ATTACHMENT "A"

BASIC SERVICES

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

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

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

IF YOU HAVE ANY QUESTIONS REGARDING CHARGES AND BILLING, PLEASE FEEL FREE TO CONTACT THE BUSINESS OFFICE AT (631) 271-5800.

ADDITIONAL CLINICAL SERVICES

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

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

If your stay is covered under Medicare Part A:

- Medicare will pay up to 100 days for your stay (assuming eligibility criteria are met and benefits are still available).
- Co-insurance payments for 2022 are $194.50 per day for day 21 to day 100.

***** It is the responsibility of the Resident, Sponsor and/or Designated Representative to verify co-insurance coverage of any secondary insurance by contacting the insurance carrier and notifying the Business Office at (718) 372-4500.***

If you are covered by Medicare Part B, for 2022:

- Annual Medicare Part B Deductible is $233.00.
- Co-Insurance payments are 20% of the approved Medicare Part B charge for all Part B covered services.
- Occupational therapy benefits are capped at a total of $2,150 per year (including co-insurance)
- Physical and speech therapy benefits (combined) are capped at a total of $2,150 per year (including co-insurance).
- Beneficiary may qualify for Therapy Cap Exception Process. However, if your request for additional services above the therapy cap is denied, you will be responsible for 100% of the Medicare Approved Charge once the cap is reached.

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

ADDITIONAL NON-CLINICAL SERVICES

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

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

IF YOU HAVE ANY QUESTIONS REGARDING CHARGES AND BILLING, PLEASE FEEL FREE TO CONTACT THE BUSINESS OFFICE AT (631) 271-5800.

ATTACHMENT "B"

SPECIAL RULES REGARDING SELECTED PAYORS

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

MEDICARE PART A PAYMENT

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

Where these five criteria are met, Medicare may provide coverage of up to 100 days of care in a skilled nursing facility (SNF): the first 20 days of covered services are fully paid for; and the next 80 days (days 21 through 100), of the covered services are paid for by Medicare subject to a daily coinsurance amount for which the Resident is responsible. For 2022, the Medicare Part A co-insurance amount is $194.50 per day.

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

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

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

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

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

MEDICARE PART B PAYMENT

Individuals who pay monthly premiums to enroll in Medicare Part B will be charged according to Facility's or the service providers' stated charge schedule for services they receive at Facility. Medicare Part B pays for a wide range of additional services beyond Part A coverage. Part B may cover some of a Residents care regardless of whether they are eligible for Part A benefits. Part B covers eighty (80%) percent of the Medicare approved charge for a specific service and the individual is responsible for the additional twenty (20%) percent. In general, Part B covers medical services and supplies. Part B covers such services as: physical, occupational and speech therapy, physician services, durable medical equipment, ambulance services and certain out-patient and clinical laboratory services. However, Part B benefits have limitations. For example, for 2022, there is a $233.00 deductible applicable to Medicare Part B benefits. Additionally, physical therapy (including speech-language pathology services) and occupational therapy are each subject to an annual limitation. The therapy financial limitations or "caps" are indexed by the Medicare Economic Index (MEI) each year. For 2022, the indexed amounts for physical therapy (including speech-language pathology services) and occupational therapy are $2150.00 each, including co-insurance. Beneficiaries may be eligible for the Therapy Cap Exception Process. Both therapy limitations are still subject to the 80% - 20% coverage limitation in that the individual will be responsible for the 20 % co-insurance payments. **The Resident is responsible for private payment of all therapy charges and any other ancillary charges above the Medicare Part B coverage limitations.** The Facility can bill and receive payment if the Resident fills out a Medicare assignment of benefits form. If the Resident completes an assignment of benefits form, a health care provider cannot charge the Resident above the Medicare approved charge. In order to determine the Resident's Part B coverage you should contact the Social Security Administration.

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

MEDICARE PART D - PRESCRIPTION DRUG COVERAGE

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

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

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

MANAGED CARE

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

PRIVATE INSURANCE

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

MEDICAID

Medicaid is a publicly-funded program of assistance that covers nursing home Residents who can demonstrate financial need. To qualify for Medicaid, an individual may have only limited assets. For example, in 2022, the individual resource limit is $16,8000 (subject to annual increases); plus any funds held in an "irrevocable burial trust" arrangement or up to $1,500 under a revocable burial account. Generally, most of the Resident's monthly income must be paid to the Facility, except for a $50 monthly "personal needs allowance" and the monthly cost of retaining a private health insurance policy. This monthly income obligation, called the NAMI (Net Available Monthly Income), is determined by the Medicaid agency. If the Resident has a spouse in the community, the spouse might be entitled to a contribution from the Resident's monthly income. During 2022, the "community spouse" is entitled to a minimum monthly income of $3,435.00 and resources up to a maximum of $137,400 (these figures are subject to increase each calendar year); increases beyond these amounts are possible, but a Department of Social Services Fair Hearing or Family Court support proceeding may be required. The Resident's home may be exempt for Medicaid eligibility purposes if the equity value is less than $955,000.00 or if the spouse or disabled or minor child resides there. Upon application, Medicaid looks back at financial transactions or transfers of assets made within a sixty (60) month period of time from the date on which the person was institutionalized and applied for Medicaid coverage. A Resident or spouse who makes a transfer within those periods may create a period of Medicaid ineligibility. Private-pay Residents should apply for Medicaid about three months before their funds are depleted. A Medicaid application must include proof of the Resident's identity, U.S. citizenship or legal alien status, and past and present financial status. Medicaid recipients are required to recertify eligibility each year in order to retain benefits. Medicaid is a complex program and a knowledgeable professional can advise Residents and their families as to their rights under the Medicaid program. To receive information about Medicaid, individuals can call their local Department of Social Services in the county in which the Resident resides.

WORKERS' COMPENSATION

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

NO-FAULT INSURANCE

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

VETERANS' BENEFITS

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