and coverage. It includes all correspondence and income, resource, and eligibility information associated with the Medicaid file, including any information pertinent to a past or pending appeal of a denial of benefits. The Facility administrator, the business office staff and social work and/or admissions department(s) will use released information to facilitate Medicaid coverage.

This authorization will expire after Medicaid determines that the Resident is eligible for coverage of the Facility's nursing facility services, or after the payment obligations for all services provided under this Agreement have been satisfied, whichever is sooner.

I retain the right to revoke this authorization at any time with written notice. I understand that the disclosure made pursuant to this authorization might be re-disclosed to others and that a revocation does not apply to information already disclosed.

«${resident.admission_date}»
Date

_____
Resident Signature

«${resident.admission_date}»
Date

_____
Resident/Responsible Party/Spouse/Financial Agent
Circle Appropriate Agency:
Power of Attorney, Resident's Agent, Designated Representative, Next-of-Kin, Guardian, Other_____

ADDENDUM IV

AUTHORIZATION TO REPRESENT RESIDENT IN THE MEDICAID PROCESS

I authorize the Administrator of Wayne County Nursing Home & Rehab Center or his/her designee to act on behalf of «${resident.first_name}» «${resident.last_name}» (Resident) in his/her Medicaid application, an appeal of denial of benefits, and the recertification process.

The Facility is authorized, but not obligated, to file or to assist the Resident with a Medicaid application, a recertification or an appeal of a denial of Medicaid eligibility on behalf of the Resident if the Resident or his/her representatives are unwilling or unable to take such actions. The Facility will appeal a Medicaid determination on the Resident's behalf only if the Facility deems an appeal necessary and prudent. This authorization for assistance does not relieve the Resident, Responsible Party or other signatories to the Admission Agreement from their obligations to the Facility. All parties also acknowledge that the Facility must have the cooperation of the Undersigned and Financial Agents in procuring necessary financial information, to the extent they are able.

The Facility is authorized to disclose to the appropriate Medicaid agency or adjudicatory tribunal protected health and financial information necessary to take any such actions. The Medicaid agency is authorized to disclose any and all information in its files to the Facility upon the Facility's request pursuant to the attached authorization [use signed Addendum III].

«${resident.admission_date}»
Date

_____
Resident Signature

«${resident.admission_date}»
Date

_____
Resident/Responsible Party/Spouse/Financial Agent
Circle Appropriate Agency:
Power of Attorney, Resident's Agent,
Designated Representative, Next-of-Kin, Guardian
Other_____

Wayne County Nursing Home & Rehab Center
1529 Nye Road
Lyons, NY 14489

ADDENDUM V

ASSIGNMENT OF DEPOSIT BALANCES

Definition of Account

For convenience, the word "Account" means the Resident's personal bank deposit account identified below, together with all present and future accumulated interest on it.

Security Interest and Facility's Rights in Accounts

To protect the above-referenced Facility on any debts and obligations of the Resident owed to the Facility (for convenience, called "Debts"), I, the owner of the Account, assign and give to the Facility a security interest in the Account. If the Resident owes the Facility for Debts under its Admission Agreement, the Facility has a right, only after the death of the Resident, to take the entire Account balance, or any portion thereof and use and apply it to pay the Debts.

No Rights of Others in the Account

I agree that I own the Account and that no one else has any present claim of any kind to the Account.

IN WITNESS WHEREOF, I hereby execute this Assignment of Deposit Balances as of the date appearing below.

_____
(Name of Resident)

Dated: _____, 20__

_____ _____
Signature of Resident or Resident's Agent — Witness

Account #__ _____

Name of Bank _____

Address of Bank _____

Account # _____

Name of Bank _____

Address of Bank _____

ADDENDUM VI

FINANCIAL AGENT'S PERSONAL AGREEMENT

AGREEMENT between Wayne County Nursing Home & Rehab Center, 1529 Nye Road, at Lyons, New York 14489 and «${resident.first_name}» «${resident.last_name}» (the "Agent"), residing at «${resident.address1}»«${resident.city}», for the benefit of and concerning the admission of «${resident.first_name}» «${resident.last_name}» (the "Resident") pursuant to the attached Admission Agreement between the Facility and the Resident and/or the Sponsor and/or the Responsible Party (the "Admission Agreement").

WHEREAS, the Agent understands that he/she is a financial agent for the Resident because the Agent has access to some or all of the Resident's assets; and

WHEREAS, the Agent understands the Resident's obligations to the Facility set forth in the Admission Agreement and acknowledges the Resident's wishes for the Agent's compliance with its terms; and

WHEREAS, the Agent wishes to assist the Resident and to facilitate the Resident's admission to the Facility, and

WHEREAS, the Agent agrees and acknowledges that the Facility will rely on the Agent's agreements contained herein;

NOW, THEREFORE, in consideration of the foregoing and for other and further valuable consideration, the parties hereby agree as follows:

The Agent agrees to provide the following assistance to the Facility in the event such assistance is needed and requested:

A. Without incurring the obligation to pay for the cost of the Resident's care from the Agent's own funds, and in recognition that the Agent is not currently the Responsible Party for the Resident, the Agent personally agrees to use the Agent's access to the Resident's funds to aid the Resident meet his/her obligations under the attached Admission Agreement if such assistance is necessary to enable the Resident to comply with the terms of such Agreement.

B. More specifically, the Agent personally agrees that, to the extent of his/her authority, the Agent will use his/her access to the Resident's assets to ensure continued satisfaction of the Resident's payment obligations to the Facility and agrees not to use the Resident's assets in a manner which places the Facility in a position where it cannot receive payment from either the Resident's funds or from Medicaid.

C. If the Resident becomes Medicaid eligible and if the Agent has access to or control over the Resident's income, the Agent personally agrees to assure that the Facility is paid that portion of the monthly Medicaid rate (the “NAMI” amount) which the Medicaid agency may direct the Resident to pay towards the cost of his/her care.

D. The Agent personally agrees to assist in meeting the insurance obligations under the Admission Agreement if necessary and if requested by providing timely financial information and/or documentation of the Resident's assets to which the Agent has access; and

E. The Agent agrees to pay damages to the Facility caused by a breach of his/her personal obligations set forth in this Agreement.

IN WITNESS WHEREOF, intending to be legally bound, the Agent hereby executes this Agreement for the benefit of the Resident as of the date indicated.

«${census.admission.date}» _____
Date Name of Financial Agent

Type(s) of Agency (e.g. Power of Attorney, Joint Tenant on Real or Personal Property, Guardian, Conservator, Representative Payee on Pension or Social Security).

«${census.admission.date}» Tanisha Whitfield Wayne County Nursing Home
Date By: & Rehab Center
Finance Clerk
[Name and Title]

A copy of the instrument(s) conferring such authority are attached hereto.

ADDENDUM VII

SHORT-TERM DISCHARGE PLAN AND NOTICE OF DISCHARGE

The Patient (also known as the "Resident"), «${resident.first_name}» «${resident.last_name}», is admitted for Short-term care, specifically for _rehabilitation_ [for example, rehabilitation following hip surgery]. The anticipated length of stay as determined by your health plan case manager is approximately ___TBD___ *weeks*. Your tentative discharge date is _____TBD_____.

Discharge will be to: «${resident.address1}» «${resident.city}»

More specific discharge planning which involves the Patient and/or the Patient's family will proceed during the Patient's stay, and a discharge plan for aftercare services will be developed.

This notice is subject to change as the Patient's progress, needs, and choices become better known.

DATED: «${census.admission.date}»

_____

Patient's Name/Representative

ADDENDUM VIII

EXTERNAL APPEAL OF MEDICAL NECESSITY DENIALS DESIGNATION AND AUTHORIZATION

By signing below, you give the Nursing Facility authority to pursue appeals with and to seek payment from your health insurer, health maintenance organization, or other payor ("Health Plan") for services provided to you by the Nursing Facility, and you authorize the release of medical information for those purposes.

I, «${resident.first_name}» «${resident.last_name}», residing at «${resident.address1}» «${resident.city}», appoint Wayne County Nursing Home & Rehab Center, located at 1529 Nye Road, Lyons, NY 14489, by its Administrator to be my designee and authorized representative to act on my behalf and to take all reasonable actions, as determined by the Facility, to pursue payment from my Health Plan and/or to pursue any appeals available to me under my Health Plan's policies or procedures and/or under applicable law, including but not limited to external appeals of coverage denials or limitations based on lack of medical necessity. The Facility will not charge me for pursuing these appeals. In pursuing such payment and/or appeals:

A. I authorize the Facility and my Health Plan to release all relevant medical information, including (if applicable) any HIV-related information, mental health or alcohol/substance abuse treatment information, which is necessary to pursue payment from my Health Plan. I understand that the Facility will release only the information it deems necessary to an external appeal agent, arbitrator, court of law or other independent third party reviewer responsible for deciding if a claim must be paid ("Independent Reviewer"), and that the Independent Reviewer will use this information to make a decision about payment. This authorization for the release of medical information is valid until all coverage issues with my Health Plan are deemed resolved by Facility;

B. I authorize the Facility to complete, to execute, to acknowledge, and to deliver any consent, demand, request, application, agreement, authorization or other documents necessary, including but not limited to, to request an appeal with my Health Plan and/or an external appeal with the New York State Department of Health, Insurance Department, U.S. Department of Labor and/or other applicable agency or body.

If the Facility pursues and wins these appeals, I authorize my Health Plan to pay any monies owed for Facility services directly to the Facility.

This Designation and Authorization may be revoked by me at any time. It shall not otherwise be affected by my subsequent disability, incompetence, or death.

IN WITNESS WHEREOF, I have signed my name this day of «${census.admission.date}»

Resident/Patient or Legal Representative	Tanisha Whitfield **WITNESS**: **ADDRESS: Wayne County Nursing Home & Rehab Center 1529 Nye Road Lyons, NY 14489**

ADDENDUM IX

ANCIILLARY FEE SCHEDULE

This fee schedule is intended to be a helpful pricing guide. It is not to be used as a guide to coverage of services by a Federally funded healthcare program, or similar payer, for any individual client or group of clients. Benefits available to residents may vary depending on the Category of Eligibility or age of the resident. Likewise, some services may be limited in the type of specialty of the provider who can be paid for a service. Some services may require prior authorization; and may be limited in number, scope, or frequency of service coverage.

Category of Service	Procedure Code	Fee	General Description
OOT97165	97165	$96.37	Occupation Therapy Eval low-Level Complex – 30 minutes
OOT97166	97166	$96.37	Occupational Therapy Eval Mod level Complex – 45 minutes
OOT97167	97167	$100.00	Occupational therapy Eval High-level Complex – 60 minutes
OOT97168	97168	$100.00	Occupational Re-Eval Estimated Plan
OPT97161	97161	$99.37	Physical Therapy Eval low-level Complex – 20 minutes
OPT97162	97162	$99.37	Physical Therapy Eval Mod-level Complex – 30 minutes
OPT97163	97163	$99.37	Physical Therapy Eval High-level Complex – 45 minutes
OST92521	92521	$100.00	Evaluation of Speech Fluency
OST92522	92522	$100.00	Evaluation of Speech sound production
OST92523	92523	$100.00	Evaluation of Speech Sound with Language
OST92610	92610	$100.00	Swallow Evaluation
OST92611	92611	$100.00	Evaluation of swallowing
OT92526	92526	$84.39	Treatment of Swallowing dysfunction
OT92610	92610	$69.33	Occupational Swallow Evaluation
OT96125	96125	$104.33	Cognitive performance test
OT97014	97014	$14.58	Electrical Stimulation Supervision
OT97116	97116	$29.56	Gait Training
OT97530	97530	$38.20	Occupational Therapy Therapeutic Activities
OT97535	97535	$32.89	Occupational Therapy Self-Care Management
OT97542	97542	$31.94	Occupational Therapy Wheelchair Management Training
PT97530	97530	$38.20	Physical Therapy Therapeutic Activities
ST92526	92526	$84.39	Speech Therapy Oral Function Therapy
ST92507	92507	$76.33	Speech-Language Pathology Treatment
VAC ADMIN-F	G0008	$25.00	Flu Vaccination Administration
VAC ADMIN-P	G0009	$25.00	Pneumovac Vaccination Administration
Ultra Mobile Imaging	Services from this provider are billed based on the resident's payer type from the Service Provider		
RRH Laboratory	Services from this provider are billed based on the resident's payer type from the Service Provider		

TRANSPORTATION FEE SCHEDULE

CATEGORY FO SERVICE	PROCEDURE CODE	MODIFIER	FEE	GENERAL DESCRIPTION
Van/Bus	A0170	-	$	Transportation, Ancillary: Parking fees, Tolls, or similar
Van/Bus	S0215	-	$2.39	Non-Emergency Transportation; Mileage: per mile
Caseworker, Caregiver	A0160		$0.40	Case Worker Transportation: Mileage: per mile ***limited circumstances: As defined by the Medicaid or Medicare Fee schedule

Notice: While every attempt has been made to ensure the fee schedule is accurate, in the event of an error or subsequent change of a fee, the pricing policy of the Medicaid and Medicare Programs will prevail rather than this fee schedule.

TO BE SIGNED BY A FACILITY REPRESENTATIVE AT A LATER TIME WHEN THIS AUTHORIZATION AND APPOINTMENT IS TO BE USED

AFFIDAVIT THAT APPOINTMENT AND AUTHORIZATION IS IN FULL FORCE
(Sign before a notary public)

STATE OF NEW YORK)
) ss.:
COUNTY OF WAYNE)

_____ being duly sworn, deposes and says:

1. The Principal within did, in writing, appoint Wayne County Nursing Home as the Principal's true and lawful Designee to pursue Health Plan payment in the within Authorization.

2. The Facility has no actual knowledge or actual notice of revocation or termination of the Authorization and Appointment, or knowledge of any facts indicating the same, the Facility further represents that the Principal has not revoked or repudiated the Appointment and the Appointment and Authorization still are in full force and effect.

3. The Facility Administrator makes this Affidavit for the purpose of inducing _____ [fill in name of the Health Plan or other person or entity] to accept delivery of the following Instrument(s), as executed by the Facility Administrator in his/her capacity as the Designee to appeal a denial or limitation of benefits based on medical necessity, with full knowledge that this Affidavit will be relied upon in accepting the execution and delivery of the Instrument(s) and in paying good and valuable consideration therefore:

Sworn to before me on
this day of , 20__

_____
NOTARY PUBLIC

By: _____
Name:
Title: ADMINISTRATOR
DESIGNEE