APPLICATION FOR ADMISSION for ALTERNATE Level of Care

Please Circle one: Short Term Rehab - Assisted Living - Skilled Nursing (LTC)

Applicant Name: _____ Social Security #: _____

Sex: __ M __ F Date of Birth: _____ Place of Birth: _____

Marital Status: _____ Name of Spouse: _____

Address: _____

Present Location: _____

Primary Care Physician: _____ Phone#: _____

Religion: _____ Church: _____

Have you been hospitalized in the past 90 days: ___ Yes ___ No

If yes, where: _____

Placement discussed with resident on: (date) _____ by _____.

Reaction to discussion of placement: _____

Persons To Be Notified:

1. Name: _____ Relationship: _____ HCP: __ No __ Yes

Address: _____

Telephone Number: Home: _____ Work: _____ Cell: _____

2. Name: _____ Relationship: _____ POA: __ No __ Yes

Address: _____

Telephone Number: Home: _____ Work: _____ Cell: _____

United States Citizen: ___ Yes ___ No

Previous Occupation: _____

Previous Employer(s): _____

Does the Applicant have a prepaid funeral arrangement? ☐ Yes ☐ No

Funeral Home of Choice: _____

Cemetery Plot? ____ Yes or ____ No

Name of Cemetery: _____

Person/Agency Responsible for Payment: _____

Address: _____ Telephone Number: _____

Do you have a Health Care Proxy: ___ Yes ___ No * please note: HCP must be 1st contact.

If yes, name: _____ Telephone Number: _____

Do you have a Power of Attorney: ___Yes ___ No * Please provide a copy

If yes, Name: _____ Telephone Number: _____

Do you have a Guardian appointed by Court? _____Yes _____No. If yes, please provide name, address and telephone number: _____

Financial Information:

The reason that Financial information is being requested is you either ..do not have secondary insurance, or have limited coverage, or is suspected that the patient will be permanent placement.

Medicare #: _____ Medicaid #: _____ Medicaid Worker _____

County (or Counties of Residence): _____

Do you have a Medicaid appointment: ___ Yes ___ No If yes, date: _____

Long Term Care Insurance & Policy#: _____ Telephone Number: _____

Other Health Insurance & Policy#: _____ Telephone Number: _____

Prescription Insurance/Medicare D Plan: _____

Do you need prior approval: ___ Yes ___ No

Veteran Status: ___ Non-veteran ___ Veteran ___ Veteran Related

Monthly Income Source	Applicant	Spouse	Total Income
Monthly Social Security			
SSDI(Disability)			
SSI			
Pension/Retirement			
Veterans Benefits			
Interest/Dividends/Annuity Income			
Other (i.e. rental income)			
Total Monthly Income			

Monthly Expense	Applicant	Spouse	Total Expenses
Health Insurance Premiums			
Mortgage			
Other (taxes, utilities, cable, phone, etc.)			
Total Monthly Expense			

Does the Applicant have a Trust which he/she created or is the beneficiary of? ☐ Yes ☐ No

Date trust was established	Type of trust	Value of trust

Date the Trust was Funded : _____
(i.e. when the assets in the trust were transferred into trust)
Name of the Trustee: _____

Address: _____ **Phone #:** _____

*****A copy of the trust must be provided prior to admission.*****

Has the Applicant transferred any of his/her assets in the past 60 months (i.e. money, stock, real estate)? ☐ Yes ☐ No

Describe Transfer(s) (including gifts):

Date of Transfer(s) and Recipient of Transfer(s)	Asset(s) Transferred and Value(s)

*****If any of the Transfers has been made within the past 60 months, Applicant must provide copies of cancelled check(s), deed(s), or other evidence documenting the Transfer(s) prior to admission.*****

Applicant's Liquid Assets (include all checking, savings, CD's, IRA's, Annuities, Mutual Funds, Stocks/Bonds, Life Insurance, or any other investments) Please attach current copies of all.

Assets	**Financial Institution & Account Number**	**Name(s) on Assets**	**Current Value**
Savings			
Checking			
Retirement			
Stocks and Bonds			
Other Assets			
Life Insurance	Term Whole Life		
TOTAL			**$**

Real Property

(Must explain Applicant's and Spouse's Ownership, Joint Tenancy, Tenants in Common Interest)

Real Property Address	Owner (s) of Property	Current Value

Please be sure all questions have been answered.

Important Notice:

Please provide copies of bank and/or investment account statements to verify assets; the first two pages of most recent IRS Form 1040; the interest and dividend schedule from your most recent income tax return; and records or gifts in excess of $2,000 made by Applicant and Spouse within the last five years.

Copies of all Advance directives (HCP, POA, MOLST, Living Will, DNR), and All insurance cards, Social Security Card, LTC Policy, Divorce Decree, and Guardianship Papers, must be submitted with the Application.

The Long Term Care Facility relies on the information disclosed in this application in making decisions regarding admission. Unless otherwise stated, this application may be shared with any of submitted sister facilities affiliates.

Submission of an application does not guarantee admission or a spot on a wait list. Placement is offered only after an application is reviewed and approved by the Long Term Care Facility.

##########

I, _____, attest that the information reported in this application is true and accurate. I understand that Long Term Care Facility is relying on the information disclosed in this application in making decisions regarding admission of the Applicant herein. I agree to supplement this application if there are any changes to the asset, liability or income information disclosed in this application.

*Effective November 15, 2007, All Long Term Care Health Facilities are now Tobacco free. Individuals are not permitted to smoke on grounds. All tobacco, including electronic cigarettes are prohibited on facility grounds.

Signature of Person Completing Form: _____ Date: _____

Federal and State law prohibit the SNF from denying admission to anyone because of race, creed, color, national origin, sex, handicap, marital status, source of payment, sexual preference, or presence or absence.

Samaritan Health
Watertown, New York

Place patient identification sticker here

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name:	Date of Birth:	MR #:
Address:		Phone:

I hereby authorize:

TO:

- ☐ Samaritan Medical Center, 830 Washington Street, Watertown, NY 13601
- ☐ Samaritan Keep Nursing Home, 133 Pratt Street, Watertown, NY 13601
- ☐ Samaritan Summit Village, 22691 Campus Drive, Watertown, NY 13601
- ☐ Samaritan Family Health Center, Location: _____
- ☐ Other: _____

to release personal health information from the medical records of the above named patient:

FROM: _____
Name & Address of Person/Organization to which disclosure is to be made

For the following purpose: _____

For the following dates of service (must be completed): _____

Type of Access Requested		Select Portions Requested	
☒ Copies of record	☐ Entire Record	☒ Labs	☒ MD Progress Notes
☐ View Record Only	☐ Emergency Room Visit	☐ Imaging/Radiology	☐ MD Orders
☒ Demo Sheet	☒ History & Physical	☐ Cardiac/EKG	☒ Other: Last Two office Visit Notes Flu + Pneumo Vacs
	☒ Consultations (if any)	☒ Discharge Summary	
	☐ Operative/Procedure	☐ Pathology Report Only	

This authorization expires on _____ unless otherwise revoked or 90 days from the date signed below.

I, the undersigned, request that the health information regarding my care and treatment be released as indicated on this form.

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996, I understand that:

1. *I have the right to revoke this authorization at any time (except to the extent that information has already been released based on this authorization) by notifying Samaritan's Health Information Management Department in writing. My written request to revoke this authorization must be signed, dated and sent to: Samaritan Medical Center, Medical Records, 830 Washington Street, Watertown, New York 13601.*
2. *Signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.*
3. *Information disclosed by this authorization might be re-disclosed by the recipient and -may no longer be protected by federal or state law. I release and discharge this facility of any liability and hold this facility harmless for complying with this "Authorization for Release of Medical Information".*

_____ Print Name

_____ Date

_____ Signature of Patient/Legal Representative

_____ Relationship/Authority

We may impose a reasonable, cost-based fee, in compliance with all laws and regulations applicable to release of information.

Federal Register, Department of Health & Human Services, 45 CFR, Standards for Privacy of Individually Identifiable Health Information, Section 164.524

Please list method used to verify identity if records are to be hand delivered.

ADMISSION AGREEMENT

This Agreement is made this _____ day of _____2018, between Samaritan Summit Village, hereinafter referred to as Samaritan and _____ hereinafter referred to as "Resident" and _____ hereinafter referred to as "Designated Representative"

Welcome! We hope that your stay with us will be as pleasant and comfortable as possible. In order to achieve this, we enter into this Agreement with the commitment that we will work with you and your representatives so that this may become your home. Please direct any questions you may have about this Agreement to the SSV Admissions Department, and we will provide you with the additional information that you need.

We reserve the right to amend this Admission Agreement as it becomes necessary. Except otherwise required by law or by the provisions of this Admission Agreement, any such amendment shall be made upon prior written notice to you and, if applicable and required by law, your Designated Representative. Notice to your Designated Representative, if required, shall be effective upon mailing such notice by first-class mail to the last known address of your Designated Representative on file with us.

1. Samaritan hereby accepts the above named applicant for residence. The duration of this contract shall be in accord with the terms and conditions herein stated.

2. The Resident may designate an individual, including a spouse, family member, or non-family member to act as the Designated Representative. The Designated Representative will be asked to sign this Agreement. By signing this Agreement, the Designated Representative agrees to assist the Resident in certain specified ways to meet his/her obligations under this Agreement, including assisting the Resident in arranging for payment from the Resident's funds to meet the Resident's obligations to pay for care and services provided by Samaritan.

3. Effective January 1, 2018, the rates will be as follows:

    a. **Private Pay**: The "basic" or Private Pay Daily Rate is the charge for a private pay Resident who is not entitled to Medicare and/or Medicaid and/or other private insurance benefits. However, even in the event the Resident is entitled to Medicare and/or Medicaid and/or other private insurance benefits, it is the Resident/Designated Representative who is ultimately responsible for payment of services.

    The Resident agrees that at the time of admission, the Resident will deposit with Samaritan the sum equivalent to one (1) month of the current daily rate, such sum representing the Resident's security deposit. Such security deposit shall be held in a separate interest bearing account. Samaritan shall have the sole discretion as to the type and nature of account in which the security deposit is held. The term "separate interest bearing account" means an account maintained by Samaritan separate and distinct from its general or other special accounts. Separate interest bearing account does not mean that Samaritan is obligated to hold each Resident's security deposit in a separate account for said Resident. Samaritan maintains the right to use a Resident's security deposit for delinquent payment of the

monthly basic charge as required herein. If Samaritan is required to use all or a part of the Resident's security deposit for payment of delinquent charges, the Resident agrees to deposit with Samaritan additional funds to replenish said Resident's security deposit to a sum equivalent to one (1) month of the monthly basic charge at the time said payment is made upon written notice to the Resident or Designated Representative.

SKILLED NURSING:
Private Room (per day) $377.00
Semi-Private Room (per day) $359.00
**There is also a 7% New York State Assessment Fee required for Skilled Nursing Facilities.*

For SKILLED NURSING (private pay only).

_____ I am requesting a private room. I acknowledge the room difference is $18 per day between semi-private and private. I agree to pay the additional charge.

_____ I am not requesting a private room. If admitted to a private room, I request to be transferred to the next available semi-private room. I do not agree to pay the additional charge.

These rates are subject to change in accordance with the terms hereinafter set forth. The Resident agrees to pay in advance the monthly charge to Samaritan on or before the 10th day of each month.

b. **Medicare**. The Facility does not require advance payment upon admission from residents eligible for Medicare reimbursement for the services provided. If the Resident meets established criteria and is deemed eligible for Medicare coverage, the appropriate charges will be billed directly to Medicare and the Resident and/or Designated Representative from Resident's funds agrees to be responsible for any co-payments, which are **$ 167.50 per day** for 2018 (unless you have a third-party insurance policy which pays this rate).

When the Resident remains in the Facility after termination of the Resident's Medicare coverage for services, the Resident and/or Designated Representative shall provide payment from the Resident's income and resources for all sums due and payable under this Agreement at the Private Pay Daily Rate until discharge and/or another source of coverage becomes available. The Resident and/or Designated Representative shall make an advance payment of one (1) month at the applicable Private Pay Daily Rate upon termination of Medicare reimbursement unless payment from Medicaid is received, as well as subsequent charges billed by the Facility, as set forth in Section 11.

c. **Medicaid**. The Facility does not require advance payment upon admission from residents currently receiving Medicaid benefits. The daily Medicaid rate is accepted by the Facility as full payment for all charges by the Facility. The Resident who is a Medicaid recipient and/or his/her legal representative, Designated Representative or next of kin shall apply personal income each month as directed by the local Department of Social Services ("DSS"). (i.e., you are required to pay Facility the "net available monthly income" ("NAMI") as determined by DSS on the LDSS-4022 form you will receive from Medicaid.) The Resident and/or Designated Representative shall advise the Facility upon admission of the receipt of or application for Medicaid. The Resident and/or Designated Representative shall make application for Medicaid to the DSS when eligible and fully cooperate in the application process. And during the pendency of the Medicaid application (after submission of the Medicaid application and before a decision on the Medicaid application is rendered), the Resident and the Designated Representative must remit to the Facility, every month, the

Resident's estimated NAMI (i.e. the amount equals to the Resident's gross monthly income minus Medicare Part B etc. if applicable and minus $50 for personal needs), starting from the month of coverage the Resident is seeking.

4. The Designated Representative agrees to timely arrange for payment from the Resident's income and resources for service provided by Samaritan pursuant to this Agreement that are not covered by third party payors.

5. The Designated Representative is not obligated to pay for the cost of the Resident's care from the Designated Representative's own funds. The Resident's spouse may, under certain circumstances, be obligated to pay for the Resident's care, in accordance with applicable law.

6. The Designated Representative is responsible for making arrangements for the continuity of payment from the Resident's funds from third-party payors to meet the Resident's payment obligations under this Agreement.

7. The Designated Representative may be held personally responsible to Samaritan for:

   a. non-payment to the extent that he or she has control over the Resident's assets, access to joint accounts and the like which have been properly applied. The Resident or the Designated Representative, as applicable, agrees not to transfer or otherwise dispose of Resident's resources to which Designated Representative has access in such a manner which would result in ineligibility for Medicaid coverage; and/or,
   b. any account balance caused by the Designated Representative's failure to provide requested information and/or documentation to Samaritan or a third party payor, including but not limited to the Department of Social Services, in a timely manner; and/or
   c. failing to cooperate in any manner with third party payors to the extent it hinders payment to the Samaritan, including the failure to initiate applications for payment; and/or,
   d. to the extent that the Samaritan relies to its detriment on false, misleading, or incomplete information and/or documentation supplied by the Designated Representative regarding matters, including, but not limited to, the Resident's financial resources, citizenship or immigration status, and/or third party insurance coverage; and/or,
   e. failure to disclose all information for the Medicaid application completely and accurately; and/or,
   f. any financial loss experienced by the Samaritan due to a refusal or delay on the part of the Designated Representative in applying for Medicaid coverage for the Resident; and/or,
   g. any financial loss experienced by Samaritan due to the Designated Representative transferring or permitting transfer or disposition of the Resident's resources in a manner which would result in the Resident's ineligibility for Medicaid coverage without retaining sufficient funds to meet their financial obligations to us during the period of Medicaid ineligibility.

   In the event that Medicaid coverage is denied as a result of actions such as a transfer or disposition of resources and assets for less than fair consideration, inadequate or insufficient documentation, failure to cooperate with the local County Department of Social Services, timely payment is expected for all services rendered until such time that the Resident is determined to be Medicaid eligible by the appropriate County Department of Social Services.

8. Samaritan agrees to provide the following services:

   a. board, including therapeutic or modified diets, as prescribed by a physician;

   b. lodging; a clean, healthful, sheltered environment, properly outfitted;

c. 24 hours-per-day nursing care;

d. the use of all equipment, medical supplies and modalities, notwithstanding the quantity usually used in the everyday care of nursing home residents, including but not limited to catheters, hypodermic syringes and needles, irrigation outfits, dressings and pads, and so forth;

e. fresh bed linen, as required, changed at least twice weekly, including sufficient quantities of necessary bed linen or appropriate substitutes changed as often as required for incontinent residents;

f. hospital gowns or pajamas as required by the clinical condition of the resident, unless the resident, next of kin or sponsor elects to furnish them, and laundry services for these and other launderable personal clothing items;

g. general household medicine cabinet supplies, including but not limited to non- prescription medications, materials for routine skin care, oral hygiene, care of hair, and so forth, except when specific items are medically indicated and prescribed for exceptional use for a specific resident;

h. assistance and/or supervision, when required, with activities of daily living, including but not limited to toilet, bathing, feeding and ambulation assistance;

i. services, in the daily performance of their assigned duties, by members of the nursing home staff concerned with resident care;

j. use of customarily stocked equipment, including but not limited to crutches, walkers, wheelchairs or other supportive equipment, including training in their use when necessary, unless such item is prescribed by a physician for regular and sole use-by a specific resident;

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

l. social services as needed;

m. physical therapy, on either a staff or fee-for-service basis, as prescribed by a physician, administered by or under the direct supervision of a licensed and currently registered physical therapist;

n. occupational therapy, on either a staff or fee-for-service basis, as prescribed by a physician, administered by or under the supervision of a qualified occupational therapist;

o. speech pathology services, on either a staff or fee-for-service basis, as prescribed by a physician, administered by a qualified speech pathologist;

p. audiology services, on either a staff or fee-for-service basis, as prescribed by a physician, administered by a qualified audiologist; and

q. dental services, on either a staff or fee-for-service basis, as administered by or under either the personal or general supervision of a licensed and currently registered dentist.

9. Samaritan will assess no additional charges, expenses or other financial liabilities in excess of the basic daily rate for services covered by said basic daily rate, except:

a. Upon express written approval and the authority of the Resident or Designated Representative;

b. Upon express written orders of the Resident's personal, alternate or staff physician stipulating specific services and supplies not included as basic services;

c. Upon at least thirty (30) days prior written notice to the Resident or Designated Representative of additional charges, expenses or other financial liabilities due to the increased cost of maintenance and for operations of Samaritan;

10. With respect to Medicare and Medicaid Residents, Samaritan shall not impose a charge against the Resident's personal funds for any item or service for which payment is made under Medicare and Medicaid (except for applicable deductible and co-insurance amounts).

11. Samaritan may charge the Resident for requested services that are more expensive or in excess of covered services, as determined by Medicare or Medicaid. Specific items and services Samaritan may charge the Resident's funds for are outlined in the Services and Policies Booklet, if said services are requested by the Resident and payment is not made by Medicare or Medicaid.

12. The Resident, or his/her Designated Representative agrees, in accordance with the regulations of the Department of Health, to permit Samaritan to conduct a comprehensive assessment of the Resident no later than fourteen (14) consecutive days after the date of admission, promptly after a significant change in the Resident's physical, mental or psycho social status and no less often than twelve (12) months thereafter. The Resident or his/her Designated Representative agree in accordance with the regulations of the Department of Health to permit Samaritan to conduct an initial screening of the oral health status of the Resident within forty-eight (48) hours of admission and shall further permit Samaritan to conduct an oral examination of the Resident by a dentist or dental hygienist within fourteen (14) days following the initial assessment and no less often than annually thereafter.

13. The Resident, or his/her Designated Representative agree in accordance with the regulations of the Department of Health to have a physician visit the Resident whenever the Resident's medical condition warrants medical attention and at regular intervals no less often than once every thirty (30) days for the first ninety (90) days after admission, and at least once every sixty (60) days thereafter. The Resident or his/her Designated Representative further agree, at the option of the physician and Samaritan, that scheduled physician visits after the initial visit may alternate between the attending physician and a registered physician's assistant or nurse practitioner. Samaritan is authorized by the Resident or his/her Designated Representative to assign a physician to conduct such Resident visits in order to meet Samaritan requirement under the regulations of the Department of Health when the Resident's attending physician or his designee is unavailable.

14. The Resident may use the services of medical physicians engaged by Samaritan or may, at the Resident's personal expense, retain his/her own physician, provided the latter (or his/her designee, in the absence of said physician) has been credentialed as a member of the Samaritan medical staff.

15. In the event that a Resident is absent from Samaritan for a period of time by reason of illness or other cause, the Resident's accommodations will be held available provided the Resident continues to pay the scheduled rate for said accommodations. If the Resident is receiving Medicaid, said Resident's room will be held in accordance with Samaritan's bed hold policy and State and Federal laws and regulations. If a Medicaid Resident's hospitalizations or therapeutic levels exceed the bed hold period prescribed by State and Federal law, Samaritan shall re-admit the Resident to the first available bed in a semi-private room if the Resident:

a. Requires the services provided by Samaritan, and

b. Is eligible for Medicaid nursing home services.

16. If the Resident leaves Samaritan as a result of a transfer or discharge for reasons beyond the control of the Resident or his/her Designated Representative, any and all monies and/or property transferred and paid over by him/her to Samaritan in excess of the amount or proportion thereof obligated for services already finished shall be returned to the Resident or his/her Designated Representative, whichever is applicable. For Residents other than those eligible for Medicaid or Medicare reimbursement whose transfer or discharge is for any reason within his/her control, or that of his/her Designated Representative, Samaritan shall retain from any prepayment made for or on behalf of the Resident an amount not in excess of one day's basic rate in addition to any amount obligated for services already furnished.

17. In the event the Resident dies, Samaritan will endeavor to notify a member or members of his/her family and/or Designated Representative, and the family and/or Designated Representative will promptly provide for and bear the expenses of the Resident's burial. In the event of the Resident's death, all funds and personal property shall be returned to the Designated Representative, next of kin or to an individual appointed by an appropriate Surrogate's Court to administer the Resident's estate. All belongings not claimed within six (6) months of the patient's death shall be transferred to the chief fiscal officer of the Resident's county of residence prior to admission or to an appropriate Public Officer under the Abandoned Property Law and section one hundred twenty eight of the Finance Law.

18. Pursuant to Title 10 Part 415 of the New York State Codes, Rules and Regulations, Samaritan shall have the right to transfer or discharge the Resident when the Resident's interdisciplinary care team, in consultation with the Resident and/or Designated Representative, determines that:

    a. The transfer or discharge is necessary for the Resident's welfare and the Resident's needs cannot be met after reasonable attempts at accommodation in the facility;

    b. The transfer or discharge is appropriate because the Resident's health has improved sufficiently so the Resident no longer needs the services provided by the facility;

    c. The health or safety of individuals in the facility would otherwise be endangered and the risk to others is more than theoretical and all reasonable alternatives to transfer or discharge have been explored and have failed to safely address the problem.

    Transfer and discharge shall also be permitted when the Resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare, Medicaid or third party insurance) a stay at Samaritan, provided the charge in question is not in dispute, no appeal or denial of benefits is pending or funds for payment are actually available and the Resident refuses to cooperate with Samaritan in obtaining those funds.

19. Samaritan shall provide the Resident and his/her Designated Representative, at least thirty (30) days prior written notice of a transfer or discharge, except that such notice shall be given as soon as practicable before transfer or discharge under, the following circumstances:

    a. The safety of individuals in the facility would be endangered;

    b. The health of individuals in the facility would be endangered;

    c. The Resident's health has improved sufficiently to allow a more immediate transfer or discharge;

    d. An immediate transfer or discharge is required by the Resident's urgent medical needs, provided, where such urgent medical needs are the result of a medical emergency, a transfer to a hospital may be made without prior notice;

e. The transfer or discharge is being made in compliance with a request by the Resident and/or Designated Representative.

20. If the Resident, during an annual assessment, is screened as mentally impaired or mentally retarded and the Commissioner of Health or his/her designee determines that the Resident is no longer suitable for nursing home services, the Resident shall be transferred or discharged to an appropriate facility. Samaritan will provide notice of such transfer or discharge in accordance with the notice provisions contained in the preceding paragraph.

21. Notwithstanding the terms and conditions of paragraphs above, in the event the Resident shall be infected with a communicable disease, unless the Resident's attending physician certifies in writing that transmittability is negligible and poses no danger to other Residents of Samaritan or Samaritan is staffed and equipped to manage such disease without endangering the health of other Residents, the Resident shall be discharged and transferred from Samaritan to an appropriate facility. Samaritan will provide the Resident and his/her Designated Representative, notice as provided for herein. In an event, Samaritan shall have no liability of any kind arising from such transfer or discharge.

22. Samaritan shall have the right to make an administrative room transfer within Samaritan.

23. In the event the Resident requires medical or surgical care which Samaritan is unable to provide, the Resident agrees to be transferred to a general or special hospital for such surgical or medical care at the expense of the Resident and/or their insurer. Samaritan will endeavor to give notice of such transfer to the Resident's next of kin or Designated Representative when feasible, but such transfer may be without notice, in cases of emergency.

24. The Resident and Designated Representative hereby acknowledge the receipt of personal copies of Samaritan Services and Policies Booklet, the Resident's Bill of Rights and this Admission Agreement. These publications explain the Resident's bill of rights and responsibilities and serve as guidelines for residing at Samaritan. The Resident agrees to adhere to the rules and regulations of Samaritan and all subsequent amendments thereto.

25. The Resident hereby acknowledges that it is the policy of Samaritan to admit and treat all Residents and to provide services without regard to race, creed, color, disability, nation origin, sex, marital status, or age.

26. Samaritan has a Grievance Complaint Procedure in the event that a Resident, family member or Designated Representative wishes to file a complaint about the services provided by Samaritan or its staff. This procedure has been developed in order to assist Residents, family members and/or Designated Representatives bring a problem to the attention of staff so that the grievances can be resolved in an appropriate manner.

27. When so requested in writing, Samaritan shall provide a service of holding monies for incidental expenses. Resident may obtain these funds from the appropriate personnel of Samaritan during designated hours.

28. Samaritan shall not be liable or responsible for injuries to the Residents or damage to the Resident's personal property unless such injury or damage is caused by the negligence of Samaritan or a violation of the Public Health Law by Samaritan.

29. The Resident and/or Designated Representative hereby authorize Samaritan to release medical information and necessary data pertaining to filing insurance documents in the interest of the Resident.

30. The Resident, other than Medicare and Medicaid Residents, agrees to pay the designated rate for as long as personal funds will allow. When such Resident becomes eligible for medical assistance, such Resident

and/or Designated Representative agree to apply immediately for medical assistance. The Resident and/or Designated Representative with Resident funds is obligated to pay the basic daily rate up to the time the Resident is determined eligible for medical assistance by a local, state or federal agency. In the event of retroactive payment by Medicaid, the facility agrees to reimburse the Resident the difference between the basic daily rate paid to Samaritan and the Medicaid rate from the date established for commencement of Medicaid eligibility to the date of the Medicaid determination, less the DSS determination of the Resident's share (NAMI monies) required to be paid to Samaritan.

31. As applicable, the Resident and Designated Representative agree that any monies or funds that are listed in the County Department of Social Services (NAMI Monies) required to be turned over Samaritan for payment to Samaritan for care rendered to the Resident will be promptly paid over to Samaritan. The Resident and Designated Representative hereby acknowledge that these funds are to be used to pay for the care of the Resident at Samaritan and that Samaritan is entitled to the prompt payment of said money or funds. The Resident agrees to be personally liable to Samaritan if at any time he/she fails to turn over the money or funds to Samaritan.

32. In the event of non-payment on the Resident's account, if Samaritan engages and retains attorneys to collect and recover monies toward the outstanding balance on the Resident's account, Samaritan is entitled to be reimbursed reasonable attorneys' fees and costs associated with such Samaritan's attorneys' efforts by the Resident and the Designated Representative.

33. This contract represents the entire agreement between the parties, and it may not be changed or modified orally. This agreement shall be binding on heirs, executors, administrators, distributees, successors and assigns or the parties hereto.

IN WITNESS WHEREOF, the parties have executed this agreement on the date written above.

Resident: _____

Signature_____

Print _____

Designated Representative
Signature_____

Print_____

Samaritan Administrator or Designee:

Signature_____

Print_____

Revised 10/13/2017

Samaritan Summit Village

Assisted Living

Residency Agreement

_____ ALP

_____ ALR

_____ EALR

RESIDENCY AGREEMENT
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TABLE OF EXHIBITS

RESIDENCY AGREEMENT

This agreement is made between Samaritan Summit Village, the "Operator," _____ _____ (the "Resident", _____ (the "Resident's Representative," if any) and _____ (the "Resident's Legal Representative," if any).

RECITALS

A. The Operator is licensed by the New York State Department of Health to operate at 22691 Campus Drive, Watertown, New York 13601 an Assisted Living Residence ("The Residence") known as Samaritan Summit Village and as an Adult Home. The Operator is also licensed to operate an Assisted Living Program and certified to operate, at this location, an Enhanced Assisted Living Residence.

B. You have requested to become a Resident at The Residence and the Operator has requested your request.

AGREEMENTS

I. <u>Housing Accommodations and Services:</u>

Beginning on _____, the Operator shall provide the following housing accommodations and services to you, subject to the other terms, limitations and conditions contained in this Agreement. This Agreement will remain in effect until amended or terminated by the parties in accordance with the provisions of this Agreement.

A. **Housing Accommodations and Services:**

1. **Your apartment/room.** You may occupy and use a private ( ) or semi-private ( ) apartment or the apartment identified on Exhibit I.A.1., subject to the terms of this Agreement.

2. **Common Areas**. You will be provided with the opportunity to use the general purpose rooms at The Residence such as lounges, dining area, and resident areas in the Commons Building, such as the gift shop, mail room, private dining area, multi-purpose room, beauty salon and café.

3. **Furnishing/Appliances Provided By the Operator**. Attached as Exhibit I.A.2. and made part of this Agreement is an inventory of furnishings, appliances and other items supplied by the Operator in your apartment/room.

4. **Furnishings/Appliances Provided by You**. Attached as Exhibit I.A.3. and made a part of this Agreement is an inventory of furnishings, appliances and other items supplied by you in your apartment/room. Such Exhibit also contains any limitations or conditions concerning what type of appliances may not be permitted (e.g. due to electrical concerns, fire safety, and resident safety).

B. **Basic Services**:

The following services ("Basic Services") will be provided by you, in accordance with your Individualized Service Plan.

1. **Meals and Snacks.** Three nutritionally well balanced meals per day and one snack per day are included in your basic rate. Food service shall be provided in a manner that respects the dietary needs of residents in relation to health conditions, food allergies and dietary intolerance, religious and ethnic mandates, and that allows for reasonable variation in taste preferences.

2. **Activities.** The Operator will provide a program of planned activities, opportunities for community participation and services designed to meet your physical, social, and spiritual needs, and will post a monthly schedule of activities in a readily visible common area of the Residence.

3. **Housekeeping**. Includes weekly vacuuming, surface and bathroom cleaning and furnishing of toilet tissue. Attention to soiling of rugs, and other items due to resident use. Additional charges may apply if excessive (beyond normal wear and tear) carpet extraction is necessary.

4. **Linen Service.** Towels and washcloths; pillow, pillowcase, blanket, bed sheets, bedspread; all clean and in good condition.

5. Laundry of your personal washable clothing.

6. **Supervision on a 24-hour basis**. The Operator will provide appropriate staff on-site to provide supervision services in accordance with law. Supervision will include monitoring (a response to urgent or emergency needs or requests for assistance on a 24-hour per day, seven days per week basis) as well as the other components of supervision as specified by law.

7. **Case Management.** The Operator will provide appropriate staff to provide case management services in accordance with law. Such case management services will include identification and assessment of your needs and interests, information and referral, and coordination with available resources to best address your identified needs and interests.

8. **Personal Care**. Includes daily reminders for bathing, grooming, dressing, toileting (if applicable), ambulation (if applicable), transferring (if applicable), and stand-by for safety with ambulation and transferring (if applicable), medication acquisition, storage and disposal, and assistance with self-administration of medications.

9. **Development of Individualized Service Plan**. Including ongoing, review and revision as necessary.

C. **Additional Services:**
Exhibit I.B., attached to and made a part of the Agreement, describes in detail any additional services or amenities available for an additional, supplemental or community fee to the Operator directly or through arrangements with the Operator. Such Exhibit states who would provide such services or amenities, if other than the Operator.

D. **Licensure/Certification Status:**
A listing of all providers offering home care or personal care services under an arrangement with the Operator, and a description of the licensure or certification of each provider is set forth in Exhibit I.C. of this Agreement. Such Exhibit will be updated as frequently as necessary.

II. **Disclosure Statement:**
The Operator is disclosing information as required under Public Health Law Section 4658 (3). Such disclosures are contained in Exhibit II., which is attached to and made part of this Agreement.

III. **Fees:**

A. Basic Rate

1. Flat Fee Arrangements
The residents, resident's representative, and resident's legal representative agree that the resident will pay, and the Operator agrees to accept, the following payment in full satisfaction of the basic services described in Section I.B. of this Agreement. The basic rate as of the date of this Agreement is:
____ $169.00 Per Day – Studio
____ $175.00 Per Day – Large Studio
____ $209.00 Per Day – One Bedroom Apartment
____ $215.00 Per Day – Large One Bedroom Apartment
____ $299.00 Per Day – One Bedroom with Den

Notwithstanding the above, the Operator will request appropriate evaluation of resources to ensure the resident has 12 months available toward the cost of residency. In the event that the resident has inability or failure to pay the monthly rate, it may be grounds for termination of this residence agreement.
**If the resident is a Medicaid recipient, the maximum room and board fee will be $1246.00/month.

B. Community Fee, Supplemental Fee, Additional Fee

A community fee is a one-time fee of $800.00 that we charge at the time of admission. The community fee goes to cover the cost of room preparation. The community fee is non-refundable. You may choose whether to accept the community fee as a condition of residency in the Residence or to reject the community fee and thereby reject residency at the Residence. Any charges by the Operator, whether a part of the basic rate, supplemental, additional or community fees shall be made only for services and supplies that are actually supplied to the resident.

A supplemental or additional fee is a fee for service, care or amenities that is in additional to those fees in the basic rate. The Operator does not have any supplemental or additional fees. Any charges by the Operator shall be made only for services and supplies that are actually supplied to the resident.

C. Rate or Fee Schedule

Attached as Exhibit III.C., and made a part of this Agreement is a rate or fee schedule covering both the basic rate and any additional, supplemental or community fee for services, supplies and amenities provided to you, with a detailed explanation of which services, supplies and amenities are covered by such rates, fees or charges.

D. Billing and Payment Terms

Payment is due by the 1st of each month and shall be delivered to the billing office. In the event the resident, resident's representative, or resident's legal representative is no longer able to pay for services provided for in this agreement or additional services or care is needed by the resident, the Case Manager will assist in making application for appropriate social service programs and assist in finding appropriate placement within the community. Termination and discharge may occur (refer to Section XIII).

E. Adjustment to Basic Rate or Additional or Supplemental Fees

1. You have the right to written notice of any proposed increase of the basic rate or any additional or supplemental fees not less than forty-five (45) days prior to the effective date of the rate or fee increase, subject to the exceptions stated in paragraph 3, 4 and 5 below.

2. Since a community fee is a one-time fee, there can be no subsequent increase in a community fee charge to you by the Operator, once you have been admitted as a resident.

3. If you, or your representative or your legal representative agrees in writing to specific rate or fee increases, through an amendment of this agreement, due to your need for additional care, services or supplies, the Operator may increase such rate or fee upon less than forty-five (45) days written notice.

4. If the Operator provides additional care, services or supplies upon the express written order of your primary physician, the Operator may, through an amendment to this Agreement, increase the basic rate or an additional or supplementary fee upon less than forty-five (45) days written notice.

5. In the event of any emergency which affects you, the Operator may assess additional charge for your benefit as are reasonable and necessary for services, material, equipment and food supplied during such emergency.

F. Bed Reservation

The Operator agrees to reserve a residential space as specified in Section I.A.I above in the event of your absence. The charge for this reservation is $_____ per day. (The total of the daily rate for a one-month period may not exceed the established monthly rate).

The basic length of time the space will be reserved is 10 consecutive days, except for hospitalizations or sub-acute rehabilitation. In the case of hospitalization or sub-acute rehabilitation, the bed will be reserved so long as the resident space does not supersede the requirements for termination as set forth in Section XIII of this Agreement. You may choose to terminate this Agreement rather than reserve such space, but must provide the Operator with any required notice.

IV. **Refund/Return of Resident Monies and Property:**

Upon termination of this Agreement or at the time of your discharge, but in no case more than three (3) business days after you leave the Residence, the Operator must provide you, your representative or any person designated by you with a final written statement of your payment and personal allowance accounts at the Residence. The Operator must also return at the time of your discharge, but in no case more than three (3) business days later, any of your money or property which comes into the possession of the Operator after your discharge. The Operator must refund on the basis of a per diem proration any advance payment(s) which you have made.

If you die, the Operator must turn over your property to the legally authorized representative of your estate. If you die without a will, and the whereabouts of your next-of-kin is unknown, the Operator shall contact the Surrogate's court of the county wherein the Residence is located in order to determine what should be done with property of your estate. The Operator does not agree to accept the responsibility to store personal property or items of value.

V. **Transfer of Funds or Property to Operator**

If you wish to voluntarily transfer money, property or belongings of value to the Operator upon admission or at any time, the Operator must enumerate the items given or promised to be given and attach to this Agreement a listing of the items given or transferred. Such

listing is attached as Exhibit IV and is made part of this Agreement. Such listing shall include any agreements made by third parties for your benefit.

VI. **Property or Items of Value Held in the Operator's Custody for You:**

The Operator does not agree to accept the responsibility to store personal property or items of value.

VII. **Fiduciary Responsibility:**

If the Operator assumes management responsibility over your funds the Operator shall maintain such funds in a fiduciary capacity to you. Any interest on money received and held for you by the Operator shall be your property.

VIII. **Tipping:**

The Operator must not accept, nor allow the Residence staff or agents to accept any tip or gratuity in any form for any services provided or arranged for as specified by statute, regulation or agreement.

IX. **Personal Allowance Accounts:**

The Operator agrees to offer to establish a personal allowance account for any resident who receives either supplemental security income (SSI) or safety net assistance (SNA) payments by executing a statement of offering (DSS-2853) with you or your representative.

You agree to inform the Operator if you receive or have applied for SSI or SNA funds. You my complete the following:

I receive SSI funds _____ or I have applied for SSI funds _____
I receive SNA funds _____ or I have applied for SNA funds _____
I do not receive either SSI or SNA funds _____

If you have a signatory to the Agreement besides yourself and if that signatory does not choose to place your personal allowance funds in a Residence maintained account, then that signatory hereby agrees that he/she will comply with the SSI or SNA personal allowance requirements.

X. **Admission and Retention Criteria for an Assisted Living Residence:**

1. Under the law which governs Assisted Living Residence (Public Health Law Article 46-b), the Operator shall not admit any resident if the Operator is not able to meet the care needs of the resident, within the scope of services authorized under such law, and within the scope of the services determined necessary within the resident's Individualized Service Plan. The Operator shall not admit any resident in need of 24-hour skilled nursing care.
2. The Operator shall conduct an initial pre-admission evaluation of a prospective resident to determine whether or not the individual is appropriate for admission.

3. The Operator has conducted such evaluation of yourself and has determined that you are appropriate for admission to the Residence, and that the Operator is able to meet your care needs within the scope of services authorized under the law and within the scope of services determined necessary for you under your Individualized Service Plan.

4. If you are being admitted to a duly certified Enhanced Assisted Living Residence, the additional terms of the "Enhanced Assisted Living Residence Addendum" will apply.

5. If you are residing in a "basic" Assisted Living Residence and your care needs subsequently change in the future to be the point that you require Enhanced Assisted Living Care or 24-hour skilled nursing care, you will no longer be appropriate for residency in the basic Residence. If this occurs, the Operator will take the appropriate action to terminate this Agreement, pursuant to Section XIII of this Agreement. However, if the Operator has an Enhanced Assisted Living unit available, and is able and willing to meet your needs in such unit, you may be eligible for Residence in such Enhanced Assisted Living unit.

6. Enhanced Assisted Living Care is provided to persons who desire to continue to age in place in an Assisted Living Residence and who:
    (a) are chronically chair-fast and unable to transfer, or chronically require the physical assistance of another person to transfer; or

    (b) chronically require the physical assistance of one or more person(s) in order to walk; or

    (c) chronically require the physical assistance of another person to climb or descend stairs; or

    (d) are dependent on medical equipment and require more than intermittent or occasional assistance from medical personnel; or

    (e) have chronic unmanaged urinary or bowel incontinence.

7. Enhanced Assisted Living Care may also be provided to certain persons who desire to continue to age in place in an Assisted Living Residence and who are assessed as requiring 24-hour skilled nursing care or medical care and who meet the conditions stated in the Enhanced Assisted Living Residence addendum.

XI. **Rules of the Residence:**

Attached as Exhibit VI, and made a part of this Agreement are the Rules of the Residence. By signing this Agreement, you and your representative agree to obey all reasonable rules of the Residence.

XII. **Responsibilities of Resident, Resident's Representative and Resident's Legal Representative:**

A. You or your representative or legal representative to the extent specified in this Agreement, are responsible for the following:

1. Payment of the basic rate and any authorized additional and agreed-to-supplemental or community fees as detailed in the Agreement.

2. Supply of personal clothing and effects.

3. Payment of all medical expenses including transportation for medical purposes, except when payment is available under Medicare, Medicaid, or other third party coverage.

4. At the time of admission and at least once every twelve (12) months thereafter, or more frequently if a change in condition warrants, providing the Operator with a dated and signed medical evaluation that conforms to regulations of the New York State Department of Health.

5. Informing the Operator promptly of any change in health status, change in physician, or change in medications.

6. Informing the Operator promptly of any change of name, address and/or phone numbers.

XIII. **Termination and Discharge:**

A. This Residency Agreement and residency in the Residence may be terminated in any of the following ways:

1. By mutual agreement between you and the Operator;

2. Upon 30 day notice form you or your representative to the Operator of your intention to terminate the Agreement and leave the Residence;

3. Upon 30 days written notice from the Operator to you, your representative, your next of kin, the person designated in this Agreement as the responsible party and any person designated by you. Involuntary termination of a Residency Agreement is permitted only for the reasons listed below subject to your rights as set forth below.

B. The grounds upon which involuntary termination may occur are:

1. You require continual medical or nursing care which the Residence is not permitted by law or regulation to provide;

2. If your behavior poses imminent risk of death or imminent risk of serious physical harm to you or anyone else;

3. You fail to make timely payment for all authorized charges, expenses and other assessments, if any, for services including use and occupancy of the premises, materials, equipment and food which you have agreed to pay under this Agreement. If your failure to make timely payments resulted from an interruption in your receipt of any public benefit to which you are entitled, no involuntary termination of this Agreement can take place unless the operator, during the thirty-day period of notice of termination, assists you in obtaining such public benefits or other available supplemental public benefits. You agree that you will cooperate with such efforts by the operator to obtain such benefits;

4. You repeatedly behave in a manner that directly impairs the well-being, care or safety of yourself to any other resident, or which substantially interferes with the orderly operation of the Residence;

5. The operator has had its operating certificate limited, revoked, temporarily suspended or the Operator has voluntarily surrendered the operation of the Residence or;

6. A receiver has been appointed pursuant to Section 461-f of the New York State Social Services Law and is provided for the orderly transfer of all residents in the Residence to other Residences or is making other provisions for the resident's continued safety and care.

C. If the operator decides to terminate the Residency Agreement for any of the reasons stated above, the operator will give you a notice of termination and discharge which must be at least 30-days after the delivery of notice, the reason for termination, a statement of your right to object and a list of free legal advocacy resources approved by the State Department of Health.

D. You may object to the operator about the proposed termination and may be represented by an attorney or advocate. If you challenge the termination, the operator, in order to terminate, must institute a special proceeding in court. You will not be discharged against your will unless the court rules in favor of the operator.

E. While legal action is in progress, the operator must not seek to amend the Residency Agreement in effect as of the date of the notice of termination, fail to provide any of the care and services required by State Department of Health regulations and the Residency Agreement, or engage in any action to intimidate or harass you.

F. Both you and the operator are free to seek any other judicial relief to which you or it may be entitled. The operator must assist you if the operator proposes to transfer or discharge you to the extent necessary to assure, whenever possible, your placement in a care setting which is adequate, appropriate and consistent with your wishes.

XIV. **Transfer:**

Nothwithstanding the above, the operator may seek appropriate evaluation and assistance and may arrange for your transfer to an appropriate and safe location, prior to termination of a Residency Agreement and without 30 day notice or court review, for the following reasons:

1. When you develop a communicable disease, medical or mental condition, or sustain an injury such that continual skilled medical or nursing services are required;

2. In the event that your behavior poses an imminent risk of death or serious physical injury to you/yourself or others; or

3. When a receiver has been appointed under the provisions of New York State Social Services Law and is providing for the orderly transfer of all residents in the Residence to other Residences or is making other provisions for your continued safety and care.

If you are transferred, in order to terminate your Residency Agreement, the operator must proceed with the termination requirements as set forth in Section XIII of this Agreement, except that the written notice of termination must be hand delivered to you at the location to which you have been moved. If such hand delivery is not possible, then the notice must be given by any of the methods provided by law for personal service upon a natural person.

If the basis for the transfer permitted under parts 1 and 2 above of this Section no longer exist, you are deemed appropriate for placement in this Residence and if the Residency Agreement is still in effect, you must be readmitted.

XV. **Resident Rights and Responsibilities:**

Attached as Exhibit VII and made a part of this Agreement is a Statement of Resident Rights and Responsibilities. This statement will be posted in a readily visible common area of the Residence. The operator agrees to treat you in accordance with such Statement of Resident Rights and Responsibilities.

XVI. **Complaint Resolution:**

A. Resident may submit complaints about the care and services provided or not provided and the lack of respect for property by anyone furnishing services on behalf of the

operator in accordance with the operator's established procedure. All complaints will be kept confidential as necessary.

B. The operator's procedures for receiving and responding to resident grievances and recommendations for change or improvements in the resident's operations and programs are attached as Exhibit VIII and made a part of this Agreement. In addition, such procedures will be posted in a readily visible common area of the Residence. The operator agrees that the residents of the Residence may organize and maintain councils or such other self-governing body as the residents may choose. The operator agrees to address any complaints, problems, issues or suggestions reported by the residents' organization and to provide a written report to the residents' organization that addresses the same.

C. Complaint handling is a direct service of the Long Term Care Ombudsman Program. The Long Term Care Ombudsman is available to identify, investigate and resolve your complaints in order to assist in the protection and exercise of your rights.

XVII. **Miscellaneous Provisions:**

1. This Agreement constitutes the entire Agreement of the parties.

2. This Agreement may be amended upon the written agreement of the parties; provided however, that any amendment or provision of this Agreement not consistent with the statute and regulation shall be null and void.

3. The parties agree that Assisted Living Residency Agreements and related documents executed by the parties shall be maintained by the operator in files of the Residence from the date of execution until three (3) years after the Agreement is terminated. The parties further agree that such Agreements and related documents shall be made available for inspection by the New York State Department of Health upon request at any time.

4. Waiver by the parties of any provision in this Agreement, which is required by statute or regulation, shall be null and void.

XVIII. **Agreement Authorization:**

We, the undersigned, have read this Agreement, have received a duplicate copy thereof, and agree to abide by the terms and conditions therein.

Dated: _____ _____

Signature of Resident

Dated: _____ _____

Signature of Resident's Representative

Dated: _____ _____

Signature of Resident's Legal Representative

Dated: _____ _____

Signature of Operator or Operator's Representative

(OPTIONAL)

Personal Guarantee of Payment

Operator has determined, pursuant to 10 NYCRR §1001.8(f)(2)(xvii), that the resident lacks the capacity to manage financial affairs and/or the financial means to assure payment due under this Agreement.

_____ personally guarantees payment of charges for your base rate.

_____ personally guarantees payment of charges for the following services, materials or equipment, provided to you, that are not covered by the basic rate:

_____

_____

_____

_____

_____

Date: _____

_____
Guarantor's Signature

_____
Guarantor's Name (Print)

(OPTIONAL)

Guarantor of Payment of Public Funds

If you have a signatory to the Agreement besides yourself and that signatory controls all or a portion of your public funds (SSI, Safety Net, Social Security, other), and if that signatory does not choose to have such public funds delivered directly to the operatory, then the signatory herby agrees that he/she will personally guarantee continuity of payment of the basic rate and any agreed upon charges above and beyond the basic rate from either your personal funds (other than your personal needs allowance) or SSI, Safety Net, Social Security or other public benefits, to meet your obligations under this Agreement.

_____ _____

Date Guarantor's Signature

_____

Guarantor's Name (Print)

EXHIBIT I.A.1

IDENTIFICATION OF APARTMENT/ROOM

_____ Studio

_____ Large Studio

_____ 1 Bedroom Apartment

_____ Large One Bedroom Apartment

_____ 1 Bedroom with Den Apartment

EXHIBIT I.A.2

FURNISHINGS/APPLIANCES PROVIDED BY OPERATOR

Standard Bed

Bedside Chair

Bedside Table

Dresser

Lamp

Closet Space

One Flat Screen TV

Small Refrigerator/Freezer

2 Sheets, Pillowcase, at least one blanket and bedspread

Towels and Washcloths

Soap and Toilet Tissue

Lockable Storage

EXHIBIT I.A.3

FURNISHINGS/APPLIANCES PROVIDED BY RESIDENT

Residents are welcome to bring in furnishings and or appliances that enhance their quality of life. We encourage residents to decorate their rooms as they would their home. If a resident would like to bring in their own personal furniture, we will remove the furniture already provided in the room. We would be happy to assist you with hanging photos, paintings, etc. on the wall. Please note that any electrical wiring and equipment shall be firmly secured to the surface on which it is mounted. All electrical appliance need to show URL approved status.

The following equipment is not allowed in the rooms; chain locks, hasps, bars, padlocks, and any similar device shall not be used in any resident area in a way that would inhibit access to the an exit or free movement of residents.

The following equipment/appliances are NOT permitted:
Portable electric space heaters, self-contained fuel burning space heaters, cooking appliances (including coffee makers, hot pots, microwaves, toaster ovens), flexible electrical cords that are not current protection devices with UL approved status, electrical extension cords, wax candles, heating pads, microwave hot wraps.

EXHIBIT I.B

ADDITIONAL SERVICES, SUPPLIES OR AMENITIES

The following services, supplies or amenities are available from the operator directly through arrangements with the operator for the following additional charges:

Item	Additional Charge	Provided By
Professional Hair Grooming	Shampoo/set $13 Shampoo $5 Men's Cut $8 Lady's haircut $13 Perm $45 Color $45 Hot Oil $13	Samaritan
Personal Toilet Articles	No charge for soap, shampoo, shave cream, hand razor, toilet tissue	Samaritan
Incontinence Products	Resident may choose to purchase their own incontinence products from any source. If residents choose to use facility provided incontinence products, they will be billed for the facilities cost of the product.	Samaritan or vendor of resident's choice
Medical Transportation	Wheelchair Van $65 within Watertown City Limits add $2.70 per loaded mile outside of city limits	Samaritan Ambulette or other vendor of resident choice
Long Distance Telephone Service	Per Verizon	Verizon or other vendor of resident choice
Local Phone Service	Per Verizon	Verizon or other vendor of resident choice
Cable TV	$16.00 per month	SSV/Time Warner Cable
Internet	FREE	SSV/Time Warner Cable

Item	Additional Charge	Provided By
Guest Meals	Guest meals are available to purchase for $5.00 per meal	Samaritan

EXHIBIT I.C

LICENSURE /CERTIFICATION STATUS OF PROVIDERS

Samaritan Summit Village Assisted Living is licensed as an Adult Home, Assisted Living Program and Enhanced Assisted Living Residence.

EXHIBIT II

DISCLOSURE STATEMENT

Samaritan Summit Village (the operator) as operator of Samaritan Summit Village (the Residence), hereby discloses the following, as required by Public Health Law Section 4658 (3).

1. The Consumer Information Guide developed by the Commissioner of Health is hereby attached as Exhibit D-1 of this Agreement.

2. The operator is licensed by the New York State Department of Health to operate at 22691 Campus Drive, Watertown, New York 13601, an Assisted Living Residence, as well as an Adult Home.

   The operator is also certified to operate at this location an Enhanced Assisted Living Residence. This additional certification may permit individuals who may develop conditions or needs that would otherwise make them no longer appropriate for continued Residence in a basic Assisted Living Residence to be able to continue to reside in the Residence and to receive Enhanced Assisted Living services, as long as the other conditions of residency set forth in the Agreement continue to be met.

   The operator is currently approved to provide:
   a. Enhanced Assisted Living services for up to a maximum of 40 persons.

   The operator will post prominently in the Residence, on a monthly basis, the then-current number of vacancies under its Enhanced Assisted Living program. **It is important that note that the operator is currently approved to accommodate within the Enhanced Assisted Living program only up to the number of persons stated above.** If you become appropriate for Enhanced Assisted Living Services, and one of those units is available, you will be eligible to be admitted into the Enhanced Assisted Living Program. If, however, such units are at capacity and there are no vacancies, the operator will assist you and your representatives to identify and obtain other appropriate living arrangements in accordance with New York State's regulatory requirements. If you become eligible for and choose to receive services in the Enhanced Assisted Living Residence program within this Residence, it may be necessary for you to change your apartment/room within the Residence.

3. The owner of the real property upon which the Residence is located is Samaritan Summit Village. The mailing address of such real property owner is 22691 Campus Drive, Watertown, NY 13601. The following individual is authorized to accept

personal service on behalf of such real property owner: Samaritan Summit Village, 22691 Campus Drive, Watertown, NY 13601.

4. The operator of the Residence is Samaritan Summit Village. The mailing address of the operator is 22691 Campus Drive, Watertown, NY 13601. The following individual is authorized to accept personal services on behalf of the operator: Samaritan Summit Village, 22691 Campus Drive, Watertown, NY 13601.

5. List any ownership interest in excess of 10% on the part of the operator (whether a legal or beneficial interest), in any entity which provides care, material, equipment or other services to residents of the Residence.

   None

6. List any ownership interest in excess of 10% (whether legal or beneficial interest) on the part of any entity which provides care, material, equipment or other services to residents of the Residence, in the operator.

   None

7. Residents of the Residence have the ability to receive services from service providers with whom the operator does not have an arrangement.

8. Residents shall have the right to choose their health care providers, notwithstanding any other agreement to the contrary.

9. Public funds for payment for residential, supportive or home health services, including but not limited to, availability of Medicare coverage of home health services, are available.

10. The New York State Department of Health's toll free telephone number for reporting of complaints regarding the services provided by the Assisted Living operator or regarding Home Care Services is 1-866-893-6772. If home care services are provided by outside provider, call 1-800-628-5972.

11. The New York State Long Term Care Ombudsman Program (NYSLTCOP) provides a toll free number 1-800-342-9871 to request an Ombudsman to advocate for the resident. (315) 393-2255 is the Local LTCOP telephone number. The NYSLTCOP web site is www.ltcombudsman.ny.us.

EXHIBIT III.B

SUPPLEMENTAL, ADDITIONAL OR COMMUNITY FEES

The community fee is non-refundable. You may choose whether to accept the community fee as a condition of residency in the Residence or to reject the community fee and thereby reject residency at the Residence.

Any charges by the operator, whether a part of the basic rate, supplemental, additional or community fees shall be made only for services and supplies that are actually supplied to the resident.

A supplemental or additional fee is a fee for service, care or amenities that is in addition to those fees included in the basic rate. The operator does not have any supplemental or additional fees. Any charges by the operator shall be made only for services and supplies that are actually supplied to the resident.

EXHIBIT III.C

RATE AND ADDITIONAL FEE SCHEDULE

Basic Rate

- Studio Apartment - $169 per day
- Large Studio Apartment - $175 per day
- 1 Bedroom Apartment - $209 per day
- Large 1 Bedroom Apartment - $215 per day
- 1 Bedroom with Den - $299 per day

The basic rate covers the following services:

a. Your room
b. Three meals and one snack per day
c. Activities
d. Housekeeping services
e. Linen services
f. Laundry of your personal washable clothing
g. Supervision on a twenty-four hour basis
h. Case management services
i. Personal Care defined – as daily reminders/prompting for grooming, dressing, eating and toileting and two showers per week
j. Development of an Individualized Service Plan for the Assisted Living Residence Program (including ongoing review and revision as necessary)
k. Medication management

There is a one-time community fee of $800.00 that covers the cost of room preparation.

Enhanced Services and the cost of those residents eligible for the EARL program are detailed in Exhibit A in the EARL Addendum.

EXHIBIT IV.

TRANSFER OF FUNDS OR PROPERTY TO OPERATOR

The facility will issue a receipt to all residents of any fund received for the following: deposits to personal allowance account established pursuant to section 485.12 of Title 18 New York Code Rules and Regulations, any other funds held in custody for the resident, any other funds received by the operator from the resident. If any funds are paid to the facility a signed receipt will be given to the resident and maintained in the facility records. All receipts will include the following: date of the receipt, the amount of funds received, the purpose of the transaction, signature of the person receiving the funds. Any resident that chooses to have a personal allowance account or any other personal funds shall not be mingled with the personal funds of the operator or operating funds of the facility. These funds will be kept separate and distinct from each other and from other accounts. Quarterly statements will be given to each resident with a personal allowance account showing total deposits and withdrawals.

EXHIBIT VI

RULES OF THE RESIDENCE

- Samaritan Summit Village will be a smoke-free environment. Smoking is prohibited. Electronic "fake" cigarettes are prohibited

- Candles and all other flames are prohibited

- Tipping or gratuity in any form shall not be accepted by the operator of Samaritan Summit Village or allowed by any of the staff and agents. This is stated per the Residency Agreement.

- Banking hours for resident funds are available at least four (4) hours a day, Monday – Friday. Resident funds will be kept at the Business Office located on the 1st floor of Skilled Nursing (across from the Hair Salon). Hours will be posted throughout the facility. Please refer to the Banking Hours Policy.

- Parking for residents is available in the parking area in front of the main entrance to the facility.

- Cooking appliances such as stoves, ovens, toasters, coffee makers, and microwaves are not permitted in resident rooms per New York State regulation 18 NYCRR § 487.11.

- Live-in pets are not permitted. Pet visitation is permitted. Please refer to Pet Visitation Policy.

- Extension cords are not permitted. Electrical strips with breakers must be approved by maintenance before use.

EXHIBIT VII

RIGHTS AND RESPONSIBILITIES OF RESIDENTS IN ASSISTED LIVING RESIDENCES

Resident's Rights & Responsibilities shall include, but not be limited to the following:

A. Every resident's participation in Assisted Living shall be voluntary, and prospective residents shall be provided with sufficient information regarding the Residence to make an informed choice regarding participation and acceptance of services.

B. Every resident's civil and religious liberties, including the right to independent personal decisions and knowledge of available choices, shall not be infringed.

C. Every resident shall have the right to have private communications and consultation with his or her physician, attorney, and any other person.

D. Every resident, resident's representative and resident's legal representative, if any, shall have the right to present grievances on behalf of himself or herself or others, to the Residence's staff, administrator or assisting living operator, to governmental officials, to long term care ombudsmen or to any other person without fear of reprisal, and to join with other residents or individuals within or outside of the Residence to work for improvements in resident care.

E. Every resident shall have the right to manage his or her own financial affairs.

F. Every resident shall have the right to have privacy in treatment and in caring for personal needs.

G. Every resident shall have the right to confidentiality in the treatment of personal, social, financial, and medical records and security in storing personal possessions.

H. Every resident shall have the right to receive courteous, fair and respectful care and treatment and a written statement of the services provided by the Residence including those required to be offered on an as-needed basis.

I. Every resident shall have the right to receive or to send personal mail or any other correspondence without interception or interference by the operator or any person affiliated with the operator.

J. Every resident shall have the right not to be coerced or required to perform work of staff members or contractual work.

K. Every resident shall have the right to have security for any personal possessions if stored by the operator.

L. Every resident shall have the right to receive adequate and appropriate assistance with activities of daily living, to be fully informed of their medical condition and proposed treatment, unless medically contraindicated, and to refuse medication, treatment or services after being fully informed of the consequences of such actions, provided that the operator shall not be held liable or penalized for complying with the refusal of such medication, treatment or services by a resident who has been fully informed of the consequences of such refusal.

M. Every resident and visitor shall have the responsibility to obey all reasonable regulations of the Residence and to respect the personal rights and private property of the other residents.

N. Every resident shall have the right to include their signed and witnessed version of the events leading to an accident or incident involving such resident in any report of such accident or incident.

O. Every resident shall have the right to receive visits from family members and other adults of the resident's choosing without interference from the Assisted Living Residence.

P. Every resident shall have the right to written notice of any fee increase not less than forty-five days prior to the proposed effective date of fee increase; provided, however, providing additional services to a resident shall not be considered a fee increase pursuant to this paragraph; and that if a resident, resident representative or resident's legal representative agrees in writing to a specific rate or fee increase through an amendment of the residency agreement due to the resident's need for additional care, services or supplies, the operator may increase such rate or fee upon less than forty-five days written notice.

Q. Every resident of an Assisted Living Residence that is also certified to provide enhanced assisting living and/or special needs assisted living shall have the right to be informed by the operator, by a conspicuous posting in the Residence, on at least a monthly basis, of the then-current vacancies available, if any, under the operator's enhanced and/or special needs assisted living programs.

Waiver of any of these resident rights shall be void. A resident cannot lawfully sign away from above stated rights and responsibilities through a waiver or any other means.

EXHIBIT VIII

OPERATOR PROCEDURES: RESIDENT GRIEVANCES AND RECOMMENDATIONS

POLICY:
A resident may submit complaints about the care and services provided or not provided and the lack of respect for property by anyone furnishing services on behalf of Samaritan Summit Village in accordance with the Samaritan Summit Village established procedure described below. All complaints will be kept confidential to the extent possible.

REFERENCE: 18 NYCRR § 766.9 (j)

PROCEDURE:
A resident may submit complaints about the care and services provided or not provided and the lack of respect for property by anyone furnishing services on behalf of Samaritan Summit Village. Additionally, residents may voice complaints and recommend changes in policies and services to Samaritan Summit Village Assisted Living/Licensed Home Care Services Agency (LHCSA) staff, the New York State Department of Health or any outside representative of the residents' choice. **The resident has the right to submit a complaint confidentially, as indicated below.** The expression of such complaints by the resident or his/her designee shall be free from interference, coercion, discrimination or reprisal.

1. The resident should voice his or her complaint to any Assisted Living/LHCSA staff member. The resident may also file a complaint confidentially and anonymously by using form located with box. Blank copies of the form are available by the elevators on the 1st floor. Completed forms may be placed in this box and the box will be checked weekly.

2. An Assisted Living/LHCSA staff member will notify the Samaritan Summit Village Administrator or his/her designee immediately after receiving an oral or written complaint. The Assisted Living Care Manager and/or Director of Social Services/Admissions will record complaints in the "Complaint Log", indicating the date of the complaint, a summary of the investigation, and the resolution of the complaint.

3. The Administrator or his/her designee will investigate the complaint by:
    A. Discussing the complaint with the resident, unless the complaint is confidential.
    B. Discussing the complaint with any other persons involved in or named in the complaint.
    C. Completing a written response to all written complaints, and to any oral complaints, if requested by the resident making the oral complaint, within 15

days of receiving the complaint. The response will explain the complaint investigation findings and the decision made by the Administrator or his/her designee, including a description of any action taken or reasons why no action was taken. The response will inform the resident-complaint of the right to appeal the decision, as explained below.

4. If the resident is not satisfied with the investigation response form the Administrator or his/her designee, the resident has a right to appeal the decision to:
    - the Vice President of Long Term Care of the decision of the Administrator or his/her designee; and
    - the Department of Health Office of Health Systems Management, which can be reached at 1-866-893-6772 or 315-477-8472 (number for the CNYRO of the NYSDOH)

The appeal will then be investigated by the Vice President of Long Term Care and with the Department of Health. Once the investigation has been completed by the these parties, a written response will explain the complaint investigation findings and the decision made by the Vice President of Long Term Care and the Department of Health, including a description of any action taken or reasons why no action was taken.

ENHANCED ASSISTED LIVING RESIDENCE
ADDENDUM TO RESIDENCY AGREEMENT
EXHIBIT IX

This Enhanced Assisted Living Residence Addendum ("Addendum") to the Assisted Living Residency Agreement ("Residency Agreement") is between Samaritan Summit Village ("Operator"), _____ ("Resident") and _____ (Resident's Representative" or "Legal Representative") stating the terms and conditions of the Resident's admission to the Samaritan Summit Village Enhanced Assisted Living Residence, located at 22691 Campus Drive, Watertown, NY 13601. The Residency Agreement is dated _____ _____.

This Addendum adds new sections and amends, if any, only the sections specified in this Addendum. All other provisions of the Residency Agreement shall remain in effect, unless otherwise amended in accordance with the Addendum.

This Addendum must be attached to, and incorporates by reference the Residency Agreement between the parties.

The parties to this Addendum understand that Enhanced Assisted Living Care may be provided to certain persons who desire to continue to age in place in an Assisted Living Residence and who meet the conditions stated in this Enhanced Assisted Living Residence Addendum. If Resident is assessed as requiring 24-hour skilled nursing care or medical care, resident may remain in an Enhanced Assisted Living Residence if the criteria in Section VII of this Addendum are satisfied.

I. **Enhanced Assisted Living Certificate**
Operator is currently certified by the New York State Department of Health to provide Enhanced Assisted Living at Samaritan Summit Village located at 22691 Campus Drive, Watertown, NY 13601.

II. **Physician Report**
Resident has submitted to Operator a written report from resident's physician, which report states that:

a. Resident's physician has physically examined resident within the last month prior to resident's admission into this Enhanced Assisted Living Residence; and
b. Resident is not in need of 24-hour skilled nursing care or medical which would require placement in a hospital or nursing home.

III. **Admission Criteria**

Enhanced Assisted Living Care is provided to persons who desire to continue to age in place in an Assisted Living Residence and who:

a. are chronically chairfast and unable to transfer, or chronically require the physical assistance of another person to transfer; or
b. chronically require the physical assistance of another person in order to walk; or
c. chronically require the physical assistance of another person to climb or descend stairs; or
d. are dependent on medical equipment and require more than intermittent or occasional assistance from medical personnel; or
e. have chronic unmanaged urinary or bowel incontinence

The operator has conducted an initial pre-admission evaluation and determined that resident is appropriate for admission to this Residence and that the operator is able to meet resident's care needs within the scope of services authorized under the law and within the scope of services determined necessary under resident's Individualized Service Plan.

IV. **Request for and Acceptance of Admission**

Resident has requested to become a resident at this Enhanced Assisted Living Residence, Samaritan Summit Village, and the operator has accepted the request.

Beginning on _____ the operator shall provide the housing accommodations and services to resident described below, subject to other terms, limitations and conditions in the Residency Agreement and this Addendum.

This Addendum will remain in effect until amended or terminated by the parties in accordance with the provisions of the Residency Agreement, Section XIII.

V. **Specialized Programs, Staff Qualification and Environmental Modifications**

Attached as Exhibits A-D and made a part of this Addendum are written descriptions of the following:

a. services to be provided at the basic rate and the costs of additional services in the Enhanced Assisted Living Residence in accordance with resident's Individualized Service Plan;
b. staffing levels

c. Staff education and training work experience, and any professional affiliations or special characteristics relevant to servicing persons in the Enhanced Assisted Living Residence;
d. Any environmental modifications that have been made to protect the health, safety and welfare of persons in the Residence

VI. **Aging in Place**

The operator has notified resident that, while the operator will make reasonable efforts to facilitate resident's ability to age in place according to resident's Individualized Service Plan, there may be a point reached where resident's needs cannot be safely or appropriately met at the Residence. If this occurs, the operator will communicate to resident regarding the need to relocate to a more appropriate setting, in accordance with law.

VII. **If 24-hour Skilled Nursing Medical Care is Needed**

If resident reaches the point where resident is in need of 24 hour skilled nursing care or medical care that is required to be provided by a hospital, nursing home, or a facility licensed under the Mental Hygiene Law, the operator will initiate proceedings for the termination of this Agreement and to discharge resident from residency, UNLESS each of the following conditions are met:

a. resident hires appropriate nursing, medical or hospice staff to care for resident's increased needs; and
b. resident's physician and a home care services agency both determine and document that with the provision of such additional nursing, medical or hospice care, resident can be safely cared for in the Residence, and would not require placement in a hospital, nursing home, or other facility licensed under Public Health Law Article 28 or Mental Hygiene Law Articles 19, 31, or 32; and
c. the operator agrees to retain resident and to coordinate the care provided by the operator and the additional nursing, medical or hospice staff; and
d. resident is otherwise eligible to reside at the Residence

EXHIBIT A

Packages offered to EALR eligible residents

The Basic Rate Core Package Covers the Following Services:

- Your room
- Three meals and one snack per day
- Activities
- Housekeeping & linens services
- Laundry of your personal washable clothing
- Supervision on a twenty-four hour basis
- Case management services
- Personal care defined – as daily reminders/prompting for grooming, dressing, eating, toileting, showers
- Development of an Individualized Service Plan for the Assisted Living Residence Program (including ongoing review and revision as necessary)
- Medication Management

PACKAGE 1-- Cost for Package 1 is the Basic Rate plus $20 per day

Includes all core services listed above in the Basic Package plus one or more of the following services:

- Administration of eye medications and/or ear drops
- Vital signs, weekly/daily weights
- Rectal suppositories/enema

PACKAGE 2-- Cost for Package 2 is the Basic Rate plus $50 per day

Includes all core services listed above in the Basic Package and Package 1, plus one or more of the following services:

- One staff to physically assist w/transfers with or without a transfer belt
- One staff to physical assist w/ambulation
- One staff to assist with ADL care eg, one assist with dressing & undressing, toileting, grooming, leg, back, wrist braces, compression stockings, socks, shoes
- Ostomy-colostomy, ileostomy, urostomy care
- Superficial wound treatment
- Incontinence program (management) to include care needed to keep clean, extra showers as needed, extra laundry services as required
- Hospice care to include if needed bed bound, turning and repositioning
- Assist with respiratory treatments & equipment to include oxygen, obstructive sleep apnea equipment & nebulizer equipment
- Skilled Nursing Assessment ex. lung sounds

EXHIBIT B

Staffing Levels

The Enhanced Living Residence will be staffed with:

- 2 Registered Nurses five days a week for 8 hours per day; excluding major holidays
- 1 Licensed Professional Nurse seven days a week for 24 hours per day; including major holidays
- 3 Licensed Professional Nurses five days per week for 8 hours per day; excluding major holidays
- 3 Home Health Aides each shift, seven days a week for 16 hours a day (day & evening shift)
- 2 Home Health Aides each shift seven days a week for 8 hours a day (night shift)

EXHIBIT C

Staff, Education, Training Work Experience, and Professional Affiliation

- All Home Health Aide staff are certified by New York State;
- All Registered Nurses and Licensed Professional Nurses are currently licensed by New York State;
- All personal care staff have First Aid and CPR certification and have completed education on fire safety, resident care, and medication assistance. Each staff member is required to have 12 hours of in-service time per year.

EXHIBIT D

Environmental Modifications in the Residence

Samaritan Summit Village has been built in accordance with Life Safety Code Standards of New York State and all other regulations as required by New York State Department of Health.

Samaritan Summit Village has been constructed to provide resident dignity, privacy, and safety.

Addendum Agreement Authorization

Mark one:

_____ PACKAGE 1-- Cost for Package 1 is the Basic Rate plus $20 per day

_____ PACKAGE 2-- Cost for Package 2 is the Basic Rate plus $50 per day

We, the undersigned, have read this Addendum to the Residence Agreement, have received a duplicate copy thereof, and agree to abide by the terms and conditions therein.

Dated: _____ _____
(Signature of the Resident)

Dated: _____ _____
(Signature of Resident's Representative/
Legal Representative)

Dated: _____ _____
(Signature of Operator or Operator's
Representative)

ASSISTED LIVING PROGRAM ADDENDUM TO THE RESIDENCY AGREEMENT
EXHIBIT X

I. General Provisions

This Assisted Living Program Addendum ("Addendum") to the Assisted Living Residency Agreement ("Residency Agreement") is between Samaritan Summit Village ("Operator") and _____ ("Resident"), and/or _____ ("Resident's Representative") stating the terms and conditions of the Resident's admission and living arrangements in the Samaritan Summit Village Assisted Living Program, located at 22691 Campus Drive, Watertown, NY 13601. The Residency Agreements is dated _____.

This Addendum adds new sections and amends, if any, only the sections specified in this Addendum. All other provisions of the Residency Agreement remain in effect, unless otherwise amended in accordance with this Addendum.

This Addendum must be attached to, and incorporates by reference, the Residency Agreement.

The parties to this Addendum understand that this program is an Assisted Living Program (ALP) providing long-term residential care and providing or arranging for home care services to the resident accordance with New York State Social Services Law and the regulations of the New York State Department of Health (the "Department").

II. Assisted Living Program Services

The Operator must be responsible for providing an organized, 24-hour-a-day program of supervision, care, and services including:

a. The services in the Residency Agreement; and
b. The provision of or arrangement for, the following home care services:
    i. Personal care services which are reimbursable under Title XIX of the federal Social Security Act;
    ii. Home Health Aide services
    iii. Personal emergency response services
    iv. Nursing services
    v. Physical therapy
    vi. Occupation therapy

vii. Speech therapy
viii. Medical supplies and equipment not requiring prior approval; and
ix. Adult day health care in a program approved by the Commissioner of Health

III. Admission Criteria

The Assisted Living Program may care only for a resident who:

(1) Is medically eligible for, and would otherwise require placement in, a residential health care facility due to the lack of a home or a suitable home environment in which to live and safely receive services;
(2) Requires more care and services to meet daily health or functional needs than can be provided directly by an adult care facility;
(3) Exhibits a stable medical condition as categorized by the long-term care patient classification system as defined in Title 10 NYCRR;
(4) Is able, with direction, to take action sufficient to assure self-preservation in an emergency, and
(5) Voluntarily chooses to participate in an assisted living program after being provided with sufficient information to make an informed choice.

IV. Resident Responsibilities

The Resident Responsibilities section of the Residency Agreement (Section XII) remains in effect for the following modification regarding medical evaluations:

a. At the time of admission and at least once every six (6) months thereafter, or more frequently if a change in condition warrants, providing the Operator with a dated and signed medical evaluation that conforms to regulations of the New York State Department of Health.

V. Financial Arrangements

The following supersedes Section III (Fees) of the Residency Agreement, except for the Supplemental Services described in subsection B of the Residency Agreement:

A. Basic Rate

The Resident, the Resident's Representative and Resident's Legal Representative agree that the Resident will pay, and the Operator agrees to accept, the following payment in full satisfaction of the Basic Services, material, and equipment which the Operator must provide according to law and regulation.

The Basic Rate of the date of this Addendum is:

Assisted Living Studio, Small	$169.00 per day
Assisted Living Studio, Large	$175.00 per day
Assisted Living, 1 Bedroom Small	$209.00 per day
Assisted Living, 1 Bedroom Large	$215.00 per day
Assisted Living, 1 Bedroom with a Den	$299.00 per day

Reservation of Space During a Temporary Absence

In the case of temporary absence of Resident, Operator will reserve a residential space for resident. The then current terms and conditions and Rate of this admission agreement will remain in effect until the Operator receives a written thirty (30) day termination notice.

If the Resident is an ALP Resident, and is in receipt of Medicaid and enters a hospital or residential health care facility, then resident agrees to privately pay the MA Daily Rate or agrees to be discharged from the ALP, due to Medicaid Payment Regulation as follows:

"*No Payment for MA funded home care services may be made to the ALP while the recipient is receiving residential health care facility services or inpatient hospital services*"

In such case Resident requests consideration for admission transfer to_____.

If the Resident is an ALP Resident, and is in receipt of Medicaid, and wants to be absent from the Assisted Living Program for 24-48 hours,

□ Resident agrees to either privately pay the MA daily rate in the absence of Facility receipt of MA funds.

□ Resident agrees to follow the procedure stated below prior to each and every absence from Facility due to Medicaid Payment Regulations, as follows:

"MA payment will continue to be made to the ALP when an MA eligible resident is absent from the ALP for a 24 hour period in order to visit friends or relatives under the following conditions:

- *The recipient has resided in the ALP for at least thirty (30) days;*
- *A statement is obtained from the recipient's physician approving the absence;*
- *The ALP can assure that the recipient's health care needs can be met during his or her absence;*
- *The visit is limited to two (2) days duration for any single absence;*
- *The ALP has obtained prior authorization from the fiscally responsible district if the recipient's total days of absence exceed ten (10) days in a twelve month period;*
- *The ALP is fiscally responsible for the provision of any home care services included in the MA home care services rate which are required by the recipient during his/her absence and the family member or friend is unable or unwilling to provide"*

A provision to reserve a residential space does not supersede the requirements for termination as set forth in the Termination Section of this agreement.

VI. Assisted Living Program Addendum Authorization

We, the undersigned, have read this Assisted Living Program Addendum, have received a duplicate copy thereof, and agree to abide by the terms and conditions therein.

Date: _____ x _____
Signature of Resident

Date: _____ x _____
Signature of Resident's Representative

Date: _____ x _____
Signature of Operator/Designee

Samaritan Summit Village

22691 Campus Drive
Watertown, NY 13601
315-782-6800

Assisted Living Check List

March 27, 2016

To whom it may concern:

Thank you for your interest in **Assisted Living Program** here at Samaritan Summit Village. We want to make the process for getting the needs of you and/or your loved one addressed a bit simpler and have developed a checklist below in order to let you know what we will need in order to move the application forward.

All of these items must be completed before we can consider you or your loved one for admission to our facility.
But please do not complete the Medical Eval until it is Requested as they it time sensitive.

1) _____ Application completed with requested documentation and signed. Once we receive the completed Application, and a room is available, we can Schedule the Tour/Assessment.

2) _____Tour/Assessment at SSV – Scheduled – once a room is available. If at the end of the Tour/Assessment you are approved, we will give you the necessary paperwork to take to your Doctor to complete the Medical Eval and TB test.

3) _____ Medical Evaluation Form (either DSS 4449C ALP or DOH 3122 ALR) Your Primary Care Physician or Attending Physician at the hospital needs to fill this out. This evaluation is valid for **30 days from the date of completion. (Please do not completed until requested)**

4) _____ PPD test. This test can also be done while having your Medical Evaluation done. This test is **valid for 30 days from the date of tested. (Please do not complete until requested)**

Samaritan Summit Village

22691 Campus Drive
Watertown, NY 13601
315-782-6800

Assisted Living Check List

5) _____ Medical Information from your Primary Care Physician. This should include the most recent two office doctor progress notes, current medication list, current labs, and a Discharge Summary from any hospitalization within the 12 months prior to admission. Your doctor's office may require an Information Release Form, which is on the last page of the Application.

6) _____ Copies of All Insurance cards = Medicare Card, Medicaid Card, Social Security Card, Medicare D Card or prescription discount card, Health Care Proxy, Power of Attorney, DNR , and/or Living Will, LTC Policy.

7) _____ A Financial Plan. Assisted Living, room and board, is covered by Supplemental Security Income (SSI) and/or private pay funds. The SSI will be applied for after admission, as the Social Security Office will not let you apply while still living in the community. Also, please note that the first month for SSI is exempt. This means **there will be an Out-Of-Pocket bill at admission**. Medicaid or Medicare will not cover room and board expenses. Only, private pay funds and some Long Term Care Policy Insurance will cover some of the daily cost. For Enhanced Assisted living, room/board as well as any additional services provided.

   A resident in the Enhanced Assisted Living Program or Private Pay, does not qualify for Medicaid or SSI, must show documentation of private pay funds for at least a year, to be considered Private Pay.

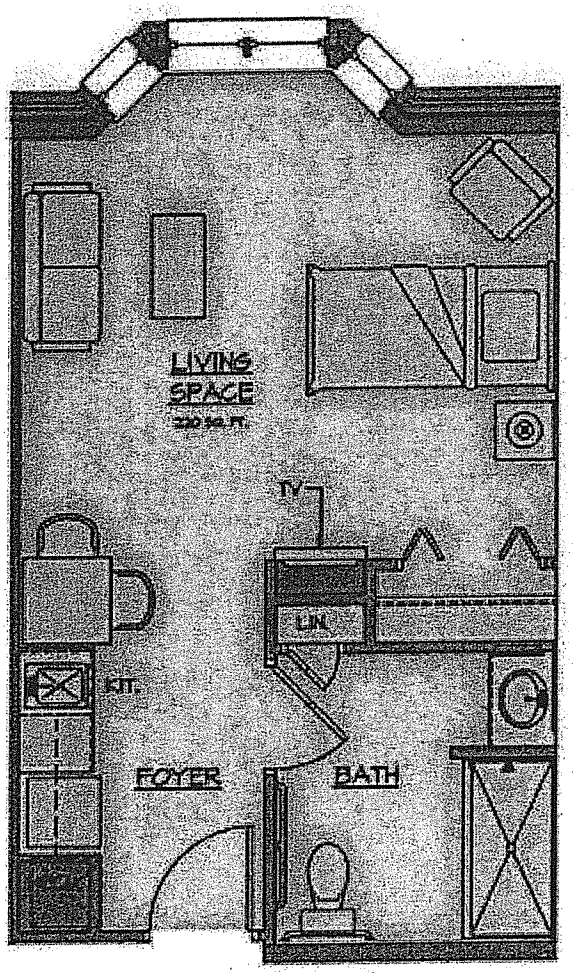
8) _____ Pre-Admission Meeting . During this meeting the Care Plan will be established and Admission Agreement reviewed and signed. If Private pay, the Community Fee and first month will be due at this time.

Please do not feel overwhelmed or uninformed with this information. Feel free to call us if you have any questions regarding these items at (315) 782-7033 or 782-7022. We appreciate your patience and understanding as we work

Samaritan Summit Village

Admissions Office
22691 Campus Drive
Watertown, NY 13601
315-782-7033
Fax: 315-782-6950

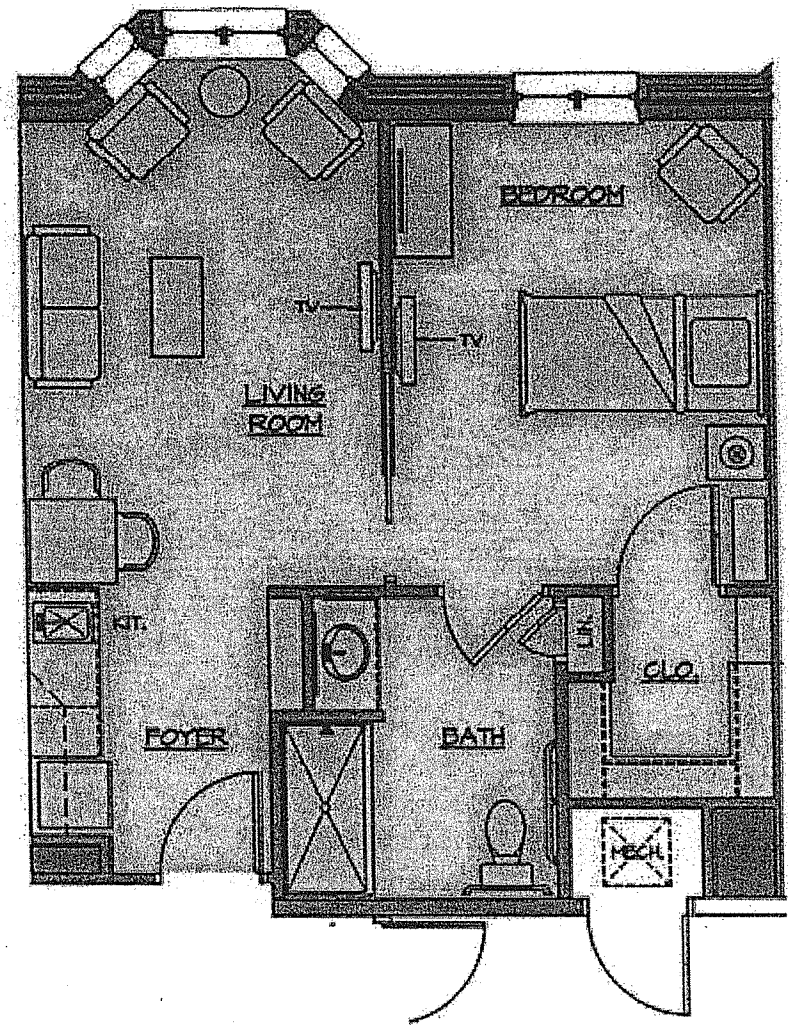
Assisted Living Resident Room



1 STUDIO UNIT PLAN

SCALE: 1/4" = 1'-0" 350 SQ. FT.

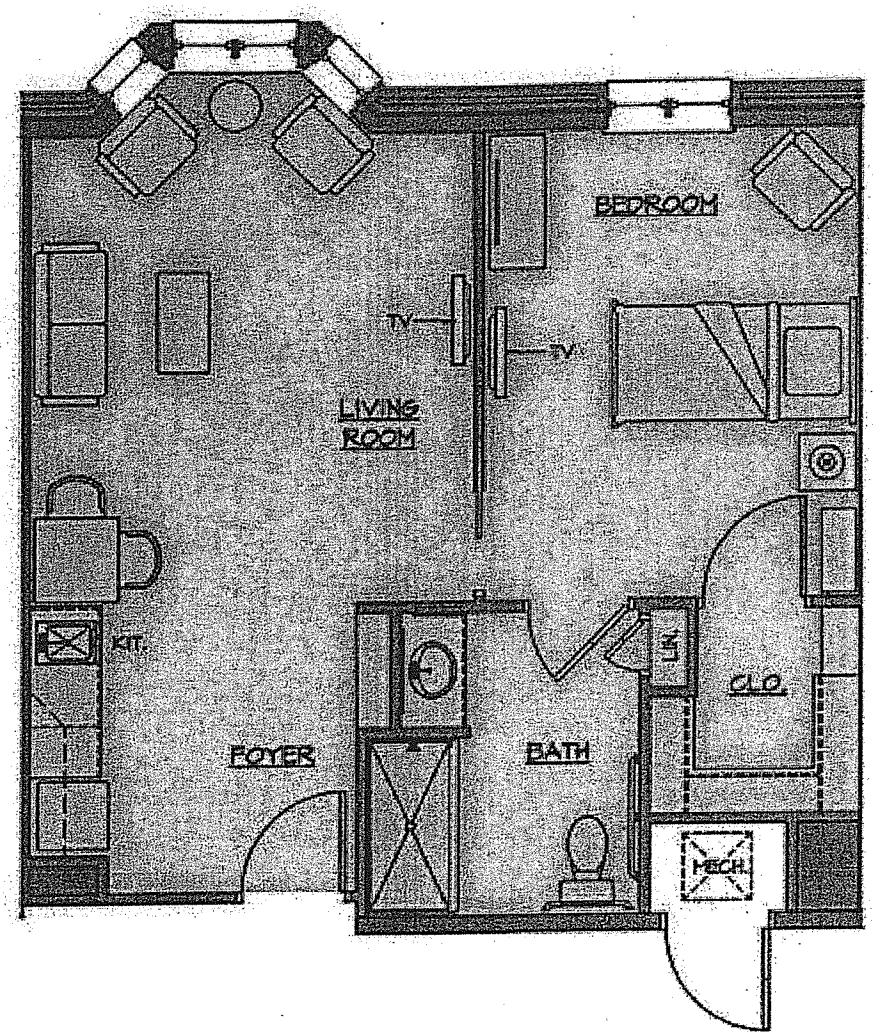
Assisted Living Resident Room



2 1 BEDROOM UNIT PLAN

SCALE: ¼" = 1'-0" 450 SQ. FT.

Assisted Living Resident Room



3 1 BEDROOM LARGE UNIT PLAN

SCALE: 1/4" = 1'-0"

520 SQ. FT.

Samaritan Summit Village

Assisted Living Rate

(Room & Board Only)

Basic Rate - 2018

Studio Apartment - $169 per day - $5070. Per month

Large Studio Apartment - $175 per day - $5250. Per month

1 Bedroom Apartment - $ 209 per day - $6270. Per month

Large 1 Bed room Apartment - $215 per day - $6450. Per month

1 Bedroom with Den - $299 per day - $8970. Per month

The Basic Rate covers the following services:

- Your Room.
- Three meals and one snack per day.
- Activities.
- Housekeeping services.
- Linen services
- Laundry of Your personal washable clothing.
- Supervision on a twenty-four hour basis.
- Case Management services.
- Personal Care.
- Development of an Individualized Service Plan for the Assisted Living Residence Program (including ongoing review and revision as necessary).

**Rates are based on a 30day month.

Samaritan Summit Village / Samaritan Keep Home

22691 Campus Drive
Watertown, NY 13601
315-782-6800

133 Pratt Street
Watertown, NY 13601
315-785-4400

Skilled Nursing Check List

December 10, 2015

To whom it may concern:

Thank you for your interest in the **Long Term Care** (Skilled Nursing) Program here at Samaritan Summit Village and Samaritan Keep Home. We want to make the process for getting the needs of you and/or your loved one addressed a bit simpler and have developed a checklist below in order to let you know what we will need in order to move the application forward.

All of these items must be completed before we can consider you or your loved one for admission to our facility. **Please do not complete the PRI & Screen until Requested, as it is time sensitive.**

1) _____ Application completed with requested documentation and signed.

2) _____ A completed PRI & Screen (Patient Review Instrument). This assessment tool can be completed by your local public health agency or if you are in a long-term care facility or hospital setting, they are able to accommodate this request. **This tool is valid for 90 days for the date of completion.**

3) _____ Medical Information from your Primary Care Physician. This should include the most recent two office doctor progress notes, current medication list, current labs, and a Discharge Summary from any hospitalization within the 12 months prior to admission. Your doctor's office may require an Information Release Form, which is on the last page of the Application.

4) _____ Copies of …All Insurance cards = Medicare Card, Medicaid Card, Social Security Card, Medicare D Card or prescription discount card, VA Cards, Driver License or ID Card, Divorce Decree, Trusts, Health Care Proxy, Power of Attorney, DNR , and/or Living Will and LTC Policy, **ALL Copies are required prior to admission**.

Samaritan Summit Village / Samaritan Keep Home

22691 Campus Drive
Watertown, NY 13601
315-782-6800

133 Pratt Street
Watertown, NY 13601
315-785-4400

Skilled Nursing Check List

5) _____ A Financial Plan. Long Term Care Skilled Nursing is covered by Medicaid and/or self-pay funds. If criteria are met, Medicare may cover for up to 100 days of Skilled Care provided you need skilled services.

Please do not feel overwhelmed or uninformed with this information. Feel free to call us if you have any questions regarding these items at (315) 782-7033 or 782-7031. We appreciate your patience and understanding as we work together through this process. Our goal is to guide you and your loved one through the steps needed to be able to provide the best opportunity for placement at this new and exciting location. We look forward to serving you and your loved one in the future. Please forward all completed materials associated with the admission process to the address below.

Tours of the Facility are done on Tuesday's and Thursday's, and must be scheduled. Please call 782-6800 to schedule your tour.

Sincerely yours,

Samaritan Summit Village
Admissions Department
22691 Campus Drive
Watertown, NY 13601
Phone; (315) 782-6800
Fax: (315) 782-6950

Samaritan Keep Home
Admissions Department
133 Pratt Street
Watertown, NY 13601
Phone; (315) 785-4400
Fax: (315) 785-4488

Samaritan Summit Village

Skilled Nursing Rates

2018

Basic Rate

Private Room - $377 per day - $11,310. Per month

(7% NYSAF = $791.70 = $12,101.70)

Shared private Room - $359 per day - $10,770. Per month

(7% NYSAF = $753.90 =$11,523.90)

** Also a 7% New York State Assessment Fee

Respite – 7days minimum – Private=$2,823.79 or Semi-shared=$2,688.91

The Basic Rate covers the following services:

- Your Room.
- Three meals and snacks.
- Activities.
- Housekeeping services.
- Linen and Laundry services.
- Supervision and Personal Care on a twenty-four hour basis.
- Case Management services.
- General household medicine cabinet supplies.
- Medical Equipment.

If you have any further questions, please call the Admissions Office at 315-782-7033.

*** Rates are based on a 30day month.