WORKERS COMPENSATION APPLICATION

DATE (MM/DD/YYYY): 3/5/2017

AGENCY NAME AND ADDRESS Insure24hrs Brokerage, Inc PO Box 1122 P.O. Box 1122 Wilkes Barre PA 18703	**COMPANY:** **UNDERWRITER:** **APPLICANT NAME:** Prestige LHCSA Management, Inc **OFFICE PHONE:** (917) 364-2650 **MOBILE PHONE:** **MAILING ADDRESS (including ZIP + 4 or Canadian Postal Code)** 329 EAST 149 TH STR 3 RD FL NY 10451 **YRS IN BUS:** 14 **SIC:** **NAICS:** **WEBSITE ADDRESS:**
PRODUCER NAME: Jake Rodriguez **CS REPRESENTATIVE NAME:** **OFFICE PHONE (A/C, No, Ext)** 718-207-1444 **MOBILE PHONE:** (718) 207-1444 **FAX (A/C, No):** 718-233-3174 **E-MAIL ADDRESS:** sales@insure24hrs.com **CODE:** **SUB CODE:** **AGENCY CUSTOMER ID:** 3282	**E-MAIL ADDRESS:** ☐ SOLE PROPRIETOR ☑ CORPORATION ☐ LLC ☐ TRUST ☐ PARTNERSHIP ☐ SUBCHAPTER "S" CORP ☐ JOINT VENTURE ☐ OTHER **CREDIT BUREAU NAME:** **ID NUMBER:** **FEDERAL EMPLOYER ID NUMBER:** 46-3406523 **NCCI RISK ID NUMBER** **OTHER RATING BUREAU ID OR STATE EMPLOYER REGISTRATION NUMBER**

STATUS OF SUBMISSION

☑ QUOTE ☐ ISSUE POLICY
☐ BOUND (Give date and/or attach copy)
☐ ASSIGNED RISK (Attach ACORD 133)

BILLING / AUDIT INFORMATION

BILLING PLAN
☑ AGENCY BILL
☐ DIRECT BILL

PAYMENT PLAN
☐ ANNUAL ☐
☐ SEMI-ANNUAL
☐ QUARTERLY % DOWN:

AUDIT
☑ AT EXPIRATION ☐ MONTHLY
☐ SEMI-ANNUAL ☐
☐ QUARTERLY

LOCATIONS

LOC #	HIGHEST FLOOR	STREET, CITY, COUNTY, STATE, ZIP CODE
1	2	329 EAST 149TH STR, 3RD FL BRONX Bronx NY

POLICY INFORMATION

PROPOSED EFF DATE	PROPOSED EXP DATE	NORMAL ANNIVERSARY RATING DATE		RETRO PLAN
02/24/2017	03/07/2018		☐ PARTICIPATING ☑ NON-PARTICIPATING	

PART 1 - WORKERS COMPENSATION (States)	PART 2 - EMPLOYER'S LIABILITY		PART 3 - OTHER STATES INS	DEDUCTIBLES (N / A in WI)	AMOUNT / % (N / A in WI)	OTHER COVERAGES	
NY	$ 100000	EACH ACCIDENT		☐ MEDICAL		☐ U.S.L. & H.	☐ MANAGED CARE OPTION
	$ 500000	DISEASE-POLICY LIMIT		☐ INDEMNITY		☐ VOLUNTARY COMP	☑
	$ 100000	DISEASE-EACH EMPLOYEE		☐		☐ FOREIGN COV	☐

DIVIDEND PLAN/SAFETY GROUP

ADDITIONAL COMPANY INFORMATION

SPECIFY ADDITIONAL COVERAGES / ENDORSEMENTS (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

TOTAL ESTIMATED ANNUAL PREMIUM - ALL STATES

TOTAL ESTIMATED ANNUAL PREMIUM ALL STATES	TOTAL MINIMUM PREMIUM ALL STATES	TOTAL DEPOSIT PREMIUM ALL STATES
$	$	$

CONTACT INFORMATION

TYPE	NAME	OFFICE PHONE	MOBILE PHONE	E-MAIL
INSPECTION	David Modnyy	(917) 364-2650		
ACCTNG RECORD	David Modnyy	(917) 364-2650		
CLAIMS INFO	David Modnyy	(917) 364-2650		

INDIVIDUALS INCLUDED / EXCLUDED

PARTNERS, OFFICERS, RELATIVES (Must be employed by business operations) TO BE INCLUDED OR EXCLUDED (Remuneration/Payroll to be included must be part of rating information section.) Exclusions in Missouri must meet the requirements of Section 287.090 RSMo.

STATE	LOC #	NAME	DATE OF BIRTH	TITLE/ RELATIONSHIP	OWNER-SHIP %	DUTIES	INC/EXC	CLASS CODE	REMUNERATION/PAYROLL
NY	1	David Modnyy		Owner	100	Owner	Inclu	8809	70,000

STATE RATING SHEET # 1 **OF** 2 **SHEETS** **AGENCY CUSTOMER ID:** 3282

STATE RATING WORKSHEET

FOR MULTIPLE STATES, ATTACH AN ADDITIONAL PAGE 2 OF THIS FORM

RATING INFORMATION - STATE: NY

LOC #	CLASS CODE	DESCR CODE	CATEGORIES, DUTIES, CLASSIFICATIONS	# EMPLOYEES FULL TIME	# EMPLOYEES PART TIME	SIC	NAICS	ESTIMATED ANNUAL REMUNERATION/ PAYROLL	RATE	ESTIMATED ANNUAL MANUAL PREMIUM
1	9051		Home Health Care	250				5,000,000		
2	8810		Office Workers	200				2,000,000		

PREMIUM

STATE: NY	FACTOR	FACTORED PREMIUM		FACTOR	FACTORED PREMIUM
TOTAL	N / A	$			$
INCREASED LIMITS		$	SCHEDULE RATING *		$
DEDUCTIBLE *		$	CCPAP		$
		$	STANDARD PREMIUM		$
EXPERIENCE OR MERIT MODIFICATION		$	PREMIUM DISCOUNT		$
1.46		$	EXPENSE CONSTANT	N / A	$
ASSIGNED RISK SURCHARGE *		$	TAXES / ASSESSMENTS *	N / A	$
ARAP *		$			$

* N / A in Wisconsin

TOTAL ESTIMATED ANNUAL PREMIUM	MINIMUM PREMIUM	DEPOSIT PREMIUM
$	$	$

REMARKS (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

AGENCY CUSTOMER ID: 3282

PRIOR CARRIER INFORMATION / LOSS HISTORY

PROVIDE INFORMATION FOR THE PAST 5 YEARS AND USE THE REMARKS SECTION FOR LOSS DETAILS					✔ LOSS RUN ATTACHED	
YEAR	CARRIER & POLICY NUMBER	ANNUAL PREMIUM	MOD	# CLAIMS	AMOUNT PAID	RESERVE
)15-201	CO: Am Trust POL #:					
)14-201	CO: NYSIF POL #:					
	CO: POL #:					
	CO: POL #:					
	CO: POL #:					

NATURE OF BUSINESS / DESCRIPTION OF OPERATIONS

GIVE COMMENTS AND DESCRIPTIONS OF BUSINESS, OPERATIONS AND PRODUCTS: MANUFACTURING - RAW MATERIALS, PROCESSES, PRODUCT, EQUIPMENT; CONTRACTOR - TYPE OF WORK, SUB-CONTRACTS; MERCANTILE - MERCHANDISE, CUSTOMERS, DELIVERIES; SERVICE - TYPE, LOCATION; FARM - ACREAGE, ANIMALS, MACHINERY, SUB-CONTRACTS.

Home Care Agency

GENERAL INFORMATION

EXPLAIN ALL "YES" RESPONSES	Y / N
1. DOES APPLICANT OWN, OPERATE OR LEASE AIRCRAFT / WATERCRAFT?	N
2. DO / HAVE PAST, PRESENT OR DISCONTINUED OPERATIONS INVOLVE(D) STORING, TREATING, DISCHARGING, APPLYING, DISPOSING, OR TRANSPORTING OF HAZARDOUS MATERIAL? (e.g. landfills, wastes, fuel tanks, etc)	N
3. ANY WORK PERFORMED UNDERGROUND OR ABOVE 15 FEET?	N
4. ANY WORK PERFORMED ON BARGES, VESSELS, DOCKS, BRIDGE OVER WATER?	N
5. IS APPLICANT ENGAGED IN ANY OTHER TYPE OF BUSINESS?	N
6. ARE SUB-CONTRACTORS USED? (If "YES", give % of work subcontracted)	N
7. ANY WORK SUBLET WITHOUT CERTIFICATES OF INSURANCE? (If "YES", payroll for this work must be included in the State Rating Worksheet on Page 2)	N
8. IS A WRITTEN SAFETY PROGRAM IN OPERATION?	N
9. ANY GROUP TRANSPORTATION PROVIDED?	N
10. ANY EMPLOYEES UNDER 16 OR OVER 60 YEARS OF AGE?	N
11. ANY SEASONAL EMPLOYEES?	N
12. IS THERE ANY VOLUNTEER OR DONATED LABOR? (If "YES", please specify)	N

AGENCY CUSTOMER ID: _____

GENERAL INFORMATION (continued)

EXPLAIN ALL "YES" RESPONSES	Y / N
13. ANY EMPLOYEES WITH PHYSICAL HANDICAPS?	N
14. DO EMPLOYEES TRAVEL OUT OF STATE? (If "YES", indicate state(s) of travel and frequency)	N
15. ARE ATHLETIC TEAMS SPONSORED?	N
16. ARE PHYSICALS REQUIRED AFTER OFFERS OF EMPLOYMENT ARE MADE?	N
17. ANY OTHER INSURANCE WITH THIS INSURER?	N
18. ANY PRIOR COVERAGE DECLINED / CANCELLED / NON-RENEWED IN THE LAST THREE (3) YEARS? **(Missouri Applicants - Do not answer this question)**	N
19. ARE EMPLOYEE HEALTH PLANS PROVIDED?	N
20. DO ANY EMPLOYEES PERFORM WORK FOR OTHER BUSINESSES OR SUBSIDIARIES?	N
21. DO YOU LEASE EMPLOYEES TO OR FROM OTHER EMPLOYERS?	N
22. DO ANY EMPLOYEES PREDOMINANTLY WORK AT HOME? If "YES", # of Employees: _____	N
23. ANY TAX LIENS OR BANKRUPTCY WITHIN THE LAST FIVE (5) YEARS? (If "YES", please specify)	N
24. ANY UNDISPUTED AND UNPAID WORKERS COMPENSATION PREMIUM DUE FROM YOU OR ANY COMMONLY MANAGED OR OWNED ENTERPRISES? IF YES, EXPLAIN INCLUDING ENTITY NAME(S) AND POLICY NUMBER(S).	N

REMARKS (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

APPLICABLE IN TENNESSEE AND VERMONT: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO ANY PARTY TO A WORKERS COMPENSATION TRANSACTION FOR THE PURPOSE OF COMMITTING FRAUD. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS THE PERSON TO CRIMINAL AND [NY: SUBSTANTIAL] CIVIL PENALTIES. (Not applicable in CO, DC, FL, HI, MA, MN, NE, OH, OK, OR, VT or WA; in LA, ME, TN and VA, insurance benefits may also be denied)

IN THE DISTRICT OF COLUMBIA, WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES.

IN MASSACHUSETTS, NEBRASKA, OREGON AND VERMONT, ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, MAY BE COMMITTING A FRAUDULENT INSURANCE ACT, WHICH MAY BE A CRIME AND MAY SUBJECT THE PERSON TO CRIMINAL AND CIVIL PENALTIES.

IN WASHINGTON, IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES, AND DENIAL OF INSURANCE BENEFITS.

APPLICANT'S SIGNATURE (Must be Officer, Owner or Partner)	DATE	PRODUCER'S SIGNATURE	NATIONAL PRODUCER NUMBER

WC LOSS RUN REPORT

AmTrust North America

Prestige LCHA Management, Inc.

Claim No / Converted # / Policy Number / Pol. Eff Date	Claimant / Insured / Class Cd / Juris St	Department / DOL / First Aware / Date Rcvd	Nature / Employee Lag / Reporting Lag	Status / Category / Adjuster	Loss Location / Part Injured / Cause / Loss Description		Indem	Medical	LAE	Total
2161821 1	Liz Marcia	329 East 149th Street, Bronx, NY 10451			329 East 149th Street, Bronx, NY 10451					
0	Prestige LCHA Management, Inc.	02/07/2016	Strain	O	Lower Back Area (Incl. Lumbar &	**Reserves**	25,479	8,466	5,048	38,993
MWC1012269	9051	02/07/2016	0 Days	TTD	Strain or Injury By - Lifting	**Payments**	5,421	1,904	1,179	8,504
01/16/2016	NY	02/18/2016	11 Days	20761	EE injured her unknown back area due to repetitive lifting of client weighing unknown. Injury resulting in a	**Recoveries**	0	0	0	0
						Incurred	30,900	10,370	6,227	47,497
2219589 1	Achampong Edward	329 East 149th Street, Bronx, NY 10451			329 East 149th Street, Bronx, NY 10451					
0	Prestige LCHA Management, Inc.	04/06/2016	Strain	O	Body Systems & Multiple Body Systems	**Reserves**	40,785	2,758	6,085	49,628
MWC1012269	9051	04/06/2016	0 Days	TTD	Motor Vehicle - Collision with Another Vehicle	**Payments**	4,908	6,362	7,376	18,646
01/16/2016	NY	04/13/2016	7 Days	23712	The employee was involved in a motor vehicle accident causing multiple muscle strains.	**Recoveries**	0	0	0	0
						Incurred	45,693	9,120	13,461	68,274

Claim No	Claimant	Department			Loss Location				
Converted #	Insured	DOL	Nature	Status	Part Injured				
Policy Number	Class Cd	First Aware	Employee Lag	Category	Cause				
Pol. Eff Date	Juris St	Date Rcvd	Reporting Lag	Adjuster	Loss Description		Indem	Medical	LAE	Total

Policy Number MWC1012269

Group Totals

	LT	Med	Total					
Open	2	0	2	Reserves	66,264	11,224	11,133	88,621
Closed	0	0	0	Payments	10,329	8,266	8,555	27,150
				Recoveries	0	0	0	0
				Incurred	76,593	19,490	19,688	115,771

Claim No / Converted # / Policy Number / Pol. Eff Date	Claimant / Insured / Class Cd / Juris St	Department / DOL / First Aware / Date Rcvd	Nature / Employee Lag / Reporting Lag	Status / Category / Adjuster	Loss Location / Part Injured / Cause / Loss Description		Indem	Medical	LAE	Total
1896138 1	Williams-Stewart Juliet	PRESTIGE LCHA Management, Inc., 329 East 149th Str			PRESTIGE LCHA Management, Inc., 329 East 149th Street, , Bronx, NY 10451					
0	Prestige LCHA Management, Inc.	05/14/2015	All Other	O	Multiple Body Parts	**Reserves**	128,021	28,038	14,941	171,000
WWC3123224	9051	05/14/2015	0 Days	PPD	Motor Vehicle - Collision with Another Vehicle	**Payments**	12,633	40,963	7,026	60,622
01/16/2015	NY	05/19/2015	5 Days	20555	EE WAS IN COLLISION WITH ANOTHER VEHICLE RESULTING IN MULTIPLE PHYSICAL	**Recoveries**	0	0	0	0
						Incurred	140,653	69,001	21,967	231,622
2031234 1	Bonilla Blanca	329 East 149th Street, Bronx, NY 10451			329 East 149th Street, Bronx, NY 10451					
0	Prestige LCHA Management, Inc.	11/11/2015	Puncture	C	Upper Leg	**Reserves**	0	0	0	0
WWC3123224	9051	11/11/2015	0 Days	TTD	Struck or Injured By - Animal or Insect	**Payments**	0	0	19	19
01/16/2015	NY	11/17/2015	6 Days	21597	EE was caring for patient when dog bit EE resulting in puncture wound and bite marks to right thigh and hip	**Recoveries**	0	0	0	0
						Incurred	0	0	19	19
2152185 1	MELENDEZ ELBA	329 East 149th Street, Bronx, NY 10451			329 East 149th Street, Bronx, NY 10451					
0	Prestige LCHA Management, Inc.	01/13/2016	Contusion	C	Lower Arm	**Reserves**	0	0	0	0
WWC3123224	9051	01/13/2016	0 Days	MED	Motor Vehicle - Collision with Another Vehicle	**Payments**	0	0	181	181
01/16/2015	NY	02/03/2016	21 Days	kagresta	EE WAS DRIVING WHEN IN A MOTOR VEHICLE ACCIDENT RESULTING IN MULTIPLE PHYSICAL	**Recoveries**	0	0	0	0
						Incurred	0	0	181	181

WC LOSS RUN REPORT
AmTrust North America

Prestige LCHA Management, Inc.

Policy Number WWC3123224

Group Totals

	LT	Med	Total
Open	1	0	1
Closed	1	1	2

	Indem	Medical	LAE	Total
Reserves	128,021	28,038	14,941	171,000
Payments	12,633	40,963	7,226	60,822
Recoveries	0	0	0	0
Incurred	140,653	69,001	22,168	231,822

WC LOSS RUN REPORT
AmTrust North America

Prestige LCHA Management, Inc.

Report Totals

					Indem	Medical	LAE	Total
Totals for Open	**LT**	**Med**	**Total**	**Reserves**	194,285	39,262	26,074	259,621
	3	0	3	**Payments**	22,961	49,229	15,581	87,772
				Recoveries	0	0	0	0
				Incurred	217,246	88,491	41,656	347,393

Totals for Closed	**LT**	**Med**	**Total**	**Reserves**	0	0	0	0
	1	1	2	**Payments**	0	0	200	200
				Recoveries	0	0	0	0
				Incurred	0	0	200	200

Report Totals	**LT**	**Med**	**Total**	**Reserves**	194,285	39,262	26,074	259,621
	4	1	5	**Payments**	22,961	49,229	15,782	87,972
				Recoveries	0	0	0	0
				Incurred	217,246	88,491	41,856	347,593

NYS Department of State

Division of Corporations

Entity Information

The information contained in this database is current through February 23, 2017.

Selected Entity Name: PRESTIGE LHCSA MANAGEMENT INC.

Selected Entity Status Information

Current Entity Name:	PRESTIGE LHCSA MANAGEMENT INC.
DOS ID #:	4426299
Initial DOS Filing Date:	JULY 03, 2013
County:	BRONX
Jurisdiction:	NEW YORK
Entity Type:	DOMESTIC BUSINESS CORPORATION
Current Entity Status:	ACTIVE

Selected Entity Address Information

DOS Process (Address to which DOS will mail process if accepted on behalf of the entity)

PRESTIGE LHCSA MANAGEMENT INC.
329 EAST 149TH STR
BRONX, NEW YORK, 10451

Chief Executive Officer

DAVID MODNYY
329 EAST 149TH STR
3RD FLOOR
BRONX, NEW YORK, 10451

Principal Executive Office

PRESTIGE LHCSA MANAGEMENT INC.
329 EAST 149TH
3RD FLOOR
BRONX, NEW YORK, 10451

Registered Agent

NONE

This office does not record information regarding the names and addresses of officers, shareholders or directors of nonprofessional corporations except the chief executive officer, if provided, which would be listed above. Professional corporations must include the name(s) and address(es) of the initial officers, directors, and shareholders in the initial certificate of incorporation, however this information is not recorded and only available by viewing the certificate.

***Stock Information**

# of Shares	Type of Stock	$ Value per Share
200	No Par Value	

*Stock information is applicable to domestic business corporations.

Name History

Filing Date	Name Type	Entity Name
JUL 03, 2013	Actual	PRESTIGE LHCSA MANAGEMENT INC.

A **Fictitious** name must be used when the **Actual** name of a foreign entity is unavailable for use in New York State. The entity must use the fictitious name when conducting its activities or business in New York State.

NOTE: New York State does not issue organizational identification numbers.

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Policy #	MWC1012269	Carrier	MILWAUKEE CASUALTY	Auditor	TONY VALLONE	Policy Period	01/16/2016 - 01/16/2017
Serial #	10001-390371	Insured	PRESTIGE LCHA MANAGEMENT INC	Date	02/07/2017	Audit Period	01/16/2016 - 01/16/2017

Policy Type: Workers Compensation
Audit Type: Annual
Audit Source: Physical

Legal Entity: Corporation
Federal ID#: 46-3406523
Ins. Name 2:

Insured Location: 329 EAST 149TH STREET
3RD FL
BRONX, NY 10451
Insured Phone: 917-364-2650

Audit Location: 329 EAST 149TH STREET
3RD FL
BRONX, NY 10451
Audit Phone: 917-364-2650
Audit Contact: DAVID MODNYY, PRES

Source of Data
- [x] Payroll Book
- [ ] Cash Book
- [ ] Check Book
- [x] Gen'l Ledger
- [ ] Gen'l Journal
- [ ]

Verification
- [x] S/S Returns
- [x] U/C Returns
- [ ] Income Tax
- [ ] Financial State.
- [ ]

Subcontractors
- [ ] Yes
- [x] No

Condition
- [x] Good
- [ ] Fair
- [ ] Poor

Time Charges
Travel:
Direct:
Write-up:

DESCRIPTION OF OPERATIONS

INSURED OPERATES AS A HOME CARE OPERATION. INSURED SUPPLIES HOME HEALTH AIDES TO CLIENTS WHO ARE IN NEED OF IN HOME DAILY LIVING CARE. NO MEDICAL PERSONEL ONLY HOME HEALTH AIDES. INSURED DOES HAVE RN'S ON THE PAYROLL BUT WORK EXCLUSIVELY PERFORMING ASSESSMENTS OF CLIENTS. NO IN HOME MEDICAL CARE GIVEN BY INSURED.

CLAIMAINTS MARCIA LIZ AND EDWARE ACHAMPONG WERE BOTH ON PAYROLL PRIOR TO LOSS DATES. EDWARED ACHAMPONG SHOULD BE CLASSIFIED UNDER 8810.

TITLE	NAME	ADJ. GROSS PAYROLL	AMOUNT INCLUDED	DAYS	STATE	CODE	DESCRIPTION OF DUTIES
President	DAVID MODNYY	67,500	67,500	365	NY	8809	ADMINSTRATION FROM OFFICE
Vice President	DIANA NABITOVSKY	0	0	365	NY	excl	INACTIVE DAY TO DAY

AUDIT SUMMARY

CLASSIFICATION	CODE	EXPOSURE
PAYROLL EXPOSURE		
PRESTIGE LCHA MANAGEMENT INC - NY - 01/16/16 to 01/16/17 - BRONX		
EXECUTIVE OFFICERS	8809	67,500
Clerical office employees	8810	2,013,250
HOME HEALTH CARE	9051	4,838,329
TOTAL		**6,919,079**

VERIFICATION SUMMARY

Worksheet 1	7,048,332
Less Adjustments	(129,254)
TOTAL	**6,919,078**

Worksheet 1 Detail

Name	Code	Exact Duties/Notes	Gross
HHA AIDE	9051	HOME AIDES	4542479.
CORPORATE	8810	ADMINSTRATION FROM OFFICE	2018154.
RN	9051	HOME ASSESSMENTS	36324.
PA	9051	HOME AIDE	362070.
ASIAN	9051	HOME AIDE	21805.

Policy #	MWC1012269	Carrier	MILWAUKEE CASUALTY	Auditor	TONY VALLONE	Policy Period	01/16/2016 - 01/16/2017
Serial #	10001-390371	Insured	PRESTIGE LCHA MANAGEMENT INC	Date	02/07/2017	Audit Period	01/16/2016 - 01/16/2017

Worksheet 1 Figures

Code	Name	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1/1/16-1/16/16	1/1/17-1/16/17	GROSS	Overtime				
PRESTIGE LCHA MANAGEMENT INC - NY - BRONX													
8809	DAVID MODNYY	15000	15000	17500	20000	(2500)	2500	67500	0				
8810	CORPORATE	473804	444964	559107	533682	(79830)	86427	2018154	14713				
9051	HHA AIDE	951271	1051975	1218478	1287227	(144999)	178527	4542479	330027				
9051	RN	3940	14579	10310	5905	(150)	1740	36324	0				
9051	PA	30467	43903	85508	177443	(3949)	28698	362070	43021				
9051	ASIAN	11561	2409	4833	4741	(2348)	609	21805	0				
excl	DIANA NABITOVSKY	0	0	0	0	0	0	0	0				
SUBTOTAL		**1486043**	**1572830**	**1895736**	**2028998**	**(233776)**	**298501**	**7048332**	**387761**				
GRAND TOTAL		**1486043**	**1572830**	**1895736**	**2028998**	**(233776)**	**298501**	**7048332**	**387761**				

Worksheet 1 Verification

1st Quarter '16	2nd Quarter '16	3rd Quarter '16	4th Quarter '16	1/1-1/16/16	1/1-1/16/17	1ST QTR DIFF	2ND QTR DIFF	3RD QTR DIFF	4TH QTR DIFF
1482969	1567031	1890962	2028808	(233776)	298501	3074	5799	4774	190
TOTAL									
7048332									

Worksheet 1 Recap for PRESTIGE LCHA MANAGEMENT INC - NY - 01/16/16 to 01/16/17 - BRONX

Recap	TOTAL	8809	8810	9051	Excluded								
Gross Payroll	**7048332**	67500	2018154	4962678									
Less Overtime	**(129253)**		(4904)	(124349)									
Less excl	**0**												
Principal Min/Max/Flat	**0**												
TOTAL	**6919079**	**67500**	**2013250**	**4838329**	**0**								

MILWAUKEE CASUALTY INSURANCE COMPANY

WORKERS' COMPENSATION

and

EMPLOYERS' LIABILITY INSURANCE POLICY

In Witness Whereof, we have caused this policy to be executed and attested, and, if required by state law, this policy shall not be valid unless countersigned by our authorized representative.

Stephen Unger, Secretary

Jeff Leo, President

To obtain information, please contact your agent or Milwaukee Casualty Insurance Company at **877-528-7878**. You may also write Milwaukee Casualty Insurance Company Consumer Relations at:

5800 Lombardo Center
Cleveland OH 44131-2550

AmTrust North America
An AmTrust Financial Company

February 04, 2017

Prestige LCHA Management, Inc.
329 East 149th Street
Bronx NY 10451

Re: Rate Change Notification
Policy No.: MWC1017146
Policy Expiration Date: 1/16/2018

Dear Prestige LCHA Management, Inc.

This letter is to notify you that your Workers' Compensation policy written through an AmTrust North America company coming up for renewal on 1/16/2017 contains a change in rate for the state of New York.

The New York State Department of Financial Services approved updated loss costs with an average overall increase of 9.3% for policies effective 10/1/2016 and later. Your policy may or may not contain an increase in rate(s) with this change. To check the impact to your specific operations, please go to the following link to view the individual classification code percentage changes. https://amtrustgroup.com/notices

The factors attributable to this rate change are listed below:

Loss Experience – The latest two policy years of experience produced a 6.8% increase in the overall loss cost level.

Legislative and Regulatory Changes – This revision includes an estimate of the cost impact of the latest increases in the maximum weekly benefits that were set forth in the 2007 workers compensation reform legislation. This component contributed 0.5% to the overall change.

Loss Adjustment Expenses – A review of the latest data available resulted in a 0.5% increase in the Loss Adjustment Expense provision.

Future Trends – The latest analysis of New York claim severity and claim frequency indicates a continuing small decrease in claim frequency and an upward trend in both indemnity and medical claim costs. Combined with a projected wage trend, the final selected net trend factor is 1.6%.

Catastrophe Provision – This revision contains no changes in the loss cost provisions for terrorism and for natural disasters and catastrophic industrial accidents.

AmTrust North America
An AmTrust Financial Company

Classification Loss Costs – Although the average manual loss cost level in increasing by 9.6%, individual classification loss cost changes are based on the most recently available loss experience for each classification. Both increases and decreases from the current loss costs have been actuarially calculated for each class. This process ensures that each classification loss cost reflects the appropriate level relative to the experience of the other classifications.

Please contact your agent with any questions or concerns regarding this notice.

We appreciate your business and hope we have the opportunity to continue to service your insurance needs.

Henry C. Sibley
Chief Underwriting Officer

Milwaukee Casualty Insurance Company

A Stock Insurance Company

WORKERS COMPENSATION
AND EMPLOYERS LIABILITY
INSURANCE POLICY

WC 99 00 01 B

INFORMATION PAGE

Ncci Code: 69103

1. Insured:

Prestige LCHA Management, Inc.
329 East 149th Street
Bronx, NY 10451

Other workplaces not shown above:
See Extension of Information Page

Producer:

AmTrust North America, Inc.
c/o Total Program Management, Inc.
4175 Veterans Memorial Hwy, Suite 306
Ronkonkoma, NY 11779

Policy Number: MWC1017146

__Individual __Partnership
X Corporation
Federal Tax ID: 463406523
Risk Id:
Renewal of: MWC1012269

2. The policy period is from 1/16/2017 to 1/16/2018 12:01 a.m. at the insured's mailing address.

3. A. Workers Compensation Insurance: Part One of the policy applies to the Workers Compensation Law of the states listed here: New York

B. Employers Liability Insurance: Part Two of the policy applies to work in each state listed in item 3.A. The limits of our liability under Part Two are:

State	Bodily Injury by Accident	Bodily Injury by Disease	Bodily Injury by Disease
	$1,000,000 each accident	$1,000,000 policy limit	$1,000,000 each employee

C. Other States Insurance: Part Three of the policy applies to the states, if any, listed here:
All states except ND, OH, WA, WY and State(s) Designated in Item 3A.

D. This policy includes these endorsements and schedules: See Extension of Information Page

4. The premium for this policy will be determined by our Manuals of Rules, Classifications, Rates and Rating Plans. All information required below is subject to verification and change by audit.

See Extension of Information Page

TOTAL ESTIMATED ANNUAL PREMIUM	**519,114**
STATE ASSESSMENT	**70,575**
TOTAL ESTIMATED COST	**589,689**
Minimum Premium	875

Issue Date: 2/4/2017 Countersigned by: _____

EXTENSION OF INFORMATION PAGE FOR ITEM #1
ITEM 1: NAMED INSURED and WORKPLACES

NAMED INSURED:	Prestige LCHA Management, Inc.	Fein: 463406523
WORKPLACES:	Location Number 1. 329 East 149th Street Bronx, NY 10451	
NAMED INSURED:	PRESTIGE LCHA Management, Inc.	Fein: 463406523
WORKPLACES:	Location Number 2. 329 East 149th Street Bronx, NY 10451	

Insured: Prestige LCHA Management, Inc. **Policy Number: MWC1017146**

EXTENSION OF INFORMATION PAGE FOR ITEM #3.D
ITEM 3.D: ENDORSEMENT SCHEDULE

State	Form Number	Description
	WC000000A	WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY
	WC990001B	DECLARATIONS PAGE
	WC000403	EXPERIENCE RATING MODIFICATION FACTOR ENDORSEMENT
	WC000404	PENDING RATE CHANGE ENDORSEMENT
	WC000406	PREMIUM DISCOUNT ENDORSEMENT
	WC000414	NOTIFICATION OF CHANGE IN OWNERSHIP ENDORSEMENT
	WC000419	PREMIUM DUE DATE ENDORSEMENT
	WC000421D	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM) PREMIUM ENDORSEMENT
	WC000422B	TERRORISM RISK INSURANCE PROGRAM REAUTHORIZATION ACT DISCLOSURE ENDORSEMENT
NY	WC310308	NEW YORK LIMIT OF LIABILITY ENDORSEMENT
NY	WC310319H	NEW YORK CONSTRUCTION CLASSIFICATION PREMIUM ADJUSTMENT PROGRAM EXPLANATORY ENDORSEMENT

Insured: Prestige LCHA Management, Inc. **Policy Number: MWC1017146**

EXTENSION OF INFORMATION PAGE FOR ITEM #4
ITEM 4: SCHEDULE OF PREMIUMS

Classifications	# of Emps	Code No.	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration	Estimated Annual Premium
New York					
Clerical Office Employees NOC	0	8810	1,500,000	0.27	4,050
Home Health Care Services:—Home Health Care—Non-Professional Employees	0	9051	5,000,000	8.53	426,500
Manual Premium					430,550
Total Manual Premium					430,550
Premium for Increased Limits Part Two: 0% (1000/1000/1000)		9812			0
Total Premium Subject to Experience Modification					430,550
Experience Modification 146%					628,603
Drug Free Workplace Credit 5%		9841			-31,430
Schedule Modifier -4%		9887			-23,887
Premium Discount 10.4%		0063			-59,622
Expense Constant		0900			250
Terrorism		9740			4,550
Natural Disasters and Catastrophic Industrial Accidents		9741			650
Total NY Premium					519,114
New York State Assessment 12.2%		0932			70,575
Total NY Cost					589,689

TOTAL ESTIMATED ANNUAL PREMIUM **519,114**

STATE ASSESSMENT **70,575**

TOTAL COST **589,689**

Insured: Prestige LCHA Management, Inc. **Policy Number: MWC1017146**

PAYMENT SCHEDULE

Statement Closing Date	Payment Due Date	Description	Amount Due
	1/16/2017	Installment 1 of 12	$49,138.00
	2/28/2017	Installment 2 of 12	$49,141.00
	3/31/2017	Installment 3 of 12	$49,141.00
	4/30/2017	Installment 4 of 12	$49,141.00
	5/31/2017	Installment 5 of 12	$49,141.00
	6/30/2017	Installment 6 of 12	$49,141.00
	7/31/2017	Installment 7 of 12	$49,141.00
	8/31/2017	Installment 8 of 12	$49,141.00
	9/30/2017	Installment 9 of 12	$49,141.00
	10/31/2017	Installment 10 of 12	$49,141.00
	11/30/2017	Installment 11 of 12	$49,141.00
	12/31/2017	Installment 12 of 12	$49,141.00
			Total Cost $589,689.00

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

In return for the payment of the premium and subject to all terms of this policy, we agree with you as follows:

GENERAL SECTION

A. **The Policy**
This policy includes at its effective date the Information Page and all endorsements and schedules listed there. It is a contract of insurance between you (the employer named in Item 1 of the Information Page) and us (the insurer named on the Information Page). The only agreements relating to this insurance are stated in this policy. The terms of this policy may not be changed or waived except by endorsement issued by us to be part of this policy.

B. **Who Is Insured**
You are insured if you are an employer named in Item 1 of the Information Page. If that employer is a partnership, and if you are one of its partners, you are insured, but only in your capacity as an employer of the partnership's employees.

C. **Workers Compensation Law**
Workers Compensation Law means the workers or workmen's compensation law and occupational disease law of each state or territory named in Item 3.A. of the Information Page. It includes any amendments to that law which are in effect during the policy period. It does not include any federal workers or workmen's compensation law, any federal occupational disease law or the provisions of any law that provide nonoccupational disability benefits.

D. **State**
State means any state of the United States of America, and the District of Columbia.

E. **Locations**
This policy covers all of your workplaces listed in Items 1 or 4 of the Information Page; and it covers all other workplaces in Item 3.A. states unless you have other insurance or are self-insured for such workplaces.

PART ONE

WORKERS COMPENSATION INSURANCE

A. **How This Insurance Applies**
This workers compensation insurance applies to bodily injury by accident or bodily injury by disease. Bodily injury includes resulting death.

1. Bodily injury by accident must occur during the policy period.
2. Bodily injury by disease must be caused or aggravated by the conditions of your employment. The employee's last day of last exposure to the conditions causing or aggravating such bodily injury by disease must occur during the policy period.

B. **We Will Pay**
We will pay promptly when due the benefits required of you by the workers compensation law.

C. **We Will Defend**
We have the right and duty to defend at our expense any claim, proceeding or suit against you for benefits payable by this insurance. We have the right to investigate and settle these claims, proceedings or suits. We have no duty to defend a claim, proceeding or suit that is not covered by this insurance.

D. **We Will Also Pay**
We will also pay these costs, in addition to other amounts payable under this insurance, as part of any claim, proceeding or suit we defend:

1. reasonable expenses incurred at our request, but not loss of earnings;
2. premiums for bonds to release attachments and for appeal bonds in bond amounts up to the amount payable under this insurance;

3. litigation costs taxed against you;
4. interest on a judgment as required by law until we offer the amount due under this insurance; and
5. expenses we incur.

E. **Other Insurance**

We will not pay more than our share of benefits and costs covered by this insurance and other insurance or self-insurance. Subject to any limits of liability that may apply, all shares will be equal until the loss is paid. If any insurance or self-insurance is exhausted, the shares of all remaining insurance will be equal until the loss is paid.

F. **Payments You Must Make**

You are responsible for any payments in excess of the benefits regularly provided by the workers compensation law including those required because:

1. of your serious and willful misconduct;
2. you knowingly employ an employee in violation of law;
3. you fail to comply with a health or safety law or regulation; or
4. you discharge, coerce or otherwise discriminate against any employee in violation of the workers compensation law.

If we make any payments in excess of the benefits regularly provided by the workers compensation law on your behalf, you will reimburse us promptly.

G. **Recovery From Others**

We have your rights, and the rights of persons entitled to the benefits of this insurance, to recover our payments from anyone liable for the injury. You will do everything necessary to protect those rights for us and to help us enforce them.

H. **Statutory Provisions**

These statements apply where they are required by law.

1. As between an injured worker and us, we have notice of the injury when you have notice.
2. Your default or the bankruptcy or insolvency of you or your estate will not relieve us of our duties under this insurance after an injury occurs.
3. We are directly and primarily liable to any person entitled to the benefits payable by this insurance. Those persons may enforce our duties; so may an agency authorized by law. Enforcement may be against us or against you and us.
4. Jurisdiction over you is jurisdiction over us for purposes of the workers compensation law. We are bound by decisions against you under that law, subject to the provisions of this policy that are not in conflict with that law.
5. This insurance conforms to the parts of the workers compensation law that apply to:
   a. benefits payable by this insurance;
   b. special taxes, payments into security or other special funds, and assessments payable by us under that law.
6. Terms of this insurance that conflict with the workers compensation law are changed by this statement to conform to that law.

Nothing in these paragraphs relieves you of your duties under this policy.

PART TWO

EMPLOYERS LIABILITY INSURANCE

A. **How This Insurance Applies**

This employers liability insurance applies to bodily injury by accident or bodily injury by disease. Bodily injury includes resulting death.

1. The bodily injury must arise out of and in the course of the injured employee's employment by you.

2. The employment must be necessary or incidental to your work in a state or territory listed in Item 3.A. of the Information Page.
3. Bodily injury by accident must occur during the policy period.
4. Bodily injury by disease must be caused or aggravated by the conditions of your employment. The employee's last day of last exposure to the conditions causing or aggravating such bodily injury by disease must occur during the policy period.
5. If you are sued, the original suit and any related legal actions for damages for bodily injury by accident or by disease must be brought in the United States of America, its territories or possessions, or Canada.

B. **We Will Pay**

We will pay all sums you legally must pay as damages because of bodily injury to your employees, provided the bodily injury is covered by this Employers Liability Insurance.

The damages we will pay, where recovery is permitted by law, include damages:

1. for which you are liable to a third party by reason of a claim or suit against you by that third party to recover the damages claimed against such third party as a result of injury to your employee;
2. for care and loss of services; and
3. for consequential bodily injury to a spouse, child, parent, brother or sister of the injured employee; provided that these damages are the direct consequence of bodily injury that arises out of and in the course of the injured employee's employment by you; and
4. because of bodily injury to your employee that arises out of and in the course of employment, claimed against you in a capacity other than as employer.

C. **Exclusions**

This insurance does not cover:

1. liability assumed under a contract. This exclusion does not apply to a warranty that your work will be done in a workmanlike manner;
2. punitive or exemplary damages because of bodily injury to an employee employed in violation of law;
3. bodily injury to an employee while employed in violation of law with your actual knowledge or the actual knowledge of any of your executive officers;
4. any obligation imposed by a workers compensation, occupational disease, unemployment compensation, or disability benefits law, or any similar law;
5. bodily injury intentionally caused or aggravated by you;
6. bodily injury occurring outside the United States of America, its territories or possessions, and Canada. This exclusion does not apply to bodily injury to a citizen or resident of the United States of America or Canada who is temporarily outside these countries;
7. damages arising out of coercion, criticism, demotion, evaluation, reassignment, discipline, defamation, harassment, humiliation, discrimination against or termination of any employee, or any personnel practices, policies, acts or omissions;
8. bodily injury to any person in work subject to the Longshore and Harbor Workers' Compensation Act (33 USC Sections 901–950), the Non-appropriated Fund Instrumentalities Act (5 USC Sections 8171–8173), the Outer Continental Shelf Lands Act (43 USC Sections 1331–1356), the Defense Base Act (42 USC Sections 1651–1654), the Federal Coal Mine Health and Safety Act of 1969 (30 USC Sections 901–942), any other federal workers or workmen's compensation law or other federal occupational disease law, or any amendments to these laws;
9. bodily injury to any person in work subject to the Federal Employers' Liability Act (45 USC Sections 51–60), any other federal laws obligating an employer to pay damages to an employee due to bodily injury arising out of or in the course of employment, or any amendments to those laws;
10. bodily injury to a master or member of the crew of any vessel;
11. fines or penalties imposed for violation of federal or state law; and
12. damages payable under the Migrant and Seasonal Agricultural Worker Protection Act (29 USC Sections 1801–1872) and under any other federal law awarding damages for violation of those laws or regulations issued thereunder, and any amendments to those laws.

D. **We Will Defend**
We have the right and duty to defend, at our expense, any claim, proceeding or suit against your for damages payable by this insurance. We have the right to investigate and settle these claims, proceedings and suits. We have no duty to defend a claim, proceeding or suit that is not covered by this insurance. We have no duty to defend or continue defending after we have paid our applicable limit of liability under this insurance.

E. **We Will Also Pay**
We will also pay these costs, in addition to other amounts payable under this insurance, as part of any claim, proceeding, or suit we defend:

1. reasonable expenses incurred at our request, but not loss of earnings;
2. premiums for bonds to release attachments and for appeal bonds in bond amounts up to the limit of our liability under this insurance;
3. litigation costs taxed against you;
4. interest on a judgment as required by law until we offer the amount due under this insurance; and
5. expenses we incur.

F. **Other Insurance**
We will not pay more than our share of damages and costs covered by this insurance and other insurance or self-insurance. Subject to any limits of liability that apply, all shares will be equal until the loss is paid. If any insurance or self-insurance is exhausted, the shares of all remaining insurance and self-insurance will be equal until the loss is paid.

G. **Limits of Liability**
Our liability to pay for damages is limited. Our limits of liability are shown in Item 3.B. of the Information Page. They apply as explained below.

1. Bodily Injury by Accident. The limit shown for "bodily injury by accident—each accident" is the most we will pay for all damages covered by this insurance because of bodily injury to one or more employees in any one accident. A disease is not bodily injury by accident unless it results directly from bodily injury by accident.
2. Bodily Injury by Disease. The limit shown for "bodily injury by disease—policy limit" is the most we will pay for all damages covered by this insurance and arising out of bodily injury by disease, regardless of the number of employees who sustain bodily injury by disease. The limit shown for "bodily injury by disease—each employee" is the most we will pay for all damages because of bodily injury by disease to any one employee. Bodily injury by disease does not include disease that results directly from a bodily injury by accident.
3. We will not pay any claims for damages after we have paid the applicable limit of our liability under this insurance.

H. **Recovery From Others**
We have your rights to recover our payment from anyone liable for an injury covered by this insurance. You will do everything necessary to protect those rights for us and to help us enforce them.

I. **Actions Against Us**
There will be no right of action against us under this insurance unless:

1. You have complied with all the terms of this policy; and
2. The amount you owe has been determined with our consent or by actual trial and final judgment.

This insurance does not give anyone the right to add us as a defendant in an action against you to determine your liability. The bankruptcy or insolvency of you or your estate will not relieve us of our obligations under this Part.

PART THREE

OTHER STATES INSURANCE

A. **How This Insurance Applies**

1. This other states insurance applies only if one or more states are shown in Item 3.C. of the Information Page.
2. If you begin work in any one of those states after the effective date of this policy and are not insured or are not self-insured for such work, all provisions of the policy will apply as though that state were listed in Item 3.A. of the Information Page.

3. We will reimburse you for the benefits required by the workers compensation law of that state if we are not permitted to pay the benefits directly to persons entitled to them.
4. If you have work on the effective date of this policy in any state not listed in Item 3.A. of the Information Page, coverage will not be afforded for that state unless we are notified within thirty days.

B. **Notice**
Tell us at once if you begin work in any state listed in Item 3.C. of the Information Page.

PART FOUR

YOUR DUTIES IF INJURY OCCURS

Tell us at once if injury occurs that may be covered by this policy. Your other duties are listed here.

1. Provide for immediate medical and other services required by the workers compensation law.
2. Give us or our agent the names and addresses of the injured persons and of witnesses, and other information we may need.
3. Promptly give us all notices, demands and legal papers related to the injury, claim, proceeding or suit.
4. Cooperate with us and assist us, as we may request, in the investigation, settlement or defense of any claim, proceeding or suit.
5. Do nothing after an injury occurs that would interfere with our right to recover from others.
6. Do not voluntarily make payments, assume obligations or incur expenses, except at your own cost.

PART FIVE—PREMIUM

A. **Our Manuals**
All premium for this policy will be determined by our manuals of rules, rates, rating plans and classifications. We may change our manuals and apply the changes to this policy if authorized by law or a governmental agency regulating this insurance.

B. **Classifications**
Item 4 of the Information Page shows the rate and premium basis for certain business or work classifications. These classifications were assigned based on an estimate of the exposures you would have during the policy period. If your actual exposures are not properly described by those classifications, we will assign proper classifications, rates and premium basis by endorsement to this policy.

C. **Remuneration**
Premium for each work classification is determined by multiplying a rate times a premium basis. Remuneration is the most common premium basis. This premium basis includes payroll and all other remuneration paid or payable during the policy period for the services of:

1. all your officers and employees engaged in work covered by this policy; and
2. all other persons engaged in work that could make us liable under Part One (Workers Compensation Insurance) of this policy. If you do not have payroll records for these persons, the contract price for their services and materials may be used as the premium basis. This paragraph 2 will not apply if you give us proof that the employers of these persons lawfully secured their workers compensation obligations.

D. **Premium Payments**
You will pay all premium when due. You will pay the premium even if part or all of a workers compensation law is not valid.

E. **Final Premium**
The premium shown on the Information Page, schedules, and endorsements is an estimate. The final premium will be determined after this policy ends by using the actual, not the estimated, premium basis and the proper

classifications and rates that lawfully apply to the business and work covered by this policy. If the final premium is more than the premium you paid to us, you must pay us the balance. If it is less, we will refund the balance to you. The final premium will not be less than the highest minimum premium for the classifications covered by this policy. If this policy is canceled, final premium will be determined in the following way unless our manuals provide otherwise:

1. If we cancel, final premium will be calculated pro rata based on the time this policy was in force. Final premium will not be less than the pro rata share of the minimum premium.
2. If you cancel, final premium will be more than pro rata; it will be based on the time this policy was in force, and increased by our short-rate cancelation table and procedure. Final premium will not be less than the minimum premium.

F. **Records**
You will keep records of information needed to compute premium. You will provide us with copies of those records when we ask for them.

G. **Audit**
You will let us examine and audit all your records that relate to this policy. These records include ledgers, journals, registers, vouchers, contracts, tax reports, payroll and disbursement records, and programs for storing and retrieving data. We may conduct the audits during regular business hours during the policy period and within three years after the policy period ends. Information developed by audit will be used to determine final premium. Insurance rate service organizations have the same rights we have under this provision.

PART SIX—CONDITIONS

A. **Inspection**
We have the right, but are not obliged to inspect your workplaces at any time. Our inspections are not safety inspections. They relate only to the insurability of the workplaces and the premiums to be charged. We may give you reports on the conditions we find. We may also recommend changes. While they may help reduce losses, we do not undertake to perform the duty of any person to provide for the health or safety of your employees or the public. We do not warrant that your workplaces are safe or healthful or that they comply with laws, regulations, codes or standards. Insurance rate service organizations have the same rights we have under this provision.

B. **Long Term Policy**
If the policy period is longer than one year and sixteen days, all provisions of this policy will apply as though a new policy were issued on each annual anniversary that this policy is in force.

C. **Transfer of Your Rights and Duties**
Your rights or duties under this policy may not be transferred without our written consent. If you die and we receive notice within thirty days after your death, we will cover your legal representative as insured.

D. **Cancelation**
1. You may cancel this policy. You must mail or deliver advance written notice to us stating when the cancelation is to take effect.
2. We may cancel this policy. We must mail or deliver to you not less than ten days advance written notice stating when the cancelation is to take effect. Mailing that notice to you at your mailing address shown in Item 1 of the Information Page will be sufficient to prove notice.
3. The policy period will end on the day and hour stated in the cancelation notice.
4. Any of these provisions that conflict with a law that controls the cancelation of the insurance in this policy is changed by this statement to comply with the law.

E. **Sole Representative**
The insured first named in Item 1 of the Information Page will act on behalf of all insureds to change this policy, receive return premium, and give or receive notice of cancelation.

EXPERIENCE RATING MODIFICATION FACTOR ENDORSEMENT

The premium for the policy will be adjusted by an experience rating modification factor. The factor was not available when the policy was issued. The factor, if any, shown on the Information Page is an estimate. We will issue an endorsement to show the proper factor, if different from the factor shown, when it is calculated.

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective
Insured Prestige LCHA Management, Inc.
Policy No. MWC1017146
Endorsement No.
Premium $519,114

Insurance Company
Countersigned by_____

WC 00 04 03
(Ed. 4-84)

PENDING RATE CHANGE ENDORSEMENT

A rate change filing is being considered by the proper regulatory authority. The filing may result in rates different from the rates shown on the policy. If it does, we will issue an endorsement to show the new rates and their effective date.

If only one state is shown in Item 3.A. of the Information Page, this endorsement applies to that state. If more than one state is shown there, this endorsement applies only in the state shown in the Schedule.

Schedule

State
NY

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

Endorsement Effective	1/16/2017	Policy No.	MWC1017146	Endorsement No.	WC000404
Insured	Prestige LCHA Management, Inc.			Premium $	519114
Insurance Company	Milwaukee Casualty Insurance Company				

Countersigned by _____

PREMIUM DISCOUNT ENDORSEMENT

The premium for this policy and the policies, if any, listed in Item 3 of the Schedule may be eligible for a discount. This endorsement shows your estimated discount in Items 1 or 2 of the Schedule. The final calculation of premium discount will be determined by our manuals and your premium basis as determined by audit. Premium subject to retrospective rating is not subject to premium discount.

Schedule

1. **State**

Estimated Eligible Premium

	First $5,000	Next $190,000	Next $1,550,000	Balance
New York	0%	9.1%	11.3%	12.3%

2. Average percentage discount: 10.4%

3. Other policies:

4. If there are no entries in Items 1, 2 and 3 of the Schedule, see the Premium Discount Endorsement attached to your policy number:

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

Endorsement Effective	1/16/2017	Policy No.	MWC1017146	Endorsement No.	WC000406
Insured	Prestige LCHA Management, Inc.			Premium $	519114
Insurance Company	Milwaukee Casualty Insurance Company				

Countersigned by _____

NOTIFICATION OF CHANGE IN OWNERSHIP ENDORSEMENT

Experience rating is mandatory for all eligible insureds. The experience rating modification factor, if any, applicable to this policy, may change if there is a change in your ownership or in that of one or more of the entities eligible to be combined with you for experience rating purposes. Change in ownership includes sales, purchases, other transfers, mergers, consolidations, dissolutions, formations of a new entity and other changes provided for in the applicable experience rating plan manual.

You must report any change in ownership to us in writing within 90 days of such change. Failure to report such changes within this period may result in revision of the experience rating modification factor used to determine your premium.

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

Endorsement Effective	1/16/2017	Policy No.	MWC1017146	Endorsement No.	WC000414
Insured	Prestige LCHA Management, Inc.			Premium $	519114
Insurance Company	Milwaukee Casualty Insurance Company				

Countersigned by _____

PREMIUM DUE DATE ENDORSEMENT

This endorsement is used to amend:

Section D. of Part Five of the policy is replaced by this provision.

PART FIVE
PREMIUM

D. **Premium** is amended to read:

You will pay all premium when due. You will pay the premium even if part or all of a workers compensation law is not valid. **The due date for audit and retrospective premiums is the date of the billing.**

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective Policy No. MWC1017146 Endorsement No.

Insured Prestige LCHA Management, Inc. Premium $519,114

Insurance Company Countersigned by_____

CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM) PREMIUM ENDORSEMENT

This endorsement is notification that your insurance carrier is charging premium to cover the losses that may occur in the event of a Catastrophe (other than Certified Acts of Terrorism) as that term is defined below. Your policy provides coverage for workers compensation losses caused by a Catastrophe (other than Certified Acts of Terrorism). This premium charge does not provide funding for Certified Acts of Terrorism contemplated under the Terrorism Risk Insurance Program Reauthorization Act Disclosure Endorsement (WC 00 04 22 B), attached to this policy.

For purposes of this endorsement, the following definitions apply:

- Catastrophe (other than Certified Acts of Terrorism): Any single event, resulting from an Earthquake, Noncertified Act of Terrorism, or Catastrophic Industrial Accident, which results in aggregate workers compensation losses in excess of $50 million.
- Earthquake: The shaking and vibration at the surface of the earth resulting from underground movement along a fault plane or from volcanic activity.
- Noncertified Act of Terrorism: An event that is not certified as an Act of Terrorism by the Secretary of Treasury pursuant to the Terrorism Risk Insurance Act of 2002 (as amended) but that meets all of the following criteria:
  a. It is an act that is violent or dangerous to human life, property, or infrastructure;
  b. The act results in damage within the United States, or outside of the United States in the case of the premises of United States missions or air carriers or vessels as those terms are defined in the Terrorism Risk Insurance Act of 2002 (as amended); and
  c. It is an act that has been committed by an individual or individuals as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion.
- Catastrophic Industrial Accident: A chemical release, large explosion, or small blast that is localized in nature and affects workers in a small perimeter the size of a building.

The premium charge for the coverage your policy provides for workers compensation losses caused by a Catastrophe (other than Certified Acts of Terrorism) is shown in Item 4 of the Information Page or in the Schedule below.

Schedule

State	Rate	Premium
NY	0.01	$650.00

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.
(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective	1/16/2017	Policy No.	MWC1017146	Endorsement No.	0
Insured	Prestige LCHA Management, Inc.			Premium $	519114
Insurance Company	Milwaukee Casualty Insurance Company				

Countersigned by_____

TERRORISM RISK INSURANCE PROGRAM REAUTHORIZATION ACT DISCLOSURE ENDORSEMENT

This endorsement addresses the requirements of the Terrorism Risk Insurance Act of 2002 as amended and extended by the Terrorism Risk Insurance Program Reauthorization Act of 2015. It serves to notify you of certain limitations under the Act, and that your insurance carrier is charging premium for losses that may occur in the event of an Act of Terrorism.

Your policy provides coverage for workers compensation losses caused by Acts of Terrorism, including workers compensation benefit obligations dictated by state law. Coverage for such losses is still subject to all terms, definitions, exclusions, and conditions in your policy, and any applicable federal and/or state laws, rules, or regulations.

Definitions

The definitions provided in this endorsement are based on and have the same meaning as the definitions in the Act. If words or phrases not defined in this endorsement are defined in the Act, the definitions in the Act will apply.

"Act" means the Terrorism Risk Insurance Act of 2002, which took effect on November 26, 2002, and any amendments thereto, including any amendments resulting from the Terrorism Risk Insurance Program Reauthorization Act of 2015.

"Act of Terrorism" means any act that is certified by the Secretary of the Treasury, in consultation with the Secretary of Homeland Security, and the Attorney General of the United States as meeting all of the following requirements:

a. The act is an act of terrorism.

b. The act is violent or dangerous to human life, property or infrastructure.

c. The act resulted in damage within the United States, or outside of the United States in the case of the premises of United States missions or certain air carriers or vessels.

d. The act has been committed by an individual or individuals as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion.

"Insured Loss" means any loss resulting from an act of terrorism (and, except for Pennsylvania, including an act of war, in the case of workers compensation) that is covered by primary or excess property and casualty insurance issued by an insurer if the loss occurs in the United States or at the premises of United States missions or to certain air carriers or vessels.

"Insurer Deductible" means, for the period beginning on January 1, 2015, and ending on December 31, 2020, an amount equal to 20% of our direct earned premiums, during the immediately preceding calendar year.

Limitation of Liability

The Act limits our liability to you under this policy. If aggregate Insured Losses exceed $100,000,000,000 in a calendar year and if we have met our Insurer Deductible, we are not liable for the payment of any portion of the amount of Insured Losses that exceeds $100,000,000,000; and for aggregate Insured Losses up to $100,000,000,000, we will pay only a pro rata share of such Insured Losses as determined by the Secretary of the Treasury.

Policyholder Disclosure Notice

1. Insured Losses would be partially reimbursed by the United States Government. If the aggregate industry Insured Losses exceed:

   a. $100,000,000, with respect to such Insured Losses occurring in calendar year 2015, the United States Government would pay 85% of our Insured Losses that exceed our Insurer Deductible.

   b. $120,000,000, with respect to such Insured Losses occurring in calendar year 2016, the United States Government would pay 84% of our Insured Losses that exceed our Insurer Deductible.

   c. $140,000,000, with respect to such Insured Losses occurring in calendar year 2017, the United States Government would pay 83% of our Insured Losses that exceed our Insurer Deductible.

   d. $160,000,000, with respect to such Insured Losses occurring in calendar year 2018, the United States Government would pay 82% of our Insured Losses that exceed our Insurer Deductible.

   e. $180,000,000, with respect to such Insured Losses occurring in calendar year 2019, the United States Government would pay 81% of our Insured Losses that exceed our Insurer Deductible.

   f. $200,000,000, with respect to such Insured Losses occurring in calendar year 2020, the United States Government would pay 80% of our Insured Losses that exceed our Insurer Deductible.

2. Notwithstanding item 1 above, the United States Government will not make any payment under the Act for any portion of Insured Losses that exceed $100,000,000,000.

3. The premium charge for the coverage your policy provides for Insured Losses is included in the amount shown in Item 4 of the Information Page or in the Schedule below.

Schedule

State	Rate	Premium
NY	0.07	$4,550.00

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.
(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective	1/16/2017	Policy No.	MWC1017146	Endorsement No.	0
Insured	Prestige LCHA Management, Inc.			Premium $	519114
Insurance Company	Milwaukee Casualty Insurance Company				

Countersigned by_____

NEW YORK LIMIT OF LIABILITY ENDORSEMENT

This endorsement applies only to the insurance provided by Part Two (Employers Liability Insurance) because New York is shown in Item 3.A. of the Information Page.

We may not limit our liability to pay damages for which we become legally liable to pay because of bodily injury to your employees if the bodily injury arises out of and in the course of employment that is subject to and is compensable under the Workers' Compensation Law of New York.

Milwaukee Casualty Insurance Company

IMPORTANT NOTICE
SMALL DEDUCTIBLE ELECTION FORM

For Policies with Premiums over $12,000 only

POLICY NUMBER	POLICY PERIOD	
MWC1017146	FROM: 1/16/2017	TO: 1/16/2018

INSURED
Prestige LCHA Management, Inc.

New York law permits an employer to purchase workers' compensation insurance with a deductible. The deductible is applicable to medical and indemnity benefits and applies to each claim. The deductibles available are as follows:

DEDUCTIBLE AMOUNT EACH CLAIM	
☐ $100	☐ $1,000
☐ $200	☐ $1,500
☐ $300	☐ $2,000
☐ $400	☐ $2,500
☐ $500	☐ $5,000

You are not required to select a deductible. However, if you choose to exercise this option, you may choose only one deductible amount. It is to be understood that we will pay the deductible amount for you and that you must reimburse us for any deductible amounts paid. The maximum amount you are obligated to reimburse us is an amount equal to your estimated annual premium at policy inception. Non-reimbursement of the deductible(s) will result in cancellation of your policy.

Please check the option you have elected and return this form to us as soon as possible.

☐ No, I do not want the deductible described in this Notice.

☐ Yes, I want the deductible checked above to apply to medical and indemnity benefits under the New York Workers' Compensation Law. I understand that the Company shall pay the deductible amount and be reimbursed by the employer shown above.

If you fail to respond promptly to the Company, it will be construed to mean you have not elected the small deductible option.

If you have any questions, please contact your agent or broker.

INSURED'S SIGNATURE AND TITLE DATE

NEW YORK CONSTRUCTION CLASSIFICATION PREMIUM ADJUSTMENT PROGRAM EXPLANATORY ENDORSEMENT

The New York Construction Classification Premium Adjustment Program (NYCCPAP) allows premium credits for some employers in the construction industry. These credits exist to recognize the difference in wage rates between employers within the same construction industries in New York.

The declarations section of this policy will show a credit of 0.00% if you are not eligible for this credit, or if you are eligible for this credit and have not yet applied for a credit. Credits are earned for average wages in excess of $23.24 per hour for each eligible class. If your policy shows one of the following classification codes, and you are experience rated, you are eligible to apply for an NYCCPAP credit:

0042	5057	5193	5429	5491	5606	6003	6229	6325	9526
3365	5059	5213	5443	5506	5610	6005	6233	6400	9527
3724	5069	5221	5445	5507	5645	6017	6235	6701	9534
3726	5102	5222	5462	5508	5648	6018	6251	7536	9539
3737	5160	5223	5473	5536	5651	6045	6252	7538	9545
5000	5183	5348	5474	5538	5701	6204	6260	7601	9549
5022	5184	5402	5479	5545	5703	6216	6306	7855	9553
5037	5188	5403	5480	5547	5709	6217	6319	8227	
5040	5190	5428							

The basis for determining the credit is the limited payroll of each employee for the number of hours worked (excluding overtime premium pay) for each construction classification (other than employees engaged in the construction of one or two-family residential housing) for the third quarter, as reported to taxing authorities, for the year preceding the policy date. Total payroll is to continue to be reported for employees engaged in the construction of one or two-family residential housing. For example:

POLICY EFFECTIVE DATE	THIRD QUARTER PAYROLL
4/1/14 thru 3/31/15	2013
4/1/15 thru 3/31/16	2014
4/1/16 thru 3/31/17	2015
4/1/17 thru 3/31/18	2016
4/1/18 thru 3/31/19	2017
4/1/19 thru 3/31/20	2018

If you have any eligible classes on your policy, you should have been notified by your insurance carrier or the New York Compensation Insurance Rating Board approximately four months prior to the inception date of this policy. If you believe you may be eligible for a credit and have not received an application, you should immediately contact your agent, insurance carrier, or the New York Compensation Insurance Rating Board.

Credits are calculated by the New York Compensation Insurance Rating Board. You must submit a completed application to: Attention: Field Services Department, New York Compensation Insurance Rating Board, 733 Third Avenue, New York, New York 10017.

Applications must be received by the Rating Board three (3) months prior to the policy renewal effective date. The Rating Board will accept and process an application if it is received between the policy effective and expiration date, however, it must be accompanied by a letter stating the reason for the delay. Under no circumstances will an application be accepted for any policy if it is received after the expiration date of the policy. For short-term policies the application must be received prior to the expiration date of the short-term policy. If it is received after the policy expiration, no credit will be calculated.

The New York Workers Compensation and Employers Liability Insurance Manual, and not this endorsement, govern the implementation and use of the NYCCPAP.

For online entry of the information requested on this form refer to: http://www.nycirb.org/cpap

STATE OF NEW YORK - WORKERS' COMPENSATION BOARD
ESTADO DE NUEVA YORK - JUNTA DE COMPENSACION OBRERA

NOTICE OF COMPLIANCE

TO EMPLOYEES

IMPORTANT INFORMATION FOR EMPLOYEES WHO ARE INJURED OR SUFFER AN OCCUPATIONAL DISEASE WHILE WORKING.

1. By posting this notice and information concerning your rights as an injured worker, your employer is in compliance with the Workers' Compensation Law.
2. If you do not notify your employer within 30 days of the date of your injury your claim may be disallowed, so do so immediately.
3. You are entitled to obtain any necessary medical treatment and should do so immediately.
4. You may choose any doctor, podiatrist, chiropractor or psychologist referred by a medical doctor that accepts NY State Workers' Compensation patients and is Board authorized. However, if your employer is involved in a certified preferred provider organization (PPO) you must first be treated by a provider chosen by your employer and your employer must give you a written statement of your rights concerning further medical care.
5. You should tell your doctor to file copies of medical reports concerning your claim with the Workers' Compensation Board and with your employer's insurance company, which is indicated at the bottom of this form.
6. You may be entitled to lost time benefits if your work-related injury keeps you from work for more than seven days, compels you to work at lower wages or results in permanent disability to any part of your body. You may be entitled to rehabilitation services if you need help returning to work.
7. You should not pay any medical providers directly. They should send their bills to your employer's insurance carrier. If there is a dispute, the provider must wait until the Board makes a decision before it attempts to collect payment from you. If you do not pursue your claim or the Board rules that your injury is not work-related, you may be responsible for the payment of the bills.
8. You are entitled to be represented by an attorney or licensed representative, but it is not required. If you do hire a representative do not pay him/her directly. Any fee will be set by the Board and will be deducted from your award.
9. If you have difficulty in obtaining a claim form or need help in filling it out, or if you have any other questions or problems about a job-related injury, contact any office of the Workers' Compensation Board.

WORKERS' COMPENSATION BOARD OFFICES
Albany, 12241 - 100 Broadway-Menands - (866) 750-5157
***Brooklyn, 11201 - 111 Livingston St. - Brooklyn - (800) 877-1373**
Binghamton, 13901 - State Office Bldg. - 44 Hawley St. - (866) 802-3604
Buffalo, 14203 - 295 Main Street, Suite 400 - (866) 211-0645
***Hauppauge, 11788 - 220 Rabro Drive - Suite 100 - (866) 681-5354**
***Hempstead, 11550 - 175 Fulton Avenue - (866) 805-3630**
***New York, 10027 - 215 W.125th St., Manhattan - (800)-877-1373**
***Peekskill, 10566 - 41 North Division St. (866) 746-0552**
***Queens, 11432 - 168-46 91st Ave., Jamaica (800) 877-1373**
Rochester, 14614 - 130 Main Street West - (866) 211-0644
Syracuse, 13203 - 935 James St. - (866) 802-3730

*** DOWNSTATE MAILING ADDRESS**
Claims-related mail for the Hauppauge, Hempstead, Peekskill and all NYC offices should be mailed to: **PO Box 5205 Binghamton, NY 13902-5205**

Statewide Fax: 877-533-0337

AVISO DE CUMPLIMIENTO

A EMPLEADOS

INFORMACION IMPORTANTE PARA EMPLEADOS QUE SEAN LESIONADOS O SUFRAN UNA ENFERMEDAD OCUPACIONAL MIENTRAS TRABAJAN.

1. Su patrono está cumpliendo la Ley de Compensación Obrera cuando despliega este comunicado concerniente a sus derechos como trabajador lesionado.
2. Si usted no notifica a su patrono dentro del término de 30 dias de haber sufrido su lesión su reclamación podría ser desestimada, por eso notifique inmediatamente.
3. Usted tiene derecho a recibir cualquier tratamiento médico necesario relacionado con su lesión y debe gestionarlo inmediatamente.
4. Para el tratamiento de cualquier lesión o enfermedad relacionada con el trabajo, usted puede escoger cualquier médico, podiatra, quiropractico ó psicologo (si es referido por un médico autorizado) que esté autorizado y acepte pacientes de la Junta de Compensación Obrera. Sin embargo, si su patrono está autorizado a participar en una organización certificada de proveedores preferidos (PPO), usted deberá obtener tratamiento inicial para cualquier lesión o enfermedad relacionada con el trabajo de la correspondiente entidad. Patronos que participen en cualquiera de estos programas establecidos por ley estan obligados a proveer a sus empleados notificación escrita explicando sus derechos y obligaciones bajo el programa a que esté acogido.
5. Usted deberá requerir de su Médico que radique copias de los informes médicos de su caso en la Junta de Compensación Obrera y en la compañia de seguros de su patrono, que se indica al final de esta forma.
6. Usted tiene derecho a compensación si su lesión relacionada con el trabajo le impide trabajar por más de siete días, le obliga a trabajar a sueldo más bajo ó resulta en incapacidad permanente de cualquier parte de su cuerpo. Usted puede tener derecho a servicios de rehabilitación si necesita ayuda para regresar al trabajo.
7. No pague a ningun proveedor médico directamente por tratamiento de su lesión o enfermedad relacionada con el trabajo. Ellos deben enviar sus facturas al asegurador de su patrono. Si el caso es cuestionado, el proveedor deberá esperar hasta que la Junta decida el caso, antes de iniciar gestión de cobro alguna contra usted. Si usted no tramita su caso ó la Junta falla que su lesión o enfermedad no está relacionada con el trabajo, usted podría ser responsable del pago de las facturas.
8. No es obligatorio el estar representado en ninguno de los procedimientos de la Junta, pero es un derecho que usted tiene, el estar representado por abogado ó por representante licenciado si usted así lo desea. Si es representado, no pague al abogado ó al representante licenciado. Cuando la Junta decida su caso, los honorarios seran determinados por la Junta y descontados de sus beneficios.
9. Si tiene dificultad en conseguir un formulario de reclamación o necesita ayuda para llenarlo ó tiene dudas sobre cualquier situación relacionada con una lesión o enfermedad comuniquese con la oficina mas cercana de la Junta.

Robert E. Beloten

ROBERT E. BELOTEN, CHAIR/PRESIDENTE

Workers' Compensation benefits, when due, will be paid by (Los beneficios de Compensación Obrera, cuando debidos, seran pagados por):

Name, address and telephone number of licensed insurance carrier, authorized group self-insurer or main office of authorized self-insurer

Milwaukee Casualty Insurance Co
800 Superior Ave East-21st Floor
Cleveland, OH 44114
(877)-528-7878

For Insurance Carriers ONLY: Policy No. MWC1017146

Policy in Force from 1/16/17 *to* 1/16/18

Name of employer (Nombre del patrono)

Prestige LCHA Management, Inc

THIS NOTICE MUST BE POSTED CONSPICUOUSLY IN AND ABOUT THE EMPLOYER'S PLACE OR PLACES OF BUSINESS.

Failure by an employer to post this notice in and about the employer's place or places of business may result in a $250 penalty for each violation.

NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Acting Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

April 23, 2015

David Modnyy, President
Hand in Hand Together Homecare
329 East 149th Street, 3rd Floor
Bronx, NY 10451

Re: 2401L001
Prestige LHCSA Management Inc. d/b/a
Hand in Hand Together Homecare

Dear Mr. Modnyy:

This is to provide notification that all necessary approvals have been received for application number 2401L submitted by Prestige LHCSA Management Inc. d/b/a Hand in Hand Together Homecare to acquire the assets of the Licensed Home Care Services Agency previously operated by AZA Home Health Care, LLC.

Therefore, approval is granted effective April 30, 2015 for Prestige LHCSA Management Inc. d/b/a Hand in Hand Together Homecare to commence operations of this agency. A license will be issued as soon as all the requisite paperwork is processed. In the interim, this letter will serve as your authority to provide home care services to residents of the counties of Bronx, Kings, Queens, New York, and Richmond.

If you have any questions regarding this matter, please contact me at (518) 402-0926 or by e-mail at homecareliccert@health.ny.gov.

Sincerely,

Linda Rush
Director
Bureau of Home Care Licensure and Certification
Division of Planning and Licensure

cc: Mr. Pankov

COVER YOUR Business.com
A BERKSHIRE HATHAWAY COMPANY

Cover Your Business
PO Box 113247
Stamford, CT 06911-3247
Toll-Free 844-472-0967
FAX 203-654-3613
www.CoverYourBusiness.com

Proposal of Insurance

Prestige LHCSA Management, Inc.
Prospect Number N9WC831857
for 02/27/2017 to 02/27/2018

We are very interested in providing coverage on this account. If you would like to discuss any portion of this proposal to ensure that we have the best possible chance of success, we encourage you to call us.

Carrier:	National Liability & Fire Insurance Company
Coverage Option:	Guaranteed Cost
Payment Terms:	10% down payment of $47,267.00 and 10 Monthly installment(s)
Payment Method:	Direct Bill
Limits Emp Liability:	100,000/500,000/100,000

Total Estimated Cost: 472,670.00

(This amount includes state surcharges, is subject to any pending rate changes or required premium modifications, and is based on the most current information available to us.)

Information Needed to Issue:

No information needed to issue your policy has currently been identified. If we subsequently recognize a need, we will contact you with our request.

Payment Terms:

* Your down payment is due in our office within ten (10) calendar days of the effective date. To make a down payment immediately, you may utilize our Direct Draft Program (see below) or Credit Card Program. Or, you may mail the initial check to NL&F Attention Accounts Receivable, PO Box 113247, Stamford, CT 06911-3247. Be sure to make your check payable to National Liability & Fire, and include your prospect number. No additional bill will be sent to you for this initial required downpayment.
* Direct billed policies will be charged a fee of $7.00 per installment.
* A Direct Draft electronic fund transfer option is offered which requires no installment fees and no checks to be mailed. A sign-up sheet is enclosed and can alternatively be downloaded from our web site at www.CoverYourBusiness.com or obtained by contacting Customer Service at 844-472-0967.

Important Notes:

* This proposal can only be accepted by our receipt of the payment quoted above by the due date; otherwise, no coverage will be provided and our offer will expire. Our only offer of insurance is stated by the terms of this proposal and can only be changed by our issuance of a revised proposal.
* Covered terrorism losses would be partially reimbursed by the United States Government under a formula established by the Act. Under this formula, the United States Government would pay 85% of covered terrorism losses exceeding our insurer deductible. The premium charged for the coverage this policy provides for insured terrorism losses is included in the amount shown in the Policy Totals included with this proposal.
* Applicable in Tennessee and Vermont: It is a crime to knowingly provide false, incomplete or misleading information to any party to a workers compensation transaction for the purpose of committing fraud. Penalties include imprisonment, fines and denial of insurance benefits.
* Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subject the person to criminal and [NY: Substantial] civil penalties. (Specific language not applicable in CO, FL, HI, MA, NE, OH, OK, OR, TN or VT; in DC, LA, ME, VA and WA, insurance benefits may also be denied).
* Final premium calculations may include amounts you pay to subcontractors (including sole proprietors without employees) who do not have their own workers compensation coverage, because such subcontractors and/or their employees can file claims against you that we are required to defend or pay under the terms of your policy.

Prestige LHCSA Management, Inc.
Prospect Number N9WC831857
Renewal of NEW for 02/27/2017 to 02/27/2018

Rating Work Sheet

New York

Classification	Code	Premium Basis: Total Estimated Annual Remuneration	Rate per $100 Remuneration	Estimated Annual Premium
Effective: 02/27/2017-01/16/2018				
CLERICAL OFFICE EMPLOYEES NOC	8810	1,769,863.00	0.28	4,956
HOME HEALTH CARE-NONPROF. EMPLOYEES	9051	4,424,658.00	8.76	387,600
Schedule Modification			5.0%	19,628
Total Estimated Premium 02/27/2017-01/16/2018				412,184
Effective: 01/16/2018-02/27/2018				
CLERICAL OFFICE EMPLOYEES NOC	8810	230,137.00	0.28	644
HOME HEALTH CARE-NONPROF. EMPLOYEES	9051	575,342.00	8.76	50,400
Schedule Modification			5.0%	2,552
Total Estimated Premium 01/16/2018-02/27/2018				53,596
Premium Discount			12.118%	-56,443
Total Estimated Annual Premium for NY				409,337

Policy Totals

Total Estimated Standard Premium for New York				409,337
Expense Constant				280
Terrorism NY	9740	0.0693	6,194,521	4,293
Catastrophe	9741	0.01	6,194,521	619
Terrorism NY	9740	0.0693	805,479	558
Catastrophe	9741	0.01	805,479	81
Minimum Premium NY	$875			
Total Estimated Annual Premium				415,168
NY Assessment 02/27/2017-01/16/2018	12.2000%			57,502
Total Estimated Cost for N9WC831857				472,670

This proposal/quote is not a binder. The Total Estimated Cost is based upon information provided to date and is subject to change even after coverage has been bound, based upon availability of additional pricing or underwriting information or considerations and/or upon the results of loss control surveys and compliance with recommendations. This summary of policy coverages, premium, and limits is not an insurance policy. For further details about the coverage, please review the policy forms and declarations pages. In the event of a conflict, the terms stated in the insurance policy shall govern. Please be aware that this proposal encompasses only the coverages listed and that those coverages are subject to the final terms and conditions stated in the policy. Our only offer of insurance is stated by the terms of this proposal, which can only be changed by our issuance of a new proposal.

Prospect Number: N9WC831857

PROPOSAL-02-23-2017-05 Accepted by: **David Modnyy**

(print name)

Prospect's Signature: _____

Date: _____

COVER YOUR Business.com
A BERKSHIRE HATHAWAY COMPANY

Cover Your Business
PO Box 113247
Stamford, CT 06911-3247
Toll-Free 844-472-0967
FAX 203-654-3613
www.CoverYourBusiness.com

Policyholder Disclosure
Notice of Terrorism
Insurance Coverage

Coverage for acts of terrorism is included in your policy. You are hereby notified that under the Terrorism Risk Insurance Act, as amended in 2015, the definition of act of terrorism has changed. As defined in Section 102(1) of the Act: The term "act of terrorism" means any act or acts that are certified by the Secretary of the Treasury - in consultation with the Secretary of Homeland Security, and the Attorney General of the United States - to be an act of terrorism; to be a violent act or an act that is dangerous to human life, property, or infrastructure; to have resulted in damage within the United States, or outside the United States in the case of certain air carriers or vessels or the premises of a United States mission; and to have been committed by an individual or individuals as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion. Under your coverage, any losses resulting from certified acts of terrorism may be partially reimbursed by the United States Government under a formula established by the Terrorism Risk Insurance Act, as amended. However, your policy may contain other exclusions which might affect your coverage, such as an exclusion for nuclear events. Under the formula, the United States Government generally reimburses 85% through 2015; 84% beginning on January 1, 2016; 83% beginning on January 1, 2017; 82% beginning on January 1, 2018; 81% beginning on January 1, 2019 and 80% beginning on January 1, 2020, of covered terrorism losses exceeding the statutorily established deductible paid by the insurance company providing the coverage. The Terrorism Risk Insurance Act, as amended, contains a $100 billion cap that limits U.S. Government reimbursement as well as insurers' liability for losses resulting from certified acts of terrorism when the amount of such losses exceeds $100 billion in any one calendar year. If the aggregate insured losses for all insurers exceed $100 billion, your coverage may be reduced.

The portion of your annual premium that is attributable to coverage for acts of terrorism is $4851.00, and does not include any charges for the portion of losses covered by the United States government under the Act.

Prepared: 02/23/2017

COVER YOUR Business.com
A BERKSHIRE HATHAWAY COMPANY

Cover Your Business
PO Box 113247
Stamford, CT 06911-3247
Toll-Free 844-472-0967
FAX 203-654-3613
www.CoverYourBusiness.com

Direct Draft Program

Available to direct bill policyholders only, our Direct Draft Program - an electronic fund transfer (EFT) system - is designed to:

- Pay your premium installments for you (which eliminates the cost of issuing and mailing checks).
- Avoid mail delays that can lead to late payments.*
- Offer FREE installment billings (because installment fees will not be charged).**

By working with our bank's pre-authorized debit program and your financial institution, we will process an automatic debit against your business bank account on the scheduled date. All you need to do is provide us with the written authorization form (shown below) along with your bank information, and we'll take care of the rest! Please note that you will be asked to indicate the duration of your authorization. If you select "one-time," a single payment will be processed via electronic fund transfer, but your regular payment methodology will not change. If you choose "ongoing," we will endeavor to send you a notice for each installment of the actual amount to be direct drafted.*** (If applicable, final audits will be handled similarly.) Please be aware that any "ongoing use" selection can be rescinded by you at any time. Until you take this action, Direct Draft will renew with your policy for you!

If you are interested in taking advantage of this option, please provide us with your completed form. If you have any questions, feel free to contact Customer Service for more information. (Our address, fax number, and phone number are shown below.)

*** Due to the high costs associated with handling delinquent payments, a $10.00 late fee will be incurred by policyholders in a number of states throughout our operating area each time an installment payment is received five or more days after the due date. By electing to participate in our Direct Draft Program and letting us take care of your premium payments for you, this fee will be avoided.**

**** Free installments do not apply to one-time use of Direct Draft.**

***** We send Billing Statements to give you advance notice of each draft amount as a courtesy to you. (The procedure for calculating premium is set forth in your policy.) We cannot guarantee that you will receive this notice or that the notice will be received in advance of the direct draft. Regardless, payment is still due in accordance with your policy terms.**

I hereby authorize National Liability & Fire to initiate pre-authorized debit transfers on behalf of my business for (select one)
[ ] **one-time use** [ ] **ongoing use** according to the information outlined below:

Policy(ies): _____
(If this authorization applies to multiple policies, list all. For each, include the policy # and/or type (i.e., Comp, etc.); also indicate new or renewal.)

Name of Policyholder: _____

Bank Account #: _____ Bank Routing #: _____

Bank: _____
Name City State

Preferred Start Date: _____ Amount (if one-time Direct Draft): _____

Statement Delivery Preference: [ ] Fax* [ ] E-mail* [ ] Mail *Fax # or E-mail: _____

Please attach a voided check to assist us in verifying your account information.

Authorized Signature: _____

Printed Name: _____

Date Signed: _____ Phone Number: _____

Attn: Accounting
PO Box 113247 • Stamford, CT 06911-3247
Telephone: 844-472-0967 · Fax: 203-989-2644

COVER YOUR Business.com
A BERKSHIRE HATHAWAY COMPANY

CoverYourBusiness.com
P.O. Box 113247
Stamford, CT 06911-3247
T: 844-472-0967
F: 203-654-3613
www.CoverYourBusiness.com

Notice of Election to Accept or Reject an Insurance Deductible for New York Workers' Compensation Benefits

New York law permits an employer to purchase Workers' Compensation insurance with a deductible. When this option is chosen, a premium credit* is provided, and a deductible will be applied to both medical and indemnity benefits paid for compensable claims.

Employers are under no obligation to elect this option. However, those who do must understand the provisions of the ***New York Benefits Deductible Endorsement (WC 31 03 15A)*** which state that the employer agrees to reimburse the Company for the full amount of the deductible promptly following receipt of notice that payment is due.

Failure to remit payment within this time frame will be treated in the same manner as non-payment of premium and may result in one or more of the following actions: (a) elimination of the premium credit and issuance of an additional premium charge and/or (b) CANCELLATION of coverage as outlined in ***Section D, Cancellation of Part Six, Conditions*** of the insurance policy.

PLEASE INDICATE YOUR PREFERENCE BELOW:

X No, I do not want the deductible described in this Notice.

____ Yes, I am electing the deductible option in the amount indicated below. I understand that the amount I have selected represents the maximum amount of the medical and indemnity benefits payment that I will be responsible for paying for compensable claims on a PER OCCURRENCE basis (each accident or illness) under my current Workers' Compensation insurance policy and each subsequent renewal. I further acknowledge that my insurance carrier will initially pay the deductible amount and then seek reimbursement from me on a timely basis.

❑ $ 100.00	❑ $ 200.00	❑ $ 300.00	❑ $ 400.00	❑ $ 500.00
❑ $1,000.00	❑ $1,500.00	❑ $2,000.00	❑ $2,500.00	❑ $5,000.00

I recognize that I have the option of modifying the above deductible at the time of renewal of my Workers' Compensation insurance policy.

IMPORTANT: Failure to return this form to the Company prior to policy inception will be construed to mean this deductible option has been waived by the employer.

Policy Number: N9WC831857 Policy Period From: 2/27/16 To: 2/27/17

Policyholder Name: Prestige LHCSA Management, Inc. dba Hand In Hand Together Home Care

Name of Authorized Representative: David Modnyy

Title of Authorized Representative: Officer

Signature of Authorized Representative: _____

Date: _____

*The premium credit will reflect the amount of the deductible elected and the hazard group of the classification with the greatest estimated premium (a factor subject to verification upon audit). To determine the discount to expect based upon your elections, please contact your insurance agent.

Morstan Workers Comp
Contractor Supplemental

General Questions	
Date:	Named Insured: PRESTIGE LHCSA MANAGEMENT INC.
FEIN: 463406523	Contact Name and Phone Number: DAVID MODNNY 917 364-2650
Website Address:	Indicate Number of Claims: 5
Number of Years Managerial Experience: 10	Number of Years With Previous WC Coverage: 4
If the insured has less than 3 years of prior WC Coverage, please provide us with a brief owner's resume:	
Nature of Business / Description of Operations: HOME CARE AGENCY	
Number of Employees: FT: 50 PT: 25	

Height Exposure Questions	
What is the maximum height worked in feet? 0 Ft.	
If over 15 feet does the applicant utilize personal fall protection equipment and train employees in its proper use in compliance with OSHA Standards? 0	
Do Operations require the use of any Scaffolding or Rigging: N	
Any work Below Grade? N	If Yes, Max Depth in feet:

Core Questions
What Percentage of work is sub contracted out? 0 %
Do all sub contractors carry their own certificates of insurance?
Is the Insured Involved in Demolition or Debris Removal N ?
If Yes, what methods of demolition are used:
Is the Insured Involved in Roofing N ? What %
If yes, Average Slope: Indicate amount of work perfomed: Sloped Roofs: % Flat Roofs %
Are there any operations outside of contracting: NO
Has the applicant ever been involved in another business venture? Under another named insured?
Any work involving abestos, hazardous product abatement, chemical/petroleum products, USL&H, underground tank or pipe replacement? NO If yes, please explain:
Any Cash Labor? NO If so, Estimate of amount paid for the year:

Morstan Workers Comp
Contractor Supplemental

Territorial Questions
List any States the applicant may work in other than the Home State: N/A
Radius of Operations: 20 Miles
Indicate the amount of work performed: Commercial _____% Residential _____% Please indicate NY Territorial Breakdown: • Territory 1…Bronx, Kings, New York, Queens and Richmond 100 % • Territory 2…Counties of Dutchess, Nassau, Orange, Putnam, Rockland, Suffolk, and Westchester 0 % • Territory 3…All other Counties within NY State 0 %

Common Carrier Questions		
Yes	No	
YES		Is there a safety program in place?
	NO	Any use of cranes booms or similar heavy equipment?
	NO	Does the applicant conduct any bridge or overpass construction or repair?
	NO	Is the applicant involved with structure demolition/moving, concrete/cement towers, oil rigs/derricks, scaffolds, barricades/guard rails, lightening rods or similar operations/activities?

Contractor Operations								
Carpentry:	0	%	Insulation:	0	%	Sewer:	0	%
Concrete:	0	%	Maintenance:	0	%	Steel (Ornamental):	0	%
Demolition:	0	%	Masonry:	0	%	Steel (Stuctural):	0	%
Drywall	0	%	Mechanical:	0	%	Street/Road:	0	%
Electrical:	0	%	Painting:	0	%	Supervisory Only (GC):	0	%
Excavating:	0	%	Plastering:	0	%	Tunneling:	0	%
Framing:	0	%	Plumbing:	0	%	Other:		%
Gas Mains:	0	%	Roofing::	0	%			%

Broker's Remarks

Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and so shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Producer's Signature: _____

Date: 02/24/2017

Applicant's Signature: _____

Date: _____

NEW YORK STATE INSURANCE FUND

Loss Run Report by Policy

		Accidents Occurred Between 01/16/2014 And 01/16/2015	AS OF 02/01/2017
WCLAIM/180/01 POLICY INQUIRY X2323 164-0	PRESTIGE LHCSA MANAGEMENT INC.	ALL CLAIMS	CYCLE NO. 14025

CLAIM NO. UNIT	CLAIMANT	ACC DATE	JCK	COMP INC	MED INC	Status	COMP PD	MED PD	POL DATE	GRP	PAYCLASS	INC	PAYT	C	DOC
67463489-370	THOMAS ANYELINA	07/31/2014	M	50,000.00	50,000.00	1	23,594.14	22,752.15	01/16/2014	90	9051	01/2017	01/2017	0	
67755587-370	RODRIQUEZ JULIA	01/07/2015	M	13,208.00	50,000.00	1	11,302.08	30,190.90	01/16/2014	90	9051	01/2017	01/2017	0	
NO OF CLAIMS FOR THIS POLICY:		**2**		**63,208.00**	**100,000.00**		**34,896.22**	**52,943.05**							

Hand in Hand Together Home Care
POLICY AND PROCEDURE MANUAL

PRE-EMPLOYMENT PHYSICAL EXAMINATION/ANNUAL HEALTH STATUS ASSESSMENT/RETURN FROM SICK LEAVE

POLICY:

Staff will participate in a pre-employment physical examination and an annual, or more frequent if necessary, health-status assessment. Employees indicated, will also participate in the requirements related to return from sick leave.

No person will be employed unless he/she is free from a health impairment which is of potential risk to the patient or which might interfere with the performance of his/her duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other substances that may alter his/her behavior.

GENERAL INFORMATION:

1. The pre-employment requirements include:
   A. Physical Examination;
   B. PPD testing or Tuberculosis screen, if proof of history of positive PPD, documentation of a negative chest x-ray;
   C. Proof of immunity to Rubella; and
   D. Proof of immunity to measles if born on or after January 1, 1957.
   E. A health status assessment that documents that the individual is free from habituation/addiction from substances that alter behavior.

2. The annual requirements include:

   A. Completion of health status assessment at least annually, or more frequent if necessary ensuring that the employee is free from any health impairment that is of potential risk to the patient, family or employees or that may interfere with the performance of duties; and

   B. PPD testing every year, or Tuberculosis screen if documented history of positive PPD. The individual is responsible for completing all parts of the physical examination and for being medically cleared prior to start of employment.

3. Failure to provide true and complete information is cause for termination of employment.

4. Failure to comply with the annual requirements shall result in disciplinary action which will include suspension or termination of employment.

5. An individual may utilize the services of his/her private physician **but** all requirements must be met and information submitted to the office.

Hand in Hand Together Home Care
POLICY AND PROCEDURE MANUAL

PRE-EMPLOYMENT PHYSICAL EXAMINATION/ANNUAL HEALTH STATUS ASSESSMENT/RETURN FROM SICK LEAVE

PROCEDURE:

1. The DPS/designee informs a new staff member of the pre-employment requirements and current staff of the annual requirements one (1) month in advance of the due date.

2. The individual staff person adheres to the requirements, as appropriate.

3. Completed forms are returned to the office for review for complete information.

4. As necessary, follow-up occurs with the individual regarding missing information.

5. Completed forms are filed in the personnel file.

RETURN FROM SICK LEAVE GENERAL INFORMATION

1. It is the employee's responsibility to keep the administrator/DPS informed of their date of return. Written documentation must be provided every three months during and extended leave of absence.

2. Sick leave of three days or longer requires a note from a physician.

3. Sick leave notes must include:

    A. The condition which the employee has received treatment, limitations.

    B. A statement that the employee is able to return to full duties including the date of return.

4. Failure to bring a note which is not specific will prevent the employee from returning to work. Failure to provide true or complete information may result in termination.

WORKERS COMPENSATION APPLICATION

DATE (MM/DD/YYYY): 2/24/2017

AGENCY NAME AND ADDRESS	COMPANY:
Insure24hrs Brokerage, Inc PO Box 1122 P.O. Box 1122 Wilkes Barre PA 18703	UNDERWRITER: APPLICANT NAME: Prestige LHCSA Management, Inc OFFICE PHONE: (917) 364-2650 MOBILE PHONE: MAILING ADDRESS (including ZIP + 4 or Canadian Postal Code): 329 EAST 149 TH STR 3 RD FL NY 10451 YRS IN BUS: 14 SIC: NAICS: WEBSITE ADDRESS:
PRODUCER NAME: Jake Rodriguez CS REPRESENTATIVE NAME: OFFICE PHONE (A/C, No, Ext): 718-207-1444 MOBILE PHONE: (718) 207-1444 FAX (A/C, No): 718-233-3174 E-MAIL ADDRESS: sales@insure24hrs.com CODE: SUB CODE: AGENCY CUSTOMER ID: 3282	E-MAIL ADDRESS: ☐ SOLE PROPRIETOR ☑ CORPORATION ☐ LLC ☐ TRUST ☐ PARTNERSHIP ☐ SUBCHAPTER "S" CORP ☐ JOINT VENTURE ☐ OTHER CREDIT BUREAU NAME: ID NUMBER: FEDERAL EMPLOYER ID NUMBER: 463406523 NCCI RISK ID NUMBER: OTHER RATING BUREAU ID OR STATE EMPLOYER REGISTRATION NUMBER:

STATUS OF SUBMISSION

☑ QUOTE ☐ ISSUE POLICY
☐ BOUND (Give date and/or attach copy)
☐ ASSIGNED RISK (Attach ACORD 133)

BILLING / AUDIT INFORMATION

BILLING PLAN	PAYMENT PLAN	AUDIT
☑ AGENCY BILL	☐ ANNUAL ☐	☑ AT EXPIRATION ☐ MONTHLY
☐ DIRECT BILL	☐ SEMI-ANNUAL	☐ SEMI-ANNUAL ☐
	☐ QUARTERLY % DOWN:	☐ QUARTERLY

LOCATIONS

LOC #	HIGHEST FLOOR	STREET, CITY, COUNTY, STATE, ZIP CODE
1	2	329 EAST 149TH STR, 3RD FL BRONX Bronx NY

POLICY INFORMATION

PROPOSED EFF DATE	PROPOSED EXP DATE	NORMAL ANNIVERSARY RATING DATE		RETRO PLAN
02/24/2017	02/24/2018		☐ PARTICIPATING ☑ NON-PARTICIPATING	

PART 1 - WORKERS COMPENSATION (States)	PART 2 - EMPLOYER'S LIABILITY		PART 3 - OTHER STATES INS	DEDUCTIBLES (N / A in WI)	AMOUNT / % (N / A in WI)	OTHER COVERAGES	
NY	$ 100000	EACH ACCIDENT		☐ MEDICAL		☐ U.S.L. & H.	☐ MANAGED CARE OPTION
	$ 500000	DISEASE-POLICY LIMIT		☐ INDEMNITY		☐ VOLUNTARY COMP	☑
	$ 100000	DISEASE-EACH EMPLOYEE		☐		☐ FOREIGN COV	☐

DIVIDEND PLAN/SAFETY GROUP

ADDITIONAL COMPANY INFORMATION

SPECIFY ADDITIONAL COVERAGES / ENDORSEMENTS (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

TOTAL ESTIMATED ANNUAL PREMIUM - ALL STATES

TOTAL ESTIMATED ANNUAL PREMIUM ALL STATES	TOTAL MINIMUM PREMIUM ALL STATES	TOTAL DEPOSIT PREMIUM ALL STATES
$	$	$

CONTACT INFORMATION

TYPE	NAME	OFFICE PHONE	MOBILE PHONE	E-MAIL
INSPECTION	David Modnyy	(917) 364-2650		
ACCTNG RECORD	David Modnyy	(917) 364-2650		
CLAIMS INFO	David Modnyy	(917) 364-2650		

INDIVIDUALS INCLUDED / EXCLUDED

PARTNERS, OFFICERS, RELATIVES (Must be employed by business operations) TO BE INCLUDED OR EXCLUDED (Remuneration/Payroll to be included must be part of rating information section.) Exclusions in Missouri must meet the requirements of Section 287.090 RSMo.

STATE	LOC #	NAME	DATE OF BIRTH	TITLE/ RELATIONSHIP	OWNER-SHIP %	DUTIES	INC/EXC	CLASS CODE	REMUNERATION/PAYROLL
NY	1	David Modnyy		Owner	100	Owner	Inclu	8809	70,000

STATE RATING SHEET # 1 **OF** 2 **SHEETS** **AGENCY CUSTOMER ID:** 3282

STATE RATING WORKSHEET

FOR MULTIPLE STATES, ATTACH AN ADDITIONAL PAGE 2 OF THIS FORM

RATING INFORMATION - STATE: NY

LOC #	CLASS CODE	DESCR CODE	CATEGORIES, DUTIES, CLASSIFICATIONS	# EMPLOYEES FULL TIME	# EMPLOYEES PART TIME	SIC	NAICS	ESTIMATED ANNUAL REMUNERATION/ PAYROLL	RATE	ESTIMATED ANNUAL MANUAL PREMIUM
1	9051		Home health care	50				5,000,000		
1	8810		Office Workers		25			2,000,000		

PREMIUM

STATE: NY	FACTOR	FACTORED PREMIUM		FACTOR	FACTORED PREMIUM
TOTAL	N / A	$			$
INCREASED LIMITS		$	SCHEDULE RATING *		$
DEDUCTIBLE *		$	CCPAP		$
		$	STANDARD PREMIUM		$
EXPERIENCE OR MERIT MODIFICATION		$	PREMIUM DISCOUNT		$
		$	EXPENSE CONSTANT	N / A	$
ASSIGNED RISK SURCHARGE *		$	TAXES / ASSESSMENTS *	N / A	$
ARAP *		$			$

* N / A in Wisconsin

TOTAL ESTIMATED ANNUAL PREMIUM	MINIMUM PREMIUM	DEPOSIT PREMIUM
$	$	$

REMARKS (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

AGENCY CUSTOMER ID: 3282

PRIOR CARRIER INFORMATION / LOSS HISTORY

PROVIDE INFORMATION FOR THE PAST 5 YEARS AND USE THE REMARKS SECTION FOR LOSS DETAILS | LOSS RUN ATTACHED

YEAR	CARRIER & POLICY NUMBER	ANNUAL PREMIUM	MOD	# CLAIMS	AMOUNT PAID	RESERVE
)15-201	CO: Milaaukee Insurance Co POL #: MWC1012269			5	347,593	
)14-201	CO: NYSIF POL #: 23231640					
	CO: POL #:					
	CO: POL #:					
	CO: POL #:					

NATURE OF BUSINESS / DESCRIPTION OF OPERATIONS

GIVE COMMENTS AND DESCRIPTIONS OF BUSINESS, OPERATIONS AND PRODUCTS: MANUFACTURING - RAW MATERIALS, PROCESSES, PRODUCT, EQUIPMENT; CONTRACTOR - TYPE OF WORK, SUB-CONTRACTS; MERCANTILE - MERCHANDISE, CUSTOMERS, DELIVERIES; SERVICE - TYPE, LOCATION; FARM - ACREAGE, ANIMALS, MACHINERY, SUB-CONTRACTS.

Home Care Agency

GENERAL INFORMATION

EXPLAIN ALL "YES" RESPONSES	Y / N
1. DOES APPLICANT OWN, OPERATE OR LEASE AIRCRAFT / WATERCRAFT?	N
2. DO / HAVE PAST, PRESENT OR DISCONTINUED OPERATIONS INVOLVE(D) STORING, TREATING, DISCHARGING, APPLYING, DISPOSING, OR TRANSPORTING OF HAZARDOUS MATERIAL? (e.g. landfills, wastes, fuel tanks, etc)	N
3. ANY WORK PERFORMED UNDERGROUND OR ABOVE 15 FEET?	N
4. ANY WORK PERFORMED ON BARGES, VESSELS, DOCKS, BRIDGE OVER WATER?	N
5. IS APPLICANT ENGAGED IN ANY OTHER TYPE OF BUSINESS?	N
6. ARE SUB-CONTRACTORS USED? (If "YES", give % of work subcontracted)	N
7. ANY WORK SUBLET WITHOUT CERTIFICATES OF INSURANCE? (If "YES", payroll for this work must be included in the State Rating Worksheet on Page 2)	N
8. IS A WRITTEN SAFETY PROGRAM IN OPERATION?	N
9. ANY GROUP TRANSPORTATION PROVIDED?	N
10. ANY EMPLOYEES UNDER 16 OR OVER 60 YEARS OF AGE?	N
11. ANY SEASONAL EMPLOYEES?	N
12. IS THERE ANY VOLUNTEER OR DONATED LABOR? (If "YES", please specify)	N

AGENCY CUSTOMER ID: _____

GENERAL INFORMATION (continued)

EXPLAIN ALL "YES" RESPONSES	Y / N
13. ANY EMPLOYEES WITH PHYSICAL HANDICAPS?	N
14. DO EMPLOYEES TRAVEL OUT OF STATE? (If "YES", indicate state(s) of travel and frequency)	N
15. ARE ATHLETIC TEAMS SPONSORED?	N
16. ARE PHYSICALS REQUIRED AFTER OFFERS OF EMPLOYMENT ARE MADE?	N
17. ANY OTHER INSURANCE WITH THIS INSURER?	N
18. ANY PRIOR COVERAGE DECLINED / CANCELLED / NON-RENEWED IN THE LAST THREE (3) YEARS? **(Missouri Applicants - Do not answer this question)**	N
19. ARE EMPLOYEE HEALTH PLANS PROVIDED?	N
20. DO ANY EMPLOYEES PERFORM WORK FOR OTHER BUSINESSES OR SUBSIDIARIES?	N
21. DO YOU LEASE EMPLOYEES TO OR FROM OTHER EMPLOYERS?	N
22. DO ANY EMPLOYEES PREDOMINANTLY WORK AT HOME? If "YES", # of Employees: _____	N
23. ANY TAX LIENS OR BANKRUPTCY WITHIN THE LAST FIVE (5) YEARS? (If "YES", please specify)	N
24. ANY UNDISPUTED AND UNPAID WORKERS COMPENSATION PREMIUM DUE FROM YOU OR ANY COMMONLY MANAGED OR OWNED ENTERPRISES? IF YES, EXPLAIN INCLUDING ENTITY NAME(S) AND POLICY NUMBER(S).	N

REMARKS (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

APPLICABLE IN TENNESSEE AND VERMONT: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO ANY PARTY TO A WORKERS COMPENSATION TRANSACTION FOR THE PURPOSE OF COMMITTING FRAUD. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS THE PERSON TO CRIMINAL AND [NY: SUBSTANTIAL] CIVIL PENALTIES. (Not applicable in CO, DC, FL, HI, MA, MN, NE, OH, OK, OR, VT or WA; in LA, ME, TN and VA, insurance benefits may also be denied)

IN THE DISTRICT OF COLUMBIA, WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES.

IN MASSACHUSETTS, NEBRASKA, OREGON AND VERMONT, ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, MAY BE COMMITTING A FRAUDULENT INSURANCE ACT, WHICH MAY BE A CRIME AND MAY SUBJECT THE PERSON TO CRIMINAL AND CIVIL PENALTIES.

IN WASHINGTON, IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES, AND DENIAL OF INSURANCE BENEFITS.

APPLICANT'S SIGNATURE (Must be Officer, Owner or Partner)	DATE	PRODUCER'S SIGNATURE	NATIONAL PRODUCER NUMBER

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Proposal of Insurance

Prestige LHCSA Management, Inc.
Prospect Number N9WC831857
for 02/27/2017 to 02/27/2018

We are very interested in providing coverage on this account. If you would like to discuss any portion of this proposal to ensure that we have the best possible chance of success, we encourage you to call us.

Carrier:	Berkshire Hathaway Direct Insurance Company
Coverage Option:	Guaranteed Cost
Payment Terms:	10% down payment of $53,515.10 and 10 Monthly installment(s)
Payment Method:	Direct Bill
Limits Emp Liability:	100,000/500,000/100,000

Total Estimated Cost: 535,151.00

(This amount includes state surcharges, is subject to any pending rate changes or required premium modifications, and is based on the most current information available to us.)

Information Needed to Issue:

No information needed to issue your policy has currently been identified. If we subsequently recognize a need, we will contact you with our request.

Payment Terms:

* Your down payment is due in our office within ten (10) calendar days of the effective date. To make a down payment immediately, you may utilize our Direct Draft Program (see below) or Credit Card Program. Or, you may mail the initial check to Berkshire Hathaway Direct Attention Accounts Receivable, PO Box 113247, Stamford, CT 06911-3247. Be sure to make your check payable to Berkshire Hathaway Direct Insurance Company, and include your prospect number. No additional bill will be sent to you for this initial required downpayment.
* Direct billed policies will be charged a fee of $7.00 per installment.
* A Direct Draft electronic fund transfer option is offered which requires no installment fees and no checks to be mailed. A sign-up sheet is enclosed and can alternatively be downloaded from our web site at www.CoverYourBusiness.com or obtained by contacting Customer Service at 844-472-0967.

PATRIOT UNDERWRITERS, INC.

(Rev 05/2016)

Patriot Underwriters Home Healthcare Providers
Workers' Compensation Supplemental Application

COMPANY NAME	Prestige LHCSA Management Inc	YEARS IN BUSINESS	3
ADDRESS:	329 East 149th Street 3rd Floor Bronx NY 10451	FEIN	263406523
WEBSITE		LIST ALL STATES WHERE SERVICES ARE PROVIED:	NY

TOTAL NUMBER OF EMPLOYEES (FULL TIME AND PART TIME)	200
TOTAL NUMBER OF EMPLOYEES PROVIDING IN-HOME CARE (FULL TIME AND PART TIME)	250
TOTAL NUMBER OF EMPLOYEES WITH PROFESSIONAL DESIGNATIONS (FULL AND PART TIME)	0
TOTAL NUMBER OF PART TIME EMPLOYEES WITH PROFESSIONAL DESIGNATIONS	0
TOTAL ANNUAL PAYROLL	$7,000,000
TOTAL ANNUAL PAYROLL FOR FULL TIME EMPLOYEES	$3.8,892,000
TOTAL ANNUAL PAYROLL FOR PART TIME EMPLOYEES	$3.1,108,000
TOTAL ANNUAL PAYROLL FOR EMPLOYEES WITH PROFESSIONAL DESIGNATIONS	$2,000,000
TOTAL ANNUAL PAYROLL FOR PART TIME EMPLOYEES WITH PROFESSIONAL DESIGNATIONS	$0
TOTAL NUMER OF CLIENTS	650
TOTAL ANNUAL REVENUE	$10,000,000

GEOGRAPHIC AREA OF OPERATIONS (Check One): ■ <100 MILES ☐ 100-200 MILES ☐ >200 MILES

AVERAGE NUMBER OF CLIENTS ASSIGNED PER CARE PROVIDER	1	MIN	3	MAX
AVERAGE NUMBER OF CLIENT VISITS PER DAY PER CARE PROOVIDER	1	MIN	2	MAX
AVERAGE DISTANCE DRIVEN (IN MILES) PER CARE PROVIDER PER DAY	0	MIN	0	MAX

DO YOU REQUIRE PRE-EMPLOYMENT PHYSICALS FOR ALL CARE PROVIDERS (INCLUDING P/T)?	☐ YES	☐ NO
DO YOU REQUIRE ANNUAL PHYSICALS FOR ALL CARE PROVIDERS (INCLUDING P/T)?	■ YES	☐ NO
DO YOU CONDUCT PRE-EMPLOYMENT DRUG TESTING FOR POTENTIAL HIRES?	■ YES	☐ NO
DO YOU CONDUCT RANDOM DRUG TESTING FOR EXISTING EMPLOYEES?	■ YES	☐ NO
DO YOU COMPLETE BACKGROUND CHECKS ON ALL PORTENTIAL CARE PROVIDERS?	■ YES	☐ NO
DO YOUR IN-HOME CARE PROVIDERS USE THEIR PERSONAL MOTOR VEHICLES?	☐ YES	■ NO
DO YOU SUPPLY COMPANY OWNED VEHICLES TO ANY EMPLOYEES?	☐ YES	■ NO
DO YOU CHECK MVRs FOR ALL POTENTIAL CARE PROVIDERS?	☐ YES	■ NO
DO YOU CHECK MVRs ANNUALLY FOR ALL EXISTING CARE PROVIDERS?	☐ YES	■ NO
DO YOU HAVE MINIMUM PERSONAL AUTO INS COVERAGE REQUIREMENTS FOR ALL CARE PROVIDERS?	☐ YES	■ NO
IINDICATE MINIMUM COVERAGE REQUIREMENTS:		
DO 3 OR MORE EMPLOYEES EVER TRAVEL TOGETHER IN ANY ONE VEHICLE?	☐ YES	■ NO
DO YOU OFFER MEDICAL OR HEALTH BENEFITS FOR FULL TIME CARE PROVIDERS?	■ YES	☐ NO
PERCENTAGE OF F/T CARE PROVIDERS PARTICIPATING IN MEDICAL/HEALTH PROGRAM	0 %	
DO ANY OF YOUR CLIENTS REQUIRE 24 HOUR CARE?	■ YES	☐ NO
IF THE ANSWER TO THE ABOVE IS "YES", HOW MANY CLIENTS REQUIRE 24 HOUR CARE?	■ YES	☐ NO
DO ANY IN-HOME CARE PROVIDERS SPEND 24 CONTINUOUS HOURS IN THE CLIENT'S HOME?	■ YES	☐ NO
HOW MANY 24 HOUR CARE ARRANGEMENTS DO YOU CURRENTLY HAVE?	10	

INDICATE ALL OPERATIONS/SERVICES PERFORMED BY YOU RIN-HOME CARE GIVERS

☐ PHYSICAL THERAPY	☑ OVERNIGHT STAYS W/ CLIENTS	☐ OCCUPATIONAL THERAPY
☐ CLIENT TRANSPORTATION	☐ MENTAL HEALTH CARE/COUNSELING	☐ ALZHEIMERS CARE
☑ HOUSE CLEANING	☐ SUBSTANCE ABUSE COUNSELING	☐ MEDICATION APPLICATION
☑ WASHING/BATHING CLIENTS	☑ GROCERY SHOPPING	☐ INTRAVENIOUS APPLICATIONS
☑ NORMAL HOUSEHOLD CHORES	☐ HOSPICE CARE	☑ COOKING/MEAL PREPERATION

☑ OTHER (EXPLAIN) reminders of medication only

INDICATE ALL LOCATIONS WHERE YOUR EMPLOYEES PERFORM THEIR SERVICES

☑ PRIVATE HOMES OR APARTMENTS	☐ HOSPITALS	☐ PHYSICAL THERAPY CENTERS
☐ NURSING HOMES	☐ DOCTORS' OFFICES	☐ SCHOOLS
☐ DAY CARE FACILITIES	☐ ASSISTED LIVING FACILITIES	☐ OCCUPATIONAL THERAPY CENTERS
☐ MEDICAL CLINICS	☐ CORPORATE OFFICES	☐ AT YOUR PRIMARY LOCATION

☐ OTHER (EXPLAIN)

IF YOU PROVIDE 24 HOUR CARE, IS THIS CARE PROVIDED VIA

☑ SINGLE EMPLOYEE IN A 24 HOUR SHIFT
☐ MULTIPLE EMPLOYEES IN MULTIPLE SHIFTS

IF PROVIDED VIA MULTIPLE EMPLOYEES IN MULTIPLE SHIFTS, HOW MANY HOURS IS THE STANDARD SHIFT? ☐ HOURS

ARE ANY OF YOUR IN-HOME CARE PROVIDERS PAID ON A PER DIEM BASIS? ☐ YES ■ NO

IF THE ANSWER TO THE ABOVE IS "YES", HOW MANY EMPLOYEES RECEIVE PER DIAM PAY?

WHAT IS THE AVERAGE NUMBER OF HOURS PER DAY WORKED BY THESE EMPLOYEES? ☐ HOURS

ARE ANY OF YOUR IN-HOME CAE PROVIDERS OVER THE AGE OF 60?	☐ YES ■ NO
DO ANY OF YOUR EMPLOYEES (FULL TIME OR PART TIME) WORK WITH EMT OPERATIONS?	☐ YES ■ NO
DO YOU PROVIDE TRAINING REGARDING THE LIFTING AND MOVEMENT OF CLIENTS?	■ YES ☐ NO
DO YOU HAVE A LIGHT DUTY OR EARLY RETURN TO WORK PROGRAM FOR INJURED EMPLOYEES?	■ YES ☐ NO
DO YOU UTILIZE ANY INDEPENDENT CONTRACTORS OR 1099 EMPLOYEES?	☐ YES ■ NO

IF THE ANSWER ABOVE IS "YES", INDICATE THE ANNUAL AMOUNT PAID TO THESE EMPLOYEES $

HAVE YOU EVER HAD INSURANCE COVERAGE CANCELLED DUE TO NON-PAYMENT OF PREMIUM ☐ YES ■ NO

If the answer above is "YES", provide the name of the insurance carrier, policy number and date of cancellation

Affirmation

The undersigned acknowledges and understands the information provided herein will be used to evaluate the applicant and a decision as to whether the applied to insurance company will offer workers' compensation insurance will be made, in part, based on the information provided. Signature below indicates the information provided is true and correct.

This Supplemental Application must be signed by a principle, owner or partner of the entity applying for insurance.

Signature **Title**

Name (Please Print) **Date**