ARNOT HEALTH SKILLED NURSING AGREEMENT

ARNOT HEALTH SKILLED NURSING FACILITIES DO NOT DISCRIMINATE ON THE BASIS OF RACE, CREED, COLOR, BLINDNESS, NATIONAL ORIGIN, DISABILITY, SEX, AGE, SOURCE OF PAYMENT, MARITAL STATUS, SEXUAL PREFERENCE OR SPONSORSHIP IN ACCORDANCE WITH STATE AND FEDERAL LAWS.

Agreement entered on _____, 20____ by

- ☐ **IRA DAVENPORT MEMORIAL HOSPITAL - FRED AND HARRIETT TAYLOR HEALTH CENTER located at 7571 State Route 54, Bath, NY 14810 ("FACILITY")**
- ☐ **ST. JOSEPH'S SKILLED NURSING FACILITY located at 555 St. Joseph's Blvd., Elmira, NY 14901 ("FACILITY")**

and _____ residing at _____
(Resident/Patient)

and _____ residing at _____
(Responsible Party)

and _____ residing at _____
(Resident's 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 financial 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 or to provide a personal financial guaranty of any payment hereunder.

By signing this Agreement, however, the Responsible Party personally guarantees continuity of payment from the Resident's own 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.

B. The Responsible Party may, but need not be, the same person who acts as the **designated representative. (Health Care Agent),** the individual or individuals designated in accordance with 10 NYCRR ' 415.2 to (1) receive any written and oral information required by regulations to be provided to

the resident if such resident lacks the capacity to understand or make use of such information and who also receives any information required to be provided to both the resident and the designated representative; and (2) participate to the extent authorized by State law in decisions and choices regarding the care, treatment and well-being of the resident if such resident lacks the capacity to make such decisions and choices.

C. **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 community spouse rules should the Resident become Medicaid-covered.

D. **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 is not primarily responsible to assist the Resident to meet the payment and/or insurance obligations under this Agreement, but because the cooperation of a Financial Agent other than the Responsible Party or Spouse often becomes necessary, the Facility requests other Financial Agents to agree to help the Resident meet his/her financial obligations hereunder (1) if requested, and (2) only to the extent permitted by their access to or control of the Resident's assets and financial information. The Financial Agent is not obligated to pay for the cost of the Resident's care from his/her own funds or provide a personal financial guaranty of any payment hereunder. The Financial Agent's Agreement is annexed hereto as Addendum IV.

The Resident, Spouse or Sponsor and Responsible Party 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, and have identified, to the best of their ability, any individuals who 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 or additional information if it becomes known.

E. THE RESIDENT'S DIRECTION TO ALL AGENTS

The Resident, or Undersigned legal representative(s) on behalf of the Resident, hereby directs the Responsible Party, Spouse or Sponsor, Financial Agents, and future appointees (collectively "Resident's Agents"), (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. By signing below, the Resident's Agents are accepting this direction and acknowledge that the Facility is relying upon their promise of cooperation in extending an offer of a bed to the Resident.

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. 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 affiliated with the Facility.

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. Physicians, physician extenders, 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 payers 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 or Sponsor, and the Responsible Party, understand and agree to the following Resident payment obligations. The Resident is obligated to pay for, or arrange to have paid for by Medicaid, Medicare or other insurers, all services provided under this Agreement. The Resident agrees to pay any required third-party deductibles, coinsurance or monthly net available monthly income budgeted by the Medicaid program (called the "NAMI" or "cost share" amount). By signing below, the Responsible Party accepts the duty to ensure continuity of payment from the resident's funds and resources to meet the Resident's payment obligations. The Spouse agrees to meet the Resident's payment obligations from their own resources as necessary, and each agrees to cooperate in arranging for timely Medicaid coverage for the Resident, 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 charges; see Subsection E., below.**

Specifically, the Resident agrees to pay, or arrange for payment of, (1) the daily basic rate of the room occupied: $_____ (private room); $_____ (semi-private room) (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 $_____.** Charges for the month are billed in advance. Payment for all services is due by the 10th of each month.

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 room telephone including installation, maintenance, and fees – IRA DAVENPORT MEMORIAL HOSPITAL- FRED AND HARRIET TAYLOR HEALTH CENTER ONLY
3. Private room TV including installation, maintenance, and cable fees – IRA DAVENPORT MEMORIAL HOSPITAL-FRED AND HARRIET TAYLOR HEALTH CENTER ONLY
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

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. 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) express written authority of the Resident, the Designated Representative, or the Undersigned.

D. 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. The Facility reserves its right to provide statements for estimated Medicaid cost share or the Resident's Net Available Monthly Income (NAMI) rates while an application is pending, and before it is approved, without waiving its right to demand payment at the private rate for any periods not covered by Medicaid.

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.

E. 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 has no known material omissions and is true in all material respects.

The Facility accepts 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. Separate assignment(s) of benefits will be signed by the Resident or authorized agent as requested by the Facility.

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 V.

Termination of Coverage. If the Resident remains in the Facility after insurance coverage is exhausted or terminates for any reason , the Resident agrees to pay the applicable private rate and charges for requested non-covered services, even if appeal of denial is pending, until such time as an appeal is successful or the Resident establishes Medicaid eligibility for Facility 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 or Sponsor 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 with 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.

F. 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 Medicaid application and recertification file. This authorization is at Addendum I.

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

documentation.

G. MONTHLY INCOME PAYMENTS UNDER MEDICAID

The Resident understands that, upon Medicaid eligibility, the Resident's "Net Available Monthly Income" or "NAMI" must be paid to the Facility as part of the Medicaid rate. 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; 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 final determination of the NAMI obligation.

4. THE PERSONAL AND INDEPENDENT OBLIGATIONS OF THE RESPONSIBLE PARTY, SPOUSE OR 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 Resident's assets, the Undersigned 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 Agents *personally agree* to cooperate in obtaining timely and continued Medicaid coverage, either with the Facility staff's assistance or independently.

5. LATE PAYMENTS AND NONPAYMENT

A. LATE CHARGES, COLLECTION COSTS, AND ATTORNEY FEES

A 2% per month late 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.

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 five (5) days' written advance notice.

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 may also 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 Agent 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.

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 Subacute/rehabilitation bed agrees to be transferred to a non-specialized unit or bed after Subacute care terminates.

8. TEMPORARY ABSENCES AND BED RESERVATIONS

Beds may be reserved privately during temporary absences if the Resident's 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 policy 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. Residents are responsible for protecting their personal property by making use of the locked storage available in each Resident's room. 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 district 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.

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.

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 through final discharge, including readmission after hospitalization or a 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 the New York county where the Facility is located. The parties agree to such Court's jurisdiction. If the matter is brought in Federal court, the parties agree to the venue of the Northern 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 Resident' 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
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 _____ (DATE)

_____
SIGNATURE (OR MARK) OF RESIDENT

_____
SIGNATURE OF SPONSOR (e.g. SPOUSE, GUARDIAN)

_____
SIGNATURE (OR MARK) OF RESPONSIBLE PARTY

_____
SIGNATURE FOR FACILITY

EXHIBIT A
BASIC SERVICES INCLUDED UNDER THE DAILY RATE

1. Lodging; a clean, healthy, sheltered environment, properly outfitted;

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 hours per day of nursing care;

4. Fresh bed linens as necessary, including sufficient quantities of necessary bed linen or appropriate substitutes changed as often as required for incontinent residents; but in no event less than twice per week;

5. Hospital gowns or pajamas as required by the clinical condition of the Resident, unless the Resident, next of kin and/or sponsor elect 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 items are 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, subject to appropriate billing under Medicare Part B for covered items when ordered by a physician;

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 reservation.

If the Resident elects not to reserve the bed, the Resident will have effected a voluntary discharge from the Facility.

BED RESERVATIONS FOR MEDICAID-COVERED RESIDENTS.

Medicaid will pay for a Resident's bed reservation for a temporary hospitalization (hereinafter "hospitalization") or a non-hospitalization therapeutic leave of absence (hereinafter "therapeutic leave") only if:

1. The Facility's vacancy rate on the first day of the Resident's absence is no more than five percent (5%); and

2. The Medicaid covered Resident has resided in the Facility for at least thirty (30) days.

A. Hospitalization Bed Reservation

The Facility will reserve a Resident's bed when the Resident is hospitalized and expected to return to the Facility in fifteen (15) or fewer days. A hospitalization bed reservation will be extended up to five (5) days beyond the fifteen (15) day limit if the extension permits the Resident to return to the Facility within twenty (20) days of his/her admission to the hospital. Unless medically contraindicated, the Facility will reserve the same bed and room the Resident occupied before being hospitalized.

Medicaid will pay for a bed reservation for a maximum of fourteen (14) days in a 12-month period for hospitalization. If a Resident exceeds the number of days for which Medicaid will pay for a bed reservation during a hospitalization, the Resident will not have a bed reservation for the remainder of the hospitalization. However, if the Resident has been a resident of the Facility for 30 days or more, the Resident will be re-admitted to the Facility upon the first availability of an appropriate bed in a semi-private room, provided the Resident continues to need the services of the Facility and that he/she continues to be eligible for Medicaid benefits.

A hospitalization bed reservation will terminate if:

1. On the fourth (4^{th}) day of the Resident's hospitalization, the planned discharge date is more than fifteen (15) days from the day the Resident was admitted; or

2. Between the morning of the fourth (4th) day of hospital care and the sixteenth (16th) day of hospital care, the Resident's planned discharge date is adjusted, and the new discharge date will not permit the Resident to return to the Facility within twenty (20) days of the hospital admission date.

If the Resident elects not to reserve the bed, the Resident will have effected a voluntary discharge from the Facility.

B. Therapeutic Leave Bed Reservation

The Facility will reserve a Resident's bed for a therapeutic leave when the Resident's plan of care provide for a leave of absence. Unless medically contraindicated, the institution will reserve the same bed and room the Resident occupied before the therapeutic leave. If a Resident's bed may not be reserved, then the Facility will give priority to the Resident's readmission, over individuals referred for their first admission.

Medicaid will pay for a bed reservation for a maximum of ten (10) days in a twelve (12) month period for a therapeutic leave if there is appropriate supporting documentation of the therapeutic value of the leave and if the Resident continues to need a skilled level of care. If a Resident exceeds the maximum number of days for which Medicaid will pay for a bed reservation during a therapeutic leave, the Resident will not have a bed reservation for the remainder of the therapeutic leave. However, if the Resident has been a resident of the Facility for 30 days or more, the Resident will be readmitted to the Facility upon the first availability of an appropriate bed in a semi-private room, provided the Resident continues to need the services of the Facility and that he/she continues to be eligible for Medicaid benefits.

A Resident's bed reservation must be terminated while on therapeutic leave if the Facility is informed that the Resident will not return from the therapeutic leave to the Facility.

C. When the Facility's Vacancy Rate Exceeds Five Percent (5%)

If on the first day of the Resident's absence the number of unoccupied beds at the Facility exceeds five percent (5%) of the Facility's total licensed beds, Medicaid will not pay for a bed reservation while the Resident is in the hospital or out of the Facility on therapeutic leave. Therefore, the Resident does not have a bed reservation. However, if the Resident has been a resident of the Facility for 30 days or more, he/she will be re-admitted to the Facility upon the first availability of an appropriate bed in a semi-private room, provided the Resident continues to need the services of the Facility and that he/she continues to be eligible for Medicaid benefits.

D. NAMI Payment

During any period of hospitalization or therapeutic leave from the Facility, the Medicaid eligible Resident remains obligated to pay to the Facility any NAMI amounts due to the Facility under this Agreement.

ADDENDUM I

WAIVER OF CONFIDENTIALITY AND CONSENT TO RELEASE OF FINANCIAL AND OTHER INFORMATION

Name of Resident:_____
Last First Middle
Social Security No.: _____- _____ - _____

PURPOSE: The purpose of this document is to allow □ Ira Davenport Memorial Hospital - Fred and Harriett Taylor Health Center (Facility) □ St. Joseph's Skilled Nursing Facility (Facility) and the County Department of Social Services responsible for the Resident's Medicaid application or its successor Medicaid agency (DSS) to communicate about any application for medical assistance (Medicaid) or other financial benefits made by me or on my behalf (the application). This Waiver and Consent allows representatives of DSS and the Facility to discuss the status of the application or ongoing benefits and permits them to release financial or other information, including protected health information, in their possession. This exchange of information is intended to assist in the timely processing of the application and determination by DSS, to encourage the earliest possible clarification of my responsibility for payment of nursing home services, and to avoid the accumulation of a large nursing home bill. This waiver and consent does not relieve me of my financial obligations to the Facility; it is intended only to facilitate the exchange of information between the Facility and DSS.

THE EXTENT OR NATURE OF THE INFORMATION TO BE DISCLOSED: Any and all information, including financial information and, without limitation, any information governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA,) in the possession of DSS or the Facility which has been provided by me or my representatives, or otherwise acquired by DSS in connection with the application or ongoing benefits.

TO WHOM DISCLOSURE IS MADE: The information as referenced above is to be released to or from the Facility or its legal representatives upon request of the Facility, its agents, or legal representatives, or DSS.

I, the undersigned Resident, or Resident's agent, have read the above and authorize the Department of Social Services, the above-named Facility, their legal representatives, agents, and employees, to disclose the information described above which is in their possession, for the purpose set forth above.

Dated: _____ _____
SIGNATURE OR MARK OF RESIDENT

_____
SIGNATURE OF WITNESS

ADDENDUM II

AUTHORIZATION FOR MEDICAID REPRESENTATION

I authorize the Administrator of □ Ira Davenport Memorial Hospital - Fred and Harriett Taylor Health Center (Facility) □ St. Joseph's Skilled Nursing Facility (Facility) or his/her designee or the Facility's attorneys at Levene Gouldin & Thompson, LLP, to act on behalf of _____ (Resident) in a Medicaid application, fair hearing or appeal of denial of benefits, and to request recertification for Medicaid benefits on behalf of the Resident.

The Facility is authorized, but not obliged, to file or to assist the Resident with a Medicaid application, Fair Hearing, or appeal of a Fair Hearing Decision on behalf of the Resident if the Resident or his/her representatives are unwilling or unable to take such actions. The Facility will request a Fair Hearing or 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 and the Medicaid agency or its successor are authorized to obtain and disclose confidential financial and other information of the Resident, including bank records and protected health information and to provide this information to the appropriate Medicaid agency or adjudicatory tribunal necessary to pursue Medicaid benefits for the Resident.

_____ _____

Date Signature or Mark of Resident

_____ _____

Date Signature or Mark of Responsible Party

_____ _____

Date Signature or Mark of Spouse or Sponsor

ADDENDUM III

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 Net Available Monthly Income (NAMI) payment, or the full amount will be applied as partial payment of the private pay amounts owed, as applicable.

The following is a summary of the Resident's income:

Source	Amount	Current Delivery Address Or Direct Deposit Account
Social Security	_____	_____
Disability	_____	_____
Pension	_____	_____
Investment Income	_____	_____
_____	_____	_____
_____	_____	_____

_____ _____
Resident Date

_____ _____
Sponsor (Spouse) Date

_____ _____
Responsible Party Date

ADDENDUM IV

FINANCIAL AGENT'S AGREEMENT

AGREEMENT between □ Ira Davenport Memorial Hospital - Fred and Harriett Taylor Health Center (Facility) □ St. Joseph's Skilled Nursing Facility (Facility) at _____, New York and _____ (the "Agent"), residing at _____, for the benefit of and concerning the admission of (the "Resident") pursuant to the attached Admission Agreement (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 the Facility is willing to admit Resident for nursing home care and services; 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 and/or the Responsible Party to meet the Resident's 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) from the Resident's funds which the Medicaid agency may direct the Resident to pay towards the cost of his/her care.

D. To the extent it becomes necessary and is requested, the Agent personally agrees to assist in 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.

_____ _____

Date Name of Financial Agent

_____

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

_____ _____ [Facility Name]

Date By:

_____

[Name and Title]

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

ADDENDUM V

EXTERNAL APPEAL OF MEDICAL NECESSITY DENIALS DESIGNATION AND AUTHORIZATION

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

I, _____, (DOB _____), appoint

- ☐ **IRA DAVENPORT MEMORIAL HOSPITAL - FRED AND HARRIETT TAYLOR HEALTH CENTER ("Facility")**
- ☐ **ST. JOSEPH'S SKILLED NURSING FACILITY ("Facility")**

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 _____, 200_,

_____ _____

Resident/Patient or Legal Representative

Witness:
Address: _____

_____

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

STATEMENT OF FACTS THAT APPOINTMENT AND AUTHORIZATION IS IN FULL FORCE
(Sign before a notary public)

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

_____ being duly sworn, deposes and says:

1. The Resident within did, in writing, appoint _____ (the "Facility") as the Resident'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 Authorization still are in full force and effect.

2.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 therefor:

Sworn to before me on
this day of , 20__

_____
NOTARY PUBLIC

By: _____
Name:
Title: ADMINISTRATOR
DESIGNEE