Welcome to

CAMPBELL HALL
REHABILITATION CENTER

We're so glad you're here!

Our goal is to provide you and your family with the highest quality health care services during your stay. Feel free to contact us with any questions.

CAMPBELL HALL
REHABILITATION CENTER

Important Contacts

Phone: (845) 294-8154 **Main Fax: (845) 294-6684**

Admissions Fax: (845) 477-1291

Administrator	Avinoam Wizman	**Ext 112**
Nursing	Sandra Lugo	**Ext 105**
Admissions	Taylor Devantier	**Ext 111**
Activities	Jennifer Muehlen	**Ext 144**
Social Services	Theodora Neizer Maria Saladino	**Ext 108**
Finance	Karen Whelder	**Ext 143**
Rehabilitation	Edward Clearwater	**Ext 114**
Food Service	Juan Arevalo	**Ext 132**
Dietitian	Cristine Vega	**Ext 134**
Facilities Management	Robert Requena	**Ext 138**

23 Kiernan Road
Campbell Hall, NY 10916

Campbell Hall Rehabilitation Center

ADMISSION AGREEMENT

ADMISSION AGREEMENT

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ADDENDUMS

ADMISSION AGREEMENT

Agreement entered on _____ between CAMPBELL HALL REHABILITATION CENTER (also referred to as the "Facility") and

_____
(Resident)

and _____
(Responsible Party)

THE PARTIES TO THIS AGREEMENT AGREE AS FOLLOWS:

1. **NON-DISCRIMINATION**

THE FACILITY DOES NOT DISCRIMINATE BECAUSE OF RACE, CREED, COLOR, NATIONAL ORIGIN, SEXUAL PREFERENCE, GENDER, BLINDNESS, DISABILITY, SPONSORSHIP IN ADMISSION, SOURCE OF PAYMENT, AGE, OR AS OTHERWISE PROHIBITED BY LAW WITH RESPECT TO THE ADMISSION, RETENTION AND CARE OF RESIDENTS.

THE FACILITY DOES NOT DISCRIMINATE AND DOES NOT PERMIT DISCRIMINATION, INCLUDING, BUT NOT LIMITED TO, BULLYING, ABUSE, HARASSMENT, OR DIFFERENTIAL TREATMENT ON THE BASIS OF ACTUAL OR PERCEIVED SEXUAL ORIENTATION, GENDER IDENTITY OR EXPRESSION, OR HIV STATUS, OR BASED ON ASSOCIATION WITH ANOTHER INDIVIDUAL ON ACCOUNT OF THAT INDIVIDUAL'S ACTUAL OR PERCEIVED SEXUAL ORIENTATION, GENDER IDENTITY OR EXPRESSION, OR HIV STATUS. YOU MAY FILE A COMPLAINT WITH THE OFFICE OF THE NEW YORK STATE LONG-TERM CARE OMBUDSMAN PROGRAM 845-229-4680 IF YOU BELIEVE THAT YOU HAVE EXPERIENCED THIS KIND OF DISCRIMINATION.

2. **SERVICES PROVIDED BY THE FACILITY**

2.1 **Services Included Under The Daily Basic Rate.** The following services are provided by the Facility under the daily basic rate:

i) Lodging in a non-private room;

ii) Board, including therapeutic or modified diets, as prescribed by a physician (but excluding artificial hydration and nutrition);

iii) Twenty-four (24) hour per day nursing care;

iv) Fresh bed linens as required;

v) Hospital gowns or pajamas as required and regular non-dry cleaning laundry services for these and other launderable personal clothing items;

vi) General household medicine cabinet supplies, including non-prescription medications, material for routine skin care, oral hygiene, care of hair, except for specific items that are medically indicated and needed for exceptional use for a specific Resident;

vii) Assistance and/or supervision when required with activities of daily living, including toileting, bathing, feeding and ambulation assistance (but excluding continuous one on one supervision);

viii) Services of members of the Facility staff performing their daily assigned patient care duties;

ix) The use of customarily stocked equipment, including 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;

x) The use of all equipment, medical supplies and modalities usually used in the everyday care of the Resident, including catheters, hypodermic syringes and needles, irrigation outfits, dressings and pads;

xi) An activities program, including a planned schedule for recreational, motivational, social and other activities, together with the necessary materials and supplies;

xii) Social services as needed; and

xiii) Physical, occupational, speech and respiratory therapies, provided in accordance with a maintenance program (but not such therapies provided in accordance with a restorative program).

2.2 **Anticipated Services**

It is anticipated that the Resident will initially require the following level of care:

☒ Long Term Care

☐ Sub-Acute Care*

* The Facility 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. 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 short term services are no longer required. It is the mutual objective of the Resident and the Facility that the Resident returns to his/her home or a less restrictive setting, if appropriate. The Resident and his/her Responsible Parties 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.

Note: Residents admitted for sub-acute care are responsible for any charges that may accrue after termination of their third party coverage if they remain in the Facility for any reason.

In the event the Resident is admitted for sub-acute services and thereafter requires long term care placement due to his/her health condition, 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.

2.3 **Physician And Ancillary Services**

Charges for physician visits and physician-ordered ancillary services are not included in the daily basic rate. Charges may be billed by the Facility or directly by the provider of the service.

The Resident is not obligated to pay for services paid for by Medicaid, Medicare (or other third-party payor) except for deductibles and co-payments. Medicaid eligible Resident's physician services are normally covered by Medicaid.

A listing of charges for ancillary services and prescription drugs which are provided by the Facility but which are not included in the daily basic rate is available to the Resident at the office of the Facility's administrator.

The Facility will arrange for physician visits, including by remote telehealth technology, as authorized under this Agreement and for ancillary services to be available to the Resident when prescribed by a physician. Telehealth services involve a health provider who is at a site remote from my location at the time of the service, and, as such, telehealth often involves the transmission of video, audio, images, and other types of data. These services will be administered or supervised by practitioners affiliated with the Facility or by non-affiliated, independent practitioners who meet the applicable New York licensing, registration and certification requirements.

The following ancillary services are normally covered by Medicare or Medicaid:

(a) Restorative Physical Therapy
(b) Restorative Audiology Services
(c) Restorative Occupational Therapy
(d) Speech Therapy
(e) Podiatry Services
(f) Psychiatric or Psychological Treatment
(g) Optometric Services
(h) Laboratory Services
(i) Radiology Services
(j) Electrocardiography Services
(k) Oxygen Therapy
(l) Dental Services

The Facility is responsible for furnishing directly, or arranging for, certain services for its residents. In arranging for the provision of such services, the Facility is required to enter into arrangements with outside providers. Further, in entering into such an arrangement, the Facility must exercise professional responsibility and control over the arranged-for services. In that regard, all services that the Resident requires must be provided by the Facility or an outside provider approved by the Facility. Resident is liable for all charges incurred by providers not approved by the Facility.

2.4 **Transportation Services**. Medicare will usually cover ambulance services that are medically necessary while Medicaid will usually cover ambulette services. In addition, some (although not many) managed care plans and third party insurance policies may provide coverage for certain transportation costs. The Resident will be responsible for payment of transportation costs that are not covered by Medicare, Medicaid or insurance carrier.

2.5 **Outside Services**. If the Resident desires to engage the services of an outside dentist, physician **or** other consultant, and the use of that consultant was not ordered by a Facility physician, the Resident is responsible for all costs associated with those services, including professional fees to the extent those fees are not covered by Medicaid, Medicare or an insurance carrier and accompanying Facility personal when transportation off-site with supervision is required. The Resident agrees to hold Facility harmless for any and all harm, injury, damage or loss the Resident might incur while away from the Facility unaccompanied by any Facility staff members.

2.6 **Prescription Drugs; Medicare Part D.** Charges for drugs prescribed by a physician are not included in the daily basic rate. To the extent that prescription drug charges are not covered by Medicaid, Medicare or insurance carrier, they must be paid by the Resident. A Resident eligible for Medicare Part D coverage agrees to enroll in a Medicare Part D prescription drug plan which has a contract with the Facility's vendor pharmacy at or prior to the date of admission, if eligible at such time or during the month the Resident first becomes eligible for Medicare Part D coverage, if such eligibility occurs after the date of admission. All prescription drugs must be administered to the Resident by the Facility.

2.7 **Eyeglasses, Hearing Aids and Prosthetic Devices.** Eyeglasses, hearing aids, dental prostheses and other prosthetic devices can be facilitated through the Facility but are not covered under the daily basic rate. To the extent that they are not paid for by Medicaid, Medicare or insurance carrier, they must be paid for or charged against the Resident's account when the cost is incurred.

2.8 **Personal Items**. Certain items and services, such as those listed below, are not covered under the daily basic rate and they are not normally paid for by Medicaid, Medicare or insurance carriers. Such items are made available by the Facility but must be paid for or charged against the Resident's account when the cost is incurred.

(a) Barber and beauty parlor services;
(b) Private telephone, television or computer in room, including installation, maintenance and monthly and service fees;
(c) Shoes (non-prescription) and personal clothing;
(d) Dry cleaning;
(e) Special transportation for personal use;
(f) Cosmetic and grooming items and services in excess of those included in the basic service;
(g) Specially prepared food, beyond that generally prepared by the Facility;
(h) Personal comfort items including tobacco products and confections; and
(i) Personal reading materials, including newspapers.

3. THE RESIDENT'S AGREEMENT TO PAY FOR SERVICES

3.1 **Resident's Direction To His/Her Agents.** The Resident hereby directs the Responsible Party to ensure that all payment obligations under this Agreement are met from the Resident's assets and to cooperate in obtaining Medicaid coverage if necessary to meet the Resident's obligations under this Agreement.

3.2 **The Resident's Obligations.** Subject to Section 3.3 below, the Resident agrees to pay for, or arrange to have paid for by Medicaid, Medicare, managed care providers or other insurers, all services provided by the Facility under this Agreement as follows:

i) Medicare or Medicaid Coverage. If the Resident qualifies for Medicaid or Medicare coverage, the Facility agrees to accept the payment from these programs, plus any related coinsurance, deductible and Medicaid surplus amounts owed by the Resident, as payment in full for the items and services covered by Medicaid or Medicare. Residents are responsible for payment of services not covered by Medicare or Medicaid. **Residents eligible for Medicaid are also required to pay over their net available monthly income as detailed in Section 3.5(c) below.**

ii) Private Pay Status. If the Resident does not qualify for Medicaid or Medicare coverage or have other third party coverage in place, the Resident agrees to pay the Facility (i) the daily basic rate of $ 425 for a Semi Private Room (as may be increased on sixty (60) days written notice to the Resident or the Responsible Party); (ii) items and services not covered under the daily basic rate pursuant to section 2.1 above (including prescription drugs and other ancillary services); (the total of the charges set forth in Subsections 3.2(b)(i) and (ii) referred to as the "Private Pay Rate"). The Resident agrees to pay the Private Pay Rate to the Facility after other coverage has been applied or exhausted until the month in which the Resident's Medicaid eligibility covers such charges. The Private Pay Rate payable for a month shall be paid in full by the first day of that month. In addition, a Resident paying

the Private Pay Rate is responsible for paying the amount of the New York State assessment levied on the Resident's payments to the Facility, including the base assessment, as may be adjusted, and any additional temporary assessments imposed. (As of January 1, 2025, the current combined assessment rate is 6.8%).

3.3 **Third Party Agreements**

i) Managed Care Agreement. Notwithstanding anything in this Agreement to the contrary but subject to Section 3.3(c) below, during such time as (i) a written agreement (the "Provider Agreement") is in effect between the Facility and a managed care company (the "Managed Care Company") for the reimbursement to the Facility for certain services ("Covered Services") to enrolled members of the Managed Care Company's plan; and (ii) the Resident continues as an enrolled Member of the Managed Care Company's plan, except to the extent permitted under the Provider Agreement the Resident will not be responsible to the Facility for the payment of any Covered Services covered under the Provider Agreement. However, the Resident will be liable to the Facility to the extent that the Facility does not receive full reimbursement due to the Resident's failure to inform the Facility of coverage, or a change of coverage, under the managed care plan. **The Resident will remain liable for services for which the Facility is not entitled to reimbursement under the Provider Agreement, including deductibles, co-payments, co-insurance and/or payment for non-Covered Services.**

ii) Insurance Company Agreement. Notwithstanding anything in this Agreement to the contrary but subject to Section 3.3(c) below, the Resident will not be responsible to the Facility for the payment of any services provided by the Facility (the "Specified Services") to the extent the Specified Services are subject to reimbursement by the Resident's insurance company pursuant to a written agreement (the "Insurance Agreement") between the Facility and the Insurance Company. **The Resident will remain liable for payment for all services for which the Facility is not entitled to reimbursement under the Insurance Agreement, including deductibles, co-payments, co-insurance and/or payment for non-Specified Services.**

iii) Requirement to Provide Information. If the Resident does not timely provide the information required for the Facility to obtain pre-certification of the Resident's admission to the Facility from a Managed Care Company or an Insurance Company, the Resident will be responsible for all charges owed pursuant to Section 3.2 above to the extent the Facility is not reimbursed by the Managed Care Company or Insurance Company due to the Facility's inability to obtain the Resident's pre-certification for coverage.

(d) Other Insurance Arrangements. To the extent that there is no written agreement between an insurance carrier and the Facility applicable to the Resident's charges under this Agreement, the Resident shall have the sole responsibility to collect or apply for any insurance benefits the Resident may be entitled to, including long term care insurance. The Facility assumes no responsibility to apply for or collect such insurance benefits.

3.4 **Security Deposit**

i) In General. If the Resident is not qualified for Medicare Part A, Medicaid, managed care, or insurance coverage on admission, the Resident agrees to prepay an amount for basic services which shall equal ninety (90) days' payment at the daily basic rate. Prepayment will be placed in an interest-bearing account (the "Prepayment Account") and any interest earned shall be credited to Resident's Prepayment Account. The Prepayment Account must be maintained at all times at an amount equal to at least ninety (90) days at the Facility's room and board rate, and is not to be used for Resident's current care (except as otherwise provided herein). If the Resident is transferred to a more expensive room, or if the Facility's daily room and board rate increases, the Facility will notify Resident and/or the Responsible Party within thirty (30) days, and additional funds will be required to increase the prepayment to reflect the increased rate. If the Resident is spending down assets to the Medicaid limit, monies in the Prepayment Account will be applied toward current care and will be used to calculate the date when Medicaid coverage begins. Upon termination of Resident's stay at the Facility or eligibility for Medicare Part A, Medicaid, managed care or insurance coverage, any outstanding bills shall be paid from the monies in the Prepayment Account. The remainder of the Prepayment Account will be refunded, together with accrued interest, to the source of payment.

ii) Exhaustion of Medicare Benefits. If the Resident qualified for Medicare Part A, managed care or insurance benefits and these benefits become exhausted and the Resident is unable to supply satisfactory evidence of entitlement to Medicaid benefits, the Resident agrees to prepay an amount equal to ninety (90) days' payment at the daily basic rate as security for payment of any financial obligation of the Resident under this Agreement.

3.5 **Payment Obligations Under Medicaid And Other Third Party Payors**

i) Obligations to Assure Third Party Payment. The Resident agrees to provide information pertaining to all potential third party payors, and either agrees to provide proof that a claim for coverage has been made or to provide the Facility with necessary information for the Facility to submit the claim.

ii) Duty to Arrange for Timely Medicaid Application. The Resident agrees to monitor the Resident's resources to assure uninterrupted payment to the Facility by making timely application to Medicaid (and/or other payors) as is necessary. The Resident will inform the Facility at least ninety (90) days prior to the Resident's exhaustion of the Resident's assets or Managed Care or Insurance Company benefits. However, if the Resident's Managed Care or Insurance Company benefits are terminated due to a change in the Resident's condition, the Resident will inform the Facility within three (3) days of the termination of benefits.

iii) Monthly Income Payments under Medicaid. The Resident understands that if he/she receives monthly income and also qualifies for Medicaid, the County Department of Social Services will require most of such income (referred to as "Net Available Monthly Income") to be paid to the Facility. In that event, the Resident guarantees that such income will be delivered to the Facility on or before the 7th of each month or that it will be sent directly to the Facility from the income payor. If the Resident's liquid assets are exhausted or unavailable prior to a determination of Medicaid coverage, the Resident agrees to pay his/her monthly income to the Facility as partial payment for the Private Pay Rate.

iv) Semi-Private Room. Medicaid covers the costs of a semi-private room. If the Resident has occupied a private room, the Resident understands and agrees that when he/she no longer pays the Private Pay Rate and does not have a medical condition requiring a private room, when the Facility otherwise has need for the room, or when Medicaid coverage begins, he/she will move to a semi-private room.

4. THE RESPONSIBLE PARTY'S OBLIGATIONS TO THE FACILITY

4.1 **Acknowledgement of Consideration.** The Responsible Party desires to facilitate the Resident's admission to the Facility and acknowledges that the Facility has agreed to enter into this Agreement and admit the Resident to the Facility in consideration of the Responsible Party's representations to the Facility under this Agreement**.**

4.2 **Payment Obligation from Resident's Funds**. The Responsible Party personally and independently guarantees continuity of payment to the Facility from the Resident's funds for the cost of the Resident's care to the extent the Responsible Party has legal access to the Resident's funds. Unless the Responsible Party is otherwise obligated by law to pay for the Resident's care, as the Resident's spouse may be, the Responsible Party is not required to use his/her personal resources to pay for such care.

4.3 **Reliance on Spouse's Credit.** It is acknowledged that, to the extent that the Resident is married, the Facility is relying upon both the Resident and the Resident's spouse's credit for any charges incurred by the Resident.

5. RESIDENT OBLIGATIONS AND REPRESENTATIONS

5.1 **Documentation.** The Resident agrees to provide the Facility with copies of all Powers of Attorney, Guardianship Orders, Health Care Proxy or other documentation in their possession authorizing an agent to act for or on behalf of the Resident.

5.2 **Prohibition on Recording.** The Resident agrees that neither they nor their agents may record other residents of the Facility or staff of the Facility (including audio, video and still pictures) without their express written consent.

5.3 **Transfers By The Resident**. The Resident understands that the Resident's ability to qualify for Medicaid coverage could be impaired by certain transfers of assets by the Resident. The Resident further understands that the purchase by the Resident or his or her spouse of an annuity contract, life estate interest in a home, loan, promissory note or mortgage will be considered a transfer under certain circumstances for Medicaid eligibility purposes. The Resident warrants and represents the following:

(a) Except as set forth below, the Resident does not have any knowledge of transfers by the Resident or his or her spouse within the last five (5) years (i) of assets for less than their fair value or (ii) to a trust of which the Resident is a beneficiary.

_____

(b) Except as set forth below, the Resident does not have any knowledge of the purchase by the Resident or his or her spouse of an annuity contract, life estate interest in a home, loan, promissory note or mortgage within the last five (5) years.

_____

6. TRUTHFULNESS OF INFORMATION PROVIDED

The Resident guarantees the truthfulness of all information that the Resident provides to the Facility (including information relating to the financial resources of the Resident and transfers by the Resident). By signing this Agreement, the Resident acknowledges that the Facility relies on such information, and the Resident agrees to pay on demand all damages directly or indirectly resulting from the Resident's misrepresentation of information provided to the Facility, including reasonable attorney's fees.

7. LATE PAYMENTS AND NON-PAYMENT

7.1 **Late Charges**. In the event of late payment of any sums due from the Resident or Responsible Party under this Agreement, the Facility will be entitled to receive a fee computed at one and one-half percent (1-1/2%) per month of said amount or the maximum amount allowed by law, whichever is less, on all accounts overdue more than thirty (30) days.

7.2 **Discharge.** It is understood that the Resident may be discharged for non-payment of sums due under this Agreement or as otherwise permitted under New York State Department of Health Regulations.

7.3 **Collection Costs.** In case of non-payment of any sum due under the terms of this Agreement, the Resident agrees to pay interest as set forth above and reasonable collection fees, including but not limited to attorney's fees and expenses, incurred by the Facility in enforcing the terms of this Agreement.

7.4 **Damages.** If the Responsible Party breaches his/her personal obligations to the Facility, and fails to pay amounts owed by the Resident under this Agreement (including the Private Pay Rate,

the Net Available Monthly Income, or the deductibles and co-insurance) from the Resident's funds to which the Responsible Party has legal access, the Responsible Party agrees to personally pay damages caused by such failure, including interest on late payments in accordance with Section 7.1 above and reasonable attorney's fees and expenses.

8. RESIDENT'S PROPERTY

The Facility has in place written policies and procedures to safeguard the Resident's property at the nursing home facility. The Facility is not liable for the replacement or reimbursement of the Resident's property except as required under the Facility's policies and procedures or applicable law.

It is the obligation of the Resident to arrange for disposition of all of the Resident's property upon discharge. The Facility may dispose of property left more than forty-five (45) days after discharge to the proper authorities.

The Resident agrees that, except as otherwise directed by Resident to the Facility at any time, any payment refunds payable upon Resident's discharge from the Facility may be paid to the payer of the Resident's charges, include joint account holders with the Resident.

9. AUTHORIZATION FOR PHYSICIAN VISITS

The Resident (or, if the Resident lacks consent and the Responsible Party has the authority make healthcare decisions on behalf of the Resident, the Responsible Party) agrees that a physician may visit the Resident in the Facility at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter, or as often as necessary to address the Resident's medical care needs.

10. OBLIGATIONS TO ABIDE BY FACILITY RULES AND REGULATIONS; NON-SMOKING FACILITY; SURVEILLANCE

The Resident agrees to abide by the Facility's Rules and Regulations, and to respect the personal rights and private property of all residents and staff. The Resident acknowledges that the Facility is a non-smoking facility (including electronic cigarettes) and will abide with all rules of the Facility restricting smoking. The Resident acknowledges that the public spaces of the Facility may be subject to camera surveillance for safety, security, and quality assurance purposes.

11. RELOCATION

The Resident may be relocated to another room or unit within the Facility if there is a change in medical condition. This includes the relocation of the Resident from the Facility's subacute unit to a long-term care unit. The Resident may also be relocated to another room if such a change is required to ensure that persons of the same gender share a room or to accommodate the clinical needs of another resident.

12. CONSENT TO JURISDICTION AND GOVERNING LAW

Each of the parties to this Agreement irrevocably (a) submits to the exclusive jurisdiction of the courts of the State of New York in the County of Orange (and the Federal courts having jurisdiction in the State of New York, County of Orange) for purposes of any judicial proceeding that may be instituted in connection with any matter arising under or relating to this Agreement or otherwise, (b) waives any objection that such party may have at any time to the laying of venue of any action or proceeding brought in any such court, and (c) waives any claim that such action or proceeding has been brought in an inconvenient forum.

13. GENERAL PROVISIONS RELATING TO THIS AGREEMENT

In addition to the parties signing this Agreement, the Agreement shall be binding on the heirs, executors, administrators, distributors, successors, and assigns of the parties. Notwithstanding anything in this Agreement to the contrary, the provisions of sections 3, 4, 5, 7, 8, 12, 13 and 14 shall survive the termination of this Agreement.

This Agreement represents the entire agreement among the parties and may not be amended or modified except in writing signed by the Facility and the Resident and/or the Responsible Party, except with respect to increases in charges as set forth in this Agreement and modifications required by changes in the law. Modifications to this Agreement necessitated by changes in statutory or regulatory requirements or their interpretations are deemed to become part of this Agreement. This Agreement shall be governed by and construed in accordance with the laws of the State of New York.

This Agreement shall remain in full force and effect upon the Resident's return to the Facility after the temporary transfer of the Resident to another facility for medical or surgical treatment or the Resident's temporary absence from the Facility when the Facility is required to readmit the Resident under applicable law.

The failure of any party to enforce any term of this Agreement or the waiver by any party of any breach of this Agreement will not prevent the subsequent enforcement of such term, and the party will not be deemed to have waived any subsequent breach of this Agreement. Should any provision of this Agreement be void or unenforceable, that provision shall be deemed omitted, and this Agreement with such other provision omitted shall remain in effect.

Headings contained in this Agreement have been inserted for reference purposes only, and shall not be construed as part of this Agreement.

[BALANCE OF PAGE INTENTIONALLY LEFT BLANK]

The parties to this Agreement have read, been advised of, understand and agree to be legally bound by the terms and conditions set forth herein.

In addition, we, the Resident and the Responsible Party, have received copies of the following:

- **the Resident's Statement of Rights;**
- **information on how Residents and their family members can look up complaints, citations, inspections, enforcement actions, and penalties taken against the Facility;**
- **physician's name, address and telephone number;**
- **New York State Department of Health "hot line" telephone number;**
- **New York State Office of the Aging Ombudsman Program telephone number;**
- **information about Medicaid and Medicare eligibility;**
- **bed retention policy;**
- **information on the right to make advanced directives or to refuse medical treatment;**
- **restraint and pain policy; and**
- **the Facility's visitation policy.**

ACCEPTED:

RESIDENT:

_____ _____
Signature Date

If signing on behalf of Resident:

_____ _____
(Name) *(Authority)*

RESPONSIBLE PARTY
(including with respect to the obligations set forth in Section 4 above):

_____ _____
Signature Date

ACCEPTED:

FACILITY:

CAMPBELL HALL REHABILITATION CENTER

By:_____ _____
Name: Date
Title:

CAMPBELL HALL
REHABILITATION CENTER

ADDENDUM I
AUTHORIZATION FOR ACCESS TO MEDICAID FILE

I hereby authorize CAMPBELL HALL REHABILITATION CENTER to have full access to the application for Medical Assistance ("Medicaid") filed on behalf of _____ and to the attendant file and recertification file maintained by any government agency in connection with that Medicaid application.

I understand that this Authorization would allow CAMPBELL HALL REHABILITATION CENTER to receive copies of all correspondence and other documents regarding the application and recertification.

_____ _____
Date Signature

Print Name:_____

Relationship:_____

_____
Witness

CAMPBELL HALL
REHABILITATION CENTER

ADDENDUM II
AUTHORIZATION TO OBTAIN MEDICAID ELIGIBILITY

I, hereby authorize **CAMPBELL HALL REHABILITATION CENTER** to act in my name, place and stead in connection with the establishment of my initial and continuing eligibility for Medicare and Medicaid benefits, including with respect to filing the appropriate applications for my initial and continuing eligibility, applying for and attending a Fair Hearing to contest any denial or discontinuance of Medicaid eligibility, and to secure copies of all applicable banking and financial statements in my name, to secure verification of my resources and any income received in my name at the time of application and during the applicable Medicaid lookback period, to secure confirmation of the face and cash value of any life insurance policy in my name, and to secure verification of any third party insurance benefits to which I may be entitled.

To induce any third party to act hereunder, I hereby agree that any third party receiving a duly executed copy or facsimile of this instrument may act hereunder, and that revocation or termination hereof shall be ineffective as to such third party unless and until actual notice or knowledge of such revocation or termination shall have been received by such party, and I for myself and for my heirs, executors, legal representatives and assigns, hereby agree to indemnify and hold harmless any such third party from and against any and all claims that may arise against such third party by reason of such third party having relied on the provisions of this instrument.

_____ _____
Dated Signature

Print Name:_____

Relationship:_____

_____
Witness

CAMPBELL HALL
REHABILITATION CENTER

ADDENDUM III
EXTERNAL APPEAL OF MEDICAL NECESSITY DENIALS
DESIGNATION AND AUTHORIZATION

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

I,_____, residing at _____
_____
appoint CAMPBELL HALL REHABILITATION CENTER (the "Facility") by its Administrator or corporate officer 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, US Department of Labor and/or other applicable agency or body.

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

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

IN WITNESS WHEREOF, I have signed my name this _____day of _____, _____.

_____ _____
Resident/Patient or Legal Representative **Witness**

CAMPBELL HALL
REHABILITATION CENTER

ADDENDUM IV
Facility Camera Consent Resident

We here at Campbell Hall Rehabilitation Center wish to respect your right to privacy. Campbell Hall Rehabilitation Center is a facility that utilizes cameras for the overall safety of our residents, staff and visitors. In order to protect every residents right to personal privacy and confidentiality the facility does not utilize surveillance cameras within resident rooms, bathrooms, shower rooms, or any other personal care areas. The cameras are located throughout the facility to cover public areas.

Your consent of this form states that you acknowledge the use of such devices and agree to the continued use of such devices.

Resident:

Signature: _____ Date : _____

Responsible Party / POA

Signature: _____ Date : _____

CAMPBELL HALL
REHABILITATION CENTER

ADDENDUM V
Privacy Practices Acknowledgement

I acknowledge I have received a copy of Campbell Hall Rehabilitation Center's Notice of Privacy Practices as per the Health Insurance Portability and Privacy Act of 1996 and updated according to revisions to date.

Resident:

Signature: _____ Date : _____

Responsible Party / POA

Signature: _____ Date : _____

CAMPBELL HALL
REHABILITATION CENTER

ADDENDUM VI
Resident Wireless Guest Network Access
Acceptable Use Policy

We are pleased you have chosen Campbell Hall Rehabilitation Center for your long- or short-term residential needs. In the spirit of providing stimulation and access to community resources, we have activated a Guest Network for your use. There are guidelines that we are expected to follow in compliance with network regulations, so we ask that you consider and observe the following while accessing the Internet via our network.

It is the company's policy to provide access to the Internet for all its residential customers. Because network resources are shared by all users, the company has implemented the following policies to govern mass market Internet service. These policies are designed to: (I) ensure that shared network resources are allocated fairly among all users; (ii) allow users and prospective users to understand service policies and any significant limitations on the service; and (iii) provide the Company with recourse if policies and guidelines are not observed per this agreement. The company does not block access to, nor discriminate against, any lawful website or Internet application that is consistent with the company's Acceptable Use Policy set forth below. Customers are encouraged to familiarize themselves with the following policies which are signed by them, as part of their Usage Agreement. By using the company's Internet service, the customer accepts, agrees to be bound by and to strictly adhere to these policies. The customer also agrees to be responsible for compliance with these policies by third parties, such as friends, family members or guests that make use of the customer's service accounts or equipment to access the network for any purpose, with or without the permission of the customer.

1. **I. ACCEPTABLE USE POLICY**

1. General Policy. The company reserves the sole discretion to deny or restrict your service, or immediately to suspend or terminate your service, if the use of your service by you or anyone using it, in our sole discretion, violates the Service Agreement or other company policies, is objectionable or unlawful, interferes with the functioning or use of the Internet or the company's network by the company or other users, or violates the terms of this Acceptable Use Policy ("AUP").

2. Specific Examples of AUP Violations. The following are examples of conduct which may lead to termination of your Service. Without limiting the general policy in Section 1, it is a violation of the Agreement and this AUP to: (a) access without permission or right the accounts or computer systems of others, to spoof the URL, DNS or IP addresses of the company or any other entity, or to penetrate the security measures of the company or any other person's computer system, or to attempt any of the foregoing; (b) transmit uninvited communications, data or information, or engage in other similar activities, including without limitation, "spamming", "flaming" or denial of service attacks; (c) intercept, interfere with or redirect email or other transmissions sent by or to others; (d) introduce viruses, worms, harmful code or Trojan horses on the Internet; (e) post off-topic information on message boards, chat rooms or social networking sites; (f) engage in conduct that is defamatory, fraudulent, obscene or deceptive; (g) violate the company's or any third party's copyright, trademark, proprietary or other intellectual property rights; (h) engage in any conduct harmful to the company's network, the Internet generally or other Internet users; (I) generate excessive amounts of email or other Internet traffic; (j) use the service to violate any rule, policy or guideline of the company: (k) use the service in any fashion for the transmission or dissemination of images containing child pornography or in a manner that is obscene, sexually explicit, cruel or racist in nature or which espouses, promotes or incites bigotry, hatred or racism; or (l) download or use the Service in Cuba, Iran, North Korea, Sudan and Syria or in destinations that are otherwise controlled or embargoed under U.S. law, as modified from time to time by the Departments of Treasury and Commerce.

3. Network Monitoring and Privacy. You acknowledge that the Company reserves the right to monitor the activity and usage of this network. This is a public network and should be treated as such. You should utilize appropriate caution in entering private, privileged or confidential information via this Internet portal. The company may, but is not required to, monitor your compliance, or the compliance of other users, with the terms, conditions or policies of the Usage Agreement and AUP. You acknowledge that the company shall have the right, but not the obligation, to pre-

screen, refuse, move or remove any content available on the service, including content that violates the law or this Agreement.

4. Network Keys. The Company reserves the right to periodically change the network key which provides access to the network. At such a time as this change is made, users are expected to acknowledge the user agreement with signature. This constitutes a periodic review of user awareness of all applicable and enforceable rules and policies governing this system's use.

Acknowledged By:

Resident:

Signature: _____ Date : _____

Responsible Party / POA

Signature: _____ Date : _____

Relation : _____

Witness:

Signature: _____ Date : _____

Wireless Network: CampbellGuest

Network Key: CampbellHallW1F1

CAMPBELL HALL
REHABILITATION CENTER

ADDENDUM VII
General Rules & Information
ELECTRICAL EQUIPMENT

Please be advised that the following devices are prohibited in this Facility: portable heating devices, including electric blankets; common extension cords; unapproved power strips; refrigerators; kitchen appliances or similar devices. Only power strips that are UL rated at 1363 are permitted. Please refer to excerpt from Campbell Hall Electrical equipment policy noted below:

*"SAFETY: **NO** use of portable electric heating devices or common extension cords."*

Although power strips/junction boxes are permitted, there are strict criteria by the State Code that must be met, regarding appropriate UL Listing. To ensure that we are compliant with these codes, any such cords must be inspected by the Maintenance Department prior to use. Additionally, please do be aware that any electrically powered device that is intended for use in the Facility, must be quality- and safety-checked by the Facility Maintenance Department. Upon said safety check, a sticker will be applied to the cord of the device, attesting to compliance. Please present all electrical appliances or devices to the Reception Desk before placement in the Resident living space.

PERSONAL ITEMS

The resident's personal items that arrive upon admission will be inventoried at that time. It is the responsibility of the Family to present items brought in after admission, to be screened for safety and to be inventoried. Notification of this responsibility is posted prominently in the lobby of the Facility. In the event that any personal item is deemed inappropriate for storage or use in a resident area, other accommodations will be considered, such as storage in the Facility safe, or secured by Nursing. If safe and responsible storage cannot be arranged, or is not in accord with Facility Policy, family/responsible parties will be asked to remove the item(s) from the Facility. Items that are of particular concern include, but are not limited to, sharp implements such as scissors, knives and bladed razors, as well as food items requiring storage in refrigeration or pest-impervious containers. The Facility discourages keeping expensive or delicate, breakable items in the resident's room, as well as those items that hold great sentimental value and cannot be replaced.

LAUNDRY

Please be advised that it is the policy of Campbell Hall Rehabilitation Center that all personal clothing brought into the Facility for your loved one must be left with the Front Desk Receptionist for proper labeling and inventory. This policy is in effect even if you intend to wash laundry at home. Finally, please do consider the laundry needs of clothing items, such as wool, wool blends or delicates, that could become damaged during the routine Facility laundering process. Failure to adhere to this policy may result in lost or misplaced items that we will not be able to replace.

The Facility may not be held liable for outcomes including loss or breakage of items that are not handled in accordance with this Policy.

Resident:

Signature: _____ Date : _____

Responsible Party / POA

Signature: _____ Date : _____

Relation : _____

CAMPBELL HALL
REHABILITATION CENTER

ADDENDUM VIII
Image Use Consent

Thank you for agreeing to appear in promotional and marketing materials to promote services at Campbell Hall Rehabilitation Center. Your signature on this form serves as an acknowledgement of your consent to use your image in a promotional brochure to be distributed to potential residents and families, in a public setting.

Campbell Hall Rehabilitation Center attests that your image will only be used for the express purpose as agreed, and that we will not sell, distribute or otherwise disseminate your image without obtaining further consent from you or your representative.

Resident:

Signature: _____ Date : _____

Responsible Party / POA

Signature: _____ Date : _____

Relation :

CAMPBELL HALL
REHABILITATION CENTER

ADDENDUM IX

RESIDENT TRUST FUND POLICY NOTIFICATION AND AUTHORIZATION

Resident Name: _____

This notice is to inform you that Campbell Hall Rehabilitation Center offers the option of maintaining a Resident Trust Fund Account for your personal use. This account is completely voluntary and is offered as a convenience to assist you in managing your personal spending money while residing in the facility. Funds placed in this account will be used solely for the benefit of the resident and may be accessed to purchase items or services requested by the resident or their representative. A written receipt is issued for every deposit or withdrawal, and the resident or their authorized representative may review the account and request a statement at any time.

Federal and state regulations require that all resident funds over $50 be placed in an interest-bearing account. The facility is bonded to protect all resident funds and maintains separate accounting for each resident's balance. Upon discharge or death, any remaining funds will be refunded to the resident, their estate, or legally authorized representative. Additionally, the facility is required to notify the resident or their representative when the resident's balance approaches the Medicaid resource limit or exceeds the Supplemental Security Income (SSI) threshold.

By signing below, I acknowledge that I have been informed of my right to manage my own personal funds.

☐ **I authorize Campbell Hall Rehabilitation Center to establish and maintain a Resident Trust Fund Account on my behalf. I understand that I may revoke this authorization at any time in writing.**

☐ **I choose not to utilize this service and retain full responsibility for managing my own finances.**

Resident Signature: _____ **Date:** _____

Authorized Representative Signature: _____ **Date:** _____

Relationship to Resident: _____

Facility Representative Signature: _____ **Date:** _____

CAMPBELL HALL
REHABILITATION CENTER

ADDENDUM X
AUTHORIZATION FOR DIRECT RECEIPT OF NAMI PAYMENTS

The Resident, _____ and/or the Signer on the Resident's behalf, agree below to arrange for direct payment of the Resident's Net Available Monthly Income (NAMI) to the Facility. The NAMI consists of the Resident's monthly income less fifty dollars ($50.00). The fifty dollars ($50.00) represents the amount that the Resident is permitted to retain for personal use. The NAMI is prescribed by law. Such monthly income (less the legally prescribed personal allowance.

The Resident and/or Signer agree to arrange for direct payment of the Resident's monthly income checks to Campbell Hall Rehabilitation Center, with the understanding that the Facility will apply the amount from such income owed to the Facility as the NAMI and will deposit the remainder in the Resident's personal account.

If, for reasons beyond the Resident's and/or the Signer's control, payments cannot be deposited directly from the payer source(s), in order to facilitate continuity of payment, I agree to notify all payers of monthly income of the Resident's address change so that the Resident's monthly income will be sent directly to the Resident at:

Campbell Hall Rehabilitation Center
23 Kiernan Rd
Campbell Hall, NY 10916

Resident Signature: _____ **Date:** _____

Authorized Representative Signature: _____ **Date:** _____

Relationship to Resident: _____

Facility Representative Signature: _____ **Date:** _____

CAMPBELL HALL
REHABILITATION CENTER

Pre-Admission Information Packet

Introducing Our Management Team,

Administrator	Avinoam Wizman
Nursing	Sandra Lugo
Food Services	Juan Arevalo
Dietitian	Cristine Vega
Social Services	Maria Saladino + Theodora Neizer
Facilities Management	Robert Requena
Admissions	Taylor Devantier

Also, we introduce our Special Dining Experience in the Lower Level at The Bistro. With made-to-order breakfast and lunch, specialty menus and special evening events.

Our five-star menu is designed by food service Director Keyno Gallimore! Recent highlights include our specialty cuisines and authentic ethnic meals ranging from Asian, Cajun, Spanish and many more. We also added resident requested comfort meals such as braised short ribs and shrimp scampi.

VISIT OR CALL FOR A PERSONAL GUIDED TOUR OF OUR FACILITY!

Thank you for considering Campbell Hall Rehabilitation Center for your sub-acute rehab, long-term care, or short-term respite care needs. We look forward to meeting you and serving you!

Phone: 845-294-8154

Fax: 845-294-6684
Admissions Fax: 845-477-1291

23 Kiernan Road
Campbell Hall, NY 10916

CAMPBELL HALL
REHABILITATION CENTER

Admission Notification of Corporate Compliance Contact Information

Welcome to Campbell Hall Rehabilitation Center!

We are committed to providing quality care in an ethical and responsible manner to all residents who select us for their rehabilitation or long-term living needs. There are extensive, comprehensive and complicated regulations and laws which govern the daily operation of this setting, including the requirement to establish policies for surveillance and investigation of potential or suspected Corporate Compliance violations.

We encourage you to share any concerns you may have with our staff. Nurse Managers, Department Heads, the Director of Nursing and the Administrator are all members of the Corporate Compliance Committee and are all resources for you to report to. You may also report your concerns directly to our Corporate Compliance Officer, Justin Wood.

Below is information that may be used to contact them via confidential or anonymous avenues. Please be aware that all reports are maintained confidentially and are investigated with the highest level of regard for privacy as well as resolution.

Thank you for the opportunity to serve you and your loved one, we look forward to a positive and rewarding relationship.

Corporate Compliance Officer:

Justin Wood

Hotline Voice Mail Box:	***Postal Mail:***	***Email Address:***
(844) 845-7784	Justin Wood c/o Campbell Hall Rehabilitation Center 23 Kiernan Rd Campbell Hall, NY 10916	cc@campbellhallrehab.com

CAMPBELL HALL
REHABILITATION CENTER

Elder/Resident External/Cooperative Advocacy Resources

Orange County Office for the Aging
Ann Marie Maglione, Director
18 Seward Avenue
Middletown, NY 10940
(845) 615-3700

NYS Long Term Care Ombudsman Program
2 Empire State Plaza
Albany, NY 12223

1-800-LTCOPNY

(582-6769)

www.ltcombudsman.ny.gov

The New York State Department of Health, Nursing Homes and ICF/IID Surveillance is responsible for investigating complaints and incidents for nursing homes in New York State, which are related to State and/or Federal regulatory violation. A complaint against a nursing home should be submitted in writing by the complainant.

The Nursing Home Complaint Form is available online to submit your complaint against a nursing home. The web address is:
https://apps.health.ny.gov/nursing_homes/complaint_form/complain.action

If you are unable to submit your complaint by using the Nursing Home Complaint Form , then you may contact the Nursing Home Complaint hotline (1-888-201-4563) which can be called 24 hours per day, seven days per week. The hotline is manned by Nursing Homes and ICF/IID Surveillance staff from 8:30 a.m. to 4:45 p.m. Monday through Friday. A voicemail message may be left during non-business hours

CAMPBELL HALL
REHABILITATION CENTER

Professional Service Providers

Dr. Amit Saxena, Medical Director
23 Kiernan Road
Campbell Hall, NY 10916
(845) 294-8154

SPEECH THERAPY: LANGUAGE FUNDAMENTALS
5 Old Grange Road
Hopewell Junction, NY 12533
Office: (845) 897-3330

Dentist: Dr. William Stone
5 Mansion Drive
Glen Cove, NY 11542
Phone/Fax: (516) 671-0504

Eye Doctor: Dr. Yakubov Markiel (Avi Mayer)
305 Division Ave
Brooklyn, NY
Phone: 347-403-3877 or FAX: 718-889-2185

Family Footcare Group, LLP(Podiatry)
427 Broadway, Ste 2
Monticello, NY 12701
Office: (845) 794-0228

Psychologist: Holly Tanenbaum

Advanced Wound Care provided by
VOHRA Post-Acute Physicians
Regional Manager: Tzvi Volosov, DPM
954-399-4680

CAMPBELL HALL
REHABILITATION CENTER

Salon Services By Vanessa

WASH & SET / BLOW DRY	**$ 25.00**
WASH, CUT, & SET OR BLOW DRY	**$ 40.00**
WASH & CUT	**$ 30.00**
PERM	**$ 65.00**
COLOR & BLOW DRY OR SET	**$ 45.00**
COLOR, CUT & SET	**$ 60.00**
BARBER SERVICES	**$ 25.00**
SHAVE	**$ 15.00**
TRIM	**$ 25.00**
STYLING	**$ 15.00**
MANICURE	**$ 25.00**

Campbell Hall Rehabilitation Center Salon is located on the first floor adjacent to the first-floor nurse's station.

Salon hours are _____.

Appointments may be made through the receptionist at the entrance of the facility.

Salon services may be paid for at the time of service, or an account may be established through the Finance Office.

Disclaimer
Salon services provided within this facility are performed by an independent contractor and not by facility staff. The facility does not supervise, manage, or assume responsibility for any salon services rendered. All decisions to receive such services are made solely at the discretion of the resident, and any arrangements, payments, or concerns regarding services should be addressed directly with the salon provider.

CAMPBELL HALL
REHABILITATION CENTER

RESIDENT RIGHTS

AS A NURSING HOME RESIDENT,

YOU HAVE RIGHTS WHICH INCLUDE, BUT ARE NOT LIMITED TO:

- *Dignity, respect and a comfortable living environment*
- *Quality of care and treatment without discrimination*
- *Freedom and assistance in participating in the development and modification of your own plan of care, including choosing those who help you make decisions*
- *Freedom of choice to make your own independent decisions*
- *Freedom to choose your own physician*
- *The safeguard of your property and money*
- *Safeguards in admission, transfer and discharge*
- *Privacy in communications*
- *Participate in organizations and activities of your choice*
- *An easy to use and responsive complaint procedure*
- *Exercise all of your rights without fear of reprisals*

CAMPBELL HALL
REHABILITATION CENTER

Resident Demographics & Contact Information

Resident Name: _____ **Room #:** _____

Religion Observed: _____ **SSN:** _____

Marital Status: Married / Widowed / Single / Divorced

VOTER REGISTRATION STATUS	**VETERAN STATUS**
Is the resident a registered voter? **Y / N**	Is the resident a Veteran? **Y / N**
If so, in which County? _____	

Preferred Funeral Parlor:
Name: _____ Phone: _____
Address: _____

Is there a Living Will? Y / N **Copy with Facility?** Y / N

Health Care Proxy: Y / N **Copy with Facility?** Y / N
Name: _____ Email Address: _____
Address: _____

Home: _____ Cell: _____ Work: _____

Other Contacts / Family:

Name: _____ Email Address: _____
Address: _____

Home: _____ Cell: _____ Work: _____

Relationship to Resident: _____ Access to Health Information? _____

Name: _____ Email Address: _____
Address: _____

Home: _____ Cell: _____ Work: _____

Relationship to Resident: _____ Access to Health Information? _____

NOTIFICATION PREFERENCES:

If you do not specify preferred hours, staff will contact you around the clock about changes in resident conditions.

If the resident has a change in condition, or there is an accident or incident:

Call me during these hours: _____ Do NOT call me during these hours: _____
Call me ANYTIME: ☐

CAMPBELL HALL
REHABILITATION CENTER

Important Financial Notifications

Thank you for your time and attention during this review of the Admission Agreement and associated information. Please visit the Finance office at your earliest convenience; at that time, you will be asked to provide pertinent documents including but not limited to insurance cards, Social Security card, Medicare and or Medicaid cards, Power of Attorney, and any other finance- or income-related documents.

Facility staff will make copies of these documents and return the originals to you immediately.

Room Rates

Please be advised that all daily rates are for room/board and services; rates do not include cost of medications, nor do they include costs associated with outside transportation or Physical, Occupational or Speech Therapies.

Private Room:
$ 450 /day + 6.8% required assessment = $ 480.60 daily.
2 months down payment requested

Semi-Private Room:
$ 425 /day + 6.8% required assessment = $ 453.90 daily.
2 months down payment requested.

Co-Insurance Costs

Co-Pay Private Pay (without co-insurance)
$ 217 /day (amount is set by Medicare, not by facility)
Typically starts on 21st covered day, but may vary depending upon Medicare policy details

Transportation Costs

Resident/Responsible Party may be required to cover transportation costs to and from professional appointments, dialysis and other outpatient treatments if insurance coverage does not extend to this service.