Answering Your

Financial Questions

Wisconsin

presbyterian homes & services

The purpose of this booklet is to assist you with understanding your financial obligations at Presbyterian Homes & Services (PHS). Please feel free to contact management in order to clarify any unanswered financial questions you may have and for information about programs available in this community.

Housing

Care Center

Medicare

Resources

Housing

Understanding Your Financial Obligations

Independent Living

Assisted Living

Memory Care/Specialty Care

Monthly Statement

You will receive a monthly statement listing charges for the apartment and ancillary (special) services. You may receive an additional statement if your payment source changes mid-month.

The statement will include charges for special services and any adjusted charges for the previous month as well as recurring charges for the month ahead.

Private Pay

Private pay means that payments are made using your own private resources.

Automatic Payment

This method of payment is recommended and preferred. Monthly and ancillary charges may be automatically deducted from a checking or savings account. Participants receive a monthly statement showing charges and the amount deducted. There is no fee for this service.

Traditional Payment

You pay monthly rent and the charges for any other services or supplies by the 10th day of the month or within 5 business days of delivery of your statement, whichever is later. Failing to do so may result in a late fee. You pay for services and supplies provided by third parties, including any other licensed/certified home health care agency, according to the billing and payment policies established by those third parties.

Public Programs

In addition to private pay, some Presbyterian Homes & Services communities may accept certain public payment sources. Please check with management for information regarding participation at this community. *(See Special Note on page 4.)*

Family Care

Family Care is a state of Wisconsin funding program for Medicaid-eligible frail elders and adults with other disabilities. Family Care program members receive supportive services to enable them to live in their home or community-based setting whenever possible.

Family Care program members enroll with a managed care organization (MCO) to receive their services. The Wisconsin Department of Health Services provides the MCO with a monthly payment for each member. The MCO then uses these funds to coordinate services for its members with participating providers.

Acceptance of your Family Care eligibility is not guaranteed at PHS communities. Per your Residency Agreement with PHS, you must involve PHS community management 12 months prior to becoming eligible for Family Care.

Family Care applications must be initiated with the respective county Aging and Disability Resource Center (ADRC) approximately three months before financial eligibility is reached.

For more information on benefits or financial eligibility, call the appropriate ADRC office.

Important Information

PHS is limited as to the number of residents using public funds that it is able to support. Therefore, acceptance of public funding at this community and/or continued participation is not guaranteed.

You may be required to move to another apartment within this community or alternate housing to utilize public assistance. Eligibility for public funds does not guarantee that funds will be available or that a qualified apartment will be available at the time of need.

Please involve management in planning for alternate housing or funding sources when your private financial resources are reduced to an amount equal to twelve month's monthly rental and service charges. This advanced notice allows time for us to assist you with planning.

PHS Benevolence Fund

Limited subsidies are available through the Presbyterian Homes & Services PHS Benevolence Fund and are based on need. Alternative payment systems should always be considered before a subsidy through the PHS Benevolence Fund is requested. For more information, see management.

Medicare

Medicare is a federal program which helps pay for certain medical expenses for those over the age of 65, as well as for some younger people with disabilities. Medicare does not provide financial coverage for the cost of assisted living or memory care; however, services provided by Optage Home Care or other providers may be covered by Medicare if certain criteria are met. Eligible services include skilled nursing visits, physical, occupational or speech therapies, and hospice care.

Third Party Long-Term Care Insurance

You are responsible for payments of all amounts billed and should work directly with any third parties, such as long-term care insurers, for any reimbursement due.

Veterans' Administration (VA)

Veterans of a certain age and income bracket may qualify for benefits to help defray the cost of living. Contact the Veteran's Service Office located in your county to assist you with application process. Visit **va.gov** for information.

Assisted Living PHS Prolonged Absence Credit Policy

For Housing Service Charges:

- All credits will begin on the eighth day of an extended absence.
- The day of departure will count as the first day of an absence.
- Full charges will resume on the date of return.
- There will be no reduction in basic rent or housing services during any absence, with the exception of a meal credit.
- For residents who receive two full meals per day as part of their rental fees, there will be a credit per day, beginning on the eighth day. The credit will be reflected on the next billing statement.
- For residents who receive three full meals per day, there will be a credit per day, beginning on the eighth day. The credit will be reflected on the next billing statement.
- Continental breakfast is not considered a full meal and there will be no credit issued.

For Assisted Living Service Charges:

- All credits will begin on the eighth day of an extended absence.
- The day of departure will count as the first day of an absence.
- Full charges will resume on the date of return.
- Residents will pay the full daily rate (the monthly service package rate, pro-rated) for the first seven days of an absence.
- Beginning on the eighth day, all private pay residents, whether living in Assisted Living, Enhanced Assisted Living or Memory Care, will pay 70% of their regular Assisted Living services package rate, pro-rated to a daily rate, for each day of their absence.
- Upon return, the resident will pay the full rate for their package level, which will be pro-rated to a daily rate until the next billing cycle. If there has been a change in condition leading to a new service level, the new service level rate will be pro-rated and applied.
- If the resident will not be returning, notice must be given to terminate both the Service Plan and the Residency Agreement (lease). Assisted Living service charges will cease the date following the day these notices are received from the resident or their designated representative. Rent will cease according to the terms of the Residency Agreement.

Special Note:

Those receiving benefits through the Family Care program should be aware that the program pays the community a reduced rate during an absence. Please contact your case manager as well as management to discuss any prolonged absence.

Care Center

Understanding Your Financial Requirements

Long Term Care

Monthly Statement

You will receive a monthly statement listing charges for the room, board and ancillary (special) services. You may receive an additional statement if the payment source changes mid-month. The statement will include charges for special services and any adjusted charges for the previous month as well as recurring charges for the month ahead.

Private Pay

Private pay means that payments are made using your own private resources.

Automatic Payment

This method of payment is recommended and preferred. Monthly and ancillary charges may be automatically deducted from a checking or savings account. Participants receive a monthly statement showing charges and the amount deducted. There is no fee for this service.

Traditional Payment

Payment in full is due upon receipt of the monthly statement. If extenuating circumstances arise, please contact the Business Office to make other arrangements.

With either payment option, certain medical supplies, physician charges, prescriptions and items (stated in the Admissions Agreement) will be billed by the appropriate suppliers. Payment for those services should be made directly to the provider.

Medical Assistance

This is a Medical Assistance/Medicaid (MA) certified facility. Medical Assistance, sometimes called Medicaid, is Minnesota's Medicaid program. It helps pay the cost of medical care for low-income seniors living in a skilled nursing facility. The cost of medical care must be more than income after certain deductions. Asset and age limits do apply. MA eligibility is determined by the County Human Services Department.

The facility will bill MA directly if the resident is an eligible recipient. MA recipients are required to contribute their monthly income resources to the facility upon application and each month thereafter. The county will establish the monthly income resources that are to be paid to the facility. Additional information is available from the PHS household coordinator.

Recipient Resources

Resources are defined as all of a resident's assets and income. MA allows a specific portion of monthly income to be used for personal needs. The balance of the monthly income is to be paid as the resident's contribution for care received at the facility. This contribution is to begin the month the application for MA is made. Resident resources are always applied before Medical Assistance. If the amount of resources changes, it is your responsibility to notify the facility Business Office. If discharged from the facility, whether by transfer or death, after the first of the month, resources are due and payable for any days the resident resided in the facility.

Guidelines for Medical Assistance Application

The facility's expectation is that an MA application will be pursued if and when the resident's assets are depleted to $20,000. The resident's household coordinator will be available to guide you through the process. If the resident is eligible for any veteran's benefits, you may be required to contact the Veteran's Administration to complete an Aid and Attendance application before MA will give final approval.

To make an application, call the County Human Services Office for the county in which the resident currently resides (phone numbers listed at the back of this document). A packet of information that is to be completed will be sent to you from the county. The county intake worker or team phone number as well as your appointment date, if applicable, should be reported to the household coordinator. This packet, along with required personal information, should be submitted. The application process could take up to 90 days. It is recommended that you keep copies of all information.

Medicare

This facility is certified for Medicare. The facility will bill Medicare directly when applicable.

Being admitted to the care center will NOT automatically make a resident eligible for Medicare Part A coverage which pays for inpatient hospital stays, eligible care in a skilled nursing facility, hospice care and some home health care. For Part A services in a nursing facility, the following conditions must be met:

1. Resident must have been:
   a. Hospitalized for at least 3 consecutive nights (not including date of discharge) before transferring to the nursing facility AND
   b. Admitted to a nursing facility within 30 days following discharge from the hospital.
2. Resident must be entitled to hospital insurance. (Medicare Part A)
3. Resident must require skilled services for any of the conditions for which resident received necessary inpatient care, and/or for an additional condition which arose while resident was receiving inpatient hospital services.
4. Physician must certify the admission for daily skilled services.
5. The daily skilled service can only be provided on an inpatient basis in a facility.

Medicare Part A excludes services:

1. Not reasonable, or
2. Custodial in nature.

An assessment will be completed to determine if resident is eligible for Medicare Part A benefits. If eligibility for benefits cannot be established, a denial letter explaining the reason for ineligibility will be provided.

If you are in disagreement with the notice for denial or discontinuation of Medicare benefits, you have the right to an appeal. Ask the facility to submit a demand bill to Medicare. This will result in a review of your situation by Medicare.

Please Be Advised

Medicare benefits may or may not last up to 100 days. The resident will be assessed periodically to determine if Medicare coverage criteria continues to be met.

If you have questions, please contact the PHS household coordinator.

Medicare Co-Insurance Payment

Under Medicare guidelines, if the resident is approved for Medicare Part A, up to 20 days may be paid in full by Medicare. The 21st day through the end of the coverage is subject to a co-insurance payment, which is the amount set by Medicare, that you must pay after paying the Medicare deductible. This co-insurance payment comes from either your resources or the resident's insurance (e.g. Medigap, HMO, etc.). The facility will bill insurers. Co-insurance payments are due 10 days following receipt of a statement from the facility. The co-insurance amount is subject to change without notice.

Medicare Part B helps pay for doctors' services, outpatient hospital care, and other medical services that are not covered by Part A. Medicare Part B services provided by Presbyterian Homes will be billed to Medicare and the resident's co-insurance.

It is your responsibility to contact the insurance carrier to determine if the Medicare co-insurance payment might be covered under the policy.

If the resident is an MA recipient, the facility will bill MA for the co-insurance amount. You must continue to make your payments to the facility.

Third Party Long-Term Care Insurance

Upon receipt of assignment of benefit, the facility will bill the insurer for authorized skilled nursing and/or services. The Business Office will assist you with the appropriate billing and medical information required. Any insurance payment for services billed by the facility and sent to you, must be given to the facility.

Refunds

If payment is made from the resident's resources for services covered by Medicare, Medicaid or private insurance, the resident may be entitled to a refund. If there are any questions about refunds, please call the Business Office.

Bed Hold

Medical Assistance

According to laws regarding hospital and therapeutic leave days and rate equalization, when a bed is held, there is a reduction of the total daily rate for each hospital or therapeutic leave day covered by MA.

A formal leave day must meet the following 2 conditions:

1. Resident is absent overnight.
2. The absence is for more than 23 hours in duration.

MA will pay up to 18 days of bed hold to the nursing facility per hospital stay. If the resident is unable to return to the facility on or before the 19th day, the facility may formally discharge her or him. The resident may re-apply for admission or you may elect to continue to hold the bed by paying the bed hold daily rate from private resources. MA will also pay for 36 therapeutic leave days per calendar year.

Private Pay

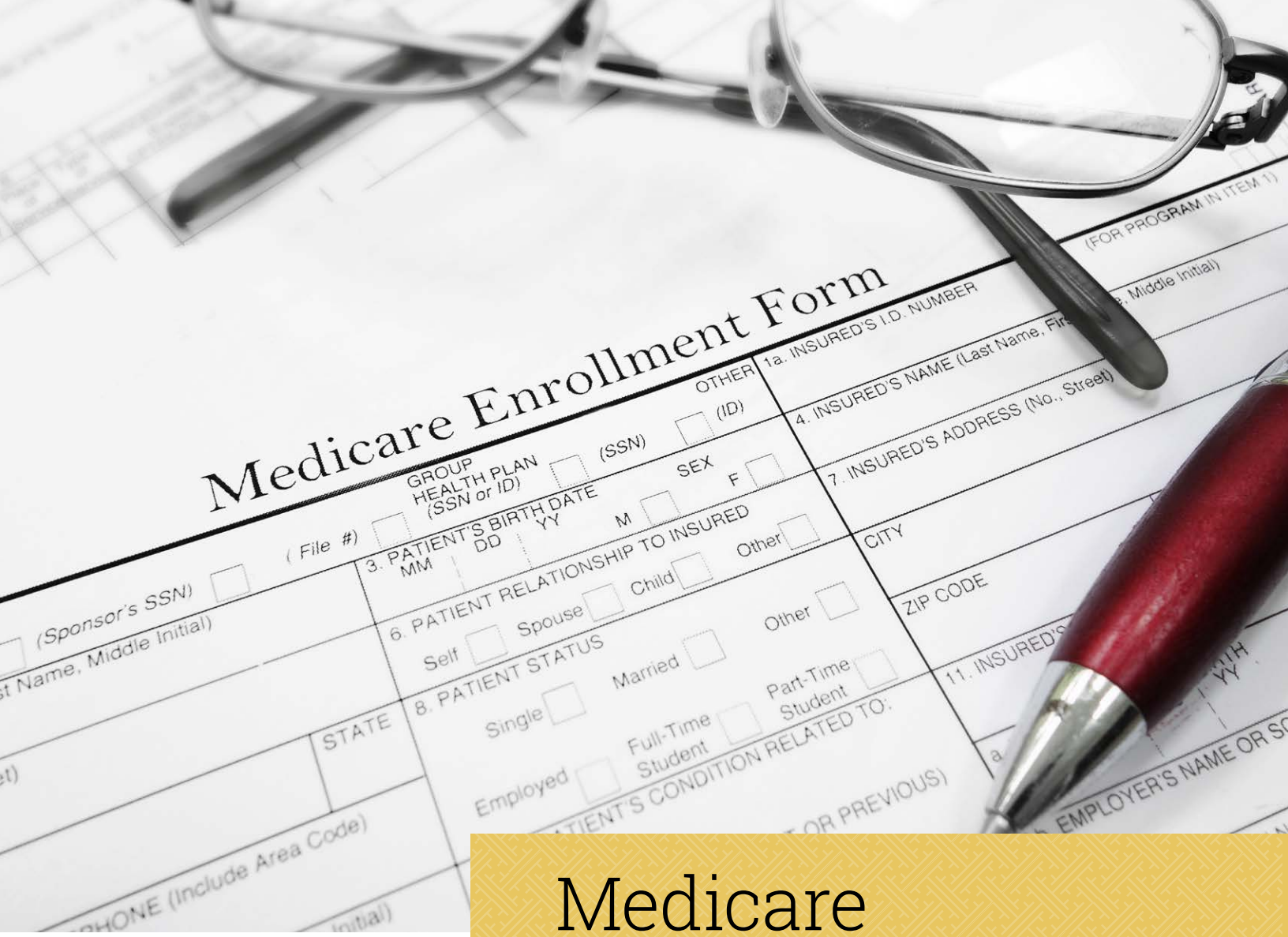
A private pay resident will be billed the full daily rate for each leave day. However, an adjustment may be applied. (Residents in private rooms are not eligible for an adjustment.) No adjustment will be made for hospital leaves after the 18th consecutive day and therapeutic leaves beyond 36 days per calendar year.

Medicare and most insurances will not pay to hold a bed.

If you do not wish to have a private pay resident's bed held during hospitalization, you must communicate this to the household coordinator.

Resident Trust Account

You may elect to place money in a Resident Trust Account for safekeeping and easy access. The account is designed to provide convenience for small purchases that the resident may wish to make (i.e. haircuts, candy, lunch outings). You must complete a Resident Trust Account Authorization form. The money shall be deposited in an interest bearing account. According to state law, a quarterly accounting statement will be provided outlining all deposits, withdrawals, and interest earned. The facility will disburse or deposit money into this account as you direct. The account must hold a sufficient balance to accommodate all disbursements of funds.



Medicare

Understanding Your Medicare Benefits

This overview represents a partial listing of services provided by Medicare. More information may be found at Medicare.gov, by calling 1-800-633-4227, or obtained from your healthcare provider.

For information on managed care product coverage, please contact the managed care organization.

Medicare Part A Services (Hospital Insurance)

Annual updates are made to the federal Medicare program, this version reflects the 2024 information.

Service	Time Limits[1]	You Pay	Medicare Pays	Not Covered	Eligibility
Hospital					
Semi-private room accommodations, meals, general nursing and other hospital services. Includes drugs, supplies, appliances and equipment ordinarily furnished, laboratory and X-ray services.	Days 1–60	$1,632 deductible for each benefit period, $0.00 coinsurance (after deductible)	100% after deductible is met	Private nurses, services of physician and surgeon, private room (unless guidelines are met for medically necessary, such as orders for extreme isolation), personal convenience items.	Over 65 and eligible for Social Security or under 65 with a valid MBI number. Hospital must be Medicare-certified. Utilization Review Committee or Peer Review approves stay.
	Days 61–90	$408 coinsurance per day	Balance		
	Days 91 & beyond	$816 coinsurance per day			
Skilled Nursing Facility including Rehabilitation Therapy with a qualifying hospital stay					
Skilled medical services including drugs, supplies, appliances and equipment ordinarily furnished, laboratory, rehabilitation services and X-ray services.	First 20 days	None	100% including, medication, supplies, skilled nursing, Occupational Therapy, Physical Therapy, Speech Language Pathology, X-rays	Same as above and all personal conveniences items such as barber, beautician, laundry, dry cleaning, private telephone and television or private nurse. Specialized equipment and transportation. Medicare does not cover custodial care (help with eating, bathing, toileting) if that is the only care needed.	Admission to a skilled nursing facility must be within 30 days of spending 3 or more qualifying and consecutive midnights in an acute care setting. Hospital observation days are not accepted as a qualifying hospital admission. There must be a need for continuous skilled care without an absence from the facility that extends past midnight.
	Days 21–100	$204 copay per day	Balance		
Home Health					
Home health services like intermittent skilled nursing care, physical therapy, speech-language services, continued occupational services and more.	Unlimited	None	100%	Nonskilled care or homemaker services, continuous 24 hour skilled care, and home delivered meals.	Must be provided through a certified home care agency. Patient must meet home bound definition including physician certification through a face to face encounter.
Hospice					
Physician services, nursing care, medical equipment, supplies, drugs, therapy, counseling, short-term inpatient care and respite care.	Two episodes of 90 days followed by unlimited 60 day episodes of care	Optional $5.00 copay on prescription medications and 5% of respite care	All covered medical services unless optional copays are required by hospice provider; bereavement follow-up and counseling	Any treatment other than pain relief, symptoms management and respite care (you can receive Medicare's standard benefits when treatment is required for a condition other than the terminal illness.) Services not related to terminal illness. Hospice does not cover room and board.	Physician certification of terminal medical status with life expectancy of six months or less. The patient must reside in a setting with a 24 hour caregiver.

Medicare Part B Services (Medical Insurance)

Annual updates are made to the federal Medicare program, this version reflects the 2024 information.

Service[2]	Time Limits	You Pay	Medicare Pays	Not Covered	Eligibility
Rehabilitation Therapy					
Diagnostic tests, therapy test, certain supplies, artificial limbs, braces and certain ambulance fees. Patient receives services while in a skilled nursing center or on an outpatient basis.	Limited Benefits: Thresholds on covered services for PT, SLP and OT	$240 deductible per year and 20% copay for services Medicare approved	80% of balance of Medicare approved charges	Nonskilled services. Medicare Part B does not pay room and board or medications. There may be a yearly maximum for therapy services that are not medically necessary.	Must enroll and pay the current monthly premium (most people will pay $174.70 per month, however, your premium may be higher based on Federal Income Guidelines). Services covered under Part A will not be simultaneously covered under Part B.
Physician Services					
Hospital, skilled and nursing facility and certain office visits or procedures.	Limited	100% of deductible plus 20% of the balance of Medicare approved charges 40% of outpatient mental health	80% of certain office visits, diagnostic tests, artificial limbs and ambulance services	Nonskilled services. Routine checkups, eyeglasses, hearing aides, dental work, cosmetic surgery, most immunizations, private duty nurses, first three pints of blood and prescription drugs.	
Hospital Outpatient					
Diagnostic tests, radiation therapy, rehabilitation, certain supplies, artificial limbs, braces and durable medical equipments. Patient resides at home.					

2024 Medicare Facts Footnotes

[1] Consult your medical providers concerning anticipated coverage.

[2] Days in the hospital that are considered "observation" do not count toward the Medicare Part A 3-day hospital stay requirement. Hospital observation will result in an admission to a skilled nursing facility under Medicare Part B or outpatient insurance.

About Your Medicare Benefits

Medicare is a federally funded health insurance program for people age 65 and older who have paid Social Security for more than two years, or people of any age with end-stage renal disease or ALS (Amyotrophic Lateral Sclerosis, also called Lou Gehrig's disease). There are two parts to the Medicare program: hospital insurance (Part A) and medical insurance (Part B).

Hospital Insurance (Part A) helps pay for:

- Acute care in hospital
- Medicare-certified care in a skilled nursing facility
- Home health services
- Hospice services

Medical Insurance (Part B) helps pay for:

- Rehabilitation therapy services
- Physician services
- Outpatient hospital care
- Durable medical equipment

County Aging and Disability Resource Center (ADRC) Offices

St. Croix County ADRC
1752 Dorset Lane
New Richmond, WI 54017
715-381-4360
800-372-2333 toll free
SCCWI.gov

Washington County ADRC
333 East Washington Street
Suite 1000
West Bend, WI 53095
262-335-4497
877-306-3030 toll free
WashingtonCountyADRC.org

Waukesha County ADRC
514 Riverview Avenue
Waukesha, WI 53188
262-548-7848
866-677-2372 toll free
WaukeshaCounty.gov/adrc

Business Offices — PHS Care Centers

The Deerfield
715-243-3900

Current PHS Residents

For billing questions, call the phone number on your monthly billing statement.

651-631-6100

2845 Hamline Avenue N
Roseville, MN 55113

PresHomes.org

presbyterian homes & services