The COMMONS IN LINCOLN
A Benchmark Lifecare Community

One Harvest Circle
Lincoln, MA 01773
781-430-6000
TheCommonsInLincoln.com

Exhibit A

Life Care Community
Pre-Residence Personal Medical History and Examination

Date: _____

APPLICANT: As part of the admissions process, you are required to complete a personal medical history. Please answer the first eight questions on this form. Please have your personal physician fill out their remaining part of the form through Question 7 on the last page. When the form is complete, please return to the sales office. If there are two applicants/residents, each of you must complete a form.

1. Name: _____ _____ _____
Last First M.I.

2. Date of Birth: _____ **3.** Place of Birth:_____

4. General condition of health: ____ excellent ____ good ____ fair ___ poor

5. Do you have any physical limitations? ____ yes ____ no If yes, please explain:

_____

_____

_____

6. Do you have any allergies? ___ yes ___ no. If yes, please list:

_____

_____

_____

7. Please list any current health insurance plans:_____

_____

_____

_____

8. Please list all current medications:

Medication	Dosage	Medication	Dosage
1.		**6.**	
2.		**7.**	
3.		**8.**	
4.		**9.**	
5.		**10.**	

Applicant's signature **Date**

PERSONAL PHYSICIAN:

Please answer the following questions through question 7 on the last page and return to the applicant.

1. Current or concomitant conditions:

D/O = Please indicate date of onset.
A = Please indicate: 1. mild, 2. moderate, 3. severe
B = Please indicate if the condition is under continuous treatment and controlled by:

1. medication, 2. diet, 3. other medical treatment, 4. no treatment

Category A	D/O	A	B
a. Endocrine disorders			
____Diabetes			
____Thyroid disease			
____Adrenal disorder			
____Pituitary disorder			
____Other (specify) _____			
b. Stable rheumatologic disease			
____Rheumatoid arthritis			
____Osteoarthritis			
____Gout			
____Other (specify) _____			
c. Gastrointestinal disease			
____Peptic ulcer disease			
____Diverticular disease			
____Inflammatory bowel disease			
____Other (specify) _____			
d. Stable heart disease			
____Congestive heart disease			
____S/P therapy for CAD			
____Treated cardiac arrhythmias			
____Hypertension			
____Post pacemaker insertion			
____Post myocardial infarction			
____Other (specify) _____			
e. Stable or reversible neurologic disease			
____Post stroke or post stroke syndrome			
____Myasthenia gravis			
____Other (specify) _____			
f. Alcoholism			

Category B	D/O	A	B
a. Chronic lung disease			
_____Emphysema			
_____Bronchiectasis			
_____Toxic lung disease			
_____Lung disease secondary to lupus			
_____Amyloidosis			
_____Environmental lung disease			
_____Bronchitis			
_____Other (specify) _____			
b. Chronic renal disease			
_____Amyloidosis			
_____Chronic glomerulonephritis			
_____Chronic uremia			
_____Chronic pyelonephritis			
_____Chronic renal failure			
_____Other (specify) _____			
c. Active malignant diseases			
_____ (specify) _____			
d. Progressive neurologic disease			
_____Amyotrophic lateral sclerosis			
_____Parkinson's disease			
_____Myopathies/neuropathies			
_____Multiple sclerosis			
_____Huntington's chorea			
_____Other (specify) _____			
Category C	**D/O**	**A**	**B**
a. Chronic brain disease (dementia)			
_____Chronic dementias			
_____Alcoholic psychoses			
_____Organic brain syndrome associated with using drugs			
_____Korsakoff's syndrome			
_____Alzheimer's disease			
_____Short term memory loss			
_____Other (specify) _____			

2. Please list any other medically related circumstances which should be considered:
a. _____ c. _____
b. _____ d. _____

3. Please list any significant hospital, rehabilitation, long-term care or similar confinements, or periods of home health care and their dates: _____
_____

4. Are you aware of all patient's current medications as listed on page 1 of this form? _____ Yes _____ No
Please list additions and changes, if any: _____
_____

5. Date of last Medical Examination: _____

6. **Functional assessment: Please indicate below your assessment of the applicant's functional status.**

	Independent	**Needs Assisting**	**Dependent**
Bathing			
Dressing			
Transferring			
Eating			
Mobility			
Toileting			
Ambulation			

Continency:	Bowel:	_____continent _____incontinent
	Bladder:	_____continent _____incontinent

Vision:	_____good	_____fair	_____poor	_____glasses
Hearing:	_____good	_____fair	_____poor	_____hearing aid

I feel that this individual is:
_____capable of independent living
_____requires some assistance
_____not capable of independent living

If assistance is needed, please list: _____
_____
_____

7. Name of Personal Physician: _____ Signature: _____ Date: _____
Please Print

_____ _____
Address Phone Number

*******[1]

COMMUNITY REPRESENTATIVES:

Medical Director: Please list pre-existing conditions. If deferred from coverage, please indicate date of next review.

Pre-Existing Conditions	Category	Covered	Not Covered	Deferred	Review date
a.					
b.					
c.					
d.					
e.					
f.					

Community Medical Director

Name: _____ Signature: _____ Date: _____

Director of Sales:

Name: _____ Signature: _____ Date: _____

[1] As stated in Section I.C.3 of the Continuing Care Contract, until the opening of the Health Center, The Commons reserves the right to have a third-party physician selected by us review this form and conduct follow-up inquiries or examinations, as deemed appropriate by us.

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PHYSICIAN CONSENT TO EXERCISE FORM

Dear Doctor,

Your Patient has expressed interest in our supervised and non-supervised exercise programs. These programs consist of the following components:

1. Muscular strength training using exercise equipment, hand weights, ankle weights, and therabands.
2. Cardiovascular training using the treadmill, recumbent stepper and bicycle.
3. Low impact exercise classes both in a chair, standing and in the water.

Please check below:

My patient has a history of:

- ☐ Lower Back Pain
- ☐ Pulmonary Disease
- ☐ Arthritis
- ☐ Other:_____
- ☐ Cardiac Disease
- ☐ Cancer
- ☐ Osteoporosis

My patient has the following contraindications to' exercise:

- ☐ Strength Training
- ☐ Cardiovascular/Aerobic Exercise
- ☐ Other:_____
- ☐ Stretching
- ☐ Water Exercises

I have reviewed the above information and agree to the following:

_____ My patient may **ONLY** participate in supervised exercise.

_____ My patient may participate in both supervised and non-supervised exercise.

_____ I would like to refer my patient to your physical therapy department.

_____ I **DO NOT** recommend any exercise at this time for my patient.

_____ M.D. _____ _____

Physician's signature | Phone | Date

EXHIBIT C

Identification of Pre-Existing Conditions

I. Definitions

A. "Continuous Treatment and Control" - Under "Continuous Treatment and Control" means that the resident is under the care of a physician for the noted condition, and that the condition is being controlled by diet, medication or other prescribed medical treatment. Continuous Treatment and Control requires the resident's compliance with course of treatment and monitoring prescribed by the personal physician, and can be required to be periodically verified by the resident's personal physician and/or the Community Medical Director. Deterioration in a resident's condition despite compliance with the prescribed treatment and monitoring does not violate the requirement for Continuous Treatment and Control.

B. "Date of Covered Confinement" - The date that a resident is admitted to the Community's Health Center.

C. "Operative Date" - The date on which the Continuing Care Contract is fully executed by resident and the Provider.

D. "Residency Date" - The date on which the resident takes up residency in the Community.

II. Categories of Pre-Existing Condition

Categories of pre-existing conditions are listed on the attached document entitled current or concomitant conditions.

III. Payment Obligations

If a resident has a pre-existing condition, Health Center stays may either be included in the Monthly Fee or be charged for on a per diem basis depending on the following requirements:

A. A resident must be able to demonstrate any period of 12 months (for Category A pre-existing conditions) or 24 months (for Category B pre-existing conditions) surrounding the Operative Date during which the resident has not been confined in a hospital, nursing facility or assisted living facility as a result of the pre-existing condition. If there has been such a confinement then any Health Center stay due to

the pre-existing condition, at any time during residency in the Community, shall be on a per diem basis.

B. A resident who has a Category A or B pre-existing condition that is not under Continuous Treatment and Control as of the Residency Date shall pay for all Health Center stays during residency in the Community, regardless of the condition giving rise to the admission, on a per diem basis.

C. A confinement to the Health Center as a result of a Category A or B pre-existing condition that is under Continuous Treatment and Control as of the Residency Date shall be covered under the Monthly Fee, provided that the pre-existing condition continues to be under Continuous Treatment and Control until the Date of Covered Confinement, and that payment on a per diem basis is not otherwise required under Paragraph A above.

D. A resident who has a Category C pre-existing condition shall pay for all Health Center stays during residency in the Community, regardless of the condition giving rise to the admission, on a per diem basis.

CURRENT OR CONCOMITANT CONDITIONS

CATEGORY A

a. Endocrine Disorders

_____ Diabetes
_____ Thyroid disease
_____ Adrenal disorder
_____ Pituitary disorder
_____ Other (specify) _____

b. Stable Rheumatologic Disease

_____ Rheumatoid arthritis
_____ Osteoarthritis
_____ Gout
_____ Other (specify) _____

c. Gastrointestinal Disease

_____ Peptic ulcer disease
_____ Diverticular disease
_____ Inflammatory bowel disease
_____ Other (specify) _____

d. Stable heart disease

_____ Congestive heart disease
_____ S/P therapy for CAD
_____ Treated cardiac arrhythmia
_____ Hypertension
_____ Post pacemaker insertion
_____ Post myocardial infarction
_____ Other (specify) _____

e. Stable or reversible neurologic disease

_____ Post stroke or post stroke syndrome
_____ Myasthenia gravis
_____ Other (specify) _____

f. _____ Alcoholism

CATEGORY B

a. **Chronic Lung Disease**

_____ Emphysema

_____ Bronchiectasis

_____ Toxic lung disease

_____ Lung disease secondary to lupus

_____ Erythematosus or amyloidosis

_____ Environmental lung disease

_____ Bronchitis

_____ Other (specify) _____

b. **Chronic Renal Disease**

_____ Amyloidosis

_____ Chronic glomerulonephritis

_____ Chronic uremia

_____ Chronic pyelonephritis

_____ Chronic renal failure

_____ Other (specify) _____

c. **Active Malignant Diseases** (specify) _____

d. **Progressive neurologic disease**

_____ Amyotrophic lateral sclerosis

_____ Parkinson's disease

_____ Myopathies/neuropathies

_____ Multiple sclerosis

_____ Huntington's chorea

_____ Other (specify) _____

CATEGORY C

a. **Chronic Brain Disease (dementia)**

_____ Chronic dementias

_____ Alcoholic psychoses

_____ Organic Brain syndrome associated with using drugs

_____ Korsakoff's syndrome

_____ Alzheimer's disease

_____ Short term memory loss

_____ Other (specify) _____