APPENDIX

NCLC and Justice In Aging's survey on nursing home debt collection practices included a request for sample admission agreements that were signed by residents and third parties, in addition to sample pleadings. Redacted versions of the documents provided are collated by state in this appendix.

Alabama

1. **Admission Agreement & Complaint:** Trussville Health and Rehabilitation Center
2. **Complaint:** ProHealth LTC-Trussville, LLC
3. **Complaint:** ProHealth LTC-Trussville, LLC

District of Columbia

4. **Admission Agreement:** Stoddard Baptist Nursing Home

Indiana

5. **Complaint & Admission Agreement:** Hooverwood Indianapolis Jewish Home
6. **Admission Agreement & Complaint:** Bell Trace Senior Living
7. **Admission Agreement & Complaint:** Northwest Manor Healthcare Center

Kentucky

8. **Admission Agreement:** Signature Healthcare of Elizabethtown

New Jersey

9. **Complaint & Admission Agreement:** Foothill Acres Nursing & Rehabilitation Center

New York

10. **Admission Agreement:** GreenField Health & Rehabilitation Center
11. **Admission Agreement:** Elderwood at Hamburg
12. **Admission Agreement:** Beechwood Homes
13. **Admission Agreement:** East Neck Nursing and Rehabilitation Center
14. **Complaint & Admission Agreement:** Warren Manor
15. **Agreement to Appoint Facility as Authorized Representative:** Autumn View Health Care Facility

Ohio

16. **Complaint & Admission Agreement:** Altercare Transitional Care of the Western Reserve
17. **Complaint & Admission Agreement:** Chesterwood Nursing Care
18. **FDCPA & ECOA Lawsuit:** Rolf Goffman Martin Lang, LLP

Alabama

Admission Agreement & Complaint: Trussville Health and Rehabilitation Center

ADMISSION AGREEMENT

This Admission Agreement ("Agreement") states the terms and conditions agreed by you, [redacted], your Responsible Party, _____ and **ProHealth LTC- Trussville, LLC d/b/a Trussville Health and Rehab Center** ("Facility"). In this Agreement, "you" and "your" refers to the person who wishes to become a resident at the Facility. Your responsible party is your legal guardian, if one has been appointed, or your Attorney-in-Fact, if you have executed a power of attorney, or some other individual or family member who agrees to assist the Facility in providing for your health, care, and maintenance. The obligations of your Responsible Party are described more fully in this Agreement, which you and your Responsible Party should read carefully before signing this Agreement.

This Admission Agreement is a legally binding contract. Do not sign this Admission Agreement until you have read it and understand its terms and have read the Resident Handbook in its entirety and understand the policies and rules contained within it. By signing this Admission Agreement, you are certifying that you have read this Agreement in its entirety and that you understand and agree to the terms of this Admission Agreement. In the event you are discharged or transferred from the Facility and are later readmitted, you will be bound by the terms of this Admission Agreement and Resident Handbook, as each has been amended.

1. Resident Handbook

You and your Responsible Party acknowledge that you have received a copy of the most recent edition of the Facility's Resident Handbook (including the Appendices, all of which are referred to in this Agreement as the "Handbook") dated 7/1/2016, and that you have read the Handbook in its entirety. The Facility has adopted the Handbook to reflect its current policies, rules, and procedures for residents of the Facility and their respective family members and guests. The Facility reserves the right to modify the Handbook from time to time as it deems necessary or advisable with or without notice. You and your Responsible Party agree to abide by all of the policies and rules contained in the Handbook, as they may be modified from time to time by the Facility.

2. Responsible Party

The person signing this Agreement as your Responsible Party has the following relationship(s) to the Resident (please check all that apply):

Spouse ✓ Relative _____ Legal Guardian _____ Attorney-in-Fact _____
Friend or Interested Person _____ Other (state relationship) _____

A copy of any documentation substantiating this relationship must be provided to the Facility. The Responsible Party represents to the Facility that he or she manages, uses, directs or controls funds or assets which may be used to pay for Resident's Facility charges and/or that he or she tends to make decisions for or otherwise act on behalf of Resident.

3. Services and Supplies

(a.) Nursing Services

Nursing staff (licensed nurses and nurse aides) work in the Facility seven days a week, 24-hours a day. The staff is assigned to provide the reasonable and customary nursing home nursing and personal care. Resident and Responsible Party recognize and agree that the services purchased hereunder are not one-on-one, seven days per week, 24-hours per day services and further that their expectations shall be contingent upon this understanding.

We reserve the right from time to time to advise you or your Responsible Party that we are not able to meet your needs with our then current staff and physical facilities. In such an event you will have the right and option to: (1) be discharged from the Facility; (2) be moved to another facility that can offer the level of care needed; or (3) to remain in the Facility upon such terms and conditions as the Facility may require, including without limitation, a requirement that you retain a private nurse or sitter or that you release us from any claims resulting from our inability to care for your deteriorated physical or mental condition.

(b.) Physician Services

The parties agree that you are and must at all times be under the medical care of the Facility's attending physician and that Facility will render its reasonable and customary nursing home services to you under the general and specific instructions of said physician. By executing this Agreement, you and your Responsible Party certify that a physician has approved your admission to the Facility and you and your Responsible Party further consent to the Facility providing such services directed by the physician as are reasonably and customarily provided by the Facility. Should a physician prescribe services beyond these reasonably and customarily provided by Facility, Facility may discharge Resident.

Although you have the right to select an attending physician, if you at anytime do not timely select an attending physician or, for any reason, your are unable to select an attending physician, depending on such physician availability, Facility may select a physician for you without any liability to Facility accruing for said selection.

The parties agree that the Facility may require your use of an alternate licensed physician if the Facility is notified of the following:

- Your attending physician does not practice in the Facility.
- Your attending physician refuses to provide care to you in accordance with all applicable federal and state laws and regulations, including but not limited to, scheduled visits to the Facility.
- Your attending physician loses his or her license to practice or is banned from participation in the Medicare or Medicaid Program.
- Any emergency and/or urgent situation requiring an immediate response to your medical needs.
- Your attending physician continues to request services beyond those reasonably and customarily provided by Facility.
- Or your medical needs are not being met for other similar reasons not specifically listed above.

Except in cases of medical emergency, the Facility will provide you with notice prior to requiring the use of an alternate physician.

Physicians operating within the Facility are independent contractors, not employees of the Facility, and the Facility shall not be liable for any acts or omissions of any physician who renders care or fails or declines to render care to you at the Facility. You are responsible for the payment of all charges of any person who renders care to you at the Facility.

(c.) Medicines and Medical Supplies

You and your Responsible Party acknowledge that you have been informed that the Facility uses Pharmacy Care Associates, LLC ("PCA") and MedCo, LLC ("MedCo") as the standard providers of medicines and medical supplies to all residents of the Facility, and understand that PCA and MedCo are under common ownership with the Facility. The Facility has strict policies with respect to the packaging, labeling, and records associated with medicines and medical supplies utilized by residents, which are important to ensure the quality and integrity of care delivered to residents of the Facility. The Facility's providers of medicines and medical supplies, including PCA and MedCo are required to comply with these policies. You and your Responsible Party agree that the Facility's providers of medicines and medical supplies may supply those medicines and medical supplies as may be prescribed by your attending physician unless you select another provider who agrees in writing to comply with this Facility's policies and demonstrates its ability to comply with these policies to the reasonable satisfaction of the Facility. Medicines can only be administered by licensed nurses due to federal and state regulations.

(d.) Dietary Services

The Facility maintains a food service program monitored by a registered dietician. The Facility shall provide you regular meals and will use reasonable efforts to provide you with therapeutic diets and snacks prescribed by your attending physician. While unable to prepare a different menu for each resident, the Facility will use its reasonable best efforts to recognize individual preferences.

(e.) Social Services

The Facility shall make available a Social Services Director to the entire resident population at the Facility. The Social Services Director will use reasonable efforts within time limitations to identify the social and emotional needs of each resident and to intervene where feasible. Services may be arranged to attempt to meet your needs, either through staff at the Facility or by referral to appropriate prudent agencies or professionals.

(f.) Laundry Services

All personal items must be marked with your name in indelible ink or with sewn in nametags. The parties agree hereto that Facility will not be responsible for your damaged, lost or misplaced clothing. Further, you and your Responsible Party understand that Facility's laundry utilizes high heat, strong chemicals, etc., in its laundry that most likely will reduce clothing life. **The Facility is not responsible for lost clothing that is not properly marked.**

Initialed: Resident _____ Responsible Party [redacted]

(g.) Service Limitations

The parties hereto agree that the services provided by Facility and others within Facility are not designed to somehow protect you or any other resident from the every-day, normal risks and responsibilities of living, including, but not limited to, such general accidents and situations such as falling, choking on food and weight loss and/or dehydration resulting from your failure to partake of food and drink. Additionally, the parties hereto understand that the services provided by the Facility **do not** include 24-hour, seven (7) days per week, one-on-one monitoring of its residents. If you or your Responsible Party wish to procure, at an additional charge, these services, in addition to those provided by Facility you may do so, at your own cost, as outlined under Section 11 of this agreement.

(h.) Refusal of Services

Facility shall make good faith efforts to provide you such services as are routinely provided at the Facility, including those prescribed by your attending physician. However, Facility shall not be responsible for outcomes associated with your refusal to comply with such services. Should you refuse food, fluids, treatments, therapies, medications, grooming, therapeutic bathing, etc., and/or refuse to comply with physician's orders (i.e., you are a diabetic with orders not to consume sugar, but you eat candy of your own will, etc.), Facility shall in no way be responsible for the outcomes associated with such behavior. This shall apply whether you are now or hereafter deemed mentally competent or incompetent. The Facility shall not be expected by you and your Responsible Party to intimidate or threaten you into doing what the Facility and/or attending physician believe is best for you. You and your Responsible Party are strongly encouraged to participate in the planning of your care both with the attending physician and Facility.

4. Incidents beyond the control of Facility

Resident and Responsible party agree that Facility will not be liable for and agree to hold Facility harmless from any circumstances that are beyond the control of Facility including, but not limited to, acts of God, acts of terrorism, strikes and changes in economic conditions that affect the Facility's operation. Additionally, Resident and Responsible Party agree that Facility will not be liable for and agree to hold Facility harmless from any changes in services or service limits due to changes in payment levels received by the Facility from Resident and/or third party payors, including, but not limited to, Medicare and Medicaid.

5. Payment

You are responsible for payment of all charges for items and services provided to you by the Facility unless these charges are paid for by a third-party reimbursement program such as Medicare or Medicaid. You are responsible for payment of all charges for medicines and medical supplies provided to you that are not otherwise paid for by third-party reimbursement programs such as Medicare or Medicaid. You are responsible for payment of all charges of any physician who renders care to you while you are a resident of the Facility, and any other charges by third parties providing items or services to you at your request.

You and your Responsible Party acknowledge receiving information from the Facility on how to apply for and use Medicare and Medicaid benefits, and you each release the Facility and each of its owners, agents, servants, and employees from any liability or responsibility in connection with your potential claim for coverage or reimbursement and for any failure to obtain such coverage or

reimbursement. If you elect to apply for Medicaid benefits, you and your Responsible Party give the Facility permission to seek and receive information on the status of your Medicaid eligibility application from the appropriate state agency.

You and your Responsible Party hereby authorize the Facility and all other providers of items and services to file in your name and on your behalf, claims for any and all third-party payments (including but not limited to Medicare, Medicaid and/or private medical insurance benefits) for items and services provided to you by the Facility or by such third-party providers, including the Facility's provider(s), and the right to receive the same.

THE FACILITY DOES NOT MAKE ANY WARRANTY OR REPRESENTATION OF ANY KIND THAT YOUR CARE WILL BE PAID FOR BY MEDICARE, MEDICAID, ANY THIRD-PARTY INSURANCE OR OTHER REIMBURSEMENT SOURCE.

Where Facility's charges for your services are eligible to be paid partially or in full by privately owned insurance, you and your Responsible Party shall remain responsible for making payments in full pursuant to this Agreement regardless of such insurance coverage and shall be responsible for paying all charges not paid by any insurance policy, including any coinsurance, copay, and/or deductible amounts required by any insurance policy. While the Facility, as a courtesy, will file claims with most privately owned insurance companies, the Facility may, at its option, require you to pay the Facility's charges in advance while awaiting payment from the insurance company.

You and your Responsible Party agree that you will be responsible for payment of all charges for items and services provided to you by the Facility pursuant to the Agreement, including both covered and non-covered services (as defined in Appendix E). Once a third-party reimbursement program assumes responsibility for payment, You agree that you will be responsible for payment of all charges for items and services provided to you by the Facility pursuant to this Agreement, including both covered and non-covered services (as defined in Appendix E). If your Responsible Party has legal access to income or resources of yours which are available to pay for care and services you receive at the Facility, then your Responsible Party agrees to provide payment to the Facility from such income or resources. The Responsible Party agrees to replace misappropriated Resident funds in the event such misappropriation(s) were to occur. By executing this Agreement, the Responsible Party agrees to ensure first priority distribution to the Facility on your behalf, from your assets, to pay for services rendered to you by Facility. The parties agree that Responsible Party shall be required to produce financial documentation to substantiate your ability to pay for charges that will be due for services rendered to you. If Facility does not timely receive payment in full, Facility may require production by Responsible Party of evidence that your assets were utilized only to prudently pay for your related expenses and that such spending gave first priority to the Facility's payments. Further, it is understood that should Facility reasonably suspect that an inappropriate handling of your funds has occurred or is occurring, Facility shall report same to appropriate authorities without liability to you and/or your Responsible Party.

You and your Responsible Party understand that a third-party guarantee of payment for Non-covered services is not required as a condition of admission. You and your Responsible Party also understand that you are not required to request or receive Non-covered services as a condition of admission. You and your Responsible Party understand that if you **do not** request that the Facility make Non-covered services available to you, Non-covered services will not be made available to you and your Responsible Party will not be personally liable for any charges for Non-covered items or services by signing this Agreement.

Notwithstanding anything herein to the contrary, you and your Responsible Party understand that if you **do** request that the Facility make Non-covered services available to you, both you and your Responsible Party agree that each of you (both you and your Responsible Party) shall be personally liable for any charges for Non-covered items or services requested by you or your Responsible Party.

Complete All Appropriate Sections Below

A. Medicare. If you have a reasonable potential of being eligible for Medicare coverage, you and your Responsible Party understand that a semi-private room, meals, certain services and supplies are covered after a three-day qualifying hospital stay. You will receive skilled services as defined by the Medicare Program. There are certain Non-covered items and services that are not covered by Medicare, and the charges for those Non-covered items and services are defined in Appendix E. Medicare pays 100% of covered charges for days 1-20. Medicare pays all covered charges **other than** a daily coinsurance rate for days 21-100. The current daily co-insurance amount under the Medicare (Part A) program is $ **167.50** per day . All Medicare services shall be provided by the Facility at the rates allowed by Medicare.

Initialed: Resident _____ Responsible Party_____ Not Applicable__X_____

B. Medicaid. If you have a reasonable potential of being eligible for Medicaid benefits, you and your Responsible Party acknowledge that you have received the Nursing Facility Resident Agreement from the Medicaid agency which outlines those items and services paid for by Medicaid under the Alabama State Medicaid Plan, as well as Non-covered items and services and the amount of the charges for those Non-covered items and services (Non-covered services are contained in Appendix E of the Contract). Responsible Party and Resident agree to promptly comply with all requirements relative to the application for and receipt of benefits under the Medicaid program. All Medicaid services shall be provided by the Facility at the rates from time to time allowed by Medicaid.

Initialed: Resident _____ Responsible Party_____ Not Applicable __X_____

C. Private Pay. If the cost of your stay at the Facility will not be covered by Medicaid or Medicare (a "Private Pay" resident) you and your Responsible Party acknowledge that you have received a list of those Non-covered items and services which are not included in the Facility's Daily Rate, and the amount of the charges for those Non-covered items and services (these lists are contained in Appendix E of the Contract). The Daily Rate in effect at the present time is $215.00 for semi-private room and $260.00 for a private room per day.

Initialed: Resident_____ Responsible Part[redacted] Not Applicable _____

You and your Responsible Party understand and agree that the Facility may revise the Daily Rate and charges for Non-covered goods and services or any of them upon thirty (30) days advance written notice.

6. Your Resident Rights

You and your Responsible Party acknowledge that the Facility has informed you, both orally and in writing in a language you can each understand, of your rights and of all policies and rules governing your conduct and responsibilities during your stay in the Facility.

A. Medical Records

You and your Responsible Party consent to the release or receipt of your medical and financial records as described in the "Medical Records" section of the Handbook.

B. Personal Property

The Facility strongly discourages residents from keeping valuable jewelry, paper, large sums of money or other personal items considered to be valuable in the Facility. The Facility will take reasonable precautions to protect your property in the Facility but you and your Responsible Party agree that the Facility will not have any responsibility or liability for the loss or theft of your personal property for any reason.

C. Personal Fund Account Authorization

You and your Responsible Party request and authorize the Facility to hold safeguard, manage and account for your personal funds in the manner described in the "Personal Funds" in Appendix A. You and your Responsible Party specifically authorize the Facility to withdraw funds from your personal account to pay for any and all charges owed by you to the Facility, including charges for Non-covered items and services requested by you or your Responsible Party. All charges will be paid directly to the Facility out of your personal account at the time the charges first become due.

7. Transfer/Discharge.

You agree, at Facility's request, to transfer within the Facility, from time to time, to rooms that, in Facility's opinion, best accommodate your ability and/or your need for services and/or to reasonably accommodate the needs of another resident of the Facility or an individual seeking needed admission into the Facility. You further recognize that the Facility will attempt to meet your reasonable nursing home service needs but also while attempting to meet the reasonable nursing home service needs of others, including the community at large which the Facility is licensed to and expected to reasonably accommodate.

The following circumstances may result in your discharge from the Facility:

- Attending physician provides a discharge order. This typically, but not necessarily, is an order for transfer to a hospital.
- Facility recognition that you will be unable to timely pay in full for services.
- You and/or a third party payor fails to timely pay in full for services.
- Your welfare (medical, psychological, etc.) needs, in the opinion of the Facility, cannot be adequately met by Facility within its reasonable and customary provision of nursing home services.
- Upon reasonable efforts of Facility, You and/or your significant others remain dissatisfied with the services of Facility as provided within Facility's reasonable and customary provision of nursing home services.
- The health and/or welfare of the other residents and/or staff living or working in the Facility is jeopardized by your behavior and/or your visitors.
- Discharge is required by governmental rules and regulations.

- Facility ceases operations.
- Labor shortages, strikes, etc.
- Destruction or partial destruction of the Facility's building.
- Your election to vacate Facility premises (requests discharge).
- Other similar circumstances not listed above.

In the event you choose to leave the Facility permanently, or a person with legal authority to act on your behalf removes you from the Facility, you and your Responsible Party agree to give the Facility written notice of your planned departure at least ten days prior to the date of your departure, unless you are a Medicare or Medicaid recipient. You and your Responsible Party agree that in the event you fail to give the required ten (10) days notice, and you are *not* a Medicare or Medicaid recipient, you will pay to the Facility an amount equal to the prevailing Daily Rate for each day within the ten-day period prior to your departure that the Facility had no written notice of your planned departure.

The Facility will use reasonable efforts to safeguard your personal property remaining at the Facility after discharge, but the Facility will not be liable for any damage to or loss of any of your personal property that is left at the Facility after your discharge. The Facility may dispose of personal property left by you if such property is not claimed by you within thirty (30) days after your discharge.

In the event of your death, you and your Responsible Party authorize the Facility to release your body to _____funeral home located in _____.

8. Photographs

The Facility may photograph or videotape you and may use such photographs or videotapes for:

a. Identification purposes
b. To provide supporting documentation of your (your resident's) medical condition. (These photographs will be placed and will remain a part of the medical record.)
c. Purposes of state and federal compliance regarding my case at the Facility.

The Facility prohibits the use of concealed audio, video, or photographic devices of any kind, in, or on the grounds of the Facility. Furthermore, videotaping, audio taping or photography is not permitted in, or on the grounds of the Facility without the express written permission of the Facility administrator. You and your Responsible Party hereby agree to follow this policy and understand and agree that neither you nor your Responsible Party may authorize anyone to act in a manner that violates this policy. This policy includes the use of camera phones.

Initialed: Resident _____ Responsible Part[redacted]

9. Activities and Trips

The Facility will have no responsibility or liability of any kind whatsoever for any injuries which you might suffer as a result of your participation in or transportation to any program of therapeutic or recreational activities outside of the Facility. See Appendix H.

10. Visitors, Companions, Sitters and Private Duty Nurses

All companions, sitters and private duty nurses engaged by you or your Responsible Party, as well as your visitors are subject to the Facility's rules and regulations. You shall pay all expenses (including meals) of such individuals. You agree to indemnify and hold the Facility harmless from all losses, damages, costs, claims, liabilities and expenses, including attorney fees and courts costs arising from the services, actions, inactions, etc., of any sitters, companions, and private duty nurses engaged by you or your Responsible Party and for same relative to any of your visitors.

All companions, sitters, and private duty nurses may be required to provide proof of freedom from communicable diseases and proof of any licenses or certifications as may apply. The Facility shall not be expected by you to review, approve or otherwise opine to the qualifications and/or abilities, etc., of any of your service providers or visitors, etc.

11. Notices

Any notice, demand or communication which is required, permitted or desired to be given under this Agreement or otherwise shall be in writing and shall be deemed sufficiently given when personally delivered or mailed to the addresses set forth in the signature page for you, your Responsible Party and the Facility. In addition to you and your Responsible Party, you hereby authorize the Facility to provide information with respect to your condition to any of the authorized individuals set forth in the signature pages or in a written notice to the Facility from you or your Responsible Party.

12. Consent to Bloodborne Pathogens

In the event any Facility employee or other healthcare worker has unprotected exposure to blood or bodily fluid, Facility is authorized to perform tests on resident for any Bloodborne Pathogen including but not limited to, hepatitis (HCV and HBV) and HIV. The resident will be advised of the results of such test. In the event such test is positive, resident/responsible party authorizes information to be placed in the medical record and the release of the test information so that any such exposed employee or healthcare worker might be notified and for reporting as is required by law of such disease. In reporting residents' identity may not be released to anyone except as is required and allowed by law or as is required by resident's insurance carrier or governmental agency to process any claim for benefits. Resident releases the Facility and its employees or agents from performing any such test on resident, and/or for reporting to exposed employee or healthcare worker or reporting as is required by law any reportable disease the test reveals.

13. Miscellaneous

A. Costs of Collection

In the event that you or your responsible party default in any payment obligation that you have hereunder, the Facility shall be entitled to reimbursement from you and your Responsible Party for all reasonable costs of collection, including, without limitation, attorneys' fees, expenses, and costs, provided that if the claim for payment is a dispute subject to the Dispute Resolution Program, Arbitration Agreement, and Waiver of Jury Trial (the "Program") set forth herein shall govern the responsibility for payment of the costs of the proceeding under the Program.

B. Amendment

This Agreement may be amended by the Facility at any time and from time to time upon not less than thirty (30) days written notice to you and your Responsible Party. Other amendments to this Agreement may be amended by the written agreement between you (or your Responsible Party) and the Facility.

C. Entire Agreement

This Agreement, together with the Handbook and all appendices and amendments hereto are the entirety of the agreement between the Facility and you and your Responsible Party. All oral statements or prior written material not specifically incorporated in this Agreement or in the Handbook shall be superseded in their entirety and have no force and effect upon the execution hereof.

D. Incorporation of Appendices

The Appendices attached hereto are specifically incorporated into this Agreement, and are a part of this Agreement.

E. Non-Assignability

You and your Responsible Party acknowledge that your right to reside at the Facility is personal and is not assignable. You may not assign your rights under this Agreement to any other person or entity. Your obligations to the Facility under this Agreement will automatically transfer to your estate and will be binding upon the heirs, representatives and successors of your estate. The Facility may assign its rights under this Agreement without the consent of you or your Responsible Party, including an assignment by reason of merger or change of ownership.

F. Binding Obligation

You and your Responsible Party agree that the terms, conditions, restrictions, and obligations of this Agreement bind you and your respective heirs, successors and self-designated representatives acting on your behalf, including but not limited to, family members, ombudsmen for the state and federal government and any other privacy or advocacy group.

G. Waiver of Breach

The waiver by any party to this Agreement of a breach of the Agreement or the violation of any provision of the Agreement shall not operate as, or be construed to be, a waiver of any subsequent breach of the Agreement or provision thereof.

H. Severability

In the event any provision of this Agreement is held to be unenforceable for any reason, such unenforceability shall not affect the remainder of this Agreement, which shall remain in full force and effect and be enforceable in accordance with its terms.

I. Governing Law

This Agreement shall be interpreted, construed and enforced pursuant to and in accordance with the laws of the State of Alabama. Jefferson County, Alabama shall be the sole and exclusive venue for any Dispute, special proceeding, or any other proceeding between the parties that may arise out of, in connection with, or by reason of this Agreement.

You and your Responsible Party further acknowledge that you have had an opportunity to question a representative of the Facility concerning the terms of this Admission Agreement and the contents of the Handbook and that any questions you had have been answered to your satisfaction.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement this [redacted] Day of [redacted], 20[redacted].

RESIDENT
(Name)_____
(signature)X_____
(address-street address required) _____
_____
_____

RESPONSIBLE PARTY
(Name)[redacted]
(signature)X[redacted]
(address) _____
_____
_____

Facility: Trussville Health & Rehab Center
Address: 119 Watterson Parkway
Trussville, AL 35173
By: Candelyn Elleissy
Its: Admissions Coordinator

Resident and Responsible Party hereby authorize the Facility to provide information with respect to Resident's condition to the individuals listed below, if any:

_____Resident [redacted]esponsible Party

Authorized Individuals:

[redacted]

Name:	Name:
Address:	Address:
Address:	Address:
Relation:	Relation:
Phone Number:	Phone Number:

PATIENT FUND AUTHORIZATION

I, [redacted], for myself or as the Responsible Party for _____, do hereby give the Facility and its designee's authorization to handle the above-named Resident's personal funds. I understand that all monies handled by this Facility will be retained in a designated bank account. I further understand that small amounts of cash will be retained in the business office and the above-named Resident may obtain up to twenty-five dollars from the business office during posted business office hours. I understand that any amount obtained from the business office will be debited from the above-named Resident's designated bank account.

I further understand that funds contained in the Resident's designated bank account may be withdrawn from the account by the Facility and its designees to pay any Non-covered charges incurred by the Resident at this Facility.

I further understand that the Facility and its designees will assume no responsibility for the above-named Resident's personal funds unless they are retained by the Facility.

You are not required to deposit your personal funds with the facility.

X I wish to deposit personal funds with the Facility

___ I DO NOT wish to deposit personal funds with the Facility

_____
RESIDENT

[redacted]
RESPONSIBLE PARTY

[redacted]
DATE

AUTHORIZATION FOR TREATMENT, ASSIGNMENT OF BENEFITS PAYMENT RESPONSIBILITY AND RELEASE OF INFORMATION

Patient's Name: [redacted]

Authorization for Treatment: The undersigned authorize Champion Partners in Rehab and/or any of their contractors (collectively referred to as "Provider"), to render to resident physical therapy, occupational therapy, speech therapy, audiology, psychological services or other related services (collectively referred to as "Therapy Services") that provider and/or Resident's physician determine to be necessary or advisable. The undersigned agree to cooperate with all reasonable requests of Provider in connection with Provider's rendition of Therapy Services.

Assignment of Benefits: The undersigned hereby assign and transfer to Provider the right to any and all third-party payments (including Medicare, Medicaid and/or private medical insurance benefits) to which the undersigned may be or become entitled to for Therapy Services rendered by Provider. The undersigned hereby authorizes Provider to apply and file for all such benefit payments in the name of and on behalf of Resident and direct that such payments be made directly to Provider. Any insurance benefit payments received by the undersigned for services rendered by Provider shall be paid to Provider.

Payment Responsibility: The Resident shall be financially responsible for any portion of Provider's invoice that is not paid, except for payments denied by Medicare or for covered services provided to Medicaid recipients. The undersigned agrees to execute any and all documents and perform any acts that Provider may reasonably request to ensure that all third-party benefits for Therapy Services are paid to Provider.

Release of Information: The undersigned hereby certify that all information provided to Provider by the undersigned is true and accurate in all respects. The undersigned hereby authorize Provider to disclose any information, medical and non-medical furnished Provider or obtained by Provider in connection with Resident's diagnosis and/or treatment, to any physician, governmental agency (including the U.S. Department of Health and Human Services or any of its intermediaries or carriers), insurance company or health care provider requesting such information. The undersigned agree to allow Provider access to Resident's medical records and agree to all Provider(s) to make copies of such records. The undersigned consent to Provider's discussing resident's medical condition with Resident's family members for medical or claims management purposes.

Executed this, [redacted] day of [redacted], 20[redacted].

Resident _____
Resident's Responsible Party (specify relationship) [redacted]
Reason Resident Is Unable To Sign _____
Witness: Candelyn Elleissy

RESIDENT SIGNATURE AUTHORIZATION FORM

I. I authorize Medicare, Medicaid, other insurance, and HMO benefits be made on my behalf to ProHealth LTC- Trussville, LLC d/b/a Trussville Health and Rehab Center for any services provided to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services. I understand that only those services which are ordered by my physician will be provided by ProHealth LTC-Trussville, LLC d/b/a Trussville Health and Rehab Center and that I am responsible for any costs which are not covered by my insurance carrier. This authorization is in effect until I choose to revoke it either by written or verbal notification. As a resident of a skilled nursing facility, I understand that this authorization is in effect for the duration of my residency at stated facility.

II. I hereby authorize such x-ray examinations, laboratory procedures, administration of drugs or other treatments as may be ordered by the doctor in charge of this resident.

III. I authorize ProHealth LTC-Trussville, LLC d/b/a Trussville Health and Rehab Center, to acquire from Pharmacy Care Associates, any and all prescription drugs or medication prescribed for the resident.

Residents Name: [redacted]

Responsible Party Signature X [redacted]

Witness Signature Candelyn Elleissy

ADVANCE DIRECTIVE ACKNOWLEDGMENT

NAME: [redacted] SOCIAL SECURITY: _____
IDENTIFICATION NO: _____ DATE OF BIRTH: _____

The Facility is required by law to have a resident or legal representative to execute an Advance Directive Acknowledgment. The Facility does not take a position regarding a resident or his legal representative executing an advance directive.

PLEASE READ THE FOLLOWING FIVE STATEMENTS
Resident and Responsible Party: Place your initials after each statement.

1. Resident and Responsible Party have been informed of rights to formulate Advance Directives.

   _____ (Resident Initials) _____ (Responsible Party Initials)

2. Resident and Responsible Party understand that they are not required to have an Advance Directive in order to receive medical treatment at this health care facility:

   _____ (Resident Initials) _____ (Responsible Party Initials)

3. Resident and Responsible Party understand that the terms of any Advance Directive that has been executed will be followed by the health care facility and caregivers to the extent permitted by law.

   _____ (Resident Initials) _____ (Responsible Party Initials)

PLEASE CHECK ONE OF THE FOLLOWING STATEMENTS

_____ **Advance Directive in existence**
__X__ **Advance Directive not in existence**

Dated: [redacted]

[redacted] Candelyn Elleissy
Resident/Responsible Party Witness

NOTE: if a resident is unable to sign, please state reason why:

_____

CONSENT TO ARBITRATION AND WAIVER OF JURY TRIAL

By my signature and/or acceptance of the services of the Facility, I hereby consent to the Dispute Resolution Program, Arbitration Agreement and Waiver of Jury Trial (the "Program"), set forth in Section 7 of the Admission Agreement for [redacted] (name of Resident) to which this consent is attached. I further represent and warrant that I have read and understand the Program; that I have been advised that it will affect my legal rights and the legal rights of the Resident; and that I have been given the opportunity to seek legal advice from counsel concerning the Program.

Dated this [redacted] day of [redacted], 20[redacted]

_____
Resident

[redacted]
Responsible Party

_____

Other Related Parties:

_____

_____

_____

_____

_____

_____

_____

NOTICE OF HOSPITAL TRANSFER AND BED HOLD AUTHORIZATION

I, [redacted], hereby certify that I have read and understand the facility's bed hold policy, as set forth below:

You or your Responsible Party may request the Facility to hold a bed open for you while you are absent from the Facility for temporary, medically necessary stays in the hospital or other facility. Except as provided below, however, the facility will have no obligation to hold open a bed unless the Facility agrees to do so in writing.

Medicaid Resident: If your care is being reimbursed by Medicaid and you are transferred to an acute care hospital, the Facility will reserve a bed without charge for the first four (4) consecutive days after you are admitted to the hospital.

If you wish to continue bed-holding after the four day reserve period following hospital admission, you or your Responsible Party will be offered the opportunity to continue bed holding at the prevailing daily rate. You or your Responsible Party must notify the Facility in writing within 24 hours of the hospital admission in order to exercise your right to continue bed holding. If you elect not to hold a bed, then you will be offered the next available and suitable bed at such time as you once again require the services of the Facility provided: 1) you do not require a level of care in excess of that the Facility is capable of providing; 2) you otherwise meet the Facility's requirements of admission; and 3) you are still eligible for Medicaid at that time.

Medicare Resident: If your care is being reimbursed by Medicare and you are transferred to an acute care hospital, the Facility will offer you or your Responsible Party the opportunity to hold a bed at the prevailing Daily Rate.

Medicare will not pay for bed holding. In order to affect a bed hold, you or your Responsible Party must notify the Facility within twenty-four (24) hours of your transfer or discharge of your desire to exercise your right to a bed hold. If you elect not to hold a bed, then you will be offered the next available semi-private bed at such time as you once again require the services of the Facility, assuming you are still eligible for Medicare at the time.

Private Pay Resident: If you are a Private Pay resident you may also request a bed hold from the Facility. You must pay the prevailing Daily Rate for the entire period of the bed hold. If you have private insurance, such private insurance may or may not cover the cost of the bed hold.

If you request a bed hold, then upon return we will make every effort to place you in the same room you occupied prior to your departure from the Facility, assuming you require the same level of care upon your return. The Facility can only guarantee a bed in the Facility, however, and may not be able to hold a particular room.

____**I hereby request that the Facility hold a bed for me.** I understand that I will be responsible for payment of the prevailing Daily Rate for each day that the Facility holds a bed for me and until such time as the Facility receives written notice from me that I am releasing the bed.

____**I hereby request that the Facility <u>not</u> hold a bed for me.**

[redacted]
Resident/Responsible Party

[redacted]
Date

[redacted]
Witness

[redacted]
Date

Pricing for Non-Covered Services

Beauty Shop – Pricing is posted on the beauty shop door and at the front desk.

· Newspaper Delivery – Contact the newspaper Company
Payment is responsibility of Resident and company.

Telephone Services – Contact Century Link
Payment and Installation is between resident and phone company

Private Pay residents will be charged for medical supplies and oxygen on the monthly statement.

Consent for Use of Monitoring System, or Alternatively, Release from Liability for Non-Use of Monitoring System

Our facility has installed a wander guard system for residents who may tend to wander from the safety of our building. This new technology will allow us to care for confused ambulatory residents without sacrificing their freedom of mobility or their quality of life.

Residents who need close supervision, either because of Alzheimer's Disease, dementia or just a tendency to wander and become disoriented, is given a lightweight, waterproof ankle bracelet which is worn 24 hours per day. The ankle bracelet contains a radio transmitter. If a resident wanders through a monitored exit, a signal is sounded at that exit as well as at the nursing station. This will enable the staff to promptly return the resident to the safety of the facility, thereby preventing what could have become a life-threatening incident.

Our wandering residents are often physically able to leave the building, accompanied by staff, but if they get outside alone they become confused and are unable to find their way back. The system will allow our residents the freedom to wander while eliminating the fear that they will wander too far. The system not only allows our wandering residents new freedom, but will also give our staff more time to care for all residents. It is a real advance for the long-term care facility.

The physically active residents who suffer from Alzheimer's disease, disorientation, or dementia have long been a major concern to nursing homes. In the past, safety measures have included physical or chemical restraints as well as around the clock supervision.

The system will allow us to provide quality care for the elderly population. It is a dignified and safe method of providing a secure environment for your loved one.

If you have any questions about the system or its use please see Social Services.

Informed Consent/Use of Restraints

It is the philosophy of the Facility that in cooperation with our residents, we will create and maintain an environment that fosters minimal use of restraints.

A physical restraint is any device applied to a resident which interferes with some aspect of independent movement such as walking. Examples of physical restraints include safety belts, soft waist belts, Geri chairs with trays, reclining Geri chairs, lapboards, handmits, wrist restraints, and side rails.

Restraints are often utilized to foster a feeling of security with residents who have poor safety awareness. They may also enable restless residents to remain seated during a meal. Studies have demonstrated that use of restraints may result in a number of adverse effects. These may include an increase in pressure sores, urinary incontinence, constipation, muscle weakness, depression, and changes in ambulatory status. When utilized appropriately, these adverse effects can be minimized or avoided.

CONSENT

I have read the information provided above and understand the content. I have also been informed about the resident care review conducted at 90-day intervals. I understand that if, as a result of the assessment done at the review, it may be necessary to use restraints as indicated in the care of the resident. The physician will at that time initiate the order for appropriate restraint use. My signature indicates agreement with that decision as well as my understanding of what a restraint is, what the positive and negative effects of usage may be, and how they will be utilized.

[redacted]

Resident or Responsible Party

[redacted]

Witness

[redacted]

Date / /

ProHealth LTC-Trussville, LLC d/b/a Trussville Health and Rehab Center's Activities department has my permission to take [redacted] _____ (resident) on a scheduled outing without notification for each event.

_____

Resident

[redacted] _____

Responsible Party

09/23/2019 03:18

=== COVER PAGE ===

TO: _____

FROM: STAPLES _____

FAX: [redacted]

TEL: [redacted]

COMMENT:

NOTICE TO FILER

Requirements for Completing Service

IN THE CIRCUIT CIVIL COURT OF JEFFERSON COUNTY, ALABAMA
PROHEALTH LTC-TRUSSVILLE, LLC V. [redacted]

[redacted]

To: MICHAEL LYNDON MCKERLEY MR.
mike@mckerleylawfirm.com

In your alias summons filing, you requested that one or more of the Defendants be served by Private Process Server:

In order to affect service, you must deliver the following document to the process server for service.

The process server, once the process server has served the recipient, must complete the "service return". This service return must be returned to the Clerk of the Court issuing service.

JACQUELINE ANDERSON SMITH
JEFFERSON COUNTY, ALABAMA
716 N. RICHARD ARRINGTON BLVD.
BIRMINGHAM, AL 35203

The summons and complaint should be served in compliance with Alabama Rules of Civil Procedure 4:

How Served and Returned. The person serving process shall locate the person to be served and shall deliver a copy of the process and accompanying documents to the person to be served. When the copy of the process has been delivered, the person serving process shall endorse that fact on the process and return it to the clerk, who shall make the appropriate entry on the docket sheet relating to the action. The return shall clearly indicate the name, address, and telephone number of the person serving process. The return of the person serving process in the manner described herein shall be prima facie evidence that process has been served.

AlaFile E-Notice

[redacted]

To: [redacted]

NOTICE OF ELECTRONIC FILING

IN THE CIRCUIT COURT OF JEFFERSON COUNTY, ALABAMA

PROHEALTH LTC-TRUSSVILLE, LLC V. [redacted]

The following alias summons was FILED on 9/10/2019 3:52:42 PM

Notice Date: 9/10/2019 3:52:42 PM

JACQUELINE ANDERSON SMITH
CIRCUIT COURT CLERK
JEFFERSON COUNTY, ALABAMA
JEFFERSON COUNTY, ALABAMA
716 N. RICHARD ARRINGTON BLVD.
BIRMINGHAM, AL, 35203

205-325-5355
jackie.smith@alacourt.gov

State of Alabama Unified Judicial System Form C-34 Rev. 4/2017	**SUMMONS** **- CIVIL -**	**Court Case Number** [redacted]

IN THE CIRCUIT COURT OF JEFFERSON COUNTY, ALABAMA
PROHEALTH LTC-TRUSSVILLE, LLC V. [redacted]

NOTICE TO: [redacted]
(Name and Address of Defendant)

THE COMPLAINT OR OTHER DOCUMENT WHICH IS ATTACHED TO THIS SUMMONS IS IMPORTANT, AND YOU MUST TAKE IMMEDIATE ACTION TO PROTECT YOUR RIGHTS. YOU OR YOUR ATTORNEY ARE REQUIRED TO FILE THE ORIGINAL OF YOUR WRITTEN ANSWER, EITHER ADMITTING OR DENYING EACH ALLEGATION IN THE COMPLAINT OR OTHER DOCUMENT, WITH THE CLERK OF THIS COURT. A COPY OF YOUR ANSWER MUST BE MAILED OR HAND DELIVERED BY YOU OR YOUR ATTORNEY TO THE PLAINTIFF(S) OR ATTORNEY(S) OF THE PLAINTIFF(S).
MICHAEL LYNDON MCKERLEY MR.
[Name(s) of Attorney(s)]

WHOSE ADDRESS(ES) IS/ARE: 300 Vestavia Parkway, Suite 2400, BIRMINGHAM, AL 35216
[Address(es) of Plaintiff(s) or Attorney(s)]

THE ANSWER MUST BE MAILED OR DELIVERED WITHIN 30 DAYS AFTER THIS SUMMONS AND COMPLAINT OR OTHER DOCUMENT WERE SERVED ON YOU OR A JUDGMENT BY DEFAULT MAY BE RENDERED AGAINST YOU FOR THE MONEY OR OTHER THINGS DEMANDED IN THE COMPLAINT OR OTHER DOCUMENT.

TO ANY SHERIFF OR ANY PERSON AUTHORIZED BY THE ALABAMA RULES OF CIVIL PROCEDURE TO SERVE PROCESS:

☑ You are hereby commanded to serve this Summons and a copy of the Complaint or other document in this action upon the above-named Defendant.

☐ Service by certified mail of this Summons is initiated upon the written request of _____ *(Name(s))* pursuant to the Alabama Rules of the Civil Procedure.

09/10/2019 *(Date)* /s/ JACQUELINE ANDERSON SMITH *(Signature of Clerk)* By: _____ *(Name)*

☐ Certified Mail is hereby requested. _____ *(Plaintiff's/Attorney's Signature)*

RETURN ON SERVICE

☐ Return receipt of certified mail received in this office on _____ *(Date)*

☐ I certify that I personally delivered a copy of this Summons and Complaint or other document to _____ *(Name of Person Served)* in _____ *(Name of County)* County, Alabama on _____ *(Date)*.

_____ *(Address of Server)*

_____ *(Type of Process Server)*

_____ *(Server's Signature)*

_____ *(Server's Printed Name)*

_____ *(Phone Number of Server)*

ALIAS ALIAS ALIAS ALIAS ALIAS ALIAS

IN THE CIRCUIT COURT OF JEFFERSON COUNTY, ALABAMA

ProHealth LTC-Trussville, LLC)
)
PLAINTIFF,)
)
vs.) **Case No.:** [redacted]
)
[redacted])
)
)
DEFENDANTS.)

COMPLAINT

Comes now the Plaintiff in the above styled cause, and represents unto this Honorable Court as follows:

1. Plaintiff, ProHealth LTC-Trussville, LLC. is an Alabama Corporation, that operates a nursing home located at 119 Waterson Parkway, Trussville, Jefferson County, Alabama.

2. Defendant, [redacted], is an individual who is a resident at the Nursing Home. Defendant, [redacted], is an individual, who lives at [redacted] who signed an admission agreement on behalf of [redacted].

Count One

3.. Plaintiff avers that the Defendant [redacted], entered into an Admission Agreement contract with the Plaintiff to be responsible for the health care services and nursing home care provided to [redacted] The Plaintiff has provided the nursing home care as requested and the sum of $67,435.70is due for said services. The Defendant has failed and refused to pay these charges and Plaintiff avers that the Defendant owe the Plaintiffs the sum of Sixty-Seven Thousand

Four Hundred Thirty-Five and 70/100 ($67,435.70), for nursing home services provided to [redacted], plus interest and costs due by breach of contract.

2. Under the terms of the agreement, Defendants agreed to be liable to Plaintiff for the payment of all balances of the account, including any account charges.

3. Defendants are presently in default to Plaintiff under the Agreement.

Defendants owe to Plaintiff the sum of $67,435.70.

4. Under the terms of the loan agreement, Defendant agreed to pay for all costs of collection of the balance of this agreement plus a reasonable attorney's fee.

WHEREFORE, Plaintiff demands judgment against the Defendant in the amount of $67,435.70, plus attorney fees, interest and costs.

Count Two

5. Plaintiff, PROHEALTH LTC-TRUSSVILLE, LLC, adopts and reaffirms each and every allegation in the foregoing paragraphs 1 through 4 as if fully set out herein, and adds the following:

6. Plaintiff regularly sent invoices to Defendant reflecting charges owed.

7. Defendant owes the Plaintiff the sum of $67,435.70due by open account.

WHEREFORE, Plaintiff demands judgment against the Defendant in the amount of $67,435.70, plus attorney fees, interest and costs.

Count Three

8. Plaintiff, PROHEALTH LTC-TRUSSVILLE, LLC, adopts and reaffirms each and every allegation in the foregoing paragraphs 1 through 7 as if fully set out herein, and adds the following:

9. Defendant owes the Plaintiff the sum of $67,435.70 by account stated.

WHEREFORE, Plaintiff demands judgment against the Defendant in the amount of $67,435.70, plus attorney fees, interest and costs.

Count Four

10. Plaintiff, PROHEALTH LTC-TRUSSVILLE, LLC, adopts and reaffirms each and every allegation in the foregoing paragraphs 1 through 9 as if fully set out herein, and adds the following:

11. Defendant owes the Plaintiff the amount of $67,435.70 for breach of contract.

WHEREFORE, Plaintiff demands judgment against the Defendant in the amount of $67,435.70, plus attorney fees, interest and costs.

/S/ Michael L. McKerley
Michael McKerley (MCK027)
Attorney for Plaintiff,
PROHEALTH LTC-TRUSSVILLE, LLC

Of Counsel:
The McKerley Law Firm
PO BOX 660955
Birmingham, Alabama 35266
Telephone: 205/979-3118
contact@mckerleylawfirm.com

PLEASE SERVE DEFENDANTS AT:

[redacted]

Complaint: ProHealth LTC-Trussville, LLC

IN THE CIRCUIT COURT OF JEFFERSON COUNTY, ALABAMA

ProHealth LTC-Trussville, LLC	)	
	)	
PLAINTIFF,	)	
	)	
vs.	)	**Case No.: CV-20-**
	)	
[redacted]	)	
	)	
DEFENDANTS.	)	

COMPLAINT

Comes now the Plaintiff in the above styled cause, and represents unto this Honorable Court as follows:

1. Plaintiff, ProHealth LTC-Trussville, LLC. is an Alabama Corporation, that operates a nursing home located at 119 Waterson Parkway, Trussville, Jefferson County, Alabama.

2. Defendant, [redacted], is an individual who was a resident at the Nursing Home. Defendant, [redacted] is an individual, believed to be residing in Jefferson County, AL, who signed an admission agreement on behalf of [redacted].

Count One

3.. Plaintiff avers that the Defendant [redacted], entered into an Admission Agreement contract with the Plaintiff to be responsible for the health care services and nursing home care provided to [redacted]. The Plaintiff has provided the nursing home care as requested and the Defendants have failed and refused to pay these charges and Plaintiff avers that the Defendants owe the Plaintiff the sum of Eleven Thousand Eight Hundred Forty and 46/100 Dollars, ($11,840.46) for nursing home services provided to [redacted], plus interest and

costs due by breach of contract.

4. Under the terms of the agreement, Defendants agreed to be liable to Plaintiff for the payment of all balances of the account, including any account charges.

5. Defendants are presently in default to Plaintiff under the Agreement.

Defendants owe to Plaintiff the sum of $11,840.46.

6. Under the terms of the loan agreement, Defendant agreed to pay for all costs of collection of the balance of this agreement plus a reasonable attorney's fee.

WHEREFORE, Plaintiff demands judgment against the Defendant in the amount of $11,840.46, plus attorney fees, interest and costs.

Count Two

7. Plaintiff, PROHEALTH LTC-TRUSSVILLE, LLC, adopts and reaffirms each and every allegation in the foregoing paragraphs 1 through 6 as if fully set out herein, and adds the following:

8. Plaintiff regularly sent invoices to Defendant reflecting charges owed.

9. Defendant owes the Plaintiff the sum of $11,840.46 due by open account.

WHEREFORE, Plaintiff demands judgment against the Defendant in the amount of $11,840.46, plus attorney fees, interest and costs. .

Count Three

10. Plaintiff, PROHEALTH LTC-TRUSSVILLE, LLC, adopts and reaffirms each and every allegation in the

foregoing paragraphs 1 through 9 as if fully set out herein, and adds the following:

11. Defendant owes the Plaintiff the sum of $11,840.46 by account stated.

WHEREFORE, Plaintiff demands judgment against the Defendant in the amount of

$11,840.46, plus attorney fees, interest and costs.

Count Four

12. Plaintiff, PROHEALTH LTC-TRUSSVILLE, LLC, adopts and reaffirms each and every allegation in the

foregoing paragraphs 1 through 11 as if fully set out herein, and adds the following:

13. Defendant owes the Plaintiff the amount of $11,840.46 for breach of contract.

WHEREFORE, Plaintiff demands judgment against the Defendant in the amount of

$1,364.00, plus attorney fees, interest and costs.

/S/ Michael L. McKerley
Michael McKerley (MCK027)
Attorney for Plaintiff,
PROHEALTH LTC-TRUSSVILLE, LLC

Of Counsel:
The McKerley Law Firm
PO BOX 660955
Birmingham, Alabama 35266
Telephone: 205/979-3118
contact@mckerleylawfirm.com

PLEASE SERVE DEFENDANTS AT:

[redacted]

This is an attempt to collect a debt and any information obtained will be used for that purpose.

Complaint: ProHealth LTC-Trussville, LLC

ELECTRONICALLY FILED
12/15/2020 3:18 PM
[redacted]
CIRCUIT COURT OF
JEFFERSON COUNTY, ALABAMA
JACQUELINE ANDERSON SMITH, CLERK

IN THE CIRCUIT COURT OF JEFFERSON COUNTY, ALABAMA

ProHealth LTC-Trussville, LLC	)	
	)	
PLAINTIFF,	)	
	)	
vs.	)	**Case No.: CV-20-**
	)	
[redacted]	)	
	)	
	)	
DEFENDANTS.	)	

COMPLAINT

Comes now the Plaintiff in the above styled cause, and represents unto this Honorable Court as follows:

1. Plaintiff, ProHealth LTC-Trussville, LLC. is an Alabama Corporation, that operates a nursing home located at 119 Waterson Parkway, Trussville, Jefferson County, Alabama.

2. Defendant, [redacted], is an individual who was a resident at the Nursing Home. Defendant, [redacted] is an individual, believed to be residing in Jefferson County, AL, who signed an admission agreement on behalf of [redacted].

Count One

3.. Plaintiff avers that the Defendant [redacted], entered into an Admission Agreement contract with the Plaintiff to be responsible for the health care services and nursing home care provided to [redacted]ylor. The Plaintiff has provided the nursing home care as requested and the Defendants have failed and refused to pay these charges and Plaintiff avers that the Defendants owe the Plaintiff the sum of Eleven Thousand Eight Hundred Forty and 46/100 Dollars, ($11,840.46) for nursing home services provided to [redacted], plus interest and

costs due by breach of contract.

4. Under the terms of the agreement, Defendants agreed to be liable to Plaintiff for the payment of all balances of the account, including any account charges.

5. Defendants are presently in default to Plaintiff under the Agreement.

Defendants owe to Plaintiff the sum of $11,840.46.

6. Under the terms of the loan agreement, Defendant agreed to pay for all costs of collection of the balance of this agreement plus a reasonable attorney's fee.

WHEREFORE, Plaintiff demands judgment against the Defendant in the amount of $11,840.46, plus attorney fees, interest and costs.

Count Two

7. Plaintiff, PROHEALTH LTC-TRUSSVILLE, LLC, adopts and reaffirms each and every allegation in the foregoing paragraphs 1 through 6 as if fully set out herein, and adds the following:

8. Plaintiff regularly sent invoices to Defendant reflecting charges owed.

9. Defendant owes the Plaintiff the sum of $11,840.46 due by open account.

WHEREFORE, Plaintiff demands judgment against the Defendant in the amount of $11,840.46, plus attorney fees, interest and costs. .

Count Three

10. Plaintiff, PROHEALTH LTC-TRUSSVILLE, LLC, adopts and reaffirms each and every allegation in the

foregoing paragraphs 1 through 9 as if fully set out herein, and adds the following:

11. Defendant owes the Plaintiff the sum of $11,840.46 by account stated.

WHEREFORE, Plaintiff demands judgment against the Defendant in the amount of

$11,840.46, plus attorney fees, interest and costs.

Count Four

12. Plaintiff, PROHEALTH LTC-TRUSSVILLE, LLC, adopts and reaffirms each and every allegation in the

foregoing paragraphs 1 through 11 as if fully set out herein, and adds the following:

13. Defendant owes the Plaintiff the amount of $11,840.46 for breach of contract.

WHEREFORE, Plaintiff demands judgment against the Defendant in the amount of

$1,364.00, plus attorney fees, interest and costs.

/S/ Michael L. McKerley
Michael McKerley (MCK027)
Attorney for Plaintiff,
PROHEALTH LTC-TRUSSVILLE, LLC

Of Counsel:
The McKerley Law Firm
PO BOX 660955
Birmingham, Alabama 35266
Telephone: 205/979-3118
contact@mckerleylawfirm.com

[redacted]

This is an attempt to collect a debt and any information obtained will be used for that purpose.

District of Columbia

Admission Agreement: Stoddard Baptist Nursing Home

Stoddard Baptist
NURSING HOME

Isolation Room Notice

Rooms 120, 220 and 320 are our designated isolation rooms. If you are assigned to one of these rooms, please be advised that you may be relocated to another room within the facility in the event another resident's medical needs require isolation. This room may or may not be a private room.

You will receive written notification about any intent to relocate, the reason for the relocation or transfer, its effective date, the location to which you will be transferred or moved to and your right regarding transfers or relocation. If you are to be relocated due to an isolation emergency situation, you will be notified of the anticipated location as soon as possible.

We look forward to you and your Next of Kin/Point of Contact or legal agent's cooperation and assistance in assuring all of the resident's needs are met.

Signature: [redacted]

Point of Contact/Next of Kin

[redacted]

Date

Witness: [redacted]

[redacted]

Date

Answer all questions and indicate YES or NO in the space provided. If any question is answered YES, complete all information in the appropriate section below. If all are answered NO, Medicare is the primary payer.

QUESTIONS:

a.	Do you or your spouse work for a company that provides you with health insurance	YES ☐	NO ☒
b.	Is this hospitalization or treatment caused by an automobile accident or other accident?	YES ☐	NO ☒
c.	Is this hospitalization or treatment caused by an accident or illness that occurred?	YES ☐	NO ☒
d.	Have you revoked standard Medicare in lieu of Hospice or HMO?	YES ☐	NO ☒

A. EMPLOYER GROUP HEALTH PLAN	B. AUTO MEDICAL OR NOT FAULT OR ANY LIABILITY INSURANCE	C. WORKER'S COMPENSATION OR BLACK LUNG
Insurance Company:	Insurance Company:	Insurance Company
Insured's Name"	Name of Insured:	Claim or Policy Number:
Patient's Relation to Insured:	Claim or Policy #:	Name of Employer:
Claim or Policy #:	Date of Accident:	Employer Location:
Name of Group or Plan:		Signature [redacted]
Group Identification:	D. REVOCATION OF MEDICARE	
Employer Name:	1. HMO _____ Date	[redacted]
Employer Location:	Revocation of HMO _____ Date	Date: [redacted]
Employer's Location	2. HOSPICE _____Date	
Patient's Retirement Date:	Revocation of Hospice _____Date	

Stoddard Baptist NURSING HOME

This is a Comprehensive Admission Agreement (referred to as "Agreement") between Stoddard Baptist Nursing Home (SBNH), 1818 Newton Street, NW, Washington, DC and [redacted] (referred to as "you" or "Resident") and _____ Resident's Next of Kin/Point of Contact.

This Agreement describes the services that SBNH will provide to you and the responsibilities of SBNH, the Next of Kin/Point of Contact.

Service and Payment

A. **Service and Resident Status.** SBNH will provide you with room and board, residential services and medical services. SBNH's medical services will be provided in accordance with a "plan of care" which SBNH and your physician will prepare after consultation with you.

B. **Resident Physician.** You have named Dr. N/A as your physician. At SBNH's discretion, we may consult with your physician and request that your physician attend to you. In the event that your physician is unavailable when needed or called upon by SBNH, SBNH may call its Medical Director or another physician, at SBNH's discretion to take care of you until your doctor is available, and you agree to pay all costs and expenses for this physician.

C. **Hospital Information.** You authorize N/A Hospital located at _____ to provide SBNH with a copy of your medical record along with any other information about you, which the hospital may have upon your discharge from the hospital and entrance and/or readmission to SBNH. The information forwarded from the hospital to SBNH will be used by SBNH only as authorized by you and/or the Next of Kin/Point of Contact in order to provide services to you.

D. **Financial Responsibility**

1. **Rate Schedule.** SBNH's current rate sheet schedule for the Daily Room Rate and other items, services and medical care have been given to you. SBNH may change the rate schedule from time to time upon no less than fifteen days written notice to you.

2. **Payment.** You agree to pay all SBNH charges and fee on or before the first day of the month following receipt of a bill. Any outstanding amounts bear interest at the rate of 1-1/2 percent per month.

3. **Daily Room Rate.** Private patients pay for SBNH's services from their own income or resources or from their own private insurance at SBNH's "Daily Room Rate" and at SBNH's rate for other items and services Payment for Veterans Administration ("VA") patients is covered by an agreement between SBNH and the VA Medicare and Medicaid patients are responsible to pay SBNH's charges and fee from their own income or resources to the extent that those charges and fees are not paid for by the VA, Medicare or Medicaid patient.

4. **Change in Status**

   a. Regardless of any change in your payment status during your stay at SBNH or any rejection or delay in obtaining eligibility under any payment program, you are responsible for all applicable SBNH charges and fees that are not timely paid under a payment program.

   b. If you are eligible to change status to become a Medicaid patient, SBNH will provide you and/or Responsible Party with information regarding an application for Medicaid eligibility. You and/or Next of Kin/Point of Contact however, have the ultimate duty and obligation to take all steps necessary, in a timely manner, to file for and obtain Medicaid eligibility. You and/or Next of Kin/Point of Contact must notify SBNH in writing as soon as possible of your intention to seek Medicaid eligibility and when your application for Medicaid is filed. If you and/or Next of Kin/Point of Contact fail to take all steps necessary in a timely manner to file for and obtain Medicaid eligibility, you and/or Next of Kin/Point of Contact will be personally liable to SBNH for all charges and fees not covered by Medicaid which otherwise would have been covered had application been made in a timely and proper manner.

5. **Ancillary Items Services and Medical Care.** SBNH offers a variety of items, service and ancillary medical care that are not covered by the Daily Room Rate and are not reimbursable under the VA, Medicare and Medicaid programs. These items and services include, but are not limited to, podiatry services, rehab services, dental services, special food, special nurses, clothing, personal laundry, beauty and barber shops, newspapers and other health, convenience and comfort items and services.

6. **Next of Kin/Point of Contact.** Next of Kin/Point of Contact agrees to set up a direct deposit of all benefits upon admission to SBNH to assure payment to residents' private resources. SBNH will transfer all but seventy (70) dollars

toward the cost of care or private portion. The seventy (70) dollars is the personal allowance per the Department of Human Resources and is subject to change upon new regulations. These monies may be maintained in a resident trust fund account as described below.

The Next of Kin/Point of Contact acknowledges that he/she has legal access to resident's income and other resources. The Next of Kin/Point of Contact agrees to pay from resident's income and other resources any amount owed by the resident to SBNH. The Next of Kin/Point of Contact agrees that upon resident's discharge from SBNH he/she will take responsibility for resident's residential and medical needs.

7. **Collection Cost and Legal Fees.** The Resident and Next of Kin/Point of Contact are liable for agency collection charges and all other expenses and collection, including reasonable attorneys' fees and court cost.

E. **Private Patients**

1. You are (_____) or are not (✓) a private patient.

2. Assignment of Insurance Benefits. You hereby assign to SBNH any private insurance coverage that you have that covers the services or items provided to you to SBNH. The coverage consists of: Policy # _____Group # _____with the _____Insurance Company.

Upon receipt by SBNH of a check or other payment order payable to you from an insurance company for services or items provided to you by SBNH, you authorize SBNH to endorse or otherwise cash this payment for you and retain the proceeds in payment for any amounts owed to SBNH and to release to your insurance companies any information about you required by the insurance companies to process payments required hereunder.

F. **VA Patients**

1. You are (_____) or are not (✓) a VA patient under terms of an agreement between SBNH and the VA.

2. Rights and Responsibilities; except as modified by SBNH's agreement with the VA, VA patients have the same rights and responsibilities as a private patients.

G. **Medicare Patients**

1. You are (✓) or are not (_____) a Medicare Part A patient.

2. You are (_____) or are not (✓) a Medicare Part B patient.

3. **Authorization.** By signing this Agreement, you make the following authorization: request that payments or authorized Medicare benefits be made on my behalf to SBNH for any service and/or supplies furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services."

4. **Medicare Eligibility**. In order to be eligible for Medicare coverage, you must meet all Medicare requirements and by signing this Agreement you certify that the information given by you or on your behalf to SBNH for Medicare eligibility purpose is correct. SBNH will make an initial recommendation of Medicare eligibility based upon good faith effort by SBNH to review medical information about you available at the time of or prior to admission to SBNH. Your condition will be reviewed biweekly by SBNH's Utilization Review Committee with respect to continued eligibility. You will remain liable for SBNH's charges in the event that Medicare coverage is rejected or restricted without regard to SBNH's involvement in that determination.

5. **Coinsurance. You understand that Medicare Part A will pay only for a maximum number of days at SBNH: for the first 20 days Medicare Part A will pay for all covered services. For the 21st day through the 100th day, Medicare Part A pays for all covered services except for a daily coinsurance amount that is your responsibility unless you are also a Medicaid recipient. The current coinsurance amount is $176.00 per day. Information can be provided regarding Medicare services.**

H. **Medicaid Patients**

1. You are (_____) or are not (✓) a Medicaid patient.

2. **Medicaid Eligibility**. In order to be eligible for Medicaid coverage you must meet all Medicaid requirements. You are responsible for filing and for retaining Medicaid coverage.20

3. **Source of Income**. If you are a Medicaid patient, SBNH is entitled to the proceeds from your Social Security and other income checks, except for the State authorized personal expenses, to be applied to the cost of your care. You authorize SBNH to endorse or otherwise cash such checks, disburse the personal allowance portion and other allowable personal expenses to you or others designated by you as entitled thereto, and to apply the balance to the cost of your care.

4. **Medicaid Patient Eligible for Medicare Part B.** If you are a Medicaid patient and you are eligible for Medicare Part B, SBNH will provide you and the Responsible Party with information and assistance regarding an application for Medicare Part B eligibility. Unless you or the Responsible Party object, it is presumed that as a Medicaid patient eligible for Medicare Part B, you and/or your assigned point of contact/next of kin will take the necessary steps to apply for Medicare Part B in a timely manner.

II. RESIDENT AND SBNH RESPONSIBILITIES

A. **Resident's Refusal to Accept Care**. You have the right to refuse treatment. If you refuse to accept any nursing care, medical or other treatment, or other item or service that SBNH or your physician believes is necessary, you accept responsibility for any consequences resulting from your refusal to accept nursing care or medical treatment and SBNH is released from any and all liability which may result from the lack of this care, treatment, item, or service.

B. **Food, Beverage and Drug Substance**. SBNH will not be liable for any services received by the resident, but not provided by SBNH, i.e. food, beverage, drug, etc.

C. **Medicine, Medication and Treatment**. SBNH will not furnish you with any medicine, medication or treatment unless your physician or SBNH's Medical Director first authorized SBNH to do so.

D. **Emergency Medical Treatment**. You authorize SBNH to provide you with any emergency medical treatment that SBNH or your physician believes necessary or to arrange for your transfer to a hospital or other facility for these purposes.

E. **Responsibility or Personal Items**. SBNH is obligated to take reasonable precautions to provide you and your personal belongings with security, including providing a reasonable amount of secured space for your belongings. SBNH, however, cannot be responsible for any loss or damage to your valuables or money that is not delivered into the custody of SBNH's Administrator or his/her designee, unless that loss or damage is caused solely by the negligent or willful action of the SBNH staff.

F. Liability for Personal Injuries, Illness, Disability, Death or Other Harm or Property Damage. SBNH will not be liable for personal injuries, illness, disability, death, or other harm or property damage of any kind suffered by you while under our care while being transferred or discharged, except where personal injury, illness, disability, death or other harm or property damage is caused by SBNH negligence.

You agree to indemnify and hold SBNH and its officers, employees and agents harmless from and against any liability for personal injuries, illness, disability, death or other harm or property damage caused by you.

III. **TRANSFER, DISCHARGE, AND TERMINATION**

A. Involuntary Transfer and Discharge. You will occupy a room assigned by SBNH and SBNH will permit you to retain the room originally assigned. However, SBNH may transfer you to another room or part of the facility, or transfer you to another facility or discharge you if:

(i) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;

(ii) The transfer or discharge is appropriate because the residents' health has improved sufficiently so the resident no longer needs the services provided by the facility;

(iii) The safety of individuals in the facility is endangered;

(iv) The health of individuals in the facility would otherwise be endangered;

(v) The resident has failed, after reasonable and appropriate notice, to pay for or to have paid under the Medicare or Medicaid stay at Stoddard Baptist Nursing Home, or any allowable charges not contrary to applicable law; or

(vi) The facility ceases to operate.

When the facility transfers or discharges a resident under any of the circumstances specified in paragraph (i) through (v) above, the resident's clinical record must be documented. The documentation must be made by -

(i) The resident's physician when transfer or discharge is necessary under paragraph (i) or (ii) of this section; and

(ii) A physician when transfer or discharge is necessary under paragraph (iv) of this section.

Stoddard Baptist Nursing Home will give at least 30 days prior written notice of any involuntary transfer or discharge (and at least 7 day notice of a relocation within the facility) and an opportunity to appeal the transfer or discharge, unless this is not

practicable, such as in an emergency when your continued presence at SBNH would be hazardous to you or others due to urgent medical needs.

We will also notify the Long Term Care Ombudsman program, the Responsible Party and, if applicable, the Director of DHS. If you are transferred because of any emergency situation, we will provide the required notice as soon as reasonable. The involuntary discharge letter will contain the reasons for the transfer, relocation or discharge and its effective date, the location to which you will be transferred, relocated or discharged, and your rights regarding discharge, relocation, or transfer. The letter will also tell you how you can appeal our decision to transfer, relocate or discharge you by requesting a hearing, and will tell you what agencies you can call.

If you are to be discharged involuntarily, we will comply with the current law in making discharge or transfer arrangements.

You and your Responsible Party or legal agent must cooperate and assist in the discharge planning, including cooperation with and assisting other facilities considering admitting you and cooperating with governmental agencies.

B. **Voluntary Transfer or Termination of Agreement**. You may arrange for your discharge from SBNH at any time and for any reason. If you do not, however, provide SBNH with at least five day notice of your departure, you will be charged for the five-day notice period (if permitted by applicable law). You will pay all amounts owed by you to SBNH prior to your departure date.

IV. RE-ADMISSION

A. **Readmission Conditions.** If you leave SBNH for the hospital, SBNH will endeavor to readmit you to SBNH unless:

1. You need a level of care not provided by SBNH.

2. Your physician or SBNH's Medical Director determines that you would be a danger to yourself or others.

3. At the time of proposed readmission, you have unpaid fees or charges owed to SBNH.

4. SBNH does not have an appropriate bed available for you.

B. **Admission Documentation**. If you are readmitted to SBNH after a hospital stay (within 45 days) this agreement and all other admission paperwork, at SBNH's option, will be in full force and effect as if no hospital stay had occurred.

C. **Resident's Rights.** As a Resident of SBNH, you have many rights under federal and State law. Some of those rights are listed in this section. You will be given a written description of all of your rights.

A. You have the right to make your own medical decisions, to manage your personal affairs and to access your medical records as permitted by law. If you become incapable of making your own decisions, it may be necessary for someone else to make decisions for you. For this reason, we recommend that you make advance directives for medical decisions and appoint a Power of Attorney for financial decisions, but you are not required to do so. It is recommended that you consult with an attorney to prepare a financial Power of Attorney. As part of the admission process you will be given a description of your legal rights to decide about your future medical treatment, as well as information about making advance directives. If you make an advance directive you should provide SBNH with a copy.

B. **Selection of a Doctor or Other Provider**

You may select your own doctor and other health care providers. Your doctor and other health care providers must follow our policies. If your doctor and other health care providers do not follow our policies and procedures, SBNH will ask you to choose other providers. You or your insurer, including the Medicaid Program are responsible for you doctor's payment. If you do not have your own doctor, you may choose one from the list of physicians who practice here. If you or your agent is unable to choose your "own doctor", we will assign one to you from this list. In case your doctor is not available when needed, our Medical Director or designee will take care of you until your doctor is available.

C. **Your Right to make Complaints and Suggest in Policies and Services**

You may make complaints about your care in the Facility and you may suggest changes in the policies and services of the Facility. You will not be harassed or discriminated against for making a complaint or suggesting a change in a policy or services. You may present your complaints orally or in writing to Facility Staff or the Administrator.

If the Facility is unable to resolve your complaint, it will be sent to the Long-Term Care Ombudsman's Office. You may request a hearing from that office.

D. **Holding Your Bed if You Leave the Facility**

If you are hospitalized or on leave from SBNH, we will hold your bed for you as follows:

1. If you are a private-pay resident or are receiving inpatient care reimbursed under the Medicare Program (and you are not covered under Medicaid Program), we will hold your bed for as long as you pay for it at the current daily rate or notify us otherwise.

2. **If Medicaid pays for part or all of your nursing home care and you need to be hospitalized, we will hold your bed for up to the maximum number of days required under Medicaid regulations, currently 18 days per DC Fiscal Year (Oct. 1 – Sept. 30). If you are away from the Facility on a leave of absence which is provided for in your plan of care and approved by your physician, we will hold your bed for up to the maximum number of days required under Medicaid regulations, currently 18 days each DC Fiscal year. While we are holding your bed, you are still required to pay the Facility any amount for which you are responsible as determined by the Medicaid Program. Whether in the hospital or on leave of absence, the days are cumulative.**

   If your hospitalization or leave exceeds the number of days paid by Medicaid Program, you may pay privately to reserve your bed for the additional days. In any case, if your hospitalization or leave of absence exceeds the total number of days paid by the Medicaid Program or any other payer, you have the right to be readmitted to the first available gender-appropriate semi-private bed.

   The maximum number of days for which the Medicaid Program will pay to hold your bed for hospitalization or leave of absence maybe increased or decreased based upon changes in the law or the regulations established by the District of Columbia Medical Assistance Program.

3. If you have applied for Medicaid, your bed will be reserved in accordance with Paragraph 2. However, if you are found to be ineligible for Medicaid, then you are required to pay for the bed as a private pay patient as described in Paragraph 1.

4. Other third-party payers may or may not have a bed hold policy. We will discuss this if it applies to you.

V. **ADVANCE DIRECTIVE ACKNOWLEDGEMENT**

A. You have received an oral and a written explanation of your right to make an Advance Decision ("Advance Directive") about life-sustaining or life-prolonging measures in cases where you are acutely and terminally ill and not conscious or otherwise competent to make decisions. SBNH will not withhold or withdraw life-sustaining or life-prolonging measures from you without an Advance Directive and a physician order. You understand that you are not required to execute an Advance Directive. The terms of any Advance Directive that you have executed will be followed by SBNH to the extent permitted by law.

B. You have (_____) or you have not (✓) executed an Advance Directive.

VI. **EQUIPMENT**

SBNH will furnish standard equipment ordered by your personal physician. In addition, with SBNH's written consent, you may bring to SBNH special equipment for your personal use. You do so, however, at your own risk.

VII. **NOTICE OF CONSENT TO AIDS/HEPATITIS 8 TESTING**

A. **Applicability**. SBNH is legally authorized to require that Residents be tested for HIV antibodies (AIDS) and for Hepatitis B Infection when a SBNH health care worker is exposed to the body fluids of a Resident in a way which may transmit AIDS or Hepatitis B.

B. **Consent**. In the event of such exposure, you have consented to testing by signing this Agreement, and you have consented to the release of the test results to the exposed health care workers. Except in emergencies, you will be informed before any of your blood is tested for AIDS or Hepatitis B, and you will be given the opportunity to ask any questions.

C. **Test Results**. You will be provided with the test results and appropriate counseling. Test results, if positive will be reported to the DC Department of Health.

VIII. **NOTIFICATION OF FUNERAL HOME**

A. In the event of your death, you authorize SBNH to contact the _____Funeral Home.

Street Address: _____
City, State and Zip Code: _____
Phone Number: _____

B. Also, in the event of your death, you authorize SBNH to enter your living quarters to inventory, secure, and store any of your property.

C. If you have made arrangements to donate your remains, please complete the remainder of this paragraph:

Name of Institution: _____
Contact Person & Phone Number: _____
Transportation Agreement: _____
Is a Funeral Home Involved? _____
Name of Funeral Home: _____

MISCELLANEOUS

A. **Assignment.** No party to the Agreement may assign his/her rights or responsebilities under the Agreement.

B. **Merger Clause**. This Agreement constitutes the entire agreement among the parties hereto and this Agreement may not be amended except in writing signed by the parties to the Agreement.

C. **Choice of Law**. The Agreement will be governed and construed in accordance with the laws and regulations of the District of Columbia.

D. **Severability**. Whenever possible, each provision of this Agreement will be interpreted in such a manner as to be effective under applicable law. If at any time any provision of this Agreement is deemed invalid, this provision will be severed from the Agreement and the remaining provision of this Agreement will be unaffected.

E. **Additional Documents**. It is not possible to cover everything that is important to your stay in our Facility in the body of this Contract. Therefore, we have included additional important documents as Exhibits. These Exhibits are part of this Contract. Please verify that you received the Exhibits and that the contents *of*

the Exhibits were explained to you by placing your initials on the line next to the description of each Exhibit.

CHANGES IN LAW

Any provision of this Contract that is found to be invalid or unenforceable as a result of a change in State or Federal law will not invalidate the remaining provisions of this Contract and. it is agreed that to the extent possible, the Resident and Facility will continue to fulfill their respective obligations under this Contract consistent with law.

The undersigned on the _____ day of 2/24/2020. having read the Agreement understand and agree to the terms and conditions of the Agreement.

[redacted]

Signature

Resident: [redacted]

Next of Kin/Point of Contact

Relationship to Resident

Address

Telephone

Witness

Admission Agreement Addendum

It is understood and agreed by Stoddard Baptist Nursing Home (the "Facility" and [redacted] ("Resident", or "Resident's Authorized Representative"), hereinafter collectively the "Resident") that any legal dispute, controversy, demand or claim (hereinafter collectively referred to as "claim" or "claims") that arises out of or relates to the Resident Admission Agreement or any service or health care provided by the Facility to the Resident, shall be resolved exclusively by binding arbitration to be conducted at a place agreed upon by the parties, or in the absence of such agreement, at the Facility, in accordance with the American Health Lawyers Association ("AHLA") Alternative Dispute Resolution Service Rules of Procedure for Arbitration which are hereby incorporated into this agreement," and not a lawsuit or resort to court process except to the extent that applicable state or federal law provides for judicial review of arbitration proceedings or the judicial enforcement of arbitration awards.

This agreement to arbitrate includes, but is not limited to, any claim for payment, nonpayment or refund services rendered to the Resident by the Facility, violations of any right granted to the Resident by law or by the Resident Admission Agreement, breach of contract, fraud or misrepresentation, negligence, gross, negligence, malpractice, or any other claim based on any departure from accepted standards of medical or health care or safety whether sounding in tort or in contract. However, this agreement to arbitrate shall not limit the Resident's right to file a grievance or complaint, formal or informal, with the Facility or any appropriate state or federal agency.

The parties agree that damages awarded, if any, in an arbitration conducted pursuant to this Arbitration Agreement shall be determined in accordance with the provisions of the state or federal law applicable to comparable civil action, including any prerequisites to, credit against or limitations on, such damages.

It is the intention of the parties to this Arbitration Agreement that it shall inure to the benefit of and bind parties, their successors and assigns, including the agents, employees and servants of the Facility, all persons who claim is derived through or on behalf of the Resident, including that of any parent, spouse, child, guardian, executor, administrator, legal representative, or heir of the Resident.

All claims based in whole or in part on the same incident, transaction, or related course of care or services provided by the Facility to the Resident, shall be arbitrated in one proceeding. A claim shall be waived and forever barred if it arose prior to the date upon which notice of arbitration is given to the Facility or received by the Resident, and is not presented in the arbitration proceeding.

The parties understand and agree that by entering this Arbitration Agreement they are giving up and waiving their constitutional right to have any claim decided in a court of law before a judge and a jury.

The Resident understands that (1) he/she has the right to seek legal counsel concerning this agreement and (2) the execution of this Arbitration is not a precondition to the furnishing of services to the Resident by the Facility. This Arbitration Agreement shall remain in effect for all care and services subsequently rendered at the Facility even if such care and services are rendered following the Resident's discharge and readmissions to the Facility.

[redacted] N/A

Resident/Representative Date Facility's Authorized Agent Date

Resident/Representative Printed Name Facility's Authorized Agent Printed Name

Stoddard Baptist
NURSING HOME
1818 Newton Street, NW, Washington DC 20010 (202) 328-7400

Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

. ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

. ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

. ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	*Example: A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	*Example: We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	*Example: We give information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as: • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect, or domestic violence • Preventing or reducing a serious threat to anyone's health or safety
Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy laws.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you: • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Linda Lee, HIPAA Officer (202) 328-7400, ext. 1323

Remy Johnson, Administrator (202) 328-7400, ext. 1306

STODDARD BAPTIST NURSING HOME

Notice of Privacy Practices

Acknowledgement of Receipt Form

I acknowledge that I have received written notice from Stoddard Baptist Nursing Home regarding the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Privacy Rule (45 C.F.R. 160 and 164). I also have been asked to carefully review the Stoddard Baptist Nursing Home NOTICE OF PRIVACY PRACTICES.

Resident Name: [redacted] [redacted]

Last First MI

[redacted]

Signature of Resident/Responsible Party

Self

Relationship

[redacted]

Date

Residents and/or Designated point of contact/responsible Party and staff have the right to request restrictions on using and disclosing of health information. I hereby authorize the release (use and/or disclosure) of my individually identifiable health information by Stoddard Baptist Nursing Home personnel for health care treatment, payment and health care business operation purposes.

N/A

Next of Kin/Point of Contact Date

N/A

Witness Date

NO permission - See

Stoddard Baptist Nursing Home

Barber and Beauty Shop Services

The Barber and Beauty Shop is open for services to residents from 9:00 a.m. to 5:30 p.m. on Wednesday and Friday. The following services are available at the indicated prices.

Residents and family members may pay for these services by check for the exact amount or by charging it to their personal accounts, if they have such an account. The Cosmetology Manager is responsible for collecting fees or charging personal accounts.

If you wish to have a resident's hair done, contact the nursing staff on the resident's floor (unit). Nursing will inform the unit clerk or their social worker to make a request for an appointment. Once the cosmetologist collects the request forms, appointments will be made. Please be sure to tell the staff member what services you are requesting.

Please note: D.C. Regulation states that monies drawn from resident's account must have authorized signatures on each form. Therefore, when requesting beauty services, the request form must be signed by authorized person(s). You may sign two or three forms at a time, date them and put them in the request book on the unit. Residents that can sign their own forms may do so. At this time, we do not accept standing appointments.

I, the undersigned resident or his/her Next of Kin/Point of Contact hereby authorize the Stoddard Baptist Nursing Home to provide services at the Beauty/Barber Shop as needed.

Resident's Name (Print or Type)	Signature of Resident/Next of Kin/Point of Contact
Witness	Date

No such stuff available to me. because I cant use it. its too far away.

BEAUTY / BARBERSHOP

toddard Baptist Nursing Home

APPOINTMENT REQUEST FORM

AME:_____ ROOM #_____ DATE OF REQUEST:_____

SERVICES REQUEST:

Request Made By:_____ _____ Please check if resident is going out.

❑ Resident
❑ Family

(Resident/Family Signature)

_____	*Shampoo & Set*	***10.00***	_____	*Permanent Relaxer*	***27.00***	_____	*Shave Only*	**2.00**
_____	*Shampoo, Set & Cut*	***15.50***	_____	*Permanent - Cold Wave*	***30.00***	_____	*Wigs*	**9.50**
_____	*Shampoo & Blow Dry*	***7.50***	_____	*Demi Perm Color*	***15.00***	_____	*Mustache Trim Only*	***1.00***
_____	*Shampoo, Blow Dry & Curl*	***8.00***	_____	*Semi Perm Color*	***15.00***	_____	*Cut Hair Ends Only*	***3.75***
_____	*Shampoo, Press & Curl*	***11.50***	_____	*Color Rinse*	***2.50***	_____	*Hair Net*	***0.35***
_____	*Shampoo & Press*	***7.50***	_____	*Men's Hair Cut*	***6.50***	_____	*Eyebrow*	***0.50***
_____	*Shampoo Only*	***3.50***	_____	*Ladies Hair Cut*	***6.50***	_____	*Ear Hair*	***0.50***
_____	*Shampoo & Hair Cut Men*	***7.00***	_____	*Hair Tint*	***15.00***	_____	*Nose Hair*	***0.50***
_____	*Shampoo & Hair Cut Ladies*	***7.50***	_____	*Bedside Service*	***4.00***		*Eyebrow, Ear, Hair Nose*	
_____	*Shampoo & Conditioner Only*	***3.50***	_____	*Hair Cut, Shampoo & Shave*	***9.50***	_____	*Hair Cut & Shave Only*	***10.00***
_____	*Shampoo, Set & Conditioner*	***11.00***	_____	*Dandruff Treatment*	***4.00***	_____	*Oil Moisturizer*	***5.00***
_____	*Shampoo, Wrap & Dry*	***10.00***	_____	*No Rinse Shampoo Men*	***3.00***	_____	*Deep Penetration Trmt*	***6.00***
_____	*Shampoo, Cut, Beard Trim*	***13.00***	_____	*No Rinse Shampoo Ladies*	***4.00***	_____	*Special Conditioner*	***4.00***
			_____	*Reconstruction Treatment*	***5.00***	_____	*Beard Trim, Hair Cut*	***12.00***
			_____	*Shampoo and Braid*	***9.00***	_____	*Shampoo, Blow Dry & Braid*	***10.00***

Check if services MUST be provided on unit ❑

CASH ❑ ACCOUNT❑ CHECK❑ Preferred Date & Time_____

PLEASE DO NOT WRITE BELOW THIS LINE

APPOINTMENT MADE:

_____ AT_____ A.M. P.M.

COSMETOLOGY MANAGER

_____

SERVICES WERE PROVIDED AS ABOVE EXCEPT AS NOTED/OTHER COMMENTS:

TOTAL COST $_____ ❑ CASH ❑ ACCOUNT ❑ CHECK #_____

_____
COSMETOLOGIST SIGNATURE

BED HOLD AGREEMENT FOR PRIVATE PAY RESIDENTS

I, [redacted] understand that Stoddard Baptist Nursing Home will continue to hold the bed for _____ in the event of leave of absence from the facility. I also hereby authorize Stoddard Baptist Nursing Home to bill or private bed hold at the rate of $350.00 per day.

☐ I agree to the above statement.

☑ I do not agree to the above statement. I understand that any leave of absence from the facility will be considered a discharge, in which case, the bed may be made available for any immediate occupancy.

[redacted]

Signature of Resident/Next of Kin/Point of Contact

[redacted]

Date

w/A Self.

Witness

[redacted]

Date

they will lock up my important stuff & clother (in black bag & other bag). &c.
I will detain the room.

Stoddard Baptist NURSING HOME

Rate Schedule
Effective May 1, 2016

Room, Board and Routine Nursing Care	
Intermediate/Skilled	**$350.00 per day**
Physical Therapy	
Evaluation	$65.00 per unit (15 minutes)
Treatment	$65.00 per unit (15 minutes)
Occupational Therapy	
Evaluation	$65.00 per unit (15 minutes)
Treatment	$65.00 per unit (15 minutes)
Speech Therapy	
Evaluation	$65.00 per unit (15 minutes)
Treatment	$65.00 per unit (15 minutes)
Clinitron Bed and Supplies	$250.00 per day
Mattress overlay	$25.00 per day
Pharmaceuticals	Billed as used + 10%
Medical Supplies	Billed as used + 10%
Transportation	
Wheel chair van	$75.00 - $100.00
Taxi	$35.00
Escort Fee	$25.00

STODDARD BAPTIST NURISNG HOME RESIDENTS RIGHTS POLICY

REGARDING ADMISSION, TREATMENT, TRANSFER, CIVIL RIGHTS AND DISCHARGES

Attached is information that you and/or your family may want to have in order to make a decision about admission to the Facility including information about policies, rates, services, resident groups, the physical and social environment, and the complaint and/or suggestion procedure.

You have the right not to be transferred or discharged except for serious medical reasons, for your own good, for the welfare of other residents or non-payment of bills. If there is a good reason to be moved, you should have 30-day notice and you have the right to an impartial hearing in the matter. Only in a medical emergency may the 30-day notice be waived.

The policy of Stoddard Baptist Nursing Home is that no person shall on the grounds of race, color, creed, social status, national origin, handicap or age be excluded from participation in, be denied benefits of, or otherwise be subjected to discrimination in the provision of any care or services. Procedures have been instituted to assist you in making a complaint in the event you feel that your rights have been violated.

REGARDING YOUR PERSONAL LIVING ENVIRONMENT

1. You have the right to create a home-like environment for yourself, as much as possible, within your living quarters, i.e., having and using your own personal possessions, clothing, furniture, etc.

2. **You have the right to receive visitors at any time**, although we recommend the hours between 11:00 am and 8:00 pm.

3. You have the right to privacy in your own room, i.e., personnel must knock before entering your room. If your spouse is also a resident, you should be permitted to share a room unless medically contraindicated and documented in your medical record by your attending physician.

4. You have the right to communicate with others in privacy, i.e., by letters, telephone and visits from your spouse, family and friends.

5. You have the right to handle your own personal business affairs or to delegate this responsibility to the facility or to a sponsor as appropriate, i.e., payments of bills. If delegated, you have the right to proper accounting at least four times a year.

6. You have the right to expect that the facility will provide for the safekeeping of limited valuables and possessions, if you request it, and that you will be given a receipt for such items, i.e., jewelry.

7. You have the right to come and go as you wish, i.e., visiting, shopping, religious or social events, unless your physician has documented otherwise.

8. You have the right to engage in practices which express your individual beliefs, values, cultural and religious preferences, i.e., hair style, food, clothing and prayer. In addition, no religious beliefs or practices may be forced upon you by others.

9. You have the right to refuse to participate in any activity or practice which is against your religion or conscience, i.e., playing cards or watching movies with the facility.

10 You have the right to be free from physical and mental harassment and abuse.

11. You cannot be required to perform services for the facility.

12. If you are unable to read, you will have these rights and anything regarding your care read to you.

13. If you cannot write or sign your name, your mark will be witnessed by two person, at least one of whom is a staff member, who will indicate by your mark the reason for your inability to write your comment or sign your name.

REGARDING YOUR PROGRAM OF CARE

1. You have the right to know your medical condition and to participate in decisions about your program of health care with the collaboration of your family. In addition, you have the right to all of the information that you want to have to plan your health care, i.e., planning for treatments, medicines, activities and diet.

2. You have the right to refuse any treatment, procedure or medicine, as long as you understand the health risk of doing so.

3. You have the right to the privacy of your health, social, financial and other personal records. Information may be given to others only with your written permission.

4. You have the right to continuous, high quality health care from competent professionals and closely supervised paraprofessionals in training and auxiliary staff, i.e., licensed nurses, physician, therapist, nursing and medical students, licensed practical nurses, and nursing assistants.

5. You have the right to retain the services of your personal physician and the responsibility to see that he/she receives payment.

6. You have the right to be fully informed to your satisfaction about research practices, studies being carried out at the facility which affect your care, and to freely accept or freely refuse to participate in them, i.e., study comparing different types of physical exercises and their effect on your ability to care for yourself.

7. You have the right to receive care in the least restrictive environment consistent with your health needs, strengths, and abilities, i.e., the facility versus that Adult Medical Day Care Center. In addition, you may not be restrained by physical or chemical means except on the specific written order of your physician.

8. You have the right to use informal and formal means to express problems that you experienced with your program of care or living environment and to receive a fair resolution of them without fear of discrimination, coercion or any other harm. A copy of the grievance procedure is attached.

REGARDING THE LIMITATIONS ON INDIVIDUAL RIGHTS

1. You have the right to the full expression of your personal identity in so far as you show respect for and do not cause harm to your fellow residents and staff, i.e., playing loud music late at night.

2. All residents will be assigned to rooms, floors and sections in a manner consistent with 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 District of Columbia Rights Act of 1977. Residents will not be asked if they are willing or desire or share a room with a person in contravention of these laws. Further, transfer of patients from the assigned rooms will not be made for such reasons.

3. Staff privileges will not be denied to professionally qualified personnel due to race, color, national origin, handicap or age. Similarly, employees will be assigned to patient services without regard to any of the characteristics stated above.

4. All facilities of the Stoddard Baptist Nursing Home shall be utilized without regard to race, color, national origin, handicap or age.

QUARTERLY ACCOUNTING OF FINANCIAL STATUS

1. Written itemized accounting of disbursements and current balances will be distributed to you or your sponsor on a quarterly basis.

RESIDENT GRIEVANCE
POLICY AND PROCEDURE

The Facility maintains the following policy and procedures for reporting grievances in order to protect resident's personal and property rights and to prevent mistreatment, neglect, or exploitation of residents.

POLICY

A resident or any person on a resident's behalf has the right to voice a grievance either personally or by a representative, orally (by telephone), in writing, or in person. Residents will in no way be subjected to retaliation or discharge as a result of submission of a grievance.

PROCEDURE

Whenever possible, resolution of a grievance should be accomplished by discussion between the complainant and the supervisor in charge of the area where the situation occurred.

When no satisfaction is realized at the supervisor level, the following procedure for reporting grievance is followed:

WRITTEN GRIEVANCES

Grievance Report Forms shall be made available in the Administrative Offices, through the Facility's social workers, and at each nursing station. Where the resident or his/her representative so desires, a social worker shall assist in the completion of the Grievance Report Form.

ORAL GRIEVANCES

Oral grievances may be made by the direct contact with the Administrator, Director of Nursing, Social Workers, or any other individual who is able to record the grievance on the Grievance Report Form.

The Grievance Report Form should be filled out completely with the resident's name, time and date of the grievance and the nature of the grievance. The grievance will be reported to the Administrator by delivery of the Grievance Report Form. Each grievance will be logged in an administrative record kept by the Administrator. The Administrator or designee shall review each grievance filed within seventy-two (72) hours of its filing and shall respond in writing to the resident or resident's representative within five (5) business days. A copy of the action taken and results will be provided to the persons filing the report. Where appropriate, entry of the occurrence shall be made in the personnel record of relevant staff in accordance with established Personnel Policies.

Grievance Reports will not be placed in the residents' Medical Record unless a medical solution is desired.

Where the Administrator is unable to resolve the grievance to the resident's satisfaction, the resident will, if he/she so desires, be assisted in contacting the Ombudsman Program of the District of Columbia Office on Aging.

The exercise of the grievance procedure shall not in any way impair, nor be a prerequisite to, the rights of any resident to pursue other remedies for the violation of his/her civil rights.

STODDARD BAPTIST NURSING HOME
RESIDENT GRIEVANCE REPORT FORM

In accordance with the facility Residents Rights Grievance Policy and Procedure, each grievance shall be reported in writing to the Administrator where the resident desires assistance will be given in completing form. The Administrator shall act on a grievance report within five (5) working days.

Date_____

Resident's Name_____

Room Number _____ ID #_____

Name of Person Completing this Form_____

Relationship to the Resident_____

Nature of Grievance (Please provide all details, including date(s), time, description, person(s) involved, etc.)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signature_____ Date_____

Date Received by the Administrator_____ Initials_____

Administrator's Findings

_____

_____

_____

_____

Action Taken

_____

_____

_____

_____ _____

Administrator/Date Department Head/Date

Follow-up Required

_____

_____

_____

Grievance Resolved Satisfactorily

_____ _____

Resident/Responsible Party/Date Administrator/Date

Grievance Not Resolved Satisfactorily – Course of Action Taken

_____

_____

_____

_____

_____ _____

Signature Date

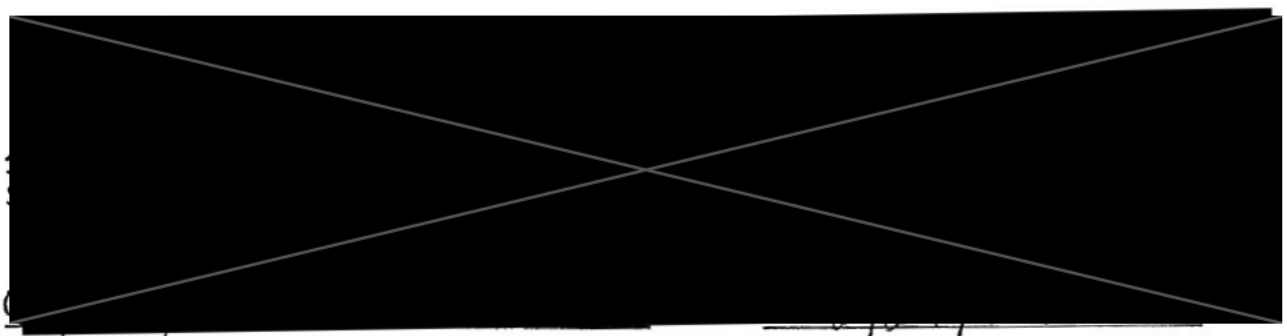
ACKNOWLEDGEMENT OF RECEIPT OF RESIDENTS RIGHTS/GRIEVANCE PROCEDURE

You are required to acknowledge in writing that you have received this document (RESIDENT'S RIGHTS/GRIEVANCE POLICY AND PROCEDURE) and all rules and regulations that govern resident conduct and responsibilities for the Stoddard Baptist Nursing Home.

This is to acknowledge that I have received a copy of the Stoddard Baptist Nursing Home Resident Rights Policy. Further, I had the opportunity to read and understand the policy and had my questions regarding it answered. I understand that in signing, I am accepting the rights and responsibilities contained in this policy.

When the resident is incapable of understanding his other rights and responsibilities, these rights will devolve to the Next of Kin/Point of Contact.

NOTE: The Residents Right Policy has been developed in accordance with 20 CFR 405.1121(k) and DCMR 22 Section 3207.



Witness

Date

1. The Stoddard Baptist Nursing Home shall permit members of community organizations and representatives of community legal services programs, whose purpose include rendering assistance without charge *to* nursing home residents, *to* have full and free access *to* the health care facility in order to:

   A) Visit, talk with, and make personal, social and legal service available to all residents.

   B) Inform residents of their rights and entitlement, and their corresponding obligations, under Federal and District Laws by means of distribution of educational materials and discussion in-groups and with individual patients.

   C) Assist residents in asserting their legal rights regarding claims for public assistance, medical assistance, and social security benefits, as well as in all other matters in which patients are aggrieved. Assistance may be provided individually, as well as on a group basis, and may include organizational activity, as well as counseling and litigation.

   D) Inspect all areas of the health care facility except the living areas of a resident who protests such inspection. Such authority shall not include the right to examine the business records of the facility without the consent of the Administrator, nor the clinical record of a resident without his consent.

   E) Engage in all other methods of assisting, advising, and representing residents so as to extend to them the full enjoyment of their rights.

2. Such access shall be permitted between the hours of 8:00 a.m. and 8:00 p.m. daily, provided, however, the facility may require proper identification and may impose conditions reasonable to protect the security of the residents and the facility or to prevent commercial solicitations.

3. Persons entering a health care facility to render assistance to residents without charge shall promptly advise the Administrator, Acting Administrator, Resident Director or other available agent of the facility of their presence. Such persons will not enter the living area of any resident without first identifying himself/herself to the resident and without receiving the resident's permission *to* enter.

4. Individual residents have the complete right to terminate any visit by persons having access pursuant *to* this section. Communications between a resident and such persons shall be confidential, unless the resident authorizes the release of such information.

5. No resident shall be punished or harassed by the health care facility or by its agent or employees because of his/her efforts *to* avail himself/herself or his/her rights.

6. The health care facility shall in a conspicuous place at or near the entrance of the facility and on each floor of the facility, post a notice which sets forth this section and shall upon admission or in the case

of the person who is already a resident in such home within 48 hours of the effective date of his regulation provide every resident with a personal copy of such notice. In the case of a resident who for any reason cannot either read or write *English* such notice shall be given orally as well as in writing a certification of the provision of personal notice as required herein shall be entered in a resident's clinical record.

7. Nothing in this section shall be constructed to restrict any right or privilege of any health care facility resident to receive visitors who are not representatives of community organizations or legal services programs as defined in subsection (a) of this section.

[redacted] [redacted]

Signature of Resident/Next of Kin/Point of Contact — Date

N/A

Witness — Date

RESIDENTS RESPONSIBILITIES FORM

I, the undersigned resident or his/her Next of Kin/Point of Contact acknowledge.

1. That to the best of my knowledge, accurate and complete information about present complaints past illnesses and hospitalizations medication and other matters to my/the residents' health has been related to the staff of Stoddard Baptist Nursing Home prior to or at the time of admission as well as during the resident's stay.

2. To report unexpected changes in the condition of me/the resident to the responsible health care practitioner.

3. To make it known to the responsible health care practitioner that I clearly comprehend the contemplated course of action and what is expected of the resident and/or me.

4. To be considerate of the rights of other residents and the facility personnel and for my/the residents' behavior in the control of noise, smoking and number of visitors.

5. To be respectful of the property of others persons and the Stoddard Baptist Nursing Home.

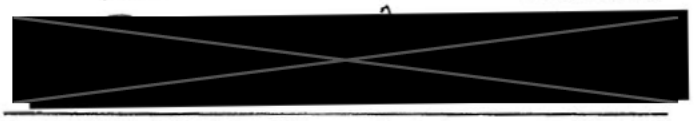
6. To assure that the financial obligations for my/the residents' health care are fulfilled as promptly as possible.

Furthermore, I, the undersigned resident or Next of Kin/Point of Contact acknowledges.

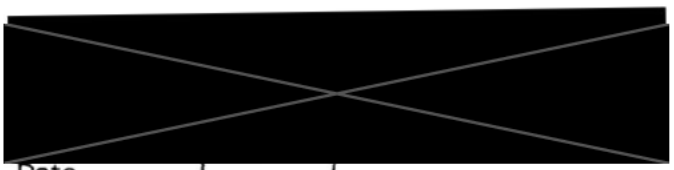
1. The resident's responsibility for following treatment plans recommended by the health care practitioner's responsibilities for his or her care and for following facility rules and regulations affecting resident care and conduct.

2. The resident's responsibility to designate persons needing to be contacted in case of an emergency and that I clearly comprehend that failure to do so is my choice.

3. The resident's responsibility for his/her actions if treatment is refused or if the health care practitioner's instructions are not followed.



Signature of Resident/Next of Kin/Point of Contact



Date

N/A

Witness

Date

STATEMENT AND REPRESENTTIONS
OF NEXT OF KIN/POINT OF CONTACT

I, _____, next of kin/point of contact for _____, resident, make the following statements and representations to Stoddard Baptist Nursing Home

1. As Next of Kin/Point of Contact, I have fully disclosed all assets, property, liabilities, income, resources, expenses, insurance coverage and insurance policies of resident for which I have knowledge.

2. As Next of Kin/Point of Contact, I have assisted Stoddard Baptist Nursing Home to the best of my knowledge and ability, in placing all sources of income of resident on direct deposit to Stoddard Resident Fund Management System (RFMS) account. ***In the event that I default in delivering the resident responsibility payment (care cost) for a period of two (2) months, I hereby authorize Stoddard Baptist Nursing Home to place all resident's income on direct deposit.***

3. As Next of Kin/Point of Contact, I will deliver to Stoddard the resident responsibility payment within 5 business days of availability of resident's income until all of resident's income is being directly deposited to a Stoddard RFMS account.

4. As Next of Kin/Point of Contact, I understand that any false or misleading statements I have made to Stoddard resulting in loss of income to Stoddard will be pursued and prosecuted to the fullest extend allowed under the law.

_____
Next of Kin/Pont of Contact Full Name (Print)

_____
Address

_____
City/State/Zip

_____
Telephone Number

_____
Signature

_____
Witness

_____
Date

ADVANCE DIRECTIVE STATUS FORM

Resident Name: [redacted]

✓ I have received information on Advanced Directives for Health Care.

_____ I have completed a Durable Power of Attorney for Health Care and/or Living Will

_____ I have not appointed anyone to make Health Care decisions for me.

_____ The resident was unable to communicate whether the Advance Directive had been executed previously.

Signatures: [redacted]

Resident Date

Next of Kin/Point of Contact Date

[redacted]

Witness Date

ADVANCE DIRECTIVE

This document has been prepared and distributed as an informational service of the District of Columbia Hospital Association.

INSTRUCTION AND DEFINITIONS

Introduction:

This is a combined durable power of attorney for health care and living will for use in D.C., Maryland and Virginia.

With this form you can:

- Appoint someone to make medical decisions for you if you in the future are unable to make those decisions for yourself.
- Indicate what Medical treatments you do or do not want if in the future are unable to make wishes known.

Directions:

- Read each section carefully
- Talk to the person you plan to appoint to make sure that he/she understands your wishes and is willing to take the responsibility.
- Place the initials of your name in the blank beside those choices you want to make.
- Fill in only those choices that you want under Part 1, 2 and 3. Your Advance Directive should be valid for whatever part(s) you fill in as long as it is properly signed.
- Add any special instructions in the blank spaces provided. You can write additional comments on a separate sheet of paper, but you should indicate on the form that there are additional pages to your Advance Directive.
- Sign the form and have it witnessed.
- Give your doctor, your nurse, the person you appoint to make your medical decisions for you, your family, and anyone else who might be involved in your care, a copy of your Advance Directive and discuss it with them.
- Understand that you may change or cancel this document at any time.

WORDS YOU NEED TO KNOW:

Advance Directive: A written document that tells what a person wants or does not want if he/she in the future can't make his/her wish known about medical treatment.

Alternative Nutrition and Hydration: When food and water are fed to a person through a tube.

Autopsy: An examination done on a dead body to fine the cause of death.

Comfort Care: Care that helps to keep a person comfortable but does not make him/her better. Bating, turning, keeping a person's lips moist are types of comfort care.

CPR (Cardiopulmonary Resuscitation): Treatment to try and restart a person's breathing or heartbeat. CPR may be done by pushing on the chest, by putting a tube down the throat or by other treatment.

Durable Power of Attorney for Health Care: An advance directive that appoints someone to make medical decisions for a person if in the future he/she can't make his/her own medical decisions.

Living Will: An advance directive that tells what medical treatment a person does or does not wants if he/she is not able to make his/her wishes known.

Organ and Tissue Donation: When a person permits his/her organs (such as eyes or kidneys) and other parts of the body (such as skin) to be removed after death to be transplanted for use by another person or to be used for experimental purposes.

Persistent Vegetative State: When a person is unconscious with no hope of regaining consciousness even with medical treatment. The body may move and eyes may be open, but as far as anyone can tell, the person can't think or respond.

Terminal Condition: An on-going condition caused by injury or illness that has no cure and from which doctors expect the person to die even with medical treatment. Life-sustaining treatments will only prolong a person's dying if the person's suffering from a terminal condition.

ADVANCE DIRECTIVE

MY DURABLE POWER OF ATTORNEY FOR HEALTH CARE

I, _____, write this document as a directive regarding my medical care.

Put the initials of your name by the choice you want.

_____ I appoint this person to make decisions about my medical care if there ever comes a time when I cannot make those decisions myself:

_____ _____ _____
Name Home # Work #

_____
Address

_____
City/State/Zip

If the person above cannot or will not make a decision for me, I appoint this person.

_____ _____ _____
Name Home # Work #

_____
Address

_____
City/State/Zip

_____ I have not appointed anyone to make health care decisions for me in this or any other document:

I want the person I have appointed, my doctor, my family and others to be guided by the decisions I have made below:

Part 2: MY LIVING WILL

These are my wishes for my future medical care if there ever comes a time when I can't make these decisions for myself

A. These are my wishes if I have a terminal condition:

Life-Sustaining Treatments

_____ I do not want life-sustaining treatments (including CPR) started. If life sustaining treatments are started, I want them stopped.

_____ I want life-sustaining treatments that my doctors think are best for me.

_____ Other wishes: _____

Artificial Nutrition and Hydration

_____ I do not want artificial nutrition and hydration started if it would be the main treatment keeping me alive. If artificial nutrition and hydration is started, I want it stopped.

_____ I want artificial nutrition and hydration even if it is the main treatment keeping me alive.

_____ Other wishes: _____

Comfort Care

_____ I want to be kept as comfortable and free of pain as possible, even if such care prolongs my dying or shortens my life.

_____ Other wishes: _____

B. These are my wishes if I am ever in a **persistent vegetative state**:

Life-Sustaining Treatments

_____ I do not want life-sustaining treatments (including CPR) started. If life sustaining treatments are started, I want them stopped.

_____ I want life-sustaining treatments that my doctors think are best for me.

_____ Other wishes:_____

Artificial Nutrition and Hydration

_____ I do not want artificial nutrition and hydration started if it would be the main treatment keeping me alive. If artificial nutrition and hydration is started, I want it stopped.

_____ I want artificial nutrition and hydration even if it is the main treatment

Other Directions

You have the right to be involved in all decisions about your medical care, even those not dealing with terminal conditions or persistent vegetative states. If you have wishes not covered in other parts of this document, please indicate them here.

_____

_____

_____

_____

Part 3. OTHER WISHES

A. Organ Donation

_____ I do not wish to donate my organs or tissues.

_____ I want to donate all of my organs and tissues

_____ I only want to donate these organs and tissues.

_____

Other Wishes: _____

B. Autopsy

_____ I do not want an autopsy

_____ I agree to an autopsy if my doctors wish it.

_____ Other wishes: _____

If you wish to say more about any of the above choices, or if you have any other statements to make about your medical care, you may do so on a separate sheet of paper. If you do so, put here the number of pages you are adding:_____

Part 4: SIGNATURES

You and two witnesses must sign the document in order for it to be legal.

A. **Your Signature**

By my signature below, I show that I understand the purpose and effect of this document.

Signature_____ Date:_____

Address_____

B. **Your Witnesses' Signature**

I believe the person who has signed this advance directive to be of sound mind, that she/her signed or acknowledged this advance directive in my presence and that he/she appears not to be acting under pressure, duress, fraud, or undue influence. I am not related to the person making this advance directive by blood, marriage or adoption, nor to the best of my knowledge, am I named in his/her will. I am not the person appointed in this advance directive. I am not a health care provider or an employee of health care provider who is now, or has been in the past responsible for the care of the person making this advance directive.

Witness #1

Signature_____ Date:_____

Address_____

Witness #2

Signature_____ Date:_____

Address_____

Dear Family Member:

Each year influenza and viral pneumonia are possible threats to the well-being of our residents. In order to protect them we have arranged to have influenza and pneumococcal vaccine made available to our residents. The influenza vaccine is effective for one season and the pneumococcal vaccine is effective for five years. Before it can be administered, however, we must have the responsible family member and attending physician's permission for each resident receiving the vaccine.

To assist us in this manner, we hereby request that you sign the permission slip below which would allow us to request an order from the resident's attending physician for the influenza and/or pneumococcal vaccination. The physician will then order the vaccine if he or she believes it will benefit the resident. Our licensed nurses will administer the vaccination to the residents.

Remember, the vaccination cannot be given to your family until the completed permission slip is returned to use. Please complete the form and return it to us as soon as possible.

Sincerely,

Lester M. Miles
Medical Director

I HEREBY GRANT PERMISSION TO THE STODDARD BAPTIST NURSING HOME TO REQUEST AN ORDER FOR THE VACCINE(S) LISTED BELOW FROM THE ATTENDING PHYSICIAN FOR: NO

_____

Resident's Name

I UNDERSTAND THAT THIS PERMISSION FORM AUTHORIZES YEARLY ADMINISTRATION OF THE INFLUENZA VACCINE.

I UNDERSTAND THAT THE PHYSICIAN WILL EVALUATE THE POSSIBLE BENEFITS AND/OR RISK FOR EACH INDIVIDUAL ANNUALLY.

Influenza Vaccine	☐ Yes	☐ No	☐ Reason_____*
Pneumococcal	☐ Yes	☐ No	☐ Reason_____*

*If resident has received either flu or pneumococcal vaccine prior to admission please indicate date received

[redacted]

Signature of Resident/Next of Kin/Point of Contact

[redacted]

Date

[redacted]

Witness

[redacted]

Date

AUTHORIZATION FOR ROUTINE MEDICAL TREATMENT AND SERVICES

I, undersigned resident or his/her responsible party hereby authorize that Stoddard Baptist Nursing Home perform and administer routine services, diagnostic procedures, medical treatments and minor surgical procedures as they are considered therapeutically beneficial or necessary. This authorization includes outside trips and activities.

[redacted]

Resident's Name (Print or Type)

[redacted]

Signature of Resident/Next of Kin/Point of Contact

[redacted]

Witness

[redacted]

Date

RESIDENT CONSENT FORM

Resident's Name [redacted] ID #_____

The undersigned hereby authorizes and consents to have photographs, videotapes, and/or motion pictures taken by Stoddard Baptist Nursing Home, its employees and/or its duly authorized agents.

Further, the undersigned consents to participate in interview sessions and/or or group and individual studies as applicable, which does not violate the resident's rights policies and procedures.

This consent shall release Stoddard Baptist Nursing Home, its employees and/or its duly authorized agents from any and all liability in connection with the taking, use, publication and dissemination of said photographs, videotapes, television coverage, motion pictures, interview and/or study data and findings.

[redacted] [redacted]

Signature of Resident/Next of Kin/Point of Contact Date / /

[redacted] [redacted]

Witness Date / /

I dont agree. Ll. 2/26/2020

PERSONAL FUND AUTHORIZATION

RESIDENT [redacted]

DATE [redacted]

This is an authorization for the Stoddard Baptist Nursing Home to hold and dispense my personal funds as my needs requires. You are to keep complete records of all deposits and disbursements of these funds and to make records available to me or my representative upon request. These funds will be transferred after the requisitions for funds form has been signed and witnessed.

Signature of Resident/Next of Kin/Point of Contact

Witness

OR

My funds will be handles by _____ it is understood that the facility, Stoddard Baptist Nursing Home, shall receive payment from the above responsible person in the amount of $_____.

Personal funds amounting to $_____ Monthly will be handled by _____

If payment is defaulted by two months, Stoddard Baptist Nursing Home has the right to do direct deposit.

Signature of Resident/Next of Kin/Point of Contact

[redacted]

Witness

RESIDENT PERSONAL LAUNDRY INFORMATION

1. Labels are provided for resident clothing. Families are asked to label all clothing entering the building and to maintain an accurate inventory of clothing. Families may choose to use name labels provided by the Facility or to label clothing with a permanent marker using the following "CODE" for the resident (Unit, First Initial, First two letters of Last Name): Example: Jane Doe from Unit 2 would be 2-JDO.

2. For new admissions, if clothing has not been labeled prior to admission, clothing will be sent to laundry in bulk for labeling by the laundry technician.

3. The Facility does resident laundry approximately twice per week.

4. The schedule for the laundry of personal clothing is:

Unit 1-	Wednesday
Unit 2 -	Tuesday
Unit 3 -	Monday

Clean Clothing will be returned to the Unit the morning following the specified personal laundry day.

5. Families desiring to do resident laundry:

A clothes hamper, labeled with the resident's name is provided for resident's whose families prefer to do the laundry themselves. Soiled clothing must be picked up at least twice per week. If clothing has not been picked up in a timely manner, the clothing will be sent to the laundry.

A notation that the resident's family desires to do laundry will be placed on the resident's closet. The home will be happy to do resident laundry when the family temporarily cannot take care of this important need. Please do not hesitate to contact the Director of Housekeeping and Laundry and notify them of this need.

When resident clothing is heavily soiled and cannot be stored in the residents' personal hamper, these items of clothing will be sent to the laundry to be washed.

[redacted] [redacted]

Signature of Resident/Next of Kin/Point of Contact Date

[redacted] [redacted]

Witness Date

NO laundry Thank Jan.

STODDARD BAPTIST NURSING HOME
SMOKE-FREE ENVIRONMENT POLICY

Stoddard Baptist Nursing Home is a **"SMOKE-FREE"** facility since January 1, 1997. NO resident, family member, visitor or staff will be allowed to smoke within the building. NO resident admitted after January 1, 1997, will be allowed to smoke in or outside of the building. This decision was reached because of the recent reports from the American Cancer Society relating to second hand smoke and the findings on Regulation 483.15. Residents found smoking or distributing smoking materials within the facility will be subject to discharge under the guidelines of Discharge/Transfer Law (6-108).

Under the grandfather clause, residents who were admitted prior to January 1, 1997 are permitted to smoke outside the building. They are however, by no means allowed to distribute smoking material to other residents admitted after January 1, 1997.

The above was discussed with me and I agree to comply with Stoddard Baptist Nursing Home's **No Smoking Policy**.

[redacted]

Signature of Resident/Next of Kin/Point of Contact — Date

W / A.

Witness — Date

GENERAL INFORMATION

1. **RELEASE OF INFORMATION:** The Stoddard Baptist Nursing Home may discuss all or part of the resident's record with any person or corporation which has interest in or which is or may be liable under a contract to Stoddard Baptist Nursing Home's charge, including, but not limited to, hospitals or medical service companies, insurance companies, worker's compensation carries or welfare funds.

2. **PERSONAL VALUABLES:** The Stoddard Baptist Nursing Home shall not be liable for loss or damage to any money, jewelry, documents or other articles of unusual value unless deposited with the Stoddard Baptist Nursing Home for safekeeping. While glasses should be marked for identification and dentures should be in a marked receptacle when not in use, Stoddard Baptist Nursing Home assumes no responsibility for their loss or damage.

3. **PROTECTIVE DEVICES:** In the event that the resident refuses to permit the use of protective devices when use has been directed by the staff of Stoddard Baptist Nursing Home, the resident assumes all risk of injury as a result of such refusal.

4. **ELECTRICAL APPLIANCES:** I assume all risk of loss of appliances brought to Stoddard Baptist Nursing Home. I also agree that such appliances may be checked for safety hazard by the Maintenance Department and may be prohibited if not safe.

5. **MEDICARE/MEDICAID RESIDENTS CERTIFICATION AND AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST:** I certify that information given by me in applying for payment under Title XVII and XIX of the Social Security Act is correct. I authorize any holder of medical or other information needed for this or a related Medicare/Medicaid claim. I request that payment of authorized benefits be made on my behalf.

6. **RESIDENT'S RIGHTS:** I have received a copy of the Resident's Rights Policy. I have had the opportunity to read and understand the policy and have my questions regarding it answered.

7. **RESEARCH:** I understand that I may have the opportunity to participate in research that is carried out in this facility. If my personal participation in a research project is desired, the research will be explained to me, my voluntary informed consent will be requested and I shall have the right to refuse. I do hereby give permission for my health care record to be reviewed for research approved by Stoddard Baptist Nursing Home.

8. **EDUCATION/TRAINING:** I understand that I may have the opportunity to voluntarily participate in the education of students from a variety of disciplines and further understand that these students shall be under supervision of professions at all times.

9. **ACCESS REGULATIONS:** I have received a copy of the Access Regulations Relating to Nursing Homes.

10. **RELEASE OF RESPONSIBILITY:** The Stoddard Baptist Nursing Home is released from any responsibility for the resident's care, should the resident at any time deliberately and intentionally leave the

premises of Stoddard Baptist Nursing Home unaccompanied by a staff and/or family member. These include damages to other persons that may be the result of actions on the part of the resident.

[redacted]

Signature of Resident/Next of Kin/Point of Contact

[redacted]

Date

N/A.

Witness

Date

Stoddard Baptist NURSING HOME

ELECTRICAL APPLIANCES/TV

Resident Name: [redacted] Room No [redacted]

Please take a few minutes to review the following.

Television service is available to residents during their stay at Stoddard. The charge for television service is $18.75 per month. If you choose to get the television service, please check how you want to pay for the service.

- ☐ Deduct from resident fund account, if available
- ☐ Monthly by check or money order

If you elect not to get the television service at this time, please check the box below.

- ☐ Do not want television service

[redacted] [redacted]

Signature of Resident/Next of Kin/Point of Contact Date

[redacted] [redacted]

Witness Date

ASSIGNMENT OF BENEFITS

STODDARD BAPTIST NURSING HOME

Stoddard Baptist Nursing Home (Stoddard) is a supplier of medical supplies and equipment. Medicare Regulations have defined standards which a supplier must meet to receive and maintain a supplier number. All of the standards are met by Stoddard and are on the back of this form.

Authorization of Assignment

Stoddard provides health care supplies to the below mentioned beneficiary. These supplies would include; enteral nutrition/supplies, ostomy, urinary tract and wound care supplies. For each claim submitted to Medicare, the supplier is responsible for obtain an authorization from the beneficiary to release medical information to Medicare. A supplier must obtain and retain in its files a one-time payment authorization from a beneficiary or her/his representative applicable to any current or future services the supplier may furnish the beneficiary. Please sign below to acknowledge your authorization.

Name: [redacted] Medicare # [redacted]

Start Date [redacted]

I request that payment of authorized Medicare benefits be made on my behalf to the above named supplier for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents for any information needed to determine these benefits.

Beneficiary Signature: [redacted] Date: [redacted]

Authorized Beneficiary: _____

Reason Patient Unable to Sign: _____

conflict of interest between supplier & user. SC 2/26/2020

PATIENT MUST BE GIVEN A COPY

Julianne Sealey-Adams, LGSW

Stoddard Baptist NURSING HOME

www.stoddardbaptisthome.org

work: 202-328-7400 ext. 1395
fax: 202-939-0950
e-mail: jsealey-adam@sbnhdc.org

1818 Newton St., N.W.
Washington, D.C. 20010

LEGAL COUNSEL for the ELDERLY

Legal Counsel for the Elderly is affiliated with AARP.

601 E Street, NW
Washington, DC 20049
www.aarp.org/lce

ALBERT REED
Nursing Home Ombudsman

Telephone: 202-434-2154
Cell: 202-674-9254
Fax: 202-434-6595
areed@aarp.org

Indiana

Complaint & Admission Agreement: Hooverwood Indianapolis Jewish Home

[redacted]
Marion Superior Court 11

Filed: 10/20/2021 12:54 AM
Clerk
Marion County, Indiana

STATE OF INDIANA	)	IN THE MARION COUNTY CIRCUIT COURT
	) SS:	
COUNTY OF MARION	)	CAUSE NO.

HOOVERWOOD INDIANAPOLIS JEWISH HOME, INC.
Plaintiff

v.

[redacted]
Defendant

COMPLAINT FOR BREACH OF CONTRACT

Comes now the Plaintiff, by counsel, and of the Defendant, [redacted], alleges and says:

1. That at all times herein, Plaintiff was a corporation duly authorized to conduct business in the State of Indiana.

2. That on or about March 9, 2020, the Defendant and HOOVERWOOD INDIANAPOLIS JEWISH HOME, INC. entered into a written contract, a copy of which is attached hereto as Exhibit 'A'.

3. That the Defendant has breached said contract in that he/she has failed and/or refused to pay the Plaintiff for services rendered to Defendant at Defendant's specific instance and request.

4. That there is presently due and owing, from Defendant to Plaintiff, the principal sum of $10,700.00.

5. That Plaintiff has made due demand of Defendant for payment, but Defendant has failed or refused to pay and Plaintiff has been damaged thereby.

6. That pursuant to the Contract, the Plaintiff is entitled to interest, attorney's fees, and court costs.

WHEREFORE, Plaintiff prays for judgment against the Defendant, [redacted] in the principal sum of $10,700.00, plus interest, attorney's fees, costs of this action, post judgment interest and for all other relief proper in the premises.

_____
Attorney for Plaintiff

BLEECKER, BRODEY & ANDREWS
9247 N. Meridian Street, Suite 101
Indianapolis, IN 46260
Phone: (888) 574-0700
THIS IS AN ATTEMPT TO COLLECT A DEBT, THE COMMUNICATION IS FROM A DEBT COLLECTOR AND ANY INFORMATION OBTAINED WILL BE USED FOR THAT PURPOSE.

Q339485C0241-

ADMISSION AGREEMENT

HOOVERWOOD

Indianapolis Jewish Home, Inc.
7001 Hoover Road
Indianapolis, IN 46260

THIS AGREEMENT is made this 2020-03-09 17:49:00.0, by and between **HOOVERWOOD, THE INDIANAPOLIS JEWISH HOME** (hereinafter called "Hooverwood" or the "Home") and the Resident, his/her responsible party, representative, legal guardian (hereinafter referred to as the "Undersigned") for the provisions by the Home of care and services to [redacted] (hereinafter referred to as the "Resident").

It is agreed that the "Admissions Application," previously submitted by the Resident and approved by the Home resulting in this agreement, is part of this agreement for all purposes.

Hooverwood welcomes all persons in need of its services without regard to handicap, race, religion, color, national origin, ancestry or sex. Hooverwood does not discriminate against age, although the operations of the Home are intended by nature of government regulations to meet primarily the needs of the frail elderly.

The following agreement will describe the requirements and responsibilities of a Resident at Hooverwood as well as the responsibilities that Hooverwood has to you as a Resident:

I. Responsibilities of the Home

A. Admitting Documents:

The Home will admit the Resident upon the execution and fulfillment of the requirements of this Admission Agreement and the completion of any other documents required by State and Federal Regulations as well as Home's policies. A Resident is not deemed admitted until such time as all requirements are met and all documents required by law have been appropriately executed.

B. Confidentiality of Medical Records:

Information contained in the Resident's medical record is confidential, and disclosure to unauthorized persons will not be made without written consent, except as required or permitted by law. The Resident authorizes disclosure to any and all appropriate parties (state agencies, Social Security Administration, fiscal intermediaries, hospitals, physicians, etc.) of all requested information from the Resident's medical record. The Resident has the right to obtain immediate access to copies of his/her medical records.

C. Basic Services Provided:

The Home will furnish the Resident: a room, meals, housekeeping services, laundry services, maintenance services, nursing care, personal care, recreational activities, and Social Services as part of the basic monthly rate. In addition, other supplies and services, as listed in the Resident Handbook, are also included in the basic monthly rate for those Residents under Medicaid, as well as Medicare Skilled Financial Status.

The Home reserves the right, in its sole discretion, to locate the Resident within the facility as medical needs of the Resident as well as the welfare needs of the Resident and others so dictate. The location of the Resident in a private or privacy-oriented room does not constitute an agreement that the Resident shall remain in the assigned bed on a permanent basis. The Home will provide 48 hours notice (or such notice as required by State or Federal Law) to the Resident and Responsible Party of plans to transfer the Resident to a different room.

D. Medications:

The Home will obtain and administer such medications as may be prescribed for the Resident. If the Undersigned selects a community pharmacy as the source of the Resident's medications, such pharmacy must provide delivery services to the Home and stock the medications normally required by nursing facility Residents and otherwise be compatible with the Home's medication policies and procedures.

The cost of the medications will be paid by the Undersigned, as billed by the Home or as billed directly by a pharmacy.

E. Recreational Activities:

The Home will provide recreational activities as appropriate for the individual Resident's needs.

F. Linens and Clothing:

The Home will furnish clean bed linens and Resident gowns as required for the proper care of the Resident. All personal clothing will be supplied by the Resident and/or Undersigned at his/her own expense.

The Home shall not be responsible for normal deterioration of clothing caused by routine washing/drying or for clothing that is missing/lost. The Home strongly encourages that all personal clothing is clearly labeled even if the Undersigned selects to launder the Resident's personal clothing. The Home's Laundry Department provides a "hot iron label service" at no charge to the Resident or Undersigned.

G. Physician Services:

The Home will provide or arrange for the services of a physician for the Resident during his/her stay at the Home. The Resident is free to choose any licensed primary care physician in the community as a personal physician. All Residents must have a primary care physician. Any physician providing care to the Resident at the Home must comply with the Home's Physician Requirements (see section V.) and requirements of federal and state laws and regulations.

The Undersigned agrees that the Home may provide or arrange for physician services to the Resident in the case of an emergency or the unavailability of the Resident's personal physician.

H. Resident's Rights and Responsibilities:

The Home will inform the Resident both orally and in writing of the Resident's rights while in the Home and all rules and regulations governing the Resident's responsibilities during his/her stay in the Home.

II. Responsibilities of the Undersigned

A. Admitting Information:

The Undersigned will provide complete and accurate information as required by the Home to process the Resident's admission, to provide appropriate care and services to the Resident, and to obtain payment for said care and services. This information must be updated on a regular basis, and when any substantial change occurs. The Home must be provided with the name, address and telephone number of the Undersigned, and an interested family member or other interested person to be contacted in the event of an emergency or any significant change in the Resident's physical or mental status.

B. Compliance with Home Policies:

The Undersigned understands and agrees that the Resident is required to comply with the rules and regulations which may from time to time be adopted by the Home for the comfort, safety, and efficiency of the delivery of care to Residents of the Home. The rules and regulations will be furnished to the Undersigned at or before the Resident's admission to the Home and updated during the Resident's stay.

C. Discharge:

The Undersigned agrees to accept the Resident from the Home on the effective date of the Resident's transfer or discharge from the Home. In the event the Undersigned fails to accept the Resident on the date specified, the Undersigned will pay to the Home the per diem rate then in effect for each day the Resident improperly remains in the Home and the Home will be authorized to make such alternate arrangements for the Resident as the Home, in its sole discretion, deems appropriate and necessary.

D. Right to Terminate:

The Undersigned understands and agrees that this Agreement does not and is not intended to constitute an understanding or contract, express or implied, to care for the Resident for life, but is entered into for the mutual benefit of the Resident and the Home. The Undersigned and the Home will have the right to terminate this Agreement, subject to any required notice, in the event that either party determines it is necessary or desirable to withdraw, transfer, or discharge the Resident from Home. Should the Resident's stay at the Home be terminated for any reason, the Home will be relieved of any further responsibility for the Resident's care or any liability of any kind resulting there from.

The Undersigned is financially responsible and hereby agrees to timely pay all amounts due to the Home incurred prior to the date the Resident is withdrawn, transferred, or discharged.

The Home shall have the legal right to discharge the Resident for any of the following reasons:

A. If Resident endangers the health, welfare or safety of the Resident himself/herself, other Residents and/or staff.

B. Medical reasons for which the Home believes it cannot adequately meet the Resident's needs.

C. Lack of payment.

E. Voluntary Withdrawal:

If the Undersigned wishes to withdraw the Resident from the Home for any reason, the Undersigned agrees to notify the Home of the date of withdrawal as soon as known, but in no event later than two (2) weeks prior to the date of withdrawal. The Undersigned agrees to pay or otherwise settle all accounts due to the Home for the Resident's care prior to the date of withdrawal.

F. Non-emergency Leave:

The Undersigned will notify the Home at least five (5) days in advance of the temporary removal of the Resident in all non-emergency circumstances.

G. Bedhold Policy:

A bedhold situation occurs when a Nursing Home Resident is out of the facility past midnight for any reason.

Hooverwood's Bedhold Policy is explained below for Medicaid and Private Pay Residents. A Resident covered under the Medicare Part A program or a skilled Medicare Replacement program is considered a Private Pay Resident for bedhold purposes.

<u>Medicaid Resident – Hospitalization</u>

Effective February 1, 2011, Medicaid does not pay for bedholds.

If the Resident is enrolled in Medicaid, Hooverwood will hold the bed for 7 consecutive days at no charge to the Resident. From day 8 through day 15, if the Resident/responsible party wishes to hold the bed, the charge will be $100 per day. Full payment of $800 must be received by Hooverwood on day 8 of the Resident's absence from the facility. If the Resident continues to remain out of the facility beginning with day 16, the Level I Private Pay daily rate for the type of room held will be charged. A 30-day payment at the Private Pay daily rate must be received by Hooverwood on day 16 of the Resident's absence from the facility. These bedhold payments are in addition to the Resident's monthly liability under the Medicaid program. If payments received exceed the Resident's monthly liability obligation and the bedhold days the Resident is out of the facility for which a fee is charged, the account will be adjusted and a refund issued, if appropriate, within 30 days of the Resident's return to the facility or permanent discharge from the facility.

If the Resident/responsible party does not wish to reserve the bed, the Resident will be discharged. The Resident's belongings must be removed from the Hooverwood room by the 10th day of absence from the facility. However, when the Resident is able to return to Hooverwood, he or she will be considered a higher priority for admission to an appropriate, vacant bed than first-time applicants.

Medicaid Resident – Voluntary Leave from the Facility

If a Medicaid Resident is not being hospitalized, but voluntarily leaving the Home on a temporary basis and staying out of the facility past midnight, the bedhold charge will be $85 per day. If the Resident/responsible party wishes to hold the bed, the payment of $85 per day for the number of days the Resident is planning on being away from the facility, is due to Hooverwood prior to the Resident leaving. These bedhold payments are in addition to the Resident's monthly liability obligation under the Medicaid program. If payments received exceed the Resident's monthly liability obligation and the bedhold days the Resident is out of the facility, the account will be adjusted and a refund issued, if appropriate, within 30 days of the Resident's return to the facility or permanent discharge from the facility.

If payment is not received prior to the Resident's absence from the facility, the Resident's belongings must be removed from the Hooverwood room prior to the Resident's absence. If payment is not received and belongings are left

in the Hooverwood room, they will be removed from the room and boxed for pick-up.

Private Pay Resident – Hospitalization or Voluntary Leave from the Facility

If the Resident is on private pay status, the bed will be held for the number of days already paid in advance. If the Resident is a private pay individual who has not paid for care in advance, arrangements must be made with the Social Services staff or Business Office to hold the bed. Payment at the daily private pay rate for the Resident's type of room is required for the number of days the Resident/responsible party wishes to hold the bed. This policy includes periods of hospitalization or voluntary leaves of absence from the facility.

If the Resident/responsible party does not wish to reserve the bed, the Resident will be discharged. The Resident's belongings must be removed from the Hooverwood room by the 3rd day of absence from the facility. If belongings are not removed, they will be boxed by Hooverwood staff for pick up.

H. Communicable Diseases:

The Undersigned will provide a medical history, physical examination, current physician's orders and physician's statement that the Resident is free from a communicable disease on admission or within the time required by the Home. If the Resident is suffering from a communicable disease, a physician's certificate will be provided to the Home that the disease is not in a transferable stage, or that adequate or appropriate isolation measures are being carried out to control transmission of the disease.

I. Resident Care and Treatment:

The Undersigned agrees to permit authorized staff of the Home to perform such functions on the Resident as are necessary to maintain the welfare of the Resident, while in the Home, including but not limited to assistance with bathing and hygiene, dressing, toileting, daily activities, performance of therapies as determined necessary by a physician, bowel and bladder training, nursing procedures, podiatric procedures, non-surgical dental procedures, and laboratory and X-Ray procedures.

Acute care or episodic physical, occupational, and/or speech therapies, provided to the Resident upon a physician's order, are not considered basic services. In cases wherein the Resident requires acute or episodic physical,

occupational and/or speech therapies, the Resident shall be responsible for such costs. The Home agrees to accept insurance assignment (primary and co-insurance) if insurance exists.

J. Medical Treatment:

The Undersigned authorizes the Home to provide medical care if necessary and authorized by the Resident's physician. If the Resident's physician determines that services are medically necessary which are not provided by the Home pursuant to this agreement, payment for such services is the responsibility of the Resident. It is understood that in the provision of such medical care, the Home is hereby authorized to transfer the Resident to whatever health, hospital, or medical facilities which may be selected by the medical staff of the Home, unless the Undersigned or the Resident's physician otherwise indicates.

The Undersigned understands and agrees that an Informed Consent will be required for any surgical treatment, for any treatment requiring the use of general anesthesia, or for any medical treatment where such consent is deemed appropriate by the Resident's physician.

The Resident has an absolute right to refuse treatment and medication as prescribed by his/her physician. However, this right must be considered in light of the rights of the other Residents and of the Home to protect the health of the Resident. In the event that the Resident refuses to authorize medical services or payment thereof, the Resident and the Undersigned release the Home from any and all liability for harm which may result to the Resident due to the lack of such medical services. In addition, the Home retains the right to discharge the Resident if the Home's staff has determined that the welfare of others will be affected by the Resident's refusal to accept such medication and/or treatment, or that the Home cannot properly care for the Resident to the detriment of the Resident's welfare without administration of the medication and/or treatment.

The Undersigned acknowledges that no guarantee or assurance has been made regarding the results which may be obtained from any care or treatment hereby authorized.

K. Medicaid/Medicare Participation:

The Resident, even though a private pay Resident, may also be a Medicare beneficiary. For any days approved by Medicare as "Skilled", the Resident will be considered a "Medicare Skilled Resident" and not a "Private Pay Resident". Resident will accept any and all financial responsibilities consistent with Resident's participation in the Federal Medicare Program, including deductibles and co-insurance.

The Home presently participates in the Medicaid and Medicare Programs. Resident hereby acknowledges that the Home's participation in the Medicaid and Medicare program is completely voluntary on its part and that the Home may terminate its participation in the Medicaid and/or Medicare program at any time after giving thirty (30) days notice to Residents at the Home. Accordingly, Private Pay Residents could be unable to convert to Medicaid and/or Medicare status at Hooverwood, if Hooverwood were ever to terminate and/or limit participation in the Medicaid and/or Medicare program.

When Resident no longer qualifies as a Medicare "Skilled" Resident and financial coverage is discontinued, payment for services rendered will be a private obligation.

L. Private Duty Certified Nurse Aides/ Companions:

The Resident may utilize Private Duty Certified Nurse Aides/ Companions at the option of the Resident. Private Duty personnel are employees of the Resident and/or the Undersigned. The Resident and/or Undersigned shall be responsible for cost and payment to the Private Duty employee as well as the conduct and cooperation of the Private Duty employee while on duty at the Home.

All Private Duty personnel must be approved by the Home's Director of Nursing, and must have acceptable credentials to work in the Home. Private Duty Personnel must abide by specific policies and procedures, as outlined by the Home's Director of Nursing, regarding dress code, signing in/out at front desk, time clock, and Kashruth. Private Duty personnel are never to receive visitors at the Home. Failure of Private Duty Personnel to follow the policies and procedures will result in Private Duty Personnel being denied further access to the Home. Furthermore, the Home is not obligated to recruit Private Duty Personnel for the Resident.

M. Resident Per Diem Charges:

The Undersigned absolutely and unconditionally accepts and agrees to pay directly to the Home the current per diem rate (per level of care and type of Resident room) to meet the current daily charges for basic services provided to the Resident, not including the special items and services listed on Attachment:

No adjustment will be made to the per diem rate in the event the Resident is unable or unwilling to receive the services included.

All payments are due and payable by the last day of the month for which the bill is received.

In the event insurance coverage is denied for services for which coverage had been expected, the Undersigned will pay such charges within thirty (30) days of receipt of billing.

Residents with long-term care insurance will be considered private pay. Reimbursement from the insurance carriers will be arranged and handled between the insurance company and the Resident/Undersigned.

All daily room rates, supply charges, dental fees, etc. are subject to change from time to time by the Home. When there is a facility-wide change of rates, charges, fees, etc., Hooverwood will provide a 30-day in advance notice to all private pay Residents and/or their responsible parties. In the event of a change in an individual Resident's daily rate, as a result of a re-assessment / change of condition, the private pay Resident and/or their responsible party will be notified that the rate change will take effect on the last day of the month in which the change of condition occurred.

In the event of a change in an individual Resident's daily rate, as a result of a room change, the private pay Resident and/or their responsible party will be notified that the rate of change will take effect on the day that the Resident is transferred to their new room.

The per diem rate is charged for the day of admission of the Resident. There is no daily charge for the day of discharge, or day of death.

N. Refund Policy:

The Home will promptly refund any unused portion or prepaid charges following the Resident's discharge or withdrawal and settlement by the

Undersigned of any amounts due to the Home incurred by or on behalf of the Resident. In the event of the Resident's death, unless otherwise specified herein, all refunds will be made promptly after settlement of the Resident's account with the Home and in accordance with Indiana law.

O. Cost of Collection:

The Undersigned will pay all costs, expenses, and reasonable attorney's fees, whether or not suit be brought, arising from the collection of any and all sums due and owing by the Undersigned to the Home.

P. Change in Financial Status:

The Undersigned agrees to notify the Home at least ninety (90) days prior to the Resident becoming eligible for Medicaid benefits. The Home will, upon request, assist the Undersigned in making application to the State on behalf of the Resident. The Undersigned agrees to fully cooperate with the Home:

To provide all information and execute any document required by the State for the Resident to obtain Medicaid or other available benefits to pay for the Resident's stay at the Home;

To promptly apply directly to the State to obtain said benefits.

The Undersigned acknowledges and agrees that failure to timely comply with the requirements of this provision may result in the discharge of the Resident from the Home in the event the Undersigned fails to pay or to have Medicaid pay for the Resident's stay at the Home.

Q. Other Payment Obligations:

The Undersigned absolutely and unconditionally accepts and agrees to pay the following obligations related to the Resident's stay at the Home:

To provide the Resident with sufficient funds to cover personal and incidental needs;

To assume full responsibility for the cost of hospital care or medical care and other services connected with such hospital or medical care, including Medicare deductible and co-insurance;

To pay the Home, an amount equal to thirty (30) days of charges at the current per diem rate, payable upon the day of admission.

If the Resident has long-term care insurance coverage, the Resident and/or Undersigned will be expected to pay privately for services rendered by the Home. It is the responsibility of the Resident and/or Undersigned to submit charges to the insurance companies for reimbursement.

R. Personal Items:

The Resident has a right to keep certain personal items in the Home as space, safety, cleanliness, and the rights of the Home's other Residents permit. The Home is not responsible for the safekeeping or said personal items, unless such items are submitted to the Home for safekeeping.

S. Release of Liability:

The Undersigned agrees to accept full responsibility for and releases the Home, its personnel, and attending physician from any liability for any event, accident, or deterioration of the Resident's medical condition while the Resident is away from the Home and not under the direct care and supervision of the Home, or if the Resident should leave the Home for any reason without first giving notice.

T. Change of Room / Roommate:

The Undersigned authorizes the Home to make changes in the Resident's room or roommate for reasons involving necessary nursing care, compatibility, changes in the needs of the Resident, or for whatever reason, in the opinion of the Home's interdisciplinary team, it is necessary to make such change. The Resident and Undersigned will be advised in advance of any such change.

U. Visitation:

The Undersigned agrees to abide by the Home's policies and regulations regarding visitation, including any policies which have been instituted for the welfare of the Resident and the conduct of the Home's operation.

V. Funeral/Burial Arrangements:

The Resident and Responsible Party assume full responsibility for all arrangements / expenses incidental to funeral and burial arrangements.

III. Protection of Resident's Personal Funds

A. Resident's Rights:

The Undersigned understands and acknowledges that the Resident has the right to manage his/her own financial affairs and is not required to deposit his/her personal funds with the Home. However, state and federal law require that the Home, upon the Resident's written authorization and request, hold, safeguard, manage, and account for the Resident's personal funds deposited with the Home. All personal funds of the Resident deposited with the Home are protected by a self insurance fund in accordance with State and Federal law. All Resident funds deposited with the Home in a one-month period which exceed $50.00 will be deposited in an interest-bearing account separate from the Home's operating accounts. On a monthly basis, the interest earned will be credited to the Resident's account.

B. Record Keeping:

The Home has a record keeping system which assures full, complete, and separate accounting of the Resident's personal funds. The Resident's individual financial record is available to the Resident or the Undersigned upon request. The Home will provide a quarterly accounting to the Resident or the Undersigned.

C. Delegation of Authority:

With the understanding that the Resident has the right to manage his/her own financial affairs, the Undersigned, including Resident's Family Member, if any, desires and hereby authorizes the Home to hold, safeguard, manage, and account for the Resident's personal funds in accordance with state and federal law. For this purpose, the Undersigned will provide information regarding the Resident's personal income and assets to the Home and will take the necessary action, including the execution of any documents required by banks or other financial institutions, for the transfer of personal funds to the Home to be managed on the Resident's behalf.

IV. Miscellaneous:

A. Entire Agreement:

The Undersigned acknowledges that he/she has read this Agreement and that this constitutes the entire Agreement and understanding between and/or among the parties, which may not be amended except by written agreement of the parties. The Undersigned further acknowledges that he/she has made the above promises and representations in good faith and knowing that the Home, in entering into this Agreement, is relying upon the truthfulness of the promises and representations of the Undersigned herein.

B. Severability:

If any term or provision of this Agreement, or application thereof to any person or circumstance, is, to any extent, be held invalid or unenforceable, the remaining terms and provisions of this Agreement, or the application of such term or provision to persons or circumstances other than those as to which it is held invalid or unenforceable, will not be affected thereby, and each term and provision of this Agreement will be valid and enforceable to the fullest extent permitted by law.

C. Governing Law:

This Agreement will inure to the benefit of the Home's successors and assigns, will be binding upon the Undersigned's successors and assigns, and will be governed by and construed in accordance with the laws of the State of Indiana. The venue and jurisdiction in any action relating to this Agreement will be Marion County, Indiana.

V. HOOVERWOOD PHYSICIAN REQUIREMENTS

1. A Resident at Hooverwood is to be seen by a physician within 48 hours of admission. A physical examination is to be completed with medical orders and progress notes written, dated, and signed. Notes are to include a statement regarding rehabilitation potential and communicable disease.

2. A Resident is to be seen at least once every thirty days during the first 90 days after admission, and at least once every sixty days thereafter. During each visit, the orders must be reviewed, dated, and signed, and a progress note is to be written, dated, and signed.

3. Medicare skilled Residents (Part A) are to be seen by a physician every 30 days.

4. Residents receiving Physical, Occupational, and/or Speech Therapies are to have physician orders updated every 30 days.

5. Residents are to receive a comprehensive physical exam including TB testing on an annual basis. Physicians' progress notes relating to this exam are to include a statement regarding communicable disease.

6. Resident and Responsible Party must agree that an outside physician must be able to visit within the above guidelines. If the physician does not visit as required and is unable to meet the Resident's needs, said physician may be denied further medical privileges for said Resident. This decision will be made by Hooverwood's Medical Director and Administrator. Hooverwood staff will make every effort to give physician reminders of timely visits. If, however, this does not result in said visits, warnings will be issued as previously stated.

VI. Signatures:

All of the Undersigned certify that this admission agreement has been read and accept all of the terms thereof:

[redacted] Resident/Respo[redacted]ty — Spouse — Relationship — 5/23/2016 — Date

[redacted]
Printed Name

STATE OF INDIANA	)	IN THE MARION COUNTY CIRCUIT COURT
	) SS:	
COUNTY OF MARION	)	CAUSE NO.

HOOVERWOOD INDIANAPOLIS JEWISH HOME, INC.
Plaintiff,

v.

[redacted]
Defendant

AFFIDAVIT OF DEBT

Comes now the affiant, and states:

1. I Diana Wysocki am a designated full-time employee of HOOVERWOOD INDIANAPOLIS JEWISH HOME, INC..
2. I am of adult age and am fully authorized by the Plaintiff to make the following representations.
3. I am familiar with the recordkeeping practices of the Plaintiff.
4. The following representations are true and accurate according to documents kept in the normal course of Plaintiff's business and/or my personal knowledge:
5. I have no information that would lead me to believe that the Defendant is a minor or an incompetent individual.
6. Plaintiff is the original owner of the debt.
7. The Account/Note was opened on March 9, 2020, a true and correct copy of which is attached hereto as Exhibit 'A.'
8. As of August 31, 2021, [redacted] has a Principal (Interest Bearing) balance of $10,700.00 due and owing on Account/Note redacted identification number: XXXX5112.
9. The last payment from Defendant was received on N/A in the amount of $N/A..
10. The type of debt is: ☒ Breach of Contract.
11. The Plaintiff is seeking interest calculated at a rate of 8.00% and continuing at said interest rate until the date of judgment. The interest on the amount listed in paragraph 8 above through September 28, 2021, is $65.67.

12. Plaintiff is seeking reimbursement of attorney's fees and additional evidence will be presented to the court prior to entry of judgment on attorney's fees.

13. The Defendant is in default of his/her obligation to the Plaintiff.

14. I am not aware of any setoffs, counterclaims or credits due and owing to the Defendant from Plaintiff.

I swear or affirm under the penalties for perjury that the foregoing representations are true.

Dated: 10/5/2021 Signature of Affiant: Diana L. Wysocki

BLEECKER, BRODEY & ANDREWS
9247 N. Meridian Street, Suite 101
Indianapolis, IN 46260
Phone: (317) 574-0700; Fax: (317) 574-0770

This is an attempt to collect a debt, the communication is from a debt collector and any information obtained will be used for that purpose.

Admission Agreement & Complaint: Bell Trace Senior Living

[redacted]

TRANSITIONAL
RESIDENCY AGREEMENT
Assisted Living Home

This Agreement is made by and between [redacted] hereinafter referred to as the "Resident(s)", and Bell Trace Senior Living, a senior living community, hereinafter referred to as the "Community." The purpose of this Residency Agreement is to set forth the parties' agreement regarding residency in an Assisted Living Apartment Home in the Community.

In consideration of the mutual promises described in this Agreement, the sufficiency of which is hereby acknowledged, the Resident(s) and the Community agree as follows:

1.0 SCOPE OF SERVICE

In consideration of the Resident(s) payment of the Monthly Service Fee, the Community agrees that the Resident(s) shall have the right to reside in the Community in accordance with the provisions of this Agreement, and to receive the services specified in this Agreement until this Agreement is terminated.

2.0 FEES

The fees associated with residing in the Community are: 1) Reservation Fee, 2) Wait List Fee, 3) Monthly Service Fee, 4) Healthcare Service Fee, 5) Refundable Security Deposit, 6) Community Fee, 7) Second Person Fee, and 8) Optional Personal Services Fee.

2.1 Reservation Fee. The Reservation Fee of $NA which is due upon signing this agreement reserves an Apartment Home at the Community. The Reservation Fee will be applied to the first month's rent upon occupancy, which must occur within 14 days of signing this Agreement. If the Resident(s) is unable to move to the Community due to health reasons, or if the Resident(s) is denied residency, the Reservation Fee is fully refundable. If, for any other reason, the Resident(s) fails to move to the Community, the Sponsor retains one-half of the Reservation Fee.

5.0 TERMINATION BY COMMUNITY

The Community may terminate this Agreement upon thirty (30) days written notice under any of the conditions described below:

5.1 Non-Compliance with Residency Agreement. The Resident(s) fails to perform their obligations as outlined in this Residency Agreement.

5.2 Failure to Abide by Community Rules. The Resident(s) fails to abide by the Community's rules and regulations, as may be adopted from time to time.

5.3 Permanent Transfer. In the event of the Resident(s)' permanent transfer to an alternate living accommodation.

6.0 PREREQUISITES FOR RESIDENCY

To reside in the Community, each Resident(s) shall be required to satisfy all of the following prerequisites, any of which may be waived at the Community's sole discretion.

6.1 Residency Agreement. Each Resident(s) shall execute a Residency Agreement, which will also be executed by an authorized agent of the Community.

6.2 Age Requirements. Each Resident(s) must be 55 years of age or older, unless waived by the Community's Administrator.

6.3 Maximum number of Residents per Apartment Home. No more than two Residents may occupy a Living Accommodation.

6.4 Ability to Live Within a Supported Environment. Each Resident(s) must be capable of living in an assisted living environment with the health care services provided.

6.5 Evaluation with Medical Director. The Community reserves the right to require that each Resident(s) be evaluated by its Medical Director to be assured of the Resident(s)' ability to live safely in an assisted living environment.

7.0 COMMUNITY'S OBLIGATIONS

7.1 Residence Service. The Community shall provide the Living Accommodation of the Resident(s)' choice subject to availability and the Resident(s)' financial capability.

7.2 Residential Services. The Community shall provide the following services and conveniences herein referred to as the "Residential Services." Credit will not be given for Residential Services that are not used.

a. Three meals per day served restaurant-style
b. All utilities (except telephone)
c. Basic cable service
d. 24-hour emergency call service including pendants
e. Individually controlled heating and air conditioning
f. Smoke detectors, fire alarm and sprinkler system
g. Weekly flat linen service
h. Weekly housekeeping service
i. Interior and exterior maintenance
j. Trash and snow removal
l. Individualized care assessment and development of personalized plan of care
m. Scheduled transportation for outings and medical appointments
n. Social, cultural, and educational programs and activities
o. Access to the community services and amenities
p. Other Bell Trace Public WiFi

7.3 Additional Services. Additional services are available to the Resident(s) on a fee for service basis.

7.4 Maintenance. The Community shall, to the extent required by ordinary wear and tear, keep and maintain the Community and its furnishings and equipment, including floor covering, in good order and repair. This includes replacement and repainting when necessary and maintaining the exterior and interior of all buildings, their structural elements, the grounds and the common areas, in such manner as the Community shall deem necessary. The Resident(s) shall inform the Community of any repairs needed in the Resident(s)' Living Accommodation. The Community shall maintain the grounds and the common areas in a clean and orderly condition. All repairs, replacements

and renewals shall be made promptly and be equal in quality and class to the original work.

8.0 RESIDENT'S OBLIGATIONS

Subject to the specific terms and conditions of this Agreement and in consideration of the services provided to the Resident(s) by the Community, the Resident(s) recognize and acknowledge the following obligations.

8.1 Rules and Regulations. The Resident(s) shall comply with all operating procedures, policies, rules, and regulations of the Community as now existing or later adopted.

8.2 Personal Property. The Resident(s) shall make arrangements by will, trust or otherwise, for the disposition of the Resident(s)' personal property located in the Community within thirty (30) days of vacating the Living Accommodation. In the event that no such written disposition is made, it is agreed that the Community shall have the right to promptly remove and store, with ordinary care and at the Resident(s)' expense, all property from the Living Accommodation of a Resident who is no longer be able to reside in the Living Accommodation for any reason.

8.3 Furnishings of Resident(s). The Resident(s) agrees that furnishings provided by the Resident(s) shall not be such as to interfere with the health, safety, peaceful habitation and general welfare of other residents. The Community reserves the right to monitor and, if necessary, require changes in the furnishings, carpeting, appliances, etc., in the Living Accommodation consistent with the health or safety of the Resident(s) or the health, safety and general welfare of other Community resident(s). The Resident(s) agrees not to possess, store, or conceal any weapons, ammunitions, explosives, or other substances which in the Community's sole judgment, are harmful to the well- being and safety of the Community's residents.

Minimal furnishings including (only for licensed Residential Communities): (A) a bed of appropriate size and height, with a clean and comfortable mattress, with comfortable bedding appropriate to the temperature of the facility; (B) a bedside cabinet; (C) a cushioned comfortable chair; (D) a bedside lamp; (E) an adjustable over the bed

table if the resident is bedfast within the Living Accommodation will be provided by the Community only if requested by the Resident(s). In order to enhance the external appearance of the property, the Community requires that all Resident(s)' furnished window treatments be white-backed.

8.4 Entry. The Resident(s) grants the Community and its agents the right to enter the Resident(s)' Living Accommodation, so long as such entry does not infringe on the Resident(s)' privacy and normal, expected occupancy of their living accommodation, for the purpose of:

a. Responding to emergencies;
b. Performing services and making necessary repairs;
c. Periodic, routine maintenance;
d. Altering or adding to the Living Accommodation;
e. Complying with applicable laws, ordinances and statutes;
f. Protecting premises; and
g. Any other lawful purposes.

8.5 Indemnification. The Community shall not be liable for, and the Resident(s) agrees to indemnify, defend, and hold the Community harmless for claims, damages, or expenses, including reasonable attorneys' fees and court costs, resulting from any injury or death to persons and any damages to property caused by, resulting from, attributable to, or in any way connected with, the negligent or intentional acts or omissions of the Resident(s) or the Resident(s)' guests or invitees.

8.6 Consent for Treatment. The Resident(s) generally consents to treatments and medications prescribed by his or her physician or a designated alternate (or by another physician in the case of an emergency); however, the Community recognizes the Resident(s)' right to refuse specific elements of care or treatment and to be informed of the consequences of this refusal with the understanding that in most cases the Community will require such refusals or requests to withhold or withdraw treatment to be put in writing by the Resident or responsible party.

8.7 Physician Coverage. To assure proper care, the Community has permission to call a physician or dentist in the event the Resident(s)'

10.3 Insurance Carried by Resident. The Resident(s) shall be responsible for damage to or loss of the Resident(s)' furniture, furnishings and other personal property from fire, water or other cause. The Resident(s) acknowledges that the Community's insurance does not cover the Resident(s)' personal property. The Resident(s) must maintain liability insurance and insurance covering the loss of the Resident(s)' personal property.

10.4 Alterations by the Community. Notwithstanding any other provisions in this Agreement, the Community may make alterations to the Living Accommodation in order to meet the requirements of any applicable statute, law or regulation.

10.5 Use of the Living Accommodation. The Living Accommodation is intended for use as a residence only and shall not be used for a business or profession, or in any manner in violation of applicable zoning restrictions.

10.6 Alterations by the Resident. The Resident(s) shall not make any repairs, alterations, additions or improvements to the interior or exterior of the Living Accommodation or any part thereof, without first obtaining the Community's written consent; and any additions to or alterations or improvements of the Living Accommodation, including partitions and fixtures of any kind, shall become at once part of the realty and belong to the Community except for unattached, moveable furniture placed in the Living Accommodation by the Resident(s). The Community may condition its consent to any proposed repairs, additions, alterations or improvements upon the Resident(s) giving prior agreement in writing that such work shall be performed by the Community, or under the Community's direction, and that upon termination of residency for any reason, the Community may require the Resident(s) at the Resident(s)' expense (or if deceased, Resident(s)' estate's expense) to remove all or any part of such additions or improvements and to restore all or part of the Living Accommodation to its condition prior to the alteration, addition or improvement. All work to be performed by or for the Resident(s) pursuant to the provisions hereof shall be performed diligently and in a first class, workmanlike manner, with the Resident(s) bearing the labor and materials costs.

10.7 Smoking. The Community is smoke-free. Smoking is prohibited for Resident(s) and guests. Failure to abide by this policy may result in the termination of this Agreement.

10.8 Overnight Guests. The Resident(s) agrees to register all overnight guests with the Community. The Resident(s) understands that there may be fees associated with guest use of the Community's services. The Resident may not have an overnight guest(s) for more than fourteen (14) nights within any ninety (90) day period without prior authorization from the Administrator.

10.9 Pets. The Resident(s) is allowed to have pets in the Community. The Resident(s) agrees to follow the rules and regulations as outlined in the document entitled Pet Companion policy. The Community reserves the right to require the removal of any pet deemed disruptive or inappropriate to the Community's environment.

10.10 Voluntary Change of Accommodations. The Resident(s) shall have the right at any time to request a change of Living Accommodation. The Community will make every attempt to comply with such requests so long as a suitable alternative living accommodation is available. The Resident(s) will be responsible for moving expenses as well as the applicable Transfer Fee.

10.11 No Property Ownership. It is expressly understood and agreed by the parties hereto that an executed Residency Agreement grants to the Resident(s) the right to occupy and use space in the Community, that Resident(s) are not given exclusive possession of the Living Accommodation in the Community, and it is understood that this Residency Agreement does not transfer or grant Resident(s) any interest in real property owned by the Community.

10.12 Assets of Community. The Resident(s) agrees that the Community has the right to apply for and receive funds from federal, state or municipal sources and to receive donations by will, deed or otherwise from corporations and individuals. The Resident(s) further agrees that the Resident(s) shall have no right, title or interest in such funds or the right to demand any accounting thereof.

10.13 Subordination. The Resident(s) agrees that all the Resident(s)' rights under this Agreement shall at all times be subordinate and junior to the lien of all mortgages or other documents creating liens encumbering the Community which have been or will be executed by the Community. Upon request, the Resident(s) agree to execute, acknowledge and deliver to such lender or lenders further written evidence of subordination as the lenders may reasonably require. The Resident(s) shall not be liable for the Community's indebtedness.

10.14 Amendments. The Resident(s) acknowledges that this Agreement constitutes the entire Agreement between the Community and the Resident(s). No amendment hereto is valid unless contained in writing and executed by all parties hereto. No prior oral or written promises shall be conferred or relied upon unless stated herein.

10.15 Validity of Provisions. The invalidity of any restriction, condition or other provision of this Agreement, or any part of the same, shall not impair or affect the validity or enforceability of the remaining provisions of this Agreement.

10.16 Non-Assignability. The Resident(s)' rights and privileges under this Agreement to living accommodations, facilities, services and health care are personal to the Resident(s) and cannot be transferred or assigned by act of the Resident(s) or by any proceeding at law or equity.

10.17 Governing State Law. This Residency Agreement is governed by Indiana law.

10.18 Notification of Community. The Resident(s) agrees to notify the Community of any material change in any of the Resident(s)' physical, financial or mental condition prior to residency.

10.19 Authorized Agent Signature. This Agreement has been executed on the Community's behalf by its duly authorized agent, and the Community's officers, directors, agents or employees of the Community shall have no personal liability to the Resident(s) under any circumstances.

10.20 Attorneys' Fee s. In the event the Resident(s) breaches this Agreement or the Community incurs attorneys' fees enforcing its rights under this Agreement, the Resident(s) shall be responsible for the Community's reasonable attorneys' fees, collection costs, and any court costs.

10.21 Waiver of Liability. The Resident(s) acknowledges that the Community is not responsible for loss or damage to the Resident(s)' personal property. The Resident(s), for themselves, guests, invitees and agents waives any claim against and releases the Community, its officers, directors, agents and employees from liability for personal injury or property damage arising out of this Agreement, including the Resident(s)' occupancy in the Community, except for injuries or damages resulting from the Community's intentional acts.

10.22 Liability for Payments. The Residents agree that each will be jointly and severally liable for all payments hereunder.

By my signature below I indicate I have received a personal copy of this Residency Agreement, Appendix A and all other pertinent admission paperwork.

This Residency Agreement is signed by the Resident(s) and/or Resident(s)' Responsible Party on this 4th day of February, 2022.

[redacted]
Resident

Resident

[redacted]
Responsible Party

Resident(s) are approved for residency in the Community on this 3rd day of February, 20 22.

By: [signature]

Title: Mktg Director

Filed: 3/6/2023 8:52 AM
Clerk
Monroe County, Indiana
Monroe Circuit Court 1

STATE OF INDIANA	)	IN MONROE CIRCUIT/SUPERIOR COURT
	)SS:	
COUNTY OF MONROE	)	CAUSE NO [redacted]

BELL TRACE, INC. *d/b/a* BELL TRACE SENIOR LIVING COMMUNITY,	)
Plaintiff,	)
vs.	)
[redacted] and [redacted],	)
Defendants.	)

COMPLAINT FOR SUIT ON ACCOUNT &
FOR BREACH OF THE INDIANA UNIFORM FRAUDULENT TRANSFERS ACT

Bell Trace, Inc. *d/b/a* Bell Trace Senior Living Community ("Bell Trace"), *by counsel*, files its Complaint for Suit on Account & for the Breach of the Uniform Fraudulent Transfers Act, against the Defendants, [redacted]rlow and [redacted]. In support, Bell Trace states and alleges:

THE PARTIES

1. Bell Trace is duly-licensed and certified by the State of Indiana as a long-term health care facility, pursuant to Ind. Code § 16-28 and does business in the State of Indiana, with its principal place of business at 800 Bell Trace Circle, Bloomington, IN 47408.

2. By information and belief, the Defendant, [redacted], is a resident of State of Indiana, currently residing at 3[redacted]

3. By information and belief, the Defendant, [redacted] is a resident of State of Indiana, currently residing at [redacted]

FACTS RELEVANT TO ALL COUNTS

4. On or about February 3, 2022, Bell Trace admitted [redacted] into its assisted living facility for senior housing, along with convenience and maintenance amenities.

5. On or about February 3, 2022, [redacted] signed the facility's Residency Agreement ("Agreement") on [redacted] behalf as his Agent. (*See* Residency Agreement attached hereto as **Exhibit A**).

6. By and through the Agreement, [redacted] agreed:

> In consideration of the Resident payment of the Monthly Service Fee, the Community agrees that the Resident shall have the right to reside in the Community in accordance with the provisions of this Agreement, and to receive the services specified in this Agreement until this Agreement is terminated. [*See Exhibit A, §1.0*]

7. By and through the Agreement, [redacted] agreed:

> [he] will be jointly and severally liable for all payments hereunder. [*See Exhibit A, §10.22*]

8. By and through the Agreement, [redacted] agreed:

> In the event the Resident breaches this Agreement or the Community incurs attorney's fees enforcing its rights under this Agreement, the Resident shall be responsible for the Community's reasonable attorneys' fees, collection costs, and any court costs. [*See Exhibit A, §10.20*]

9. For the months of February 2022 through January 2023, [redacted] incurred a substantial account balance for senior housing and services Bell Trace provided to him. (*See* Affidavit of Debt attached hereto as **Exhibit B**).

10. For [redacted] residency, an account balance of $20,308.88 exists due and owing Bell Trace. (*See* Itemized Statement attached hereto as **Exhibit C**).

11. This account is wholly unsatisfied and has not been excused by the Plaintiff. The Defendant, [redacted], has not paid the account, despite the Plaintiff's demand.

12. Prior to [redacted] Bell Trace admission, he owned real estate located at [redacted] (the "Property").

13. On August 30, 2019, [redacted] conveyed his interest in the Property to the Defendant, [redacted], via a Quitclaim Deed, recorded August 30, 2019 in the Office of the Monroe County Recorder. (*See* August 30, 2019 Quitclaim Deed attached hereto as **Exhibit E**).

14. The transfer of the Property was made for no consideration and rendered [redacted] indigent.

COUNT I – SUIT ON ACCOUNT

15. Bell Trace incorporates averments 1-14 of its Complaint as if set forth herein.

16. On or about February 3, 2022, when Bell Trace admitted [redacted] into its facility, [redacted] signed Bell Trace's Residency Agreement on [redacted] behalf as his Agent. Via the Agreement, [redacted] promised to pay Bell Trace for senior housing and services provided to [redacted]. (*See Exhibit A*).

17. For the months of February 2022 through January 2023, Bell Trace provided [redacted] with senior housing and services for which he has not paid. (*See Exhibit B*).

18. As a result of [redacted] failure to pay for his services, an account balance in the amount of Twenty Thousand Three Hundred Eight and 88/100s Dollars ($20,308.88) exists due and owing Bell Trace. (*See Exhibit C*).

19. This account is wholly unsatisfied and has not been excused by Bell Trace. [redacted] has not paid the account, despite Bell Trace's demand.

20. For [redacted] residency, he owes Bell Trace an account balance in the amount of Twenty Thousand Three Hundred Eight and 88/100s Dollars ($20,308.88), plus costs of this action,

post-judgment interest, and reasonable attorney fees (all of which is allowed under Exhibit A), plus Indiana's statutory pre-judgment 8% interest rate.

COUNT II – BREACH OF INDIANA UNIFORM FRAUDULENT TRANSFER ACT

21. Bell Trace incorporates averments 1-20 of its Complaint as if set forth herein.

22. On or about February 3, 2022, Bell Trace admitted [redacted] into its facility to receive senior housing and services.

23. On or about February 3, 2022, [redacted] signed Bell Trace's Admission Agreement on [redacted] behalf as his Agent. Via the Agreement, [redacted] promised to use his income and assets to pay for his senior housing and services provided by Bell Trace.

24. Prior to [redacted] Bell Trace admission, he was the deeded co-owner of the Property.

25. On August 30, 2019, [redacted] conveyed his interest in the property to [redacted], via a Quitclaim Deed, recorded August 30, 2019 in the Office of the Monroe County Recorder. (*See Exhibit E*).

26. Bell Trace believes [redacted] made such a grant and transfer to avoid the property being used to satisfy his account with Bell Trace. The transfer of the property was made for no consideration and rendered [redacted] indigent.

27. This action arises under the Uniform Fraudulent Transfer Act of 1994, Ind.Code § 32-18-2-1 *et.seq.* (1994). The conveyance violated Indiana's Uniform Fraudulent Transfer Act.

WHEREFORE, Bell Trace, Inc. d/b/a Bell Trace Senior Living Community, respectfully requests this Court enter a judgment in its favor and against the Defendants, [redacted] and [redacted], as follows:

1. For **Count I** of this Complaint, the Court awards Bell Trace a judgment in its favor and against [redacted] for his account balance in the amount of Twenty Thousand Three Hundred Eight and 88/100s Dollars ($20,308.88), plus costs of this action, post-judgment interest, and reasonable attorney fees (allowed under Exhibit A), plus Indiana's statutory pre-judgment 8% interest rate;

2. For **Count II** of this Complaint, the August 30, 2019 Quitclaim Deed, recorded in the Office of the Monroe County Recorder, from [redacted] to [redacted], is deemed null and void, and is canceled of record;

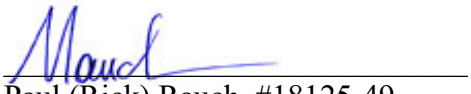
3. For **Count II** of this Complaint, the title of the property located at [redacted], [redacted], is restored to [redacted] as it stood before August 30, 2019;

4. The Court awards Bell Trace all relief available to it under Indiana's Uniform Fraudulent Transfer Act [Ind.Code § 32-18-2 *et.seq.*] against the Defendants, [redacted] and [redacted], jointly and severally, including, but not limited to, tangible and intangible damages suffered, treble damages, costs of collection, reasonable attorney fees and/or court fees to file this cause of action; and,

5. The Court grants Bell Trace all other relief, just and proper in the premises.

Respectfully submitted,

DREWRY SIMMONS VORNEHM, LLP



Paul (Rick) Rauch, #18125-49

Paul (Rick) Rauch, #18125-49
Jessica L. Wood, # 32343-29
DREWRY SIMMONS VORNEHM, LLP
736 Hanover Place, Suite 200
Carmel, Indiana 46032
Telephone: (317) 713-6046
Facsimile: (317) 580-4855
Email: rrauch@dsvlaw.com
jwood@dsvlaw.com

Admission Agreement & Complaint: Northwest Manor Healthcare Center

Filed: 1/6/2023 3:15 PM
Clerk
Marion County, Indiana

NORTHWEST MANOR HEALTH CENTER
ADMISSION AGREEMENT

It is Northwest Manor Health Center's (the Facility) policy to admit and retain only those residents whose health care needs can be by the Facility's staff in cooperation with community resources and other providers under contract with the Facility. The Facility does not discriminate due to race, color, sex, national origin, age, religion, handicap, marital status or source of payment in its admission practices. The Facility does not admit persons with mental illness or mental retardation without prior determination by the State Mental Health Authority the individual requires this Facility's services. All individuals determined to meet the PASRR criteria are screened annually for continued residency in the Facility.

PROCEDURE TO ASSURE ORAL/WRITTEN NOTICE RESIDENT RIGHTS

Upon admission to the Facility and as soon as is practicable, the Facility will inform the resident and Legal Representative both orally and in writing in a language they understand of his/her rights under Federal and State law. The Facility also makes the resident aware of the rules and regulations governing the resident's conduct and responsibilities during his/her Facility stay. This notification is made upon admission and updated as changes occur during the resident's stay. The facility will publish all updates and amendments in writing and require the resident or his/her Legal Representative to sign a written acknowledgement as is practicable. By signing this admission agreement, the resident and Legal Representative acknowledge the Facility fully disclosed and discussed the Facility's policies to the extent deemed necessary by the parties.

ADMISSION AGREEMENT

1. **PREAMBLE**

Northwest Manor Health Center located at 6440 West 34th Street, Indianapolis, IN, 46224, and licensed by the State of Indiana enters into this Agreement on 4/29/2022 with:

[redacted]

Date

_____ and _____.
Resident Legal Representative

2. **PARTIES TO AGREEMENT**

A. **Resident**. The individual "Resident" identified in the preamble above who receives services and use of accommodations from the Facility under the terms and conditions of this Agreement. Along with the Legal Representative, the Resident is liable to pay all of the contract's charges and fees.

EXHIBIT A

B. **Legal Representative.** By signing this agreement, the Legal Representative states and affirms is acting on his/her own behalf and is acting on the Resident's behalf as a Legal Representative. The Legal Representative shall receive a copy of and execute this Agreement on behalf of the Resident and the Legal Representative. Herein, Legal Representative is defined as:

a. **For a Medicaid Resident:** the individual with access to the Resident's income and assets, who shall be responsible for ensuring the Resident's income and assets are used to pay the Resident's financial obligations to the Facility. This term may include a court-appointed Guardian, Power of Attorney, Attorney-In-Fact or Durable Power of Attorney. The Legal Representative of a Medicaid Resident agrees the Facility may hold him/her personally liable up to the value of the Resident's income and assets the Legal Representative does not use to pay the Facility for the Resident's long term care and, by signing this Agreement, the Legal Representative agrees to be liable if s/he does not use the Resident's income and assets, for any reason, to pay the Facility for the care provided to the Resident. By signing this Agreement, the Legal Representative under this subsection acknowledges the facility is not requiring a third-party guarantee of payment by Legal Representative as a condition of admission.

b. **For all other Residents:** the individual who is personally liable along with the resident, jointly and severally, for any and all charges for services provided by the Facility to the Resident, beginning on the date of admission and ending on the date of discharge. This includes, but is not limited to, the Facility's charges incurred due to: (1) any denial and/or delay of the Resident's application to participate in the Medicaid program; (2) Insurance and Medicare co-insurance and Insurance and Medicare non-covered services charges; (3) Third-party payor source denial of coverage; and (4) the Resident and Legal Representative's failure to apply for Medicaid eligibility, to cooperate in establishing the Resident's eligibility, or to take the appropriate actions to achieve annual Medicaid recertification. By signing this Agreement, the Legal Representative under this subsection acknowledges the facility is not requiring a third-party guarantee of payment by Legal Representative as a condition of admission.

Under the following terms and conditions, the parties agree as follows:

Admission: The Facility shall exercise such reasonable care towards the resident as his/her known condition may require. However, the Resident and Legal Representative agree not to hold the Facility an insurer of the resident's safety or welfare and agrees never to apply any liability as such to the Facility. The Facility shall provide nursing care in a non-discriminatory basis so all residents are admitted and receive benefits and

DocuSign Envelope ID: [redacted]

services without regard to race, religion, color, national origin, age, handicap, and source of payment. The Facility does not require a third party surety or guarantee of payment as a condition of admission or condition of stay.

Likewise, the Facility does not charge, solicit, accept, or receive any amount otherwise required to be paid under State plan, any gift money or donation as a precondition to admission or continued stay. The Resident and Legal Representative agree not to hold the Facility responsible or liable for the loss or damage of any of the Resident's money, jewelry, documents or other personal property or possessions. All articles retained in the resident's possession, including dentures, eyeglasses, hearing aides, etc. . . . shall be entirely the Resident's responsibility.

Room Reservations: A bed hold charge will be made if the resident or Legal Representative elects to reserve the bed during the Resident's absence from the Facility. The Legal Representative and Resident, jointly and severally, reserve and will pay all daily Bed Hold charges effective on the discharge date at the standard rate so long as the Resident is away from the Campus for more than Twenty-four (24) hours and for each day the Resident is away from the Campus. The Legal Representative and Resident will pay the incurred Bed Hold Charges by the fifth (5th) of the month following the final day of the month with the incurred charges – for example, if the Bed Hold Charges are from April 25-30, the Legal Representative and Resident agree to pay these charges on or before May 5. Legal Representative and Resident acknowledge they understand Medicare will not pay bed hold charges.

If no re-admission to the Campus occurs due to a change in health status or death, the Resident and Legal Representative promise to notify the Campus **in writing** as soon as practicable to cancel continuing charges. Charges will be stopped effective the day the Legal Representative or Resident notifies the Campus thereof. The Legal Representative and Resident reserve the right to cancel this authorization at any time. This cancellation will be effective the date the Campus' Business Office receives written notice of cancellation from the Legal Representative or Resident. The Legal Representative confirms s/he has the right and authority to bind the Resident and him/herself to the promises made in this Agreement. Should the Legal Representative and/or Resident not pay the charges as promised by the due date identified above, they both agree, jointly and severally, to pay the account balance and all costs of collection, fees, and reasonable attorney fees incurred by the Campus attempting to collect the fees due via this agreement. The Legal Representative and Resident also agree to pay interest on the unpaid balance at 1.5% per month.

The Resident and Legal Representative will choose whether or not to hold the Resident's bed during a discharge. If the Resident and Legal Representative decline the option, every effort will be made to accommodate the resident with a bed upon his/her request for re-admission. However, depending on bed availability or other considerations, the Facility reserves the right not to re-admit the Resident. If this occurs, the Resident and Legal Representative agree to pick up the Resident's personal belongings within 10 days of the declined request to re-admit.

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The Resident or Legal Representative represents, warrants and agrees the information provided in the Resident's application for move-in to the Facility is true, complete, and accurate, and the Facility may rely on same for purposes of admitting the Resident to the Facility and providing the Resident with services under this Agreement.

Duties of Legal Representative: The resident and Legal Representative shall:

1. Pay for care and services rendered and supplies furnished by the Facility under this admission agreement's terms and conditions.
2. Arrange for the attending physician of choice's services and a designated alternate to be contacted in the event the attending physician is unavailable. The arrangement will include a commitment to see the resident either by visitations in the Facility or through office visits. In case of emergency or if medical orders cannot be obtained upon admission, the resident and Legal Representative authorize the Facility's Medical Director or designee to give temporary orders until the attending physician fulfills his/her responsibility.
3. To ensure the resident has a physical examination prior to admission and annually thereafter and otherwise to be seen by a physician as required by State and Federal agencies.
4. Provide a written inventory of the Resident's personal belongings, clothing, and personal items, documented on the Facility's approved inventory form A copy shall be retained by the Legal Representative and Facility as a receipt.
5. Provide funds as needed to meet the resident's personal needs, including spending money.
6. Provide properly labeled wash and wear clothes marked in sufficient quantities to keep the resident neatly dressed.
7. Be responsible for hospital charges and transportation to the same if hospitalization of the resident becomes necessary.
8. Be responsible for all physician fees, medication, special equipment, oxygen, and other services or aids ordered by the attending physician.
9. Accept the Facility's requirement only one member of the family may have any jurisdiction over the admission, care or discharge of the resident.
10. Accept all financial and legal responsibilities for any private nurses engaged for the resident. The Legal Representative will ensure all special duty nurses or sitters follow the Facility's rules and regulations and must be certified by the State of Indiana and will be subject to dismissal for violations.

Prescriptions: A licensed physician must prescribe and administer all drugs in accordance with the resident's assessment. The cost will be paid by the Resident and Legal Representative. The Legal Representative will make all arrangements for the medication purchases from a pharmacy chosen by the resident. The pharmacy of choice shall provide medicine according to our pharmacy policy. All medications will be under security precaution as required by law. The Facility is authorized to order all medications required for the resident from the resident's designated pharmacy. Medications, including controlled drugs, will be released to the resident at discharge only via the attending physician's order.

DocuSign Envelope ID: [redacted]

Grant of Authority: The resident and Legal Representative hereby grant to the Facility the authority to:

1. Have the resident visited by a dentist, oral hygienist, podiatrist, physical therapist, occupational therapist, speech therapist, or other person deemed necessary for the rendering of care to the resident by the attending physician upon written permission of the attending physician.
2. Allow the resident to participate in any activities within the scope of the resident's mental and physical capabilities as authorized by the attending physician, the resident and Legal Representative. The resident and Legal Representative release the Facility from any responsibility for the resident during participation in activities either within the Facility or which take the resident outside the Facility.

Rules and Regulations: The resident and Legal Representative agree to pay the Facility the rate of $_____ per day for the care and services rendered to the resident and shall pay $_____ for one month in advance at admission and a like sum thereafter on the first of each month. The Resident and Legal Representative agree to pay for the Facility's provided services and this payment requirement survives the resident's death regardless of any law or rule regarding estates, trusts or descent and distribution.

For example, if the Legal Representative and the resident have any joint accounts with rights of survivorship at any financial institutions or any other jointly held assets with rights of survivorship, the Legal Representative agrees this caveat does not relieve the requirement of payment from the jointly held accounts or assets. The resident and Legal Representative agree to be liable to pay for any willful destruction of property. These charges may be presented by separate billing, either from the Facility or directly from the contractor, providing or repairing the property willfully destroyed.

If the resident is receiving or ever shall receive governmental financial assistance, the resident and Legal Representative hereby acknowledge the agency giving financial assistance may adjust the monthly rate for which such governmental agency is responsible. The resident and Legal Representative hereby agree that, when the government agency makes such an adjustment, this agreement will be automatically adjusted so the resident and Legal Representative shall pay the Facility all portions of the monthly rate and any other sums for care, services and supplies furnished and not paid for by the governmental agency giving financial assistance.

If at any time or for any reason Medicaid denies payment to the Facility for services rendered and supplies furnished to the resident or requires the Facility to repay payments previously paid for services rendered to the resident, the resident and Legal Representative shall pay to the Facility an amount of money equal to the payment denied or recouped within thirty days of this notice along with other costs and fees allowed via this Agreement.

DocuSign Envelope ID: [redacted]

Medicare residents will agree to pay the Facility the Medicare co-insurance beginning the 21st day of coverage under Medicare.

Payment: In consideration of the care and services rendered and supplies furnished, the resident and Legal Representative shall pay, under this agreement's terms and conditions, all sums due at the Facility's office on the first day of the month, unless other arrangements are made. Accounts, which are not paid by the 10th of the month, will be charged interest at the rate of 18% per annum from the date of indebtedness until paid.

In the event of a delinquent account for any reason, the resident and Legal Representative agree to be liable for all of the Facility's costs of collection. The resident and Legal Representative will be responsible, under this agreement's terms and conditions, for paying the account balance, plus all incurred reasonable attorney fees, pre-judgment interest, court fees and collection expenses.

Part of the consideration for entering into this agreement is that the Legal Representative, in his/her capacity as Legal Representative, is to be responsible for and accept the custody of the resident if required by the Facility.

Refunds: Residents desiring to move shall provide written notice thereof and a request to receive a refund on any unexpended portion of the monthly rate to which they are entitled. So long as the Resident and Legal Representative meet all of this agreement's terms, the Facility agrees to issue the refund within 30 days of discharge.

Duration of Agreement: Either party may without cause terminate this agreement upon 30 days written notice. Such notice shall not act as cancellation of financial responsibility. This does not mean the resident will be forced to remain in the Facility against his/her will, but the Facility would appreciate time for discharge planning so that it will be less traumatic for the resident. The Legal Representative shall upon termination be responsible for and accept custody of the resident.

Resident Care Policy: The resident and Legal Representative acknowledge the Facility provided each with access to a copy of, have read, and do understand the Facility's policies and each agrees to and shall be bound and abide by the terms and provisions thereof.

Resident Care Policy: The resident and Legal Representative acknowledge each has been provided access to a copy of, have read, and do understand the Facility's policies and each agrees to and shall be bound and abide by the terms and provisions thereof.

3. MISCELLANEOUS PROVISIONS

A. **Governing Law.** This Agreement shall be interpreted in accordance with the laws of the State of Indiana and shall be binding upon and benefit each of the undersigned parties and their respective heirs, personal representatives, successors, and assigns.

DocuSign Envelope ID: [redacted]

B. **Severability.** This Agreement's various provisions shall be severable one from another. If a Court or Administrative Body finds any Agreement provision to be invalid, the other provisions shall remain in full force and effect as if the invalid provision had not been a part of this Agreement.

C. **Entire Agreement.** This Agreement represents the entire understanding between the parties and supersedes all previous representations, understandings, or agreements, oral or written, between the parties to the Agreement. All of this Agreement's parties had the right to have this document reviewed by their attorneys and agree nobody shall be deemed this Agreement's drafter.

D. **Modifications.** The Facility reserves the right to modify this Agreement's terms and to conform its provisions to any subsequent changes in applicable laws or regulations. To the extent reasonably possible, the Facility will give the Resident and the Legal Representative thirty (30) days' advance written notice of any such modifications.

E. **Waiver of Provisions.** The Facility reserves the right to waive any Resident obligation under this Agreement's provisions in its sole and absolute discretion. None of this Agreement's terms, provisions, or obligations shall be deemed to have been waived by the Facility unless such waiver is in writing by the Facility. Any waiver by the Facility shall not be deemed a waiver of any other term, provision or obligation of this Agreement, and the other obligations of the Resident and this Agreement shall remain in full force and effect.

F. **Arbitration.** Any and all disputes or claims arising out of or relating to the validity, interpretation, enforceability or performance of this Agreement, including, without limitation, this arbitration clause, but, at the Facility's sole discretion, excluding collection and billing matters, shall be solely and finally settled by binding arbitration in Indianapolis, Indiana, and, except as otherwise provided herein, in accordance with the then prevailing Commercial Arbitration Rules of the American Arbitration Association ("AAA"); provided, however, that in any case where AAA or its successors are not in existence, the arbitration shall proceed in accordance with the laws relating to arbitration then in effect in the State of Indiana.

By written notice to the Resident (or the Legal Representative, if applicable) or to the Facility, as the case may be, a party may demand a disputed matter be submitted to arbitration. The demand notice shall specify the nature of the dispute. An arbitrator shall be chosen in accordance with the prevailing Commercial Arbitration Rules of AAA. The arbitrator shall permit or prohibit discovery in his sole discretion and may admit or exclude evidence in his sole discretion.

The arbitrator shall decide the dispute or claim in accordance with the then prevailing Commercial Arbitration Rules of AAA, applying the substantive laws of Indiana. Judgment upon the arbitral award may be entered in any court having jurisdiction over a party or such party's assets. No party may take any dispute or claim subject to arbitration hereunder to any court until an arbitration decision has been made, except that any party shall have the right to institute any legal actions for provisional relief pending final settlement by arbitration.

The expense of any arbitration or any related court proceedings, shall be allocated to and borne by the parties, as determined by the arbitrator in his sole discretion; provided, however, that each party shall bear and pay for the cost of its own experts, witnesses, evidence and counsel and any other cost in connection with the arbitration and presentation of its case.

The resolution of such arbitration shall be final and binding on the parties hereto and enforceable in a court of competent jurisdiction.

If the Resident and Legal Representative have any questions regarding this Agreement, they agree they will contact the Admissions Director or Administrator.

Legal Rights: The resident and Legal Representative have full freedom of choice in the selection and retention of the resident's attending physician. The physician designated for the care of [redacted] is:

Resident's Name

[redacted]	Ophthalmologist's Name
[redacted]	
Physician's Phone Number	Podiatrist's Name
[redacted]	
Pharmacy Name	Dentist's Name

At any time, if the designated health care professionals fail to provide adequate care to the resident, the Resident and Legal Representative accepts the responsibility to change to another health care professional of choice. The facility's medical staff is open to all physicians who comply with the requirements for care as listed in these policies. These requirements are necessary to comply with the Federal and State regulations under which we are governed. The Resident and Legal Representative agree they will not hold the facility liable for any alleged negligence of any physician or other health care provider not within the Facility's specific employ.

DocuSign Envelope ID: [redacted]

ACKNOWLEDGEMENT SHEET

(Signature Page)

This signature page is a part of a binding legal contract. Please read the Agreement's contents and attachments carefully before signing to make sure you fully understand the terms and obligations you are assuming. This Agreement becomes effective on the day it is signed and stays in effect until it is terminated pursuant to the terms listed under this Agreement.

Please note that, in addition to signing this signature page, you may be asked to sign separately several attachments to this Agreement.

Please maintain a copy of this signature page for your records, as it will be the proof of your binding contract with the Facility.

For The Facility

CHRISTINA HOEPNER
Signature of Authorized Facility Signatory

ADMISSIONS DIRECTOR
Title of Authorized Signatory for the Facility

For Resident: [redacted] **(Resident Name)**

DocuSigned by:
[redacted]
Signature of the Resident (if available)

Legal Representative's signature

•

Print the Name of Resident and the Legal Representative

4/29/2022
Date of Signature

•

Legal Representative's Address, City, State and Zip Code

•

(H)_____(W)_____(C)_____
**Legal Representative's Home, Work & Cellular Telephone Numbers

*
_____
**Legal Representative's Employer and its address

*
_(SS#)_____(D.O.B.)_____
**Legal Representative's Social Security Number and Date of Birth

* **Required information**
** **The Legal Representative's information will not be released to any third-party, unless this Contract is allegedly breached, without the Legal Representative's express written consent.**

Filed: 1/6/2023 3:15 PM
Clerk
Marion County, Indiana

STATE OF INDIANA	)	IN MARION CIRCUIT/SUPERIOR COURT
	)SS:	
COUNTY OF MARION	)	CAUSE NO.

ADAMS COUNTY MEMORIAL HOSPITAL *d/b/a* NORTHWEST MANOR HEALTHCARE CENTER

Plaintiff,

vs.

[redacted] and [redacted],

Defendants.

COMPLAINT FOR SUIT ON ACCOUNT

Adams County Memorial Hospital *d/b/a* Northwest Manor Healthcare Center (*hereinafter* "Northwest Manor"), *by counsel*, files its Complaint for Suit on Account against the Defendants, [redacted] and [redacted], jointly and severally. In support, Northwest Manor states and alleges:

1. Northwest Manor does business in the State of Indiana, with its principal place of business located at 6440 West 34th Street, Marion County, Indianapolis, Indiana 46224.

2. Northwest Manor is duly licensed and certified by the State of Indiana as a long-term health care facility, pursuant to Ind. Code § 16-28.

3. By information and belief, the Defendants, [redacted] and [redacted], are residents of State of Indiana, each currently residing at 3944 Steinmetz Dr., Indianapolis, IN 46254.

4. On or about March 29, 2022, Northwest Manor admitted [redacted] into its long-term care facility to receive health care and services.

5. On or about March 29, 2022, when Northwest Manor admitted [redacted] into its facility, he signed the facility's Admission Agreement on his own behalf. (S*ee* Admission Agreement attached hereto as **Exhibit A**).

6. By and through the Agreement, the Defendant, [redacted], agreed:

> The individual "Resident" … receives services and use of accommodations from the Facility under the terms and conditions of this Agreement. The Resident is liable to pay all of the contract's charges and fees.
> (*See* **Exhibit A, §2A**).

7. By and through the Agreement, the Defendant, [redacted], agreed:

> [To] pay for care and services rendered and supplies furnished by the Facility.
> (*See* **Exhibit A, §2**).

8. By and through the Agreement, the Defendant, [redacted], agreed:

> [T]he resident … shall pay … all sums due at the Facility's office on the first day of the month, unless other arrangements are made. Accounts, which are not paid by the 10th of the month, will be charged interest at the rate of 18% per annum from the date of indebtedness until paid. In the event of a delinquent account for any reason, the resident … agrees to be liable for all of the Facility's costs of collection … plus all incurred reasonable attorney fees, pre-judgment interest, court fees and collection expenses.
> (*See* **Exhibit A, §2**).

9. For the months of March 2022 and April 2022, [redacted] received health care and services for which the Defendants have not paid. (*See* Affidavit of Debt attached hereto as **Exhibit B**).

10. The Defendants were married as husband and wife throughout [redacted] residency at Northwest Manor.

11. [redacted] is also liable for [redacted] balance via Indiana's Doctrine of Necessaries.

12. This account is unsatisfied and has not been excused by the Plaintiff. The Defendants have not paid this account, despite the Plaintiff's demand.

13. For [redacted] residency, the Defendants owe Northwest Manor an account balance of Four Thousand Six Hundred Thirty-Four and 98/100s dollars ($4,634.98) (*see* Itemized Statement attached hereto as **Exhibit C**), plus costs, pre-and post-judgment interest, and reasonable attorney fees.

WHEREFORE, Adams County Memorial Hospital *d/b/a* Northwest Manor Healthcare Center, respectfully requests this Court enter a judgment in its favor and against the Defendants, [redacted] and [redacted], jointly and severally, in the amount of Four Thousand Six Hundred Thirty-Four and 98/100s dollars ($4,634.98), plus costs, pre- and post-judgment interest and reasonable attorney fees (all of which is allowed under Exhibit A); and, the Court grant it all other relief, just and proper in the premises.

Respectfully submitted,

DREWRY SIMMONS VORNEHM, LLP

Paul (Rick) Rauch, #18125-49
Attorney for Plaintiff

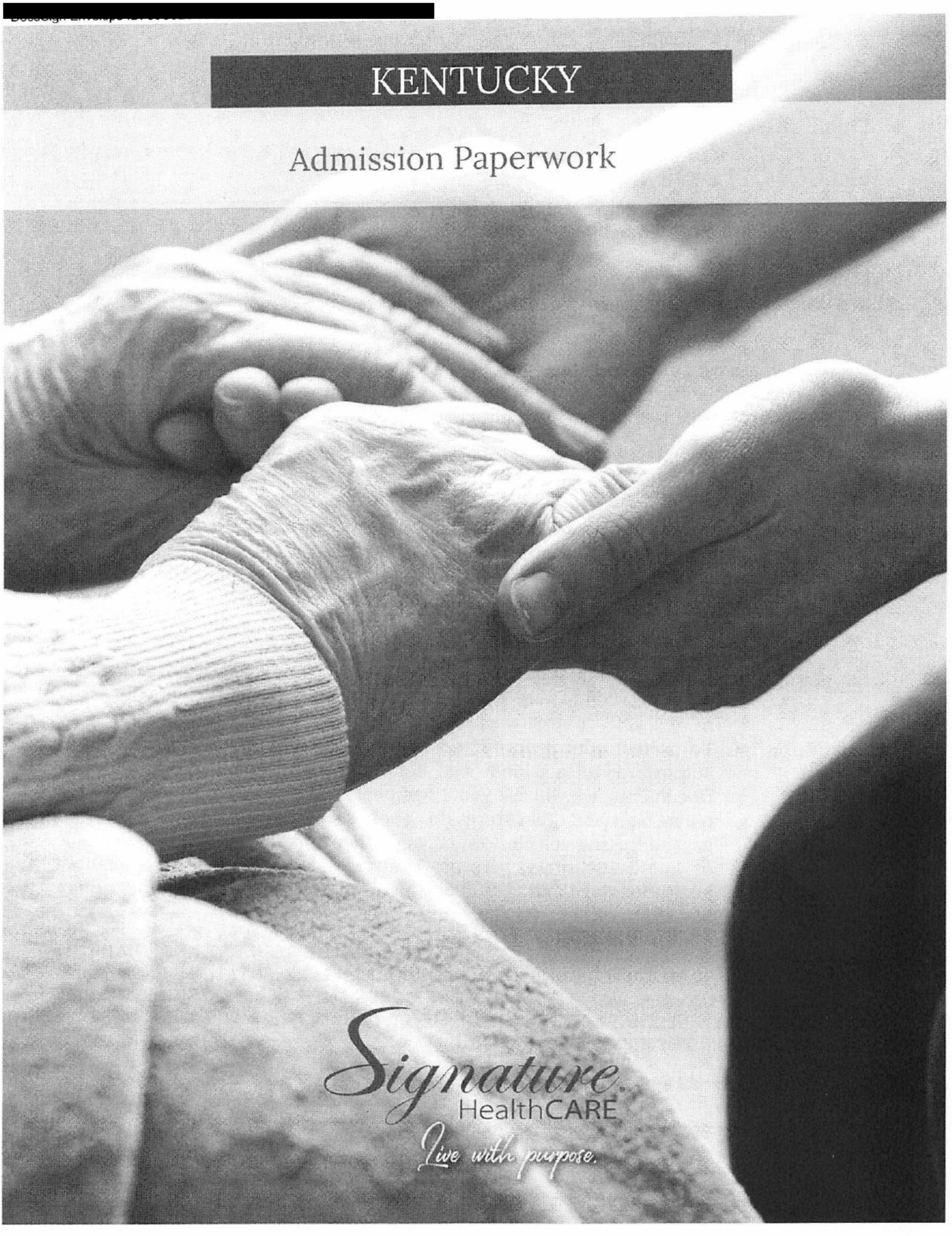
Paul (Rick) Rauch, #18125-49
Drewry Simmons Vornehm, LLP
736 Hanover Place, Suite 200
Carmel, IN 46032
(317) 580-4848 (main)
(317) 713-6046 (direct)
(317) 580-4855 (fax)
rrauch@dsvlaw.com

Kentucky

Admission Agreement: Signature Healthcare of Elizabethtown

KENTUCKY

Admission Paperwork



DocuSign Envelope ID: [redacted]

Signature HealthCARE
Live with purpose.

WELCOME TO OUR FACILITY!

Dear New Community Member,

Thank you for choosing our community! We are honored to care for your loved one, and have recently implemented several new technologies to better enhance our customer service:

- ✓ If you have questions or seek updates about your loved one, please call our new customer information center, available 24/7, and speak to qualified persons (including licensed nurses) with direct access to your loved one's information:

  CARE Navigation
  1-844-SHC-CHAT

- ✓ Our admissions process is now fully electronic, which means the standard paper and ink pen signing method is history! You will review, sign, and return all Admissions Documents electronically on either a Facility provided tablet, through your email, or by regular mail. If by tablet, a Facility representative will present and explain all documents to you in person. If by email or regular mail, a Facility representative will do the same through a scheduled phone call.
  - Electronic or digital signatures on paperwork are legally valid. If you have signed a credit card receipt at a store with an electronic pen or your finger -- well, you are already a pro!
  - To protect your security and ensure it is really **YOU** (a person legally authorized to act and sign for Resident) signing the Admissions Documents, we will ask you 4 personal security questions, just like your online bank and other stores do. These security questions ask about your past addresses, vehicles owned, and other topics not readily discoverable or known by other persons. Fourteen of the top 20 U.S. financial institutions use and rely upon this form of authentication, and we are pleased to offer this technology to you!

I REPRESENT THAT I AM AUTHORIZED TO ACT AND SIGN FOR RESIDENT AND THAT IT IS REASONABLE FOR FACILITY TO RELY UPON MY AUTHORITY REPRESENTATION. I AGREE AND UNDERSTAND THAT ALL FACILTIY ADMISSION DOCUMENTS WILL BE SIGNED BY ME ELECTRONICALLY, AND THAT MY ELECTRONIC SIGNATURE ON THEM WILL LEGALLY SERVE AS IF I HAD SIGNED THEM WITH AN INK PEN.

Resident Authorized Legal Representative:

[redacted] _____ [redacted] _____ [redacted]

(Print Name) (Signature) (Date)

Resident Name: [redacted] Facility Name: Signature HealthCARE of Elizabetht

DocuSign Envelope ID: [redacted]

Signature HealthCARE

RESIDENT LEGAL DOCUMENT CHECKLIST

By initialing and signing below, I represent that:

1. I marked that the legal authority documents below exist for Resident. I will give a copy of them to Signature HealthCARE of Elizabethtown (Facility Name). I understand, accept, and find it reasonable for Facility to rely upon the representations I have made about these documents, including the authority they convey upon me to act for, and on, Resident's behalf. I represent that such authority specifically includes, but is not limited to, the signing of any and all admission and medical paperwork for Resident, including, but not limited to, an arbitration agreement.

_____ [redacted] **(Signer's Initials)**

Document Type	Check all that Apply/Exist
Power of Attorney	x
Health Care Proxy	
Health Care Surrogate	
Guardianship Order	
Living Will	x
Advanced Directive	

2. Resident verbally gave me permission to act on Resident's behalf, and this authority specifically includes, but is not limited to, the signing of any and all Facility admission and medical paperwork for Resident, including, but not limited to, an arbitration agreement. I understand, accept, and find it reasonable for Facility to rely upon this representation about my authority to act for, and on, Resident's behalf.

_____ [redacted] **(Signer's Initials)**

Resident Authorized Legal Representative:

[redacted] _____ [redacted] _____ [redacted]

(Print Name) **(Signature)** **(Date)**

Resident Name: [redacted] Facility Name: Signature HealthCARE of Elizabethtowr

DocuSign Envelope ID: [redacted]

Signature HealthCARE

HEALTH CARE SURROGATE APPOINTMENT

[redacted]

(Resident Name)

By signing below, I represent that:

- I am the Resident's (check one):
  - _____ Legal Spouse
  - ___X___ Adult Child
  - _____ Parent
  - _____ Nearest Living Relative

- I am an adult, of sound mind, who voluntarily agrees to serve as Resident's Health Care Surrogate. I am unaware of any court order or legal document authorizing a person to act on Resident's behalf. I agree to assume all authority to make health care related decisions for Resident, including signing any needed paperwork related to Resident's placement in a health care facility or for medical care, and acknowledge that this may include an arbitration agreement.

MICHAEL BUCKNER

Resident Surrogate (Print Name)

DocuSigned by: [redacted]

Resident Surrogate (Signature)

[redacted]

(Date)

PHYSICIAN NOTIFICATION AND APPROVAL

I am the primary care physician for Resident. I find that Resident (check one):

_____Lacks capacity _____Has capacity

to understand the benefits, risks, and alternatives of making health care decisions, including, but not limited to, reading and signing health care admission and other documents. I agree that a Surrogate(s) should be appointed for Resident and that the above-named person has agreed to serve. Any health care decisions the Surrogate(s) made for the Resident are deemed valid as of the Surrogate'(s) signature date.

Physician Signature

Date

DocuSign Envelope ID: [redacted]

RESIDENT CARE CONSENTS AND AUTHORIZATIONS

By initialing each paragraph, I represent that (i) I agree with the information contained therein, (ii) I am authorized by Resident or have other legal authority to act for and on Resident's behalf, and (iii) Facility can and should rely upon my representations, initials, and signature on this document.

➢ Consent to Facility / Medical Treatment

Initials [redacted]

I consent to Resident being admitted and medically treated at Facility. I understand that Resident will be cared for in accordance with the plan that Resident's physician(s) and Facility deem appropriate, and that I have the right to revoke this consent and/or refuse medical treatment for Resident at any time.

➢ Consent to General Release of Resident Information

Initials [redacted]

I consent and agree that Facility may verbally and generally discuss Resident's medical information with the person(s) listed below. I can add or remove names at any time, but until I do so in writing, Facility is authorized to proceed and disclose.

_____
(Name)

_____
(Name)

➢ Emergency Contact

Initials [redacted]

The following person(s) should be contacted about Resident in case of emergency:

[redacted] _____ [redacted] _____
(Name) **(Phone)**

[redacted] _____ [redacted] _____
(Name) **(Phone)**

➢ Resident Care Team Meetings / CARE Navigation

Initials [redacted]

Facility will schedule important meetings with Resident's care team to discuss Resident's health status, new care orders, and more. Resident and family are strongly encouraged to attend them, as they are a primary form of Facility communication. Otherwise:

Authorized Person(s) Can Receive Live Updates on Resident, 24/7
Call the CARE Navigation Team
(844) SHC- CHAT

Resident Name: [redacted] Facility Name: Signature HealthCARE of Elizabethtown

DocuSign Envelope ID: [redacted]

Signature HealthCARE
Live with purpose

➢ Consent for Associate and Independent Provider Services

Associate and Independent Providers include licensed physicians, nurse practitioners, and other professionals, who offer resident services at the Facility.

Before consenting below, please ask how these services are provided and for the names of the professionals and companies who will provide them to you. Otherwise, the name and company affiliation of your service professional will be identified to you at or near the time of service.

☒ I want Resident to receive these services, if needed. **Initials** [redacted]

➢ Consent for Virtual Services

Facility and other physicians may provide Virtual Services at Facility. I understand that anyone virtually or physically present during a Virtual Service with the Resident may receive Resident's personal health information.

Virtual Services may include but not limited to:

Telehealth
Behavioral Health Integration (BHI)
Chronic Care Management (CCM)
Clinical Remote Resource Center (CRRC)
Remote Patient Monitoring (RPM)
Remote Therapeutic Monitoring (RTM)

Check one:

☐ I consent for Resident to participate in and receive Virtual Services.

☒ I DO NOT consent for Resident to participate in or receive Virtual Services.

Initials [redacted]

Resident Authorized Legal Representative:

[redacted]	DocuSigned by: [redacted]	[redacted]
(Print Name)	**(Signature)**	**(Date)**

Resident Name: [redacted] Facility Name: Signature HealthCARE of Elizabethtown

DocuSign Envelope ID: [redacted]

Signature HealthCARE

RESIDENT COVID-19 VACCINE EDUCATION ACKNOWLEDGEMENT

By initialing and signing below, I understand and represent that:

- Facility partners with various national pharmacy companies to offer the COVID-19 vaccine to all residents and staff.
- Facility has no control over which vaccine is made available to it, or when, as this depends solely on the pharmacy's vaccine supply.
- Depending on the vaccine supply available, Facility may offer either the Pfizer, Moderna, or Johnson & Johnson vaccine to its residents and staff.
- There are risks and benefits associated with all of these COVID-19 vaccine types, and I should read and understand them before deciding whether to be vaccinated.
- Facility has provided me education on all three types of COVID-19 vaccines, including through the EUAs issued directly from the vaccine manufacturers and has answered any questions I had.
- I have voluntarily decided ***(initial one line only)***:

_____**I want to be vaccinated for COVID-19, using the vaccine available to Facility.**

_____**I DECLINE TO BE VACCINATED for COVID-19.**

DS
[redacted] **I have been vaccinated for COVID-19 and will provide proof to Facility**

Resident Authorized Representative Name: [redacted]

DocuSigned by:
[redacted]

(Resident Authorized Representative Signature) [redacted] **(Date)**

Resident Name [redacted] Facility: Signature HealthCARE of Elizabethtown

Rev 051523

DocuSign Envelope ID: [redacted]

Signature HealthCARE
Care with purpose.

RESIDENT FLU AND PNEUMOCOCCAL VACCINE EDUCATION ACKNOWLEDGEMENT AND CONSENT

By initialing and signing below, I understand and represent that:

- Each year, on an annual basis, Facility partners with various national pharmacy companies to offer the Flu and Pneumococcal vaccines to all residents and staff.
- Facility has no control over which manufacturer's Flu and Pneumococcal vaccines are made available to it, or when, as this depends solely on the pharmacy's vaccine supply.
- Each year, on an annual basis, Facility will offer residents and staff the Flu and Pneumococcal vaccines made available to it.
- There are risks and benefits associated with the Flu and Pneumococcal vaccines, and I should read and understand them before choosing to be vaccinated.
- Facility has provided me education on the Flu and Pneumococcal vaccines (either in the Resident Handbook or through handout materials) and has answered any questions I had.
- **I HAVE LEGAL AUTHORITY TO ACT FOR AND ON RESIDENT'S BEHALF.**
- FOR THE FLU: I have voluntarily decided ***(initial one line only)***:

  DS [redacted] **consent / want Resident vaccinated for the Flu, using the vaccine available to Facility. I can refuse the vaccine or change my mind at any time.**

  _____ **I DO NOT WANT RESIDENT VACCINATED for the Flu.**

  _____ **Resident recently was vaccinated for the Flu and I will provide Facility proof.**

  Date: _____

  Location: _____

- FOR PNEUMOCOCCAL: I have voluntarily decided ***(initial one line only)***:

  DS [redacted] **consent / want Resident vaccinated for Pneumococcal, using the vaccine available to Facility. I can refuse the vaccine or change my mind at any time.**

  _____ **I DO NOT WANT RESIDENT VACCINATED for Pneumococcal.**

  _____ **Resident recently was vaccinated for Pneumococcal and I will provide Facility proof.**

  Date: _____

  Location: _____

Resident Authorized Representative Name: [redacted]

(Resident Authorized Representative Signature) DocuSigned by: [redacted] **(Date)** [redacted]

Resident Name: [redacted] Facility: Signature HealthCARE of Elizabethtown

DocuSign Envelope ID: [redacted]

Signature HealthCARE

CONSENT TO TAKE AND USE RESIDENT IMAGES FOR CARE PURPOSES

By signing below, I understand, acknowledge, and agree that:

- Signature HealthCARE of Elizabethtown, LLC, and any of its parent and affiliated companies, and their employees, agents, officers, and health care professionals (collectively, the "Facility") may take or use photographic and other images of Resident for Resident identification (e.g., in Facility directory), medical treatment and administration (including, but not limited to, skin issues), and/or quality assurance purposes.

- Facility will treat Resident's images as confidential, house them in the Resident's medical record, and not release them, except with express permission and/or as required by law.

- This Consent does <u>not</u> cover the use of Resident's image(s) in any verbal or written testimonial, printed story, or Facility media or marketing event. A separate release will be offered under the Health Insurance Portability and Affordability Act of 1996 (HIPAA) for this purpose.

- Facility is released from any, and all liability and damages of any kind, for taking, or using, Resident's photograph, or image, as authorized in this Consent.

Resident Authorized Legal Representative:

[redacted]	DocuSigned by: [redacted]	[redacted]
(Print Name)	**(Signature)**	**(Date)**

Resident Name: [redacted] Facility Name: Signature HealthCARE of Elizabethtown

DocuSign Envelope ID: [redacted]

Signature HealthCARE
Care with purpose

RESIDENT PHOTO/MEDIA CONSENT AUTHORIZATION

The Health Information Portability and Accountability Act (HIPAA) protects Resident's privacy and prevents Facility use or disclosure of Resident's medical information or image (Protected Health Information or PHI) without written authorization.

- Facility Signature HealthCARE of Elizabethtown (Name), its parents, and affiliates (collectively "Facility")
- Resident Name: [redacted]
  Date of Birth: [redacted]

- Facility may, for internal and/or external marketing and communication purposes, ***only as marked below***:
  a. Use or disclose Resident's PHI, and
  b. Copyright, use, and publish Resident's personal image/photograph(s) and verbal or written testimonial.
     - X As part of Facility activity programs, marketing, or special Facility events.
     - X In all Facility internal communication systems and/or marketing or advertising mediums, including but not limited to, Facility training/education/orientation, bulletin boards, newsletters, intranet pages, and email.
     - X In all Facility **external** communication systems, marketing or advertising mediums, and/or other news sources, including but not limited to, Facility brochures, DVDs, Facebook and other social media networks, publicly accessible websites, and community outreach programs, and in response to media requests.

☒ **Yes, I Authorize** the Above Use and Disclosure, As Marked ☐ **No, I DO NOT Authorize**

- **Unless expressly agreed, Facility may not:**
  a. Use or disclose photographs of Resident that Facility takes for identification, medical treatment, or quality assurance purposes, except as required by law.
  b. Use or disclose photographs, name, or written/verbal testimonials of Resident in a manner that would disclose Resident's PHI, except that Resident lives at Facility.
- **Resident can:**
  a. Refuse to sign this and Resident will still receive Facility care and services.
  b. Revoke this Authorization at any time by notifying Facility.
- **Resident understands:**
  a. Resident's PHI may be re-disclosed by recipient, which may not be protected by HIPPA.
  b. Resident is waiving the right to review PHI/photograph before Facility use or disclosure.
  c. That unless Resident informs Facility otherwise, this Consent and Release will expire when only Facility no longer uses Resident's information for the stated or for a different purpose.
  d. Resident will not be compensated, paid, or receive any royalties of any kind for use of Resident's PHI, information, story, photographs, or image.

I HAVE READ THIS FORM, HAVE LEGAL AUTHORITY TO SIGN IT FOR RESIDENT, AND DO SO VOLUNTARILY.

Resident Authorized Legal Representative:

[redacted] **(Print Name)** [redacted] **(Signature)** [redacted] **(Date)**

Resident Name: [redacted] Facility: Signature HealthCARE of Elizabethtown

DocuSign Envelope ID: [redacted]

Signature HealthCARE

RESIDENT ACTIVITY OUTING CONSENT AND RELEASE

Resident may leave Facility and participate in Facility activity outings, such as:

Ball parks	Movies/theaters	Scenic rides
Community Centers/Clubs	Museums	Schools
Fairs	Parks	Shopping trips
Fishing trips	Picnics	Sight-seeing
Libraries	Restaurants	Stadiums

- Facility will answer any questions about any activity outing upon request.
- There are risks related to Resident leaving Facility and attending an outing, including, but not limited to, possible physical and mental injury of Resident, even death. These risks can be discussed with Facility before Resident attends.
- I, on behalf of Resident and myself individually, fully release Facility and its owners, managers, directors, affiliates, subsidiaries, agents, officers, and employees from any and all liability, claims, causes of action, damages, or losses of any kind to Resident related to or arising in any way from Resident attending an outing. I agree this release is binding upon Resident and Resident's heirs, executors, administrators, and personal representatives.

Resident Authorized Legal Representative:

[redacted] _____ [redacted]

(Print Name) **(Signature)** **(Date)**

Resident Name: [redacted] Facility Name: Signature HealthCARE of Elizabeth

DocuSign Envelope ID [redacted]

Signature HealthCARE

☒ *Check here if Resident qualifies for Medicare A, do not complete SND*

NOTICE OF SKILLED NURSING DETERMINATION ("SND")

Facility has reviewed Resident's available medical information and believes Resident does not qualify for coverage under Medicare Part A for the following reason(s):

- ☐ No qualifying 3-day inpatient hospital stay
- ☐ No days left in current benefit period
- ☐ Care not ordered or certified by a physician
- ☐ Daily skilled care not needed
- ☐ Skilled Nursing Facility transfer requirement not met
- ☐ Facility/Bed not Medicare certified
- ☐ Care not given by, nor supervised by, skilled nursing or rehabilitation staff
- ☐ Items or services not provided by Facility
- ☐ Resident is enrolled in a managed Medicare plan
- ☐ Other:_____

Facility made this determination, not Medicare. Facility believes Medicare will not pay for Resident's care here. If you request, Facility can still submit billing statements to Medicare and third-party Medicare intermediary will notify you of its pay determination. If you disagree with that determination, you may file an appeal.

NOTICE: RESIDENT IS RESPONSIBLE TO PAY FOR CARE AND SERVICES KNOWN NOT TO BE COVERED BY MEDICARE, IF REASONABLE AND NECESSARY.

Questions about a bill or liability to pay for services before this Notice date? Ask us to submit the bill to Medicare!

Please select one option:

- ☐ A. Submit Resident's bill to Medicare. If you do not receive a formal Notice of Medicare Determination within 90 days of this request, you should contact:

  Mutual of Omaha - Medicare
  P.O. Box 1602, Omaha NE 68101
  (877) 647-6528

- ☐ B. DO NOT submit Resident's bill to Medicare. I will waive any right to a Medicare appeal.

NOTE: You do not have to pay for services Medicare may cover until a Medicare decision has been made.

Resident Name: [redacted] Facility: Signature HealthCARE of Elizabethtown

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DocuSign Envelope ID: [redacted]

Signature HealthCARE

➢ **Check/Complete Only One:**

☐ C. I, the Resident, personally received this Notice of Medicare non-coverage of services on [redacted] (Date).

[redacted]

Resident Authorized Legal Representative (Signature) **Date**

☐ D. I, Facility representative, personally notified the Resident [redacted] (Name) about this Notice of Medicare non-coverage by either:

Phone call on [redacted]

Email, followed up by a phone call on [redacted] (Date)

Tonya Devers-Hawkins

Facility Representative (Print Name)

[redacted]

Facility Representative (Signature) **Date**

Resident Name: [redacted] Facility: Signature HealthCARE of Elizabethtown

DocuSign Envelope ID: [redacted]

Signature HealthCARE

MEDICARE SECONDARY PAYOR

The following questions will assist Facility in identifying other payment sources for Resident's care. Please answer them in sequence and follow the instructions after each question to help direct you to the next appropriate question. "You" means Resident.

PART I

1. Are you receiving Black Lung (BL) Benefits?
   ____ Yes, Date benefits began_____**BL is primary payor only for claims related to BL**
   _x_ No.
2. Are the services to be paid by a government program such as a research grant?
   ____ Yes, **Government research program will pay primary benefits for services**
   _x_ No.
3. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for care at this facility?
   ____ Yes, **DVA is primary for these services**
   _x_ No.
4. Was the illness/injury due to a work-related accident/condition?
   ____ Yes, Date of injury/illness: _____
   Name and address of WC plan: _____
   Policy or identification number:_____
   Name and address of your employer:_____
   WC (Worker's Comp.) is primary payor only for claims related for work related injuries or illness, GO TO PART III.

   _x_ No. **GO TO PART II.**

PART II

1. Was illness/injury due to a non-work-related accident?
   ____ Yes, Date of accident: _x_ No. **GO TO PART III.**
2. Is no-fault insurance available? (No-fault insurance is insurance that pays for health care services resulting from injury to you or damage to your property regardless of who is at fault for causing the accident.)
   ____ Yes, Name and address of no-fault insurer(s) and no-fault insurance policy owner:
   _____
   Insurance claim number:
   _____

   ____ No.

3. Is liability insurance available? (Liability insurance is insurance that protects against claims based on negligence, inappropriate action or inaction, which results in injury to someone or damage to property.)

_____ Yes, Name and address of liability insurer(s) and responsible party:

_____

Insurance claim number: _____

_____ No.

NO-FAULT Insurer is primary payer only for those services related to the accident. Liability insurance is primary payer only for those services related to the liability settlement, judgement, judgement, or award. GO TO PART III.

PART III

1. Are you entitled to Medicare based on:

_x_ Age. **GO TO PART IV.**

_____ Disability. **GO TO PART V.**

_____ End-Stage Renal Disease (ESRD). **GO TO PART VI.**

Please note that both "Age" and "ESRD" OR "Disability" and "ESRD" may be selected simultaneously. An individual cannot be entitled to Medicare based on "Age" and "Disability" simultaneously. Please complete ALL "PARTS" associated with the patient's selections.

PART IV

1. Are you currently employed?

_____ Yes, Name and address of your employer: _____

_____

_x_ No. If applicable, date of retirement: _____

_____ No. Never Employed

2. Do you have a spouse who is currently employed?

_____ Yes, Name and address of your spouse's employer: _____

_____

_x_ No. If applicable, date of retirement: _____

_____ No. Never Employed

If the patient answered "NO" to both questions 1 and 2, Medicare is primary unless the patient answered "YES" to questions in part I or II.
DO NOT PROCEED FURTHER.

3. Do you have group health plan (GHP) coverage based on your own or a spouse's current employment?

_____ Yes, both. _____Yes, self. _____Yes, spouse.

_x_ No.

STOP. Medicare is primary payer unless the patient answered YES to the questions in Part I or II.

4. If you have GHP coverage based on your own current employment, does your employer that sponsors or contributes to the GHP employ 20 or more employees?

_____ Yes, **GHP is primary. Obtain the Following Info:**

Name and address of GHP:_____

Policy identification number (this number is sometimes referred to as the health insurance benefit package number):_____

Group identification number: _____

Membership number (prior to the Health Insurance Portability and Accountability Act (HIPAA), this number was frequently the individual's Social Security Number (SSN); it is the unique identifier assigned to the policyholder/patient): _____

Name of policyholder/named insured:_____

Relationship to patient:_____

_____ No.

5. If you have GHP coverage based on your spouse's current employment, does your spouse's employer, that sponsors or contributes to the GHP, employ 20 or more employees?

_____ Yes, **GHP is primary. Obtain the Following Info:**

Name and address of GHP: _____

Policy identification number (this number is sometimes referred to as the health insurance benefit package number):_____

Group identification number:_____

Membership number (prior to the Health Insurance Portability and Accountability Act (HIPAA), this number was frequently the individual's Social Security Number (SSN); it is the unique identifier assigned to the policyholder/patient):

_____

Name of policyholder/named insured:_____

Relationship to patient:_____

_____ No.

If the patient answered "NO" to both questions 4 and 5, Medicare is primary unless the patient answered "YES" to questions in Part I or II.

PART V

1. Are you currently employed?

_____ Yes, Name and address of your employer:_____

_____ No. If applicable, date of retirement:_____

_____ No. Never Employed.

2. Do you have a spouse who is currently employed?
____ Yes, Name and address of spouse's employer:_____
__x__ No. If applicable, date of retirement:_____
____ No. Never Employed.

3. Do you have group health plan (GHP) coverage based on your own or a spouse's current employment?
____ Yes, both. ____Yes, self. ____Yes, spouse. __x__No.

4. Are you covered under the GHP of a family member other than your spouse?
____ Yes, Name and address of your family member's employer:
_____
____ No.

If the patient answered "NO" to both questions 1,2,3, and 4, STOP. Medicare is primary unless the patient answered "Yes" to questions in Part I or II.

5. If you have GHP coverage based on a family member's current employment, does your family member's employer, that sponsors or contributes to the GHP, employ 100 or more employees?
____ Yes, **GHP is primary. Obtain the Following Info:**
Name and address of GHP:_____
_____
Policy identification number (this number is sometimes referred to as the health insurance benefit package number):
_____
Group identification number:_____

Membership number (prior to HIPAA, this number was frequently the individual's SSN; it is the unique identifier assigned to the policyholder /patient): _____
Name of policyholder/named insured: _____
Relationship to patient: _____
____ No.

If the patient answered "NO" to questions 5, 6, and 7, Medicare is primary unless the patient answered "YES" to questions in Part I or II.

Signature HealthCARE

PART VI

1. Do you have group health plan (GHP) coverage?

_____ Yes, **If, applicable, your GHP information:**

Name and address of GHP: _____

Policy identification number (this number is sometimes referred to as the health insurance benefit package number):_____

Group identification number: _____

Membership number (prior to HIPAA, this number was frequently the individual's SSN; it is the unique identifier assigned to the policyholder/patient):_____

Name of policyholder/named insured:_____

Relationship to patient: _____

Name and address of employer, if any, from which you receive GHP coverage:

_____

If applicable, your spouse's GHP information: _____

Name and address of GHP: _____

Policy identification number (this number is sometimes referred to as the health insurance benefit package number):_____

Group identification number: _____

Membership number (prior to HIPAA, this number was frequently the individual's SSN; it is the unique identifier assigned to the policyholder /patient): _____

Name of policyholder/named insured:_____

Relationship to patient: _____

Name and address of employer, if any, from which you receive GHP coverage:

_____

_____

If applicable, your family member's GHP information:

Name and address of GHP:_____

_____

Policy identification number (this number is sometimes referred to as the health insurance benefit package number): _____

Group identification number: Membership number (prior to HIPAA, this number was frequently the individual's SSN; it is the unique identifier assigned to the policyholder/patient): _____

Name of policyholder/named insured:_____

Relationship to patient: _____

Name and address of employer, if any, from which you receive GHP coverage:

_____

_____

_____No. **STOP. Medicare is primary.**

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2. Have you received a kidney transplant?
   _____Yes, Date of transplant:_____
   _____ No.

3. Have you received maintenance dialysis treatments?
   _____ Yes, Date dialysis began:_____
   If you participated in a self-dialysis training program, provide date training started:_____
   _____ No.

4. Are you within the 30-month coordination period that starts?
   (The 30-month coordination period starts the first day of the month an individual is eligible for Medicare (even if not yet enrolled in Medicare) because of kidney failure (usually the fourth month of dialysis). If the individual is participating in a self-dialysis training program or has a kidney transplant during the 3-month waiting period, the 30-month coordination period starts with the first day of the month of dialysis or kidney transplant.)
   _____ Yes.
   _____ No. **STOP. Medicare is primary.**

5. Are you entitled to Medicare based on either ESRD and age or ESRD and disability?
   _____ Yes.
   _____ No.

6. Was your initial entitlement to Medicare (including simultaneous or dual entitlement) based on ESRD?
   _____ Yes, **STOP. GHP continues to pay primary during the 30-month coordination period.**
   _____ No. **Initial entitlement based on age or disability.**

7. Does the working aged, or disability MSP provision apply (i.e., is the GHP already primary based on age or disability entitlement)?
   _____ Yes, **GHP continues to pay primary during the 30-month coordination period.**
   _____ No. **Medicare continues to pay primary.**

➢ **By signing below, I represent that I have answered the above questions truthfully, to the best of my knowledge.**

[redacted] _____ [redacted]

Resident Authorized Legal Representative (Signature) **Date**

_____

Resident Medicare #

Resident Name [redacted] Facility: Signature HealthCARE of Elizabethtown

Rev 080121

DocuSign Envelope ID: [redacted]

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Live with purpose.

AGREEMENT FOR FACILITY CARE / SERVICES

1. Signature HealthCARE of Elizabethtown ("**Facility**") will provide [redacted] ("**Resident**") care and other services, in exchange for payment, as described below.

2. **Facility:**
   - ➢ Does not provide Resident one-on-one care or monitoring; Facility is not a hospital.
   - ➢ Will provide Resident general nursing care, as ordered by Resident's physician(s).
   - ➢ Makes no representation or guarantee, express or implied, about Resident's medical outcome.
   - ✓ If Resident fell before coming to Facility, chances are high Resident may fall again while at Facility.
   - ✓ If Resident had skin breakdown issues before coming to Facility, or arrived with, or develops certain medical conditions while at Facility, chances are high Resident may have skin issues while here.
   - ➢ May refer Resident to care from another provider outside Facility.
   - ➢ Admits and treats all persons without regard to race, gender, religion, national origin, sexual preference, veteran status, disability, age, or any other legally protected status.
   - ➢ Will provide Resident a room (which includes storage for a reasonable amount of personal items), board, housekeeping, recreational and social programs, personal care, mail service, and an option to store personal funds with Facility.
   - ➢ Will send Resident a bill by the 3rd business day of each month (absent extenuating circumstances).
   - ➢ Will send Resident written notice of any increase in charges for care or services 30 days in advance.

3. **Resident:**
   - ➢ Agrees:

   a. To timely pay for Facility care and services, and Facility may charge interest on all amounts not timely paid (except for Medicaid funds).

   b. To assign all insurance benefits to Facility.

   c. That Facility may require money for care and services at time of admission.

   d. To provide Facility all needed information (medical, financial, insurance, etc.), in a truthful and complete manner.

e. That person(s) with access to or control over Resident's money/property must and will use those funds to pay for Resident's care and services at Facility, and if misused, may be held personally liable. Facility may take legal action against them.

f. That if payment for Facility care and services is not made, Resident may be discharged from Facility and will pay all of Facility's costs in collecting same, including Facility's legal and attorney fees and costs.

g. If needed, Resident will apply to Medicaid and cooperate fully and truthfully in that process.

h. Facility is not responsible for any loss or damage to Resident's personal property that is not given to Facility for safe keeping, unless proven to be caused by Facility. Resident should mark all clothing and not keep money, jewelry, or other items of value in Resident room.

i. Resident is responsible to pay Facility for any loss or damage to Facility property caused by Resident or Resident's visitors.

j. The Resident Handbook contains additional information about Facility, including policies that Resident and Resident's visitors must follow and a list of Resident's Rights (federal and state).

➢ **Further agrees and understands:**

a. Everything in this Agreement, especially that Facility does not provide one-on-one care, or monitoring and the statements about medical outcomes above.

b. Facility does not provide care and services for free.

c. Facility can only require Resident or Resident's insurers to pay.

d. ***Medicare/Medicaid/some insurances* DO NOT PAY *the entire Facility bill. Resident must pay remainder and all required co-pays or patient liability.***

e. Most rooms are SEMI-PRIVATE. Private rooms cost extra, and insurance may not cover it.

f. Certain items that Resident or Resident's physician may request are not included in Facility's daily rate, and Resident will pay Facility separately, in addition to, the daily rate for those items (e.g., ancillary medical supplies, certain equipment or medications, clothing, hair services, private nurse or sitter, etc.).

g. Resident's need for Skilled Nursing Care can affect Medicare/Medicaid coverage. Facility will notify Resident of this determination at admission, or by day 100 of stay.

h. An itemized bill for Resident's care, services, and other charges (including what is or is not covered by insurance) can be requested from Facility at any time.

i. This Agreement can be cancelled at any time, at which point all outstanding charges for Facility care and services is due for payment from Resident immediately.

➢ **Acknowledges and understands the following payment information:**

Medicare

- If Resident had a 3-day hospital stay in the last 30 days and a qualifying admitting diagnosis, Medicare Part A pays 100% of Resident's first 20 days at Facility.
- For days 21-100, Resident also must pay Facility a co-pay/patient liability amount of ($200.00)per day.
- At day 100, Part A does not pay. Facility will notify Resident if Skilled Nursing Care (SNC) is needed.
    a. If Resident qualifies for SNC, Medicare Parts B and D will pay for therapy and pharmacy. Resident must pay rest of Facility bill unless Medicaid or other insurance pays for Resident's care.
    b. If Resident does not qualify for SNC, Resident must pay rest of Facility bill, unless Medicaid or other insurance pays for Resident's care.
        (i) If this occurs, and Resident has Medicaid, see below Section.
        (ii) If this occurs, and Resident does not have Medicaid, Resident must pay Facility bill ($292.00 per day) and complete an Insurance Screening form.
        (iii) Resident must pay the amount listed in (ii) above, unless and until Medicaid approves Resident or other insurance will pay for Resident's care.

Medicaid

- If Resident has Medicaid on admission, Resident must pay Facility the first patient liability amount of $_____. Thereafter, this amount must be paid by the 10th of each month.
- If Resident does not have Medicaid on admission, Resident must apply to Medicaid within 30 days.
- If Resident Facility stay is less than 30 days from admission, or fails to complete Medicaid application, Resident must pay private room rate ($292.00 per day) for the number of days stayed.

Other Insurance

- Facility room and board is charged at $292.00 per day, plus ancillary and pharmacy charges, and a 20% Medicare Part B co-pay.
- Resident must pay Facility co-pay of $_____per day, starting on _____and continuing through _____, as required by _____insurance.

No Insurance / Private Pay

- At admission, Resident must pay a 30-day advance payment of $292.00 per day.
- Billing statements will issue by the 3rd business day each month, and will include room and board, ancillary, and 20% Part B therapy co-pay.

4. **Facility and Resident Agree:**
   - With everything in this Agreement, Resident Handbook, and all Admission Documents.
   - That the ***Resident Handbook***, this ***Agreement***, and all ***Admission Documents*** represent the entire understanding between them, and supersede all previous representations, understandings, or agreements, oral or written.
   - That if any part of this Agreement is legally invalid or unenforceable, all remaining parts will remain valid and enforceable.

BY SIGNING BELOW, I REPRESENT THAT I HAVE READ AND UNDERSTOOD THIS AGREEMENT, HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT IT, AND HAVE LEGAL AUTHORITY TO ENTER INTO AND EXECUTE THIS AGREEMENT.

[redacted]	[redacted]	[redacted]
Resident Authorized Representative (Name)	**Resident Authorized Representative (Signature)**	**Date**
Tonya Devers-Hawkins	DocuSigned by: Tonya Devers-Hawkins	[redacted]
Facility Representative (Name)	**Facility Representative (Signature)**	**Date**

DocuSign Envelope ID: [redacted]

Signature HealthCARE

RESIDENT FACILITY AUTHORIZATIONS, ASSIGNMENTS

By signing below, I represent and acknowledge that:

➢ Mail

Facility can assist Resident in opening, reading, and handling Resident's mail. Please check below.

☐ YES ☒ NO Facility can open and assist with Resident's personal mail.

☐ YES ☒ NO Facility can open and assist with Resident's financial mail.

☐ YES ☒ NO Facility can handle and address all of Resident's financial mail.

➢ Assignment of Benefits

I authorize all of Resident's insurance benefits or payments be made directly to Facility for the care and services provided Resident, which Facility is authorized to bill, including for any third-Party physician or nurse practitioner services Resident receives at Facility.

➢ Resident Funds / Trust

Resident may choose to deposit monies into Facility's Resident Trust Account (RTA) for safekeeping and use.

1. Facility can assist Resident with RTA funds. **Check one:**

   __x__ Facility **CANNOT** handle Resident's Trust funds.

   OR

   _____ Facility **MAY** handle Resident's Trust funds, as follows:
   a. Through the administrator or his/her designee only.
   b. Endorse and deposit all checks made payable to Resident in Facility's RTA, which is at/through a bank.
   c. Send Resident a RTA account statement every quarter.
   d. Disburse RTA funds only per Resident's instruction.
   e. Apply Resident's RTA funds to pay for Facility care and services as due.

2. If Resident funds remain in the RTA at Resident's passing, Facility should pay all remaining funds to this beneficiary:

   Beneficiary Name:_____

   Address:_____

   Phone:_____

➢ Funeral Home Preference

Facility should contact this funeral home for Resident's arrangements upon Resident's passing.

[redacted] _____ [redacted] _____

(Funeral Home Name) **(Phone Number)**

Resident Authorized Legal Representative:

[redacted] _____ [redacted] _____ [redacted] _____

(Print Name) **(Signature)** **(Date)**

DocuSign Envelope ID: [redacted]

Signature HealthCARE

ACCOUNT NO.

Resident Fund Management Service

AUTHORIZATION AND AGREEMENT TO HANDLE RESIDENTFUNDS

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

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

Facility Name Signature HealthCARE of Elizabethtown Facility Resident ID _____
Optional Data - Max 12 Characters

Statement Address _____
Only if different than Facility address.

CHECK ACCOUNT TYPE

1. RESIDENT FUND ACCOUNT

____NON-TRANSFERRING ACCOUNT (No automatic transfer of deposits to pay for care cost.)
____TRANSFERRING ACCOUNT (Automatic transfer of care cost payments due the facility) with $_____MONTHLY ALLOWANCE AMOUNT.

2. BURIAL ACCOUNT (Deposit only account - monies to be used for burial expenses only.)

____Revocable (May be closed prior to death.)
____Irrevocable (To be closed after death or if resident transfers from facility or if transferred to another burial account.)
____Non-interest-bearing burial account (Interest will be paid if this item is NOT checked.)

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

____Social Security ____Supplemental Security Income _____
____Veterans Administration ____Civil Service _____
____Railroad Retirement ____Miners Benefit/Black Lung _____

*** **Note** – Enter the direct deposit information in the RFMS software or complete the appropriate direct deposit form (Direct Deposit Enrollment Form or other pension form). ***

By my signature below, I authorize the facility to establish and manage an FDIC insured interest bearing resident fund or burial account, with the options as specified above. I understand that, I may have my recurring checks directly deposited into my resident fund account, that I may make deposits to and withdrawals from my resident fund account at the facility, and that I will receive a statement of any account I have there at least quarterly. In the event I elect to have a resident fund account, I direct that the amount stipulated by me or required or permitted under federal, state or local law (as amended from time to time) be withheld monthly for my personal use, and that the remainder be transferred and dispersed to the facility for the payment of my care costs. I hereby authorize the facility administrator and/or his/her designated staff, to adjust my personal allowance amount from time to time and as needed to comply with applicable governing laws. In the event of my death, I direct that any funds owed to the facility or previously advanced to me by the facility are to be paid from my resident fund account to the facility, with any remaining balance to become part of my estate. By signing this form, I under penalties of perjury, certify that (1) the number shown on this form is my correct taxpayer identification number, and (2) I am not subject to backup withholding because (a) I have not been notified that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (b) the Internal Revenue Service (IRS) has notified me that I am no longer subject to backup withholding. [If the signer has been notified by the IRS that he/she is subject to backup withholding, cross out the language in (2) above.]

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

Witness: _____ RESIDENT * _____
Signature or Mark (X)

Witness: _____ Date: [redacted]

* ANYONE SIGNING FOR THE RESIDENT MUST SIGN THE CERTIFICATION BELOW

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

[redacted] _____
PRINTED NAME OF REPRESENTATIVE SIGNATURE OF LEGAL REPRESENTATIVE

[redacted] LEGALTITLE: _____
DATE REP PAYEE; GUARDIAN; CONSERVATOR; TRUSTEE; POA

Resident Name: [redacted] Facility: Signature HealthCARE of Elizabethtown

DocuSign Envelope ID: [redacted]

Signature HealthCARE

NOTICE OF PRIVACY PRACTICES / RECORD OF ACKNOWLEDGEMENT

Facility is committed to preserving the privacy and confidentiality of Resident's health information, whether we create or maintain it. Certain state and federal regulations require Facility to implement policies and procedures to safeguard the privacy of Resident's Protected Health Information (PHI) as defined under the Health Insurance Portability and Accountability Act (HIPAA). They also require Facility to follow the privacy practices described in this Acknowledgment and the Privacy Practices Notice found in the Resident Handbook, including any future revisions made to them, as may become necessary or authorized by law.

Effective Date of Our Privacy Notices **4/23/2003**

Changes or Revisions to our Privacy Notice

Facility reserves the right to change our *Privacy Notices* at any time and to make the change effective for PHI Facility already has and may receive in the future. Facility will post a copy of any *Privacy Notice* changes in its main lobby and copies may be obtained from Facility's Business Office or on Facility's website (as applicable).

[X] Our Privacy Notices were revised on **7/1/2004; 8/2013; 3/24/2016; 11/16/2016; 3/14/2019**

[ ] No changes since the effective date listed above

Privacy Notices, Information Restrictions, Record Amendments/Corrections, Disclosures of Information, Revoking Authorization, Inspection and Copying of Records, Confidential Communications, Filing Complaints, Etc.

For questions about Facility's privacy practices, obtaining *Privacy Notice* copies, requesting restrictions on release of PHI, revoking an authorization, amending or correcting PHI, obtaining a list of PHI Facility has disclosed, inspecting or copying PHI, the manner of communicating PHI, denial of access to PHI, filing complaints about PHI, or other Facility privacy practice concerns, please contact:

Compliance Department
12201 Bluegrass Pkwy, Louisville KY 40299
(502) 568-7800 (phone) / (502) 568-7146 (fax)
compliance@signaturehealthcarellc.com (email)
www.ltcrevolution.com (website)

US Department of Health and Human Services
2001 Independence Avenue S.W.,
Washington, DC 20201
(202)619-0257 / Toll Free 1-877-696-6755

Signed Acknowledgement

By signing below, I represent that I am [redacted]'s **(Resident Name)**, authorized legal representative, I received and understand this *Privacy Notice*, I had the opportunity to review and ask questions about it and Resident's privacy rights, and I believe Facility is committed to protecting PHI.

Resident Authorized Legal Representative:

[redacted] [redacted] [redacted]

(Print Name) **(Signature)** **(Date)**

**** Give copy of *Resident Handbook* and file this Acknowledgment in Resident's medical record ****

Resident Name: [redacted] Facility: Signature HealthCARE of Elizabethtown

Rev. 080121

DocuSign Envelope ID [redacted]

Signature HealthCARE

AGREEMENT TO INFORMALLY RESOLVE AND ARBITRATE ALL DISPUTES

Thank you for considering our Facility!
Signing this Agreement is not a condition of Resident's admission or care here.
Please read this document carefully.

[redacted] (and all agents, entities, or representatives asserting rights or claiming
("Resident" or "Party") by or through)
RESIDENT NAME

and
Signature HealthCARE of Elizabethtown, **LLC** (and all affiliates, parents, directors, officers, agents, owners, and
("Facility" or "Party") assigns)
FACILITY NAME

RESIDENT AND FACILITY ("Parties") UNDERSTAND AND AGREE THAT:

1. If a dispute(s) or legal claim(s) of any kind arises between or among the Parties to this agreement (collectively a "dispute"), (i) neither Party will seek a representative, consolidated, or class treatment or action for the dispute and (ii) both Parties agree to resolve the dispute, as follows:
   - First, informally between the Parties.
   - If that does not succeed, the Parties will mediate the dispute.
   - If mediation is not successful, the Parties will arbitrate the dispute.

2. To start the informal dispute, mediation, or arbitration process, a Party must:
   - Send a request in writing to the other Party (via certified mail, return receipt) and include a detailed account of the dispute and what process is being initiated (informal, mediation, or arbitration).
   - If informal resolution is initiated, the Parties will schedule a mutually convenient time to discuss the dispute and possible resolution(s).
   - If mediation or arbitration is initiated, the Parties will discuss and agree upon a single mediator and/or arbitrator who will mediate or arbitrate the dispute, and when mediation or arbitration will occur. The Parties agree that the mediator and/or arbitrator will be an independent, disinterested, and qualified attorney with at least 7 years' experience in long-term care matters, unless otherwise agreed. If the Parties cannot agree on a mediator and/or arbitrator, then each Party will nominate its own mediator and/or arbitrator candidate, and together, the candidates will agree upon and select another independent, disinterested, and qualified attorney with at least 7 years' experience in long-term care matters to mediate and/or arbitrate the dispute.

3. The arbitrator will be a neutral person who will decide the dispute, and who the Parties agree:
   - Can award either Party the same damages or injunctive relief as a court could.
   - Will apply Kentucky law and Rules of Civil Procedure and Rules of Evidence, including Kentucky statutes of limitation.
   - Will decide all questions about this agreement, including, but not limited to, whether the Party signing it has proper authority and whether it is valid and enforceable.
   - The arbitrator's decision(s) will be **FINAL**.

THIS MEANS THAT NEITHER PARTY WILL FILE A LAWSUIT AGAINST THE OTHER, AND THAT EACH PARTY IS GIVING UP, OR WAIVING, THE RIGHT TO FILE A LAWSUIT AND HAVE A JUDGE OR A JURY DECIDE THE DISPUTE AND/OR ANY ISSUES ABOUT THIS AGREEMENT.

This also means that the Parties agree to avoid the court system and will not have a judge or jury deciding any part of the dispute (except for motions to compel arbitration and any appeals or appellate proceedings therefrom). The Parties are free to talk about the dispute with any other federal or state agency outside the court system, including but not limited to, federal and state surveyors, other federal or state health department employees and representatives of the Office of the State Long-Term Care Ombudsman.

4. For the convenience of the Parties, the mediation and/or arbitration will take place in **KENTUCKY**, in the county where the Facility is located, unless otherwise agreed. Each Party can have an attorney present and is responsible for all of their own attorney fees and costs. Each Party will share the costs of mediation and/or arbitration equally, unless otherwise agreed or the arbitrator orders differently if permitted under applicable law.

5. The substantive law of both the Federal Arbitration Act and the Kentucky Uniform Arbitration Act will govern and control this agreement, and any related arbitration or judicial proceedings. If there is any material, substantive conflict or inconsistency between these two Acts, the Federal Arbitration Act will control. However, the procedural law of the Kentucky Uniform Arbitration Act and other Kentucky law shall govern any appeal or appellate proceedings from any judicial order denying a motion by either of us to compel arbitration.

6. This agreement will bind any person or entity that is now or later appointed to be a representative of either Party or to act on a Party's behalf. It will also remain valid and of full force and effect even if a Party later becomes disabled or incompetent. Each Party agrees this agreement will be upheld and enforced against each of them individually, as well as against

their respective heirs, beneficiaries, estates, estate or personal representatives, successors, statutory wrongful death beneficiaries, and assigns.

7. Unless rescinded within thirty (30) days under Paragraph 10 below, this agreement will also remain valid and of full force and effect even if the Resident is discharged and then later re-admitted to Facility. It will also apply to all of the Resident's subsequent admissions and stays at any Signature Facility.

8. Each signatory to this agreement represents to the other that they have the proper authority to enter into and sign this agreement, and that the other signatories can and should fully reasonably rely upon this representation to their detriment.

9. If any part of this agreement is found invalid or unenforceable, the Parties agree that all remaining parts of it will remain in full force and effect.

10. ***The Parties understand and agree that either Party can rescind this agreement by, and only by, providing written notice to the other within thirty (30) days of the date of signing this agreement.***

SIGN HERE!

I ACKNOWLEDGE THAT THIS AGREEMENT HAS BEEN EXPLAINED TO ME BY A FACILITY REPRESENTATIVE IN A FORM, MANNER AND LANGUAGE THAT I UNDERSTAND. I HAVE READ THIS AGREEMENT, UNDERSTAND IT, HAVE HAD THE CHANCE TO ASK QUESTIONS, AND ACKNOWLEDGE MY RIGHT TO SPEAK WITH AN ATTORNEY ABOUT IT. I VOLUNTARILY CONSENT TO ALL OF ITS TERMS AND CONDITIONS, IN ALL CAPACITIES THAT I SIGN. I HAVE RECEIVED A COPY OF THIS AGREEMENT OR UNDERSTAND AND AGREE THAT THE FACILITY WILL PROVIDE A COPY TO ME UPON MY REQUEST.

I AM SIGNING THIS DOCUMENT ELECTRONICALLY AND ATTEST IT IS VALID AND MY SIGNATURE.

I represent and warrant that I have permission from Resident or other authority to sign documents on Resident's behalf and Facility can and should rely upon this representation as truthful. I will not later contest my permission or authority to sign. I am also signing in my individual capacity.

[redacted]

Resident Representative Name (Print)

[redacted]

Resident Representative (Signature), in all named capacities

[redacted]

Date

DocuSigned by:
Tonya Devers-Hawkins

Facility Representative (Signature)

[redacted]

Date

Resident Name: [redacted] Facility: Signature HealthCARE of Elizabethtown

Signature HealthCARE

RESIDENT HANDBOOK ACKNOWLEDGEMENT

By signing below, I represent and acknowledge that:

- I received and agree Resident will follow and be bound by the terms and conditions contained in Facility's Resident Handbook.
- I understand there is important information for me in the Handbook, including, but not limited to, a list of Resident's Rights (federal and state), and that many questions about Facility are answered in the Handbook.
- If I am not the Resident listed below, but I plan to visit the Resident, I will follow and abide by all policies in the Handbook regarding visitation and expected visitor conduct.
- If I have questions about anything in the Handbook, I will ask Facility.

Resident Authorized Legal Representative:

[redacted]	[redacted]	[redacted]
(Print Name)	**(Signature)**	**(Date)**

Resident Name: [redacted] Facility: Signature HealthCARE of Elizabethtown

DocuSign Envelope ID: [redacted]

Signature HealthCARE

CONSENT AND AUTHORIZATION FOR DISCLOSURE, ACCESS, AND USE OF MY SIGNATURE PORTAL

With resident' s authorized legal representative's written permission,

Signature HealthCARE of Elizabethtown, will ***provide only the following information*** directly from the resident's electronic medical record to the My Signature Portal App (the "App"):

A. Vital signs, if available (e.g., temperature, blood pressure, heart rate, and oxygen saturation).

B. Active medications

C. Physician Name

Facility maintains the confidentiality and privacy of resident's health information in compliance with its policies and all applicable laws, regulations. Once the above information is disclosed to the App, the information may no longer be subject to any resident privacy protections.

By signing this Consent and Authorization, I understand and agree that:

1. I have read, understand, and agree with this document
2. I am signing it voluntarily and know that the Facility will not condition treatment to resident based on me signing.
3. This Consent and Authorization may be revoked at any time, in writing to the Facility.
4. **The Facility does not own, operate, or manage any part of the App. The App is owned, Operated and managed by a third party, Safekeeping Software.** The Facility only (i) Offers individuals the ability to access the App, subject to the platform's terms and Conditions, and (ii) with authorized permission, sends selected information to the App.
5. The information on the App is ***not*** medical advice.
6. I will not hold the Facility responsible for, and agree to fully waive any and all claims and Damages (of any kind) against it that are related in any way to the access, use, operation, or management of the App including but not limited to the release of the above listed health information to the App as well as any claims related to what an Authorized Person may do (or does) with the resident's information on or from the App.
7. This authorization expires 7 ***days*** upon discharge from the Facility.

Resident Name: [redacted] Facility: Signature HealthCARE of Elizabethtown

DocuSign Envelope ID [redacted]

☒ I [redacted] am a legally authorized representative for the named resident, with written authority to sign this consent on the resident's behalf. I consent to have resident's information disclosed to the App, and I want access to it.

☐ I also give consent for the following person to access the resident's information on the App.

☐ I DO NOT consent for Resident to participate in the My Signature Portal App.

Authorized Person's Name **Authorized Person's Email Address (Required)**

Resident Authorized Legal Representative:

[redacted] [redacted] [redacted]

(Print Name) **(Signature)** **(Date)**

*Complete this required information for your **SafeKeeping Software** account:*

First Name: [redacted] Last Name: [redacted]

Email Address: [redacted]

Mobile Phone Number: [redacted]

I prefer to receive notifications via:

☐ Email ☐ Text Message ☒ Both

Resident Name: [redacted] Facility: Signature HealthCARE of Elizabethtown

Rev 07/14/22

DocuSign Envelope ID: [redacted]

Signature HealthCARE

DECLARATION OF (NAME): Tonya Devers-Hawkins

JOB TITLE: Director of Admissions

* * * * * *

1. My name is Tonya Devers-Hawkins, and I am over eighteen years of age.

2. I verify that the following information is true and accurate. I would testify at trial under oath to this.

3. I work at Signature HealthCARE of Elizabethtown **(Facility Name)** in the job title listed above. In this role, I have personal knowledge of the facts set forth in this document.

4. On or about [redacted] presented Facility's standard package of admission paperwork concerning [redacted] **(Resident's Name)**'s admission to Facility for review and execution to the person listed below, who represented themselves to me as having legal authority to act and sign for Resident:

[redacted]

(Resident Representative Name, "Signer")

5. I presented and explained the Admission Documents to Signer (check all that apply):

_____ In person to Signer at _____ **(Location)**.

__X__ By sending the documents to Signer via email, using an email address Signer provided me, and followed by a phone call from me to and with Signer.

_____ By sending the documents to Signer via regular U.S. Mail, using an address Signer provided me and followed by a phone call from me to and with Signer.

6. The following additional person(s) were present (either in person or by phone) when I verbally explained the Admissions Documents to Signer:

_____ **(Name)**

_____ **(Name)**

7. The admission paperwork included an Arbitration Agreement. When presenting and explaining it, I explained to Signer:

   ✓ The Arbitration Agreement was not required as a condition for Resident's admission or care.

- ✓ The Arbitration Agreement waived both Resident's (and Representative's right) and Facility's right to have a legal claim between them presented and tried in a court of law before a Judge and/or Jury.

8. I explained all admissions paperwork to Signer in his/her native language. If not in English, the Arbitration Agreement was explained in Singer's native language:

_____ **(List Language Name)**

_____ **(List Interpreter's Name)**

9. Signer was given an opportunity to read and ask questions about the admission paperwork, including the Arbitration Agreement, before signing. Signer did not state s/he could not read or needed glasses.

10. **CHECK ONLY ONE:**

_____ Signer specifically represented him/herself to me as a person with permission and legally authorized to act and sign for Resident and to execute all admission paperwork, including the Arbitration Agreement, Signer either presented paperwork to me evidencing such authority or made specific verbal and/or written representations to me about it, and I relied on these representations.

NO_____ Signer REFUSED to sign the Arbitration Agreement.

11. **CHECK ONLY ONE:**

_____ I personally witnessed Signer electronically sign the admission paperwork in front of me on a computer or tablet.

X Signer returned the admission paperwork executed with Signer's electronic signature, including the Arbitration Agreement, to me via email.

_____ Signer mailed me a printed copy of the admission paperwork executed with Signer's electronic or pen signature, including the Arbitration Agreement.

12. I could not and did not electronically sign *any* of the Admission Documents for Signer.

By signing below, I declare, under penalty of perjury, that I have read the information in this Declaration, marked where appropriate, and verify it is true and correct.

DocuSigned by:
Tonya Divers-Hawkins

(Declarant Signature) **(Date)** [redacted]

Resident Name [redacted] Facility Name: Signature HealthCARE of Elizabethtow

New Jersey

Complaint & Admission Agreement: Foothill Acres Nursing & Rehabilitation Center

The Simone Law Firm, P.C.

Michael S. Simone, Esquire
Eric M. Wetzel, Esquire
Colleen M. McCafferty, Esquire
Members of PA and NJ Bars
Robert G. Minnich, Esquire*
**Member of PA, NJ and FL Bars*

700 Professional Plaza
700 Route 130, Suite 201
Cinnaminson, NJ 08077
(856) 833-1788 Phone
(856) 833-1780 Fax
www.thesimonelawfirm.com
msimone@thesimonelawfirm.com

June 30, 2023

Shana Siegel, Esq.
Norris McLaughlin, P.A.
400 Crossing Boulevard, 8th Floor
P.O. Box 5933
Bridgewater, NJ 08807
ssiegel@norris-law.com

Re: Foothill Acres Rehabilitation & Nursing Center v. [redacted], Estate of
Docket No. [redacted]

Dear Ms. Siegal:

As you are aware I represent Foothill Acres Rehabilitation & Nursing Center in the above referenced matter. Please see the enclosed Complaint filed with the Court on June 28, 2023. Please confirm if you will be representing the Defendants. An Acknowledgment of Service is enclosed for your execution. If you will be accepting service, please advise shortly so we can plan accordingly.

If you have any questions or concerns, please contact me at the above number.

Respectfully,

Michael S. Simone

MSS/eay
cc: Foothill Acres Rehabilitation

Michael S. Simone, Esq.
Attorney I.D. Number 006782002
The Simone Law Firm, P.C.
700 Professional Plaza
700 Route 130, Suite 201
Cinnaminson, NJ 08077
Phone: (856) 833-1788
Fax: (856) 833-1780
Attorney for Plaintiff

FOOTHILL ACRES REHABILITATION AND NURSING CENTER LLC 39 East Mountain Road Hillsborough, NJ 08844 Plaintiff, v. ESTATE OF [redacted] and ROSANNA HUNT [redacted] Defendants	Superior Court of New Jersey Law Division Hunterdon County Docket No.: [redacted] Civil Action **ACKNOWLEDGEMENT OF SERVICE**

The undersigned, Attorney for the Defendants, Estate of [redacted] and [redacted] hereby acknowledges service of a copy of the Plaintiff's Summons and Complaint filed in the above-entitled matter on June 28, 2023.

Norris McLaughlin, P.A.

By: _____
Shana Siegel, Esq.
Attorney for Defendant

[redacted]

The Simone Law Firm, P.C.

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msimone@thesimonelawfirm.com

June 26, 2023

Hunterdon County Court - Law Division
65 Park Avenue
Flemington, NJ 08822

Re: Foothill Acres Rehabilitation & Nursing Center v. [redacted]*, Estate of*

Dear Sir or Madam:

Please be advised that I represent Foothill Acres Rehabilitation and Nursing Center LLC in the above referenced matter. Enclosed you will find the Complaint for filing. Please file and deduct the filing fees from our **collateral account number 140860**.

If you have any questions or concerns regarding this matter, please contact our office.

Respectfully,

Michael S. Simone

MSS/eay
Enclosures

[redacted]

Michael S. Simone, Esq.
Attorney I.D. Number 006782002
The Simone Law Firm, P.C.
700 Professional Plaza
700 Route 130, Suite 201
Cinnaminson, NJ 08077
Phone: (856) 833-1788
Fax: (856) 833-1780
Attorney for Plaintiff

FOOTHILL ACRES REHABILITATION AND NURSING CENTER LLC 39 East Mountain Road Hillsborough, NJ 08844 Plaintiff, v. [redacted] and [redacted] Defendants	Superior Court of New Jersey Law Division Hunterdon County Docket No.: Civil Action **SUMMONS**

From The State of New Jersey To The Defendant(s) Named Above:

The plaintiff, named above, has filed a lawsuit against you in the Superior Court of New Jersey. The complaint attached to this summons states the basis for this lawsuit. If you dispute this complaint, you or your attorney must file a written answer or motion and proof of service with the deputy clerk of the Superior Court in the county listed above within 35 days from the date you received this summons, not counting the date you received it. (A directory of the addresses of each deputy clerk of the Superior Court is available in the Civil Division Management Office in the county listed above and online at http://www.judiciary.state.nj.us/pro se/10153_deptyclerklawref.pdf.) If the complaint is one in foreclosure, then you must file your written answer or motion and proof of service with the Clerk of the Superior Court, Hughes Justice Complex, P.O. Box 971, Trenton, NJ 08625-0971. A filing fee payable to the Treasurer, State of New Jersey and a completed Case Information Statement (available from the deputy clerk of the Superior Court) must accompany your answer or motion when it is filed. You must also send a

[redacted]

copy of your answer or motion to plaintiff's attorney whose name and address appear above, or to plaintiff, if no attorney is named above. A telephone call will not protect your rights; you must file and serve a written answer or motion (with fee of $135.00 and completed Case Information Statement) if you want the court to hear your defense.

If you do not file and serve a written answer or motion within 35 days, the court may enter a judgment against you for the relief plaintiff demands, plus interest and costs of suit. If judgment is entered against you, the Sheriff may seize your money, wages or property to pay all or part of the judgment.

If you cannot afford an attorney, you may call the Legal Services office in the county where you live or the Legal Services of New Jersey Statewide Hotline at 1-888-LSNJ-LAW (1-888-576-5529). If you do not have an attorney and are not eligible for free legal assistance, you may obtain a referral to an attorney by calling one of the Lawyer Referral Services. A directory with contact information for local Legal Services Offices and Lawyer Referral Services is available in the Civil Division Management Office in the county listed above and online at http://www.judiciary.state.nj.us/prose/10153_deptyclerklawref.pdf.

Dated: 6/28/2023

/s/ Michelle M. Smith, Esq.
Clerk of the Superior Court

Name and Address of Defendants to Be Served:

ESTATE OF [redacted]

[redacted]

[redacted]

Michael S. Simone, Esq.
Attorney I.D. Number 006782002
The Simone Law Firm, P.C.
700 Professional Plaza
700 Route 130, Suite 201
Cinnaminson, NJ 08077
Phone: (856) 833-1788
Fax: (856) 833-1780
Attorney for Plaintiff

FOOTHILL ACRES REHABILITATION AND NURSING CENTER LLC 39 East Mountain Road Hillsborough, NJ 08844 Plaintiff, v. ESTATE OF [redacted] and [redacted] Defendants	Superior Court of New Jersey Law Division Hunterdon County Docket No.: Civil Action **COMPLAINT (ON CONTRACT)**

The Plaintiff, Foothill Acres Rehabilitation and Nursing Center LLC, respectfully avers as follows:

I. THE PARTIES

1. Plaintiff is a New Jersey corporation with its principal place of business as set forth in the caption and is a skilled nursing facility.

2. Based on knowledge, information and belief, Plaintiff avers that Defendant, Estate of [redacted], is an individual who maintained an address, upon belief, as set forth in the caption and was a resident at the Plaintiff's facility.

[redacted]

3. Based on knowledge, information and belief, Plaintiff avers that Defendant, [redacted], is an individual who maintains an address, upon belief, as set forth in the caption.

4. The agreements and transactions that form the basis of this complaint took place in Hunterdon County, New Jersey. Venue is placed in Hunterdon County pursuant to R.4:3-2(b) because the Defendants reside in Hunterdon County.

II. STATEMENT OF FACTS

5. Plaintiff incorporates by reference the allegations set forth hereinabove at Paragraphs 1 through 4, as though the same were set forth at length herein.

6. The Admissions Agreement, which is a contract for nursing home services from the Plaintiff, dated June 12, 2020 was signed by [redacted] on June 12, 2020. See attached "Exhibit A".

7. [redacted] was admitted into the Plaintiff's facility on or about June 11, 2020.

8. Defendants have an outstanding balance due for services rendered at the Plaintiff's facility totaling $119,490.78, as set forth in "Exhibit B".

9. Plaintiff provided an Admissions Agreement that explains [redacted] will be responsible for payment to the Plaintiff when the Defendant is no longer eligible for reimbursement of *his care by Medicare benefits, as set forth in "Exhibit A".

10. Sinc[redacted] was admitted into the Plaintiff's facility, the Plaintiff has been trying to work together with Defendants for payment.

11. Specifically, no payments were made to the facility and no cooperation was given to coordinate the potential private health insurance coverage in the skilled nursing care other than attached "Exhibit B".

12. To this date, the Plaintiff has not received any payments since the amounts stated on the "Exhibit B."

COUNT ONE – BREACH OF CONTRACT AGAINST DEFENDANT, ESTATE OF [redacted]

13. Plaintiff incorporates by reference the allegations set forth hereinabove at Paragraphs 1 through 12, as though the same were set forth at length herein.

14. The Defendant was obligated to pay for the services rendered from the Plaintiff as set forth in "Exhibit A".

[redacted]

15. The outstanding balance due is composed of charges that are fair, reasonable and customary within the region and are those that the Defendant agreed to pay.

16. The Defendant benefited from the bargain with the Plaintiff, and Plaintiff has thus received full accord and satisfaction.

17. The signed Admissions Agreement provides that interest will be charged at the rate of 1.0% per month on unpaid account balances, or 12% per annum, when such account balances are twenty (20) days overdue, and the interest due shall accumulate and be added to and become part of the principal amount due, in addition the patient is responsible for reasonable attorney's fees that are based on $220.00 per hour as set forth in "Exhibit A". Additional attorney's fees will be sought for litigating the matter

18. Unpaid charges for services rendered by the Plaintiff to Estate of [redacted] accrued in the amount of $119,490.78, which despite numerous demands, remain unpaid. A true and correct copy of a bill for the balance due is attached hereto, made a part hereof and marked as "Exhibit B".

19. All amounts accrued, which include unpaid balance, interest, and reasonable attorney fees are set forth in "Exhibit C."

WHEREFORE, the Plaintiff demands that Defendants pay the amount of $161,769.29 plus interest, costs and attorney's fees from the remaining assets of the Defendant, Estate of [redacted], or from funds transferred to Defendant, [redacted], from Defendant, Estate [redacted], and Defendants, [redacted], individually..

COUNT TWO – BREACH OF CONTRACT AGAINST DEFENDANT, [redacted]

20. Plaintiff incorporates by reference the allegations set forth hereinabove at Paragraphs 1 through 19, as though the same were set forth at length herein.

21. The Defendant was obligated to pay for the services rendered from the Plaintiff as set forth in "Exhibit A".

22. The outstanding balance due is composed of charges that are fair, reasonable and customary within the region and are those that the Defendant agreed to pay.

23. The Defendant benefited from the bargain with the Plaintiff, and Plaintiff has thus received full accord and satisfaction.

[redacted]

24. The signed Admissions Agreement states that the resident is responsible for reasonable attorney's fees that are based on $220.00 per hour as set forth in "Exhibit A". Additional attorney's fees will be sought for litigating the matter.

25. Unpaid charges for services rendered by the Plaintiff to Estate of [redacted] accrued in the amount of $119,490.78 ,which despite numerous demands, remain unpaid. A true and correct copy of a bill for the balance due is attached hereto, made a part hereof and marked as "Exhibit B".

26. All amounts accrued, which include unpaid balance, interest, and reasonable attorney fees are set forth in "Exhibit C."

WHEREFORE, the Plaintiff demands that Defendants pay the amount of $161,769.29 plus interest, costs and attorney's fees from the remaining assets of the Defendant, Estate of [redacted], or from funds transferred to Defendant, [redacted], from Defendant, Estate of [redacted], and Defendants, [redacted], individually.

COUNT THREE - UNJUST ENRICHMENT AGAINST DEFENDANT, ESTATE OF [redacted]

27. Plaintiff incorporates by reference the allegations set forth hereinabove at Paragraphs Nos. 1 through 26, as though the same were set forth at length herein.

28. Plaintiff agreed and undertook the engagement and, in connection therewith, commenced and completed skilled nursing care agreed to with Defendant.

29. Defendant has enjoyed the benefit of the services provided by the Plaintiff, which was skilled nursing care.

30. The Defendant's skilled nursing care, provided by the Plaintiff without fully compensating the Plaintiff for the services provided would be unjust.

31. The reasonable value of the medical services provided, is equal to $119,490.78.

32. The Defendant is also responsible for court cost.

33. The Defendant, therefore, owes Plaintiff the sum of $161,769.29 plus interest, costs and attorneys' fees.

WHEREFORE, the Plaintiff demands that Defendants pay the amount of $161,769.29 plus interest, costs and attorney's fees from the remaining assets of the Defendant, Estate of [redacted], or from funds transferred to Defendant, [redacted], from Defendant, Estate of [redacted], and Defendants, [redacted], individually.

[redacted]

COUNT FOUR - QUANTUM MERUIT AGAINST DEFENDANT, ESTATE OF [redacted]

34. Plaintiff incorporates by reference the allegations set forth hereinabove at Paragraphs Nos. 1 through 33, as though the same were set forth at length herein.

35. Defendant has enjoyed the benefit of the services provided by the Plaintiff, which was skilled nursing care.

36. Plaintiff is entitled to the quantum meruit value of skilled nursing care rendered.

37. The quantum meruit value of medical services provided by the Plaintiff to the Defendant for which the Defendant has failed and refused to compensate the Plaintiff is $119,490.78.

38. The Defendant is also responsible for court cost.

39. The Defendant, therefore, owes Plaintiff the sum of $161,769.29 plus interest, costs and attorneys' fees.

WHEREFORE, the Plaintiff demands that Defendants pay the amount of $161,769.29 plus interest, costs and attorney's fees from the remaining assets of the Defendant, Estate of [redacted], or from funds transferred to Defendant, [redacted], from Defendant, Estate of [redacted], and Defendants, [redacted] individually.

COUNT FIVE – EQUITABLE ESTOPPEL AND PROMISSORY ESTOPPEL AGAINST DEFENDANT, ESTATE OF [redacted]

40. Plaintiff incorporates by reference the allegations set forth hereinabove at Paragraphs Nos. 1 through 39, as though the same were set forth at length herein.

41. Plaintiff rendered valuable goods and services, including but not limited to room and board and ancillary services in the amount of $119,490.78 to [redacted], for which full payment has not been received.

42. Plaintiff, in agreeing to admit [redacted], and in continuing to provide valuable goods and services to [redacted], detrimentally relied upon the statements and/or misrepresentations of Defendant, Estate of [redacted].

43. Defendant, Estate of [redacted] should be estopped from denying the representations that were made to Plaintiff.

44. Plaintiff has suffered pecuniary damages as a result of its reliance upon the statements and/or representations of the Defendant, Estate of [redacted].

[redacted]

WHEREFORE, the Plaintiff demands that Defendants pay the amount of $161,769.29 plus interest, costs and attorney's fees from the remaining assets of the Defendant, Estate of [redacted], or from funds transferred to Defendant, [redacted], from Defendant, Estate [redacted] and Defendants, [redacted], individually.

COUNT SIX – EQUITABLE ESTOPPEL AND PROMISSORY ESTOPPEL AGAINST DEFENDANT, [redacted]

45. Plaintiff incorporates by reference the allegations set forth hereinabove at Paragraphs Nos. 1 through 44, as though the same were set forth at length herein.

46. Plaintiff rendered valuable goods and services, includ[redacted] room and board and ancillary services in the amount of $119,490.78 [redacted] which full payment has not been received.

47. Plaintiff, in agreeing to ad[redacted] and in continuing to provide valuable goods and services to [redacted] detrimentally relied upon the statements and/or misrepresentations of Defendant, [redacted].

48. Defendant, [redacted] Hunt should be estopped from denying the representations that were made to Plaintiff.

49. Plaintiff has suffered pecuniary damages as a result of its reliance upon the statements and/or representations of the Defendant, [redacted]

WHEREFORE, the Plaintiff demands that Defendants pay the amount of $161,769.29 plus interest, costs and attorney's fees from the remaining assets of the Defendant, Estate o[redacted], or from funds transferred to Defendant, [redacted], from Defendan[redacted] and Defendants, [redacted], individually.

COUNT SEVEN – DETRIMENTAL RELIANCE AGAINST DEFENDANT, [redacted]

50. Plaintiff incorporates by reference the allegations set forth hereinabove at Paragraphs Nos. 1 through 49, as though the same were set forth at length herein.

51. Plaintiff in agreeing to admit [redacted] and in continuing to provide valuable goods and services to [redacted], detrimentally relied upon the statements and/or representations of the Defendant Estate of [redacted]

52. Plaintiff has suffered pecuniary damages as a result of its reliance upon the statements and/or representations of Defendant, Estate [redacted]

WHEREFORE, the Plaintiff demands that Defendants pay the amount of $161,769.29 plus interest, costs and attorney's fees from the remaining assets of the Defendant, Estate of [redacted] or from funds transferred to Defendant, [redacted], from Defendant, Estate of [redacted] and Defendants, [redacted] individually.

COUNT EIGHT – DETRIMENTAL RELIANCE AGAINST DEFENDANT, [redacted]

53. Plaintiff incorporates by reference the allegations set forth hereinabove at Paragraphs Nos. 1 through 52, as though the same were set forth at length herein.

54. Plaintiff in agreeing to admit [redacted] and in continuing to provide valuable goods and services to [redacted] detrimentally relied upon the statements and/or representations of the Defendant [redacted]

55. Plaintiff has suffered pecuniary damages as a result of its reliance upon the statements and/or representations of Defendant, [redacted]

WHEREFORE, the Plaintiff demands that Defendants pay the amount of $161,769.29 plus interest, costs and attorney's fees from the remaining assets of the Defendant, Estate of [redacted], or from funds transferred to Defendant, [redacted] from Defendant, Estate of [redacted], and Defendants, [redacted] nt, individually.

COUNT NINE – DOCTRINE OF NECESSARIES FOR DEFENDANT, [redacted]

56. Plaintiff incorporates by reference the allegations set forth hereinabove at Paragraphs Nos. 1 through 55, as though the same were set forth at length herein.

57. Defendant, Ro[redacted] is married to Defendant, Estate of [redacted].

58. Pursuant to New Jersey Common Law and Jersey Shore Medical Center-Fitkin Hospital v. Estate of Baum, 84 N.J. 137, 141 (N.J. 1980) Doctrine of Necessaries obligates a spouse to the debt of the other spouse that are deemed for the support and maintenance of the family.

59. Plaintiff has attempted to collect the balances owed for skilled nursing care from [redacted] initially with no success.

60. As a result, Plaintiff seeks payment pursuant to the doctrine of necessaries on the Defendant, [redacted] in the amount of $161,769.29.

WHEREFORE, the Plaintiff demands that Defendants pay the amount of $161,769.29 plus interest, costs and attorney's fees from the remaining assets of the Defendant, Estate of [redacted], or from funds transferred to Defendant, [redacted] from Defendant, Estate of [redacted] rry, and Defendants, [redacted], individually.

Dated: 06/28/2023

THE SIMONE LAW FIRM, P.C.
/s/ Michael S. Simone
Michael S. Simone
Attorney for Plaintiff

[redacted]

CERTIFICATION PURSUANT TO RULE 4:5-1

I certify that the matter in controversy is not the subject of any other action or arbitration proceeding, now or contemplated, and that no other parties should be joined in this action, R. 4:5-1.

THE SIMONE LAW FIRM, P.C.

Dated: 06/28/2023

/s/ Michael S. Simone
Michael S. Simone

[redacted]

FOOTHILL ACRES REHABILITATION & NURSING CENTER

NAME [redacted] MEDICAL ID [redacted] DATE OF ADMISSION: 06/11/2020

Please complete this form and leave with the admissions paperwork. Thank you.

NICKNAME: [redacted] SSN: [redacted]

BIRTHPLACE: [redacted] EDUCATION: [redacted]

RELIGION: [redacted] NO. OF CHILDR [redacted]

LIFETIME OCCUPATION(S)/INDUSTRY: Business: [redacted]

MARITAL STATUS: Married NAME OF SPOUSE(S): [redacted]

MILITARY: [redacted] REGISTERED VOTER? [redacted] es No

LEVEL OF FUNCTIONING PRIOR TO ADMISSION: Ambulatory. Pretty alert + clear in the mornings. Becomes agitated in PM about 3pm. Elopes.

HOW DID YOU HEAR ABOUT US? from Nightingale NJ. Kelly

EMERGENCY CONTACTS

NAME: [redacted] [redacted] IP: wife

ADDRESS [redacted]

~~WORK:~~ [redacted]

EMAIL: [redacted]

ARE YOU [redacted]

CAN WE [redacted]

[redacted]

EXHIBIT A

[redacted]

FOOTHILL ACRES REHABILITATION & NURSING CENTER

[redacted] MEDICAL ID#: [redacted] DATE OF ADMISSION: 06/11/2020

1. AGREEMENT

This Responsible Person Agreement (hereinafter "Agreement") is made between **Foothill Acres Rehabilitation & Nursing Center** (hereinafter "Facility") and [redacted] the legal representative or representative individual(s) (hereinafter "Responsible Person(s)") of the Resident _____(hereinafter "Resident").

WHEREAS, the Responsible Person(s) and Facility enter into this Agreement to facilitate the provision of care to the Resident.

THEREFORE, Facility and Responsible Person(s) agree to the following terms and conditions:

a) It is the policy of Foothill Acres to admit and treat all Residents equally regardless of race, color, national origin, religion, gender, sexual preference, age, handicap and/or source of payment. The Facility accepts Medicaid, Long Term Care Insurance, private pay, most commercial insurance carriers and Medicare when applicable.

b) The Resident/Responsible Person consents to the Resident's admission to Foothill Acres and to the care rendered by Foothill Acres employees, attending physician and/or consultants/consulting services. The Resident/Responsible Person will pay Foothill Acres as may be applicable either at the current rate, the co-insurance, the Medicare co-payment or the full amount of available monthly resources as determined by Medicaid.

c) The Resident/Responsible Person consents to all care provided by Foothill Acres, which includes but is not limited to, routine skilled nursing, laboratory, diagnostic and medical treatments that the physician(s) may deem necessary and advisable.

d) **Your Legal Representative** does not, by reason of signing this Agreement, assume an obligation to reimburse us for your care, except from your income, assets and resources; however, your Legal Representative does assume other legal obligations as set forth in this Agreement and may be held legally responsible for failing to fulfill these obligations.

e) **Financial Information**
If Patient is applying for admission on a private pay basis, the Patient and the Patient's representative agree to provide all financial information required by the Facility to determine the extent of the Patient's resources, as well as benefits and income. If it is ever determined that Patient or Patient's Representative participated in the disclosure of incomplete or inaccurate information, including but not limited to such information that the Patient's resources are exhausted at a date other than that which reasonably could have been anticipated on admission, the incomplete or inaccurate disclosure shall be deemed a material breach of this Agreement and Facility reserves the right to pursue all available legal remedies against the Patient and/or Patient Representative, including but not limited to an action for breach of contract.

f) **Financial Disclosure**
Notwithstanding any other provision of this agreement, if, at the time of admission, if Medicaid has determined that you are eligible for Medicaid benefits to pay our charges, you are not required to comply with the financial disclosure requirements, except that you must provide or consent to have Medicaid provide documentation of your eligibility and of the amount and source(s) of your income Medicaid requires you to pay us.

If you shall become a private pay resident and therefore not Medicaid eligible, You and your Legal Representative represent and warrant that on the Financial Disclosure Sheets accompanying this Agreement, you have disclosed all assets owned by you or in which you have any right (and the value of your share of ownership in each such asset), either solely or jointly with others, including all insurance policies; bank accounts; cash; real estate;

investments; periodic income of any kind and character; automobiles; works of art; debts owed to you; security deposits owed to you; and liens held by you.

Initial: [redacted]

[redacted]

FOOTHILL ACRES REHABILITATION & NURSING CENTER

NAME: [redacted] **MEDICAL ID#:** [redacted] **DATE OF ADMISSION: 06/11/2020**

In anticipation of your potential application for Medicaid benefits you and your Legal Representative represent and warrant that you have not transferred, given, encumbered or changed the ownership of any of your assets, including any income, for less than full value, to any person, entity or to a trust to any form during the past five (5) years, which may cause ineligibility.

You and your Legal Representative agree, represent and warrant that you will not perform, cause or allow the transfer, gift, encumbrance or change of ownership of any asset, including any income, in such a manner as would cause you any period of Medicaid ineligibility. You and your Legal Representative agree, represent and warrant that any such transfer, gift, encumbrance or change of ownership as described above shall be void. If you fail to bring a legal action to recover the asset disposed of under a void disposition, you hereby assign to us a right to bring a legal action against the person who received the asset in addition to the person for transferred the asset to recover the full value of the asset, if possible, however, we are not required to do so.

If you shall become a private pay resident and therefore not Medicaid eligible, You and your Legal Representative agree to provide us with and updated, accurate and complete set of Financial Disclosure Sheets, including disposition and location of assets, as reasonably requested, from time-to-time, by us. You and your Legal Representative further agree that every six (6) months shall not be considered unreasonable.

As soon as you are eligible or entitled, you and your Legal Representative shall apply for and seek to establish eligibility and entitlement to receive benefits under the Medicare and/or Medicaid programs. You and your Legal Representative shall apply for and seek to establish eligibility and entitlement to receive benefit under the Medicare and/or Medicaid programs. You and Your Legal Representative agree to diligently take all steps necessary to apply for and obtain any available benefits. You and Your Legal Representative further agree that this promise is separate from any promise to pay for care. This means that if, as a result of any failure or delay on your part or on the part of your Legal Representative to promptly apply for benefits and fully complete the application process when you are eligible for benefits, you and/or your Legal Representative will be liable for any loss suffered by us as a result of the failure or delay.

g) The Facility agrees to furnish room & board, 24-hour supervision, prescribed special diets, general nursing care, and services required for the safety and well-being of each Resident.

2. RELEASE OF INFORMATION

It may become necessary for Foothill Acres to release information about the Resident to various institutions/agencies/insurance carriers involved in the Resident's care. The Resident/Responsible Person acknowledges this requirement and authorizes the release of information from his/her clinical record to appropriate institutions/agencies. (See "Notice of Privacy Practices document")

3. PHYSICIAN

Foothill Acres offers several Attending Physicians who are credentialed to provide services to the Residents of our facility. A list of Attending Physicians will be provided to all Residents and/or the Responsible Person upon request. The Resident/Responsible Person has the right to retain the services of a physician of his/her choice at the Resident's own expense or through a health care plan outside of the facility. The facility will try to accommodate any physician selected by the Resident/Responsible Person, who is not on the Attending Physician

list, provided that they submit the pertinent documents, and agree to comply with the rules and regulations of the facility, as well as, State & Federal guidelines.

Initial: [redacted]

FOOTHILL ACRES REHABILITATION & NURSING CENTER

N[redacted] MEDICAL ID#: [redacted] DATE OF ADMISSION: 06/11/2020

4. MEDICARE/SUPPLEMENTAL INSURANCE

a) If the Resident is eligible for Medicare and the facility determines that such care will be covered, the Resident will be admitted to a Medicare-certified bed. The facility will submit the claim to the fiscal intermediary for approval and payment to the facility on behalf of the Resident/Patient. However, the mere submission of such a claim by the facility does not relieve the Resident/Responsible Person from liability to the facility if it should be determined by the fiscal intermediary that such care is not covered for the Resident/Patient.

b) Physicians and other healthcare providers such as the Podiatrist, Dentist, laboratory, x-ray technicians, ambulance companies, durable medical equipment companies, etc., bill through Medicare Part B or supplemental insurance. If the Resident/Patient is not a participant in Medicare and/or has no supplemental insurance, the Resident/Patient is financially responsible for amounts not covered by these or any other third-party payers.

c) If the Resident is admitted to the facility under the Medicare program, the Resident/Responsible Person shall pay the Medicare co-insurance promptly as billed. The current co-insurance rate is **$176.00** per day. If a Resident remains at Foothill Acres following the termination of Medicare coverage, the Resident /Responsible Person shall pay all charges as a private pay Resident, unless the Resident is eligible for Medicaid. If the Resident/Responsible Person fails to remit the above payment, Foothill Acres reserves the right to retain the service of a collection agency or attorney, and the Resident/Responsible Person shall be responsible for all collection agency fees, attorneys' fees, court costs, and any other collection expenses including interest at the rate of 12 percent per annum, to be paid out of the Resident's income, assets, or resource.

5. COMMERCIAL INSURANCE

a) The facility is contracted with multiple commercial insurance carriers. The facility will submit the claim to the fiscal intermediary for approval and payment to the facility on behalf of the Resident/Patient. However, the mere submission of such a claim by the facility does not relieve the Resident/Responsible Person from liability to the facility if it should be determined by the insurance carrier/fiscal intermediary that such care is not covered for the Resident/Patient.

b) If the Resident is admitted to the facility under a commercial insurance plan, it is the Resident/Responsible Person responsibility to be aware of and shall pay any co-insurance, co-pays and/or deductibles promptly as billed. If a Resident remains at Foothill Acres following the termination of the commercial insurance coverage, the Resident/Responsible Person shall pay all charges as a private pay Resident, unless the Resident is eligible for Medicaid. If the Resident/Responsible Person fails to remit the above payment, Foothill Acres reserves the right to retain the service of a collection agency or attorney, and the Resident/Responsible Person shall be responsible for all collection agency fees, attorneys' fees, court costs, and any other collection expenses including interest at the rate of 12 percent per annum, to be paid out of the Resident/Responsible Persons' income, assets, or resources.

6. PRIVATE PAY RESIDENTS

Upon admission, two checks will be collected, one for the remainder of the month of admission (including day of admission), the second, a one (1) month security deposit. The security deposit will be used toward the last month of private pay; it will be returned partially or in its entirety in the event of death or involuntary discharge, once the account is settled.
Resident/Patient/Responsible Person/ Representative agree to pay the cost of the Basic Services in full each month for the entire month in advance, along with any charges for services or supplies provided during the

previous month which are not included in the Basic Services. All amounts are due by the tenth (10th) day of the month for which the billing statement was submitted.
Facility may assess a late charge on the unpaid balance of any bill at a rate not to exceed the maximum statutory rate applicable in the State of New Jersey. Such interest will accrue beginning twenty (20) days following the date payment was due under (a) above. Should Facility retain an attorney to enforce any provision of this Agreement.

Initia[redacted]

[redacted]

FOOTHILL ACRES REHABILITATION & NURSING CENTER

NAME: [redacted] **MEDICAL ID#:** [redacted] **DATE OF ADMISSION: 06/11/2020**

Resident/Patient/Responsible Person/ Representative agrees to pay reasonable attorney's fees, collection costs, and other costs of litigation and any other collection expenses including interest at the rate of 12 percent per annum. Facility will assess a service charge of $25.00 for any checks returned for lack of funds.
The daily room rate of $365.00 for semi-private & $399.00 for private includes room and board, personal laundry and use of equipment such as wheelchairs, walkers and generic personal care items. Some charges for private pay residents are not included in the daily rate. These include, but are not limited to, oxygen, transportation, special medical equipment (including but not limited to Negative Pressure Wound Therapy and feeding tubes), prescription drugs, physical, occupational, speech therapy charges and/or accessories, radiology & laboratory services, attending physician and/or consulting physician fees.

7. APPLICATION FOR MEDICAID

Resident/Responsible Person agrees to provide the Facility with accurate information regarding his or her qualification for payments under Title XIX of the Social Security Act ("Medicaid"). To ease the transition from private pay to Medicaid, a private paying Patient shall provide written notice to the Facility's Business Office when the Resident's/Patient's remaining funds reach approximately $35,000 for the purpose of ensuring that the Resident/Patient can be Pre-Admission Screened and Annual Resident Review ("PASRR") approved under the Medicaid program. Resident/Responsible Person further agrees that if he or she is eligible for Medicaid payments, such payments, which are Resident's/Patients Social Security checks less a personal need allowance ("PNA"), shall be made to the Facility for Resident's/Patients account.

Resident/Responsible Person acknowledges that although the Facility may assist Resident/Patient in applying for Medicaid, the Facility does not make any representations or assurances of any kind that Resident/Patient will be eligible for or will continue to be eligible for Medicaid payments. Resident/Responsible Person shall take all steps reasonably necessary to apply for Medicaid benefits in a timely and complete manner. If Resident/Patient/Responsible Person fails to apply for Medicaid in a timely and complete manner, Resident/Patient shall be personally responsible for all charges which are incurred while a Resident/Patient, measured from the date the Resident/Patient would have been financially eligible to qualify for Medicaid benefits until such time as Medicaid benefits are granted.

Resident/Responsible Person agrees that neither the Facility, its agents, servants nor employees, will be liable or responsible if Resident/Patient is denied coverage or continuation of coverage under Medicaid.

Resident/Responsible Person agrees that if he or she becomes eligible for Medicaid during Resident's stay at the Facility, Resident will not convert to Medicaid payment while at the Facility until all current outstanding charges at the Facility have been paid in full.

Medicaid eligibility determination is made by the Department of Social Services in the local jurisdiction in which the Resident resides. If Medicaid determines that the Resident/Responsible Person engaged in "gifting" or transferring the Resident's assets for the benefit of the Responsible Person or a third party within the five years preceding the Medicaid application and Medicaid thus deems the Resident ineligible for Medicaid benefits, any financial penalty assessed by Medicaid will be the responsibility of the Residents/Responsible Person. Once

private funds are exhausted & the Resident is applying for New Jersey Medicaid, Foothill Acres is entitled to payment consisting of the full Social Security benefits and pension as part of the Medicaid program. Upon determination of Medicaid eligibility, the local board of Social Services will establish a financial profile of available income (PA-3L) which will be due the facility for skilled nursing care (less personal need allowance of $50.00 for Resident). Both the facility and the Resident/Responsible person will receive a copy of this document. It is recommended that the Social Security check, pension checks, etc. be forwarded directly to the Facility by the issuer. The Resident/Responsible Person agrees to allow the facility to execute the necessary forms to accomplish that purpose. The Admissions/Business Office can assist you in completing any necessary forms to have the pensions mailed directly to Foothill Acres.

Initial: [redacted]

[redacted]

FOOTHILL ACRES REHABILITATION & NURSING CENTER

NAME: [redacted] **MEDICAL ID#:** [redacted] **DATE OF ADMISSION: 06/11/2020**

8. MEDICAID RECIPIENTS

Per Medicaid guidelines, when a Resident is a Medicaid recipient, upon admission, his/her Social Security check and all other income belongs to Foothill Acres. It is recommended that the Social Security check, pension checks, etc. be forwarded directly to the Facility by the Issuer. The Resident/Responsible Person agrees to allow the facility to execute the necessary forms to accomplish that purpose. The Admissions/Business Office can assist you in completing any necessary forms to have the pensions mailed directly to Foothill Acres. When a person is admitted under the Medicaid program, the Resident/Responsible Person must submit the required available incomes to the facility by the 10th day of each month. If the Resident/Responsible Person fails to make payment of the above, Foothill Acres reserves the right to retain the service of a collection agency or attorney. The Resident/Responsible Person shall be responsible for all collection agency and attorney's fees, court costs and any other collection expenses including interest at the rate of 12 percent per annum. The Resident/Responsible Person acknowledges that they have represented to this facility that the personal financial statement is a true and accurate representation of the Resident's present financial condition and ability to pay. The Resident/Responsible Person acknowledges and agrees that Foothill Acres has accepted the Resident based on this representation.

Items covered by Medicaid include all meals, routine nursing services, activity services, social services, routine personal hygiene services (including items), and maintenance for the room and bed.

9. PERSONAL NEEDS ALLOWANCE (PNA) ACCOUNT

A Medicaid Resident is allowed a monthly stipend of $50.00 from his/her Social Security check that is called the Personal Needs Allowance. The PNA funds may be handled by the Resident/Responsible Person or by Foothill Acres. If you wish to have the Facility manage the PNA funds, you must sign a permission form. This allows the Facility to make deposits, make purchases on the Residents behalf, pay incidental expenses and manage the Resident's PNA. Receipts must substantiate all withdrawals. The Resident/Responsible Person agree that in the event funds remain in the PNA account upon the death or discharge of the resident from the Facility, the Facility may apply the PNA account balance to any open balance due to the Facility on the Resident's account.

If managed by Foothill Acres, PNA monies are kept in an interest-bearing account and quarterly statements will be provided to the Resident/Responsible Person. Items/services purchased on behalf of the Resident can be charged to Resident's PNA account. Private Pay, Medicare and Commercial Insurance residents can open a PNA account, deposit personal funds and make withdrawals.

10. BED HOLD

PRIVATE PAY - In the event the Resident is hospitalized, his/her bed will automatically be held at 90% of the private pay rate. It is the responsibility of the Resident and/or Responsible Person to notify the Admissions Office in writing if his/she does not wish to hold the bed, otherwise, the bed will automatically be held at one of the above rates.

MEDICARE A - In the event the Resident is hospitalized, his/her bed will NOT be held. It is the responsibility of the Resident and/or Responsible Person to notify the Admissions Office if his/she wishes to hold the bed. If the Resident/Responsible Person wishes to hold the bed the rate will be at 90% of the current private rate.

MEDICAID - In the event the Resident is hospitalized, Medicaid requires for a bed to be held for ten (10) days. If the Resident is hospitalized for longer than 10 days, Foothill Acres will make every attempt to readmit the Resident. If this is not possible, he/she will be placed on the wait list. Should the Resident/Responsible Person wish to pay privately to hold the bed after the ten-day bed hold period they will be billed at the current private pay rate.

Foothill Acres will make every effort to readmit our Residents if we are able to provide the services required by the Resident at time of readmission.

Initial: [redacted]

[redacted]

FOOTHILL ACRES REHABILITATION & NURSING CENTER

[redacted] MEDICAL ID#: [redacted] DATE OF ADMISSION: 06/11/2020

11. CHANGES IN ROOM RATE & CHARGES

The per diem rate set by the Facility and other charges may be increased periodically to reflect rising Facility costs, in compliance with Federal, State and local regulations. A thirty (30) day written notice will be given, except in the event of a health emergency that requires the Resident to receive immediate special service and supplies.

12. GRIEVANCE PROCEDURE

The Resident/Responsible Person has the right to voice grievances to the staff without discrimination or fear of reprisal. All concerns/suggestions should be voiced to the charge nurse on the unit in which the Resident resides, the Administrator, Director of Nursing and/or a Department Head. An effort will be made to resolve grievances in a timely manner.

13. LIMITATIONS ON LIABILITY

Although Foothill Acres will take every precaution to protect the Resident's personal belongings, the facility is not responsible for loss or damage to any valuables, personal belongings (including dentures, hearing aides, eyeglasses, etc.), or money brought into the facility by the Resident/Patient and/or any visitors, unless the loss or damage is caused by willful or grossly negligent action of the facility.
Foothill Acres shall not be liable for any injuries suffered by the Resident while under the facility's care. If the Resident leaves or is removed from the Facility for any reason, its agents and employees are released by the Resident/Patient/Responsible Person from all liability for injury suffered by the Resident/Patient while away from the facility.

14. ROOM CHANGE

Transfer of a Resident from one room to another is at the discretion of the facility. The Resident/Responsible Person will be notified of room changes. When possible, a twenty-four (24) hour notice will be given. This does not apply to emergency situations. The Sub Acute Unit is reserved for short term residents only. When a Resident from the Sub-Acute Unit is transferred to the hospital, the Facility will make every effort to hold the same bed previously occupied by the Resident however, there is no guarantee the Facility will be able to make that accommodation.

15. TRANSFER/DISCHARGE

Foothill Acres may discharge and/or transfer a Resident for the following reasons:

a) The Resident's medical condition changes so that his/her needs can no longer be met by the Facility
b) The Resident's health has improved sufficiently so that he/she no longer requires the services of the Facility
c) The Resident presents a danger to his/her own health and safety and/or the health and safety of other Residents or staff
d) In the existence of a mental illness which must be treated by a mental health professional in a specialized setting
e) For non-payment of fees in situations not prohibited by law – thirty (30) days written notice will be given
f) If the Facility closes – if this occurs the Facility will assist in finding another facility and will arrange transportation if necessary.
g) Any other reason permitted by law.

16. TERMINATION OF AGREEMENT

a) The Resident will be responsible for all charges and services performed by Foothill Acres up to and including the day of departure.
b) Removal of the Resident Against Medical Advice (AMA) terminates any responsibility of the Facility.
c) Any incidents that occur while the Resident is off the premises with any person are not the liability of the facility.

Initial [redacted]

[redacted]

FOOTHILL ACRES REHABILITATION & NURSING CENTER

NAME: [redacted] **MEDICAL ID#:** [redacted] **DATE OF ADMISSION: 06/11/2020**

d) If the Resident is transferred to an acute care facility, this agreement shall remain in effect upon return to this Facility. Upon readmission, this agreement and all previous consents are fully reinstated.

17. MISCELLANEOUS

a) **THE RESIDENT/RESPONSIBLE PERSON** is responsible for personal items, such as, clothing, beauty & barbershop services, telephone & electronic devices, and off premises social events that are outside the scope of the activities program.
b) **BELONGINGS** - All personal effects should be marked with the Resident's name and inventoried on the Personal Clothing Record upon admission. The facility strongly discourages bringing any monetary or sentimental valuables into the facility. In the event the Resident is temporarily transferred out of the facility, the Resident agrees to allow the Facility to collect and/or organize the Residents personal property for safekeeping.
c) All of the Resident's belongings must be claimed by the Resident/Responsible Person within thirty (30) days after discharge or death. Any belongings not claimed will be disposed of at the discretion of Foothill Acres.
d) **CHANGE OF ADDRESS** - The Person(s) signing this agreement is responsible for informing Foothill Acres in writing of any change of address or telephone number(s.
e) **DIETARY SERVICE** – Foothill Acres offers a "kosher style" menu; a non "kosher style" alternative will be available to residents upon request.
f) **FOOD ITEMS** - Feel free to bring the Resident his/her favorite foods, but always check first with the unit nurse and/or the dietician to see if the Resident is on a special diet. All food items must be labeled and placed in airtight containers. If the item requires refrigeration it will be tagged with the Residents name, dated and placed in a refrigerator for a maximum of three (3) days.
g) **FURNITURE** - If a Resident has a favorite chair, end table, etc., the item(s) can be placed in the room upon approval of a member of the Administrative Staff.
h) **HAIR CARE** - Routine hair care is provided. There is a separate charge for these services (see fee schedule).
i) **MEDICATIONS** – No medications shall be brought into the facility for the Resident without the permission of the Administrator, Director of Nursing or the facility's Medical Director. Only those medicines, medications or treatments which are ordered or prescribed by the facility's Medical Director/Attending Physician shall be given to the Resident. Residents shall not order or obtain prescriptions from a pharmacy or source other than the facility's contracted pharmacy, unless the Resident has made prior arrangements with the Administrator or the Director of Nursing.
j) **PHARMACY** - Pharmacy Services are provided by Specialty RX. If a Resident has PAAD or an insurance that requires use of another pharmacy, we will make every effort to order medications through a participating pharmacy.
k) **RESIDENT RIGHTS** - The Resident/Responsible Person will receive a copy of the Resident Rights upon admission. The Social Worker and/or his/her designee will review these rights at Resident Council meetings throughout each year. If a Resident is unable to understand, a copy of the Resident Rights will be mailed to the Responsible Person.
l) **SMOKING RULES** – Foothill Acres is a smoke-free facility. We will provide smoking cessation products upon request.
m) **TRANSPORTATION** – Ambulance transportation and/or invalid coach transportation will be arranged for the Resident at the discretion of Foothill Acres. Should transportation to and/or from the hospital or provider be necessary, the cost will be the responsibility of the Resident/Responsible Person or third-party billing.
n) **VACCINES** - All Residents are entitled to receive the pneumonia and flu vaccinations. The pneumonia vaccination will be given upon admission unless the new Resident has already received such. The Flu vaccination is given annually. If for some reason the Resident/Responsible Person does not want either or both vaccines, a waiver must be signed. Informed consent sheets are provided to each Resident and/or Responsible Person.
o) The facility does not allow any resident, visitor or family member to take photographs and/or video of any resident and/or employee without the express permission from the Administrator or his/her designee.

Initial [redacted]

[redacted]

FOOTHILL ACRES REHABILITATION & NURSING CENTER

[redacted]

DATE OF ADMISSION: 06/11/2020

Responsible Person(s) is/are obligated to perform all provisions in the Admission Agreement related to Responsible Person(s), including submitting claims to Resident's insurance company for reimbursement for covered services. Responsible Person(s) acknowledge(s) that he/she/they has/have received a copy of the Admission Agreement and understand(s) the terms and conditions contained therein.

Responsible Person(s) acknowledge(s) and represent(s) that he/she/they is/are the Guardian of the Resident, or the Agent under a valid Power of Attorney, or has/have been authorized by the Resident to execute the Admission Agreement on behalf of the Resident and for the benefit of the Resident or has/have been previously authorized by the Resident to act on his/her behalf as his/her Agent. Facility shall discuss and consult with Responsible Person(s) regarding pertinent decisions related to Resident's stay and care at the Facility.

In the event Resident designates more than one individual as Responsible Person, then such individuals shall be jointly and severally liable for each other's obligations under this Admission Agreement.

The various provisions of this Agreement shall be severable one from another. If any provision of this Agreement is found by a court or administrative body of proper jurisdiction and authority to be invalid, the other provisions shall remain in full force and effect as if the invalid provision had not been a part of this Agreement.

This agreement shall be binding upon the parties, their heirs, and legal representatives.

I ACKNOWLEDGE THAT I HAVE READ AND FULLY UNDERSTAND THE CONTENTS OF THIS ADMISSION AGREEMENT. I ACKNOWLEDGE THAT I HAVE SIGNED IT FREELY AND VOLUNTARILY AND THAT ANY QUESTIONS HAVE BEEN SATISFACTORILY ANSWERED. I ALSO ACKNOWLEDGE THAT SIGNING THIS AGREEMENT IS NOT A CONDITION FOR ADMISSION AND I HAVE BEEN GIVEN A SIGNED COPY OF THIS ADMISSION AGREEMENT AND ALL OTHER ADMISSION DOCUMENTS.

SIGN HERE

_____ _____

Date

[redacted]

_____

Name of Responsible Person (please print)

SIGN HERE

_____ 6-12-2020

Signature of Responsible Person to Resident

[redacted]

Phone

SIGN HERE

_____ _____

Signature of Facility Representative *Date*

[redacted]

FOOTHILL ACRES REHABILITATION & NURSING CENTER

NAME [redacted] MEDICAL ID#: [redacted] DATE OF ADMISSION: 06/11/2020

BED-HOLD POLICY

POLICY:
It is the policy of this facility to readmit any resident transferred to the hospital to the first available/appropriate accommodation.

PROCEDURE:
When a resident is transferred from this facility to another facility, such as a hospital, with return admission anticipated, the resident's bed will be held as outlined below:

1. Any resident paying privately for services that is transferred to the hospital will be placed on a private bed hold at 90% of the current private daily rate. If a resident/resident's representative does not want the bed held, they may contact the Admissions Department to make this change.
2. Any Medicaid or General Assistance recipient will have their bed held for ten (10) days or until the resident returns to the facility, whichever is shorter.
3. Should a resident/resident representative choose not to have a bed held or should the 10-day Medicaid Bed Hold expire, the facility will readmit any resident as soon as an appropriate bed is made available as long as the resident continues to meet the admission criteria and the facility is able to meet the residents needs.
4. A resident receiving Medicaid benefits placed on a therapeutic leave will be entitled to a total of 24 overnight stays in a calendar year.

A copy of this policy will be provided to you within 24hrs of discharge to the hospital. Please indicate the preferred method of communication below.

✓ Email (provide email address): [redacted]

____ Fax (provide fax number): ____

____ Standard Mail

SIGN HERE

Signatu[redacted]

6/12/2020
Date

SIGN HERE

Signature of Responsible Party

Wife
Relationship to Patient

[redacted]

FOOTHILL ACRES REHABILITATION & NURSING CENTER

[redacted]

DATE OF ADMISSION: 06/11/2020

LETTER OF AGREEMENT FOR MEDICAID RESIDENTS/PATIENTS

RESOURCE SPEND-DOWN--WHEN DOES MEDICAID ELIGIBILITY EXIST?

Medicaid eligibility will exit on the **first day** of the **first month after** the individual's total resources are equal to or less than the **$2,000** or **$4,000** resource limit.

The $2,000 resource limit is for applicants of the Medicaid Only program and the $4,000 resource limit applies to applicants of New Jersey Care - Special Medicaid Programs, including the Medically Needy segment. Additional resources may be spent down by paying privately for the individual's care or used for other legitimate purposes until the appropriate resource limit is reached. In all instances of spend-down, assets cannot be transferred for less than fair market value or given away without compensation.

Countable resources include, but are not limited to:

- Bank accounts
- Property other than principal residence
- Stocks, bonds, certificates of deposit
- Cash surrender value of a life insurance policy that exceeds $1,500 in face value.

Excludable resources include, but are not limited to:

- A home which serves as a principal residence of a spouse or other dependent relative (if a home is not occupied by a dependent relative and the period of institutionalization is expected to be six months or less, the home may also be excluded),
- A life insurance which does not exceed $1,500 in face value,
- Burial spaces, and burial funds not exceeding $1,500 (less excluded cash surrender value of life insurance and/or funds held in an irrevocable burial arrangement),
- One automobile to the extent that its current market value does not exceed $4,500,
- One wedding and engagement ring.

It is important to remember that in the spend-down process, eligibility cannot be established in *any* month where on the *first moment* of the *first day* of that *month*, the resources exceed the resource limit of $2,000 or $4,000.

Example: An individual has $6,000 in a checking account. The applicant owes $4,000 to a nursing facility for care. If a check for $4,000 is written to the nursing facility on or after May 1, eligibility cannot be established before June 1. The May nursing facility charges would be the responsibility of the applicant.

SIGN HERE

[redacted]

Signature of Responsible Party

6/12/2020

Date

Wife

Relationship to Patient

[redacted]

FOOTHILL ACRES REHABILITATION & NURSING CENTER

[redacted] DATE OF ADMISSION: 06/11/2020

ACKNOWLEDGEMENT OF
RECEIPT OF NOTICE OF PRIVACY PRACTICE

Resident Name: [redacted]
Medical Record
Facility Name: FOOTHILL ACRES REHABILITATION & NURSING CENTER

I have been given a copy of Foothill Acres Rehab and Nursing's *Notice of Privacy Practices* ("*Notice*"), which describes how my PHI is used and shared. I understand that Foothill Acres has the right to change this *Notice* at any time. I may obtain a current copy by contacting the Foothill Acres' Privacy Officer, or by visiting their website.

My signature below acknowledges that I have been provided with a copy of the *Notice of Privacy*

[redacted] 6/12/2020

Signature of Resident or Personal Representative — Date

PRINT HERE [redacted]

Print Name

SIGN HERE [redacted]

Personal Representative's Title (e.g., Guardian, Executor of Estate, Health Care Power of Attorney)

For Foothill Acres Rehabilitation & Nursing Center Use Only: Complete this section is you are unable to obtain a signature.

1. If the resident or personal representative is unable or unwilling to sign this Acknowledgement, or the Acknowledgement is not signed for any other reason, state the reason:

Describe the steps taken to obtain the resident's or personal representative's signature on the Acknowledgement:

Completed by:

SIGN HERE

Signature of Foothill Acres Representative — Date

PRINT HERE

Print Name

File original in resident's Business Office Record

[redacted]

FOOTHILL ACRES REHABILITATION & NURSING CENTER

[redacted]

DATE OF ADMISSION: 06/11/2020

Check the appropriate box and answer the questions.

DNA

1. ILLNESS OR INJURY CAUSED BY ACCIDENT
   A. ( ) Motor Vehicle: Name of Patient's Automobile Insurer: _____
   B. ( ) Another Party was Responsible for the Accident.
      Name & Address of Liability Insurer: _____
      Name and Address of Attorney: _____
   C. ( ) Work Related: Name of Workman's Comp. Insurer: _____
   D. ( ) Other Accident (slip and fall etc.): Explain where accident occurred: _____
      If Other than patient's home, has the patient filed or intends to file a liability suit?
      ( ) Yes: Name and Address of:
      Liability Insurer _____
      Attorney _____

      Bill other insurer prior to Medicare; submit documentation to Medicare if conditional payment requested
      ( ) No: Bill Medicare and send copies of all pertinent documentation.

DNA

2. EMPLOYER GROUP COVERAGE FOR THOSE 65 AND OVER
   A. ( ) Patient employed at time of this service. Give name of Patient's company/employer:
      _____
      Does employer employee 20 or more employees? ( ) Yes ( ) No
      Does Patient have Employer Group Health Plan (EGHP) because of his/her current employer?
      ( ) Yes ( ) No: If "Yes" give the name of the EGHP: _____
      Bill EGHP prior to Medicare.
   B. ( ) Patient's Spouse employed at time of this service. Give name of spouse's company/employer:
      _____
      Does the spouse's employer employee 20 or more employees? ( ) Yes ( ) No
      Does the spouse have EGHP because of current employment that covers the patient?
      ( ) Yes ( ) No: If "Yes" give the name of the EGHP: _____
      Bill EGHP prior to Medicare.

DNA

3. EMPLOYER GROUP COVERAGE FOR THOSE YOUNGER THAN 65
   A. ( ) Patient is entitled to Medicare solely due to End Stage Renal Disease and in first 12 months of Medicare entitlement. Date of first dialysis treatment or date of kidney transplant: _____
      Does patient have coverage through his/her spouse's, a parent's, or a guardian's EGHP?
      ( ) No: Medicare Primary ( ) Yes: Give Name of the Employer: _____
      Give Name of the EGHP _____
      Bill EGHP prior to Medicare.
   B. ( ) The Patient is entitled to Medicare solely because of disability (does not have/has not had EGHP) Does patient have coverage through his/her spouse's, a parent's, or a guardian's EGHP?
      ( ) No: Medicare Primary ( ) Yes: Continue
      Does employer(s) employ 100 or more employees? ( ) No: Bill Medicare ( ) Yes
      If "Yes" give name of each insured whose policy covers the patient:

Name	Employer
Name	Employer
Name	Employer

Bill EGHP(s) prior to Medicare.

PRINT HERE

Print Resident Name

SIGN HERE

Resident Signature Date Facility Representative Signature Date

PRINT HERE

Print Responsible Party Name

SIGN HERE

Responsible Party Signature Date Facility Representative Signature Date

[redacted]

FOOTHILL ACRES REHABILITATION & NURSING CENTER

[redacted] DATE OF ADMISSION: 06/11/2020

MEDICARE ONE TIME AUTHORIZATION

Medicare#:
I request that payment of authorized Medicare benefits be made on my behalf to authorized physicians and/or service providers for any/all services rendered. I authorize release of medical information about me to the Health Care Financing Administration and/or its agents for the purposes of determining eligibility.

SIGN HERE

Signature of Resident/Patient *Date*

SIGN HERE [redacted] wife 9/13/2020

Signature of Responsible Party *Relationship to Resident/Patient* *Date*

This is to advise you that DR. JOHN HEATH the physician for the above-named Resident/Patient and has certified the above for Medicare coverage.

Please contact the Admissions Office with questions.

[redacted]

FOOTHILL ACRES REHABILITATION & NURSING CENTER

[redacted] DATE OF ADMISSION: 06/11/2020

Discharges and Transfers

- To be notified of a change in your room or roommate and to have an informal hearing with the administrator first.
- To receive assistance in awakening, dressing and participating in activities unless your physician specifies the reason(s) in your medical record.
- To discharge yourself from the nursing home by presenting a release signed by you, your next of kin, or your guardian.
- To be transferred or discharge only for one or more of the following reasons:
  1. In an emergency, with notification of your physician and your next of kin or guardian.
  2. For medical reasons, to protect your welfare or the welfare of others or to comply with your Advance Directive.
  3. For nonpayment of fees, in situation not prohibited by law
- To receive notice at least 30 days in advance when the nursing home requests your transfer or discharge, except in an emergency.

Mail/Telephone/Internet/Misc.

- To receive and send your mail in unopened envelopes. You also have a right to request and receive assistance in reading and writing correspondence.
- To access the internet to the extent available to the facility.
- To have private access to a telephone. You may have a private telephone in your living quarters at your own expense.
- To view the results of the three most recent annual surveys, any certification surveys, and all complaint surveys during the last three years, plus related plans of correction.

Protection of Your Rights

- To be given a written statement of your rights as well as any additional regulations established by the nursing home involving your rights and responsibilities. Copies should also be given to your family and the staff.
- To be informed about the facility's grievance policy. To make complaints and file grievances
- To retain and exercise all the constitutional, civil and legal rights to which you are entitle by law. The nursing home is required to encourage and help you to exercise these rights.

Concerns and Questions

You have the right to voice complaints without being threatened or punished. Below are two government agencies you can call or write for information and assistance

Office of the Ombudsman for the Institutionalized Elderly
PO Box 807, Building 12-B, Quakerbridge Rd
Trenton, NJ 08625-0807
(877) 582-6995

NJ Department of Health and Senior Services
Long Term Care Systems, PO Box 367
Trenton, NJ 08625-0367
Complaints: (800) 792-9770
Questions: (800) 367-6543

SIGN HERE

Signature of Resident/Patient *Date*

SIGN [redacted] wife 6-113-2020

Signature of Responsible Party *Relationship to Resident/Patient* *Date*

[redacted]

Foothill Acres Rehab

39 East Mountain Road ✦ Hillsborough, NJ 08844

[redacted]

Statement Date: 4/17/2023
Resident Name: [redacted]
Resident ID: [redacted]

Date	Description	For the Period	Days	Rate	Charges	Credits	Balance
6/01/2020	Room and Board	6/11/2020 - 6/30/2020	20	375.00	7,500.00		$7,500.00
7/01/2020	Payment	6/11/2020 - 6/30/2020				7,500.00	$0.00
7/01/2020	Room and Board	7/01/2020 - 7/31/2020	31	375.00	11,625.00		$11,625.00
7/01/2020	Payment	7/01/2020 - 7/31/2020				11,625.00	$0.00
8/01/2020	Physical Therapy Priv	6/12/2020 - 6/30/2020			110.00		$110.00
8/01/2020	Physical Therapy Priv	7/03/2020 - 7/31/2020			180.00		$290.00
8/01/2020	Room and Board	8/01/2020 - 8/31/2020	31	375.00	11,625.00		$11,915.00
8/10/2020	Payment	8/01/2020 - 8/31/2020				11,625.00	$290.00
9/01/2020	Room and Board	9/01/2020 - 9/30/2020	30	375.00	11,250.00		$11,540.00
9/30/2020	Physical Therapy Priv	6/12/2020 - 6/30/2020				110.00	$11,430.00
9/30/2020	Physical Therapy Priv	7/03/2020 - 7/31/2020				180.00	$11,250.00
9/30/2020	Payment	9/01/2020 - 9/30/2020				11,335.00	$(85.00)
10/01/2020	Room and Board	10/01/2020 - 10/31/2020	31	375.00	11,625.00		$11,540.00
10/30/2020	Payment	10/01/2020 - 10/31/2020				2,118.60	$9,421.40
10/31/2020	Adjustment	9/01/2020 - 9/30/2020				(85.00)	$9,506.40
11/01/2020	Physical Therapy Priv	8/03/2020 - 8/14/2020			40.00		$9,546.40
11/01/2020	Room and Board	11/01/2020 - 11/30/2020	30	375.00	11,250.00		$20,796.40
11/30/2020	Payment	11/01/2020 - 11/30/2020				2,118.60	$18,677.80
12/01/2020	Room and Board	12/01/2020 - 12/31/2020	31	375.00	11,625.00		$30,302.80
12/07/2020	Physical Therapy Priv	8/03/2020 - 8/14/2020				40.00	$30,262.80
12/30/2020	Payment	12/01/2020 - 12/31/2020				2,111.61	$28,151.19
1/01/2021	Room and Board	1/01/2021 - 1/31/2021	31	385.00	11,935.00		$40,086.19
2/01/2021	Room and Board	2/01/2021 - 2/28/2021	28	385.00	10,780.00		$50,866.19
2/02/2021	Payment	1/01/2021 - 1/31/2021				2,137.71	$48,728.48
2/26/2021	Payment	2/01/2021 - 2/28/2021				2,376.01	$46,352.47
3/01/2021	Room and Board	3/01/2021 - 3/31/2021	31	385.00	11,935.00		$58,287.47
3/29/2021	Payment	3/01/2021 - 3/31/2021				2,376.01	$55,911.46
4/01/2021	Room and Board	4/01/2021 - 4/30/2021	30	385.00	11,550.00		$67,461.46

EXHIBIT B

[redacted] [redacted]

Foothill Acres Rehab

39 East Mountain Road ◆ Hillsborough, NJ 08844

[redacted]

Statement Date: 4/17/2023
Resident Name: [redacted]
Resident ID: [redacted]

[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
4/30/2021	Payment	4/01/2021 - 4/30/2021				2,376.01	$65,085.45
5/01/2021	Room and Board	5/01/2021 - 5/31/2021	31	385.00	11,935.00		$77,020.45
6/01/2021	Room and Board	6/01/2021 - 6/30/2021	30	385.00	11,550.00		$88,570.45
6/02/2021	Payment	5/01/2021 - 5/31/2021				2,376.01	$86,194.44
6/28/2021	Payment	6/01/2021 - 6/30/2021				2,376.01	$83,818.43
7/01/2021	Room and Board	7/01/2021 - 7/31/2021	31	385.00	11,935.00		$95,753.43
8/01/2021	Room and Board	8/01/2021 - 8/31/2021	31	385.00	11,935.00		$107,688.43
8/05/2021	Payment	7/01/2021 - 7/31/2021				2,376.01	$105,312.42
8/31/2021	Payment	8/01/2021 - 8/31/2021				2,333.00	$102,979.42
9/01/2021	Room and Board	9/01/2021 - 9/30/2021	30	385.00	11,550.00		$114,529.42
9/29/2021	Payment	9/01/2021 - 9/30/2021				2,369.02	$112,160.40
10/01/2021	Room and Board	10/01/2021 - 10/31/2021	31	385.00	11,935.00		$124,095.40
11/01/2021	Payment	10/01/2021 - 10/31/2021				2,376.01	$121,719.39
11/01/2021	Room and Board	11/01/2021 - 11/30/2021	30	385.00	11,550.00		$133,269.39
11/30/2021	Payment	11/01/2021 - 11/30/2021				2,376.01	$130,893.38
12/01/2021	Room and Board	12/01/2021 - 12/31/2021	31	385.00	11,935.00		$142,828.38
12/27/2021	Payment	12/01/2021 - 12/31/2021				2,376.01	$140,452.37
1/01/2022	Room and Board	1/01/2022 - 1/31/2022	31	395.00	12,245.00		$152,697.37
1/31/2022	Payment	1/01/2022 - 1/31/2022				2,504.01	$150,193.36
2/01/2022	Room and Board	2/01/2022 - 2/28/2022	28	395.00	11,060.00		$161,253.36
2/28/2022	Payment	2/01/2022 - 2/28/2022				2,504.01	$158,749.35
3/01/2022	Room and Board	3/01/2022 - 3/31/2022	31	395.00	12,245.00		$170,994.35
3/29/2022	Payment	3/01/2022 - 3/31/2022				2,504.01	$168,490.34
4/01/2022	Room and Board	4/01/2022 - 4/30/2022	30	395.00	11,850.00		$180,340.34
4/30/2022	Payment	8/01/2021 - 8/31/2021				50.00	$180,290.34
5/01/2022	Room and Board	5/01/2022 - 5/31/2022	31	395.00	12,245.00		$192,535.34
5/02/2022	Payment	4/01/2022 - 4/30/2022				2,504.01	$190,031.33
5/31/2022	Adjustment	8/01/2021 - 8/31/2021				(6.99)	$190,038.32

[redacted]

Foothill Acres Rehab

39 East Mountain Road ✦ Hillsborough, NJ 08844

[redacted]

Statement Date: 4/17/2023

[redacted]

Resident ID: [redacted]

[redacted]	Period Covered	[redacted]	[redacted]	[redacted]	Credit	Balance
5/31/2022 Payment	9/01/2021 - 9/30/2021				6.99	$190,031.33
5/31/2022 Payment	5/01/2022 - 5/31/2022				2,504.01	$187,527.32
6/01/2022 Room and Board	6/01/2022 - 6/30/2022	30	395.00	11,850.00		$199,377.32
6/07/2022 Payment	10/01/2020 - 10/31/2020				235.40	$199,141.92
6/07/2022 Payment	11/01/2020 - 11/30/2020				235.40	$198,906.52
6/07/2022 Payment	12/01/2020 - 12/31/2020				235.40	$198,671.12
6/07/2022 Payment	1/01/2021 - 1/31/2021				238.30	$198,432.82
6/28/2022 Payment	6/01/2022 - 6/30/2022				2,504.01	$195,928.81
7/01/2022 Room and Board	7/01/2022 - 7/31/2022	31	395.00	12,245.00		$208,173.81
7/29/2022 Payment	7/01/2022 - 7/31/2022				2,504.01	$205,669.80
8/01/2022 Room and Board	8/01/2022 - 8/31/2022	31	395.00	12,245.00		$217,914.80
8/29/2022 Payment	8/01/2022 - 8/31/2022				2,504.01	$215,410.79
9/01/2022 Room and Board	9/01/2022 - 9/30/2022	30	395.00	11,850.00		$227,260.79
10/01/2022 Room and Board	10/01/2022 - 10/31/2022	31	395.00	12,245.00		$239,505.79
10/04/2022 Payment	9/01/2022 - 9/30/2022				2,504.01	$237,001.78
11/01/2022 Payment	10/01/2020 - 10/31/2020				5,510.70	$231,491.08
11/01/2022 Payment	11/01/2020 - 11/30/2020				5,257.00	$226,234.08
11/01/2022 Payment	12/01/2020 - 12/31/2020				5,517.69	$220,716.39
11/01/2022 Payment	1/01/2021 - 1/31/2021				5,488.69	$215,227.70
11/01/2022 Payment	2/01/2021 - 2/28/2021				4,727.59	$210,500.11
11/01/2022 Payment	3/01/2021 - 3/31/2021				5,488.69	$205,011.42
11/01/2022 Payment	4/01/2021 - 4/30/2021				5,234.99	$199,776.43
11/01/2022 Payment	5/01/2021 - 5/31/2021				5,488.69	$194,287.74
11/01/2022 Payment	6/01/2021 - 6/30/2021				5,234.99	$189,052.75
11/01/2022 Payment	7/01/2021 - 7/31/2021				5,618.89	$183,433.86
11/01/2022 Payment	8/01/2021 - 8/31/2021				5,618.89	$177,814.97
11/01/2022 Payment	9/01/2021 - 9/30/2021				5,360.99	$172,453.98
11/01/2022 Payment	10/01/2021 - 10/31/2021				5,618.89	$166,835.09

[redacted]

Foothill Acres Rehab

39 East Mountain Road • Hillsborough, NJ 08844

[redacted]

Statement Date: 4/17/2023

Resident Name: [redacted]

Date	Description	Period Covered	Days	Charges	Credits	Balance
11/01/2022	Payment	11/01/2021 - 11/30/2021			5,360.99	$161,474.10
11/01/2022	Payment	12/01/2021 - 12/31/2021			5,618.89	$155,855.21
11/01/2022	Payment	1/01/2022 - 1/31/2022			5,490.89	$150,364.32
11/01/2022	Payment	2/01/2022 - 2/28/2022			4,717.19	$145,647.13
11/01/2022	Payment	3/01/2022 - 3/31/2022			5,490.89	$140,156.24
11/01/2022	Payment	4/01/2022 - 4/30/2022			5,232.99	$134,923.25
11/01/2022	Payment	5/01/2022 - 5/31/2022			5,490.89	$129,432.36
11/01/2022	Payment	6/01/2022 - 6/30/2022			5,232.99	$124,199.37
11/01/2022	Payment	7/01/2022 - 7/31/2022			2,197.59	$122,001.78
11/01/2022	Payment	10/01/2022 - 10/31/2022			2,511.00	$119,490.78

Total Amount Due: $119,490.78

[redacted]

Foothill Acres Rehab

39 East Mountain Road + Hillsborough, NJ 08844

[redacted]

Statement Date: 4/17/2023
Resident Name: [redacted]
Resident ID:

[redacted]

If you'd like to discuss this statement please contact Yudi at 732-994-5900 x308

Please detach and return with your payment.

Foothill Acres Rehab and Nursing Center
39 East Mountain Road
Hillsborough, NJ 08844

[redacted]

Statement Date: 4/17/2023
Resident Name: [redacted]
Resident ID:

[redacted]

[redacted]

Foothill Acres Rehabilitation & Nursing Center
vs. [redacted]
[redacted] to the present time

Month	Balance	Payments	Account Balance	12% Interest Per Annum	Monthly Interest Amount	Balance w/ Interest	$220 an hour Attorney's Fees
June-2020	$ 7,500.00	$ -	$ 7,500.00	1.0%	$ 75.00	$ 7,575.00	$ -
July-2020	$ 11,625.00	$ (19,125.00)	$ -	1.0%	$ -	$ 75.00	$ -
August-2020	$ 11,915.00	$ (11,625.00)	$ 290.00	1.0%	$ 2.90	$ 367.90	$ -
September-2020	$ 11,250.00	$ (11,625.00)	$ (85.00)	1.0%	$ -	$ (7.10)	$ -
October-2020	$ 11,665.00	$ (2,033.60)	$ 9,546.40	1.0%	$ 95.46	$ 9,719.76	$ -
November-2020	$ 11,250.00	$ (2,118.60)	$ 18,677.80	1.0%	$ 186.78	$ 19,037.94	$ -
December-2020	$ 11,625.00	$ (2,151.61)	$ 28,151.19	1.0%	$ 281.51	$ 28,792.84	$ -
January-2021	$ 11,935.00	$ -	$ 40,086.19	1.0%	$ 400.86	$ 41,128.71	$ -
February-2021	$ 10,780.00	$ (4,613.72)	$ 46,352.47	1.0%	$ 463.52	$ 47,858.51	$ -
March-2021	$ 11,935.00	$ (2,376.01)	$ 55,911.46	1.0%	$ 559.11	$ 57,976.62	$ -
April-2021	$ 11,550.00	$ (2,376.01)	$ 65,085.45	1.0%	$ 650.85	$ 67,801.46	$ -
May-2021	$ 11,935.00	$ -	$ 77,020.45	1.0%	$ 770.20	$ 80,506.66	$ -
June-2021	$ 11,550.00	$ (4,752.02)	$ 83,818.43	1.0%	$ 838.18	$ 88,142.83	$ -
July-2021	$ 11,935.00	$ -	$ 95,753.43	1.0%	$ 957.53	$ 101,036.36	$ -
August-2021	$ 11,935.00	$ (4,709.01)	$ 102,979.42	1.0%	$ 1,029.79	$ 109,291.15	$ -
September-2021	$ 11,550.00	$ (2,369.02)	$ 112,160.40	1.0%	$ 1,121.60	$ 119,593.73	$ -
October-2021	$ 11,935.00	$ (2,376.01)	$ 121,719.39	1.0%	$ 1,217.19	$ 130,369.91	$ -
November-2021	$ 11,550.00	$ (2,376.01)	$ 130,893.38	1.0%	$ 1,308.93	$ 140,852.84	$ -
December-2021	$ 11,935.00	$ (2,376.01)	$ 140,452.37	1.0%	$ 1,404.52	$ 151,816.35	$ -
January-2022	$ 12,245.00	$ (2,504.01)	$ 150,193.36	1.0%	$ 1,501.93	$ 163,059.28	$ -
February-2022	$ 11,060.00	$ (2,504.01)	$ 158,749.35	1.0%	$ 1,587.49	$ 173,202.76	$ -
March-2022	$ 12,245.00	$ (2,504.01)	$ 168,490.34	1.0%	$ 1,684.90	$ 184,628.65	$ -
April-2022	$ 11,850.00	$ (50.00)	$ 180,290.34	1.0%	$ 1,802.90	$ 198,231.56	$ -
May-2022	$ 12,245.00	$ (5,008.02)	$ 187,527.32	1.0%	$ 1,875.27	$ 207,343.81	$ -
June-2022	$ 11,850.00	$ (3,448.51)	$ 195,928.81	1.0%	$ 1,959.29	$ 217,704.58	$ 150.00
July-2022	$ 12,245.00	$ (2,504.01)	$ 205,669.80	1.0%	$ 2,056.70	$ 229,502.28	$ 370.00
August-2022	$ 12,245.00	$ (2,504.01)	$ 215,410.79	1.0%	$ 2,154.11	$ 241,397.37	$ 335.00
September-2022	$ 11,850.00	$ -	$ 227,260.79	1.0%	$ 2,272.61	$ 255,519.98	$ -
October-2022	$ 12,245.00	$ -	$ 239,505.79	1.0%	$ 2,395.06	$ 270,160.04	$ 440.00
November-2022	$ -	$ (120,015.01)	$ 119,490.78	1.0%	$ 1,194.91	$ 151,339.94	$ 60.00
December-2022	$ -	$ -	$ 119,490.78	1.0%	$ 1,194.91	$ 152,534.84	$ 270.00
January-2023	$ -	$ -	$ 119,490.78	1.0%	$ 1,194.91	$ 153,729.76	$ 200.00
February-2023	$ -	$ -	$ 119,490.78	1.0%	$ 1,194.91	$ 154,924.66	$ 150.00
March-2023	$ -	$ -	$ 119,490.78	1.0%	$ 1,194.91	$ 156,119.57	$ -
April-2023	$ -	$ -	$ 119,490.78	1.0%	$ 1,194.91	$ 157,314.48	$ 50.00
May-2023	$ -	$ -	$ 119,490.78	1.0%	$ 1,194.91	$ 158,509.38	$ 50.00
June-2023	$ -	$ -	$ 119,490.78	1.0%	$ 1,194.91	$ 159,704.29	$ -
Total	$ 337,436.00	$ (217,944.22)	$ 119,490.78	-	$ 40,213.51	$ 159,704.29	$ 2,066.00
	(A)	(B)			(C)		(D)

[A-B+C]: $ 159,704.29
Attorney's Fees: $ 2,066.00

Total outstanding balance plus accumulating interest and attorney's fees: TOTAL: $ 161,769.29

EXHIBIT C

[redacted]

Civil Case Information Statement

Case Details: HUNTERDON | Civil Part Docket# [redacted]

Case Caption: FOOTHILL ACRES REHAB ILITATION VS ESTATE OF [redacted]
Case Initiation Date: 06/28/2023
Attorney Name: MICHAEL S SIMONE
Firm Name: THE SIMONE LAW FIRM, PC
Address: 700 PROFESSIONAL PLAZA 700 RTE 130, STE 201
CINNAMINSON NJ 08077
Phone: 8568331788
Name of Party: PLAINTIFF : Foothill Acres Rehabilitation
Name of Defendant's Primary Insurance Company (if known): None

Case Type: CONTRACT/COMMERCIAL TRANSACTION
Document Type: Complaint
Jury Demand: NONE
Is this a professional malpractice case? NO
Related cases pending: NO
If yes, list docket numbers:
Do you anticipate adding any parties (arising out of same transaction or occurrence)? NO
Does this case involve claims related to COVID-19? NO

Are sexual abuse claims alleged by: Foothill Acres Rehabilitation ? NO

THE INFORMATION PROVIDED ON THIS FORM CANNOT BE INTRODUCED INTO EVIDENCE

CASE CHARACTERISTICS FOR PURPOSES OF DETERMINING IF CASE IS APPROPRIATE FOR MEDIATION

Do parties have a current, past, or recurrent relationship? NO

If yes, is that relationship:

Does the statute governing this case provide for payment of fees by the losing party? NO

Use this space to alert the court to any special case characteristics that may warrant individual management or accelerated disposition:

Do you or your client need any disability accommodations? NO
If yes, please identify the requested accommodation:

Will an interpreter be needed? NO
If yes, for what language:

Please check off each applicable category: Putative Class Action? NO **Title 59?** NO **Consumer Fraud?** NO

I certify that confidential personal identifiers have been redacted from documents now submitted to the court, and will be redacted from all documents submitted in the future in accordance with *Rule* 1:38-7(b)

06/28/2023
Dated

/s/ MICHAEL S SIMONE
Signed

[redacted]

New York

Admission Agreement: GreenField Health & Rehabilitation Center

GreenField
Health & Rehabilitation Center

ADMISSION AGREEMENT

between

GREENFIELD HEALTH AND REHABILITATION CENTER ("Facility") and

____and _____

("Resident") ("Resident Representative")

DATE OF ADMISSION: ___ _____

1. DEFINITIONS

a. **Charges:** The amount(s) owed to the Facility, which includes without limitation: (1) the Daily Room Charge, as set forth in Section 2(A) and itemized the Facility's Fee Schedule, (2) Physician and Other Services/Supplies, as set forth in Section 2(B), Personal Services/Items, as set forth in Section 2(C), Additional Charges, as set forth in Section 3(D), and, if the Resident is determined eligible to receive Medicaid benefits for chronic care, the Net Available Monthly Income or "NAMI," budgeted by the applicable Department of Social Services.

b. **Daily Room Charge:** The charge per day, which is itemized in the Facility's Fee Schedule, provided with Agreement, for the "Basic Services" identified in Section 2(A) provided to the Resident by the Facility. The Daily Room Charge may be adjusted by the Facility, on a semi-annual or annual basis.

c. **Resident Representative:** An individual executing this Agreement, who maintains legal access to the Resident's income, assets and insurance, and agrees to use their access to the Resident's income, assets and insurance in the performance of their duties outlined in this Agreement. A Resident Representative will, in most but not all cases, be one of the following:

i. The Resident's spouse;

ii. An individual designated by the Resident to act on their behalf, in order to support the Resident in decision-making, in accessing medical, social or other personal information of the Resident, in managing financial matters and maintaining access to the Resident's Funds, or receiving notifications; or

iii. A person authorized by state or federal law to act on behalf of the Resident in order to support the Resident in decision-making, in accessing medical, social or other personal information of the Resident, in managing financial matters and maintaining access to the Resident's Funds, or in receiving notifications, such as a court-appointed Guardian, an Agent Under Power of Attorney, a representative payee or other fiduciary, or a "legal representative" as defined in Section 712 of the Older Americans Act (42 USC 3058g[b][1][B][1][i]).

2. SERVICES PROVIDED BY FACILITY

a. Basic Services: The Facility will provide the following basic services included in the Daily Room Charge, which is itemized in the Facility's Fee Schedule:

i. Lodging – a clean, properly outfitted, healthful, sheltered environment;

ii. Board, including therapeutic/modified diets, as prescribed by a physician;

iii. 24-hour/day nursing care, health services and supervision as needed by the Resident;

iv. Use of all necessary equipment, medical supplies and modalities, notwithstanding the quantity usually used in the everyday care of nursing home residents, including, but not limited to catheters, hypodermic syringes and needles, irrigation outfits, dressings and pads, and so forth;

v. Fresh bed linen, as required, changed at least twice weekly, including sufficientquantities of necessary bed linen or appropriate substitutes changed as often as required for incontinent residents;

vi. Hospital gowns or pajamas as required by the clinical condition of the Resident, unless the Resident, or another person on the Resident's behalf, elects to furnishthem, and laundry services for these and other washable personal clothing items;

vii. General household stock medicine cabinet supplies, including but not limited to, non-prescription medications, materials for routine skin care, oral hygiene, care ofhair, and so forth, except when specific items that are medically indicated and prescribed for exceptional use for a specific Resident;

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

ix. Services in the daily performance of their assigned duties, by the appropriate members of the Facility Staff concerned with Resident care;

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

xi. Activities Program including but not limited to a planned schedule of recreational, motivational, social, pastoral and other activities, together with the necessary materials and supplies to make the Resident's life more meaningful;

xii. Social Services *and religious programs* as needed.

b. <u>Physician and Other Services/Supplies *Not* Included in Daily Room Charge:</u>
Physician's services and physician-ordered services and supplies will be arranged as necessary. These include, but are not limited to physical, occupational, speech and hearing therapies; and psychiatric, psychological, optometry, ophthalmology, podiatry, dental, transportation, pharmacy, laboratory; X-ray, and oxygen services. These servicesand supplies are <u>not</u> included in the Facility's Daily Room Charge and <u>may</u> be covered by the Resident's third-party payer(s) (i.e. Medicaid, Medicare, private insurance). Coverage for such services is determinedby the third-party payor and may be subject to deductibles and/or co-payments for which the Resident is responsible. All payment for these services, including applicable co-pays, are due and payable at the time of service.

c. Personal Services/Items *Not* Included in Daily Room Charge or by Insurance:
The following personal services and items are currently available to the Resident and are not included in the Daily Room Charge or covered by third-party payers. Such services anditems must be paid for by the Resident or charged against the Resident's personal account when the cost is incurred.

i. Barber/beauty services;

ii. Private telephone and TV (installation, maintenance, fees), unless specifically provided by the Facility at no additional charge;

iii. Newspapers, postage, stationery;

iv. Shoes, clothing and dry cleaning;

v. Some ambulance and special transportation for personal use.

d. Notwithstanding: Notwithstanding any other provision in this contract, the Facility remains responsible forensuring that any service provided pursuant to this contract complies with all pertinent provisions of Federal, State, and local statues, rules and regulations.

3. SERVICES PROVIDED BY FACILITY

a. Resident's Payment Obligations: The Resident agrees to pay the Facility, or have paid for by third-party payors, all Charges, which include the following.

i. Daily Room Charge (per the Facility's Fee Schedule),

ii. Physician and Other Service/Supply Charges (Section 2[B]), and

iii. Personal Service/Item Charges (Section 2[C]).

The Daily Room Charge and all other charges must be paid in advance, no later than three (3) days following receipt of the monthly account statement. The Resident agrees to pay all charges that are not paid for by third-party payors including insurance deductibles, co-payments, non-covered services and supplies, any "private room differential," and, if the Resident has been determined eligible to receive Medicaid, the Resident's Net Available Monthly Income or "NAMI," as budgeted by the local Department of Social Services.

The Resident further agrees to pay estimated "NAMI" while an application for Medicaid on behalf of the Resident is pending. In the event a paid estimated "NAMI" is greater than the "NAMI" budgeted by DSS, the Facility will refund the balance.

b. Resident's and Resident Representative's Obligations to Provide Payment:

i. The Resident Representative agrees to use their access to the Resident's income, assets and insurance to meet the Resident's payment obligations under this Agreement from the Resident's own income, assets, and insurance to the extent of the Resident Representative's access to and/or control over the Resident's income, assets and insurance. If the Resident Representative is the Resident's Spouse, they may also be independently obligated to pay for the Resident's care.

ii. The Resident and the Resident Representative agree(s):

1. To keep insurance premiums current, provide the Facility with all necessary authorization and insurance information to file claims for provided services, and notify Facility of changes in insurance, denials of insurance benefits or termination of coverage;

2. Should the Resident's care placement exceed the anticipated length of stay, the Resident and/or Resident Representative will provide the Facility all financial information and documentation which has not already been provided, as requested in the Facility's Confidential Data Application;

3. That all the financial and insurance information which they have provided to the Facility, including the Confidential Data Application, is represented and warranted to be true, accurate, and complete. The Facility has relied upon, and will continue to rely upon this information;

4. To use the Resident's assets and income solely for the Resident's benefit, and to safeguard such assets and income so as to ensure full and uninterrupted payment to the Facility;

5. To notify the Facility three (3) months prior to the date when the Resident's assets will approximate the Medicaid resource level;

6. To file a timely and complete Medicaid application with the appropriate county Department of Social Services (DSS), no later than three (3) months prior to the exhaustion of the Resident's assets, and promptly provide all requested information and documentation to DSS;

7. To authorize the Facility to have access to the Medicaid application and annual recertification files and supporting information and documentation, and to represent the Resident in the application and re-certification process, if necessary, by signing Addendum I;

8. To pay the Facility the Resident's Social Security check and other monthly income, less the Resident's personal needs allowance and applicable deductions as determined by DSS (the Resident's "NAMI") within three (3) days of which it was received, or arrange for its direct payment to the Facility

iii. Authorized Benefits/Secondary Benefits for Items or Services

1. The Resident and Resident Representative understand and agree that the Resident may be entitled to payment of authorized benefits or secondary benefits provided through the Centers for Medicare & Medicaid Services, medical or other insurances for items or services received by the Resident. The Resident, or Resident Representative on the Resident's behalf, specifically request the payment of authorized benefits or secondary benefits, for items or services received by the Resident, be made either to the Resident, or on the Resident's behalf, to such entity or entities as identified by the Facility.

   The Resident and Resident Representative specifically authorize any holder of medical information about the Resident, needed to determine such benefits payable for related items or services, to release such medical information to the Centers for Medicare & Medicaid Services, Ltd., or any medical or third-party insurer, for the purpose of determining the Resident's eligibility to receive authorized benefits or secondary benefits for items or services provided to the Resident.

c. Resident Rights: We will not require any Resident to waive their rights as set forth by Federal, State, or local licensing laws, including but not limited to their rights to Medicare or Medicaid. A statement of the Resident's Rights will be given to each Resident with a form for them to sign acknowledging their acceptance.

d. Additional Charges: The Facility will assess no additional charges in excess of the Daily Room Charge except

   i. Upon express approval of the Resident or Resident Representative;

   ii. Upon express written orders of the Resident's physician stipulating specific services and supplies not included in the Daily Room Charge;

   iii. Upon sixty (60) days written notice to Resident or Resident Representative of additional charges due to the increased cost of maintenance and/or operation of Facility;

   iv. In the event of a health emergency which requires immediate special services or supplies.

e. Interest, Collection Costs and Fees: In the case of the breach of any provision set forth in this Agreement or non-payment of any sum due under this Agreement, the Resident and Resident Representative agree to pay a service charge of 1.5% per month (18% per year) on accounts thirty (30) days overdue, and collection costs, reasonable attorney fees and damages incurred by the Facility for breach of their obligations as described in this Agreement and/or non-payment of any sum due under this Agreement.

f. Refunds: The Facility will refund any amount paid by or on behalf of the Resident in excess of the amount due for services rendered within a reasonable time after discharge. The Resident and Resident Representative understand and agree that, in the event of the Resident's death, the Facility will comply with all applicable laws and regulations governing refunds

4. DISCHARGE AND TRANSFER

a. Involuntary Discharge from Facility: The Facility has the right to transfer or discharge the Resident involuntarily afterappropriate notice due to the

   i. Health or safety of others is/will be endangered;

   ii. Resident's urgent medical needs necessitate an immediate transfer or

discharge;

iii. Resident's health has improved sufficiently, and the Resident no longer needs theFacility's services;

iv. Resident has failed to pay for or arrange for payment for services and supplies provided under this Agreement

If the Resident is a Medicaid recipient, non-payment occurs when the Resident and/or Resident Representative fail(s) to pay the Resident's monthly "NAMI" to the Facility, no denial of benefits is pending, or funds for payment are available and the Resident, or the Resident Representative, refuses to cooperate with the Facility in obtaining the funds.

b. Transfers within Facility: Residents may be transferred to another appropriate bed or room after prior notice to, consultation with, and reasonable accommodation to the Resident. The Resident and Resident Representative agree to cooperate with the Facility if such a move becomes necessary. We will provide written notice explaining the reason for transfer and effective date which will be provided to the Resident or Resident Representative. In addition, the Facility cannot guarantee continued stay in private rooms. If the Resident has occupied a private room, the Resident understands and agrees that when they no longer pay the private rate, they will move to a semi-private room as soon as one becomes available.

   In the event of a medical necessity, the Resident may be asked to move with little or no advance notice to accommodate the special needs of another Resident who may require a private room. Certain private rooms have been designated as "isolation rooms." The displaced Resident will be charged the rate for the room to which they have been moved. When the medical necessity is over, the displaced resident will be returned to their original room if available

c. Short-Term Rehabilitation/Sub-Acute Unit: The Facility has designated certain rooms as its Short-Term/Sub-Acute Unit. Placement in the Sub-Acute Unit is reserved for Residents requiring a Short-Term/Sub-Acute Program with the goal and expectation of discharge to home or other living accommodations, following Program completion. In the event that the Resident is unable to achieve the short-term goals within the anticipated time frame as established by the Facility's interdisciplinary care team, the Facility, at its sole discretion, reserves the right to immediately transfer the Resident to a non-Sub-Acute room.

5. RESIDENT'S PROPERTY

a. **Resident's Personal Account:** The Facility will hold the Resident's personal funds for incidental expenses if the Resident or Resident Representative executes a "Personal Account" authorization form. At the Resident or Representative's request, the Facility will deposit the Resident's funds, as identified by the Resident or Representative, in an interest-bearing account and provide an accounting statement to the Resident annually and upon request. Resident funds in amounts less than $50.00 will be maintained in a non-interest-bearing account. Upon discharge, the balance will be applied toward amounts owed to the Facility, and within thirty (30) days after discharge, be given to the Resident, or, if the Resident is deceased, within one-hundred and eighty (180) days, to the individual or probate jurisdiction administering the Resident's estate, or the New York State Comptroller.

b. **Resident's Personal Property:** The Facility has appropriate policies and procedures to provide for reasonable security of the Resident's personal property. However, the Facility will only be responsible for the Resident's

   i. Valuable items (such as jewelry and money) if they are deposited in the Facility's safe;

   ii. Other personal property included on an inventory list, if the Facility is proven to be at fault for loss or damage

The Resident may request to have a locked drawer in their room. Keys may be obtained upon request

c. **Disposition of Property:** The Resident or Resident Representative must promptly arrange for disposition of the Resident's tangible personal property upon the Resident's discharge or death. The Resident/Representative agrees that, within one-hundred and eighty (180) days thereafter, the Facility may deliver such property to the individual or probate jurisdiction administering the Resident's estate, the New York State Comptroller, or, in accordance with New York State Abandoned Property Law and State Finance Law, distribute or dispose of such tangible personal property that remains.

6. AUTHORIZATIONS

a. Consent to Treatment: The Resident and/or Resident Representative authorize(s) the Facility, its employees, and agents, to provide all skilled nursing facility services, including medical treatment, rehabilitative therapies,nursing, psycho-social/psychiatric support for treatment of the Resident's condition(s). The Facility will exercise reasonable care toward the Resident; however, there are some risks that are unavoidable in any skilled nursing facility and the Facility cannot ensure the complete safety and welfare of the Resident.

b. Physician Visits: The Resident and/or Resident Representative agree(s) that a physician may visit the Resident in the Facility whenever the Resident's medical condition warrants the medical attention, but not less than once within the first fourteen (14) days of admission and every thirty (30) days for the first ninety (90) days and every sixty (60) days thereafter. The Facility may arrange for another physician to see the Resident if the Resident's personal, alternate or staff physician is delinquent in visitation or is unable to see the Resident when medically necessary.

7. BED RESERVATION POLICY

a. Bed Reservation for Non-Medicaid residents: In the event that a private-paying (non-Medicaid) Resident, covered by Medicare or insurance, leaves the Facility due to hospitalization or leave-of-absence ("LOA"), the following will apply

i. The Facility will not reserve the Resident's bed while the Resident is absent from the Facility for temporary hospitalization, or on LOA, unless requested by the Resident or the Resident's Representative, within one-day of the Resident leaving the Facility;

ii. If the Resident or the Resident Representative requests the Resident's bed held while hospitalized or on LOA, the Facility will hold the Resident's bed, and which, during such time, the Daily Room Charge remains payable under this Agreement;

iii. After fourteen (14) days absent, any written request for an extension, which is within the sole discretion of the Facility to grant, the bed reservation is terminated and the resident will be discharged.

b. Bed Reservation for Medicaid residents: For Residents who are currently receiving Medical Assistance ("Medicaid"), the following will apply with respect to temporary hospitalization or LOA:

i. Unless the Medicaid-covered Resident is receiving Hospice services, the Facility will not reserve the Resident's bed while absent from the Facility for temporary hospitalization;

ii. If the Medicaid-covered Resident is receiving Hospice services, the Facility will automatically reserve the Resident's bed while absent from the Facility for temporary hospitalization, in accordance with New York State regulations. In such instance, the bed reservation may not exceed a maximum of fourteen (14) days within any twelve (12) month period;

iii. If the Medicaid-covered Resident leaves the Facility overnight to visit friends/relatives, or to participate in a medically acceptable therapeutic or rehabilitative plan of care, and only if the Resident's care plan provides for leaves of absence, the Facility will reserve the Resident's bed while LOA in accordance with New York State Regulations. The maximum reservation time may not exceed ten (10) days in a twelve (12) month period;

iv. If the Medicaid-covered Resident remains hospitalized or LOA in excess of the maximum reservation times as set forth above, he/she will be discharged from the Facility and his/her bed will be made available to someone else. The Facility will give priority readmission to the Resident for the next appropriate semi-private bed.

8. REINSTATEMENT OF THIS AGREEMENT AND ADDENDA

In the event the Resident is transferred to the hospital or another facility and returns to the facility within one-hundred and eighty (180) days of the date of transfer, the Resident and the undersigned agree that this Agreement, including all Addenda, and other documents provided to me/us at the time of admission and any revised information (including revised charges) provided to me/us after the initial admission, shall be reinstated and have full force and legal effect as of the date of the Resident's return to the facility

9. SIGNATURES

I/We, the undersigned, has read, and understands this Agreement, and agrees to be legally bound to its terms.

I/We have been given copies of the Facility's Fee Schedule, the Facility's New Resident/Family Admission Information Booklet, which includes the Resident's Bill of Rights, information on AdvanceDirectives, Suggestions, Rules and Regulations for Our Residents, and other documents.

I/We have also received a copy of the Facility's Notice of Privacy Information Practices, incompliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I/We have had an opportunity to discuss these documents with the Facility's staff, and agree to be legally bound to the rules and regulations described in these documents.

I/We certify that the information I/We have provided to the Facility is true, accurate and complete, and I/We agree to pay, on demand, all damages resulting from any misrepresentation of information provided to the Facility or failure to provide information requested by the Facility

ACCEPTED:

Signature/Mark of Resident Representative

Signature of POA or Resident

Print Name

Print Name

7-19-22

Date

Date

Address

Address

GREENFIELD HEALTH AND REHABILITATION CENTER

Signature of Facility of Representative

Admissions

Title of Representative

7-19-22

Print Name

Date

This Facility does not discriminate in admission or retention or care of its Residents because of race, creed,color, national origin, gender, disability, age, source of payment, marital status or sexual preference

Admission Agreement: Elderwood at Hamburg

EXHIBIT "D"

ADMISSION AGREEMENT

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

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

1. THE RESIDENT'S AGENTS

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

By signing this Agreement, however, the Responsible Party personally guarantees continuity of payment from the Resident's funds to which he/she has access or control and agrees to arrange for third-party payment if necessary, to meet the Resident's cost of care.

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

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

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

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

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

D. THE RESIDENT'S DIRECTION TO ALL AGENTS

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

2. SERVICES PROVIDED BY THE FACILITY

A. SERVICES INCLUDED UNDER THE DAILY BASIC RATE

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

B. SUBACUTE SERVICES

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

Discontinuance of Subacute Services. The Resident and the Undersigned have accepted and agreed to the initial discharge notice and the discharge plan at Addendum VII subject to

subsequent adjustments as the Resident's needs, choices and post-discharge options are better evaluated. They also agree to cooperate in securing adequate aftercare services, if needed. Upon discontinuance of subacute services, if the Resident is not discharged, he or she agrees to transfer to another room or unit after appropriate notice.

C. PHYSICIAN AND ANCILLARY SERVICES

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

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

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

Ancillary services are generally covered by Medicaid and Medicare Part A or Part B, but certain benefits may be subject to annual payment caps. Other third payors who have negotiated a rate with the Facility may cover all or some of these services but may require the use of plan participating physicians and providers. The resident is responsible to pay for benefits or services beyond the capped or covered amounts.

Participating Providers. To obtain full coverage from "managed" benefit plans, beneficiaries must use plan participating physicians and ancillary service providers. The Resident

agrees to use plan participating providers unless the Facility is notified to the contrary and agrees to pay privately for requested non-covered non-participating providers' services.

3. AGREEMENT TO PAY OR TO ARRANGE FOR PAYMENT

By entering this Agreement, the Resident, the Resident's Spouse and/or the Undersigned Agents on the Resident's behalf, understand and agree to the following Resident payment obligations. The Resident agrees to pay for, or arrange to have paid for by Medicaid, Medicare or other insurers, all services provided under this Agreement, and agrees to pay any required third-party deductibles, coinsurance or monthly income budgeted by the Medicaid program (called the "NAMI" amount). The Undersigned Agents accept the duty to ensure continuity of payment. This includes the duty to arrange for timely Medicaid coverage, if Medicaid coverage becomes necessary.

A. PRIVATE PAY STATUS

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

Specifically, the Resident agrees to pay, or arrange for payment of, (1) the daily basic rate of the room occupied: $449.00 (private room), or $438.00 (semi-private room) or $512.00; (2) physician and ancillary medical services as set forth above; (3) any applicable deductibles or coinsurance; (4) including New York State Cash Receipts Assessments, and (5) individual purchases and "extras" described below. Payment for all services is due by the *[1st]* of each month.

B. ITEMS/SERVICES NOT INCLUDED IN THE BASIC RATE

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

1. Barber/Beauty Parlor
2. Telephone
3. Television
4. Newspapers, sundries
5. Specially prepared catered or alternate meals apart from the regular meal service
6. Dry cleaning
7. Special transportation for personal use

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

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

C. PREPAID AMOUNTS AND SECURITY DEPOSITS

This section left blank intentionally.

D. ADDITIONAL CHARGES AND RATE INCREASES

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

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

E. DUTY TO PAY PRIVATE RATE UNTIL MEDICAID COVERED

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

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

F. THIRD PARTY COVERAGE

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

1. Assignment of Benefits.

The Resident, or the Undersigned Agents on the Resident's behalf, assigns the benefits due to the Resident to the Facility and requests the Facility to claim payment from Medicare or other insurance for covered services or supplies received during the Resident's stay at the Facility. The Resident authorizes release of information necessary for the Facility to claim and receive such

payments on the Resident's behalf. If separate assignment of benefits is required by the Resident's plan or program, it will be signed and attached to this Agreement at Addendum I.

The Facility accepts as payment in full daily rates it has negotiated with a Resident's insurer or managed health plan and, as applicable, the Medicaid, Medicare, or VA rate plus any deductibles, coinsurance or the Medicaid budgeted income payments. If the Facility has no agreement with the Resident's health insurance plan to accept a negotiated rate, the Resident agrees to pay any portion of or all of the applicable private rate and ancillary charges which the plan does not cover. All health plan benefits are assigned to the Facility.

2. **Managed Care and Insurance Benefit Denials.**

The Facility is authorized to provide skilled nursing services for certain managed care organizations ("MCOs"). A current list of the MCOs with which the Facility participates is available upon request. The Resident and/or the Responsible Party shall notify the Facility in writing prior to enrolling with a MCO or switching Resident's MCO enrollment. **Unless the Facility is authorized to participate with an MCO, the MCO will not cover the Facility's services.**

Actions of Managed Care Organizations and Insurers. Residents with coverage for all or part of the Facility's charges by a managed care plan or insurer understand that although the Facility relies on the plan's verification of eligibility, payment for covered services is not guaranteed. Coverage may be subject to specific preauthorization requirements, to modification by the plan, and to the plan's determination that recommended services continue to be or are "medically necessary" as well as covered. The Facility is not responsible for benefit denials by MCOs and insurers, and it makes no representations regarding the coverage decisions of any MCO or insurer with which the Facility participates. The Facility will, however, use its best efforts (1) to present information to support the medical necessity of recommended treatment; and (2) to notify the Resident and/or Responsible Party as soon as it is informed that coverage will cease or decrease.

Obligations of Resident. Medicare, MCOs and insurers pay in full only for those services and supplies that Medicare, MCO or insurer determines to be covered under the terms of the plan. Resident is responsible to pay any co-payments of $_____ or other costs assigned to Resident under the specific terms of his or her health benefit plan due by _____. Resident must also pay for any services or supplies which Medicare, MCO or insurer declines to cover under the specific terms of the Medicare or managed care plan. Such plans typically require pre-authorization of services. If Resident chooses to have services which the plan refuses to preauthorize, Resident shall be responsible to pay the Facility for those services. Resident shall pay the Facility in a timely manner for all non-covered services retroactive to the date of the initial delivery of services.

Withdrawal from Participation in the MCO. The Facility reserves the right to terminate its contractual relationship and its status as a network or authorized provider with one or more of the listed MCOs at any time in accordance with law and the terms of the applicable agreement. In the event that the Facility terminates its contractual relationship with the MCO in which Resident is enrolled, Resident may convert his or her coverage to a health plan for which the Facility is an

authorized provider or transfer to a facility that is an authorized provider for Resident's MCO. The Facility shall provide thirty (30) days advance notice of its decision to withdraw as a participating provider from Resident's MCO so as to enable Resident and the MCO to coordinate a transfer to another facility.

Notice of Change in Insurance Coverage. Resident and/or Responsible Party shall notify the Facility immediately of any change in Resident's insurance status or coverage made by the insurance carrier including, but not limited to, the insurance carrier's discontinuation of coverage for, or any decrease or increase in insurance benefits applicable to, the Resident. The Resident and/or Responsible Party shall notify the Facility before Resident is unable to meet Resident's insurance premium or before Resident implements an increase, decrease or termination from insurance coverage.

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

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

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

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

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

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

3. To assist with appeals of denials of payment; and

4. Upon request, to provide the Facility updated insurance information, including copies of the summary of benefits or policy riders or amendments.

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

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

3. **Medicare Part D Prescription Drug Benefits**

Enrollment in Medicare Part D Plan. If Resident is an eligible beneficiary under the Medicare Part D insurance program and has enrolled or has been enrolled in a Medicare Part D Prescription Drug or Medicare Advantage Plan ("PDP"), Resident shall, upon admission, provide Facility with written notification of Resident's chosen PDP. If Resident becomes an eligible beneficiary under Medicare Part D after admission, or subsequently chooses to enroll in a PDP following admission, Resident shall, prior to such enrollment, provide Facility with written notification of Resident's chosen PDP. If Resident elects to change PDPs, Resident shall advise Facility and shall, prior to the effective date of the change, provide Facility with written notification of such election, including the name/identity of the newly selected PDP.

Resident's Responsibility to Pay for Pharmaceuticals. Resident is responsible to pay the charges for all prescription and other drugs and medications while a resident is in the Facility, except to the extent that the drugs and medications are covered in whole or in part by an applicable government reimbursement program. Some or all of the charges for prescription and other drugs and medications may be covered by certain benefits available through Medicare Part D or other private insurance or governmental insurance/benefit programs, including Medicare Part A or B. If an applicable governmental reimbursement program or other potentially available third-party payor or insurance program denies coverage for any prescription drug, supply, medication or pharmaceutical provided to Resident, then Resident shall remain responsible to pay for all such prescription drugs, supplies, medications or pharmaceuticals.

Actions of Medicare Part D Plan. Facility is not responsible for and has made no representations regarding the actions or decisions of any PDP, including but not limited to, the establishment of the PDP formulary, denial of coverage issues, or contractual arrangements between the PDP and the Resident, or regarding any decisions by the PDP relating to any long term care pharmacy provider that may be under contract with Facility.

Dually Eligible Residents. If Resident becomes eligible for Medicaid at any time during Resident's stay at Facility, and also qualifies for benefits under Medicare, then Resident shall be required to enroll in a PDP to ensure coverage of Resident's prescription drug needs. Resident and/or Responsible Party shall take all necessary action to enroll Resident in a PDP and shall advise Facility of such enrollment upon Resident's acceptance into the PDP. Resident acknowledges that, in the event that the Resident and/or Responsible Party fails to select a PDP, then the federal Centers for Medicare and Medicaid Services ("CMS") will assign Resident to a PDP. In either event, Resident shall provide Facility with written notification of Resident's PDP and the effective date of enrollment.

Billing and Resident Cost-Sharing Obligations. To the extent that Resident is a beneficiary under Medicare Part D, and Medicare Part D covers the pharmacy prescriptions and/or services ordered by a physician, then the pharmaceutical provider (as required by law) shall bill

the charges for the covered services to the Resident's PDP. Resident is responsible for and shall pay any and all cost-sharing amounts applicable under the Medicare Part D program. Facility shall not be responsible to pay for any fees or cost-sharing amounts, including co-insurance and deductibles, relating to the provision of covered Medicare Part D pharmaceuticals to Resident. To the extent that Resident may qualify as a "subsidy eligible individual" who would be entitled to a reduction or elimination of some or all of the cost-sharing or premium amounts under the Medicare Part D benefit, Resident and/or Responsible Party has the sole responsibility to apply for such benefits.

Authorization to Request and/or Appeal Coverage Determinations. In the event that Resident is denied coverage under Resident's PDP for pharmaceutical services or supplies prescribed by Resident's attending physician, then the following shall apply:

1. Resident and/or Responsible Party may independently (i) request an exception from Resident's PDP to cover non-formulary or non-covered Medicare Part D drugs that are otherwise needed or required by Resident;

   (ii) file a request for a redetermination of any coverage denial issued by Resident's PDP; and/or (iii) file an appeal with the appropriate agency and judicial tribunals to challenge any denial of a request for redetermination.

2. In the event of Resident's incapacity, and if there is no other legal representative of Resident known to the facility or any other friend or relative available or willing to act timely on behalf of Resident, or if Resident's physician is unable or unwilling to act on behalf of Resident, then Resident authorizes Facility to (i) request an exception from Resident's PDP to cover non-formulary or non-covered Medicare Part D drugs that are otherwise needed or required by Resident; (ii) file a request for a redetermination of any coverage denial issued by Resident's PDP; (iii) file an appeal with the appropriate agency and judicial tribunals to challenge any denial of a request for redetermination.

3. If a request for exception (filed by Resident, Facility or any other authorized representative) is ultimately denied following either reconsideration by the PDP or appeal to an appropriate tribunal, and if the requested pharmaceuticals are deemed medically necessary by Resident's physician, and no reasonably acceptable substitute as determined by Facility's Medical Director from the formulary of Resident's PDP exists, then Facility shall make arrangements to provide the requested pharmaceuticals to Resident through an arrangement with an outside pharmacy. In such situation, Resident shall be responsible to pay all fees and costs for the non-covered pharmaceuticals, consistent with the requirements of this Section.

No Effect on Medicare Part A Covered Nursing Services. Resident's Medicare Part D prescription drug benefits do not apply while the Resident's stay in the Facility is covered under

Medicare Part A. While the Resident is in the Facility on a Medicare Part A stay, the Medicare Part A program generally covers Resident's pharmaceutical needs.

Non-Covered Services. Resident is and remains obligated to pay the Facility for services and supplies not covered by the Medicaid or Medicare programs.

G. DUTY TO ARRANGE FOR TIMELY MEDICAID APPLICATION

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

Release of Medicaid Information to the Facility. To facilitate the Medicaid application and annual recertification, the Facility requests access to the Resident's Department of Social Services ("DSS") Medicaid application and recertification file. This authorization, to take effect now or only if this Agreement cannot be met without such authorization, is at Addendum III.

Authorization to Act on Resident's Behalf. The Facility requests the authority to file and participate in an appeal of a Medicaid denial if it deems appropriate and if the Resident or Undersigned are unable or unavailable to appeal. The resident/responsible party/spouse or financial agent has provided authorization for Facility participation in an appeal with a separate letter to the local Department of Social Services. The Undersigned agree to cooperate in any such appeal and to provide timely financial and other required documentation.

Authorization to File Medicaid Hardship Waiver. The Facility requests authority, in its discretion, to apply for a hardship waiver in the event that the Resident is deemed ineligible for Medicaid due to a transfer of assets for less than fair market value within the time period prescribed by law. Authorization for the Facility to file an undue hardship waiver application is at Addendum IX. The Undersigned agree to cooperate in any such application and to provide timely financial and other required documentation.

H. MONTHLY INCOME PAYMENTS UNDER MEDICAID

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

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

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

A. TIMELY PAYMENT FROM RESIDENT'S FUNDS

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

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

Payment of Medicaid NAMIs. If Medicaid eligibility is established, the Undersigned Agents either (i) *personally agree to* pay the Resident's monthly NAMI or (ii) agree to arrange to have such income deposited directly with the Facility pursuant to Addendum II and II-A.

B. TRANSFERS OF ASSETS

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

C. MEDICAID OBLIGATIONS

The Undersigned Agents *personally agree* to cooperate in obtaining timely and continued Medicaid coverage as follows:

1. By timely filing the Resident's Medicaid application to ensure uninterrupted payments to the Facility and by notifying the Facility of the filing date;

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

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

5. LATE PAYMENTS AND NONPAYMENT

A. LATE CHARGES, COLLECTION COSTS, AND ATTORNEY FEES

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

B. DISCHARGE FOR NONPAYMENT

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

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

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

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

6. RETENTION AND DISCHARGE

A. This section left blank intentionally.

B. INVOLUNTARY DISCHARGE

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

and the Resident, or the Undersigned with access to or control over the NAMI, refuses to pay the NAMI.

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

1. when the interdisciplinary care team, in consultation with the Resident or the Resident's Designated Representative determines that the transfer or discharge is necessary for the Resident's welfare and the Resident's needs cannot be met after reasonable attempts at accommodation in the facility;

2. because the Resident's health has improved, and he/she no longer needs nursing facility services;

3. if the health or safety of individuals in the facility would otherwise be endangered, the risk to others is more than theoretical and all reasonable alternatives to transfer or discharge have been explored and have failed to safely address the problem; or

4. the Facility closes.

7. CONSENTS

A. ROUTINE SERVICES

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

B. PHYSICIAN VISITS

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

C. IDENTIFIABLE HEALTH INFORMATION

Subject to specific federal or state law limitations, the Facility may use and disclose the Resident's personally identifiable health, insurance and financial information for treatment, payment and health care operations, or as permitted or required by law.

D. RESIDENT PHOTOGRAPH

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

E. ROOM TRANSFERS

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

F. CONSENT FOR PARTICIPATION IN THE NURSE AIDE TRAINING PROGRAM

Residents may be asked to participate in the Nurse Aide Training Program for training and testing of Nurse Aide Trainees. Residents will receive an explanation of the program, including the use of trainees to provide care and the process for selecting residents to participate in the training program.

Residents will also be informed of the following at the beginning of any Nurse Aide Training Program (NATP) held at the facility. Residents of the facility can choose to participate or not participate in the NATP, there will be no adverse repercussions.

8. TEMPORARY ABSENCES AND BED RESERVATIONS

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

9. PERSONAL PROPERTY

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

10. RESIDENT PERSONAL ACCOUNTS

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

Refunds for the balance in the personal account, less amounts owed to the Facility, will be made to the Resident after discharge. Following a Resident's death, refunds will be made to the person or probate jurisdiction administering the Resident's estate or by a New York "small estate" affidavit unless the funds are otherwise properly claimed by DSS to recoup Medicaid payments.

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

11. FACILITY RULES

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

12. GENERAL PROVISIONS ABOUT THE AGREEMENT

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

DURATION. This Agreement remains in effect upon readmission to the Facility after a hospitalization or temporary absence.

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

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

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

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

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

WE THE RESIDENT AND UNDERSIGNED HAVE READ, BEEN ADVISED OF, UNDERSTAND AND AGREE TO BE LEGALLY BOUND BY THE TERMS AND CONDITIONS OF THIS AGREEMENT. WE ALSO CERTIFY TO RECEIVING THE FOLLOWING.

- Physician Contact Information
- "Your Rights As a Nursing Home Resident" including:
  - ~Statement of Residents' Rights
  - ~New York State Department of Health "Hot Line" Telephone Number
  - ~AIM's Ombudsman Program Telephone Number
- Bill of Rights for Residents – Policies and Procedures
- Emergency Medical Care - Facility Policy on Advanced Directives
- Facts About Health Care for Residents - Facility Rules and Regulations
- Information about Medicaid and Medicare Eligibility
- Explanation of the Effect of Transfer of Asset(s) on Medical Assistance Eligibility
- Statement on the Minimum Data Set
- The Notice of Privacy Practices

Accepted on 1 / 21 / 21

_____

Signature (or mark) of Resident

Print Name

Signature (or mark) of Responsible Party

Print Name

EXHIBIT A:
BASIC SERVICES INCLUDED UNDER THE DAILY RATE

1. Lodging;
2. Board, including therapeutic or modified diets as prescribed by a physician; Kosher food will be provided upon request of the patient who, as a matter of religious belief, wishes to follow Jewish dietary laws;
3. Twenty-four hour per day nursing care;
4. Fresh bed linens;
5. Hospital gowns or pajamas as required by the clinical condition of the Resident, unless the Resident, next of kin and/or sponsor elects to furnish them, and regular non-dry-cleaning laundry services for these and other launderable personal clothing items;
6. General household medicine cabinet supplies, including, but not limited to, non-prescription medications, material for routine skin care, oral hygiene, care of hair, and so forth, except for specific items that are medically indicated and needed for exceptional use for a specific resident;
7. Assistance and/or supervision when required with activities of daily living, including, but not limited to, toileting, bathing, feeding and ambulation assistance;
8. Services of members of the Facility staff performing their daily assigned patient care duties;
9. The use of customarily stocked equipment, including, but not limited to, crutches, walkers, wheelchairs, or other supportive equipment, and training in their use when necessary, unless such item is prescribed by a physician for the regular and sole use by a specific resident;
10. The use of all equipment, medical supplies and modalities, notwithstanding the quantity usually used in the everyday care of the Resident including, but not limited to catheters, hypodermic syringes and needles, irrigation outfits, dressings and pads, and so forth;
11. An activities program, including, but not limited to, a planned schedule for recreational, motivational, social and other activities, together with the necessary materials and supplies to make the Resident's life more meaningful;
12. Social services as needed.

EXHIBIT B:
BED RESERVATIONS FOR TEMPORARY ABSENCES

PRIVATELY PAYING AND MEDICARE PART A COVERED RESIDENTS.

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

BED RESERVATIONS FOR MEDICAID-COVERED RESIDENTS.

A bed reservation for the temporary hospitalization of a resident who is receiving Medicaid will be automatically in effect for up to fourteen (14) days in a twelve (12) month period after discharge to the hospital provided that:

1. the Resident has lived in the Facility for a minimum of thirty (30) days; and
2. the Facility occupancy rate is over 95% on the day of transfer to the hospital.

If the Medicaid-sponsored Resident takes leave of absence overnight for other than hospitalization, Medicaid will pay to hold the bed for up to ten (10) days in any twelve (12) month period if, provided that:

1. on the day of the Resident's departure, the Facility has more than a 95% occupancy rate.
2. The Resident has been in the facility at least thirty (30) days; and
3. The leave of absence is deemed appropriate and therapeutic by the attending physician and documented accordingly as part of the resident's medically acceptable therapeutic or rehabilitative plan of care

The NAMI income/amount continues to be due and owing during the hospital or therapeutic leave bed-hold period.

The bed reservation will be cancelled and expire if:

1. The Resident or responsible party cancels the bed reservation;
2. The resident requires hospitalization beyond the bed reservation, or exceeds the therapeutic leave, day limits set by Medicaid; or
3. The Resident expires while in the hospital.

If a Resident receiving Medicaid does not qualify for a reserved bed, or if the limit on reserve days is exceeded, or if the bed reservation expires or is cancelled, the Resident will be discharged and the Facility will release the bed. The Resident will be readmitted to the Facility into their prior room, if it is still available, or immediately into the first available bed in a semi-private room, if provided the Resident: (a) requires the services provided by the Facility; and (b) is eligible for Medicaid nursing home services.

BED RESERVATION THROUGH THE VETERANS ADMINISTRATION

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

ADDENDUM I:
ASSIGNMENT OF BENEFITS
TO

RESIDENT:
INSURANCE ID:
MEDICARE NO.:
MEDICAID NO.: _____

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

DATE: 12/1/21

_____
Resident

_____
Legal Authorization or Designation

ADDENDUM II:
AGREEMENT TO ARRANGE DIRECT PAYMENT OF MONTHLY INCOME TO THE FACILITY

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

I hereby agree to have direct payment of the Resident's monthly income checks to Elderwood at Hamburg to apply the amount owed to the Facility with any remainder deposited in the Resident's personal account.

_____ _____
Resident Date

_____ _____
Sponsor (Spouse) Date

_____ _____
Responsible Party Date

ADDENDUM II-A:
AGREEMENT TO CHANGE THE RESIDENT'S ADDRESS

Date: _____

To: _____

Address: _____

_____

_____

Re: _____

Dear Representative;

Please re-direct my monthly income check to be mailed to my current address as listed below:

Address: _____

_____

_____

Please complete this change of address effective immediately.

Thank you for your assistance.

Sincerely,

ADDENDUM III:
AUTHORIZATION FOR RELEASE OF INFORMATION BY
[redacted]CIAL SERVICES

Individu _____ Date of Birth [redacted]

I hereby [redacted]able health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a heath plan, health care provider or clearinghouse, the released information may no longer be protected by federal privacy regulations, except that a recipient may be prohibited from redisclosing alcohol and drug related information under federal substance abuse confidentiality requirements. State law governs the release of confidential HIV related information and you may request a list of persons authorized to re-release such information.

Persons/organizations providing the information: _____

Persons/organizations receiving the information: _____

1. Describe information to be released: _____

   From: _____

   To: _____

I consent to the release of confidential HIV related information and alcohol and drug abuse information unless a box is checked.

☐ Do not disclose confidential HIV related information. ☐ Do not disclose drug and alcohol information

I consent in the future to the release of protected health information based upon my verbal authorization unless the box is checked. My telephone number is _____ (optional).

☐ Do not disclose without my written authorization.

2. Purpose of the use / disclosure: _____

3. Will the person/program requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing health information described above? Yes ☐ No ☐

4. I understand that my health care and the payments for my health care will not be affected if I do not sign this form except in some situations when information is needed for payment, enrollment, etc.

5. I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it.

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6. I herby authorize the Department of Social Services to accept the written authorization of the following person or agency to act as my authorized personal representative in matters concerning the use or disclosure of my protected health information, including my application or re-application for financial or medical assistance.

7. I may revoke this authorization at any time by writing to the local HIPAA Privacy Officer, but if I do it will not have any affect on my actions they took before they received the revocation:
This authorization will expire on _____ or when the following event occurs _____.

_____ _____
Signature of individual or personal representative Date

Print name of individual's personal representative: _____

Relationship to the individual: _____

HIV/AIDS specific information:
For questions/complaints regarding HIV/AIDS discrimination, call New York State Division of Human Rights at (212) 480-2493. I do not have to check the confidential HIV related information box and I can change my mind at any time by indicating my change in writing.

Federally protected alcohol and drug abuse information:
I understand that my records are protected under the federal regulations governing confidentiality of alcohol and drug abuse patient records; 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has already been taken based upon it.

This form must be witnessed by a Department of Social Services
Employee or Notary Public

Social Services Employee: _____ _____ _____
Print Name Signature DSS Phone #

STATE OF NEW YORK):
):
COUNTY OF _____):

On the _____ day of _____ , 20____ , before me the undersigned, a notary public in and for said state, personally appeared _____ personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her capacity and that by his/her signature on the instrument, the individual or the person on behalf of which the individual acted, executed the instrument.

_____
Notary Public

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ADDENDUM V:
ASSIGNMENT OF DEPOSIT BALANCES

Definition of Account

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

Security Interest and Facility's Rights in Accounts

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

No Rights of Others in the Account

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

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

Dated: _____, 20__

_____ Signature of Resident or Resident's Agent

_____ Witness

Account #

ADDENDUM VI:
INANCIAL AGENT'S PERSONAL AGREEMENT

Γ d at Hamburg ("the Facility"), located at 5775 Maelou

ive
residir

for the benefit of and [redacted] ("the "Resident") pursuant to the attached Admission Agreement between the Facility and the Resident and/or the Sponsor and/or the Responsible Party (the "Admission Agreement").

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

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

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

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

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

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

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

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

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

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

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

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

1-21-21
Date

Name of Financial Agent

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

1-21-21
Date

Elderwood at Hamburg [Facility Name]

[Name and Title]

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

ADDENDUM VII:
SUBACUTE DISCHARGE PLAN AND NOTICE OF DISCHARGE

The Patient (also kn
admitted for subacute care, i

Discharge will be to

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

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

DATED: _____

_____
Patient's Name

ADDENDUM VIII:
EXTERNAL APPEAL OF MEDICAL NECESSITY DENIALS DESIGNATION AND AUTHORIZATION

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

appoint Elderwood at Hamburg ("Facility"), located at 3775 Maelen Drive Hamburg, NY 14075, by its Administrator to be my designee and authorized representative to act on my behalf and to take all reasonable actions, as determined by the Facility, to pursue payment from my Health Plan and/or to pursue any appeals available to me under my Health Plan's policies or procedures and/or under applicable law, including but not limited to external appeals of coverage denials or limitations based on lack of medical necessity. The Facility will not charge me for pursuing these appeals. In pursuing such payment and/or appeals:

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

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

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

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

IN WITNESS WHEREOF, I ha)21,

Admission Agreement: Beechwood Homes

EXHIBIT A

SHORT STAY ADMISSION AGREEMENT

between
Beechwood Health Care Center, Inc., d/b/a
BEECHWOOD HOMES (the "Home")

NOT MY DESIGNATED REPRESENTATIVE

_____ and _____
("Resident") ("Designated Representative")

The Home admits the Resident as of 6/30/2021, the effective date of this Agreement, subject to the following terms and conditions. The Resident and the Designated Representative understand and agree that this Agreement governs the Resident's anticipated short term stay at Beechwood's Wesley Rehabilitation Center or for Respite. If the Resident wishes to stay longer than his/her anticipated short stay, the Resident and the Designated Representative agree that the Resident will have to apply for long term placement by completing and submitting: 1) an Application for Admission; 2) a Financial Disclosure Form; and 3) a Long Term Admission Agreement. Beechwood's acceptance of the Resident for long term placement will depend on the submission of these documents, the Resident's needs, and the availability of a bed.

1. SERVICES PROVIDED BY THE HOME

A. Basic Services and Supplies Included in the Daily Rate

The Home will provide the following services to the Resident:

1. Room and board;
2. 24-hours per day nursing care;
3. Assistance and/or supervision when required with daily living activities;
4. Services of the Home's resident care staff;
5. Social work services as needed;
6. Activities program;
7. Use of customarily stocked equipment, unless such item is prescribed by a physician for the exclusive use by the Resident;
8. Use of standard equipment, medical supplies and modalities;
9. General household medicine cabinet supplies;
10. Hospital gowns or pajamas and other commercially launderable personal clothing items;
11. Housekeeping services and clean bed linens as needed;
12. Dental services, as appropriate;
13. Pastoral care services; and
14. Basic cable and internet access.

B. Special Services

The following services and supplies are called "Special Services" and they are not included in the Daily Rate. They may be covered by Medicaid, Medicare or other insurance (except for any co-payments and deductibles). If they are not covered by Medicaid, Medicare or other insurance, the Resident and Designated Representative are responsible for payment of all charges incurred from the Resident's income and resources.

1. Physician, P.A. or N.P. services	8. Speech therapy service/supplies
2. Podiatry services	9. Physical therapy services/supplies
3. Radiology services	10. Occupational services/supplies
4. Laboratory services	11. Audiology services
5. Electrocardiograms	12. Prescription medications
6. Respiratory therapy services/supplies	13. Transportation
7. Ophthalmology services	

C. Personal Services/Items Not Included in Daily Rate

The Home can arrange for additional personal amenities such as beautician and barber services, gift shop purchases and newspapers.

2. RESIDENT'S AND DESIGNATED REPRESENTATIVE'S PAYMENT OBLIGATIONS

A. Duty to Pay All Charges

The Resident and Designated Representative agree to pay all charges incurred under the terms of this Agreement from the Resident's income and resources, or arrange to have all charges paid for by Medicaid, Medicare or other insurance. This payment obligation includes payment of insurance deductibles, co-pays and any amounts not covered by insurance.

B. Designated Representative's Personal and Independent Obligations

In consideration of the fact that the Designated Representative cannot otherwise provide adequate nursing care to the Resident and wishes to facilitate the Resident's admission to the Home, the Designated Representative personally and independently guarantees continuity of payment from the Resident's income and resources to which he/she has access and/or control and also agrees to arrange for payment of the Home's charges from Medicare, Medicaid or other insurance to meet the cost of the Resident's care.

The Designated Representative agrees to pay damages resulting from a breach of his/her personal and independent promises to the Home. The foregoing shall not be construed to be a personal guaranty by the Designated Representative of the Resident's obligation to pay for the room, board or services provided except to the extent that such obligation arises as a result of a breach of the Designated Representative's personal agreements set forth in this Agreement.

C. Duty to Pay Health Insurance and Provide Information to Home

The Resident and/or Designated Representative shall maintain the Resident's health insurance by paying the insurance premiums, providing the Home with the necessary authorization and information to file claims for payment of the Home's services, and notifying the Home of any changes in insurance, denials of insurance claims, and terminations of coverage.

D. Duty to Not Transfer Resident's Money or Assets

If the Designated Representative has received a gratuitous transfer of money or assets from the Resident (or has assisted or participated in the gratuitous transfer of money or assets from the Resident to a third party) which causes the Resident: (a) to be disqualified from Medicaid or (b) to be unable to pay the Home for its services to the Resident, the Designated Representative

agrees to use any such transferred money or assets from the Resident or an amount equal to the amount of the transferred money or assets to pay the Home.

E. Additional Charges and Refunds

1. The Home reserves the right to charge a finance fee each month on any balance due over 30 days from the billing date. This charge does not apply to any amounts due from insurance.
2. The Resident and Designated Representative shall pay all costs, including reasonable attorney's fees and collection costs, incurred by the Home in order to collect any sum owed to the Home under the terms of this Agreement.
3. The Home will not assess any charges in addition to those described in this Agreement except as permitted by law.
4. Refunds due for overpayment of charges will be made within fourteen (14) days following verification of the overpayment.

3. RESIDENT'S AND DESIGNATED REPRESENTATIVE'S OTHER OBLIGATIONS.

A. Compliance with the Home's Rules and Regulations

The Resident and Designated Representative agree:

1. To notify the Home of any change in the Designated Representative's contact information (phone number(s), home, work, email addresses).
2. To abide by the Home's rules and regulations and the Resident Bill of Rights and comply with reasonable requests of the Home's Administrator or other authorized persons.
3. To deposit money and/or items of value in the Home's safe. The Home shall not be responsible for any disappearance or loss of any money, valuables or other property retained by the Resident unless the Home is determined to be at fault.

B. Care and Treatment Obligations

The Resident and Designated Representative agree:

1. To designate a personal physician who is on the Home's medical staff.
2. To report unexpected changes in Resident's condition to the nursing staff and/or Resident's physician.
3. To participate in the Resident's care plan and proposed treatment including prescribed rehabilitation therapy.
4. To utilize the Home's designated pharmacy for all medications, unless alternate arrangements are approved in advance by the Home.

C. **Consent for Treatment**

Subject to the Resident's right to refuse specific medical treatment, the Resident and/or Designated Representative consent to the receipt of routine skilled nursing home services, medical assessments, and comprehensive Medicare assessments. The Resident and the Designated Representative will sign a consent for the release of Resident's Protected Health Information for purposes of treatment, payment and health care operations. The Home will exercise reasonable care toward Resident, however, there are some risks that are unavoidable in any skilled nursing home and the Home cannot insure the complete safety and welfare of Resident.

4. ADMISSION AND RETENTION STANDARDS

The Home shall accept and retain only those residents for whom it can provide adequate care. The Home also affirms that all persons seeking admission to the Home and all residents of the Home are entitled to services without regard to age, race, creed, color, national origin, sex, blindness, disability, sponsor, marital status, sexual preference or religion. The Resident and the Designated Representative agree that the Resident's photograph may be taken for identification purposes, treatment purposes as is medically necessary, and for submission to the Resident's insurance if required.

5. TRANSFER AND/OR DISCHARGE FROM THE HOME

This Agreement does not guarantee a particular length of stay. The Resident and Designated Representative agree that the Resident has been admitted for a short term stay, and the Resident will leave when discharged by the Home at the conclusion of the short term stay. In addition, the Home has the right to transfer or discharge Resident under certain circumstances. In the event of a proposed involuntary discharge, the Home will provide the Resident and/or the Designated Representative with a copy of the Resident's legal rights.

A. Transfer and/or Discharge

The Resident and Designated Representative agree:

1. The Home may make arrangements for the Resident's transfer to an appropriate and safe location after appropriate notice for the following reasons:
   a. A transfer or discharge is necessary for the Resident's welfare and the Resident's needs cannot be met in the Home;
   b. A transfer or discharge is appropriate because the Resident's health status has improved sufficiently so that the Resident no longer requires the short stay services;
   c. A transfer or discharge is necessary because the health or safety of others is or will be endangered;
   d. The Resident and/or Designated Representative has/have failed to pay for or to arrange for timely payment of services and supplies provided by the Home under this Agreement; or
   e. The Home closes.

2. Prior to discharge, whether voluntary or involuntary, the Resident and/or Designated Representative must make arrangements with the Home for payment of any amounts due to the Home for the care, services and supplies provided to the Resident.

B. Temporary Absences and Bed Reservations

The Resident and Designated Representative agree that the Home's Bed Reservation Policy was provided to him/her upon admission.

WE, THE RESIDENT AND THE UNDERSIGNED, HAVE READ, UNDERSTAND AND AGREE TO BE LEGALLY BOUND BY THE TERMS AND CONDITIONS OF THIS AGREEMENT.

Jennifer Gelormini
Business Office Rep.

Susan M. Terrance

Resident's Signature

Business Office Signature

X Date

Date

The Designated Representative agrees to abide by the terms of this Agreement and to notify the Home if he/she becomes aware of a change in his/her status as the Designated Representative. Addendum "A" of this Agreement may be used to appoint (or change) the Designated Representative.

Jennifer Gelormini
Business Office Rep.

Business Office Signature

Date

NOT MY DESIGNATED REPRESENTATIVE

FOR OFFICE USE ONLY

Received for the HOME by Jennifer Gelormini on 1

Date

Paperwork completed with _____ on _____

Date

BB421-0213-1

BEECHWOOD HOMES
ADDENDUM "A" TO ADMISSION AGREEMENT

ve

RESIDENT'S NA ____

1. I appoir _____

(Phone) _____

to act as my representative for the purpose of conducting my personal and business affairs at BEECHWOOD HOMES ("Home"). If I have a Health Care Proxy, health care decisions will be made by my Health Care Proxy if I am unable to make such decisions for myself.

This appointment supersedes all prior appointments of Designated Representatives, if any, at the Home.

☒ I do not wish to appoint a representative.

2. If it becomes necessary for me to apply for assistance under the Medicaid program, I authorize the release of any necessary information to support my Medicaid application and/or appeal. In the event that I am unable to apply for Medicaid and/or proceed with an appeal, I will notify the facility business office immediately.

3. The statements below are to be confirmed in writing upon admission/readmission to the Home by the Resident or the Representative appointed above.

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act (Medicare) is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

✖ Admission ☐ Readmission

Date Resident Signature or Designative Representative

BEECHWOOD HOMES

ADDENDUM "B" TO ADMISSION AGREEMENT

(Personal Funds Account for Beauty/Barbour Shop, Guest Meals, Gift Shop, Etc.)

RESIDENT'S NAME: _____ ADMISSION DATE: _____

BEECHWOOD HOMES ("Home") will hold monies in a segregated fund so that you may have money available for incidental expenses. These funds will be held in a collective account, bearing the current rate of interest based on the end of the month balance. A monthly statement will be issued. This Addendum will be kept at the Home's business office at 2235 Millersport Highway, Getzville, NY.

Disbursements to any person other than you or your Designated Representative will be made only when valid receipts for authorized expenditures are presented to the Home which identifies the items purchased for you, charges, and dates of purchase. The Home reserves the right to deduct charges made on your behalf from your Personal Funds Account. Under certain circumstances, payments from this account may be at the discretion of and only with written authorization by the County Department of Social Services and/or Surrogates Court. The Home also reserves the right to defer expenditures and/or refunds pending written authorization from the County Department of Social Services and/or Surrogate's Court.

Select one of the following options:

* Must sign with selection "I Authorize" if short-term resident wishes to make an appt. with the Beauty/Barber Shop

✓ I authorize the Home to receive and hold my personal funds.

_____ I do not authorize the Home to receive and hold by personal funds.

In addition to myself, I am designating this (these) person(s) to act for me in expending funds from my Personal Funds Account:

_____ _____

I request the Monthly Statement regarding my Personal Funds Account to be sent to:

Name: _____

Address: _____

X 7/__/2021 X _____

Date Resident/Designated Representative's Signature

THIS ADDENDUM MAY NOT BE ADDED TO OR ALTERED. THE ADDENDUM BEARING THE MOST CURRENT DATE SHALL BE CONSIDERED PART OF THE ADMISSION AGREEMENT. FOR OFFICE USE ONLY

This Addendum: (Check one)

✓ is the first "Addendum B" signed

_____ supersedes the previous "Addendum B" signed: _____
Date

Received for the Home by: Admission Clerk – Susan Terranova on 7/7/2021
Date

BB313-0213

BEECHWOOD HOMES
ADDENDUM "C"
TO ADMISSION AGREEMENT

INSTRUCTIONS: Beginning with Item A1, answer each question in sequence. Comply with any instructions which follow an answer you have checked. If the instructions direct you to go to another item, answer in sequence each question under the new item.

ITEM A:

1. Is the illness/injury relating to admission due to an accident/car accident?
   _____yes; **GO TO A2** / _x_____no; **GO TO ITEM B**

2. **What type of accident caused this illness/injury?**
   _____**automobile; Insurer's Name:** _____
   STOP: AUTO INSURER IS PRIMARY PAYOR
   _____other; **specify:**_____

3. Was another party responsible for this accident?
   _____If YES, state Responsible Liability Insurer on back of this form.

2. Is this Resident (or Resident's spouse) employed?
   _____yes _____no; **STOP: MEDICARE IS PRIMARY PAYOR**
3. Is this Resident covered by (Resident's spouse's) Employer Group Health Plan?
   _____yes; PLAN NAME_____
   STOP: EMPLOYER GROUP HEALTH PLAN IS PRIMARY PAYOR
   _____NO; **STOP: MEDICARE IS PRIMARY PAYOR**

ITEM D:

1. Is this claim for End Stage Renal Disease services?
   _____yes; _____no; **STOP: MEDICARE IS PRIMARY PAYOR**
2. Is the Resident covered by an Employer Group Health Plan?
   _____yes; _____no; **STOP: MEDICARE IS PRIMARY PAYOR**
3. Is this the first End Stage Renal Disease claim filed by this Resident?
   _____yes; **STOP: EMPLOYER GROUP HEALTH PLAN IS PRIMARY PAYOR** _____no
4. Has the Resident completed the coordination period for this spell of illness?
   _____yes; **STOP:** RE RY R _____)

ON D E Γ.

X_____121
D e

Resider

Numbe

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Privacy Notice 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 organization reserves the right to change their notice and practices and prior to implementations will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

X _____ X 7/7/2021

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Susan M. Turnbull 7/7/2021

ess e

BB777-0611

Internal Use Only
Beechwood Homes

BB421-0213-1

Admission Agreement: East Neck Nursing and Rehabilitation Center

DocuSign Envelope ID: [redacted]

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 March 18, 2019, between **EAST NECK NURSING AND REHABILITATION CENTER**, located at 134 Great East Neck Road, West Babylon, New York 11704 (hereinafter "Facility") and [redacted] (hereinafter referred to as "Resident"), whose residence is located at [redacted] and [redacted] (hereinafter "Designated Representative") residing at [redacted] and [redacted] Resident's spouse (hereinafter "Sponsor", if not listed as "Designated Representative") residing at [redacted].

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 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, 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, 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, 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.

DS [redacted]

DocuSign Envelope ID: [redacted]

The Resident, Designated Representative and 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).

X Sub-Acute Care*: [Check one of the following: _____ Medically Complex X 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, 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, Designated Representative and/or Sponsor understand and agree to the payment obligations set forth herein:

(a) Obligation of Resident, 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

[redacted]

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(s) of the Resident, shall be required to execute the Financial Agent Agreement attached as Exhibit 2.

(b) Anticipated Payor

The Resident, 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 X 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. 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, Designated Representative and/or Sponsor to apply for third party coverage, it is ultimately the responsibility of the Resident, 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 **$555.00 per day** for a semi-private room and **$565.00 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, personal telephone 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 the Sponsor fail to make payments within thirty (30) days of the date payment is due, the Resident, Designated Representative and/or Sponsor shall pay (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.

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

DocuSign Envelope ID [redacted]

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 as discussed more fully below.

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, the Designated Representative and/or the 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.

(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, Designated Representative and/or Sponsor 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 search the Resident's room and confiscate any necessary materials which would cause harm to the Resident or anyone else within the Facility.

(h) Phone Service

The Facility provides free phone service to local area codes for the first 120 days of care in the Facility. Thereafter, the Resident may choose to continue the service and pay $15.00 per month prior to the start of the 5th day of the month. Such fees will be automatically deducted out of the Resident's personal account or billed separately by the Finance Department at the beginning of each month.

(i) 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.

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(j) 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 may be placed in any appropriate bed available in the Facility at the time of his or her return from hospitalization or therapeutic leave.

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:

1. Notifying the Admission Department by telephone;
2. Signing a bed guarantee letter with the Admission Department stating their intent to hold a bed at the Facility's private pay rate; and/or
3. Continuing payment at the private pay rate.

Private Pay Residents may also authorize a bed hold (if the Resident is hospitalized) in advance for a period of at least three (3) days by signing below:

_____ I wish to have the Facility retain my/the Resident's bed for a period of three (3) days if hospitalized. By initialing this section, I have agreed to ensure prompt payment, from my/the Resident's funds, of the Facility's private pay daily rate for the three-day bed hold period.

_____ I do not wish to authorize the Facility at this time to retain my/the Resident's bed if hospitalized. However, should hospitalization be required, I will be consulted at that time as to whether or not I would choose to hold the bed.

(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: The Facility will allow residents who are Medicaid beneficiaries and have been residing in the Facility for at least thirty (30) days up to a maximum of ten (10) days bed reservation during any twelve (12) month period when they are on a pre-approved Therapeutic Leave.

Medicaid recipients who do not meet the 30-day residency requirement, or whose bed-hold has expired or has been terminated, may elect to secure the same bed in the Facility by:

1. Notifying the Admission Department by telephone 631-422-4800; and
2. Signing a bed guarantee letter with the Admission Department stating their intent to hold a bed at the Facility's private pay rate.

If the Resident, Designated Representative and/or Sponsor do not choose to hold the bed privately, a Medicaid

Resident on Therapeutic Leave will be given priority for re-admission when an appropriate bed becomes available, unless there are special circumstances which would preclude a Resident's return.

Please Note: Medicaid Residents who are not entitled Therapeutic Leave and who choose to leave the Facility (i.e., family member chooses to take resident home for the weekend/holiday) may only secure their bed by following the Private Pay bed hold procedure stated above and paying the Facility at the Private Pay rate. Without any such private pay arrangements, Medicaid Recipients will be re-admitted to the Facility to their previous room only if available or immediately upon the first availability of a bed in a semi-private room provided that the resident continues to require the services provided by the Facility and is eligible for Medicaid nursing home services.

(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.

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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 and/or Sponsor may purchase items on behalf of the Resident and be reimbursed upon presentation of adequate documentation to the Facility's Finance Department.)

X. SMOKING POLICY

The Facility is committed to maintaining a smoke-free environment. The Resident agrees that under no circumstances will he/she and/or his/her visitors smoke anywhere on the grounds or in the buildings of the Facility. Smoking is only allowed in designated areas outside of the Facility. Smoking and/or the use of spark producing devices is strictly prohibited in all other areas of the Facility. The Resident agrees to comply with the Facility's smoking 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.

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.

DS [redacted]

(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, which the parties may elect as applicable to this Agreement. 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 contains the entire understanding between the Resident, the 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

[redacted]

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.

OS [redacted]

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

1. Schedule of Coverage and Fees for Ancillary Services
2. Medicare and Medicaid Eligibility Information
3. Welcome Booklet & Resident Information Guide; Statement of Resident's Rights and Facility Responsibilities
4. Policies and Procedures for Residents
5. 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)
6. 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)
7. Statement Regarding the Use of the Medicare Minimum Data Set (MDS) and the Privacy Act of 1974
8. Notice of Privacy Practices for Protected Health Information
9. HIPAA Authorization Form
10. Medicare Signature on File 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.

Resident refused to sign agreement.

ACCEPTED AND AGREED:

Date	Signature of RESIDENT*	Print Name
		[redacted]
3/19/2019		
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
3/19/2019	DocuSigned by: [redacted]	[redacted]
Date	Signature of SPONSOR	Print Name

EAST NECK NURSING AND REHABILITATION CENTER

Date	Signature of FACILITY'S REPRESENTATIVE	Print Name and Title
3/19/2019	DocuSigned by: Alyssa Myhre	

DS [redacted]

I agree, and it is my intent, to sign this record/document and affirmation by electronically signing and by electronically submitting this record/document to the East Neck Nursing and Rehabilitation Center. I understand that my signing and submitting this document in this fashion is the legal equivalent of having placed my handwritten signature on the submitted record/document and this affirmation. I understand and agree that by electronically signing and submitting this record/document in this fashion I am affirming the truth of the information contained therein.

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Medicare Assignment of Benefits Form
Signature on File (SOF)

Date: 3/19/2019

Name of Resident [redacted] Date of Admission March 18, 2019

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:
DocuSigned by:
Alyssa Myhre
3423DD2F81A4429

RESIDENT/DESIGNATED REP/SPONSOR:
DocuSigned by:
[redacted]
1C41C15ZAB5445A...

DS
[redacted]

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EXHIBIT 1 - BINDING ARBITRATION AGREEMENT

The parties (the "Parties") to this binding arbitration agreement (the "Arbitration Agreement") are also some or all of the parties to the admission agreement (the "Admission Agreement") for the Resident designated below at the nursing facility operated by EAST NECK NURSING AND REHABILITATION CENTER (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 Responsible Party (as those Parties are indicated below) (or their respective successors, assigns 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, allegations by Resident of neglect, abuse or negligence, or allegations by the Facility for monies owed, shall be submitted to binding arbitration in accordance with the Commercial Arbitration Rules of the American Arbitration Association then in effect. The arbitration shall take place in Suffolk County, New York. The arbitrator shall have the authority to issue any appropriate relief, including interlocutory and final injunctive relief, including interlocutory and final injunctive relief. 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. Each Party shall undertake to keep confidential all awards and orders in the arbitration, as well as all information and materials in the arbitration proceedings not otherwise in the public domain, unless disclosure is required by law or is necessary for the enforcement of a Party's legal rights. While an arbitration proceeding is ongoing, the Facility, Resident and Responsible Party shall continue to perform their respective obligations under the Admission Agreement for so long as the Resident resides at the Facility.

The Resident and the Responsible Party have the right to opt out of this agreement to arbitrate by providing written notice of his or her intention to do so to the Facility within thirty (30) days of the execution of the Arbitration Agreement by the Resident and the Responsible Party.

ACCEPTED AND AGREED:

Date	Signature of RESIDENT*	Print Name
3/19/2019		[redacted]
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.

3/19/2019		[redacted]
Date	Signature of DESIGNATED REPRESENTATIVE	Print Name
Date	Signature of SPONSOR	Print Name

EAST NECK NURSING AND REHABILITATION CENTER

3/19/2019		
Date	Signature of FACILITY'S REPRESENTATIVE	Print Name and Title

DocuSign Envelope ID: [redacted]

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 March 18, 2019 between EAST NECK NURSING AND REHABILITATION CENTER (hereinafter referred to as the "Facility") and [redacted] (hereinafter referred to as the "Financial Agent,") residing at [redacted], concerning the admission of [redacted] (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 Responsible Party 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

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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, and insurance information and documentation, 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.

DocuSigned by: [redacted]
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SIGNATURE OF FINANCIAL AGENT — DATE: 3/19/2019

[redacted] — PRINT NAME

Daughter — 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)

DocuSigned by: Alyssa Mybre
3425D22F81A4428...

SIGNATURE OF FACILITY REPRESENTATIVE — DATE: 3/19/2019

PRINT NAME — TITLE

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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.

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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 2019 are $170.50 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 2019:

- Annual Medicare Part B Deductible is $185.00.
- 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 $2,040 per year (including co-insurance)
- Physical and speech therapy benefits (combined) are capped at a total of $2,040 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.

DS [redacted]

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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.

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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 2019, the Medicare Part A co-insurance amount is $170.50 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.

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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 2019, there is a $185.00 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 2019, the indexed amounts for physical therapy (including speech-language pathology services) and occupational therapy are $2,040.00 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.

Complaint & Admission Agreement: Warren Manor

STATE OF NEW YORK
SUPREME COURT COUNTY OF CHAUTAUQUA

HCF OF WARREN, INC. d/b/a WARREN MANOR	:	SUMMONS
Plaintiff	:	Index No: _____
v.	:	
Defendants.	:	

TO THE ABOVE NAMED DEFENDANTS:

YOU ARE HEREBY SUMMONED to answer the Complaint in the above entitled action and to serve a copy of your Answer on the plaintiff's attorney within twenty (20) days of the service of this Summons, exclusive of the day of service, or within thirty (30) days after service of the same is complete where service is made in any manner other than by personal delivery within the State. The United States of America, if designated as a defendant in this action, may answer or appear within sixty (60) days of service. In case of your failure to appear or answer, judgment will be taken against you by default for the relief demanded in the Complaint.

CHAUTAUQUA County is designated as the place of trial. The basis of venue is the residence of the defendants.

Date: 6/30/22

By: _____

Adam Fleischer, Esquire
482 Main St.
Harleysville, PA 19438
NY Address: 11 Broadway
Suite 615
New York, NY 10004
(717) 233-7100 ext. 106
Attorneys for Warren Manor

STATE OF NEW YORK
SUPREME COURT COUNTY OF CHAUTAUQUA

HCF OF WARREN, INC. d/b/a WARREN MANOR	:	VERIFIED COMPLAINT
	:	Index No: _____
Plaintiff.	:	
v.	:	
	:	
	:	
Defendant.	:	

Plaintiff, HCF of Warren, Inc. d/b/a Warren Manor ("Warren Manor" or "Plaintiff"), by and through its attorneys, Kennedy, PC Law Offices, files the within Complaint against Defendant, and in support thereof provides as follows:

1. Plaintiff is a skilled nursing facility located at 682 Pleasant Drive, Warren, PA 16365.

2.

3. is an adult individual currently residing at

4. an Admission Agreement ("Agreement") with Warren Manor with regard to at Warren Manor. (Plaintiff's counsel attaches a copy of the Admission Agreement as Exhibit "A".)

5. Under the Admission Agreement, agreed to the following conditions:

a. "Duty of Representative on Behalf of Resident. During the term of his/her residency, the Resident may need assistance in arranging for the payment for the

services provided. You have asserted to the Manor that the Representative shall act in a fiduciary capacity on the Resident's behalf to satisfy the Resident's financial obligations under this Agreement if the Resident chooses not to, or is unable to, meet those obligations. (Agreement, Exhibit C at C2)

b. "Legal Authority to Access Resident's Funds... You have asserted that the Representative has legal access to and control over the Resident's income, assets, personal and real property, and resources... You agree that if any of these Resources transfer by operation of law while the Resident still has outstanding debts to the Facility and such transfer causes the Resident's remaining resources to be insufficient to pay the debt in full, then the Representative agrees to be personally responsible for the remaining debt to the Facility.

c. "Diversion of Resident's Resources... The Representative understands and agrees that the misappropriation, theft, use or redirection of those Resources so that the Resident's financial obligations under this Agreement are not met is a violation of this Agreement. If any Resources are withheld, used for personal use, or otherwise not liquidated and provided to the Facility in order to satisfy the Resident's financial obligations under this Agreement, then the Representative agrees to pay those amounts due to the Facility from the Representative's own resources (including, but not limited to, the Representative's income, assets, real and personal property).

d. "Cooperation in Medicaid Process. The Representative shall cooperate fully in any application, redetermination or appeals process related to Medicaid eligibility. The Representative agrees to pay from his/her own resources any unpaid charges due to the Facility as a result of the Representative's failure to cooperate in Medicaid eligibility or redetermination process, or appeals thereto. "Failure to cooperate" shall include, but is not limited to, failing to provide documentation to the Medicaid agency in the time frames defined by law or as indicated by the relevant representative of the Medicaid agency.

6. did not use all of resources to fully pay Warren Manor for the cost of services Warren Manor provided to him.

7. The total outstanding balance owed to Warren Manor for the goods and services Warren Manor provided to s $10,049.00.

Count One

Breach of Contract

8. Plaintiff incorporates its averments in paragraphs 1 through 7 by reference in this count as if those paragraphs were included in this count.

9. Under the Admission Agreement, agreed to obtain access to resources and to fully and promptly pay Warren Manor from resources.

10. may have breached the Admission Agreement by failing to fully use resources to pay Warren Manor for the costs of the goods and services that Warren Manor's representatives provided t

11. Under the Admission Agreement also agreed, if she breached the Admission Agreement, to pay Warren Manor's collection costs including attorney fees and costs.

12. Warren Manor hired Kennedy, P.C. Law Offices to collect payment and to prepare and file this Complaint.

13. has not paid Warren Manor's collection costs including attorney fees and costs.

14. As a result of breaches of the Admission Agreement, Warren Manor suffered damages.

WHEREFORE, in addition to any other relief that this Honorable Court may deem appropriate, Warren Manor requests the Court Orde to pay Warren Manor the lesser of $ 10,049.00. In addition, if the Court finds breached the Admission Agreement, Warren Manor requests the Court Order to pay Warren Manor's collection costs including attorney fees and costs collectible under the Admission Agreement.

Respectfully Submitted,

Date: 6/30/22 By: _____

Adam Fleischer, Esquire
482 Main St.
Harleysville, PA 19438
NY Address: 11 Broadway
Suite 615
New York, NY 10004
(717) 233-7100 ext. 106
Attorneys for Warren Manor

STATE OF NEW YORK
SUPREME COURT COUNTY OF CHAUTAUQUA

HCF OF WARREN, INC. d/b/a WARREN MANOR	:	VERIFICATION
	:	Index No: _____
Plaintiff.	:	
v.	:	
	:	
Defendant.	:	

I, Jodi Bennett, am the Business Ofc Sup. of HCF of Warren, Inc. d/b/a Warren Manor, Plaintiff in the herein action. As such, I am familiar with the within action, have read the annexed Verified Complaint and know the contents thereof to be true to the best of my knowledge, except those matters therein which are stated to be alleged on information and belief, and as to those matters, I believe them to be true. My belief as to those matters stated to be alleged on information and belief is based upon the following: correspondence, memoranda and statements of account in my possession.

Jodi Bennett
HCF of Warren, Inc. d/b/a
Warren Manor

Exhibit A

Warren Manor

Consent to Treat & Admission Agreement

This Consent to Treat & Admission Agreement is made and entered into this day of Jan 17, 2018, by and between HCF of Warren, Inc. dba Warren Manor (the "Facility"), _____ ("Resident"), and the Representative(s) whose names appear below. Hereinafter, when capitalized, the term "You" and "Your" shall refer jointly and severally to the Resident and the Representative.

In consideration of the mutual promises contained in this Agreement, Resident, Representative, and the Facility hereby agree as follows:

1. **Services.** The Facility will provide room, board, laundry, housekeeping, social, activities and general nursing services as required by law ("Basic Services") to the Resident. In addition to the Basic Services, the Facility will provide additional non-routine services and supplies ("Additional Services") in accordance with the orders of a prescribing professional and/or upon Your request or consent.

2. **Exhibits.** You agree to abide by all of the terms and conditions of the following exhibits, which are hereby incorporated into this Agreement by reference: Exhibit A - Potential for Discharge & Personal Guarantee of Payment; Exhibit B - Financial Terms; Exhibit C - Representative Authority & Duties; Exhibit D - General Terms; and the Fee Schedule.

YOU HAVE READ ALL OF THE TERMS OF THIS AGREEMENT, INCLUDING THE EXHIBITS, AND YOU HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS REGARDING THOSE TERMS. YOU UNDERSTAND THAT YOU HAVE THE RIGHT TO SEEK LEGAL COUNSEL REGARDING THIS AGREEMENT.

YOU DO FOR YOURSELF, AND YOUR HEIRS, ADMINISTRATORS AND EXECUTORS, AGREE TO THE TERMS OF THIS AGREEMENT IN CONSIDERATION OF THE FACILITY'S ACCEPTANCE OF AND RENDERING SERVICES TO THE RESIDENT.

The parties, intending to be legally bound, have signed this Agreement as of the date first above written.

RESIDENT

_____
Signature

_____
Printed Name

REPRESENTATIVE

_____
Signature

_____
Printed Name

HCF OF WARREN, INC.

_____

_____

REPRESENTATIVE

_____
Signature

_____
Printed Name

EXHIBIT A
Potential for Discharge & Personal Guarantee of Payment

The Facility cannot continue to provide services without payment. If the Facility is not paid timely and in full by someone, then it will seek to discharge the Resident.

Many people wish to make sure that care and services to their loved ones are not terminated when the resident does not have the resources to pay for care. This could happen, for example, if third party payment (Medicare, Medicaid, Insurance) were to be temporarily interrupted, delayed, or not approved. Thus, we provide the opportunity for Representatives to make payments on the Resident's behalf.

If the Representative would like to protect the Resident from being discharged for non-payment by agreeing to pay on their behalf if it becomes necessary, then he/she should initial "yes" below.

If the Representative does not wish to protect the Resident from being discharged for non-payment by agreeing to pay on their behalf if it becomes necessary, then he/she should initial "no" below.

BY INITIALING "YES", THE REPRESENTATIVE IS AGREEING TO VOLUNTARILY PERSONALLY GUARANTEE PAYMENT TO THE FACILITY, BE JOINTLY AND SEVERALLY LIABLE FOR ALL SERVICES AND SUPPLIES RECEIVED BY THE RESIDENT, AND TO MAKE ALL PAYMENTS WHEN THEY COME DUE. THE REPRESENTATIVE UNDERSTANDS THAT HE OR SHE IS NOT REQUIRED BY LAW OR THE FACILITY TO PERSONALLY GUARANTEE PAYMENT. THE REPRESENTATIVE AGREES THAT THIS GUARANTEE WILL CONTINUE UNTIL ALL FINANCIAL OBLIGATIONS TO THE FACILITY HAVE BEEN PAID IN FULL.

Please initial below.

Representative **Yes** _____ **No** _____

Representative **Yes** _____ **No** _____

EXHIBIT B
Financial Terms

B1. **Duty to Pay.** You agree to pay all charges and fees that are billed to You by the Facility when they become due. Except as specifically provided otherwise in the Agreement or as agreed to by Representative, all financial obligations in this Agreement are the Resident's and payment obligations refer to payments from the Resident's resources.

B2. **Rates.** You will be charged the Basic Rate for the Basic Services. The Basic Rate may be adjusted by the Facility at any time upon sixty (60) days' advance written notice to You. Current charges for Additional Services are available to You in the Fee Schedule. In addition, if the Resident's payment source changes at any time during the Resident's stay at the Facility, the Facility's fees and charges to be paid by You may be adjusted immediately to reflect the charges for that payment source. This Agreement covers all sources of payment for the Resident's care and shall remain in effect even after the source of payment for the Resident's care changes.

B3. **Billing to Governmental Payers.** As a service to You, the Facility will accept payment from a governmental payer, such as Medicare or Medicaid. However, unless specifically prohibited under applicable law, the Resident remains responsible for any charges that are not paid for by a governmental payer at the Facility's then-current rates.

B4. **Billing to Health Insurance Plans.** The Facility will bill the Resident's health insurance plan as a service to You. Unless otherwise agreed upon between the Facility and the Resident's health insurance plan: You agree to pay the Facility its private pay rate if the plan does not agree to pay the Facility directly; and You also agree to pay the Facility directly and in full upon receipt of an invoice if the Resident's insurance plan does not pay the Facility within forty-five (45) days of billing.

B5. **Late Charges & Collection.** *Private Pay*: You must pay the Basic Rate no later than the last business day of the month prior to which services are to be received and any amounts due for Additional Services within thirty (30) days of the date of invoice. *Medicaid/Medicaid Pending*: You must pay all resources/income no later than the fifth (5th) day of each month that services are received and any amounts due for Additional Services within thirty (30) days of the date of invoice. If any charge or fee is not paid on the date that such payment is due, You agree to pay interest to be calculated at the rate of one and one-half percent (1.5%) of the unpaid balance per month, effective as of the date the balance was originally due until the date the balance is paid in full. In addition, if the Facility retains the services of a collection agency or an attorney to obtain the payment of amounts due under this Agreement, the Facility shall be entitled to recover from You all collection agency and attorney's fees, court costs and other collection expenses. You authorize the Facility to release information about the Resident's residency, the services provided and any debts owed to a law firm or collection agency in attempting to collect amounts due and not paid. Furthermore, the Facility or its agents may use the telephone numbers (including cell phone numbers) or email addresses You have provided to the Facility or its affiliates for debt collection calls or messages (including autodialed or prerecorded debt collection calls) in the event You do not pay amounts due; Your consent to this provision is not a condition of receiving services from the Facility.

B6. **Deposit & Refund.** Deposits for private pay residents are due at the time of admission and will be based on the Basic Rate. The deposit amount will include the number of days in the current month as well as the number of days for the following month. If the Facility determines that an overpayment has occurred, the Facility shall refund the overpaid amount to the Resident, or if the Resident is deceased, to his or her estate within sixty (60) days.

B7. **Disputed Debts.** If You disagree with a charge, You must notify the Administrator in writing of any dispute, and provide reasons and evidence of why You believe the charge is incorrect, within thirty (30) days after receipt of the first invoice that includes the disputed charge. If You do not submit such a written notification, then all charges shall be deemed accurate and any dispute will be deemed waived. All communications concerning disputed debts, including an instrument tendered as full satisfaction of a debt, are to be sent directly to the Administrator of the Facility in writing.

EXHIBIT C
Representative Authority & Duties

C1. **Representative as Resident's Agent.** The Resident gives permission to the Representative to sign any and all documents that are part of the admission process to the Facility on the Resident's behalf as his or her agent. The Resident agrees that in signing on his or her behalf, the Representative binds the Resident to all duties imposed by such documents as if the Resident had signed them himself or herself, including, but not limited to, the duty to pay the Facility for services rendered.

C2. **Duty of Representative on Behalf of Resident.** During the term of his/her residency, the Resident may need assistance in arranging for payment for the services provided. You have asserted to the Facility that the Representative shall act in a fiduciary capacity on the Resident's behalf to satisfy the Resident's financial obligations under this Agreement.

C3. **Legal Authority to Access Resident's Funds.** You have asserted that the Representative has legal access to and control over the Resident's income, assets, personal and real property, and resources, including, but not limited to, social security, pension or retirement funds, annuities, insurance, bank accounts, and mutual funds (collectively, "Resources"); and You understand that the Facility is entering into this Agreement in reliance on that assertion. You agree that all such Resources shall be considered the Resident's Resources for purposes of this Agreement. You agree that if any of these Resources transfer by operation of law while the Resident still has outstanding debts to the Facility and such transfer causes the Resident's remaining resources to be insufficient to pay the debt in full, then the Representative agrees to be personally responsible for the remaining debt to the Facility. You agree that if You have misrepresented the Representative's legal authority to control the Resident's Resources or to enter into this Agreement on behalf of the Resident, or if the Representative has misrepresented any information to the Facility as part of the admission process, then the Representative agrees to be personally liable for all of the Resident's responsibilities in this Agreement.

C4. **Limitation on Legal Authority to Act on Behalf of Resident.** You hereby certify that no one else has financial access or control over the Resident's Resources, and that You will not grant any other person or entity access or control over said Resources (with the exception of the Facility) during the term of this Agreement, unless such other person or entity first becomes a party to this Agreement.

C5. **Diversion of Resident's Resources.** The Representative agrees to be a good financial steward of all of the Resident's Resources. The Representative understands and agrees that the misappropriation, theft, use or redirection of those Resources so that the Resident's financial obligations under this Agreement are not met is a violation of this Agreement. If any Resources are withheld, used for personal use, or otherwise not liquidated and provided to the Facility in order to satisfy the Resident's financial obligations under this Agreement, then the Representative agrees to pay those amounts due to the Facility from the Representative's own resources (including, but not limited to, the Representative's income, assets, real and personal property).

C6. **Cooperation in Medicaid Process.** The Representative shall cooperate fully in any application, redetermination or appeals process related to Medicaid eligibility. The Representative agrees to pay from his/her own resources any unpaid charges due to the Facility as a result of the Representative's failure to cooperate in the Medicaid eligibility or redetermination process, or appeals thereto. "Failure to cooperate" shall include, but is not limited to, failing to provide documentation to the Medicaid agency in the time frames defined by law or as indicated by the relevant representative of the Medicaid agency.

EXHIBIT D
General Terms & Conditions

D1. **Obligation to Keep the Facility Informed.** You have the responsibility of keeping the Facility informed of any changes in the Resident's health condition or financial status. You will inform the Facility immediately if: (a) the Resident's assets reach a value of $20,000 or less due to a transfer any property, money or stock to another person or entity or similar transaction; (b) a decision has been made to have the Resident switch or join insurance companies or managed care programs; or (c) if the Resident is currently having services paid for by Medicaid, the Resident inherits any property or money, or receives property or money as a gift. You agree to be personally responsible for any payments not made to the Facility timely based on your failure to notify the facility per this section. You agree to provide the Facility with an accurate financial disclosure of the Resident's income, resources and liabilities in a format requested or approved by the Facility upon request by the Facility.

D2. **Term & Termination.** This Agreement shall continue until it is terminated by You or the Facility. You may terminate this Agreement at any time; however, the Facility requests that You provide it with at least three (3) days advance notice so that it can conduct proper discharge planning. This Agreement shall automatically terminate upon the death of the Resident. This Agreement may be terminated by the Facility upon any of the following events, subject to State and Federal transfer and discharge provisions: (a) the Resident's welfare and the resident's needs cannot be met in the facility; (b) the Resident's health has improved sufficiently so the Resident no longer needs the services provided by the facility; (c) the safety of individuals in the facility is endangered due to the clinical or behavioral status of the Resident; (d) the health of individuals in the facility would otherwise be endangered; (e) the facility ceases to operate; (f) the resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Non-payment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the Resident refuses to pay for his or her stay; (g) the Resident is a beneficiary under the Medicare program and the Facility's participation in the Medicare is involuntarily terminated or denied; or (h) the Resident is a beneficiary under the Medicaid program and the Facility's participation in the Medicaid program is involuntarily terminated or denied.

You agree that all accrued charges and fees must be paid prior to the effective date of termination or, if later, on the date You receive a final bill. Your duty to pay for all items and services billed by the Facility shall survive the termination of the Agreement.

After the Agreement is terminated, You agree that You will ensure that the Resident moves out of the Facility. This includes moving out of the Facility by the date specified in the discharge notice in the event of an involuntary discharge. If the Resident does not move out of the Facility by the termination date, then You agree to pay the Facility a per diem rate equal to two times the Facility's then-current private pay rate for all days that the Resident remains in the Facility after termination of the Agreement. You agree to pay all of the Facility's expenses, including attorney's fees and court costs, for any legal action commenced by the Facility to enforce its rights to discharge or otherwise remove the Resident from the Facility.

D3. **Authorization for Care.** Unless You otherwise explicitly refuse a particular treatment, the Resident's admission to the Facility shall constitute Your authorization and consent to the provision of all care and services provided in the Facility.

D4. **Rules & Policies.** You agree to abide by all of the Facility's rules, policies and procedures, including, but not limited to, those contained in the Admission Authorizations, Receipts of Documents, Information Regarding Payment & Rights, and Skilled Nursing Facility Resident Handbook as may be amended from time-to-time in the Facility's sole discretion.

D5. **Waiver.** The failure of the Facility in any one or more instances, to insist upon strict compliance by You with, or its waiver of any breach of, any of the terms or provisions of this Agreement, shall not be construed to be a waiver by the Facility of its rights to insist upon strict compliance by You with all of the terms and provisions of this Agreement.

D6. **Partial Illegality.** If any portion of this Agreement is determined to be illegal or not in conformity with applicable laws and regulations, such part shall be deemed to be modified so as to be in accordance with such laws and regulations, and the validity of the balance of this Agreement shall not be affected. This Agreement shall be construed in accordance with the laws of the State of Pennsylvania.

D7. **Complete Agreement; Amendments.** The Facility is not liable for, nor bound in any manner by, any statements, representations or promises made by any person representing or purporting to represent the Facility, unless such statements, representations or promises are set forth in writing and made a part of this Agreement. Modification of this Agreement may be made only by agreement of both/all the parties in writing; provided, however, the Facility reserves the right to amend the Agreement at any time in order to conform to changes in Federal, State, or local laws or regulations that require modifying the Agreement. The Facility will notify You of its intent to make any such modification at least thirty (30) days prior to making the modification.

D8. **Assignment.** No assignment of this Agreement or the rights and obligations hereunder shall be valid without the specific written consent of both parties hereto, provided, however, that this Agreement may be assigned by the Facility or the Organization to any successor entity operating it, and such assignment shall forever release the Facility hereunder.

D9. **Representation of Accuracy.** You represent that the information contained on the application forms, financial statements, this Agreement, and the Resident's health history are true to the best of Your knowledge and belief. You understand that the Facility has relied upon such information in agreeing to admit the Resident to the Facility.

D10. **Incorporation of Other Documents.** The following documents are hereby incorporated into this Agreement by reference: all attached rate schedules and all of the Facility's policies governing the Resident's responsibilities, as may be amended from time-to-time by the Facility in its sole discretion; all application forms, financial statements, and medical records provided to the Facility as part of the Resident's application for admission to the Facility; and all documents that You signed or received during the admission process to the Facility.

D11. **Headings.** The headings contained in this Agreement are for reference purposes only and shall not affect in any way the meaning or interpretation of this Agreement.

Submit by Email

Agreement to Appoint Facility as Authorized Representative: Autumn View Health Care Facility

RESIDENT NAME:

AUTUMN VIEW HEALTH CARE FACILITY

WE THE RESIDENT AND UNDERSIGNED HAVE READ, BEEN ADVISED OF, UNDERSTAND AND AGREE TO BE LEGALLY BOUND BY THE TERMS AND CONDITIONS OF THIS AGREEMENT. WE ALSO CERTIFY, THAT ANY INFORMATION CONTAINED IN THE COMPLETED ADMISSION APPLICATION IS TRUE, ACCURATE AND CURRENT; AND TO RECEIVING THE FOLLOWING:

- Admission Agreement
- Information About Medicaid and Medicare Eligibility
- Discharge Time Policy
- Beauty Shop Rates
- Administration / Department Head Listing
- Veterans Administration Information
- Side Rail Educational Pamphlet
- Immunization Information
- Health Care Proxy Information
- Patient/Resident Handbook
- Discharge Agreement (as appropriate)
- Safe Food Handling Practices Educational Information

ACCEPTED/EFFECTIVE ON 2-23-21 **(DATE OF ADMISSION)**

RESPONSIBLE PARTY

2/23/21

The McGuire Group and its facilities do not discriminate in the admission, retention or care given to residents/patients in terms of age, race, creed, color, national origin, gender, gender identity, marital status, sexual preferences, handicap, blindness, disability or sponsor.

APPOINTMENT OF AUTHORIZED REPRESENTATIVE

KNOW ALL MEN BY THESE PRESENTS th _____ **appoint THE MCGUIRE GROUP ERICA ECKENRODE, AMANDA MILEWICZ, TAYLOR ALIANELLO , KATHY WILL, BLAIR EDHOLM and/or KATHRYN NIEDBALSKI** as agents of **THE MCGUIRE GROUP** to act as my true and lawful representative, and in my name, place and stead. I do hereby authorize the aforesaid to do any and all acts you may deem appropriate for the purpose of filing an application for medical assistance (Medicaid) with the Department of Social Services for

_____ _____ **(Resident's Name).**

Youare authorized to sign and file all documents, forms and correspondence that you deem necessary in order to secure the benefits set forth above.

You are hereby authorized to be instituted on my behalf, Administrative Hearings and Judicial Review, where you deem appropriate, pertaining to any determination or lack of proper or timely determination by a Federal, State, or County agency or entity, arising out of my application or continuing eligibility (Recertification) for the medical benefits described above.

You are authorized to obtain and release all of the medical and financial information, including information of Social Security, Veteran's benefits, pensions, and matrimonial settlements from and to all private and public sources, in connection with these applications, Administrative Hearings or Judicial Review.

You are authorized to obtain and release all of my Social Security information including but not limited to a TPQY.

I understand that my cooperation with you is absolutely necessary. I agree to sign all documents, forms and letters that you deem necessary to obtain medical benefits to which entitlement is needed. I will also inform you of any change of my address, and make myself available to you should you seek further information. In the event Administrative or Judicial review of eligibility determination is pursued, I understand my presence and participation may be necessary.

A copy of this Appointment of Authorized Representative, and Consent to Release Information, shall be as effective as the original.

This instrument shall survive my incompetence or my death.

By signing below, I acknowledge that I received a copy of Appointment of Authorized Representative, and Consent to Release Information, and I understand its terms.

IN WITNESS WHEREOF, I have hereunto set my hand and seal the_____

State of New York)
County of Erie)

On the 2/23 2021 **Resident or POA)** before me personally came to me known to be the individual described above, and who executed the foregoing instrument, with his/her mark, and he/she executed the same.

Mary E Po **Notary Public**

MARY E POLOVINUK
Notary Public - State of New York
NO. 01PO6395898
Qualified in Erie County
My Commission Expires Aug 5, 2023

Ohio

Complaint & Admission Agreement: Altercare Transitional Care of the Western Reserve

IN THE COURT OF COMMON PLEAS
SUMMIT COUNTY, OHIO

ALTERCARE TRANSITIONAL CARE OF THE WESTERN RESERVE, INC. 5000 Sowul Boulevard Stow, Ohio 44224, Plaintiff, v. [redacted] and [redacted] Defendants.	CASE NO. JUDGE: **COMPLAINT**

NOW COMES Plaintiff, Altercare Transitional Care of the Western Reserve, Inc. ("Plaintiff"), by and through counsel, and for its Complaint against Defendants [redacted] and [redacted] states the following:

PARTIES

1. At all times material to this action, Plaintiff conducted business as a licensed skilled-nursing facility in Summit County, Ohio.

2. [redacted] is a natural person residing in Summit County, Ohio.

3. [redacted] is a natural person residing in Summit County, Ohio.

JURISDICTION AND VENUE

4. Jurisdiction is proper in this Court pursuant to R.C. 2305.01

5. The case is properly venued in this Court because all or part of the Plaintiff's claim for relief arose within this Court's jurisdiction and both of the Defendants reside within this Court's jurisdiction.

FACTUAL BACKGROUND

6. On or about May 17, 2022, Defendant [redacted] admitted to Plaintiff's facility in order to receive health care services, supplies, and room and board from Plaintiff.

7. On or about May 17, 2022, [redacted] in her personal capacity, executed the Admission Agreement, wherein she was identified as the Representative with distinct contractual duties. A true and accurate copy of the Admission Agreement is attached as *Exhibit 1* to this Complaint.

8. Pursuant to the terms of the Admission Agreement, payment for the care and services was expected to be the personal financial responsibility of Defendant [redacted].

9. Pursuant to the Admission Agreement, [redacted] asserted that she had access to [redacted] funds or assets and income and agreed to pay for [redacted]s care and services from [redacted]s funds or assets and income.

10. Further, under the terms of the Admission Agreement, [redacted] agreed to apply for and/or cooperate with the Medicaid process in obtaining Medicaid coverage for Defendant [redacted] if [redacted]s assets or resources were exhausted and/or insufficient to pay for the care and services provided by Plaintiff.

11. Plaintiff provided care and services to Defendant [redacted] in reasonable reliance on, and in consideration of, [redacted]'s agreed upon contractual obligations, which were to use Defendant [redacted]'s funds or resources and income to pay Plaintiff and

to apply for and/or cooperate with the Medicaid process if Defendant [redacted]'s assets or resources were exhausted.

12. Although Plaintiff requested payment for the care and services it provided, Defendant [redacted] did not pay.

13. Additionally, [redacted] did not pay, as promised, from Defendant [redacted]'s assets or resources and income.

14. Moreover, assuming the failure to pay was due in part to Defendant [redacted] not having sufficient assets or resources to pay, [redacted] did not fully and timely cooperate in obtaining Medicaid coverage for the care and services received.

15. [redacted]'s failure to pay and [redacted]'s failure and/or refusal to use [redacted]'s available assets or resources and income to pay for the care and services that Plaintiff provided resulted in damages suffered by Plaintiff. A true and accurate copy of the Account Statement is attached as Exhibit 2.

16. Further, [redacted]'s failure to apply for and/or cooperate in obtaining Medicaid coverage for the care and services provided to [redacted], in accordance with her representations and contractual obligations, resulted in damages suffered by Plaintiff.

17. Further, in the event payment from [redacted]'s funds was not made or Medicaid not obtained, [redacted] agreed to personally guarantee payment, which said guaranteed was not requested or required of [redacted]. Exhibit 1.

18. Defendant [redacted]'s failure to pay and [redacted]'s failure to perform as agreed resulted in damages amounting up to $13,265.00.

19. In addition to the agreement to pay for the care and services rendered, pursuant to the Admission Agreement, the parties agreed that interest at the rate of 1.5% per month (18% per annum) would be charged on all delinquent monthly payments that remain unpaid.

20. Moreover, the Admission Agreement stated that if Plaintiff retains the services of an attorney to obtain payment of the amounts due, the attorney fees incurred would be charged and/or recoverable.

CLAIMS FOR RELIEF

COUNT I
Unjust Enrichment against Defendant [redacted]

21. Plaintiff incorporates the preceding paragraphs by reference as if fully rewritten herein.

22. Plaintiff provided health care, services, supplies, and room and board to Defendant [redacted]

23. The reasonable value of said services and supplies provided to Defendant [redacted] which remains unpaid, is in the amount of $13,265.00.

24. Defendant [redacted] knew about and accepted the health care, services, supplies, and room and board provided to her and benefitted from her receipt of said health care, services, supplies, and room and board.

25. It would be unjust and/or inequitable to permit Defendant [redacted] to retain the benefit of the health care, services, supplies, and room and board without paying Plaintiff the amount owed.

26. Plaintiff is therefore entitled to judgment against Defendant [redacted] in the principal amount of $13,265.00, plus statutory interest and the costs of the within proceeding.

COUNT II
Breach of Contract against [redacted]

27. Plaintiff incorporates the preceding paragraphs by reference as if fully rewritten herein.

28. [redacted] entered into a valid and binding contract with Plaintiff.

29. Pursuant to the terms of the contract, [redacted] did assert that she had access to [redacted]'s funds or assets and income and agreed to pay for [redacted]'s care and services from [redacted]'s funds or assets and income.

30. In reliance on [redacted]'s representations and promises, Plaintiff substantially performed all of its obligations under the Admission Agreement by providing health care, services, supplies, and room and board to [redacted].

31. By not paying Plaintiff from [redacted]'s resources for substantially all health care, services, supplies, and room and board provided to [redacted] [redacted] has failed to perform her obligations under the Admission Agreement, thus breaching the contract.

32. Further, pursuant to the Admission Agreement, [redacted] agreed to cooperate in obtaining and maintaining Medicaid on behalf of [redacted] if and when necessary, including the timely payment of the monthly patient liability.

33. In contravention of her agreed upon contractual obligation, [redacted] failed to apply and/or cooperate with Medicaid and failed to abide by the applicable rules governing Medicaid in obtaining coverage on behalf of [redacted] resulting in damage to Plaintiff.

34. [redacted]'s breach of contract has proximately caused Plaintiff to suffer damages in the amount of $13,265.00.

35. Pursuant to the Admission Agreement, Plaintiff is also entitled to recover interest on the unpaid principal balance and attorney fees.

36. Accordingly, Plaintiff is therefore entitled to judgment against [redacted] in an amount up to $13,265.00, plus accrued and continued interest at the rate of 18% per annum until the principal balance is paid in full, attorney fees and the costs of the within proceeding.

COUNT III
(In the alternative to Count II) Promissory Estoppel against [redacted]

37. Plaintiff incorporates the preceding paragraphs by reference as if fully rewritten herein.

38. [redacted] represented to Plaintiff that she maintained access to and control of [redacted]'s resources and income.

39. [redacted] promised Plaintiff that she would pay and/or arrange for payment for all health care, services, supplies, and room and board that Plaintiff provided to [redacted] from [redacted]'s resources.

40. [redacted] represented that [redacted] maintained sufficient assets from which to pay for the charges incurred and that she would apply for and cooperate in obtaining Medicaid on [redacted]'s behalf if it became financially necessary.

41. [redacted] should have reasonably expected Plaintiff to rely on her representations and promises, and Plaintiff did rely on her representations and promises in admitting and providing [redacted] health care, services, supplies, and room and board.

42. Plaintiff's justifiable reliance on the aforementioned promises and representations, and the fact that such promises and representations were ignored and/or false, proximately caused Plaintiff to suffer harm in an amount up to $13,265.00.

COUNT IV
Breach of Personal Guarantee against [redacted]

43. Plaintiff incorporates the preceding paragraphs by reference as if fully rewritten herein.

44. Pursuant to the Personal Guarantee of Payment, [redacted] entered into a valid and binding contract with Plaintiff to pay for the healthcare services, supplies, and room and board that Plaintiff provided to [redacted]

45. Although knowledgeable of the debt due, [redacted] has failed to pay for those services, thus failing to perform her obligations under the Personal Guarantee of Payment and breaching the contract.

46. Pursuant to the Admission Agreement, Plaintiff is also entitled to recover interest on the unpaid principal balance and attorney fees.

47. Accordingly, Plaintiff is therefore entitled to judgment against [redacted] in the amount of $13,265.00, plus accrued and continued interest at the rate of 18% per annum until the principal balance is paid in full, attorney fees and the costs of the within proceeding.

WHEREFORE, Plaintiff requests entry of judgment in its favor against Defendants, jointly and severally, awarding the following relief:

As to Count I, an award of compensatory damages against Defendant, [redacted] in the amount of $13,265.00, plus statutory interest and the costs of the within proceeding;

As to Count II, an award against Defendant, [redacted], in an amount up to $13,265.00, plus accrued and continued interest at the rate of 18% per annum until the principal balance is paid in full, attorney fees and the costs of the within proceeding;

As to Count III, an award of compensatory damages against Defendant, [redacted] in an amount up to $13,265.00, plus statutory interest and the costs of the within proceeding

Accordingly, Plaintiff is therefore entitled to judgment against Defendant, [redacted] in the amount of $13,265.00, plus accrued and continued interest at the rate of 18% per annum until the principal balance is paid in full, attorney fees and the costs of the within proceeding;

And any other relief the Court deems necessary and appropriate.

Respectfully submitted by,

ROLF GOFFMAN MARTIN LANG LLP

/s/ David S. Brown
David S. Brown 0082233
W. Cory Phillips 0082489
31105 Bainbridge Rd., STE 4,
Cleveland, Ohio 44139
(216) 514-1100 (Telephone)
(216) 626-7623 (Facsimile)
Brown@RolfLaw.com
Phillips@RolfLaw.com

Attorneys for Plaintiff

EXHIBIT 1

Altercare

Altercare Transitional Care of the Western Reserve, Inc.

ADMISSION DOCUMENTS

Altercare Transitional Care of the Western Reserve, Inc.

Admission Agreement

This Agreement is made and entered into this day of May 17, 2022, by and between Altercare Transitional Care of the Western Reserve, Inc. "Facility"), [redacted] ("Patient"), and [redacted] ("Representative"). Hereinafter, when capitalized, the term "You" and "Your" shall refer jointly and severally to the Patient and the Representative.

In consideration of the mutual promises contained in this Agreement, Patient, Representative, and Facility hereby agree as follows:

1. **Services.** Facility will provide room, board, laundry, housekeeping, social, activities and general nursing services as required by law ("Basic Services") to the Patient. In addition to the Basic Services, Facility will provide additional non-routine services and supplies ("Additional Services") in accordance with the orders of the Patient's attending physician and/or upon Your request or consent.

2. **Exhibits.** You agree to abide by all of the terms and conditions of the following exhibits, which are hereby incorporated into this Agreement by reference: Exhibit A – Potential for Discharge & Personal Guarantee of Payment; Exhibit B – Financial Terms; Exhibit C – Representative Authority & Duties; and Exhibit D – General Terms & Conditions.

YOU HAVE READ ALL OF THE TERMS OF THIS AGREEMENT, INCLUDING THE EXHIBITS, AND YOU HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS REGARDING THOSE TERMS.

YOU DO FOR YOURSELF, AND YOUR HEIRS, ADMINISTRATORS AND EXECUTORS, AGREE TO THE TERMS OF THIS AGREEMENT IN CONSIDERATION OF FACILITY'S ACCEPTANCE OF AND RENDERING SERVICES TO THE PATIENT.

The parties, intending to be legally bound, have signed this Agreement as of the date first above written.

PATIENT

_____
Signature

[redacted]
Print Name

FACILITY

_____
Signature

Amy T. Harris
Print Name

REPRESENTATIVE

_____
Signature

[redacted]
Print Name

EXHIBIT A
Potential for Discharge & Personal Guarantee of Payment

Facility cannot continue to provide services without payment. If the facility is not paid timely and in full by someone, then it will seek to discharge the Patient.

Many people wish to make sure that care and services to their loved ones are maintained when the Patient does not have the resources to pay for care. Circumstances that may cause non-payment may include, for example when an insurance company no longer provides payment when rehabilitation care has concluded or when Medicaid eligibility has not been maintained or approved. Thus, they agree to make payments on their loved ones' behalf in those instances.

BY SIGNING BELOW, THE PERSONAL GUARANTOR IS AGREEING TO VOLUNTARILY PERSONALLY GUARANTEE PAYMENT TO FACILITY, BE JOINTLY AND SEVERALLY LIABLE FOR ALL SERVICES AND SUPPLIES RECEIVED BY THE PATIENT, AND TO MAKE ALL PAYMENTS WHEN THEY COME DUE. THE PERSONAL GUARANTOR UNDERSTANDS THAT HE OR SHE IS NOT REQUIRED BY LAW OR FACILITY TO PERSONALLY GUARANTEE PAYMENT. THE PERSONAL GUARANTOR AGREES THAT THIS GUARANTEE WILL CONTINUE UNTIL ALL FINANCIAL OBLIGATIONS TO FACILITY HAVE BEEN PAID IN FULL.

[redacted]

Printed Name of Personal Guarantor

Signature of Personal Guarantor
(Must be someone other than patient. Do not use title such as POA or Guardian when signing.)

EXHIBIT B
Financial Terms

B1. **Duty to Pay.** You agree to pay all charges and fees that are billed to You by Facility when they become due.

B2. **Rates.** You will be charged the Basic Rate for the Basic Services. The Basic Rate may be adjusted by Facility at any time upon thirty (30) days advance written notice to You. Current charges for Additional Services are available to You upon request. In addition, if the Patient's payment source changes at any time during the Patient's stay at Facility, Facility's fees and charges to be paid by You may be adjusted immediately.

B3. **Billing to Governmental Payers.** The Facility is approved for and accepts payment from both Medicare and Medicaid. If you are financially and medically-eligible for Medicare and/or Medicaid services, then we will submit claims and accept payment from these payers. If Your services are eligible for Medicare, then You will remain responsible for any and all applicable deductibles and/or copayments. If You become approved for Medicaid, then You will remain responsible for any monthly resource payments, patient liability or resident portion of the monthly charge, as determined by Your County Department of Jobs and Family Services.

B4. **Billing to Health Insurance Plans.** The Facility will submit claims and accept payment from any health insurance plan that the Patient is enrolled in, has benefits for and is medically-eligible for covered services. You will remain responsible for any charges that are deemed patient responsibility by Your health plan, including annual deductibles, copayments or out of pocket charges. If Your health insurance plan does not provide payment to us within 120 days, then You agree to pay in full for any outstanding charges for room and board, ancillary services and/or coinsurance.

B5. **Late Charges & Collection.** You must pay the Basic Rate no later than the seventh (7^{th}) day of each month in advance of the month that services are received, and any amounts due for Additional Services within thirty (30) days of the date of invoice. If any charge or fee is not paid on the date that such payment is due, You agree to pay interest to be calculated at the rate of one and one-half percent (1.5%) of the unpaid balance per month, effective as of the date the balance was originally due until the date the balance is paid in full. In addition, if Facility retains the services of a collection agency or an attorney to obtain the payment of amounts due under this Agreement, Facility shall be entitled to recover from You all collection agency and attorney's fees, court costs and other collection expenses. You authorize Facility to release information about the Patient's residency, the services provided and any debts owed to a law firm or collection agency in attempting to collect amounts due and not paid.

B6. **Refunds.** If Facility determines that an overpayment has occurred, Facility shall refund the overpaid amount to the Patient, or if the Patient is deceased, as required by law.

B7. **Assignment of Benefits.** You hereby direct all payments made on the Patient's behalf by third-party payers, including payments from Medicare and Medicaid, to be made directly to Facility for any services furnished by Facility. If the Patient is or will be a Medicaid recipient, then in addition You hereby direct all resource payments made to the Patient or on Patient's behalf, including payments from the Social Security Administration and pension benefits, to be made directly to Facility. You agree to take any steps necessary to implement this assignment of benefits, such as redirecting the direct deposit of Social Security Administration funds.

B8. **Disputed Debts.** If You disagree with a charge, You must notify the Customer Service Department of the home office in writing of any dispute, and provide reasons and evidence of why You believe the charge is incorrect, within thirty (30) days after receipt of the first invoice that includes the disputed charge. If You do not submit such a written notification, then all charges shall be deemed accurate and any dispute will be deemed waived. All communications concerning disputed debts, including an instrument tendered as full satisfaction of a debt, are to be sent directly to the Customer Service Department of the home office in writing.

Initials

EXHIBIT C
Representative Authority & Duties

In addition to his/her general duties under the Agreement, the following shall apply to the Representative:

C1. **Representative as Patient's Agent.** The Patient gives permission to the Representative to sign any and all documents that are part of the admission process to Facility on the Patient's behalf as his or her agent. The Patient agrees that in signing on his or her behalf, the Representative binds the Patient to all duties imposed by such documents as if the Patient had signed them himself or herself, including the duty to pay Facility for services rendered and to agree to arbitrate legal disputes.

C2. **Duty of Representative on Behalf of Patient.** During the term of his/her residency, the Patient may need assistance in arranging for payment for the services provided. You have asserted to Facility that the Representative shall act in a fiduciary capacity on the Patient's behalf to satisfy the Patient's financial obligations under this Agreement if the Patient chooses not to, or is unable to, meet those obligations. The Patient shall be primarily responsible for making payments to Facility until such time as he/she assigns the responsibility for making payment to the Representative or until he/she can no longer make payments on his/her own behalf; at such time, the Representative shall become primarily responsible for making such payments. Except as specifically provided otherwise in the Agreement or as agreed to by Representative, all financial obligations in this Agreement are the Patient's.

C3. **Access Patient's Funds.** You have asserted that the Representative has legal access to, or is willing to take the steps necessary to obtain access to, the Patient's income, assets, personal and real property, and resources, including, but not limited to, social security, pension or retirement funds, annuities, insurance, bank accounts, and mutual funds (collectively, "Resources"); and You understand that Facility is entering into this Agreement in reliance on that assertion. You agree that all such Resources shall be considered the Patient's Resources for purposes of this Agreement. You agree that if any of these Resources transfer by operation of law while the Patient still has outstanding debts to Facility and such transfer causes the Patient's remaining resources to be insufficient to pay the debt in full, then You shall be personally responsible for the remaining debt to Facility. You agree that if You have misrepresented Your legal authority to control the Patient's Resources or to enter into this Agreement on behalf of the Patient, or if You have misrepresented any information on the financial application for admission, then You agree to be personally, jointly and severally liable for all of the Patient's responsibilities in this Agreement.

C4. **Diversion of Patient's Resources.** The Representative agrees to be a good financial steward of all of the Patient's Resources. The Representative understands and agrees that the misappropriation, theft, use or redirection of those Resources so that the Patient's financial obligations under this Agreement are not met is a violation of this Agreement. If any Resources are withheld, used for personal use, or otherwise not liquidated and provided to Facility in order to satisfy the Patient's financial obligations under this Agreement, then the Representative agrees to pay those amounts due to Facility from the Representative's own resources (including, but not limited to, the Representative's income, assets, real and personal property).

C5. **Cooperation in Medicaid Process.** The Representative shall cooperate fully in any application, redetermination or appeals process related to Medicaid eligibility. The Representative agrees to pay from his/her own resources any unpaid charges due to Facility as a result of the Representative's failure to cooperate in the Medicaid eligibility or redetermination process, or appeals thereto. "Failure to cooperate" shall include, but is not limited to, failing to provide documentation to the Medicaid agency in the time frames defined by law or as indicated by the relevant representative of the Medicaid agency.

_____
Initials

EXHIBIT D
General Terms & Conditions

D1. **Obligation to Keep Facility Informed.** You have the responsibility of keeping Facility informed of any changes in the Patient's health condition or financial status. You will inform Customer Service Department of the home office immediately if: (a) the Patient's assets reach a value of $15,000 or less due to a transfer of any property, money or stock to another person or entity or similar transaction; (b) a decision has been made to have the Patient switch or join insurance companies or managed care programs; or (c) if the Patient is currently having services paid for by Medicaid, the Patient inherits any property or money, or receives property or money as a gift. You agree to be personally responsible for any payments not made to Facility timely based on your failure to notify the facility per this section. You agree to provide Facility with an accurate financial statement of the Patient's income and resources in a format requested or approved by Facility upon request by Facility.

D2. **Term & Termination.** This Agreement shall continue until it is terminated by You or Facility. You may terminate this Agreement at any time; however, Facility requests that You provide it with at least three (3) days advance notice so that it can conduct proper discharge planning. This Agreement shall automatically terminate upon the death of the Patient. This Agreement may be terminated by Facility upon any of the following events, subject to State and Federal transfer and discharge provisions: (a) the Patient's failure to make payment or have payment made on his/her behalf, subject to the limitations in this section below; (b) discharge from Facility; (c) the Patient's continued stay jeopardizes the health, safety or welfare of this Patient or other patients of Facility; and (d) Facility's license or certification has been revoked, renewal denied, or Facility is voluntarily closed.

You agree that all accrued charges and fees must be paid prior to the effective date of termination or, if later, on the date You receive a final bill. Your duty to pay for all items and services billed by Facility shall survive the termination of the Agreement.

After the Agreement is terminated, You agree that You will ensure that the Patient moves out of Facility. This includes moving out of Facility by the date specified in the discharge notice in the event of an involuntary discharge. If the Patient does not move out of Facility by the termination date, then You agree to pay Facility a per diem rate equal to two times Facility's then-current private pay rate for all days that the Patient remains in Facility after termination of the Agreement. You agree to pay all of Facility's expenses, including attorney's fees and court costs, for any legal action commenced by Facility to enforce its rights to discharge or otherwise remove the Patient from Facility.

D3. **Authorization for Care.** Unless You otherwise explicitly refuse a particular treatment, the Patient's admission to Facility shall constitute Your authorization and consent to the provision of all care and services provided in Facility.

D4. **Rules & Policies.** You agree to abide by all of Facility's rules, policies and procedures, including, but not limited to, those contained in the Patient Handbook, as may be amended from time-to-time in Facility's sole discretion.

D5. **Nondiscrimination.** Facility offers its services to persons whose needs can be met by Facility, without regard to race, creed, sex, age, religion, national origin, handicap, or disability.

D6. **Waiver.** The failure of Facility in any one or more instances to insist upon strict compliance by You with, or its waiver of any breach of, any of the terms or provisions of this Agreement, shall not be construed to be a waiver by Facility of its rights to insist upon strict compliance by You with all of the terms and provisions of this Agreement.

_____
Initials

D7. **Partial Illegality.** If any portion of this Agreement is determined to be illegal or not in conformity with applicable laws and regulations, such part shall be deemed to be modified so as to be in accordance with such laws and regulations, and the validity of the balance of this Agreement shall not be affected. This Agreement shall be construed in accordance with the laws of the State of Ohio.

D8. **Complete Agreement; Amendments.** Facility is not liable for, nor bound in any manner by, any statements, representations or promises made by any person representing or purporting to represent Facility, unless such statements, representations or promises are set forth in writing and made a part of this Agreement. Modification of this Agreement may be made only by agreement of both/all the parties in writing; provided, however, Facility reserves the right to amend the Agreement at any time in order to conform to changes in Federal, State, or local laws or regulations that require modifying the Agreement. Facility will notify You of its intent to make any such modification at least thirty (30) days prior to making the modification.

D9. **Assignment.** No assignment of this Agreement or the rights and obligations hereunder shall be valid without the specific written consent of both parties hereto, provided, however, that this Agreement may be assigned by Facility or the Organization to any successor entity operating it, and such assignment shall forever release Facility hereunder.

D10. **Mail.** I authorize Facility to open mail addressed to me from the Ohio Department of Job & Family Services, the Centers for Medicare and Medicaid Services, the Social Security Administration, the Department of Veteran's Affairs, and any other organization that I designate to make payments on my behalf for services provided pursuant to this Agreement.

D11. **Representation of Accuracy.** You represent that the information contained on the application forms, financial statements, this Agreement, and the Patient's health history are true to the best of Your knowledge and belief. You understand that Facility has relied upon such information in agreeing to admit the Patient to Facility.

D12. **Incorporation of Other Documents.** The following documents are hereby incorporated into this Agreement by reference: all attached rate schedules and all of Facility's policies governing the Patient's responsibilities, as may be amended from time-to-time by Facility in its sole discretion; all application forms, financial statements, and medical records provided to Facility as part of the Patient's application for admission to Facility; the Patient Handbook; and all documents that You signed or received during the admission process to Facility.

D13. **Headings.** The headings contained in this Agreement are for reference purposes only and shall not affect in any way the meaning or interpretation of this Agreement.

_____
Initials

EXHIBIT 2

RESIDENT STATEMENT from

Altercare
Attn: Accounts Receivable Department
P.O. Box 550
Green, OH 44232
330-498-8179

BILLING DATE	DUE DATE	ACCOUNT NUMBER
02/07/2023	within 10 days	2022072-01
TOTAL BALANCE DUE		**$13,265.00**

AMOUNT PAID $ ☐☐,☐☐☐.☐☐

Please make check or money order payable to **Altercare Transitional Care of the Western Reserve**

[redacted]

Altercare Transitional Care of the Western Reserve
P.O. Box 550
Green, OH 44232

Please detach and return this portion with your remittance to the address above.

lotes
lease contact Julie, your customer service representative, at 330-498-8179 or julie.f@altercareonline.net with any questions on your tatement.

' you no longer reside at Altercare, please contact Dana at 330-498-8055 or dana.r@altercareonline.net with any questions on your ccount.

>=October	November	December	January	PreBill	BALANCE DUE
$11,565.00	$1,700.00	$0.00	$0.00	$0.00	$13,265.00

Dates	Description	Days/ Units	Rate	Charges/ (Credits)	Payments	Balance
12/31/2019	Beginning Balance					0.00
05/31/2022	05/20/2022 to 05/31/2022 Room Charge - 302/2	12	326.00	3,912.00		3,912.00
06/01/2022	06/01/2022 to 06/30/2022 PreBill Room Charge - 302/2	30	326.00	9,780.00		13,692.00
07/06/2022	Payment - PVT DEPOSIT				2,076.00	11,616.00
08/01/2022	07/01/2022 to 07/09/2022 Patient Responsibility - Due Monthly - Room Charge - 302/2	9		2,025.00		13,641.00
08/12/2022	Payment - PVT DEPOSIT				2,076.00	11,565.00
11/01/2022	08/01/2022 to 08/08/2022 Patient Responsibility - Due Monthly - Room Charge - 302/2	8		1,700.00		13,265.00
	Total Balance Due:					**$13,265.00**

RESIDENT STATEMENT from

Altercare
Attn: Accounts Receivable Department
P.O. Box 550
Green, OH 44232
330-498-8179

BILLING DATE	DUE DATE	ACCOUNT NUMBER
02/07/2023	within 10 days	2022072-01
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P.O. Box 550
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TOTAL BALANCE DUE		**$13,265.00**

AMOUNT PAID $ ☐☐,☐☐☐.☐☐

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[redacted]

Altercare Transitional Care of the Western Reserve
P.O. Box 550
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	Total Balance Due:					**$13,265.00**

Complaint & Admission Agreement: Chesterwood Nursing Care

IN THE COURT OF COMMON PLEAS
WARREN COUNTY, OHIO

CHESTERWOOD NURSING CARE, LTD 6524 Owlwood Drive Mason, Ohio 45040, Plaintiff, v. [redacted] Defendant.	CASE NO. [redacted] JUDGE Tepe **COMPLAINT**

NOW COMES Plaintiff, Chesterwood Nursing Care, LTD ("Plaintiff"), by and through counsel, and for its Complaint against Defendant, [redacted] ("Defendant"), states the following:

PARTIES

1. At all times material to this action, Plaintiff conducted business as a licensed skilled-nursing facility in Warren County, Ohio.

2. Defendant is a natural person residing in Warren County, Ohio.

JURISDICTION AND VENUE

3. Jurisdiction is proper in this Court pursuant to R.C. 2305.01.

4. The case is properly venued in this Court because the Defendant resides within and all or part of the Plaintiff's claim for relief arose within this Court's jurisdiction.

FACTUAL BACKGROUND

5. On or about January 27, 2021, [redacted] executed an Admission Agreement with Plaintiff for admission to its facility. A true and accurate copy of the Admission Agreement is attached as *Exhibit 1* to this Complaint.

6. Pursuant to the terms of the Admission Agreement, [redacted] agreed to pay for the healthcare services, supplies, and room and board provided to him.

7. Plaintiff provided [redacted] with the requested services and supplies in accordance with the terms of the Admission Agreement.

8. [redacted] has failed to pay Plaintiff as agreed and required by the Admission Agreement, thus resulting in a principal balance due and owing Plaintiff in the amount of $73,905.74. A true and accurate copy of the Account Statement is attached as *Exhibit 2*.

9. On or about November 17, 2021, [redacted] died leaving an unpaid balance of $73,905.74 due and owing Plaintiff.

10. Plaintiff presented a creditor's claim into the Estate of [redacted] on or about April 28, 2022.

11. It is believed that [redacted]' estate contains no assets from which payment can be made on Plaintiff's claim.

CLAIMS FOR RELIEF

COUNT I
Claim for Necessaries Furnished to Spouse under R.C. 3103.03(C)

12. Plaintiff incorporates the preceding paragraphs by reference as if fully rewritten herein.

13. Plaintiff provided, in good faith, healthcare services supplies, and room and board to decedent [redacted] who at all times relevant to this matter was the spouse of Defendant.

14. The healthcare services, supplies, and room and board rendered to [redacted] by Plaintiff were necessary for his support.

15. The healthcare services, supplies, and room and board are provided at the same cost for all residents in Plaintiff's facility, which is published and made known to each resident and his or her family or representatives.

16. Although Plaintiff has made repeated demands for payment, Plaintiff has not been paid in full for its services.

17. Upon information and belief, [redacted] did not maintain the ability to pay for or provide for his support and maintenance, which includes the necessary services he received at Plaintiff's facility.

18. Upon information and belief, Defendant does maintain the ability to pay and provide the necessary financial support for [redacted]' necessary care.

19. Defendant, however, has not provided the required support to [redacted] in accordance with the spousal obligation under R.C. 3103.03(A).

20. The reasonable value of the necessary services provided to [redacted] for which Plaintiff has not been paid is in the amount of $73,905.74.

21. Pursuant to R.C. 3103.03(C), Defendant is legally required to compensate Plaintiff for the reasonable value of the necessaries supplied by Plaintiff.

22. Plaintiff, pursuant to R.C. 3103.03(C), is entitled to judgment against Defendant in the amount of $73,905.74, plus statutory interest and the costs of the within proceeding.

WHEREFORE, Plaintiff requests entry of judgment in its favor against Defendant in the amount of $73,905.74, plus statutory interest and the costs of the within proceeding, and any other relief the Court deems necessary and appropriate.

Respectfully submitted by,

ROLF GOFFMAN MARTIN LANG LLP

W. Cory Phillips (0082489)
David S. Brown (0082233)
31105 Bainbridge Road, Suite 4
Cleveland, Ohio 44139
(216) 514-1100 (Telephone)
(216) 626-7623 (Facsimile)
Phillips@RolfLaw.com
Brown@RolfLaw.com
Attorneys for Plaintiff

EXHIBIT 1

HILLA N DA LE

Consent to Treat & Admission Agreement

This Consent to Treat & Admission Agreement ("**Agreement**") is made and entered into this day of 01 / 27 / 2021, by and between Chesterwood, Inc. ("**Chesterwood**"), [redacted] ("**Resident**"), and the Representative(s) whose names appear below. Hereinafter, when capitalized, the term "**You**" and "**Your**" shall refer jointly and severally to the Resident and the Representative.

In consideration of the mutual promises contained in this Agreement, Resident, Representative, and Hillandale hereby agree as follows:

1. **Services.** Hillandale will provide room, board, laundry, housekeeping, social, activities and general nursing services as required by law ("**Basic Services**") to the Resident. In addition to the Basic Services, Hillandale will provide additional non-routine services and supplies ("**Additional Services**") in accordance with the orders of a prescribing professional and/or upon Your request or consent.

2. **Exhibits.** You agree to abide by all of the terms and conditions of the following exhibits, which are hereby incorporated into this Agreement by reference: Exhibit A – Financial Terms; Exhibit B – Representative Authority & Duties; Exhibit C – General Terms; and the Fee Schedule.

YOU HAVE READ ALL OF THE TERMS OF THIS AGREEMENT, INCLUDING THE EXHIBITS, AND YOU HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS REGARDING THOSE TERMS. YOU UNDERSTAND THAT YOU HAVE THE RIGHT TO SEEK LEGAL COUNSEL REGARDING THIS AGREEMENT.

YOU DO FOR YOURSELF, AND YOUR HEIRS, ADMINISTRATORS AND EXECUTORS, AGREE TO THE TERMS OF THIS AGREEMENT IN CONSIDERATION OF HILLANDALE'S ACCEPTANCE OF AND RENDERING SERVICES TO THE RESIDENT.

The parties, intending to be legally bound, have signed this Agreement as of the date first above written.

RESIDENT

[redacted]
Signature

[redacted]
Print Name

✓ I Authorize this Signature

REPRESENTATIVE

Signature

Print Name

I Authorize this Signature

REPRESENTATIVE

Signature

Print Name

I Authorize this Signature

HILLANDALE

Debbe Asbrock
Signature

Debbe Asbrock
Print Name

✓ I Authorize this Signature

[redacted]

EXHIBIT A Financial Terms

A1. **Duty to Pay.** You agree to pay all charges and fees that are billed to You by Hillandale when they become due. You agree to use Resident's income, assets, personal and real property, and resources, including, but not limited to, social security, pension or retirement funds, annuities, insurance, bank accounts, and mutual funds (collectively, "**Resources**") to pay the charges when due, and agree to liquidate any Resources to pay such charges.

A2. **Rates.** You will be charged the Basic Rate for the Basic Services. The Basic Rate may be adjusted by Hillandale at any time upon sixty (60) days' advance written notice to You. Current charges for Additional Services are available to You in the Fee Schedule. In addition, if the Resident's payment source changes at any time during the Resident's stay at Hillandale, Hillandale's fees and charges to be paid by You may be adjusted immediately to reflect the charges for that payment source. This Agreement covers all sources of payment for the Resident's care and shall remain in effect even after the source of payment for the Resident's care changes.

A3. **Billing to Governmental Payers.** As a service to You, Hillandale will accept payment from a governmental payer, such as Medicare or Medicaid. However, unless specifically prohibited under applicable law, the Resident remains responsible for any charges that are not paid for by a governmental payer at Hillandale's then-current rates.

A4. **Billing to Health Insurance Plans.** Hillandale will bill the Resident's health insurance plan as a service to You. Unless otherwise agreed upon between Hillandale and the Resident's health insurance plan: You agree to pay Hillandale its private pay rate if the plan does not agree to pay Hillandale directly; and You also agree to pay Hillandale directly and in full upon receipt of an invoice if the Resident's insurance plan does not pay Hillandale within forty-five (45) days of billing.

A5. **Late Charges & Collection.** You must pay the Basic Rate no later than the first day of each month in advance of the month that services are received, and any amounts due for Additional Services within thirty (30) days of the date of invoice. If any charge or fee is not paid on the date that such payment is due, You agree to pay interest to be calculated at the rate of one and one-half percent (1.5%) of the unpaid balance per month, effective as of the date the balance was originally due until the date the balance is paid in full. In addition, if Hillandale retains the services of a collection agency or an attorney to obtain the payment of amounts due under this Agreement, Hillandale shall be entitled to recover from You all collection agency and attorney's fees, court costs and other collection expenses. You authorize Hillandale to release information about the Resident's residency, the services provided and any debts owed to a law firm or collection agency in attempting to collect amounts due and not paid. Furthermore, Hillandale or its agents may use the telephone numbers (including cell phone numbers) or email addresses You have provided to Hillandale or its affiliates for debt collection calls or messages (including autodialed or prerecorded debt collection calls) in the event You do not pay amounts due; Your consent to this provision is not a condition of receiving services from Hillandale.

A6. **Deposit & Refund.** Deposits for private pay residents are due at the time of admission and will be based on the Basic Rate. The deposit amount will include the number of days in the current month as well as the number of days for the following month. If Hillandale determines that an overpayment has occurred, Hillandale shall refund the overpaid amount to the Resident, or if the Resident is deceased, to his or her estate within thirty (30) days.

A7. **Disputed Debts.** If You disagree with a charge, You must notify the Administrator in writing of any dispute, and provide reasons and evidence of why You believe the charge is incorrect, within thirty (30) days after receipt of the first invoice that includes the disputed charge. If You do not submit such a written notification, then all charges shall be deemed accurate and any dispute will be deemed waived. All communications concerning disputed debts, including an instrument tendered as full satisfaction of a debt, are to be sent directly to the Administrator of Hillandale in writing.

EXHIBIT B Representative Authority & Duties

B1. **Representative as Resident's Agent.** The Resident gives permission to the Representative to sign any and all documents that are part of the admission process to Hillandale on the Resident's behalf as his or her agent. The Resident agrees that in signing on his or her behalf, the Representative binds the Resident to all duties imposed by such documents

as if the Resident had signed them himself or herself, including, but not limited to, the duty to pay Hillandale for services rendered and to agree to arbitrate disputes – include this language if the facility is currently utilizing an arbitration agreement.

B2. **Duty of Representative on Behalf of Resident.** You have asserted to Hillandale that the Representative shall act in a fiduciary capacity on the Resident's behalf to satisfy the Resident's financial obligations under this Agreement, and Representative agrees to act in such a fiduciary capacity. All financial obligations in this Agreement are the Resident's and payment obligations refer to payments from the Resident's resources.

B3. **Legal Authority to Access Resident's Funds.** You have asserted that the Representative has legal access to and control over the Resident's income, assets, personal and real property, and resources, including, but not limited to, social security, pension or retirement funds, annuities, insurance, bank accounts, and mutual funds (collectively "Resources"), and You understand that Hillandale is entering into this Agreement in reliance on that assertion. You agree that all such Resources shall be considered the Resident's Resources for purposes of this Agreement. You agree to take all steps necessary to prevent any of these Resources from transferring by operation of law while the Resident still has outstanding debts to Hillandale.

B4. **Limitation on Legal Authority to Act on Behalf of Resident.** You hereby certify that no one else has financial access or control over the Resident's Resources, and that You will not grant any other person or entity access or control over said Resources (with the exception of Hillandale) during the term of this Agreement, unless such other person or entity first becomes a party to this Agreement.

B5. **Diversion of Resident's Resources.** The Representative agrees to be a good financial steward of all of the Resident's Resources. The Representative agrees not to withhold, use for personal use, misappropriate or redirect the Resident's Resources, and to immediately inform Hillandale if he or she learns that someone else has done so.

B6. **Cooperation in Medicaid Process.** The Representative shall cooperate fully in any application, redetermination or appeals process related to Medicaid eligibility. Representative's cooperation shall include, but is not limited to, providing documentation to the Medicaid agency in the time frames defined by law or as indicated by the relevant representative of the Medicaid agency.

EXHIBIT C General Terms & Conditions

C1. **Obligation to Keep Hillandale Informed.** You have the responsibility of keeping Hillandale informed of any changes in the Resident's health condition or financial status. You will inform Hillandale immediately if: (a) the Resident's assets reach a value of $15,000 or less due to a transfer any property, money or stock to another person or entity or similar transaction; (b) a decision has been made to have the Resident switch or join insurance companies or managed care programs; or (c) if the Resident is currently having services paid for by Medicaid, the Resident inherits any property or money, or receives property or money as a gift. You agree to provide Hillandale with an accurate financial disclosure of the Resident's income, resources and liabilities in a format requested or approved by Hillandale upon request by Hillandale.

C2. **Term & Termination.** This Agreement shall continue until it is terminated by You or Hillandale. You may terminate this Agreement at any time; however, Hillandale requests that You provide it with at least three (3) days advance notice so that it can conduct proper discharge planning. This Agreement shall automatically terminate upon the death of the Resident. This Agreement may be terminated by Hillandale upon any of the following events, subject to State and Federal transfer and discharge provisions: (a) the Resident's welfare and the resident's needs cannot be met in the facility; (b) the Resident's health has improved sufficiently so the Resident no longer needs the services provided by the facility; (c) the safety of individuals in the facility is endangered due to the clinical or behavioral status of the Resident; (d) the health of individuals in the facility would otherwise be endangered; (e) the facility ceases to operate; (f) the resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Non-payment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the Resident refuses to pay for his or her stay; (g) the Resident is a beneficiary under the Medicare program and Hillandale's participation in the Medicare is involuntarily terminated or denied; or (h) the Resident is a beneficiary under the Medicaid program and Hillandale's participation in the Medicaid program is involuntarily terminated or denied.

You agree that all accrued charges and fees must be paid prior to the effective date of termination or, if later, on the date You receive a final bill. Your duty to pay for all items and services billed by Hillandale shall survive the termination of the Agreement.

After the Agreement is terminated, You agree that You will ensure that the Resident moves out of Hillandale. This includes moving out of Hillandale by the date specified in the discharge notice in the event of an involuntary discharge. If the Resident does not move out of Hillandale by the termination date, then You agree to pay Hillandale the normal per diem rate for all days that the Resident remains in Hillandale after termination of the Agreement. You agree to pay all of Hillandale's expenses, including attorney's fees and court costs, for any legal action commenced by Hillandale to enforce its rights to discharge or otherwise remove the Resident from Hillandale.

C3. **Authorization for Care.** Unless You otherwise explicitly refuse a particular treatment, the Resident's admission to Hillandale shall constitute Your authorization and consent to the provision of all care and services provided in Hillandale.

C4. **Rules & Policies.** You agree to abide by all of Hillandale's rules, policies and procedures, including, but not limited to, those contained in the Information Regarding Payment, Services & Rights, as may be amended from time-to-time in Hillandale's sole discretion.

C5. **Waiver.** The failure of Hillandale in any one or more instances, to insist upon strict compliance by You with, or its waiver of any breach of, any of the terms or provisions of this Agreement, shall not be construed to be a waiver by Hillandale of its rights to insist upon strict compliance by You with all of the terms and provisions of this Agreement.

C6. **Partial Illegality.** If any portion of this Agreement is determined to be illegal or not in conformity with applicable laws and regulations, such part shall be deemed to be modified so as to be in accordance with such laws and regulations, and the validity of the balance of this Agreement shall not be affected. This Agreement shall be construed in accordance with the laws of the State of Ohio.

C7. **Complete Agreement; Amendments.** Hillandale is not liable for, nor bound in any manner by, any statements, representations or promises made by any person representing or purporting to represent Hillandale, unless such statements, representations or promises are set forth in writing and made a part of this Agreement. Modification of this Agreement may be made only by agreement of both/all the parties in writing; provided, however, Hillandale reserves the right to amend the Agreement at any time in order to conform to changes in Federal, State, or local laws or regulations that require modifying the Agreement. Hillandale will notify You of its intent to make any such modification at least thirty (30) days prior to making the modification.

C8. **Assignment.** No assignment of this Agreement or the rights and obligations hereunder shall be valid without the specific written consent of both parties hereto, provided, however, that this Agreement may be assigned by Hillandale or the Organization to any successor entity operating it, and such assignment shall forever release Hillandale hereunder.

C9. **Representation of Accuracy.** You represent that the information contained on the application forms, financial statements, this Agreement, and the Resident's health history are true to the best of Your knowledge and belief. You understand that Hillandale has relied upon such information in agreeing to admit the Resident to Hillandale.

C10. **Incorporation of Other Documents.** The following documents are hereby incorporated into this Agreement by reference: all attached rate schedules and all of Hillandale's policies governing the Resident's responsibilities, as may be amended from time-to-time by Hillandale in its sole discretion; all application forms, financial statements, and medical records provided to Hillandale as part of the Resident's application for admission to Hillandale; the Resident Rights and Responsibilities Manual; and all documents that You signed or received during the admission process to Hillandale.

C11. **Headings.** The headings contained in this Agreement are for reference purposes only and shall not affect in any way the meaning or interpretation of this Agreement.

EXHIBIT 2

STATEMENT

Chesterwood Nursing Care-SNF
4170 Tonya Trail
Hamilton, OH 45011
513-813-4339

Resident: [redacted]
Location: -
Statement Date: 4/1/2021
Payment Due Date: 4/10/2021

ALL TRANSACTIONS PROCESSED AFTER Mar 22, 2021
WILL APPEAR ON YOUR NEXT STATEMENT

[redacted]

Amount Due $24,012.00

PLEASE DETACH AND RETURN WITH YOUR PAYMENT Amount Enclosed $ _____

Chesterwood Nursing Care-SNF
4170 Tonya Trail
Hamilton, OH 45011
513-813-4339

Resident: [redacted]
Location: -
Statement Date: 4/1/2021
Payment Due Date: 4/10/2021

Effective Date	Description	Units	Unit Amount	Amount
	BALANCE FORWARD			$0.00
2/26/2021	Room & Board charges Feb 26-28 2021 (STD)	3	$375.00	$1,125.00
3/1/2021	Room & Board charges Mar 1-31 2021 (STD)	31	$375.00	$11,625.00
4/1/2021	Room & Board charges Apr 1-30 2021 (STD)	30	$375.00	$11,250.00
[redacted]		1	$12.00	$12.00
	BALANCE DUE			$24,012.00

STATEMENT

Chesterwood Nursing Care-SNF
4170 Tonya Trail
Hamilton, OH 45011
513-813-4339

Resident: [redacted]
Location: -
Statement Date: 5/1/2021
Payment Due Date: 5/2/2021

ALL TRANSACTIONS PROCESSED AFTER Apr 22, 2021
WILL APPEAR ON YOUR NEXT STATEMENT

[redacted]

Amount Due $35,637.00

PLEASE DETACH AND RETURN WITH YOUR PAYMENT Amount Enclosed $ _____

Chesterwood Nursing Care-SNF
4170 Tonya Trail
Hamilton, OH 45011
513-813-4339

Resident: [redacted]
Location: -
Statement Date: 5/1/2021
Payment Due Date: 5/2/2021

Effective Date	Description	Units	Unit Amount	Amount
	BALANCE FORWARD			$24,012.00
5/1/2021	Room & Board charges May 1-31 2021 (STD)	31	$375.00	$11,625.00
	BALANCE DUE			$35,637.00

STATEMENT

Chesterwood Nursing Care-SNF
4170 Tonya Trail
Hamilton, OH 45011
513-813-4339

Resident: [redacted]
Location: -
Statement Date: 6/1/2021
Payment Due Date: 5/30/2021

ALL TRANSACTIONS PROCESSED AFTER May 20, 2021
WILL APPEAR ON YOUR NEXT STATEMENT

[redacted]

Amount Due $46,887.00

PLEASE DETACH AND RETURN WITH YOUR PAYMENT Amount Enclosed $ _____

Chesterwood Nursing Care-SNF
4170 Tonya Trail
Hamilton, OH 45011
513-813-4339

Resident: [redacted]
Location: -
Statement Date: 6/1/2021
Payment Due Date: 5/30/2021

Effective Date	Description	Units	Unit Amount	Amount
	BALANCE FORWARD			$35,637.00
6/1/2021	** Room & Board charges Jun 1-30 2021 (STD) **	30	$375.00	$11,250.00
	BALANCE DUE			$46,887.00

STATEMENT

Chesterwood Nursing Care
4170 Tonya Trail
Hamilton, OH 45011
513-813-4336

Resident: [redacted]
Statement Date: 7/1/2021
Payment Due Date: 7/10/2021

ALL TRANSACTIONS PROCESSED AFTER Jun 22, 2021
WILL APPEAR ON YOUR NEXT STATEMENT

[redacted]

Amount Due $58,524.00

PLEASE DETACH AND RETURN WITH YOUR PAYMENT Amount Enclosed $ _____

Chesterwood Nursing Care
4170 Tonya Trail
Hamilton, OH 45011
513-813-4336

Resident: [redacted]
Location: -
Statement Date: 7/1/2021
Payment Due Date: 7/10/2021

Effective Date	Description	Units	Unit Amount	Amount
	BALANCE FORWARD			$46,887.00
6/1/2021	Room & Board charges Jun 1-6 2021 (STD)	6	$375.00	$2,250.00
6/1/2021	** Room & Board charges Jun 1-30 2021 (STD) **	30	$375.00	($11,250.00)
6/7/2021	** Room & Board Jun 7-30 2021 **	24	$375.00	$9,000.00
7/1/2021	** Room & Board Jul 1-31 2021 **	31	$375.00	$11,625.00
[redacted]		1	$12.00	$12.00
	BALANCE DUE			$58,524.00

STATEMENT

Chesterwood Nursing Care
4170 Tonya Trail
Hamilton, OH 45011
513-813-4336

Resident: [redacted]
Location: -
Statement Date: 9/1/2021
Payment Due Date: 9/15/2021

ALL TRANSACTIONS PROCESSED AFTER Aug 31, 2021
WILL APPEAR ON YOUR NEXT STATEMENT

[redacted]

Amount Due $82,074.74

PLEASE DETACH AND RETURN WITH YOUR PAYMENT Amount Enclosed $ _____

Chesterwood Nursing Care
4170 Tonya Trail
Hamilton, OH 45011
513-813-4336

Resident: [redacted]
Location: -
Statement Date: 9/1/2021
Payment Due Date: 9/15/2021

Effective Date	Description	Units	Unit Amount	Amount
	BALANCE FORWARD			$58,524.00
8/1/2021	** Room & Board Aug 1-31 2021 **	31	$375.00	$11,625.00
9/1/2021	** Room & Board Sep 1-30 2021 **	30	$375.00	$11,250.00
[redacted]		1	$106.00	$106.00
		1	$79.86	$79.86
		1	$15.18	$15.18
		1	$27.58	$27.58
		1	$39.06	$39.06
		1	$14.28	$14.28
		1	$12.92	$12.92
		1	$29.62	$29.62
		1	$9.68	$9.68
		1	$40.42	$40.42
		1	$9.34	$9.34
		1	$27.58	$27.58
		1	$106.00	$106.00
		1	$79.86	$79.86
		1	$39.06	$39.06
		1	$29.62	$29.62
		1	$9.68	$9.68
	BALANCE DUE			$82,074.74

STATEMENT

Chesterwood Nursing Care-SNF
4170 Tonya Trail
Hamilton, OH 45011
513-813-4339

Resident: [redacted]
Location: -
Statement Date: 10/1/2021
Payment Due Date: 10/10/2021

ALL TRANSACTIONS PROCESSED AFTER Sep 30, 2021
WILL APPEAR ON YOUR NEXT STATEMENT

[redacted]

Amount Due $72,882.74

PLEASE DETACH AND RETURN WITH YOUR PAYMENT Amount Enclosed $ _____

Chesterwood Nursing Care-SNF
4170 Tonya Trail
Hamilton, OH 45011
513-813-4339

Resident: [redacted]
Location: -
Statement Date: 10/1/2021
Payment Due Date: 10/10/2021

Effective Date	Description	Units	Unit Amount	Amount
	BALANCE FORWARD			$82,074.74
6/7/2021	Room & Board charges Jun 7-30 2021 (STD)	24	$375.00	$9,000.00
6/7/2021	** Room & Board Jun 7-30 2021 **	24	$375.00	($9,000.00)
7/1/2021	Room & Board charges Jul 1-31 2021 (STD)	31	$375.00	$11,625.00
7/1/2021	** Room & Board Jul 1-31 2021 **	31	$375.00	($11,625.00)
8/1/2021	Room & Board charges Aug 1-31 2021 (STD)	31	$375.00	$11,625.00
8/1/2021	** Room & Board Aug 1-31 2021 **	31	$375.00	($11,625.00)
9/1/2021	** Room & Board Sep 1-30 2021 **	30	$375.00	($11,250.00)
9/1/2021	Patient Liability Due Sep 1-30 2021			$1,023.00
10/1/2021	Patient Liability Due Oct 1-31 2021			$1,023.00
[redacted]		1	$12.00	$12.00
	BALANCE DUE			$72,882.74

STATEMENT

Chesterwood Nursing Care-SNF
4170 Tonya Trail
Hamilton, OH 45011
513-813-4339

Resident: [redacted]
Location: -
Statement Date: 11/1/2021
Payment Due Date: 10/30/2021

ALL TRANSACTIONS PROCESSED AFTER Oct 20, 2021
WILL APPEAR ON YOUR NEXT STATEMENT

[redacted]

Amount Due $73,905.74

PLEASE DETACH AND RETURN WITH YOUR PAYMENT Amount Enclosed $ _____

Chesterwood Nursing Care-SNF
4170 Tonya Trail
Hamilton, OH 45011
513-813-4339

Resident: [redacted]
Location: -
Statement Date: 11/1/2021
Payment Due Date: 10/30/2021

Effective Date	Description	Units	Unit Amount	Amount
	BALANCE FORWARD			$72,882.74
11/1/2021	Patient Liability Due Nov 1-30 2021			$1,023.00
	BALANCE DUE			$73,905.74

FDCPA & ECOA Lawsuit: Rolf Goffman Martin Lang, LLP

[redacted]

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION

[redacted]	CASE NUMBER: 1:23-cv-561
	JUDGE:
Plaintiff,	**COMPLAINT WITH JURY DEMAND**
v.	
ROLF GOFFMAN MARTIN LANG LLP SERVE: Paul Lang, Partner 31105 Bainbridge Road, Suite 4 Cleveland, OH 44139	
AND	
W. CORY PHILLIPS 31105 Bainbridge Road, Suite 4 Cleveland, OH 44139	
AND	
DAVID S. BROWN 31105 Bainbridge Road, Suite 4 Cleveland, OH 44139	
Defendants.	

INTRODUCTION

1. This action is brought by Plaintiff, [redacted] ("Plaintiff") for actual, statutory, and civil penalties against the Defendants, Rolf Goffman Martin Lang LLP, W. Cory Phillips, and David S. Brown (collectively, "Defendants") for violations of the Fair Debt Collection Practices Act, 15 U.S.C. §1692 *et seq*. (hereinafter, "FDCPA"), which prohibits debt collectors from engaging in abusive, deceptive, and unfair practices.

2. Plaintiff also brings claims against Defendants for violations of the Equal Credit Opportunity Act, 15 U.S.C.A. § 1691 *et seq.*, and Regulation B, 12 C.F.R. § 1002.1 *et seq.*

[redacted]

(hereinafter, "ECOA") for using Ohio's necessaries statute to impose guarantor liability on a spouse.

3. Plaintiff also brings claims against Defendants for actual, non-economic and statutory damages under the Ohio Consumer Sales Practices Act, O.R.C. § 1345.01 *et seq.* (hereinafter, "OCSPA"), which prohibits debt collectors from engaging in abusive, deceptive, and unfair debt collection practices.

JURISDICTION AND VENUE

4. Jurisdiction of this Court arises under 15 U.S.C. §1692k(d), 15 U.S.C. §1691e(f) and 28 U.S.C. §1337.

5. Supplemental jurisdiction over state law claims arises under 28 U.S.C. §1367.

6. Declaratory relief is available pursuant to 28 U.S.C. §§ 2201 and 2202.

7. Venue in this Judicial District is proper in that the Defendants transact business in this Judicial District and the conduct complained of occurred in this District.

THE PARTIES

8. Plaintiff, [redacted] ("Plaintiff"), is a natural person residing in Warren County, Ohio, and the surviving spouse of [redacted] ([redacted]").

9. Plaintiff is a "consumer" as defined by the FDCPA, 15 U.S.C. § 1692a(3) and O.R.C. § 1345.01(D).

10. Defendant, Rolf Goffman Martin Lang LLP (hereinafter, "Rolf") is an Ohio legal professional association of attorneys regularly engaged in the practice of collecting debts on behalf of the third parties by filing collection suits.

11. Defendants, W. Cory Phillips ("Phillips") and David S. Brown ("Brown") at all times relevant herein were and are attorneys employed by Rolf.

[redacted]

12. Defendants, Rolf, Phillips and Brown were and are "debt collectors" as defined by the FDCPA, 15 U.S.C. §1692a(6), because they regularly collect or attempt to collect debts owed or asserted to be owed or due another.

13. Defendants are also "suppliers" as defined by O.R.C. § 1345.01(C) and engaged in "consumer transactions" pursuant to O.R.C. § 1345.01(A) by regularly collecting debts from consumers.

14. Phillips and Defendants are creditors under the ECOA as defined by 12 C.F.R. § 1002.2(l).

FACTUAL ALLEGATIONS

15. Defendant, Rolf, is a law firm engaged in the practice of collecting debts on behalf of third parties by filing collection suits. Defendants, Phillips and Brown, are either principals or employees of Defendant, Rolf, and are debt collectors as defined at 15 U.S.C. § 1692a(6) because they regularly collect or attempt to collect debts owed, or asserted to be owed, to another.

16. According to the firm's website, Rolf represents long-term care organizations and holds itself out as a firm that is "well equipped to assist our clients in seeking to collect on bad debts."

17. According to Rolf's website, Defendants, Phillips and Brown focus their practice on assisting "clients with receivables, debt collection, revenue cycle and Medicaid entitlement and appeals."

18. At all times relevant herein, Rolf, Phillips and Brown represented Chesterwood Nursing Care, Ltd., a skilled-nursing facility located in Warren County, Ohio ("Chesterwood").

[redacted]

19. On or around January 27, 2021, Plaintiff's spouse, [redacted], was discharged from Bethesda North Hospital and admitted with a diagnosis of dementia to Chesterwood's facility for care.

20. Chesterwood had [redacted] sign the admission agreement. Plaintiff was not present with [redacted] upon his admission nor did she sign the agreement.

21. [redacted] died on November 17, 2021.

22. Five days later, on November 22, 2021, Defendants filed a debt collection action against [redacted] in the amount of $73,905.74, in the Warren County Common Pleas Court, Case No. 21CV94726, *Chesterwood Nursing Care, Ltd. v. Lawrence R. Parks*, which it dismissed on March 25, 2022, upon learning of his death. A copy of the Complaint is attached hereto and incorporated herein at Exhibit A.

23. Pursuant to the statute of limitations in effect at the time, Chesterwood had until May 17, 2022 in which to present its claim to a representative of [redacted] estate.

24. On or before April 28, 2022, as creditors of the estate, Defendants took steps to open [redacted] estate.

25. Defendant, Phillips filed an Application for Authority to Administer Estate and an Application for Appointment of Special Administrator in the Estate of [redacted], Warren County Probate Court, Case No. [redacted].

26. In his Application, Phillips represented that he was both the Applicant and the Attorney for the Applicant.

27. In the probate filings, Phillips wrongfully identified [redacted] next of kin and failed to identify or provide notice of his Application for Appointment to any of [redacted] children.

[redacted]

28. Phillips made additional misstatements of fact, including without limitation, that "the surviving spouse is the natural or adoptive parent of all of the decedent's children," when she is not; that [redacted] did not leave a Will, when, in fact, he did leave a Will; that [redacted] real property was an asset of the estate, when it was not; and that "there are no known assets in the Estate to be administered," when there were.

29. Phillips also failed to file the required bond and failed to execute a written acceptance of his fiduciary duties as required under Ohio law.

30. On April 28, 2022, an Entry Appointing Fiduciary and Letters of Authority were issued to Phillips appointing him Special Administrator.

31. As acknowledged in Phillips' application seeking appointment, Ohio law requires notice be sent to the surviving spouse. However, at no time did Phillips send notice to the Plaintiff that he had opened an estate.

32. Phillips also failed to send notice to Plaintiff of any rights she had as surviving spouse.

33. On May 5, 2022, Phillips filed a notice of Chesterwood's claim in the amount of $72,882.74. No notice of said claim was sent to the Plaintiff.

34. The estate remained open for another four months without notice to Plaintiff of the estate or of Chesterwood's claim.

35. The first and only document Plaintiff received concerning [redacted] estate was the Special Administrator's Motion to Close and Terminate Estate, which Phillips filed on September 7, 2022.

36. Plaintiff was shocked, confused and emotionally distraught upon learning that her late husband's estate had been opened without her knowledge and was pending closure.

[redacted]

37. On September 6, 2022, Defendants filed a debt-collection complaint against Plaintiff in the case styled, *Chesterwood Nursing Care, Ltd. v.* [redacted], Warren County, Ohio Court of Common Pleas, Case No. [redacted] (the "Complaint"). A copy of the Complaint is attached hereto and incorporated herein at Exhibit B.

38. Plaintiff was served with summons and a copy of the Complaint on September 9, 2023.

39. Plaintiff further suffered anxiety, fear, anger, panic and extreme emotional distress upon reading the allegation in the Complaint that she owed $73,905.74 to Chesterwood.

40. Defendants filed the Complaint while Phillips was still serving as the fiduciary for [redacted] estate.

41. Phillips was discharged as Special Administrator on September 8, 2022.

42. Defendants Rolf and Phillips then filed a Notice of Release of Claim on behalf of Chesterwood on September 9, 2022. The Notice represented that the "estate consists of zero assets." However, Phillips did not conduct an investigation into the estate's assets and did not file an inventory.

43. Plaintiff retained counsel and filed a motion in the probate court seeking to reopen her husband's estate, revoke Phillips' Letters of Authority, and vacate the Entry Appointing Fiduciary as *void ab initio*.

44. In granting her motion, the probate court found in part that:

- [redacted] had priority of appointment and was entitled to administer Decedent's estate as his surviving spouse pursuant to R.C. 2113.06, but did not receive the required statutory notice of Phillips' Application, and did not sign a Waiver of Right to Administer;

- Phillips was not among the preferred class of persons entitled to administer Decedent's estate pursuant to R.C. 2113.06;

- No hearing was held on Phillips' Application pursuant to R.C. 2113.06 and/or R.C. 2113.07, as required;

- The Citation to Surviving Spouse was never served on [redacted]. In addition, she never received a summary of her rights and did not sign a Waiver of Service to Surviving Spouse of the Citation to Elect;

- A Notice of Special Administrator's Receipt of Presented Claim was filed by Phillips on May 5, 2022, citing his receipt of a creditor's claim presented to him on April 28, 2022, by Chesterwood Nursing Care, LTD ("Chesterwood") in the principal amount of $72,882.74;

- A Special Administrator's Motion to Close and Terminate Estate was filed by Phillips on September 7, 2022;

- The Estate was closed on September 8, 2022; and

- Phillips filed a Notice of Release of Creditor's Claim as the attorney for Chesterwood on September 9, 2022."

45. Finding that it had exclusive jurisdiction to grant and revoke letters of administration and the same power as the court of common pleas to vacate or modify its orders, the probate court ordered that (1) the Letters of Authority issued to W. Cory Phillips be "revoked and held to be *void ab initio*," and that (2) the Entry Appointing Fiduciary W. Cory Phillips as Special Administrator be "VACATED as being *void ab initio*."

46. A copy of the Entry is attached hereto and incorporated herein at Exhibit C.

47. Counsel for Plaintiff served Defendants with a copy of the Entry.

48. In the debt collection action against Plaintiff, Defendants alleged that [redacted] died leaving an unpaid balance in the amount of $73,905.74 for necessary services in the form of healthcare services, supplies, and room and board while he was a resident of Chesterwood.

49. Defendants further alleged that Plaintiff is legally required to compensate Chesterwood for the reasonable value of the necessaries supplied to [redacted] and that Chesterwood was entitled to judgment against Plaintiff in the amount of $73,905.74.

[redacted]

50. Defendants' sole claim against Plaintiff is based on Ohio's necessary statute, O.R.C. § 3103.03.

51. Ohio law requires Defendants to seek payment from the resident. Only when the resident is unable to pay can Defendants seek payment from the resident's spouse.

52. Further, when the resident has died, under Ohio law the claim must be presented to the resident's estate within 6 months of death, otherwise it is barred by R.C. § 2117.06.

53. As the Defendants failed to timely present Chesterwood's claim to the resident's estate, it is time-barred.

COUNT ONE
VIOLATION OF THE FEDERAL DEBT COLLECTION PRACTICES ACT (FDCPA)

54. Plaintiff restates, realleges and incorporates by reference each of the foregoing paragraphs herein.

55. In attempting to collect the debt, Defendants violated the FDCPA and engaged in false, misleading, and deceptive conduct by making material misstatements in [redacted] estate, failing to exhaust debt-collection efforts in the estate, and filing suit against Plaintiff on a time-barred debt.

56. Such violations include, but are not limited to, the following:

a) The use of "false, deceptive, or misleading representation or means in connection with the collection of any debt," prohibited by 15 U.S.C.A. § 1692e;

b) The "false representation of the character, amount, or legal status of any debt," prohibited by 15 U.S.C.A. § 1692e(2)(A);

c) The "use of any false representation or deceptive means to collect or attempt to collect any debt or to obtain information concerning a consumer," prohibited by 15 U.S.C.A. § 1692e(10); and

d) The use of "unfair or unconscionable means to collect or attempt to collect any debt," prohibited by 15 U.S.C.A. § 1692f.

[redacted]

57. In attempting to collect the debt, Defendants further violated the FDCPA and engaged in false, misleading, and deceptive conduct by providing legal representation to Chesterwood in the debt collection action against Plaintiff, while at the same time acting as creditor, the attorney for the creditor, and fiduciary to [redacted] estate and, in that role, owing a fiduciary duty to Plaintiff.

58. Such violations include, but are not limited to, the following:

a) The use of "false, deceptive, or misleading representation or means in connection with the collection of any debt," prohibited by 15 U.S.C.A. § 1692e;

b) The "false representation of the character, amount, or legal status of any debt," prohibited by 15 U.S.C.A. § 1692e(2)(A);

c) The "use of any false representation or deceptive means to collect or attempt to collect any debt or to obtain information concerning a consumer," prohibited by 15 U.S.C.A. § 1692e(10); and

d) The use of "unfair or unconscionable means to collect or attempt to collect any debt," prohibited by 15 U.S.C.A. §1692f.

59. In attempting to collect the debt, Defendants further violated the FDCPA and engaged in false, misleading, and deceptive conduct by attempting to impose guarantor liability on Plaintiff as [redacted] spouse and using a collection method which could not legally be taken.

60. Such violations include, but are not limited to, the following:

a) The use of "false, deceptive, or misleading representation or means in connection with the collection of any debt," prohibited by 15 U.S.C.A. § 1692e;

b) The "false representation of the character, amount, or legal status of any debt," prohibited by 15 U.S.C.A. § 1692e(2)(A);

c) The "use of any false representation or deceptive means to collect or attempt to collect any debt or to obtain information concerning a consumer," prohibited by 15 U.S.C.A. § 1692e(10); and

d) The use of "unfair or unconscionable means to collect or attempt to collect any debt," prohibited by 15 U.S.C.A. §1692f.

61. As a direct and proximate result of each of the foregoing violations, the Plaintiff suffered actual and statutory damages in an amount to be proved at trial.

62. Defendants are therefore liable to the Plaintiff for declaratory judgment that the Defendants' conduct violated the FDCPA and that Plaintiff is entitled to actual damages, statutory damages, costs, attorney's fees and such further relief which this Court deems appropriate.

COUNT TWO
VIOLATION OF THE OHIO CONSUMER SALES PRACTICES ACT (OCSPA)

63. Plaintiff restates, realleges and incorporates by reference each of the foregoing paragraphs herein.

64. At all times relevant herein, the foregoing conduct of Defendants Rolf, Phillips and Brown also constitutes unfair and deceptive acts or practices in violation of the Ohio Consumer Sales Practices Act, §§1345.02 and 1345.03.

65. Defendants are therefore liable to the Plaintiff for declaratory judgment that the foregoing conduct violated the OCSPA.

66. As a direct and proximate result of the foregoing violations, Plaintiff suffered actual, non-economic and statutory damages in an amount to be proved at trial.

67. Therefore, Defendants are liable to the Plaintiff for actual damages, non-economic damages, statutory damages, treble damages, costs, and attorney's fees as provided for under O.R.C. § 1345.09 and related provisions, and such further relief which this Court deems appropriate.

COUNT THREE
VIOLATION OF THE EQUAL CREDIT OPPORTUNITY ACT (ECOA)

68. Plaintiff restates, realleges and incorporates by reference each of the foregoing paragraphs herein.

[redacted]

69. At all times relevant herein, Chesterwood, in the ordinary course of business regularly extended, offered to extend, or arranged for extension of credit to its consumer customers.

70. As such, Chesterwood is a creditor under ECOA.

71. Under O.R.C. § 2113.06(C), a creditor may be granted letters of administration to administer an estate.

72. Phillips filed an Application for Authority to Administer Estate for the sole purpose of imposing guarantor liability against Plaintiff under Ohio's necessaries statute, O.R.C. § 3103.03.

73. Therefore, Phillips is a creditor under ECOA.

74. Plaintiff is an applicant under ECOA and Regulation B. 12 C.F.R. § 1002.2(e).

75. Further, O.R.C. § 3103.03(C) is preempted by ECOA. 15 U.S.C. § 1691d(f); 12 C.F.R. § 1002.11(b).

76. As a direct and proximate result of the foregoing violations, Plaintiff suffered damages in an amount to be proved at trial.

77. The Defendants are therefore liable to Plaintiff for declaratory judgment that the Defendants' conduct violated ECOA, actual damages, punitive damages of $10,000 against each defendant, costs, attorney's fees, and such further relief which this Court deems appropriate. 15 U.S.C. § 1691E(B)&(C); 12 C.F.R. § 1002.16(b)(1).

WHEREFORE, Plaintiff, [redacted], respectfully requests that judgment be entered against Defendants, Rolf Goffman Martin Lang, LLP, W. Cory Phillips, and David S. Brown, jointly and severally, for the following:

A. Declaratory judgment that the conduct of Defendants, Rolf Goffman Martin Lang, LLP, W. Cory Phillips, and David S. Brown violated the FDCPA;

B. Actual damages suffered by Plaintiff, including statutory damages in the amount of $1,000.00 against each Defendant, Rolf Goffman Martin Lang, LLP, W. Cory Phillips, and David S. Brown, pursuant to 15 U.S.C. §1692k for violations of the FDCPA;

C. Declaratory judgment that the conduct of Defendants, Rolf Goffman Martin Lang, LLP, W. Cory Phillips, and David S. Brown violated the OCSPA;

D. Compensatory damages, non-economic damages, statutory damages and treble damages against each Defendant pursuant to Ohio Rev. Code §1345.09 for each and every unfair and deceptive act or practice;

E. Costs and reasonable attorney's fees pursuant to 15 U.S.C. §1692k, 15 U.S.C. §1691e(d) and Ohio Rev. Code §1345.09;

F. Declaratory judgment that Defendants' conduct as outlined herein violated the ECOA, 15 U.S.C. §1691 *et seq.* and Regulation B, 12 C.F.R. §1002.1 *et. seq*.

G. Declaratory Judgment that Ohio Rev. Code §3103.03(C) is preempted by the ECOA, 15 U.S.C. §1691d(f); 12 C.F.R. §1002.11(b);

H. Actual damages suffered by the Plaintiff against each Defendant as well as punitive damages in the amount of $10,000.00 against each Defendant pursuant to 15 U.S.C. §1691(b)(1); 12 C.F.R. §1002.16(b)(1) for violation of the ECOA;

I. For such other and further relief as the Court may deem just and proper.

Respectfully submitted,

/s/ Tracye T. Hill
Tracye T. Hill, Esq. (0081864)
Miriam H. Sheline, Esq. (0018333)
Pro Seniors, Inc.
7162 Reading Road, Suite 1150
Cincinnati, Ohio 45237
(513) 345-4160
thill@proseniors.org
msheline@proseniors.org

Attorneys for Plaintiff

DEMAND FOR JURY TRIAL

Plaintiff demands trial by jury of all issues so triable in this action.

/s/ Miriam H. Sheline
Miriam H. Sheline
Attorney for Plaintiff