EAST NECK NURSING AND REHABILITATION CENTER

134 Great East Neck Road
West Babylon, New York 11704
(631) 422-4800

ADMISSION AGREEMENT

Agreement effective as of _____, between **EAST NECK NURSING AND REHABILITATION CENTER,** located at 134 Great East Neck Road, West Babylon, New York 11704 (hereinafter "Facility") and _____ (hereinafter referred to as "Resident"), whose residence is located at

_____

and _____(hereinafter "Designated Representative") residing at

_____

and _____ Resident's spouse (hereinafter "Sponsor", if not listed as "Designated Representative") residing at

_____.

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

I. ADMISSION AND CONSENT

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

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

Pharmacy services are available through the Facility. Residents whose care is paid for by Medicare Part A must utilize the pharmacy specified by the Facility. If the Resident is not receiving care and services covered by Medicare Part A, the Resident and/or Designated Representative and/or Sponsor may designate another pharmacy provider through Medicare Part D or at the Resident's expense. Residents who choose coverage under Medicare Part D are encouraged to select a plan that covers as many medications as possible. In all cases, the pharmacy must agree to provide services in accordance with all applicable federal and state statutes and regulations and the requirements of the Facility, including but not limited to 24-hour service and delivery, labeling, unit dose form, and monitoring. The Facility is authorized to use generic name medications except as otherwise ordered, in writing, by the Resident's physician. The Facility's Director of Nursing Services and the Consultant Pharmacist are authorized to destroy any excess or undesired medications in accordance with applicable law.

During the Resident's stay at the Facility, the Facility is authorized to require a standard method of Resident identification, e.g., an identification bracelet or photographic print.

The Resident and/or Designated Representative and/or Sponsor hereby understand and agree that Admission to the Facility is conditioned upon the review and execution of this Agreement and related documents as more fully set forth herein.

II. MUTUAL CONSIDERATION OF PARTIES

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

The Resident and/or Designated Representative and/or Sponsor understand and agree that the Facility's acceptance of the Resident is based on the Resident's and/or Designated Representative's and/or Sponsor's representation that the Resident has resources, insurance coverage and/or is eligible for government benefits (including Medicare and/or Medicaid) to cover the cost of care at the Facility. Furthermore, the Resident and/or Designated Representative and/or Sponsor agree to take all necessary steps to ensure that the Facility and its associated providers receive payment from these and/or other available sources consistent with this Agreement. The Resident and/or Designated Representative and/or Sponsor may be required to file an application for admission, make full and complete disclosure to the Facility of all income (including Social Security, pension and other periodic receipts), assets, insurance coverage and any other resources available to the Resident that could be available to pay for the cost of care and provide a certification regarding the full and complete disclosure of all financial resources, all of which the Facility will rely upon in accepting the Resident for admission. We also require proof of U.S. citizenship.

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

III. ANTICIPATED SERVICES

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

_____ Sub-Acute Care*: [Check one of the following: _____ Medically Complex _____ Rehabilitation]

_____ Long Term Care

_____ Hospice Care

_____ Other _____

*EAST NECK NURSING AND REHABILITATION CENTER defines sub-acute care as goal-oriented, comprehensive, inpatient care designed for an individual who has an acute illness, injury, or exacerbation of a disease process and who intends to be discharged to the community. It is generally rendered at the Facility immediately after, or instead of, acute hospitalization. Sub-acute care lasts for a limited time or until a condition is stabilized or a predetermined treatment course is completed.

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

In the event Resident is admitted for sub-acute services and subsequently, by virtue of his or her health condition, requires long-term care placement, an intra-facility room change or transfer to a more appropriate setting may be necessary. Any such room change shall be carried out in accordance with applicable law and the Facility's policies and procedures.

IV. FINANCIAL ARRANGEMENTS

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

(a) Obligation of Resident and/or Designated Representative and/or Sponsor

The Resident and/or Designated Representative and/or Sponsor shall ensure that the Resident has a continuous payment source and/or shall pay the Facility on a private pay basis, with private insurance, and/or by means of a third party government payor, such as Medicare or Medicaid. A Resident's obligation to guarantee payment is personal and limited to the extent of his/her finances, and, consistent with applicable laws, rules and regulations, to the extent of his/her spouse's income and resources as well. The Designated Representative is responsible for providing payment from the Resident's income and resources to the extent he/she has access to such income and resources without the Designated Representative incurring personal financial liability. By signing this Agreement, however, the Designated Representative personally guarantees a continuity of payment from the Resident's funds to which he/she has access or control and agrees to arrange for third-party payment, if necessary, to meet the Resident's cost of care. Unless the Designated Representative is also the resident's spouse or Sponsor, the Designated Representative is not obligated to pay for the cost of the Resident's care from his/her own funds, except to the extent of his/her breach of this Agreement. A Sponsor, usually the Resident's spouse, as defined pursuant to 10 NYCRR §415.2, is "the agency or the person or persons, other than the resident, responsible in whole or in part for the financial support of the Resident, including the costs of care in the Facility." The Resident, Designated Representative and/or Sponsor agree to provide or arrange for payment for any portion or all of the applicable private pay room and board rate, the ancillary charges incurred for services not covered by third party payors and/or any required deductibles, co-insurance or monthly income budgeted by the Medicaid program (NAMI) and may be responsible to the Facility for the damages arising from his/her breach of this Agreement. Payment to the Facility shall be made on a monthly basis as billed.

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

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

The Resident and Designated Representative and Sponsor each separately warrant that he/she has disclosed to

the Facility the identity of all individuals with legal access to the Resident's income or resources. The Designated Representative and Sponsor, as Financial Agent of the Resident, shall be required to execute the Financial Agent Agreement attached as Exhibit 2.

(b) Anticipated Payor

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

_____Medicare _____Medicaid _____Veteran's Administration Benefits
_____Private Payment _____No Fault Insurance Benefits _____Worker's Compensation Benefits
_____ Managed Care Organization: (Specify Name of Organization**):**_____
_____Other private insurance: (Specify Name of Insurance Company): _____

_____ Other (Please Specify): _____

The Resident and/or the Designated Representative and/or Sponsor agree to provide the Facility with all relevant information and documentation regarding all potential third party payors including, but not limited to, all documentation required under State or Federal Law to verify eligibility for Medicare or Medicaid. The Resident and/or the Designated Representative and/or Sponsor understand that if the anticipated payor does not pay for the full cost of care, then the Resident and/or the Designated Representative and/or Sponsor will be responsible for paying for the cost of such care through the Resident's funds to which he/she has legal access and/or by securing coverage through another third party payor. This provision will be applied consistent with any agreement the Facility may have with a third party payor.

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

(c) Private Payment

If the Resident is paying privately for the cost of his or her care, and part or all of such payment is not covered by a third party payor, the private room rate for room and board is **$680.00 per day** for a semi-private room and **$690.00 per day** for a private room In addition, the Resident will be billed for ancillary services including, but not limited to, urinary care supplies, trach and ostomy supplies, surgical supplies, parenteral and enteral feeding supplies, occupational, speech and physical therapy, physician services, prescription medications, laboratory tests, x-rays and other diagnostic services, ambulance/ambulette services, beauty and barber services, and newspaper delivery and extraordinary rehabilitative devices according to the Facility's and/or the service providers' charge schedules. However, rates of payment to the Facility may differ for individuals with additional sources of payment such as Medicare, Medicaid and third-party insurance. A copy of the Facility charge schedule for ancillary services is attached to this Agreement and included in your admission package. Payment must be made to the Facility upon receipt of the bill by the Resident, Designated Representative and/or Sponsor. The private pay room and board rate and additional services charges are subject to increase upon thirty (30) days written notice to the Resident, Designated Representative and/or Sponsor.

(d) Private Pay Advance Billing Policy

The Facility bills private pay individuals for the private pay room and board charges on a two (2) month advance basis. Bills for ancillary charges are generated in the month following the month the services were rendered. All bills are generated by the end of each month and cover the next month of room and board charges and the

previous month's ancillary charges. All payments are due upon receipt of the bill by the Resident, Designated Representative and/or Sponsor.

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

(e) Late Charges

Interest at the rate of eighteen (18%) percent per annum [1 1/2% per month] will be assessed on all accounts more than thirty (30) days overdue.

(f) Collection Costs, Including Attorney and Court Fees

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

(g) Third Party Private Insurance and Managed Care

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

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

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

Alternate Physician or Professional Provider of Service: The Resident and/or Designated Representative and/or Sponsor agree that if the physician or any other professional provider of service designated by the Resident and/or Designated Representative and/or Sponsor is not available to serve the Resident, fails to serve the Resident, or fails to comply with any applicable provision of federal or state law, the Facility is authorized to obtain the services

of a substitute physician or professional provider of service. Payment for such services will be made in accordance with this Agreement.

The Resident is responsible for timely advising the Facility of what benefits, if any, may be available from his or her private insurance and/or managed care plan. Charges may be assessed above the covered benefit for skilled nursing facility care depending on the insurance coverage, managed care plan and/or written agreement with the Facility. Furthermore, the Resident's coverage may be subject to co-insurance, deductibles and/or co-payments which will be the Resident's responsibility and billed according to the terms for private payment stated above.

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

(h) Medicaid

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

Transfer(s) of the Resident's assets that occurred on or after February 18, 2006 may result in a period of Medicaid ineligibility. The Resident, Designated Representative and/or Sponsor represent that no such transfer(s) have been made that would leave the Resident without a payment source when he or she is otherwise eligible for Medicaid.

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

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

(i) Direct Deposit

All long-term residents and all short-term residents transferred to long-term care may have their Net Available Monthly Income or NAMI (Social Security, pension benefits, etc.) deposited in the Facility's account and/or their "personal income allowance" deposited in their personal account via electronic direct deposit. If you would like the Facility to assist you/the Resident in obtaining direct deposit of these income sources, **please initial all that apply below.** By initialing below you are agreeing to allow the Facility to become representative payee for direct deposit purposes.

_____ I wish to have my/the Resident's **Social Security** Income directly deposited into the Facility's account

as Representative Payee.

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

(Specify Name of Pension benefit organization) _____.

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

(Specify Name of the income source) _____.

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

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

(j) Medicare

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

Medicare will terminate coverage for Medicare beneficiaries receiving physical, occupational and/or speech therapy ("therapy services") if the Resident does not receive therapy for three (3) consecutive days, whether planned or unplanned, for any reason, including illness or refusals, doctor appointments or religious holidays. If such therapy was the basis for Medicare Part A coverage, the Resident, Designated Representative and/or Sponsor would be responsible for the cost of such stay, in accordance with applicable Federal and State laws and regulations, unless another payor source is available.

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

the Resident.

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

MEDICARE PART A BENEFICIARIES
Except for specifically excluded services, nursing home services provided to Medicare Part A beneficiaries are covered under the consolidated billing requirements. Under these requirements, the Facility is responsible for furnishing directly, or arranging for, the services for its residents covered by Medicare Part A. When not directly providing services, the Facility is required to enter into arrangements with outside providers and must exercise professional responsibility and control over the arranged-for services. All services that the Resident requires must be provided by the Facility or an outside provider approved by the Facility. Before obtaining any services outside of the Facility, the Resident must consult the Facility. **While the Resident has the right to choose a health care provider, the Resident understands that by selecting the Facility, the Resident has effectively exercised his/her right of free choice with respect to the entire package of services for which the Facility is responsible under the consolidated billing requirements. The Resident agrees that he/she will not arrange for the provision of ancillary services unless the Resident has obtained prior approval of the Facility.**

V. AUTHORIZATIONS AND ASSIGNMENTS TO THE FACILITY

(a) Authorization to Release Information

By execution of this Agreement, the Resident, Designated Representative and/or Sponsor authorizes the Facility to release to government agencies, insurance carriers or others who could be financially liable for any medical care provided to the Resident, all information needed to secure and substantiate payment for such medical care and to permit representatives thereof to examine and make copies of all records relating to such care. The Facility is authorized to release Resident discharge planning summaries and medical information to any other health care institution or provider to which the Resident is transferred or from which the Resident is receiving care, and as otherwise required or permitted by law, throughout the Resident's stay at the Facility and thereafter if required or permitted by law.

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

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

(c) Authorization to Obtain Records, Statements and Documents

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

(d) Authorization to Represent Resident Regarding Medicaid

By execution of this Agreement, the Facility shall be authorized to have access to the Resident's Medicaid file and to act on behalf of the Resident in connection with any and all matters involving Medicaid, including, but not limited to, applying for and representing the Resident in connection with such application for benefits. If the Resident designates and the Facility so elects then the Facility shall also represent the Resident in an administrative appeal regarding an adverse Medicaid determination up to and including an Administrative Fair Hearing.

(e) Authorization to Take Resident's Photograph

By execution of this Agreement, the Resident, Designated Representative and/or Sponsor authorize the Facility to take and keep a photograph of the Resident for identification purposes. All such photographs shall become part of the Resident's file at the Facility.

(f) Public Relations Release Form

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

(g) Authorization to Search Resident's Room

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

(h) Security Cameras

Security cameras have been installed throughout the Facility; however, they will not routinely be used in areas where there is an expectation of privacy, such as restrooms or patient care areas.

(i) Camera Use Throughout the Facility

Taking pictures and videos of other residents and/or staff may violate their privacy rights and may subject you to legal action, including but not limited to, civil and monetary damages. Accordingly, taking pictures and/or video at the Facility is strictly prohibited without prior administrative authorization.

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

If the Resident leaves the Facility due to hospitalization or a therapeutic leave, the Facility shall NOT be obligated to hold the Resident's bed available until his or her return, unless prior arrangements have been made for a bed hold pursuant to the Facility's "Bed Hold Reservation Policy and Procedure" and pursuant to applicable law. In the absence of a bed hold, the Resident **is not guaranteed readmission unless the resident is eligible for Medicaid and requires the services provided by the Facility. However, the Resident may be placed in any appropriate bed in a semi-private room in the Facility at the time of his or her return from hospitalization or therapeutic leave provided a bed is available and the Resident's admission is appropriate and meets the readmission requirements of the Facility.**

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

(a) **Private Pay Residents** who elect to retain a bed in the Facility during a period of hospitalization or therapeutic leave may do so by notifying the Admission Department and signing a bed hold reservation form with the Admission Department stating their intent to hold, and pay for the bed at the Facility's private pay

rate, and continuing payment at the private pay rate. The bed hold will be in effect until the Facility received written notice of discontinuance by the Resident/Designated Representative or payment if discontinued.

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

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

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

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

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

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

(d) Hold Harmless

During any leave of absence or "out on pass" absence from the Facility, the Resident shall be solely responsible and hereby releases and holds harmless Facility, its partners, shareholders, directors, officers, employees and/or agents from and against any and all responsibility or liability (including attorneys' fees and expenses) relating to the welfare of the Resident, for injury, death or damage to loss of any property, including but not limited to personal property, removed from the Facility by the Resident, Designated Representative, Sponsor family member or friend of the Resident, or any other person or party authorized by the Resident, Designated Representative and/or Sponsor to remove such property.

VII. DISCHARGE, TRANSFER AND INTRA-FACILITY ROOM CHANGES

(a) Involuntary Discharge for Non-Payment

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

(b) Involuntary Discharge for Non-Financial Matters

The Facility may transfer or discharge the Resident if the transfer or discharge is necessary for the Resident's welfare and/or for any other reason permitted by applicable law.

The Resident will be informed of his or her due process rights in the event that the Facility initiates a transfer

or discharge and may appeal the Facility's determination in accordance with applicable regulations.

(c) Voluntary Discharge

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

(d) Intra-Facility Room Change

The Facility makes all resident room assignments. The Facility reserves the right to transfer the Resident to a new room on an as-needed basis, consistent with applicable law. Residents that are admitted as sub-acute residents who subsequently become long term residents will be the subject of an intra-facility transfer to rooms that are better suited for long term residents. By execution of this Agreement the Resident understands and agrees that if he/she, or any third party payor, no longer pays the private rate covering the private room or upon Medicaid coverage, he/she will move to a semi-private room if requested by the Facility unless the provision of a private room is medically necessary. The Facility may also initiate a room change for medical or social reasons consistent with applicable law and the Resident's rights. In the event that a Resident not requiring sub-acute care is placed on the sub-acute unit, it is understood that a room change will be implemented as soon as a room becomes available elsewhere in the Facility.

VIII. RESIDENT'S PERSONAL PROPERTY

The Resident has the option of keeping valuable personal property (such as jewelry, money and clothing) in a locked drawer in his or her room, or to request the Facility to hold such property for safekeeping. The Facility will NOT be liable for the loss of the Resident's property that is kept in the Resident's room. It shall be the sole responsibility of the Resident, the Designated Representative and/or Sponsor to arrange for the disposition of the Resident's property upon discharge. Property left in the Facility for more than thirty (30) days after discharge will be disposed of at the discretion of the Facility.

In the event of an evacuation or transfer due to a disaster, whether natural or otherwise, the Facility will NOT be liable for any damage or loss of the Resident's property.

IX. RESIDENT'S PERSONAL BANK ACCOUNT

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

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

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

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

X. SMOKING AND VAPING POLICY

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

Facility. The use of spark producing devices is strictly prohibited in all areas of the Facility. The Resident agrees to comply with the Facility's non-smoking and non-vaping policy.

XI. REFUNDS

Upon a Resident's discharge, the Facility shall promptly and in not more than thirty (30) days from the date of such discharge, refund any monies held by Facility that are in excess of any payments, monies, or balance due to the Facility for the services rendered to the Resident pursuant to terms of this Agreement.

XII. GENERAL PROVISIONS

(a) Option For Binding Arbitration: The Parties may agree that it is in their mutual interest to provide for a faster, less costly, and more confidential solution to disputes that may arise between them and hereby elect to execute the Binding Arbitration Agreement set forth in the attached Exhibit 1 hereby exercising their option for any and all disputes or controversies between them exceeding the jurisdictional threshold for small claims court to be resolved by final and binding arbitration. It is acknowledged that agreeing to binding arbitration is optional for each party and is not a condition for the Resident's admission to the Facility, or as a requirement to continue to receive care at the Facility.

By opting to participate in binding arbitration as indicated above, the Undersigned acknowledge that he/she/they are waiving the right to a trial by jury or a judge in a court of law, except for small claims court matters or as otherwise set forth above.

(b) Governing Law and Dispute Resolution: This Agreement shall be governed by and construed in accordance with the laws of the State of New York, excluding, however, any provision which would impede the application of the Federal Arbitration Act. In the event the arbitration agreement is held to be void, unenforceable or the parties mutually agree to waive it, the parties agree that litigation arising hereunder shall be submitted to the exclusive jurisdiction of the state courts in the County of Suffolk, State of New York or the United States District Court for the Eastern District of New York, and that each party agrees to personal jurisdiction in such courts and waives any objection which he/she/it may have now or hereafter to the laying of the venue of such action or proceeding and irrevocably submits to the jurisdiction of any such court in any such suit, action or proceeding.

(c) Binding Effect

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

(d) Continuation of This Agreement

Temporary transfer of the Resident to another health care facility for medical or surgical treatment, or the Resident's authorized temporary absence from the Facility for any other purpose shall not terminate this Agreement. Upon the Resident's return and re-admission in accordance with the admission assessment criteria set by the New York State Department of Health and by the Facility, this Agreement shall continue in full force and effect. Should the Resident subsequently be re-admitted within one (1) year of the initial admission, if a new agreement is not executed, then this Agreement will be deemed to remain in full force and affect for such admission(s) subject to the then applicable daily rate.

(e) Entire Agreement

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

(f) Severability

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

(g) Counterparts

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

(h) Relationship between Parties

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

(i) Section Headings

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

(j) Non-Discrimination

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

THE REMAINDER OF THIS PAGE IS LEFT BLANK INTENTIONALLY.

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

1. Arbitration Agreement
2. Schedule of Coverage and Fees for Ancillary Services
3. Medicare and Medicaid Eligibility Information
4. Welcome Booklet & Resident Information Guide; Statement of Resident's Rights and Facility Responsibilities
5. Policies and Procedures for Residents
6. Facility Information Sheet (Attending Physician's name, address and telephone number; Grievance Policy including the New York State Department of Health "Hot Line" telephone number and the New York State Office of Aging Ombudsman Program)
7. Advance Directive Information (Summary of Facility's Policy; Planning in Advance for Your Medical Treatment; Do Not Resuscitate Orders: A Guide for Residents and Families; Appointing Your Health Care Agent: New York State's Health Care Proxy Law)
8. Statement Regarding the Use of the Medicare Minimum Data Set (MDS) and the Privacy Act of 1974
9. Notice of Privacy Practices for Protected Health Information
10. HIPAA Authorization Form
11. Medicare Signature on File Form
12. Advance Bed Hold Reservation Form

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

ACCEPTED AND AGREED:

_____ _____

Date Signature of RESIDENT* Print Name

_____ _____

Date Signature of WITNESS Print Name

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

_____ _____

Date Signature of DESIGNATED REPRESENTATIVE Print Name

_____ _____ _____

Date Signature of Sponsor Print Name

EAST NECK NURSING AND REHABILITATION CENTER

_____ _____

DateSignature of FACILITY'S REPRESENTATIVE Print Name and Title

Medicare Assignment of Benefits Form
Signature on File (SOF)

Date: _____

Name of Resident _____ Date of Admission _____

HICN (Medicare) # _____

I request that payment of authorized Medicare benefits be made on my behalf to EAST NECK NURSING AND REHABILITATION CENTER, for any services furnished to me at that facility. I authorize any holder of medical or other information concerning me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or benefits for related services.

WITNESS: RESIDENT/DESIGNATED REP/SPONSOR

_____ _____

EXHIBIT 1 – VOLUNTARY BINDING ARBITRATION AGREEMENT

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

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

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

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

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

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

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

The Resident, Designated Representative and/or Sponsor have the right to opt out or rescind this agreement to arbitrate by providing written notice of his or her intention to do so to the Facility within thirty (30) calendar days of the execution of the Arbitration Agreement by the Resident and/or the Designated Representative and/or the Sponsor. The Resident, Designated Representative and/or Sponsor do not need to sign this Arbitration Agreement

as a condition of admission to, or as a requirement to continue to receive care at the Facility. In the event that the Parties opt for arbitration, the Facility will retain copies of the signed Arbitration Agreement for binding arbitration and the arbitrator's final decision for five years after the resolution of any dispute resolved through arbitration and make the documents available or inspection upon request by CMS or its designee.

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

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

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

_____ _____ _____
Date Signature of RESIDENT* Print Name

_____ _____ _____
Date Signature of WITNESS Print Name

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

_____ _____ _____
Date Signature of DESIGNATED REPRESENTATIVE Print Name:

_____ _____ _____
Date Signature of SPONSOR Print Name

_____ _____ _____
Date Signature of Translator Print Name

_____ Initial if Translator Not Needed

EAST NECK NURSING AND REHABILITATION CENTER

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

EXHIBIT 2

AGREEMENT TO ASSIST RESIDENT WITH FINANCIAL MATTERS

THIS DOCUMENT CONSTITUTES AN ENFORCEABLE CONTRACT BETWEEN THE RESIDENT'S FINANCIAL AGENT AND THE NURSING HOME. IF THERE IS ANYTHING IN THIS CONTRACT THAT YOU DO NOT UNDERSTAND, CONSULT AN ATTORNEY BEFORE SIGNING.

AGREEMENT made on _____ between EAST NECK NURSING AND REHABILITATION CENTER (hereinafter referred to as the "Facility") and _____ (hereinafter referred to as the "Financial Agent,") residing at _____ _____, concerning the admission of _____ (hereinafter referred to as the "Resident") to the Facility.

1. THE FINANCIAL AGENT.

1.1 A "FINANCIAL AGENT" is the Designated Representative and/or Sponsor of the Resident and is an individual that has legal access to the Resident's income, assets or resources that can be used to pay for the care provided by the Facility. A Resident may have more than one Financial Agent and the Facility is entitled pursuant to federal and state regulations to require each individual with such access to execute this Financial Agent Personal Agreement. An individual that has executed the Resident's Admission Agreement as the Designated Representative and/or Sponsor is also considered a Financial Agent.

1.2 "LEGAL ACCESS" may include, but is not limited to, being designated as the Resident's agent by a Power of Attorney, as a Representative Payee on the Resident's Pension or Social Security benefits, a joint-tenant on real property, a co-owner of personal property, joint account holder, appointment as a Guardian or Conservator.

2. REPRESENTATIONS BY FINANCIAL AGENT.

2.1 The Financial Agent acknowledges that the Resident has applied for admission at, or been admitted to, the Facility, subject to the Resident's obligation under the Admission Agreement to ensure continuity of payment out of the Resident's income, assets and resources.

2.2 The Financial Agent acknowledges that the Resident directs the Financial Agent to comply with the Resident's obligations under the Admission Agreement, including the obligation to safeguard the Resident's income, assets and resources and to use them to pay for the Resident's care at the Facility.

2.3 The Financial Agent wishes to assist the Resident and to facilitate the Resident's admission to, or continued stay at, the Facility.

3. OBLIGATIONS OF THE FINANCIAL AGENT.

In consideration of the Facility's approval of the Resident's application for admission, or its retention of the Resident, and for other and further valuable consideration, the Financial Agent voluntarily agrees to provide the following assistance to the Facility:

3.1 Without incurring the obligation to pay for the cost of the Resident's care from the Financial Agent's own funds, the Financial Agent personally agrees to use his/her access to the Resident's income, assets and resources to aid the Resident in meeting his/her obligations under the terms of the Admission Agreement.

3.2 More specifically, the Financial Agent personally agrees to use his/her access to the Resident's income, assets

or resources to ensure continued satisfaction of the Resident's payment obligations to the Facility and agrees not to use the Resident's income, assets or resources in such a way as to place the Facility in a position where it cannot receive payment from either the Resident's funds or Medicaid.

3.3 If the Resident applies for Medicaid benefits, the Financial Agent personally agrees to use his/her access to the Resident's income to ensure partial payment to the Facility, to the maximum extent possible, while the Medicaid application is pending.

3.4 If the Resident becomes Medicaid eligible, the Financial Agent personally agrees to ensure that the Facility is paid that portion of the monthly Medicaid rate which the Medicaid agency may direct the Resident to pay towards the cost of his/her care.

3.5 The Financial Agent personally agrees to assist in meeting the Resident's obligations under the Admission Agreement, if requested, by providing timely financial information and documentation of the Resident's income, assets, insurance information and documentation, and any documentation required under State or Federal Law (e.g. identification, citizenship or residency documentation when applying for Medicaid) to the extent that the Financial Agent has access to such information or documentation.

3.6 The Financial Agent personally agrees to pay damages to the Facility for any breach of his/her personal obligations as set forth in this Personal Agreement, including reasonable collection costs, including, but not limited to, collection agency fees and/or attorneys' fees, incurred by the Facility in enforcing the terms of this Financial Agent Personal Agreement.

4. MISCELLANEOUS.

This Financial Agent Personal Agreement shall be governed by and construed in accordance with the laws of the State of New York. Any dispute or litigation arising hereunder shall be submitted to the exclusive jurisdiction of the state courts in the County of Suffolk, State of New York or the United States District Court for the Eastern District of New York. Each party agrees to personal jurisdiction in such courts and waives any objection which he/she/it may have now or hereafter to the laying of the venue of such action or proceeding and irrevocably submits to the jurisdiction of any such court in any such suit, action or proceeding.

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

SIGNATURE OF FINANCIAL AGENT	DATE
PRINT NAME	TYPE OF AGENCY (e.g., Attorney-in-Fact (Power of Attorney), Representative Payee on Pension or Social Security checks, Joint Tenant on Real or Personal Property, Guardian, Conservator)
SIGNATURE OF FACILITY REPRESENTATIVE	DATE
PRINT NAME	TITLE

EXHIBIT 3

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

NOTICE OF COMMON OR FAMILIAL OWNERSHIP TO THE FACILITY

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

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

Exhibit 4

EAST NECK
NURSING & REHABILITATION CENTER

134 Great East Neck Road
West Babylon New York 11704

October 20, 2021

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

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

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

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

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

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

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

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

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

ATTACHMENT "A"

BASIC SERVICES

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

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

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

IF YOU HAVE ANY QUESTIONS REGARDING CHARGES AND BILLING, PLEASE FEEL FREE TO CONTACT THE BUSINESS OFFICE AT (631) 422-4800.

ADDITIONAL CLINICAL SERVICES

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

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

If your stay is covered under Medicare Part A:

- Medicare will pay up to 100 days for your stay (assuming eligibility criteria are met and benefits are still available).
- Co-insurance payments for 2024 are $204.00 per day for day 21 to day 100.

***** It is the responsibility of the Resident, Sponsor and/or Designated Representative to verify co-insurance coverage of any secondary insurance by contacting the insurance carrier and notifying the Business Office at (631) 422-4800.***

If you are covered by Medicare Part B, for 2024:

- Annual Medicare Part B Deductible is $240.00.
- Co-Insurance payments are 20% of the approved Medicare Part B charge for all Part B covered services.
- Occupational therapy benefits are capped at a total of $2,330 per year (including co-insurance)
- Physical and speech therapy benefits (combined) are capped at a total of $2,330 per year (including co-insurance).
- Beneficiary may qualify for Therapy Cap Exception Process. However, if your request for additional services above the therapy cap is denied, you will be responsible for 100% of the Medicare Approved Charge once the cap is reached.

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

ADDITIONAL NON-CLINICAL SERVICES

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

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

IF YOU HAVE ANY QUESTIONS REGARDING CHARGES AND BILLING, PLEASE FEEL FREE TO CONTACT THE BUSINESS OFFICE AT (631) 422-4800.

ATTACHMENT "B"

SPECIAL RULES REGARDING SELECTED PAYORS

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

MEDICARE PART A PAYMENT

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

Where these five criteria are met, Medicare may provide coverage of up to 100 days of care in a skilled nursing facility (SNF): the first 20 days of covered services are fully paid for; and the next 80 days (days 21 through 100), of the covered services are paid for by Medicare subject to a daily coinsurance amount for which the Resident is responsible. For 2024, the Medicare Part A co-insurance amount is $204.00 per day.

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

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

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

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

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

MEDICARE PART B PAYMENT

Individuals who pay monthly premiums to enroll in Medicare Part B will be charged according to Facility's or the service providers' stated charge schedule for services they receive at Facility. Medicare Part B pays for a wide range of additional services beyond Part A coverage. Part B may cover some of a Residents care regardless of whether they are eligible for Part A benefits. Part B covers eighty (80%) percent of the Medicare approved charge for a specific service and the individual is responsible for the additional twenty (20%) percent. In general, Part B covers medical services and supplies. Part B covers such services as: physical, occupational and speech therapy, physician services, durable medical equipment, ambulance services and certain out-patient and clinical laboratory services. However, Part B benefits have limitations. For example, for 2024, there is a $240.00 deductible applicable to Medicare Part B benefits. Additionally, physical therapy (including speech-language pathology services) and occupational therapy are each subject to an annual limitation. The therapy financial limitations or "caps" are indexed by the Medicare Economic Index (MEI) each year. For 2024, the indexed amounts for physical therapy (including speech-language pathology services) and occupational therapy are $2330.00 each, including co-insurance. Beneficiaries may be eligible for the Therapy Cap Exception Process. Both therapy limitations are still subject to the 80% - 20% coverage limitation in that the individual will be responsible for the 20 % co-insurance payments. **The Resident is responsible for private payment of all therapy charges and any other ancillary charges above the Medicare Part B coverage limitations.** The Facility can bill and receive payment if the Resident fills out a Medicare assignment of benefits form. If the Resident completes an assignment of benefits form, a health care provider cannot charge the Resident above the Medicare approved charge. In order to determine the Resident's Part B coverage you should contact the Social Security Administration.

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

MEDICARE PART D - PRESCRIPTION DRUG COVERAGE

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

Dual eligible Medicare/Medicaid beneficiaries are automatically enrolled in, and assigned to an approved benchmark prescription drug plan ("PDP") in the region. As of January 1, 2006, Medicaid no longer pays for prescription drug cost for dual eligibles. Dual eligibles in nursing homes will receive prescription drug coverage through Medicare Part D for the drugs listed on the selected PDP's formulary. As long as dual eligibles are enrolled in benchmark plans in their region, they will not be responsible for premiums, deductibles and cost sharing obligations.

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

MANAGED CARE

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

PRIVATE INSURANCE

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

MEDICAID

Medicaid is a publicly-funded program of assistance that covers nursing home Residents who can demonstrate financial need. To qualify for Medicaid, an individual may have only limited assets. For example, in 2024, the individual resource limit is $30,182 (subject to annual increases); plus any funds held in an "irrevocable burial trust" arrangement or up to $1,500 under a revocable burial account. Generally, most of the Resident's monthly income must be paid to the Facility, except for a $50 monthly "personal needs allowance" and the monthly cost of retaining a private health insurance policy. This monthly income obligation, called the NAMI (Net Available Monthly Income), is determined by the Medicaid agency. If the Resident has a spouse in the community, the spouse might be entitled to a contribution from the Resident's monthly income. During 2024, the "community spouse" is entitled to a minimum monthly income of $3853.50 and resources up to a maximum of $154,140 (these figures are subject to increase each calendar year); increases beyond these amounts are possible, but a Department of Social Services Fair Hearing or Family Court support proceeding may be required. The Resident's home may be exempt for Medicaid eligibility purposes if the equity value is less than $1,071,000.00 or if the spouse or disabled or minor child resides there. Upon application, Medicaid looks back at financial transactions or transfers of assets made within a sixty (60) month period of time from the date on which the person was institutionalized and applied for Medicaid coverage. A Resident or spouse who makes a transfer within those periods may create a period of Medicaid ineligibility. Private-pay Residents should apply for Medicaid about three months before their funds are depleted. A Medicaid application must include proof of the Resident's identity, U.S. citizenship or legal alien status, and past and present financial status. Medicaid recipients are required to recertify eligibility each year in order to retain benefits. Medicaid is a complex program and a knowledgeable professional can advise Residents and their families as to their rights under the Medicaid program. To receive information about Medicaid, individuals can call their local Department of Social Services in the county in which the Resident resides.

WORKERS' COMPENSATION

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

NO-FAULT INSURANCE

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

VETERANS' BENEFITS

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

EAST NECK NURSING & REHABILITATION CENTER

HIPAA Authorization Form

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

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

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

I understand that I have the right to:

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

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

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

_____ _____
Signature Date

_____
Print Name

_____ _____ _____
Resident's Name Room # File #

East Neck Nursing and Rehabilitation Center

Effective Date: November, 2013

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT FORM

I, _____, the Resident, acknowledge and agree that I have received a copy of East Neck Nursing and Rehabilitation Center's Notice of Privacy Practices.

_____ _____
Resident Signature Date

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

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

_____ _____
Witness Date

FOR EAST NECK NURSING AND REHABILITATION CENTER USE ONLY:

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

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

East Neck Nursing and Rehabilitation Center made the following good faith efforts to obtain the above referenced individual's written acknowledgment of receipt of the Notice of Privacy Practices:

_____
_____
_____
_____

_____ _____
East Neck Nursing and Rehabilitation Center Representative Signature Date

East Neck Nursing and Rehabilitation Center

EMERGENCY & DISASTER PREPAREDNESS FORM

In accordance with New York State Law and New York State Department of Health Regulations, East Neck Nursing and Rehabilitation Center has developed an Emergency and Disaster Preparedness Plan.

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

Please check below as applicable:

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

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

_____

Signature

_____

Relationship to Resident

_____

Date

ASSIGNMENT OF BENEFITS

PROVIDER INFORMATION		
L.I. SCRIPT, LLC		
333 CROSSWAYS PARK DRIVE		
Phone: (631) 312 – 3850	Fax: (631) 321 – 3899	Email: billing@liscript.com

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

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

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

Signature: _____ Date: _____

Print Name: _____ Date: _____

Witness: _____ Date: _____

Notice of Privacy Practice

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

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

Your Health Information Rights:
You have the following rights with respect to health information about you.
Right to Copy of Notice of Privacy Practices. You have the right to a paper copy of our Notice of Privacy Practices at any time. To obtain a copy of our current Notice of Privacy Practices, please contact L.I.Script, LLC at the address or phone listed below.
Right to Inspect and Copy. You have the right to inspect and/or obtain a copy of the health information about you that we maintain in certain groups of records that are used to make decisions about your care. Your request must be in writing. If you request a copy of your health information, we will charge you a fee to cover the costs of copying and mailing the information. In certain very limited circumstances, we may deny your request to inspect and copy your health information. If you are denied access to your health information, we will explain our reasons in writing. You have the right to request that another person at L.I.Script, LLC review the decision. We will comply with the outcome of the review. For information about this right, see 45C.F.R. § 164.524.
Right to Amend. If you feel that health information about you that we maintain in certain groups of records is inaccurate or incomplete, you have the right to request that we amend the information. You have the right to request an amendment as long as we maintain the information. Depending on the nature of your request, we may ask that you submit it in writing and include a reason supporting the request. In certain circumstances, we may deny your request to amend your health information. If your request for an amendment is denied, we will explain our reasons in writing. You have the right to submit a statement explaining why you disagree with our decision to deny your amendment request. We will share your statement when we disclose health information about you that we maintain in certain groups of records. For more information about this right, see 45 C.F.R. § 164.526.
Right to an Accounting of Disclosures. You have the right to request an accounting or detailed listing of certain disclosures of your health information. The time period covered by the accounting is limited. Your request must be in writing. If you request an accounting more often than once every twelve (12) months, we may charge you a fee to cover the costs of preparing the accounting. For more information about this right, see 45 C.F.R. § 164.528.
Right to Request Restrictions. You have the right to request a restriction or limitation on the health information about you that we use or disclose. Your request must be in writing. Please be aware that we are not required to agree to your request for restrictions. If we agree to your request for a restriction, we will comply with it unless the information is needed for emergency treatment. For more information about this right, see 45 C.F.R. § 164.522.
Right to Revoke Authorization. You have the right to revoke your authorization to use or disclose health information, except to the extent that action has been taken in reliance upon your authorization. Your request must be in writing.
Right to Request Alternative Method of Contact. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. Your request must be in writing. We will agree to the request to the extent that it is reasonable for us to do so. For example, you may request that we use an alternative address for billing purposes. For more information about this right, see 45 C.F.R. § 164.522(b).

Complaints
If you believe your privacy rights have been violated, you may complain to L.I.Script, LLC and to the Department of Health and Human Services. You may make a complaint to us by contacting L.I.Script, LLC at the address or phone listed below. You will not be retaliated against for filing a complaint.

L.I.Script, LLC's Obligations
L.I.Script, LLC is required to:
- maintain the privacy of protected health information;
- provide you with this Notice of our legal duties and privacy practices with respect to your health information;
- abide by the terms of the Notice of Privacy Practices currently in effect;
- notify you if we are unable to agree to a requested restriction on how your health information is used or disclosed;
- accommodate reasonable requests you may make to communicate health information by alternative means or at alternative locations;
- obtain your written authorization to use or disclose your health information for reasons other than those identified in this Notice and permitted by law; and
- comply with your state's laws if they provide you with greater rights over your health information or provide for more restrictions on the use or disclosure of your health information.

L.I.Script, LLC reserves the right to change the terms of this Notice, our privacy practices, and to make the new provisions effective for all protected health information we maintain. You may contact L.I.Script, LLC at the address or phone listed below to obtain a revised Notice of Privacy Practices.

Uses or Disclosures of Your Health Information
Treatment. We may use and disclose health information about you to provide you with pharmaceutical care or other medical treatment or services. To this end, we may communicate with other health care providers regarding your treatment and coordinate and manage your health care with others. For example, information related to your treatment may be obtained by a health care provider, such as a pharmacist, nurse, respiratory therapist, or other person providing health services to you, and will be recorded in your medical record. This information is necessary for health care providers to determine what treatment you should receive. Health care providers also may record actions taken by them in the course of your treatment and note how you responded to the actions.

Payment. We may use and disclose health information about you to others for purposes of receiving payment for treatment and services that you receive.

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

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

We may also use and disclose medical information to:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Contact Information

If you have any questions, requests, or concerns about your L.I.Script, LLC.-related health information rights or our use and disclosure of health information, please contact:

L.I.Script, LLC
333 Crossways Park Drive
Woodbury, NY 11797
Phone: 631-321-3850