KIRKHAVEN
RESIDENT ADMISSION AGREEMENT

THIS RESIDENT ADMISSION AGREEMENT (this "Agreement") is entered into the __ day of _____, 20__ by and between **GENESEE VALLEY PRESBYTERIAN NURSING CENTER, D/B/A KIRKHAVEN, 254 ALEXANDER STREET, ROCHESTER, NEW YORK 14607** (hereinafter referred to as "Facility" or "Kirkhaven"), and _____ (hereinafter referred to as "Resident" or "You"/"you"/"your").

RECITALS

Facility is duly licensed under New York State law to provide skilled nursing facility services. The Resident's physician has determined that the Resident requires skilled nursing facility services.

Resident warranties that all statements and financial information provided to the Facility prior to and along with the signing of this Agreement are true and accurate. By signing this Agreement the Resident acknowledges that the Facility relies on such information to determine the source of payment and to ensure continuity of payment. The Resident personally agrees to pay all damages directly or indirectly resulting from the Resident's misrepresentation of information provided to the Facility.

Resident hereby stipulates that valuable and sufficient consideration exists for Resident's obligations under this Agreement, including but not limited to, the Facility's agreement to admit Resident to the Facility, and any and all services and other things of value provided to Resident since Resident's admission to the Facility. Therefore, Facility and the Resident agree to the following terms and conditions relating to the admission and provision of services to the Resident by Facility:

1. CONDITIONS TO RESIDENT ADMISSION.

1.1 Admission/Physician. You must have a physician order to be admitted to the Facility. You agree to appoint a licensed New York physician as your personal physician to oversee your medical care throughout your stay at the Facility. You agree to a physician visit at least once every thirty (30) days for the first ninety (90) days after admission and at least once every sixty (60) days thereafter and more often when medically indicated.

1.2 Dental Examinations. You agree to an admission dental examination to be performed within seven (7) days after completion of your initial comprehensive assessment after admission by a licensed and currently registered dentist or dental hygienist. Kirkhaven will arrange and pay for the admission examination and periodic dental examinations and oral hygiene treatments, at Kirkhaven, at least annually. Other routine or emergency examinations or treatments outside of Kirkhaven will be arranged as needed and requested, at your own expense, either through Kirkhaven's consulting dentist or your own personal dentist.

1.3 Additional Examinations. You authorize all of your physicians, other medical personnel and the Facility's Medical Director to perform all such necessary examinations as may be required by law or regulation.

1.4 Financial Statement. You agree to furnish Facility prior to admission, whenever your financial circumstances change, and also upon request a true statement of your financial resources and income available to pay for your care. You agree to notify Facility promptly if you add or discontinue any medical insurance coverage, and if there are any other changes in your Medicare or private insurance coverage. In addition, you agree to notify Facility when your personal resources have declined to $45,000.00 above the Medicaid eligibility level to allow sufficient time to process your Medicaid application. By signing this Agreement, Resident warranties that the financial information provided to Facility is accurate and complete and will be relied upon by Facility.

1.5 Rights and Responsibilities. Resident shall be entitled to the rights and must abide by the responsibilities, specified in the Facility's "The Rights and Responsibilities of Residents" document, which will be provided to Resident and which is incorporated into this Agreement. By signing this Agreement, you specifically acknowledge that you and your Designated Representative and the other Resident Agents you appoint understand and agree to abide by and accept the responsibilities set forth in the Facility's "The Rights and Responsibilities of Residents" document. Additionally, by signing this Agreement, you specifically acknowledge receipt of the document entitled "Living at Kirkhaven: An Orientation Handbook for Residents and Families" (which contains the Resident Complaint/Grievance Procedure).

1.6 Resident Agents. Resident represents (knowing that Facility will rely upon such representation) that Resident will, as appropriate, appoint individuals to act as agents to act on Resident's behalf, including, but not limited to, the Resident's Designated Representative, Power of Attorney/Attorney-In-Fact (and/or other Financial Representative), and Health Care Proxy (and/or other Health Care Agent). These individuals are each a "Resident Agent" and collectively "Resident Agents." See **Schedule A** to this Agreement for designations of such Resident Agents. You agree to promptly notify Facility of all changes in address, phone number, or identity of any Resident Agent. You direct all current and future Resident Agents to (1) meet all payment obligations under this Agreement from Resident's assets and/or insurance coverage, including by signing additional authorizations as required, (2) cooperate in applying for and obtaining Medicaid and recertification of Medicaid for Resident, if needed, (3) manage Resident's assets responsibly so that Facility will not be denied payment for the cost of care from Resident's assets and from Medicaid, and (4) sign **Schedule B (Personal Agreement)** to this Agreement (as applicable). You agree to fulfill the financial obligations set forth in this Section if they cannot be performed by a Resident Agent and you personally agree to ensure that your assets, income, and other resources are not used or transferred in any way to prevent you from qualifying for Medicaid or other insurance benefits. Resident authorizes Facility and its agents, including but not limited to, the Facility's attorneys and debt collectors, to communicate directly with Resident Agents and family members regarding any issues arising under this Agreement and with any third parties for the purposes of collecting any unpaid charges or bills.

2. SERVICES, CHARGES, AND PAYMENT FOR SERVICES.

2.1 Basic Services; Additional Services. Facility shall provide the Resident the Basic Services as specified in this Agreement and the attached **Schedule C** for the Basic Charge as defined in this Agreement. Additionally, Facility agrees to make available to you on a fee-for-service basis the Additional Services listed on the attached **Schedule C**. Resident authorizes the consultant medical practitioners and other medical staff of the Facility to administer routine

nursing facility services as may be deemed necessary in the diagnosis and treatment of the Resident.

2.2 MDS Assessment. Resident agrees to cooperate with the Facility regarding the MDS assessment, as follows: State and Federal law require the Facility to complete an assessment (called the MDS assessment) of every resident, including the Resident, at pre-determined intervals. The MDS assessment may be used by the government to determine the reimbursement amounts to be received by Facility and to ensure that Facility is providing appropriate and quality care to its residents. The MDS assessment, upon completion, is submitted electronically to the New York State Department of Health and to the Centers for Medicare and Medicaid Services. Facility endeavors to ensure every resident that the information collected in the MDS assessment is confidential and is protected from improper disclosure, as required by federal law. Questions regarding the use of the MDS assessment and/or the submission process may be directed to the Resident's social worker or to the Director of Medical Records.

2.3 Charges. Resident agrees to pay the "Basic Charge" as the cost for all Basic Services as set forth in this Agreement and in the attached **Schedule D**. Resident also agrees to pay for all Additional Services as detailed in Section 2.1 and **Schedule D** of this Agreement. Resident agrees at all times to remain personally liable for any Basic Charges, Additional Services, or other charges determined not covered by any third-party payor, including but not limited to Medicare, Medicaid, or any third-party health plan or insurance carrier. Facility may change any charge prospectively, including but not limited to, the Basic Charge and charges for Additional Services, upon giving sixty (60) days prior notice to Resident or Resident Agents.

2.4 Payment. The payment terms applicable for Resident under this Agreement are set forth in this Agreement in the attached **Schedule E**. As applicable, upon or prior to admission, the Resident shall complete a Direct Payment Authorization Form (**Schedule F** to this Agreement) indicating preference for how and when payment for charges will be made.

3. REFUND. Upon discharge from Kirkhaven, any outstanding bills will be paid from a prepaid amount (if any). The balance of the prepayment and of the personal funds account will be refunded within thirty (30) days after termination of the Resident's stay, or in accordance with legal obligations. In the event of the Resident's death, such refund may only be delivered to the individual, entity, or probate jurisdiction which is appointed to administer the Resident's estate, to the Department of Social Services (or other comparable agency) upon an authorized claim, or as otherwise authorized or required by law.

4. DISCHARGE OF RESIDENT.

4.1 Discharge by Resident. The Resident is free to leave Facility at any time. The Resident is requested to give seven (7) days prior written notice of intent to leave. If Resident discharges himself/herself from Facility against the advice of the attending physician, Resident shall indemnify and hold harmless Facility and its employees and agents against all claims, actions, proceedings, costs, damages, and liabilities, including, but not limited to, attorneys' fees, interest, and court costs arising out of, connected with or resulting from such discharge.

4.2 Discharge by Facility. Facility may, upon appropriate prior written notice, transfer or discharge the Resident if: the Resident fails to timely pay for the care provided and for any other purpose permitted under New York State and federal regulations.

4.3 Discharge Planning. Resident agrees to accept discharge planning upon the advice of his/her personal physician and the Facility's rehabilitation team to be discharged from the Facility upon attainment of the goals set forth in the Resident's care plan. Resident agrees to cooperate and participate with the Facility staff in preparing and effectuating the discharge plan.

5. RESIDENT'S PERSONAL PROPERTY; PERSONAL ALLOWANCE.

5.1 While Kirkhaven has appropriate policies and procedures to provide reasonable security for the Resident's personal property, it can only ensure against the loss of valuable items (such as jewelry or money) if they are deposited with the management for safekeeping or kept in a locked space when not in use. Kirkhaven shall not be responsible for lost or damaged items of any kind including, but not limited to eyeglasses, hearing aids, or dental prosthesis, unless such items have been given by the Resident to Kirkhaven for safekeeping or the loss or damage is due to the negligence of Kirkhaven or its employees. The Resident shall pay for personal items, including clothing, and in the event that any Additional Services are not paid for, the Resident shall indemnify and hold Kirkhaven harmless from all claims, actions, proceedings, costs, damages, and liabilities, including attorneys' fees, interest, and court costs arising out of, connected with, or resulting from the lack of payment for such Additional Services or supplies.

5.2 A private pay resident may deposit money in a Resident Personal Checking Account for use in paying for personal items. A Medicaid Resident shall receive such personal money as may be provided under Medicaid regulations, and the Resident may have all or any part of these funds held in trust in the Resident Personal Checking Account. Such money will be maintained by Kirkhaven in an interest-bearing account and may be withdrawn as petty cash or by check. Kirkhaven will not be responsible for cash withdrawn by Residents. Residents will receive a quarterly statement of the account including the pro-rata share of interest earned less bank service charges in the account.

5.3 It is the obligation of the Resident and undersigned to arrange for disposition of the Resident's property upon discharge. Kirkhaven shall not be responsible for any property upon discharge. Kirkhaven shall not be responsible for any property left more than fourteen (14) days after discharge. After fourteen (14) days, Kirkhaven has the right to dispose of such personal items as it sees fit.

6. MEDICAL CARE; COMMUNICABLE DISEASES.

6.1 It is the policy of Kirkhaven to implement the directions of each Resident regarding medical treatment as set forth in Advance Directives which comply with the laws and regulations of the State of New York. Advance Directives include without limitation a Health Care Proxy and a Do Not Resuscitate Order. Upon admission, each Resident shall receive written information on his or her right to make Advanced Directives as required by Federal and State laws and regulations. Kirkhaven shall not discriminate against an applicant nor condition care based upon whether or not the Resident has executed an Advance Directive. The existence of a copy of a Resident's Advance Directive(s) shall be documented on and attached to the medical record of that Resident. The authority of such Advance Directive shall be effective only after a Resident's Attending Physician and other physician, as required by law, shall determine and document in the Resident's medical record that the Resident no longer has capacity to make treatment decisions for herself or himself.

6.2 In emergency situations, advance directives will be honored to the extent legally and practically possible. In the absence of advance directives to the contrary, the parties recognize that for proper resident care, certain emergency surgical and medical procedures may become necessary and must be applied without previous consultation with the Resident or the Designated Representative. In each case, the Facility will endeavor to obtain the consent of the Resident or legal representative. If such prior consent cannot be obtained, and the treating physician and/or the nursing staff determines that such surgical or special medical treatment is essential to save the Resident's life or to prevent adverse immediate and serious physical consequences, the Resident hereby authorizes the Facility to perform such treatment or to transfer the Resident to a facility where such treatment may be performed without prior consultation and without written permission.

6.3 A resident suffering from a communicable disease will only be admitted or retained if a physician certifies in writing that transmissibility is negligible and poses no danger to other residents, and if Kirkhaven is staffed and equipped to manage such cases without endangering the health of other residents.

7. RECORDS. Kirkhaven shall keep such records on the Resident as are required by applicable laws and regulations. Kirkhaven shall maintain the confidentiality of the Resident's records. However, Kirkhaven is authorized by the Resident to disclose information from Resident's records to representatives of the State Health Department and other governmental bodies when required, appropriate health care professionals and personnel treating Resident, and as required by third-party contract payors. Kirkhaven is also authorized by the Resident to electronically submit standardized resident assessment information to the State and Federal government to be used for the purpose of evaluating and improving the quality of care provided by nursing homes that participate in Medicare and Medicaid.

8. RULES AND REGULATIONS. The Resident agrees to abide by the Kirkhaven rules, as may be amended from time to time, and regulations and to respect the personal rights and private property of other residents and staff.

9. MISCELLANEOUS PROVISIONS.

9.1 Facility and Resident agree that the Schedules referenced in this Agreement are incorporated in and are a part of this Agreement. This Agreement, along with the Schedules and other documents referenced in this Agreement, which the Resident hereby acknowledges having received, contain the entire agreement between the parties. This Agreement may not be amended or modified except in writing signed by the parties. Notwithstanding the foregoing, if there are changes to Federal, State, or Local laws or regulations or regulatory guidance which require modifications to the terms of this Agreement such modifications shall supersede the provisions set forth in this Agreement when required by the laws, regulations, and/or guidance. The Schedules to this Agreement, as may be amended in the future, may be distributed to residents and/or their representatives as stand-alone policies of the Facility. This Agreement is governed by the laws of the State of New York. The parties specifically consent that the courts of the State of New York shall have exclusive jurisdiction over any dispute arising from or related to this Agreement and the venue of any such action or proceeding shall be in the County in which the Facility is physically located. This Agreement shall supersede all prior Admission Agreements, if any, between the parties; notwithstanding the foregoing, any rights or claims of either party

accruing or arising under such prior Admission Agreements, if any, shall continue to survive as permitted by the provisions of such prior Admission Agreements.

9.2 If any provision of this Agreement is determined by a court of competent jurisdiction to be invalid, illegal, or unenforceable, such provision shall be construed so as to render it enforceable and effective to the maximum extent possible in order to effectuate the intent of this Agreement and the validity, legality, and enforceability of the remaining provisions in this Agreement shall not in any way be affected or impaired thereby.

9.3 This Agreement remains in effect if the Resident is readmitted to the Facility after a hospitalization or other temporary absence of less than thirty (30) days duration. Notwithstanding any other term in this Agreement or the length or purpose of the Resident's stay, this Agreement shall continue in force and effect until a new agreement is signed between the parties.

9.4 Resident acknowledges receipt of the Facility's Bed Hold/Red Reservation Policy (see **Schedule G**).

9.5 By signing this Agreement, Resident hereby acknowledges receipt of the Facility's HIPAA Privacy Notice and a Privacy Act Statement (as applicable). Additionally, by signing this Agreement, Resident consents to any uses and disclosures of protected health information for the Resident's care, payment for the care, and the Facility's health care operations, and for such other uses that are permitted or required under Federal or State law without the Resident's consent or authorization.

9.6 Resident also agrees to the execution of the Statement of Intent to Return to Primary Residence, as applicable (see **Schedule H**).

9.7 The Resident's facial photographs, and photographs of specific injuries or conditions, may be taken to use as identification or for other health care operations of the Facility, as necessary. For example, for public relations purposes, video, website photos, and photography of Kirkhaven is often used. In the event that the Resident's image appears in any footage or photos, Resident hereby grants full and irrevocable consent to the use and publication of such for educational, commercial, or public relations purposes by the Facility.

9.8 Only those terms, conditions, or provisions of this Agreement intended to survive termination of this Agreement shall so survive.

9.9 **Facility admits and treats all residents who are appropriate for placement in a skilled nursing facility on a nondiscriminatory basis in compliance with New York State and Federal laws which prohibit discrimination in admission, retention, and care of residents on the basis of race, creed, color, blindness, marital status, disability, national origin, sex, sexual preference, source of payment, sponsorship, or age.**

9.10 **By signing this Agreement, Resident certifies that the information given by Resident in applying for payment under Title XVIII of the Social Security Act is correct. Resident authorizes any holder of medical or other information about Resident to release to the Social Security Administration or its intermediaries or carriers any information needed**

for a Medicare claim. The Resident requests that payment of authorized benefits be made on the Resident's behalf.

9.11 By signing this Agreement, Resident acknowledges that Facility has the right, at its election, to act as the Resident's agent for submitting payment requests to Medicaid or other payors, and assisting with any Medicaid application, and for appealing any and all denials of such requests or applications. Resident acknowledges and agrees that the primary obligation to complete Medicaid application(s) and appeals remains with the Resident. As necessary, Resident agrees to provide Facility and Medicaid with any and all records and supporting documents, including bank and financial records, that may be required. Resident hereby authorizes personnel of any banks or other financial institutions maintaining Resident funds or other assets to release information to Facility representatives.

9.12 By signing this Agreement, Resident expressly authorizes personnel of the county and/or state department of social services, other Federal, State, or local agencies, Medicare, and other third-party payors to communicate with and furnish information to Facility concerning Resident's eligibility for Medicaid, Medicare or other insurance. Resident grants Facility access to the Resident's Department of Social Services Medicaid application and recertification file.

9.13 By signing this Agreement, Resident assigns to Facility any and all rights Resident has to appeal or challenge determinations by Medicare or the Medicare intermediary regarding Resident's placement in a particular "RUG," "PDPM," or successor category or classification, including any reclassification. Resident agrees to assist Facility in any such appeal.

9.14 By signing this Agreement, Resident expressly agrees to assign to Facility all Resident's long-term care insurance benefits and agrees that any such payments received shall be applied to amounts owed to Facility under this Agreement. Resident agrees to execute any required assignment of benefits form(s) or other documentation necessary to effectuate this assignment of benefits. Notwithstanding the foregoing, Resident agrees at all times to comply with the payment terms of this Agreement.

9.15 Resident acknowledges that he/she has been advised of, understands, and agrees to be legally bound by the following policies (which can be revised from time to time by the Facility at its discretion):

- HIPAA Privacy Notice for Kirkhaven and Kirkhaven's Pharmacy
- The Rights and Responsibilities of Residents
- Information/documents regarding Advance Directives
- "Welcome to the Neighborhood": A Handbook for Residents and Families

IN WITNESS WHEREOF, Facility, and Resident have signed this Agreement this ___ day of _____, 20___.

RESIDENT

_____
Signature of Resident
(Or Legal Representative)

FACILITY

By: _____
Signature of Facility's Representative

Title: _____

FACILITY CERTIFICATION: This Admission Agreement was signed only after an in-person or telephone interview with _____, during which the terms of this Agreement were reviewed, and I answered any questions concerning Facility policies asked of me.

_____ (Name/Signature of Facility's Representative)

SCHEDULE A

DESIGNATION OF RESIDENT AGENTS

WHO WILL EXERCISE YOUR RIGHTS AND RESPONSIBILITIES IF YOU CANNOT:

Resident Agents.

(a) **Designated Representative:** You are requested to designate some person (family member, friend, advisor) as your Designated Representative. By signing this Agreement you designate _____ (name), _____ (street), _____ (city), _____ (state and zip) _____ (phone) as your Designated Representative. The Designated Representative shall receive information from Facility as required by Department of Health regulations. You authorize Facility to contact the Designated Representative whenever it is deemed necessary or appropriate by you or by Facility to seek the assistance of a third party in discussing and/or conducting transactions between the parties.

(b) **Financial Representative** (such as a Power of Attorney/Attorney-In-Fact or Guardian)**:** You are required to advise Facility as to the identity of any and all individuals who you have authorized to act in your place as Power of Attorney/Attorney-In-Fact when you signed the legal document known as the Power of Attorney. You identify the following individual(s) as the person(s) you have designated as your Power of Attorney/Attorney-In-Fact: _____ (name), _____ (street), _____ (city), _____ (state and zip) _____ (phone) _____ (soc. sec. #). (Submit a copy of the Power of Attorney Form.)

Other Financial Representatives/Agents are listed as follows:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

This person(s) may have been given control over your money by you and will be responsible for seeing that charges incurred for your care are promptly paid either through the use of your personal resources or by any applicable third-party payor. You further agree to immediately notify Facility if you revoke such designation and/or identify any other individual(s) to be your Power of Attorney/Attorney-In-Fact. If your Power of Attorney/Attorney-In-Fact or any other person has access to or control over your income or assets, he/she/they will be required to sign **Schedule B** to this Agreement. Your Resident Agents may be asked to assist you to fulfill your responsibilities hereunder and to cooperate with Facility in its efforts to see that your needs are met. Your Resident Agents are expected to cooperate with Facility in obtaining timely payment from available funds and to assist you in applying for all payment programs to which you may be entitled.

(c) **Health Care Agent:** By executing a form known as the Health Care Proxy, you may authorize an individual to make health care decisions for you in the event that you are no longer able to make those decisions for yourself. Facility encourages all residents to carefully consider and to execute a Health Care Proxy. If you have already designated someone to be your Health Care Agent, you are required to provide Facility with a copy of your Health Care Proxy form. The Social Worker can assist you in completing a Health Care Proxy form if you have not already designated someone to act as your Health Care Agent. _____ has been validly appointed as your Health Care Proxy.

(d) **Direction to Resident Agent:** You agree to promptly notify Facility of any and all changes in address, phone number or identity of any Resident Agent. You direct all current and future Resident Agents to comply with all obligations as set forth in the Admission Agreement.

If you are declared legally incompetent under State law, all Rights and Responsibilities specified shall devolve upon your judicially designated legal representative.

WHO CAN THE FACILITY COMMUNICATE WITH REGARDING YOUR CARE AND TREATMENT WHILE YOU ARE AT THE FACILITY:

The Facility may disclose to a family member, other relative, a close friend, or any other person identified by you your protected health information directly relevant to that person's involvement with your care or the payment for your care. The Facility may also use or disclose your protected health information to notify or assist in notifying (including identifying or locating) such person of your location, general condition or death. However, this can only occur if you agree to a disclosure to such person. If you wish to name such a person and agree to such disclosures, please designate the family member, other relative, close personal friend, or any other person and to whom the Home may make such disclosures (a "Family Member/Friend"):

_____
_____
_____

SCHEDULE B

PERSONAL AGREEMENT

This Agreement is effective the ___ day of _____, between **GENESEE VALLEY PRESBYTERIAN NURSING CENTER, D/B/A KIRKHAVEN** (the "**Facility**") and _____, residing at _____ (hereinafter "**Signator**").

Signator hereby stipulates that valuable and sufficient consideration exists for Signator's obligations under this Agreement, including but not limited to, the Facility's agreement to admit _____ ("**Resident**") to the Facility and to provide any and all services and other things of value to Resident as specified in the Resident's Admission Agreement with Facility (the "**Admission Agreement**") since Resident's admission to the Facility. Therefore, in consideration of the Facility's agreement to admit **Resident** and to provide the services specified in the Admission Agreement,

NOW, THEREFORE, for other good and valuable consideration, the parties hereby agree as follows:

1. Signator warranties that Signator has authority to represent and/or legal access to the income, funds, and resources of the Resident.

2. Signator agrees that this Agreement is valid and binding upon Signator and incorporates the terms of the Admission Agreement without regard to whether the Admission Agreement is signed or binding upon the Resident. If a court of competent jurisdiction determines that the Admission Agreement is not binding upon Resident, Signator agrees that the Facility is still legally entitled to payment for Resident's stay from Resident's assets, income, Medicare and insurance benefits, and other resources (collectively "**Resources**"), and agrees that the amount owed to the Facility shall be calculated based upon the terms of the Admission Agreement as if it were binding and effective.

3. Signator agrees to promptly and timely assist the Resident in fulfilling his/her financial responsibilities under the Admission Agreement, the terms of which are fully incorporated into this Agreement.

4. Signator warranties that if any information is entered on any financial questionnaire of the Facility, it is true, complete and accurate to the best of Signator's knowledge. Signator agrees to use Signator's legal authority to assist Resident in making all payments due to the Facility in accordance with the terms of the Admission Agreement.

5. Signator agrees that Resident's Resources will be used to timely pay all of Resident's charges, fees and expenses, payments for physician visits and all properly authorized additional charges and rate increases at the Facility.

6. Signator agrees to promptly and timely initiate and complete applications, recertifications, and appeals for Medicaid benefits on behalf of the Resident when he/she becomes eligible. In the event that Facility agrees to assist Resident in applying for, recertifying for, or appealing Medicaid benefits, Signator will cooperate with Facility in that process. In connection

with any application or re-certification for Medicaid benefits, Signator agrees to fully cooperate with the New York State and the local county Department of Social Services or comparable agency ("**DSS**") in securing the Resident's continued eligibility for Medicaid benefits, including but not limited to, personally ensuring the timely submission of any documentation requested by DSS.

7. Signator agrees, as the agent of the Resident, to adhere to his/her obligations to pay any Net Available Monthly Income ("**NAMI**") specified by DSS to the Facility. If Signator should fail to ensure payment of NAMI in accordance with the Admission Agreement, Facility is authorized at its option to apply for and become Representative Payee of the Resident to provide for the direct deposit of Social Security benefits and to become Representative Payee of the Resident with respect to any Resident pension(s).

8. Signator warranties that no transfer of Resident's Resources has taken place or will occur which would prevent Resident from qualifying for Medicaid benefits or result in Resident having insufficient funds to pay Facility's bill.

9. Signator agrees to take all steps necessary to effect the terms of this Agreement, including without limitation signing additional authorizations as requested by Facility or Resident's benefit providers, providing documentation and information as requested by Facility or Resident's benefit providers, and pursuing legal action on behalf of Resident to recover funds fraudulently transferred from Resident.

10. Signator agrees to pay damages to Facility caused by a breach of his/her personal responsibilities under this Agreement including without limitation, attorney's fees, interest, and costs.

11. Signator agrees to permit Facility and its agents, including without limitation, Facility's attorneys and debt collectors attempting to enforce the rights of the Facility under the Admission Agreement and/or this Agreement, to communicate directly with third parties in connection with the terms of the Admission Agreement and this Agreement, including without limitation, for purposes of collection of any debt owed to Facility.

12. Signator agrees that although Facility may help in its discretion, Signator and Resident are and remain solely responsible for any application, recertification, and/or appeal for third-party benefits (including without limitation Medicaid, Medicare, and private insurance) on behalf of Resident. Facility is not required to mitigate its damages by assuming responsibility for any application, recertification, and/or appeal of third-party benefits. In consideration of the possibility that Facility will decide to help with an application, recertification, and/or appeal for Medicare or Medicaid benefits for Resident, Signator hereby also agrees to the following:

a. Signator specifically designates Facility as an entity that may act as Resident's agent for the purpose of processing requests for Medicaid and Medicare eligibility and for appealing any denial of such eligibility;

b. Signator agrees to provide Facility with any and all records and supporting documents required to complete a Medicaid application or recertification, including without limitation banking and financial records, and Signator hereby

directs all institutions, entities, and individuals to release to Facility all records of Resident accounts;

c. Signator will comply with requests for documentation and information from the Facility, and/or any agency or entity responsible for administering Medicare or Medicaid, such as DSS, in a prompt manner and, in any event, no later than the time frame set forth by such agency; and

d. Signator authorizes any agency responsible for administrating Medicare or Medicaid, and any other third-party payors, to provide information to Facility concerning Resident's eligibility for benefits.

13. Signator agrees that any final determination by any third-party benefit provider/payor concerning eligibility for benefits or the amount of any co-pay, co-insurance, NAMI, or cost sharing amount is binding upon the Resident and Signator unless the same is subject to an appeal or court action against such benefits provider.

This Agreement may be signed in one or more counterparts all of which will constitute one and the same instrument.

DATED: _____ _____
SIGNATOR

DATED: _____ _____
FACILITY'S REPRESENTATIVE

SCHEDULE C

BASIC SERVICES

Facility shall provide the Resident the following Basic Services:

1. Room. Lodging, in a clean, healthful, sheltered environment and in a properly outfitted and attractive room. Resident understands that room changes may become necessary as care needs dictate during your stay at the Facility and you agree to cooperate in making such changes. Facility will give Resident notice prior to any room or roommate change, in accordance with all legal obligations.

2. Board. Board, including therapeutic or modified diets, as prescribed by the Attending Physician. The Facility will provide a kosher meal for the Resident upon request as long as it is realized that the Facility does not have a kosher kitchen on the premises.

3. Nursing and Other Services. Twenty-four-hours-per-day of nursing care and services by other staff members in the daily performance of their assigned duties. You understand you will be touched by members of Facility's staff in providing these services and you consent to all appropriate touching and physical contact.

4. Equipment and Supplies. All equipment, medical supplies and modalities, notwithstanding the quantity usually used in the everyday care of Facility's residents, including but not limited to catheters, hypodermic syringes and needles, irrigation outfits, dressings and pads, and so forth. Also, the use of equipment customarily stocked by Facility 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 Resident's Attending Physician for Resident's regular and sole use. Provided, however, if any equipment is ordered at Resident's request for Resident's sole use, regardless of whether or not it requires a physician order, Resident will be charged a separate fee for any such equipment if not covered by any applicable insurance or third-party coverage.

5. Bed Linen. Fresh bed linen, changed at least as often as required by applicable regulations, including sufficient quantities of necessary bed linen or appropriate substitutes changed as often as required for incontinent residents.

6. Gowns or Pajamas. Hospital gowns or hospital pajamas as required by the clinical condition and needs for privacy and dignity of the Resident, unless the Resident elects to furnish these items.

7. Laundry Service. Laundry services for hospital gowns or pajamas and other launderable personal clothing items used by Resident.

8. Medicine Cabinet Supplies. General household medicine cabinet supplies, including but not limited to, nonprescription medications, materials for routine skin care, oral hygiene, routine care of hair and so forth, except when specific items are medically indicated and prescribed for exceptional use by a specific resident.

9. Assistance/Supervision. Assistance and/or supervision, when required, with activities of daily living, including, but not limited to, toileting, bathing, feeding, and getting up and moving around.

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

11. Social Services; Religious Services; Pastoral Services. Social services, as needed. Resident and Family Services counseling and support services as needed. Interdenominational and Roman Catholic Services to meet the religious needs of all residents wishing to attend. Services and times will be posted on each unit's activity schedule board. The Facility will also obtain pastoral counseling for any Resident requesting such services.

ADDITIONAL SERVICES

Additionally, Facility agrees to make available to you on a fee-for-service basis the Additional Services listed below to the extent that they are ordered by your personal physician or other authorized and qualified practitioner. Resident shall be responsible for and shall promptly pay all fees, co-payment, co-insurance, and deductible amounts due for any and all of these Additional Services provided to the Resident:

12. Audiology. Services related to Resident's hearing to be administered by a qualified audiologist.

13. Therapy Services. Physical, occupational and/or speech pathology treatment provided by or under the supervision of a qualified therapist as prescribed by Resident's physician. The federal government may require a cap on the amount of funds Medicare will pay for these services in one year. This amount may be changed from time to time. Resident agrees to pay for any services not covered by Medicare or any other third-party payor.

14. Lab and X-Ray. Laboratory and radiology services administered by appropriately licensed personnel.

15. Podiatry. Podiatry services administered by an appropriately qualified specialist that may include special nail care, corn and callous care, and other procedures as ordered by Resident's physician.

16. Medical Specialty Services. Medical specialty services including, but not limited to psychiatry, dermatology, orthopedics, surgery, and ophthalmology, provided by a qualified specialist.

17. Prescription Drugs. Prescription drugs are not included in the Facility daily rate/Basic Charge. For residents with Medicare Part D or other third-party coverage, the costs of prescription drugs will be billed to such payor on a monthly basis. The cost of the Resident's prescription drugs not covered by any third-party plan, including but not limited to Medicare Part D, will be billed monthly to the Resident and Resident shall

promptly pay all charges, co-payments, co-insurance, and deductible amounts due for the prescription drugs provided to the Resident. Facility utilizes generic medications whenever available.

18. Dental Surgery and Prosthesis. Dental surgery, orthodontia work; dental prosthesis (including repair).

19. Additional Services and Supplies. Additional supplies or services will be provided if prescribed or recommended by the attending physician. Examples of additional services and supplies, include but are not limited to: (a) diagnostic services as ordered by a physician and not routinely provided by Facility; (b) audiology equipment; (c) eye exams and/or eyeglasses; and (d) intravenous therapy.

20. Transportation Expenses. Facility shall make arrangements for Resident transportation as necessary for medical care or services provided outside Facility. The Resident shall pay or provide for the payment of transportation expenses not covered by third-party payors.

21. Personal Items. Resident shall pay directly for items of a personal nature including clothing/shoes, personal items, beautician and barber services, professional dry cleaning, cosmetics, specialty brand toiletries, newspapers, magazines, personal televisions, television stands, authorized personal appliances, personal telephones in rooms (including installation and maintenance charges), companion and/or guest meals, and special transportation costs.

Additionally, any other health care service charges that the Resident may incur shall also be paid by the Resident if they are not covered by insurance or other third-party payor. Information regarding rates is available upon request from the Facility.

SCHEDULE D

BASIC CHARGES

FOR MEDICARE PART A COVERED RESIDENTS AND ALL NON-MEDICAID RESIDENTS: Resident, who is not covered by Medicare Part A, agrees to pay Facility the sum of $ _____ (private) (semi-private) per day, plus any assessment levied by New York State from time to time (e.g., NYS Assessment), payable monthly in advance for the Basic Services. If Resident is a Medicare beneficiary whose stay is covered under Medicare Part A, the Basic Charge for the Covered Services shall be the Medicare Part A rate for Facility (plus any applicable cost-sharing amount). Each Resident's case is reviewed by Facility and the intermediary, in accordance with Medicare regulations, to determine eligibility and length of coverage, if any. If Resident has met all of the Medicare eligibility requirements, Resident will be eligible to receive up to one hundred (100) days of Medicare Part A coverage, per Benefit Period, if medically qualified. The full cost of Covered Services for the first twenty (20) days will be paid to Facility by Medicare through Medicare Part A rate. For the next eighty (80) days, providing the Resident continues to meet the eligibility requirements and remains a Medicare beneficiary, the Resident agrees to pay Facility the amount of co-insurance/co-payment provided for in the applicable Medicare regulations, as amended. The balance of the cost of Covered Services for the next eighty (80) days will be paid to Facility by Medicare. The Finance Office will, at your request, tell you the current Medicare Part A rate. The current Medicare Part A co-payment amount is $_____ per day. The Part A rate and co-payment amount are set by the federal government and are subject to change from time to time. The Resident is responsible for the annual Medicare Part A, Part B and Part D deductibles and for any and all Medicare Part A, Part B and/or Part D co-insurance. In addition to the Basic Charge, Resident will be charged for services requested that are not paid for by Medicare or other applicable insurance coverage.

FOR MEDICAID RECIPIENTS: If Resident is a Medicaid recipient and Medicaid covers Resident's stay, the Basic Charge for the Basic Services listed in the Agreement (Basic Services for Medicaid recipients shall also include prescription drugs and rehabilitative services) shall be the Medicaid rate for Facility. The current Medicaid rate is set by New York State. The Finance Office will, at your request, tell you the current Medicaid rate. This rate may be changed from time to time by the State Government without notice to the Resident. Resident, upon qualifying for Medicaid coverage for Resident's stay, will be advised by the Department of Social Services (or other comparable agency) that Resident will be responsible for paying a portion of the charges made by Facility and the Department shall pay the balance (See the County Department of Social Services Budget Letter(s) made a part of this Agreement by your signing this Agreement). Resident understands that the Department of Social Services (or other comparable agency) may from time to time change the portion of the charges Resident must pay. Resident agrees to forward a copy of each and every Budget Letter received from the Department of Social Services (or other comparable agency) to the Finance Office within seven (7) days after receipt of each Budget Letter. In addition to the Basic Charge, Resident will be charged for services requested and for which payment is not made by Medicaid.

SCHEDULE E

PAYMENT

The payment terms applicable for Resident under this Agreement are set forth as follows:

(a) Resident always agrees to the payment of any applicable assessment levied by New York State from time to time regardless of payor source (the "NYS Assessment").

(b) If you wish to have your Social Security benefit issued directly to the Facility, the Business office will assist you. As applicable and in accordance with the law, Fifty Dollars ($50) from each Social Security check will be placed in your Resident Fund account. If your Social Security check is directly deposited in an account that is shared with or can be accessed by someone else, that person is required to execute **Schedule B** and use your funds to pay for your care.

(c) If the Resident is private pay, then the Resident agrees to pay the applicable per day Private Room or Semi-Private Room rate as detailed in **Schedule D**, as appropriately modified by the Facility and as detailed in Section 2.3 of this Agreement. This charge will be paid monthly in advance by or on behalf of the Resident. Payment is due by the 10th of the month following the billing date.

(d) If the Resident is a Medicaid recipient, whenever Medicaid is approved, the Resident shall provide Facility with a copy of the Budget Letter(s) issued to the Resident and Resident expressly agrees to pay and hereby directs his/her Resident Agents to pay Facility the amount specified in the Budget Letter(s) as may be amended from time to time. If Resident fails to make any payment required by this Agreement in a timely manner, Facility is authorized to apply for and become Resident's Representative Payee to provide for direct deposit to the Facility of your Social Security benefits and pension(s).

(e) If Resident has Medicare Part A coverage upon or relating back to the Resident's first day of admission to Facility, typically there will be no co-payment or other charges incurred for each covered day of skilled nursing care until the 21st day of Medicare Part A coverage, unless the Resident has previously exhausted his/her skilled nursing care benefits or unless coverage is denied. If you have Medicare coverage in effect on the day of admission, or if you request a Medicare eligibility review, you must arrange to provide advance payment to Facility equal to twenty (20) days advance payment of the Basic Charge, plus the NYS Assessment. Notwithstanding the foregoing, on the 21st or other applicable day after the commencement of Medicare Part A coverage, Resident shall be responsible to pay to Facility the amount of co-payment due under Medicare in advance until the end of the current month and for the subsequent month, and each month thereafter while Resident is eligible for Medicare Part A coverage.

(f) If the Resident is an enrollee in a Health Maintenance Organization ("HMO") and has met the HMO eligibility requirements for nursing facility coverage, Kirkhaven will bill the HMO directly at the prevailing daily rate or contract rate. If the Resident does not or no longer meets the eligibility requirements for nursing facility coverage, or if the Resident elects to receive additional non-covered services, the Resident agrees to pay Kirkhaven the applicable per day Private Room or Semi-Private Room rate.

(g) If the Resident is a beneficiary of a long term care insurance policy and has met the policy's eligibility requirements for nursing facility coverage, the Resident is responsible for paying Kirkhaven as a self-pay Resident at the prevailing daily rate and filing claims forms for the appropriate insurance reimbursement. Resident agrees to pay Kirkhaven any such remaining balance or amounts.

(h) If the Resident is a beneficiary of a Motor Vehicle Accident (MVA) insurance policy and has met the policy's eligibility requirements for nursing facility coverage, Kirkhaven will bill the insurance company directly at the prevailing daily rate. The Resident agrees to pay Kirkhaven any remaining balance or any amounts not otherwise covered or paid in full by the MVA insurance.

(i) With respect to any late payments, Kirkhaven has the right in its discretion to assess on the Resident a Thirty Dollar ($30) fee for all returned checks, any applicable electronic funds and/or credit card fee amounts, plus any applicable bank processing fees.

(j) If Resident fails to timely make any payment owed under this Agreement, Resident agrees to pay any costs incurred by Facility to collect such payment, including but not limited to, Facility's attorneys' fees, interest, and court costs. Kirkhaven will not hesitate to take legal action on delinquent accounts for non-payment.

(k) It is Resident's, not Facility's, obligation to obtain and maintain any third-party payor coverage and/or benefits, including but not limited to, those provided by Medicaid, Medicare, health plans, and long-term care insurance plans. In the event Resident anticipates coverage and/or benefits from such third-party payors to pay any portion of the Basic Charge or other charges, fees, and expenses, Resident agrees to timely pay the Facility for the amount of all charges, fees, and expenses owed without such coverage and/or benefits until Facility receives written notice that such coverage and benefits are approved and will be paid. Therefore, the Resident must continue to pay the private-pay rate while any application for third-party coverage and/or benefits is pending. Additionally, the submission of a claim to Medicare or a request for reconsideration of a claim to Medicare does not relieve the Resident from any payment obligations under this Agreement if the fiscal intermediary determines that the Resident's cost of care is not covered by Medicare.

(l) By signing this Agreement, the Resident acknowledges receipt of information regarding the Medicaid and Medicare programs including that set forth in **Schedule D**.

SCHEDULE F

DIRECT PAYMENT AUTHORIZATION FORM

Resident Name _____ Resident ID _____
Financial Institution _____
Name on Account _____
Transit Routing Number _____ Account Number _____
( ) Checking ( ) Savings

Effective Date _____

Withdrawals to be applied to: ( ) Monthly Room & Board and Ancillary Charges
( ) Initial Deposit - $_____ To Resident Personal Account
( ) Monthly - $_____ To Resident Personal Account
Optional Withdrawals: $_____ to _____

I authorize Facility to initiate withdrawals on the 10th of each month from my account at the financial institution named in this application for payment of my monthly room and board bill and other designated withdrawal options as indicated. I will notify Facility if I change banks or account numbers by providing a new voided check or deposit slip. This authorization will remain valid until either I, the Facility, or my financial institution revokes it.

I can suspend payment of a monthly bill by notifying the billing office of Genesee Valley Presbyterian Nursing Center d/b/a Kirkhaven at (585) 442-4315 at any time prior to 3:00 p.m. three business days before the payment is scheduled to be deducted from my account. I understand that other financial arrangements need to be made at that time.

I understand that the Direct Payment Program is an alternative method of payment only and does not otherwise affect my rights or the rights of the Facility or my financial institution with respect to each other.

I further understand that the Facility and my financial institution reserve the right to terminate the Direct Payment Program and/or my participation in it. If I wish to discontinue my participation in the Direct Payment Program, I may do so by notifying Genesee Valley Presbyterian Nursing Center d/b/a Kirkhaven in writing.

_____

Authorized Account Holder Signature Date

Direct Payment Program Termination:
Please terminate my participation in the Direct Payment Program as of _____.

_____

Authorized Account Holder Signature Date

SCHEDULE G

BED HOLD/BED RESERVATION POLICY

A. When a Resident is transferred to an acute care hospital setting, the bed is retained when:

1. For **Non - Medicaid residents (such as Medicare and Private Pay residents)** and for **Medicaid residents that are not described in Section (2) below**: The Facility will not offer such residents the opportunity to hold their bed during any period of temporary hospitalization.

2. For **Medicaid residents as described in subsections (a) and (b) below**, the Facility will comply with Medicaid regulations concerning a bed hold (including all applicable Facility vacancy requirements), as detailed in part below:

(a) Medicaid residents **aged 21 years or older**, who have been residing within the Facility for a period of at least thirty (30) days since initial admission, will have a bed held related to the resident's hospitalization **only with respect to residents who are receiving hospice services within the Facility** and only as follows:

(i) If the attending physician's prognosis is that the Resident can be expected to return to that bed within fourteen (14) days, the bed will be held for the Resident, and the Medicaid program will pay the Facility for the bed hold (subject to applicable Medicaid regulations, including Facility vacancy requirements). Reserved bed days for temporary hospitalizations are limited by Medicaid to a total of fourteen (14) days in a twelve-month period; and

(ii) After fourteen (14) days, the bed hold will be cancelled; and

(iii) Payment will be reimbursed at 50% of the Medicaid rate.

(b) Medicaid residents **under the age of 21 years**, who have been residing within the Facility for a period of at least thirty (30) days since initial admission, will have a bed held and paid for by the Medicaid program (subject to applicable Medicaid regulations, including Facility vacancy requirements), and payment will be reimbursed at 100% of the Medicaid rate.

B. When a Resident is on therapeutic leave, the bed is retained as follows:

1. For **Non - Medicaid residents,** Facility will not offer such residents the opportunity to hold their bed during any period of therapeutic leave.

2. For Medicaid residents **aged 21 years or older**, reserved bed days for therapeutic leaves of absence outlined in a recipient's medically acceptable therapeutic or rehabilitative plan of care are limited to ten (10) days in a twelve-month period. Payment will be reimbursed at 95% of the Medicaid rate.

3. For Medicaid residents **under the age of 21 years**, reserved bed days for therapeutic leaves of absence will be outlined in a recipient's medically acceptable therapeutic or rehabilitative plan of care. Payment will be reimbursed at 100% of the Medicaid rate.

C. **Written Notice**:

a. A resident whose hospitalization or therapeutic leave exceeds the bed hold period will be readmitted to the nursing facility immediately upon the first availability of a bed in a semi-private room if the resident requires the services provided by the nursing facility and is eligible for Medicaid nursing home services.

b. A resident who has resided in the nursing facility for thirty (30) days or more and who has been hospitalized or who has been transferred or discharged on therapeutic leave without being given a bed hold is readmitted to the nursing facility immediately upon the first availability of a bed in a semi-private room if the resident requires the services provided by the nursing facility and is eligible for Medicaid nursing home services.

**This policy is subject to revision in accordance with changes in applicable Federal and/or State laws and regulations, as well as clarifications by the New York State Department of Health.

**Additionally, the parties acknowledge that a private insurance plan, such as ElderOne (or a successor), may provide bed hold coverage over and above the provisions set forth in this policy. If a Resident has such applicable coverage, those bed hold provisions shall apply for Resident, as legally applicable.

SCHEDULE H

STATEMENT OF INTENT TO RETURN TO PRIMARY RESIDENCE

The undersigned is the Resident referred to in the attached Admission Agreement or is the person representing the Resident. The undersigned has knowledge that the Resident currently owns a primary residence and Resident intends to return to that primary residence when Resident is able to be discharged from the Facility.

Dated:

_____
Resident

_____
Resident Representative