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SC Court of Appeals

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM SPARTANBURG COUNTY
Court of Common Pleas

The Grace Gilchrist Knie, Circuit Court Judge

Case No. 2020-CP-42-03818
Case No. 2020-CP-42-03819
Appellate Case No. 2021-000681

Terry Putnam, Individually and as Personal Representative
of the Estate of Margaret Hensley, ... Respondent,

v.

White Oak Estates, Inc., White Oak Management, Inc., and
White Oak Manor, Inc., ... Appellants.

RECORD ON APPEAL - VOLUME I

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STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF SPARTANBURG	)	C.A. No.: 2020-CP-42-03818 &
	)	2020-CP-42-03819
Terry Putman, Individually and as	)	
Personal Representative of the Estate	)	
of Margaret Hensley,	)	
	)	
Plaintiff,	)	
	)	
v.	)	ORDER REGARDING
	)	DEFENDANTS' MOTION TO
	)	DISMISS, COMPEL
White Oak Estates, Inc., White Oak	)	ARBITRATION, AND FOR A
Management, Inc., and White Oak	)	PROTECTIVE ORDER OR,
Manor, Inc.,	)	ALTERNATIVELY, TO STAY THE
	)	ACTION PENDING ARBITRATION
Defendant(s).	)	
	)	

Hearing Date:	March 17th, 2021, at 2:30 p.m.
Hearing Judge:	Grace Gilchrist Knie
Counsel for Plaintiff:	Matthew W. Christian
Counsel for Defendants:	Joshua T. Thompson
Court Reporter:	Linda D. Moffitt

This matter came before the Court on March 17th, 2021, at 2:30 p.m. on Defendants White Oak Estates, Inc., White Oak Management, Inc., and White Oak Manor, Inc.'s Motion to Dismiss, Compel Arbitration, and for a Protective Order or, Alternatively, to Stay the Action Pending Arbitration filed with the Court on February 19th, 2021. Counsel for the parties appeared virtually pursuant to the South Carolina Supreme Court's recent Order regarding COVID-19 protocol. Present representing the Defendants was Joshua T. Thompson, Esq., of Boulter Thompson & Barnes, LLC, in Spartanburg, South Carolina, and present representing the Plaintiff was Matthew W. Christian, Esq., of Christian & Christian, LLC, in Greenville, South Carolina. The Court Reporter was Linda D. Moffitt.

Having listened to oral arguments from counsel and having reviewed the parties' legal memoranda with attached exhibits for reasons set forth more fully below, the Court hereby denies the Defendants' Motions.

BACKGROUND

This matter arises out of two civil actions, a survival action and a wrongful death action. Both actions involve allegations of nursing home negligence and corporate negligence resulting in the death of Margaret Hensley (hereinafter "Decedent"). Terry Putman (hereinafter "Daughter") was Decedent's daughter and serves as Personal Representative of Decedent's Estate. Decedent was admitted to White Oak Estates, Inc. (hereinafter "White Oak Estates") for short-term rehabilitation after undergoing a hip arthroplasty at Spartanburg Regional Medical Center. At the time of admission, Decedent had an articulating brace for her leg to help keep it immobilized as a result of her hip surgery. Plaintiff alleges that as a result of Defendants' negligence, that Decedent developed a wound near the area of the articulating brace which Plaintiff alleges to have significantly deteriorated resulting in infection, sepsis, emergency transport to the hospital, and ultimately, her death. At the time of admission, Daughter signed an admission agreement and an arbitration agreement presented to her by agents of White Oak Estates. The Arbitration Agreement was signed by Daughter as "resident/representative" and by an agent of the facility for "White Oak Estates".

Plaintiff filed the Notice of Intent to File Suit on March 25th, 2020 and subsequently served the Defendants on June 9th, 2020. The parties engaged in the mandatory pre-suit mediation which was unsuccessful. Daughter as Personal Representative then filed the Complaints on November 2nd, 2020, for wrongful death and

survival actions and timely served the Defendants. Defendants filed their Motion to Compel Arbitration on February 19, 2021. Plaintiff contends that the arbitration agreement is unenforceable under state contract law.

LEGAL ANALYSIS

The party seeking to enforce an agreement to arbitrate has the burden of establishing the existence of a valid arbitration agreement. See Aiken v. World Finance Corp. of S.C., 373 S.C. 144, 149, 644 S.E.2d 705, 708 (2007); MBNA America Bank, N.A. v. Christianson, 377 S.C. 210, 659 S.E.2d 209 (S.C. Ct. App. 2008). It is well established that “where one party denies the existence of an arbitration agreement raised by an opposing party, a court must immediately determine whether the agreement exists in the first place. If no agreement is found to exist, the Court must deny any application to arbitrate. Simpson v. MSA of Myrtle Beach, Inc., 373 S.C. 14, 644 S.E.2d 663, 667 (S.C. 2007) (internal citation omitted). Whether a valid arbitration agreement exists is a matter for judicial determination. York v. Dodgeland of Columbia, Inc., 406 S.C. 67,78,749 S.E.2d 139, 144 (Ct. App. 2013).

Whether the parties agreed to arbitration is a question of substantive state law. Simpson v. MSA of Myrtle Beach, Inc., 373 S.C. 14, 644 S.E.2d 663, 668 (S.C. 2007) (“General contract principles of state law apply in a court’s evaluation of the enforceability of an arbitration clause.”). Arbitration agreements must satisfy the basic tenets and requirements of contract law. Towles v. United Healthcare Corp., 338 S.C. 29, 37, 524 S.E.2d 839, 844, (Ct. App. 1999). Section 2 of the Federal Arbitration Act dictates that arbitration agreements are enforceable except “upon such grounds as exist at law or equity for the revocation of any contract”. 9 U.S.C. §2. The courts, not arbitrators, are charged

with deciding certain “gateway matters” including whether the parties have a valid arbitration agreement or whether the arbitration clause applies to a certain type of controversy. New Hope Missionary Baptist Church v. Paragon Builders, 379 S.C. 620, 629, 667 S.E.2d 1, 5 (Ct. App. 2008). Thus, unless there is a valid, irrevocable, and enforceable contract, the Federal Arbitration Act does not apply. The purpose of the Federal Arbitration Act is “to make arbitration agreements as enforceable as other contracts, but not more so.” Prima Paint Corp. v. Flood & Conklin Mfg. Co., 388 U.S. 395, 404 n.12, 87 S. Ct. 1801, 18 L. Ed. 2d 1270 (1967).

Further, the party seeking enforcement of the agreement bears the burden to prove a valid arbitration agreement exists that is enforceable, knowing, voluntary, and intentional. See Aiken v. World Finance Corp. of S.C., 373 S.C. 144, 149 (2007); MBNA America Bank, N.A. v. Christianson, 377 S.C. 210, 659 S.E.2d 209 (Ct. App. 2008); Hinson-Barr, Inc. v. Pinckard, 292 S.C. 267, 268, 356 S.E.2d 115, 116 (1986). Whether the arbitration contract is valid is addressed by applying general principles of state law governing contract formation. Munoz v. Green Tree Fin. Corp., 343 S.C. 531, 538, 542 S.E.2d 360, 363 (2001). Therefore, the burden is on the moving party to demonstrate the absence of any genuine dispute of material fact, Adickes v. S.H. Kress & Co., 398 U.S. 144, 157 (1970), and that the movant is “entitled to judgment [compelling arbitration] as a matter of law.” Burrell v. 911 Restoration Franchise Inc., 2017 WL 5517383, at *3 (D. Md. November 17, 2017) (citing Fed. R. Civ. P. 56(a)). The arbitration agreement at issue in this particular case with White Oak Estates is not valid and Defendants cannot meet their burden of proof.

Defendants’ Motion to Dismiss, Compel Arbitration, and for a Protective Order or, Alternatively, to Stay the Action Pending Arbitration are effectively motions to enforce

contracts. In the ordinary course, a nursing home resident who alleges injuries would bring her claim before the Court as the Plaintiff has done here and the nursing home would mount its defense in the same forum. A valid contract to arbitrate their disputes is the only way to opt out of the litigation process. The Court finds that Defendants have no such contract with Decedent. The arbitration agreement is invalid for numerous reasons as set forth hereinbelow.

I. The Admission Agreement and Arbitration Agreement are Separate and Do Not Merge.

South Carolina Appellate Courts have examined the issue of whether admission agreements and arbitration agreements have merged on at least three separate occasions and rejected the contention of merger each time. Coleman v. Mariner Healthcare, Inc., 407 S.C. 346, 755 S.E.2d 450 (2014); Thompson v. Pruitt Corp., 416 S.C. 43, 784 S.E.2d 679 (Ct. App. 2016); Hodge v. UniHealth Post-Acute Care of Bamberg, LLC, 422 S.C. 544, 813 S.E.2d 292 (Ct. Appt. 2018). It should also be noted that the Court of Appeals recently rejected, for a fourth time, the argument of estoppel where the arbitration agreement was contained within the admission agreement itself. Weaver v. Brookdale Senior Living, Inc., 431 S.C. 223, 847 S.E.2d 268 (Ct. App. 2020). In the end, the Defendants' pursuit of the merger argument fails for the same reasons as the nursing homes in Coleman, Thompson, and Hodge.

In the case at hand, as noted in the aforementioned cases, the Courts have traditionally recognized that arbitration agreements which are separate and distinct from the admission agreement do not merge. As the Coleman Court noted, the merger principle cannot apply unless the writings in question were executed "at the same time, by the same parties, for the same purpose, and in the course of the same transaction." Coleman, 407

S.C. at 355, 755 S.E.2d at 455. Even then, merger does not apply if there is “*anything* indicating a contrary intention.” Coleman, 407 S.C. at 355, 755 S.E.2d at 455 (emphasis added). Thus, simultaneously executed writings related to the same general subject matter will not be viewed as a single or merged agreement if either the language or the circumstances even hint that the parties actually intended the writings to be distinct, separate contracts.

The Defendants cannot show that the Admission Agreement and Arbitration Agreement were executed for the same purpose. The Admission Agreement was “for the provision of nursing services for Margaret Hensley.” Admission Agreement, p. 1. Therefore, the contract by its express terms sets forth the purpose of the agreement was for the provision of skilled nursing care. That purpose is born out in the nineteen (19) pages of the Admission Agreement. The facility agreed to provide services identified on pages 2-3 of the agreement in exchange for payment by the resident as outlined in pages 4-12. On the other hand, the Arbitration Agreement covers a completely different issue. It is solely devoted to directing an alternative dispute resolution method and purporting to eliminate its parties’ right to relief through the courts. These two contracts cannot have the same purpose because, as Defendants admit, the Arbitration Agreement was not a pre-condition for admission.

Second, the terms and context show that the parties intended the Admission Agreement and Arbitration Agreement to be separate contracts. Also, admission and arbitration contracts cannot merge if they contain inconsistent terms, especially provisions related to how each contract may be terminated. Coleman, 407 S.C. at 355, 755 S.E.2d at 455; Thompson, 416 S.C. at 53, 784 S.E.2d at 685. Moreover, courts look at the way the

contracts are structured, finding it unlikely that parties intended two contracts to be treated as one if they chose separate titles, required separate signatures, and numbered each contract's pages differently. Thompson, 416 S.C. at 53 n. 1 784, S.E.2d at 685 n. 1; Hodge, 422 S.C. at 562, 813 S.E.2d at 302. Finally, Hodge held a nursing home cannot argue for merger when it chose to separate arbitration and admission into two agreements while taking the position that agreeing to the former was not required to obtain the benefits of the latter. Hodge, 422 S.C. at 562-63, 813 S.E.2d at 302.

As present in the aforementioned cases, the Admission Agreement contains the "entire agreement" provision identifying the contract's limited scope. Second, the parties did not intend for the two contracts to be read as one because they chose to apply different substantive law to both agreements. Hodge, 422 S.C. at 562, 813 S.E.2d at 302. In the present case, state law purportedly governs the Admission Agreement and federal law purportedly governs the Arbitration Agreement. Admission Agreement p. 16; Arbitration Agreement p. 1.

Coleman, Thompson, and Hodge made special notes of inconsistent provisions in admission and arbitration contracts regarding when each contract may be canceled at the resident's urging. Coleman, 407 S.C. at 355, 755 S.E.2d at 455; Thompson, 416 S.C. at 53, 784 S.E.2d at 685; Hodge, 422 S.C. at 551, 813 S.E.2d at 296. The Admission Agreement provides that the resident may terminate the contract with three days advance written or oral notification. However, the Arbitration Agreement provides that the resident may terminate/opt-out of the agreement within thirty (30) days. Admission Agreement p. 12; Arbitration Agreement p. 3-4. Further, the Admission Agreement allows the facility to unilaterally modify the terms of the agreement with thirty (30) days advance written

notice. However, the Arbitration Agreement states that the agreement may not be modified except by subsequent written agreement. Admission Agreement p. 16, ¶ 19.5; Arbitration Agreement p. 4, ¶ 22.

Finally, an arbitration contract is far less likely to merge with an admission contract if the nursing home admits arbitration is not required for admission. In Hodge, our Appellate Court cited as further evidence against merger where arbitration contract provisions state that arbitration was not a pre-condition to a resident's acceptance to the nursing home. Hodge, 422 S.C. at 562-63, 813 S.E.2d at 302; See also Arrendondo v. SNH S.E. Ashley River Tenant, LLC, Op. No. 28011 (S.C. Sup. Ct. Filed March 10, 2021)(Shearhouse Adv. Sh. No. 8 at 40, 49-50)(finding that, since arbitration was optional, it was not a healthcare decision or "necessary" to such decisions and the son's power of attorney-based authority did not extend to arbitration matters). Similarly, in the present case, Defendants admit that executing the Arbitration Agreement was not mandatory and was not a pre-condition.

In sum, the arbitration agreement and admission agreement have the same four indicators that South Carolina Courts have cited in the past to find simultaneously executed contracts were not intended to merge into one. Further, the present arbitration and admission agreements have additional factors indicating their separateness. Any uncertainty about the four indicators must be resolved in Decedent's favor, not to her detriment. The facility must prove that all four of the indicators discussed hereinabove are absent here and the Defendants must not just oppose one of the four indicators discussed above but prove all four are absent here. Additionally, the facility drafted these form

contracts of adhesion and any ambiguities must be construed against it. Therefore, based on all of the above factors, the two agreements do not merge.

II. The Arbitration Agreement is Unenforceable Because it is Unconscionable.

In South Carolina, unconscionability is defined as the absence of meaningful choice on the part of one party due to one-sided contract provisions, together with terms that are so oppressive that no reasonable person would make them, and no fair and honest person would accept them. Carolina Care Plan, Inc. v. United HealthCare Servs., Inc., 361 S.C. 544, 554, 606 S.E.2d 752, 757 (2004). If a court as a matter of law finds any clause of a contract to have been unconscionable at the time it was made, the court may refuse to enforce the agreement. S.C. Code Ann. § 36-2-302(1) (2003). In analyzing claims of unconscionability in the context of arbitration agreements, the Fourth Circuit has instructed courts to focus generally on whether the arbitration clause is geared towards achieving an unbiased decision by a neutral decision-maker. See Hooters of Am., Inc. v. Phillips, 173 F.3d 933, 938 (4th Cir.1999). It is under this general rubric that courts must determine whether a contract is unconscionable due to both an absence of meaningful choice and oppressive, one-sided terms.

Absence of meaningful choice on the part of one party generally speaks to the fundamental fairness of the bargaining process in the contract at issue. See Carlson v. General Motors Corp., 883 F.2d 287, 295 (4th Cir.1989). In determining whether a contract was "tainted by an absence of meaningful choice," Id. at 295, courts should take into account the nature of the injuries suffered by the plaintiff; whether the plaintiff is a substantial business concern; the relative disparity in the parties' bargaining power; the parties' relative sophistication; whether there is an element of surprise in the inclusion of

the challenged clause; and the conspicuousness of the clause. Id. at 293. See also Holler v. Holler, 364 S.C. 256, 269, 612 S.E.2d 469, 476 (Ct.App.2005) ("A determination whether a contract is unconscionable depends upon all the facts and circumstances of a particular case." (quoting 17 A Am.Jur.2d Contracts§ 279 (2004))); see also Simpson v. MSA of Myrtle Beach, Inc., 373 S.C. 14, 25, 644 S.E.2d 663, 669 (2007).

The choice of a nursing home is made in the midst of a crisis brought on by a precipitous deterioration in health status, disability level, or the loss of a care giver or spouse.¹ Frequently, the need to find placement for a loved one arises quickly and nursing home admissions are often unplanned, and there is often little time to investigate options or wait for an opening at a nursing home. Time pressure impairs the ability to seek and consider alternatives. This is further confirmed by Daughter's Affidavit. Daughter and her family had no choice or time in making such a decision as Daughter's affidavit reflects that she was required to sign the Admission Agreement under stress during her mother's hospitalization shortly before discharge to the facility. As Daughter's Affidavit further reflects, she was not explained the Arbitration Agreement and no one made her aware of the Arbitration Agreement.

Further, Daughter lacked a meaningful choice in the terms of the Arbitration Agreement which are oppressive and one-sided, and it was presented to her on a take it or leave it basis. She did not contribute to the drafting of the agreement and did not possess the bargaining power to negotiate the terms of the Arbitration Agreement. Further, there

¹ See, e.g., Podolosky v. First Healthcare Corp., 58 Cal.Rptr. 2d 89, 101 (Cal. Ct. App. 1996) (citing Donna Ambrogi, *Legal Issues in Nursing Home Admissions*, 18 Law Med. & Health Care 254, 258 (1990)); see also Marshall B. Kapp, *The "Voluntary" Status of Nursing Facility Admissions: Legal, Practical, and Public Policy Implications*, 24 N.E. J. on Crim. & Civ. Confinement. 1, 3 (1998) (stating that an older person's move to a nursing home also follows a period of acute hospitalization, when their care giving family is unable to adequately manage the demands of home care).

is an inherent disparity in bargaining power between the parties in this transaction as the nursing home is a sophisticated entity well versed in arbitration agreements revolving around admissions to their facility. The alleged injuries are significant including wrongful death and serious injury.

Further, the terms of the Arbitration Agreement are unfair and no person would voluntarily agree to them. The Arbitration Agreement at issue in this case is fundamentally and substantively unfair on numerous levels. First, the Arbitration Agreement provides that three arbitrators will be on the panel to hear the case. However, two of the arbitrators do not have to be attorneys or have any education or experience in matters dealing with the subject matter or legal issues. Arbitration Agreement, pages 1-2, ¶ 4-6. Additionally, the arbitrator may be anyone that the party knows at the time with very limited exceptions. If the arbitrator chosen by Daughter and the arbitrator chosen by Defendants cannot agree to a third arbitrator, the third arbitrator will be determined by a coin toss wherein the winner of the coin toss gets to determine the third arbitrator. Arbitration Agreement, page 2, ¶ 6. The essential result is that the party prevailing on a matter of luck/coin toss is more likely to win discovery disputes, evidentiary concerns, and arbitration proceeding as the majority of the arbitrators will be anyone chosen by the winner of the coin toss. No party would agree to these fundamentally unfair principles regarding the Arbitration Agreement rendering the result to a matter of chance and luck. Further, not having two of the arbitrators being completely neutral or having any type of knowledge or education on the subject matter or legal field creates a fundamental unfairness.

Additionally, the Arbitration Agreement allows for extensive delays in the process when the entire purpose of arbitration is to promote efficiency and timeliness. The facility

in this particular situation would have ninety (90) days/three months to name their arbitrator after the Plaintiff named the arbitrator. Arbitration Agreement, page 102, ¶ 5-6. Further, after the second arbitrator is chosen, another ninety (90) days/three months would pass before the third arbitrator is chosen. The third arbitrator would then have thirty (30) days to notify the parties as to whether or not he/she would agree to arbitrate the proceedings. Arbitration Agreement, page 2, ¶ 6. Therefore, a minimum of seven (7) months would pass before the parties could even begin the arbitration process. This is antithetical to the entire premise of arbitration and is further evidence of the unconscionability.

Third, the Arbitration Agreement provides that the decision regarding the outcome of the arbitration shall be made by the majority of the arbitrators picking an offer/demand made separately by both of the parties twenty-four (24) hours prior to the hearing. The arbitrators have no discretion to award any different decision other than one of the offers or demands given by each of the parties. Arbitration Agreement, page 3, ¶ 13. Finally, whoever the non-prevailing party is (the party whose offer/demand is not chosen by the majority of the arbitrators) will be required to pay all of the prevailing party's costs and expenses including, but not limited to, the third arbitrator's fees, costs of deposition, and any other costs associated with the hearing. Arbitration Agreement, page 2, ¶ 9; page 3, ¶ 19.

As a result, the cost of arbitration far outweighs the cost of proceeding in Court and therefore the agreement is unconscionable. Also, the costs of the arbitration must be paid by the parties including the Estate of Margaret Hensley which contains no money, income, or assets. Plaintiff's Affidavit on page 2 specifically states that the Estate has no assets and

no income whatsoever. Plaintiff did not and does not have the financial wherewithal to pay or prepay arbitration fees or pay the opposing side's costs should the majority not pick her demand at the resolution. The amount of money that it would cost to begin and proceed through the arbitration process, including hearing, exceeds that available to the Plaintiff.

Although the costs of arbitration may be a basis for determining that an agreement to arbitrate is substantially unconscionable, since Green Tree the issue of the prohibitive costs of arbitration has developed into a separate defense to the enforcement of an arbitration agreement. See Zephyr Haven, 122 So.3d at 921–22. “[W]here ‘a party seeks to invalidate an arbitration agreement on the ground that arbitration would be prohibitively expensive, that party bears the burden of showing the likelihood of incurring such costs.’ ” Id. at 921 (quoting Green Tree, 531 U.S. at 92, 121 S.Ct. 513). In determining whether the costs of arbitration in a fee splitting arrangement are so prohibitive as to render the agreement unenforceable because it denies the plaintiff access to the arbitral forum, a case-by-case analysis is appropriate. Id. at 922. The focus is on the claimant's ability to pay the arbitration fees and costs, the expected cost differential between arbitration and litigating in court, and whether the cost differential is so substantial as to deter the bringing of the claims. Id. In order to invalidate the arbitration agreement, the plaintiff, at an evidentiary hearing, must show the expected cost of arbitrating the specific claim is greater than litigating it and that the cost of arbitration would be prohibitively expensive. Id.

Fi-Tampa, LLC v. Kelly-Hall, 135 So.3d 563 (Fla. App., 2014)

An arbitration agreement may be substantively unconscionable if the fees and costs to arbitrate are so excessive as to “deny a potential litigant the opportunity to vindicate his or her rights.” [Cite omitted] Green Tree Fin. Corp. Ala. v. Randolph, 531 U.S. 79, 81, 121 S.Ct. 513, 148 L.Ed.2d 373 (2000) (holding that excessive arbitration costs may preclude litigants from effectively vindicating their rights). The party seeking to invalidate an arbitration agreement on such grounds has the burden of proving that arbitration would be prohibitively expensive. [cites omitted] Whether arbitration is prohibitively expensive is a question of fact that depends on the unique circumstances of each case. See Harrington, 119 P.3d at 1055 (explaining that “the Supreme Court adopted a case-by-case approach to determining whether fees imposed under an arbitration agreement deny a potential litigant the opportunity to vindicate his or her rights”) (citing Randolph, 531 U.S. at 92, 121 S.Ct. 513). ”

Defendants contend that Daughter had previously signed the same arbitration agreement on two prior admissions in 2012 and 2014. The circumstances surrounding the execution of the prior arbitration agreements some three to five years earlier are unknown and are not relevant to the present case. The circumstances under which Decedent was admitted on those prior occasions was never presented by the Defendants. Further, previous admissions have no bearing on either of the unconscionability prongs of lack of meaningful choice or grossly unfair terms. However, even if the prior agreements were relevant to the present admission, they differ significantly in some of the material terms. For example, the prior agreements contain deadlines for the selection of the arbitrators which are much shorter and more efficient (one-third of the time shorter) than the present arbitration agreement in this case. As a result of the deadlines in the present Arbitration Agreement, the arbitration process would potentially not be able to start until at least after seven (7) months, assuming the arbitration selection process went smoothly. The prior arbitration agreements would have provided that the arbitration process could have started much sooner. Further, in the event the two arbitrators selected by each party could not agree on the third, the prior arbitration agreements determined that the third arbitrator in the panel of three would be appointed by the American Arbitration Association. The arbitration agreement in the present case requires that in the event that the two arbitrators selected by each party cannot agree upon the third arbitrator, that the third arbitrator will be selected by the party who wins a coin toss. Therefore, while the circumstances of the prior arbitration agreements are unknown and irrelevant to the issues of unconscionability, they nonetheless differ significantly from the present arbitration agreement in the current case.

Therefore, based on all of the factors hereinabove, the Arbitration Agreement should not be enforced because it is unconscionable.

III. The Arbitration Agreement is Unenforceable Because it Lacks Consideration.

Plaintiff argued the Admission Agreement is unenforceable due to lack of valid consideration. The Court agrees that it is axiomatic that every contract in South Carolina be supported by mutual consideration in order to be valid and enforceable. Defendant argued the Arbitration Agreement was not involuntary and instead made in consideration of admission and that the Arbitration Agreement states it is “for valuable consideration.” However, as discussed below, this does not constitute effective consideration to make the Arbitration Agreement enforceable.

While federal law preempts state laws that would invalidate arbitration agreements on most public policy grounds, the FAA looks to state law to decide the threshold questions of contract formation. Munoz v. Green Tree Financial Corp., 343 S.C. 531, 542 S.E.2d 360, 364 (2001); Towles v. United Healthcare Corp., 338 S.C. 29, 37, 524 S.E.2d 839, 844 (Ct. App. 1999) (“the court should apply ‘ordinary state-law principles that govern the formation of contracts.’”). Therefore, arbitration agreements guided by the FAA are subject to the same defenses applicable to all other contracts. Rent-A-Center, West, Inc., 561 U.S. at 63, 130 S.Ct. at 2776; Simpson, 373 S.C at 14, 644 S.E.2d at 663 (“general contract principles of state law apply in a court's evaluation of the enforceability of an arbitration clause.”). The necessary elements of a contract are an offer, acceptance, and valuable consideration. Sauner v. Public Service Authority of S.C., 354 S.C. 397, 581 S.E.2d 161, 166 (2003). “Valuable consideration to support a contract may consist of some right, interest, profit or benefit accruing to one party or some forbearance, detriment, loss or

responsibility given, suffered or undertaken by the other.” Plantation A.D., LLC v. Gerald Builders of Conway, Inc., 386 S.C. 198, 206, 687 S.E.2d 714, 718 (Ct. App. 2009) (quoting Prestwick Golf Club, Inc. v. Prestwick Ltd. P'ship., 331 S.C. 385, 389, 503 S.E.2d 184, 186 (Ct. App. 1998)). Where a contract lacks valuable consideration, the contract will be deemed unenforceable.

Our courts have held that where there is a mutual promise to arbitrate, there must be additional consideration. See Reidman Corp. v. Jarosh, 290 S.C. 252, 253, 349 S.E.2d 404, 405 (1986). However, in determining whether adequate consideration exists in a contract, or arbitration agreement under the FAA guided by principles of contract law, our courts must examine and stay within the confines of the four corners of the instrument. State Accident Fund v. S.C. Second Injury Fund, 388 S.C. 67, 76, 693 S.E.2d 441, 445 (Ct. App. 2010) (internal citations omitted). Daughter was asked to sign the Admission paperwork prior to Decedent’s presentation to the facility. Daughter was also asked to sign the separate Arbitration Agreement. Having already signed the admission paperwork, there was no additional consideration in agreeing to the Arbitration Agreement itself. Therefore, neither party gained a right, interest, profit, or benefit by agreeing to the Arbitration Agreement. Additionally, neither party suffered a forbearance, detriment, loss or responsibility given, suffered, or undertaken by the other party when agreeing to the Arbitration Agreement. Further, simply because the Arbitration Agreement states that it is for valuable consideration does not make it so. Any allegedly legal consideration is not identified. There is no more meaning to such a statement than the Agreement attempting to improperly bind non-parties and non-signatories. Therefore, after analyzing the four

corners of the Arbitration Agreement itself, this Court finds no valuable consideration exists. As such, the Arbitration Agreement is unenforceable.

IV. The Arbitration Agreement Does Not Apply to the Wrongful Death Action

South Carolina law is clear that a wrongful death claim exists for the statutory beneficiaries and that such claims are distinct and separate from those brought under survival claims. Bennett v. Spartanburg Railway Gas and Electric Co., 97 S.C. 27, 81 S.E. 189 (1914). The alleged Arbitration Agreement with White Oak by its own terms is an agreement between “White Oak Estates (‘The Facility’), and Margaret Hensley (‘the Resident’).” While at some point during Decedent’s admission to the facility, she might have had the authority to bind herself and her claims to arbitration but was never given the chance. However, even if Decedent had agreed to arbitration, she did not have the legal authority to bind her statutory beneficiaries who are not a party to the Arbitration Agreement. The signatories to the agreement are Daughter on behalf of Decedent and White Oak Estates. The scope of the agreement does not include the statutory beneficiaries’ claims.

While Defendants would like to contend that the agreement covers statutory beneficiaries’ claims, which it does not, the problem with this contention is that Decedent/Son had no authority to waive the statutory beneficiaries’ claims. While dealing with a separate arbitration issue in a nursing home case and finding the arbitration agreement to be unenforceable, the Court of Appeals in Hodge recognized the separateness of the statutory beneficiaries/estate’s claims from those of the patient/resident. In discussing the Maryland court’s case of Dickerson, the Court noted that the nursing home was attempting “to use equitable estoppel against [the patient’s] estate based on actions

that [daughter] took in *her individual capacity*. The fact that [daughter] is *now the Personal Representative for [the patient's] [e]state* is of no moment; we will not hold this circumstance against [the patient's] [e]state. Simply put, [the patient's] [e]state is the plaintiff in this case, and Respondent has alleged no conduct on the part of [the patient's] [e]state, or by [daughter] in *her capacity as Personal Representative* of [the patient's] [e]state....” Hodge quoting Dickerson v. Longoria, 995 A.2d. 721, 743 (Md. 2010). As recognized in this discussion, actions taken by Daughter in her *individual capacity* will not be held against the estate and as the Court noted, the estate may well have other beneficiaries or creditors.

Further confirming the separateness of each statutory beneficiary’s claim from that of the survival action, a Federal District Court in South Carolina has analyzed this issue under the South Carolina Non-Economic Awards Act of 2005. Diane Boyle as Personal Representative of the Estate of John Francis Boyle v. United States of America, United States District Court for the District of South Carolina, Beaufort Division (2009). In Boyle, the Court concluded that the wrongful death beneficiaries’ claims were separate and distinct claims for purposes of stacking damage caps and for purposes of being individual claimants. These analyses confirm that the wrongful death claimants have separate and distinct claims apart from that of the survival action. As such, Daughter and Decedent were incapable of waiving the statutory beneficiaries’ right to a trial by jury.

The wrongful death claims are separate claims apart from the Decedent’s claims. According to South Carolina’s Wrongful Death Act:

“Whenever the death of a person shall be caused by the wrongful act, negligent or the fault of another and the act, negligent or the fault is such as would, if death had not ensued, had entitled party injured to maintain an

action and recover damages in respect thereof, the person who would have been liable, if death had not ensued shall be liable to an action for damages.”

South Carolina Code Annotated §15-51-10 (1977)

The wrongful death beneficiaries are as follows:

“Every such action shall be for the benefit of the wife, or husband and child or children of the person whose death shall have been so caused, and, if there be no such wife, husband, child or children, then for the benefit of the parent or parents, and if there be none, for the benefit of the heirs or the person whose death shall have been so caused.”

South Carolina Code Annotated §15-51-20 (Supp. 2001)

The general element of damages recoverable are pecuniary loss, mental shock and suffering, wounded feelings, grief and sorrow, loss of companionship, and deprivation of the use and comfort of the Decedent, society, including the loss of her experience, knowledge, and judgment in managing the affairs of herself and her beneficiaries. Self v. Goodrich, 300 S.C. 349, 351, 387 S.E.2d. 713, 714 S.C. (Ct. App. 1989).

The wrongful death claim is a separate claim than the claims a decedent might bring on his/her own behalf under the survival statute. In Bennett v. Spartanburg Railway Gas and Electric Company, 97 S.C. 27, 81 S.E. 189 (1914), the Supreme Court held that wrongful death and survival actions are different claims for different injuries. The Court stated “necessarily, therefore, there must be separate verdicts and separate judgments, there should be separate actions.” Id. at 31. See also Strickland v. Southern Ry Co., 111 S.C. 248, 97 S.E. 695 (1918) (Supreme Court Affirmed Appeal from Circuit Court’s ruling noting that survival claims are independent of wrongful death claims), Claussen v.

Brothers, 148 S.C. 1, 145 S.E. 539 (1928) (discussing the difference between survival and wrongful death claims as being independent of each other).

It is true that our Supreme Court reaffirmed that a claim under the Wrongful Death Act lies in the decedent's estate only when the decedent possessed the right of recovery at his death. Estate of Stokes ex rel. Spell v. Pee Dee Family Physicians, L.L.P., 389 S.C. 343, 699 S.E. 2d 143 (2010). This rule, however, does not dictate the conclusion that a wrongful death claim is wholly derivative of the decedent's claim. Instead, the rule provides that if the defendant has a defense that would completely bar the decedent's claim had the decedent survived, then the wrongful death beneficiaries may not bring a claim under the statute. For instance, in Stokes, the statute of limitations had run on the decedent's claim, and the wrongful death beneficiaries were accordingly totally barred from pursuing their claims under the statute. The Supreme Court cited the following from United States District Court case of Quattlebaum v. Carey Canada, Inc., 685 F. Supp. 939 (D.S.C. 1988): "anything that would have *defeated the decedent's recovery* had he survived the accident, (such as contributory negligence, a valid release, or similar acts on his part." (Emphasis added). The Court held Quattlebaum was correctly decided and adheres to the principle that a decedent's estate may maintain an action only when the decedent would have been entitled to maintain an action had he survived." Estate of Stokes ex rel. Spell v. Pee Dee Family Physicians, L.L.P., 389 S.C. 343, 143, 146, 699 S.E.2d (S.C. 2010) at 146.

White Oak Estates has never asserted that the claims here are completely barred or that Decedent's recovery has been "defeated" by operation of law, such as by the running of the statute of limitations or the execution of a release. Instead, what White Oak Estates asserts is that Decedent may not bring a claim in court but must pursue her remedies in

arbitration. Thus, neither Stokes nor the wrongful death statute operate to cut off the statutory beneficiaries' rights, even if the claims had been subject to arbitration.

While dealing with a separate arbitration issue in a nursing home case and finding the arbitration agreement to be unenforceable, the Court of Appeals in Hodge v. Uni-Health Post-Acute Care of Bamberg, LLC, 422 S.C. 544, 813 S.E.2d 292(Ct.App.2018), recognized the separateness of the statutory beneficiaries/estate's claims from those of the patient/resident. In discussing the Maryland court's case of Dickerson, the Court noted that the nursing home was attempting "to use equitable estoppel against [the patient's] estate based on actions that [daughter] took *in her individual capacity*. The fact that [daughter] is *now the Personal Representative for [the patient's] [e]state* is of no moment; we will not hold this circumstance against [the patient's] [e]state. Simply put, [the patient's] [e]state is the plaintiff in this case, and Respondent has alleged no conduct on the part of [the patient's] [e]state, or by [daughter] in *her capacity as Personal Representative* of [the patient's] [e]state...." Hodge quoting Dickerson v. Longoria, 995 A.2d. 721, 743 (Md. 2010). As recognized in this discussion, actions taken by Daughter in her *individual capacity* will not be held against the estate and as the Court noted, the estate may well have other beneficiaries or creditors.

The statutory beneficiaries' claim is much more akin to the claims of the non-signatory Plaintiffs in Wilson v. Willis, 926 S.C. 326, 827 S.E.2d 167 (2019), where the South Carolina Supreme Court held the non-signatories could not be bound by the arbitration agreement. Much like the non-signatories in Wilson, the statutory beneficiaries in the instant case are not attempting to exploit or receive a direct benefit from the agreement and were not even aware of the existence of the arbitration provision.

Defendants confuse the benefit Decedent received from admission and attempt to argue the statutory beneficiaries received a benefit personally from the admission. That argument is without merit.

As the Wilson Court notes, “Equitable estoppel is ultimately a theory designed to prevent injustice, and it should be used sparingly. See Hirsch v. Amper Fin. Servs., LLC, 71 A.3d 849, 852 (N.J. 2013)(observing equitable estoppel should be used sparingly to compel arbitration and noting ‘it is more properly viewed as a shield to prevent injustice rather than a sword to compel arbitration’); 28 Am.Jr.2d Estoppel and Waiver §29 (2011)(stating equitable estoppel should be used with restraint and only in exceptional circumstances).” As further stated in Wilson, direct benefits estoppel does not apply simply because the claim relates to or arose because of the existence of the contract.

Further, Defendants’ reliance on Dean v. Heritage Healthcare of Ridgeway, LLC, 408 S.C. 371, 759 S.E.2d 727 at n3, is misplaced. The Dean court held that courts cannot refuse to enforce an arbitration agreement simply because a wrongful death claim is involved. However, courts may refuse to enforce an arbitration agreement on state law contract defenses such as the statutory beneficiaries not being parties and signatories to the agreement.

Because the statutory beneficiaries have separate and independent claims and were not covered by the scope of this agreement or parties to this agreement, the Arbitration Agreement drafted by White Oak Estates cannot reach the claims of the wrongful death statutory beneficiaries.

V. The Arbitration Agreement Does not Apply to Defendants White Oak Estates, Inc. and White Oak Manor, Inc.

The Arbitration Agreement clearly states that it is between “White Oak Estates (‘the Facility’) and Margaret Hensley (‘the Resident’). The only signatories to the Agreement were Daughter as “Resident Representative” and Karen Baker for “White Oak Estates”, the facility. No other entity or individual is identified as a party to the agreement at any point in the Arbitration Agreement. Defendants White Oak Management, Inc. and White Oak Manor, Inc. are not identified as parties to the Arbitration Agreement.

South Carolina law is clear in that White Oak’s Co-Defendants are not third-party beneficiaries to either of these contracts. South Carolina courts have held that third-party non-signatories should only be included in arbitration agreements in exceptionally limited circumstances. Wilson v. Willis, 926 S.C. 326, 827 S.E.2d 167 (2019). Further, “South Carolina contract law carries a presumption that an individual who is not a party to a contract lacks privity to enforce it”. Trancik v. USAA Insurance Company, 354 S.C. 549, 553, 581 S.E.2d 858, 861 (Ct. App. 2003). “It is to be observed that the presumption is that the parties contract for their own benefit and not for that of others not parties to the contract.” Ancrum v. Camden Water, Light and Ice Company, 82 S.C. 284, 295, 64 S.E. 151, 155 (1909). The rule of contract interpretation is to ascertain and give legal effect to the intentions of the parties as determined by the contract language. Schulmeyer v. State Farm Fire and Casualty Company, 353 S.C. 492, 495, 579 S.E.2d 132, 134 (2003). Generally, courts do not have the authority to alter a contract by construction or make new contracts for the parties and words cannot be read into a contract which give an intent not expressed within the contract. Gilstrap v. Culpepper, 283 S.C. 83, 86, 320 S.E.2d 445, 447 (1984). Only if a contract is made for the benefit of the third person and the contracting

parties intended to create a direct, rather than incidental or consequential benefit to the third person, can the third person make a claim based on the contract. Windsor Green Owners Association v. Allied Signal, Inc., 362 S.C. 12, 17, 605 S.E.2d 750, 752 (Ct. App. 2004).

As a result, Defendants White Oak Management, Inc. and White Oak Manor, Inc. are unable to carry their burden to overcome the presumption that the contract was only intended for the benefit of the parties to the contract. Therefore, the Arbitration Agreement does not extend to these Defendants.

CONCLUSION

The Court acknowledges and appreciates the amount of research and preparation for the hearing by counsel, as well as, the professionalism of counsel in their presentations to the Court. After consideration of the record, arguments of counsel, all memoranda of counsel, and the applicable law, and for the reasons set for above,

It is ordered that Defendants White Oak Estate, Inc., White Oak Management, Inc., and White Oak Manor, Inc.'s Motion to Dismiss and Compel Arbitration filed with the Court on February 19th, 2021, is respectfully denied; and

It is further ordered that Defendants White Oak Estate, Inc., White Oak Management, Inc., and White Oak Manor, Inc.'s Motion for a Protective Order or Alternatively, to Stay the Action Pending Arbitration, filed with the Court on February 19th, 2021, are denied as those motions are now moot.

IT IS SO ORDERED.

/s/Grace Gilchrist Knie

The Honorable Grace Gilchrist Knie
Resident Judge, Seventh Judicial Circuit

Date: April 9th, 2021
Spartanburg, South Carolina



Spartanburg Common Pleas

Case Caption: Terry Putman , plaintiff, et al VS White Oak Estates, Inc. , defendant,
et al
Case Number: 2020CP4203819
Type: Order/Other

IT IS SO ORDERED.

S/GRACE GILCHRIST KNIE - 2760

Electronically signed on 2021-04-09 15:07:45 page 25 of 25

STATE OF SOUTH CAROLINA)
COUNTY OF SPARTANBURG)

IN THE COURT OF COMMON PLEAS

Terry Putman, Individually and as)
Personal Representative of the Estate)
Of Margaret Hensley,)

Plaintiff,)

v.)

White Oak Estates, Inc.; White Oak)
Management, Inc.; and White Oak)
Manor, Inc.,)

Defendants.)

**FINAL ORDER REGARDING
MOTION FOR RECONSIDERATION**

C.A. Number: 2020-CP-42-03818

C.A. Number: 2020-CP-42-03819

Hearing Judge: Grace Gilchrist Knie
Counsel for Plaintiff/s: Matthew W. Christian
Counsel for Defendant/s: Joshua T. Thompson

A Rule 59(e) SCRCPP motion to reconsider and to alter or amend this Court's order issued on April 9th, 2021, has been received from the Defendants, filed with the Court on April 19th, 2021, and properly served on The Court per Rule 59(g) SCRCPP. Pursuant to Rule 59(f), SCRCPP, The Court indicated to the parties by prior order that it would decide the issue on written submissions. Further, the Court informed the parties that written submissions were not required by the non-moving party, and that the moving party could rely upon its filings or supplement. The deadlines to file written submissions regarding the motion have now passed.

After careful consideration of the able arguments and filings of Counsel and review of the record, the Court is unable to discover any material fact or principle of law that either has been overlooked or disregarded and further finds no error of law or fact not appropriately considered.

Accordingly, the Motion for Reconsideration made pursuant to Rule 59, SCRCP, ¹ is DENIED.

AND IT IS SO ORDERED.

May 28th, 2021
Spartanburg, SC

/s/Grace Gilchrist Knie
Grace Gilchrist Knie, Judge
Seventh Judicial Circuit

¹ The Court, in its discretion, has determined this Motion on the filings, without oral argument, pursuant to Rule 59(f), SCRCP.



Spartanburg Common Pleas

Case Caption: Terry Putman , plaintiff, et al VS White Oak Estates, Inc. , defendant,
et al
Case Number: 2020CP4203819
Type: Order/Other

IT IS SO ORDERED.

S/GRACE GILCHRIST KNIE - 2760

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STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF SPARTANBURG	)	C.A. No.: 2020-CP-42-_____
	)	
Terry Putman, Individually and as	)	
Personal Representative of the Estate	)	
of Margaret Hensley,	)	
	)	
Plaintiff,	)	COMPLAINT
	)	(Jury Trial Demanded)
v.	)	(Wrongful Death Action)
	)	
White Oak Estates, Inc., White Oak	)	
Management, Inc., and White Oak	)	
Manor, Inc.,	)	
	)	
Defendant(s).	)	
	)	

The Plaintiff would show this Honorable Court the following:

1. At all times relevant herein, Terry Putman is and was the daughter of Margaret Hensley and is the duly appointed Personal Representative of the Estate of Margaret Hensley, who at the time of her death was a resident of Spartanburg County, South Carolina. The Estate is administered through the Probate Court of Spartanburg County, South Carolina.

2. That Defendant White Oak Estates, Inc. (hereinafter "White Oak Estates") is a business organized and existing under the laws of the State of South Carolina. At all times relevant herein, this Defendant is and was a business which employs and/or contracts for their employment of physicians, nurses, therapists, and related staff to provide healthcare services to patients and operates nursing home facilities in the State of South Carolina. This business holds itself out as being highly capable and highly skilled at providing physician services, nursing services, long term care, rehabilitative services to

the public at large and persons such as Margaret Hensley. This Defendant owns and/or leases property, advertises, maintains agents, and transacts business deriving substantial revenue therefrom in Spartanburg County, South Carolina, both through its individual actions and in connection with its affiliated and/or parent and/or subsidiary entities of White Oak Management, Inc. and White Oak Manor, Inc. At all times relevant herein, agents, employees, servant and apparent agents of White Oak Estates acted on behalf of themselves and/or on behalf of White Oak Estates. Further White Oak Estates on behalf of itself and on behalf of White Oak Management, Inc. and White Oak Manor, Inc.

3. That Defendant White Oak Management, Inc. (hereinafter “White Oak Management”) is a business organized and existing under the laws of a state other than the State of South Carolina. This Defendant owns and/or leases property, advertises, maintains agents, and transacts business, deriving substantial revenue therefrom, in Spartanburg County, South Carolina both through its individual actions and through those of its subsidiaries, affiliates, and parent companies. Furthermore, at all times relevant herein, agents, employees, servants and apparent agents of White Oak Management acted on behalf of themselves and/or on behalf of White Oak Management and White Oak Estates. Defendant White Oak Management is and was a business which either, directly or indirectly, provided nursing home services in conjunction with its subsidiary, White Oak Estates. At all times relevant herein, White Oak Management used its position to control the management, operation, funding, and staffing at White Oak Estates, all of which directly affected resident care such as Margaret Hensley’s.

4. That Defendant White Oak Manor, Inc. (hereinafter “White Oak Manor”) is a business organized and existing under the laws of a state other than the State of South

Carolina. This Defendant owns and/or leases property, advertises, maintains agents, and transacts business, deriving substantial revenue therefrom, in Spartanburg County, South Carolina both through its individual actions and through those of its subsidiaries, affiliates, and parent companies. Furthermore, at all times relevant herein, agents, employees, servants and apparent agents of White Oak Manor acted on behalf of themselves and/or on behalf of White Oak Manor and White Oak Estates. Defendant White Oak Manor is and was a business which either, directly or indirectly, provided nursing home services in conjunction with its subsidiary, White Oak Estates. At all times relevant herein, White Oak Manor used its position to control the management, operation, funding, and staffing at White Oak Estates, all of which directly affected resident care such as Margaret Hensley's.

CORPORATE DISCUSSION

5. The Defendants were engaged in a joint venture in the operation of White Oak Estates.

6. Because of the joint venture, Defendants owed a joint and independent duty to Margaret Hensley to provide the same level of care and treatment as any other reasonably prudent similar business that owns, operates, manages, and/or controls a nursing facility would have provided under the same or similar circumstances, taking into account Margaret Hensley's known mental and physical conditions.

7. Because of their joint venture, Defendants had an independent and joint obligation to sufficiently staff White Oak Estates to ensure that each of their residents received the necessary care and services in order for them to attain or maintain the

highest practical physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.

8. This joint obligation required Defendants to base the number of registered nurses (RNs), licensed vocational nurses/licensed practical nurses (LPNs), and certified nurse aides (CNAs) to be provided at White Oak Estates not only upon the number of residents residing in their facility (commonly referred to as "resident census") but also on the intensity of nursing care required by the residents.

9. The term used by caregivers and health science literature to describe the intensity of nursing care required by a resident is "acuity level".

10. Acuity levels are reflected in the resident's "Resource Utilization Group" classification or "RUGs". RUGs are mutually exclusive categories that reflect the amount of resources that will be needed in order to meet the needs of a particular resident in nursing facilities. They are assigned to residents based on data derived from an assessment tool referred to as "Minimum Data Set" ("MDS").

11. An MDS is prepared for each resident of a nursing facility regardless of who is paying for their stay in the nursing facility. MDSs are required to be prepared when a resident initially arrives at the facility and periodically thereafter depending on the course of the resident's medical progression. At a minimum, an MDS is to be prepared for every resident in a nursing facility on a quarterly basis.

12. The completion of an MDS by a nursing facility is part of the federally mandated process for clinical assessments of all residents in nursing facilities. MDSs need to be as detailed and comprehensive as possible so that they reflect all of the needs of each of the residents in the nursing facility. When done properly, an MDS provides a

comprehensive assessment of each resident's functional capabilities and helps the staff of a nursing facility identify all of the health problems of each resident.

13. The information contained in an MDS is used to slot the resident into a RUG. RUGs are organized in a hierarchy from residents who will need the greatest amount of resources to residents who will need the least amount of resources during their stay at the nursing facility. Residents who will need the greatest amount of resources are assigned to higher groups in the RUG hierarchy. RUGs also determine the level of compensation a nursing facility will receive in order to provide the level of care necessary for each of their residents. Residents in higher RUGs place higher demands for care and services on the nursing facility and its staff. Providing care to residents in higher RUGs is more costly and is, therefore, reimbursed at a higher level.

14. The RUG assigned to a resident can be found in section Z of each resident's MDS.

15. The only way to determine the total acuity level and corresponding RUG of each of the residents at White Oak Estates on any given day is by examining section Z of every MDS in effect on that day.

16. The Centers for Medicare and Medicaid Services ("CMS") is the federal agency that is tasked with regulating all nursing facilities in this country. Through the years, CMS has sponsored multiple studies to determine the amount of time that RNs, LPNs, and CNAs in a nursing facility spend providing direct care to residents as well as other elements of resident care.

17. Because of these studies, CMS is able to set a number of hours of direct care that they expect to be provided to residents by RNs, LPNs, and CNAs based on the

nursing facility's total acuity level. This expectation is expressed in terms of "hours per patient day" or "HPPD".

18. Using the information contained in the MDSs of every resident in a nursing facility, CMS is able to determine an HPPD that is expected for each nursing facility in the country. This is referred to as the "expected HPPD". They are also able to adjust the HPPD per facility on a quarterly basis based on the updated MDSs that are provided to CMS.

19. Nursing facilities, like White Oak Estates, are required to submit an annual "cost report" to CMS known as "CMS Form 2540-10". The cost report is a financial report that identifies the costs and charges related to healthcare treatment and activities in a particular nursing facility.

20. Included in the costs are extensive details as to how much money the nursing facility spent on RNs, LPNs, and CNAs during that year. The cost report also reports the resident census, hours paid, and the hourly rate that the nursing facility paid each category of direct caregivers during that year. By dividing the paid hours by the resident census, it is possible to determine how many hours the nursing facility paid for each category of direct caregivers per resident per day for the time period covered by that particular cost report. This number is referred to as the "reported HPPD".

21. The reported HPPD is actually an inflated number due to the fact that hours paid includes sick pay and vacation pay. By removing the sick pay and vacation pay from the hours paid, the resulting HPPD would be closer to the actual HPPD provided by caregivers to residents in nursing facilities.

22. The actual HPPD for any given nursing facility can be determined by examining the data the nursing facilities use to track the number of hours their employees work. This information is easily accessed through reports that are commonly referred to as “Time Detail Reports”, “Punch Detail Data Reports”, or some other similarly named report depending on the time keeping system used by the particular nursing facility. This information can reveal the actual HPPD for any period of time including a year, a quarter, a month, or even a day.

23. Nursing facilities like White Oak Estates also report their staffing levels for a two-week period to CMS for the two weeks prior to the inspection by the local state agency in the Form 671. In South Carolina, it is South Carolina Department of Health and Environmental Control. This information is frequently used to give the facility its rating in the five-star rating system given by CMS. Frequently, nursing facilities like White Oak Estates inflate their staffing during this two-week period prior to their inspection to reflect inflated staffing numbers and to improve their five-star rating with CMS. Typically, the staffing numbers for the two-week period prior to the inspection are higher than the staffing numbers reflected in the cost report submitted to Medicare for the rest of the year.

24. According to CMS expectations in 2017, the Nursing Home Defendants failed to provide the level of staffing necessary to meet the needs of their residents. In the Form 671 which was submitted to S.C. DHEC and which was used for the five-star rating system (a number which is expected to be above the actual staffing numbers for the remainder of the year), White Oak Estates reported in 2017 that it was staffing RNs at 0.822840 HPPD. However, based on the census and acuity at the facility, CMS expected

the facility to staff RNs at 1.03076 HPPD. Therefore, White Oak Estates, by its own representation, was staffing RNs at more than twenty percent (20%) less than the expected staffing requirements for RNs by CMS for White Oak Estates. That further, the Payroll Based Journal (PBJ) information submitted by the facility reflects even lower levels of RN staffing for the relevant time period by way of RN time being staffed at 0.73 HPPD, reflecting understaffing of at least thirty percent (30%).

25. Additionally, whenever more accurate staffing information is made available to Plaintiff by way of employee timecards, the percentage of understaffing will likely be increased significantly.

26. Because RN staffing is typically the most expensive element of staffing at a nursing facility like White Oak Estates, the Defendants realized a significant savings of money in 2017 due to their understaffing.

27. Plaintiff alleges that Defendants jointly exercised control over the operation and management of White Oak Estates prior to and during Margaret Hensley's period of residency therein, including but not limited to, the creation, setting, funding, and/or implementation of budgets; the monitoring of resident acuity levels; the monitoring of staffing levels; control over resident admissions and discharges; and control over the number of hours of direct care provided to the residents by RNs, LPNs, and CNAs. Plaintiff alleges that each of these managerial and operational functions had a direct impact on the amount and quality of care delivered to Margaret Hensley while she resided at White Oak Estates and were taken in furtherance of the operational and managerial objectives.

28. Plaintiff alleges that Defendants engaged in the systematic process of ensuring White Oak Estates maintained the highest acuity levels possible while failing to provide sufficient and qualified staff to meet the individual needs of the residents during Margaret Hensley's period of residency therein.

29. Plaintiff alleges that understaffing, although quite profitable for the Defendants, directly resulted in their failure to provide the necessary and basic services Margaret Hensley needed in order to prevent her from suffering injuries, skin breakdown, and infection.

30. Because of their joint venture, Defendants had a joint obligation to sufficiently fund White Oak Estates to ensure that each of their residents received the necessary care and services in order for them to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with their residents' comprehensive assessments and plans of care.

31. This joint obligation required Defendants to sufficiently fund White Oak Estates so that there would be enough staff and resources in order to meet the needs of their residents.

32. White Oak Estates was totally dependent on Defendants' generosity in their decision-making process as to whether they would allow them to keep the money they were earning.

33. The cost reports mentioned include information regarding transactions with what are referred to as "related parties". CMS considers a party to be "related" to a nursing facility when the nursing facility "to a significant extent is associated or affiliated

with or...is controlled by the organization furnishing the services, facilities, or supplies.”

42 C.F.R. §413.17(b)(1).

34. Federal law requires nursing facilities to disclose information on related parties that meet the following criteria:

- a. Anyone with direct or indirect ownership in the nursing facility of 5% or more;
- b. Officers, directors, and partners;
- c. Managing employees; and
- d. Anyone who is an “additional disclosable party” which is defined as any person or entity who:
 - 1) exercises operation, financial, or managerial control over the nursing facility or a part thereof, provides policies or procedures for any of the operations, or provides financial or case management services to the nursing facility;
 - 2) leases or subleases real property to the nursing facility, or owns a whole or part interest of 5% or more of the total property value of the nursing facility; or
 - 3) provides management services, administrative services, clinical consulting services, accounting services, or financial services to the nursing facility.

(See 24 U.S.C. §1320a-3)

35. By definition, the Nursing Home Defendants other than White Oak Estates are among a group of corporations that would be considered “related parties” of White Oak Estates.

36. Cost reports submitted by or on behalf of White Oak Estates reveal excessive payments to related parties during the relevant time period with regard to related party/home office costs in the amount of \$1,388,825.00 which represented more than \$477,311.00 in non-allowable payments according to CMS. This payment

amounted to additional unnecessary large profits for the related party Defendants and siphoned money from the facility that was necessary for resident care.

37. White Oak Estates could not have continued doing business except for the continual influx of substantial amount of cash from Defendants. See *Cupples Coiled Pipe, Inc. v. Esco Supply Co.*, 591 S.W.2d 615, 618 (Tex. Civ. App. 1979) writ refused NRE (May 14, 1980).

38. Plaintiff alleges that while holding White Oak Estates out to Plaintiff and other members of the public as providing excellent care, Defendants and their related parties extracted considerable profits through the management and operation of White Oak Estates by overpaying Defendants herein and other related parties from funds which should have been utilized instead to hire, train, and retain a sufficient number of qualified staff to meet the needs of all of their residents including Margaret Hensley.

39. Plaintiff alleges that this siphoning left White Oak Estates with insufficient cash to provide sufficient and qualified staff to meet the individual needs of the residents in their facility during Margaret Hensley's period of residency therein.

40. Plaintiff alleges that throughout 2017, Defendants through their operational, budgetary, consultation, and managerial decisions and actions provided grossly inadequate funding as measured by the nature and magnitude of the corporate undertaking of ensuring that each of their residents received the necessary care and services in order for them to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with each resident's comprehensive assessments and plans of care including those of Margaret Hensley.

41. In other words, Defendants' actions in 2017 resulted in an underfunded nursing home during Margaret Hensley's residency.

42. That further, at no point did Defendants ever advise Margaret Hensley and her family that there was insufficient staff at the facilities to provide the necessary care for Margaret Hensley.

43. Plaintiff alleges that this underfunding and corresponding understaffing, although profitable for Defendants and their related parties, directly resulted in their failure to provide the necessary and basic services to Margaret Hensley that she needed in order to prevent him from sustaining injuries.

CLINICAL DISCUSSION

44. Margaret Hensley was admitted to the Defendants' facility at White Oak Estates on or about August 29, 2017 for short-term rehabilitation after undergoing a hip arthroplasty.

45. As a result of the hip surgery, she received an articulating brace for her leg to help keep the leg immobile. An abrasion/discoloration existed near the area of the brace on the right lower leg at the time of admission. No care plan was ever enacted with regards to this abrasion/discoloration on the right lower leg and right lower medial calf/leg.

46. Orders were given on August 30, 2017 regarding the treatment for the right lower leg. By September 11, 2017, the area on the right inner calf had become unstageable.

47. The right lower extremity wound continued to worsen and deteriorate. Despite the worsening of the wound, Margaret Hensley would go multiple days without

nurses charting in the departmental notes/nursing notes. In fact, there was no charting in the departmental notes/nursing notes from September 4, 2017 until September 14, 2017 and then again from September 15, 2017 until September 18, 2017 and then again from September 19, 2017 until September 23, 2017. Further, none of the departmental notes/nursing notes mention the right lower extremity wound on her calf/shin area.

48. That further, the Minimum Data Set (MDS) submitted to Medicare under the penalty of perjury did not mention the wound to the right lower extremity.

49. That on September 12, 2017, when Margaret Hensley went to Dr. Sanchez for a follow-up visit from the hip surgery, the wound had deteriorated to the extent that Dr. Sanchez made a referral to the wound care center due to the right lower extremity wound and gave further order for wound care to be conducted at White Oak Estates.

50. That Margaret Hensley continued to show signs and symptoms of deterioration in her wound and began to show signs and symptoms of infection as a result of her wound.

51. That on September 20th, physical therapy records reflect that Margaret Hensley felt bad all over secondary to wound treatment earlier and that she complained of pain all over.

52. That further, physician notes from September 20, 2017 at White Oak Estates reflect that the wound nurse at White Oak Estates communicated that there were no complications with Margaret Hensley's wound but that she would be going to the wound center the following week for evaluation.

53. On September 22nd, physical therapy notes reflect that Margaret Hensley was complaining of burning in the right lower extremity wound.

54. Despite continued deterioration of Margaret Hensley's wound and sign and symptoms of infection, Margaret Hensley was not transported to the hospital.

55. By September 23rd, Margaret Hensley's white blood cell count was at 24.9 reflective of significant infection. Additionally, other labs for Margaret Hensley during her admission reflected her ongoing infection.

56. Finally, on September 23rd, Defendants requested that Margaret Hensley be emergently transported to Spartanburg Regional Medical Center where she was admitted with altered mental status, tachycardia, hypoxia, and complaining of "everything hurts" and difficulty breathing.

57. The emergency room records at Spartanburg Regional further note that the hospital staff was concerned about Margaret Hensley's hypoxia which had existed since at least EMS had arrived at the nursing home. Furthermore, the emergency room records indicate that Margaret Hensley had "sepsis and sig. RLE wound infection". The emergency room records also note that surgery was examining the wound and she would likely need an admission to the ICU. It was noted that she had sepsis and resulting cardiac failure. It was further noted that the sepsis was "likely from leg wound". The notes also reflect that "surgery eval this [sic] and they spoke with family about possible amputation" but medical management was pursued.

58. The Spartanburg Regional records also reflected that she had developed A-fib RVR which was likely a response to the sepsis and that her INR was already significantly elevated.

59. The hospital records further reflect that Margaret Hensley was at high risk for surgery, "her prognosis was felt to be poor with conservative management and with

surgery”. As a result of Margaret Hensley’s injuries, she continued to deteriorate and died on September 25, 2017 as a result of sepsis from the right lower extremity wound.

60. That in addition to the above-referenced injuries, Margaret Hensley suffered with multiple other areas of skin breakdown, bedsores, pressure ulcers, and the worsening thereof. Further, she suffered with significant weight loss during her admission as well, all of which was caused by substandard poor care at the Defendants’ facility.

61. That the Defendants were aware of the failures to provide adequate care as described above and below and were aware of residents such as Margaret Hensley and knew that the failures existed at the facility resulting from the decisions made by the Defendants to purposely understaff and underfund the facility in a way that would maximize corporate profits for the Defendants rather than provide adequate and proper care to the residents such as Margaret Hensley. That these duties by the Defendants to the residents such as Margaret Hensley were non-delegable duties. Furthermore, the acts, omissions, and decisions of the Defendants directly affected resident care such as that of Margaret Hensley, and directly caused her injuries. The acts of the Defendants were negligent, willful, wonton, grossly inadequate, and in a reckless disregard for the safety and wellbeing of patients such as Margaret Hensley. That further, the Defendants acted as each other’s agent, alter ego, in a joint enterprise, and with an amalgamation of interest. Further, they are directly liable for their corporate and clinical negligence, all of which combined and contributed to cause Margaret Hensley’s injuries.

62. As a direct and proximate result of the Defendants’ acts and/or omissions, Margaret Hensley suffered the following injuries and damages:

- a. Skin breakdown and worsening thereof;
- b. Pressure ulcers and bedsores and worsening thereof;
- c. Worsening of infection of wounds;
- d. Nutritional compromise and weight loss;
- e. Decreased levels of cognition, health, and consciousness;
- f. Pain, suffering, stress and anxiety;
- g. Loss of enjoyment of life;
- h. Infection and sepsis;
- i. Injuries to her body;
- j. Loss of dignity;
- k. Hospitalization;
- l. Underwent medical procedures which otherwise she would not have to undergo;
- m. Death;
- n. Medical expenses; and
- o. In such and further ways as discovery and trial shall prove.

63. The Plaintiff will show that this action is brought pursuant to the wrongful death provision of South Carolina Code of Law 15-79-125, South Carolina Code of Laws pursuant to the Common Laws of the State of South Carolina. Further, this action is brought on behalf of statutory beneficiaries of the Estate of the deceased, Margaret Hensley, pursuant to the Laws of the State. The statutory beneficiaries include, but are not limited to, Terry Putman and Kevin Hensley, who have and will continue to suffer the loss of companionship, mental shock and suffering, wounded feelings, grief, sorrow, and

deprivation of society as well as the love and affection of Margaret Hensley as a direct and proximate result of Defendants' acts and/or omissions.

FIRST CAUSE OF ACTION
(Negligence as to All Defendants)

64. Plaintiff restates and re-alleges each paragraph previously pleaded as if repeated verbatim.

65. Defendants were negligent, careless, reckless, grossly negligent, willful and wanton in the following particulars:

- a. In failing to properly treat, evaluate, and obtain diagnostic measures at the appropriate times to care for Margaret Hensley;
- b. In failing to timely obtain appropriate and necessary consultations by specialists and/or other qualified physicians for the care, evaluation, and treatment of Margaret Hensley;
- c. In failing to timely and properly communicate about the care, symptoms, and treatment of Margaret Hensley among the treating and referring physicians and related medical staff;
- d. In failing to provide proper wound care;
- e. In failing to timely and appropriately monitor Margaret Hensley's nutritional and hydrational status;
- f. In failing to timely and appropriately implement intervention in a patient/resident at risk for and with obvious nutritional and hydrational decline;

- g. In failing to provide the most basic care which does not require medical training or education, but is care that if not provided, will lead to suffering and decline in health as it did in this case;
- h. In negligently hiring, retaining, and supervising staff at the Defendants' facility;
- i. In failing to provide adequate staffing, adequately paid and adequately trained staff at their facilities to care for residents such as Margaret Hensley, and with full knowledge of such inadequate staff and practices which put patients such as Margaret Hensley at risk;
- j. In having License Practical Nurses practice outside the scope of their field;
- k. In failing to provide proper, comprehensive, and timely assessments and evaluations outlining all factors for Margaret Hensley;
- l. In failing to properly design, adhere to or modify an appropriate care plan;
- m. In failing to timely and appropriately implement intervention in a patient/resident with obvious decline;
- n. In failing to properly monitor, evaluate and treat Margaret Hensley's skin conditions, pressure injuries, and skin wounds and in failing to timely notify the physicians and family about such wounds/injuries and the worsening thereof;
- o. In failing to properly assess and appreciate the severity of the wounds;

- p. In failing to have and implement appropriate infection control to prevent the spread of infection;
- q. In failing to timely turn and reposition Margaret Hensley;
- r. In failing to provide sufficient food, supplements, and fluids.
- s. In failing to have and/or implement adequate and effective policies, procedures, staff and equipment to adequately monitor, supervise and treat Margaret Hensley;
- t. In failing to follow and comply with Defendants' own policies and procedures directed at the care and treatment of the patients;
- u. In failing to properly staff, fund, operate and manage the facility to the extent that resident care was affected and caused injuries to Margaret Hensley;
- v. In negligently administering and operating the Defendants' nursing home;
- w. In failing to comply with the applicable State, and Federal Statutes and Regulations designed to protect persons such as Margaret Hensley;
- x. In failing to adequately provide care as a reasonable and prudent nursing home would do under the same or similar circumstances; and
- y. In such other and further ways as Discovery and Trial shall prove.

66. As a direct and proximate result of the Defendants' acts and/or omissions, Plaintiff's decedent, Margaret Hensley, suffered injuries and damages as set forth herein and above.

FOR A SECOND CAUSE OF ACTION
(Ordinary Negligence as to All Defendants)

67. Plaintiff restates and re-alleges each and every paragraph previously pled herein as if repeated verbatim.

68. Defendants were negligent, careless, reckless, grossly negligent, willful, and wanton in failing to provide ordinary and basic care in the following particulars:

- a. In failing to provide basic assistance with feeding and hydration;
- b. In failing to turn and reposition Margaret Hensley; and
- c. In failing to provide the most basic care which does not require medical training or education but is care that, if not provided, will lead to suffering and decline in health as it did in the case at hand.

69. As a direct and proximate result of the Defendants' acts and/or omissions, Margaret Hensley suffered injuries and damages as set forth herein and above.

FOR A THIRD CAUSE OF ACTION
(Negligence *per se* as to All Defendants)

70. Plaintiff restates and re-alleges each paragraph previously pled as if repeated verbatim.

71. The conduct of the Defendants is governed by The Adult Protection Act of South Carolina Code §43-35-5, *et seq*, The Bill of Rights for Residents of Long Term Care Facilities at South Carolina Code §44-81-10, *et seq*, South Carolina Department of Health and Environmental Control Regulations at Regulation 61-17, *et seq*, as well as similar protective Federal Regulations and Statutes by 42 U.S.C. §1396(r), *et seq*, and 42 C.F.R. §483, *et seq*.

72. The Statutes and Regulations set out above were enacted for the benefit and protection of a class of the public, of which Margaret Hensley was a member at all times relevant to this action. The Defendants violated these Statutes and Regulations in their failure to properly care for Margaret Hensley and other similarly situated patients at their facility.

73. As a direct and proximate result of the violation of these Statutes and Regulations by the Defendants, which constitutes negligence *per se*, Margaret Hensley suffered injuries and damages as set forth above.

FOR A FOURTH CAUSE OF ACTION
(Corporate Negligence as to All Defendants)

74. Plaintiff restates and re-alleges each paragraph previously pleaded as if repeated verbatim.

75. The Defendants were negligent, careless, grossly negligent, reckless, willful, wanton, and intentional in their failure to provide White Oak Estates with adequate and proper management, funding, staffing, and supplies necessary to provide for the appropriate care for residents such as Margaret Hensley and provide care within the standard of care.

76. That these Defendants, especially those other than White Oak Estates, exercised sufficient control over White Oak Estates and divested White Oak Estates of the necessary monies, finances, staff, and supplies to provide care to the residents within the standard of care and care that met the federal and state regulations and statutes which applied to White Oak Estates.

77. That Defendants other than White Oak Estates did this through a complex corporate scheme whereby such funds were divested from White Oak Estates which were

necessary for resident/patient care and were siphoned from the facility through a central cash management system where the income for the facility was swept up into a central account for the corporate Defendants, whereby other monies from White Oak Estates were siphoned from the facility through exorbitant rent, exorbitant management fees, and other exorbitant monies taken by the corporate Defendants from White Oak Estates. That these monies were divested from the facility with the full knowledge that such money was necessary for resident care.

78. As a direct and proximate result of the corporate Defendants' acts and/or omissions, Plaintiff has suffered injuries and damages as set forth hereinabove.

WHEREFORE, Plaintiff prays for judgment against all Defendants in the following particulars:

For actual, punitive and special damages in an amount to be determined by the trier of fact;

For the costs and disbursements of this action;

For the attorneys' fees and costs; and

For such other and further relief as this Court deems just and proper.

Plaintiff respectfully requests a Jury Trial.

[SIGNATURE ON NEXT PAGE]

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s/Matthew W. Christian
Matthew W. Christian
S.C. Bar No.: 70516
Attorney for Plaintiff

Greenville, South Carolina
Date: November 2, 2020

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF SPARTANBURG	)	C.A. No.: 2020-CP-42-_____
	)	
Terry Putman, Individually and as	)	
Personal Representative of the Estate	)	
of Margaret Hensley,	)	
	)	
Plaintiff,	)	COMPLAINT
	)	(Jury Trial Demanded)
v.	)	(Survival Action)
	)	
White Oak Estates, Inc., White Oak	)	
Management, Inc., and White Oak	)	
Manor, Inc.,	)	
	)	
Defendant(s).	)	
	)	

The Plaintiff would show this Honorable Court the following:

1. At all times relevant herein, Terry Putman is and was the daughter of Margaret Hensley and is the duly appointed Personal Representative of the Estate of Margaret Hensley, who at the time of her death was a resident of Spartanburg County, South Carolina. The Estate is administered through the Probate Court of Spartanburg County, South Carolina.

2. That Defendant White Oak Estates, Inc. (hereinafter "White Oak Estates") is a business organized and existing under the laws of the State of South Carolina. At all times relevant herein, this Defendant is and was a business which employs and/or contracts for their employment of physicians, nurses, therapists, and related staff to provide healthcare services to patients and operates nursing home facilities in the State of South Carolina. This business holds itself out as being highly capable and highly skilled at providing physician services, nursing services, long term care, rehabilitative services to

the public at large and persons such as Margaret Hensley. This Defendant owns and/or leases property, advertises, maintains agents, and transacts business deriving substantial revenue therefrom in Spartanburg County, South Carolina, both through its individual actions and in connection with its affiliated and/or parent and/or subsidiary entities of White Oak Management, Inc. and White Oak Manor, Inc. At all times relevant herein, agents, employees, servant and apparent agents of White Oak Estates acted on behalf of themselves and/or on behalf of White Oak Estates. Further White Oak Estates on behalf of itself and on behalf of White Oak Management, Inc. and White Oak Manor, Inc.

3. That Defendant White Oak Management, Inc. (hereinafter “White Oak Management”) is a business organized and existing under the laws of a state other than the State of South Carolina. This Defendant owns and/or leases property, advertises, maintains agents, and transacts business, deriving substantial revenue therefrom, in Spartanburg County, South Carolina both through its individual actions and through those of its subsidiaries, affiliates, and parent companies. Furthermore, at all times relevant herein, agents, employees, servants and apparent agents of White Oak Management acted on behalf of themselves and/or on behalf of White Oak Management and White Oak Estates. Defendant White Oak Management is and was a business which either, directly or indirectly, provided nursing home services in conjunction with its subsidiary, White Oak Estates. At all times relevant herein, White Oak Management used its position to control the management, operation, funding, and staffing at White Oak Estates, all of which directly affected resident care such as Margaret Hensley’s.

4. That Defendant White Oak Manor, Inc. (hereinafter “White Oak Manor”) is a business organized and existing under the laws of a state other than the State of South

Carolina. This Defendant owns and/or leases property, advertises, maintains agents, and transacts business, deriving substantial revenue therefrom, in Spartanburg County, South Carolina both through its individual actions and through those of its subsidiaries, affiliates, and parent companies. Furthermore, at all times relevant herein, agents, employees, servants and apparent agents of White Oak Manor acted on behalf of themselves and/or on behalf of White Oak Manor and White Oak Estates. Defendant White Oak Manor is and was a business which either, directly or indirectly, provided nursing home services in conjunction with its subsidiary, White Oak Estates. At all times relevant herein, White Oak Manor used its position to control the management, operation, funding, and staffing at White Oak Estates, all of which directly affected resident care such as Margaret Hensley's.

CORPORATE DISCUSSION

5. The Defendants were engaged in a joint venture in the operation of White Oak Estates.

6. Because of the joint venture, Defendants owed a joint and independent duty to Margaret Hensley to provide the same level of care and treatment as any other reasonably prudent similar business that owns, operates, manages, and/or controls a nursing facility would have provided under the same or similar circumstances, taking into account Margaret Hensley's known mental and physical conditions.

7. Because of their joint venture, Defendants had an independent and joint obligation to sufficiently staff White Oak Estates to ensure that each of their residents received the necessary care and services in order for them to attain or maintain the

highest practical physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.

8. This joint obligation required Defendants to base the number of registered nurses (RNs), licensed vocational nurses/licensed practical nurses (LPNs), and certified nurse aides (CNAs) to be provided at White Oak Estates not only upon the number of residents residing in their facility (commonly referred to as "resident census") but also on the intensity of nursing care required by the residents.

9. The term used by caregivers and health science literature to describe the intensity of nursing care required by a resident is "acuity level".

10. Acuity levels are reflected in the resident's "Resource Utilization Group" classification or "RUGs". RUGs are mutually exclusive categories that reflect the amount of resources that will be needed in order to meet the needs of a particular resident in nursing facilities. They are assigned to residents based on data derived from an assessment tool referred to as "Minimum Data Set" ("MDS").

11. An MDS is prepared for each resident of a nursing facility regardless of who is paying for their stay in the nursing facility. MDSs are required to be prepared when a resident initially arrives at the facility and periodically thereafter depending on the course of the resident's medical progression. At a minimum, an MDS is to be prepared for every resident in a nursing facility on a quarterly basis.

12. The completion of an MDS by a nursing facility is part of the federally mandated process for clinical assessments of all residents in nursing facilities. MDSs need to be as detailed and comprehensive as possible so that they reflect all of the needs of each of the residents in the nursing facility. When done properly, an MDS provides a

comprehensive assessment of each resident's functional capabilities and helps the staff of a nursing facility identify all of the health problems of each resident.

13. The information contained in an MDS is used to slot the resident into a RUG. RUGs are organized in a hierarchy from residents who will need the greatest amount of resources to residents who will need the least amount of resources during their stay at the nursing facility. Residents who will need the greatest amount of resources are assigned to higher groups in the RUG hierarchy. RUGs also determine the level of compensation a nursing facility will receive in order to provide the level of care necessary for each of their residents. Residents in higher RUGs place higher demands for care and services on the nursing facility and its staff. Providing care to residents in higher RUGs is more costly and is, therefore, reimbursed at a higher level.

14. The RUG assigned to a resident can be found in section Z of each resident's MDS.

15. The only way to determine the total acuity level and corresponding RUG of each of the residents at White Oak Estates on any given day is by examining section Z of every MDS in effect on that day.

16. The Centers for Medicare and Medicaid Services ("CMS") is the federal agency that is tasked with regulating all nursing facilities in this country. Through the years, CMS has sponsored multiple studies to determine the amount of time that RNs, LPNs, and CNAs in a nursing facility spend providing direct care to residents as well as other elements of resident care.

17. Because of these studies, CMS is able to set a number of hours of direct care that they expect to be provided to residents by RNs, LPNs, and CNAs based on the

nursing facility's total acuity level. This expectation is expressed in terms of "hours per patient day" or "HPPD".

18. Using the information contained in the MDSs of every resident in a nursing facility, CMS is able to determine an HPPD that is expected for each nursing facility in the country. This is referred to as the "expected HPPD". They are also able to adjust the HPPD per facility on a quarterly basis based on the updated MDSs that are provided to CMS.

19. Nursing facilities, like White Oak Estates, are required to submit an annual "cost report" to CMS known as "CMS Form 2540-10". The cost report is a financial report that identifies the costs and charges related to healthcare treatment and activities in a particular nursing facility.

20. Included in the costs are extensive details as to how much money the nursing facility spent on RNs, LPNs, and CNAs during that year. The cost report also reports the resident census, hours paid, and the hourly rate that the nursing facility paid each category of direct caregivers during that year. By dividing the paid hours by the resident census, it is possible to determine how many hours the nursing facility paid for each category of direct caregivers per resident per day for the time period covered by that particular cost report. This number is referred to as the "reported HPPD".

21. The reported HPPD is actually an inflated number due to the fact that hours paid includes sick pay and vacation pay. By removing the sick pay and vacation pay from the hours paid, the resulting HPPD would be closer to the actual HPPD provided by caregivers to residents in nursing facilities.

22. The actual HPPD for any given nursing facility can be determined by examining the data the nursing facilities use to track the number of hours their employees work. This information is easily accessed through reports that are commonly referred to as “Time Detail Reports”, “Punch Detail Data Reports”, or some other similarly named report depending on the time keeping system used by the particular nursing facility. This information can reveal the actual HPPD for any period of time including a year, a quarter, a month, or even a day.

23. Nursing facilities like White Oak Estates also report their staffing levels for a two-week period to CMS for the two weeks prior to the inspection by the local state agency in the Form 671. In South Carolina, it is South Carolina Department of Health and Environmental Control. This information is frequently used to give the facility its rating in the five-star rating system given by CMS. Frequently, nursing facilities like White Oak Estates inflate their staffing during this two-week period prior to their inspection to reflect inflated staffing numbers and to improve their five-star rating with CMS. Typically, the staffing numbers for the two-week period prior to the inspection are higher than the staffing numbers reflected in the cost report submitted to Medicare for the rest of the year.

24. According to CMS expectations in 2017, the Nursing Home Defendants failed to provide the level of staffing necessary to meet the needs of their residents. In the Form 671 which was submitted to S.C. DHEC and which was used for the five-star rating system (a number which is expected to be above the actual staffing numbers for the remainder of the year), White Oak Estates reported in 2017 that it was staffing RNs at 0.822840 HPPD. However, based on the census and acuity at the facility, CMS expected

the facility to staff RNs at 1.03076 HPPD. Therefore, White Oak Estates, by its own representation, was staffing RNs at more than twenty percent (20%) less than the expected staffing requirements for RNs by CMS for White Oak Estates. That further, the Payroll Based Journal (PBJ) information submitted by the facility reflects even lower levels of RN staffing for the relevant time period by way of RN time being staffed at 0.73 HPPD, reflecting understaffing of at least thirty percent (30%).

25. Additionally, whenever more accurate staffing information is made available to Plaintiff by way of employee timecards, the percentage of understaffing will likely be increased significantly.

26. Because RN staffing is typically the most expensive element of staffing at a nursing facility like White Oak Estates, the Defendants realized a significant savings of money in 2017 due to their understaffing.

27. Plaintiff alleges that Defendants jointly exercised control over the operation and management of White Oak Estates prior to and during Margaret Hensley's period of residency therein, including but not limited to, the creation, setting, funding, and/or implementation of budgets; the monitoring of resident acuity levels; the monitoring of staffing levels; control over resident admissions and discharges; and control over the number of hours of direct care provided to the residents by RNs, LPNs, and CNAs. Plaintiff alleges that each of these managerial and operational functions had a direct impact on the amount and quality of care delivered to Margaret Hensley while she resided at White Oak Estates and were taken in furtherance of the operational and managerial objectives.

28. Plaintiff alleges that Defendants engaged in the systematic process of ensuring White Oak Estates maintained the highest acuity levels possible while failing to provide sufficient and qualified staff to meet the individual needs of the residents during Margaret Hensley's period of residency therein.

29. Plaintiff alleges that understaffing, although quite profitable for the Defendants, directly resulted in their failure to provide the necessary and basic services Margaret Hensley needed in order to prevent her from suffering injuries, skin breakdown, and infection.

30. Because of their joint venture, Defendants had a joint obligation to sufficiently fund White Oak Estates to ensure that each of their residents received the necessary care and services in order for them to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with their residents' comprehensive assessments and plans of care.

31. This joint obligation required Defendants to sufficiently fund White Oak Estates so that there would be enough staff and resources in order to meet the needs of their residents.

32. White Oak Estates was totally dependent on Defendants' generosity in their decision-making process as to whether they would allow them to keep the money they were earning.

33. The cost reports mentioned include information regarding transactions with what are referred to as "related parties". CMS considers a party to be "related" to a nursing facility when the nursing facility "to a significant extent is associated or affiliated

with or...is controlled by the organization furnishing the services, facilities, or supplies.”

42 C.F.R. §413.17(b)(1).

34. Federal law requires nursing facilities to disclose information on related parties that meet the following criteria:

- a. Anyone with direct or indirect ownership in the nursing facility of 5% or more;
- b. Officers, directors, and partners;
- c. Managing employees; and
- d. Anyone who is an “additional disclosable party” which is defined as any person or entity who:
 - 1) exercises operation, financial, or managerial control over the nursing facility or a part thereof, provides policies or procedures for any of the operations, or provides financial or case management services to the nursing facility;
 - 2) leases or subleases real property to the nursing facility, or owns a whole or part interest of 5% or more of the total property value of the nursing facility; or
 - 3) provides management services, administrative services, clinical consulting services, accounting services, or financial services to the nursing facility.

(See 24 U.S.C. §1320a-3)

35. By definition, the Nursing Home Defendants other than White Oak Estates are among a group of corporations that would be considered “related parties” of White Oak Estates.

36. Cost reports submitted by or on behalf of White Oak Estates reveal excessive payments to related parties during the relevant time period with regard to related party/home office costs in the amount of \$1,388,825.00 which represented more than \$477,311.00 in non-allowable payments according to CMS. This payment

amounted to additional unnecessary large profits for the related party Defendants and siphoned money from the facility that was necessary for resident care.

37. White Oak Estates could not have continued doing business except for the continual influx of substantial amount of cash from Defendants. See *Cupples Coiled Pipe, Inc. v. Esco Supply Co.*, 591 S.W.2d 615, 618 (Tex. Civ. App. 1979) writ refused NRE (May 14, 1980).

38. Plaintiff alleges that while holding White Oak Estates out to Plaintiff and other members of the public as providing excellent care, Defendants and their related parties extracted considerable profits through the management and operation of White Oak Estates by overpaying Defendants herein and other related parties from funds which should have been utilized instead to hire, train, and retain a sufficient number of qualified staff to meet the needs of all of their residents including Margaret Hensley.

39. Plaintiff alleges that this siphoning left White Oak Estates with insufficient cash to provide sufficient and qualified staff to meet the individual needs of the residents in their facility during Margaret Hensley's period of residency therein.

40. Plaintiff alleges that throughout 2017, Defendants through their operational, budgetary, consultation, and managerial decisions and actions provided grossly inadequate funding as measured by the nature and magnitude of the corporate undertaking of ensuring that each of their residents received the necessary care and services in order for them to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with each resident's comprehensive assessments and plans of care including those of Margaret Hensley.

41. In other words, Defendants' actions in 2017 resulted in an underfunded nursing home during Margaret Hensley's residency.

42. That further, at no point did Defendants ever advise Margaret Hensley and her family that there was insufficient staff at the facilities to provide the necessary care for Margaret Hensley.

43. Plaintiff alleges that this underfunding and corresponding understaffing, although profitable for Defendants and their related parties, directly resulted in their failure to provide the necessary and basic services to Margaret Hensley that she needed in order to prevent him from sustaining injuries.

CLINICAL DISCUSSION

44. Margaret Hensley was admitted to the Defendants' facility at White Oak Estates on or about August 29, 2017 for short-term rehabilitation after undergoing a hip arthroplasty.

45. As a result of the hip surgery, she received an articulating brace for her leg to help keep the leg immobile. An abrasion/discoloration existed near the area of the brace on the right lower leg at the time of admission. No care plan was ever enacted with regards to this abrasion/discoloration on the right lower leg and right lower medial calf/leg.

46. Orders were given on August 30, 2017 regarding the treatment for the right lower leg. By September 11, 2017, the area on the right inner calf had become unstageable.

47. The right lower extremity wound continued to worsen and deteriorate. Despite the worsening of the wound, Margaret Hensley would go multiple days without

nurses charting in the departmental notes/nursing notes. In fact, there was no charting in the departmental notes/nursing notes from September 4, 2017 until September 14, 2017 and then again from September 15, 2017 until September 18, 2017 and then again from September 19, 2017 until September 23, 2017. Further, none of the departmental notes/nursing notes mention the right lower extremity wound on her calf/shin area.

48. That further, the Minimum Data Set (MDS) submitted to Medicare under the penalty of perjury did not mention the wound to the right lower extremity.

49. That on September 12, 2017, when Margaret Hensley went to Dr. Sanchez for a follow-up visit from the hip surgery, the wound had deteriorated to the extent that Dr. Sanchez made a referral to the wound care center due to the right lower extremity wound and gave further order for wound care to be conducted at White Oak Estates.

50. That Margaret Hensley continued to show signs and symptoms of deterioration in her wound and began to show signs and symptoms of infection as a result of her wound.

51. That on September 20th, physical therapy records reflect that Margaret Hensley felt bad all over secondary to wound treatment earlier and that she complained of pain all over.

52. That further, physician notes from September 20, 2017 at White Oak Estates reflect that the wound nurse at White Oak Estates communicated that there were no complications with Margaret Hensley's wound but that she would be going to the wound center the following week for evaluation.

53. On September 22nd, physical therapy notes reflect that Margaret Hensley was complaining of burning in the right lower extremity wound.

54. Despite continued deterioration of Margaret Hensley's wound and sign and symptoms of infection, Margaret Hensley was not transported to the hospital.

55. By September 23rd, Margaret Hensley's white blood cell count was at 24.9 reflective of significant infection. Additionally, other labs for Margaret Hensley during her admission reflected her ongoing infection.

56. Finally, on September 23rd, Defendants requested that Margaret Hensley be emergently transported to Spartanburg Regional Medical Center where she was admitted with altered mental status, tachycardia, hypoxia, and complaining of "everything hurts" and difficulty breathing.

57. The emergency room records at Spartanburg Regional further note that the hospital staff was concerned about Margaret Hensley's hypoxia which had existed since at least EMS had arrived at the nursing home. Furthermore, the emergency room records indicate that Margaret Hensley had "sepsis and sig. RLE wound infection". The emergency room records also note that surgery was examining the wound and she would likely need an admission to the ICU. It was noted that she had sepsis and resulting cardiac failure. It was further noted that the sepsis was "likely from leg wound". The notes also reflect that "surgery eval this [sic] and they spoke with family about possible amputation" but medical management was pursued.

58. The Spartanburg Regional records also reflected that she had developed A-fib RVR which was likely a response to the sepsis and that her INR was already significantly elevated.

59. The hospital records further reflect that Margaret Hensley was at high risk for surgery, "her prognosis was felt to be poor with conservative management and with

surgery”. As a result of Margaret Hensley’s injuries, she continued to deteriorate and died on September 25, 2017 as a result of sepsis from the right lower extremity wound.

60. That in addition to the above-referenced injuries, Margaret Hensley suffered with multiple other areas of skin breakdown, bedsores, pressure ulcers, and the worsening thereof. Further, she suffered with significant weight loss during her admission as well, all of which was caused by substandard poor care at the Defendants’ facility.

61. That the Defendants were aware of the failures to provide adequate care as described above and below and were aware of residents such as Margaret Hensley and knew that the failures existed at the facility resulting from the decisions made by the Defendants to purposely understaff and underfund the facility in a way that would maximize corporate profits for the Defendants rather than provide adequate and proper care to the residents such as Margaret Hensley. That these duties by the Defendants to the residents such as Margaret Hensley were non-delegable duties. Furthermore, the acts, omissions, and decisions of the Defendants directly affected resident care such as that of Margaret Hensley, and directly caused her injuries. The acts of the Defendants were negligent, willful, wonton, grossly inadequate, and in a reckless disregard for the safety and wellbeing of patients such as Margaret Hensley. That further, the Defendants acted as each other’s agent, alter ego, in a joint enterprise, and with an amalgamation of interest. Further, they are directly liable for their corporate and clinical negligence, all of which combined and contributed to cause Margaret Hensley’s injuries.

62. As a direct and proximate result of the Defendants’ acts and/or omissions, Margaret Hensley suffered the following injuries and damages:

- a. Skin breakdown and worsening thereof;
- b. Pressure ulcers and bedsores and worsening thereof;
- c. Worsening of infection of wounds;
- d. Nutritional compromise and weight loss;
- e. Decreased levels of cognition, health, and consciousness;
- f. Pain, suffering, stress and anxiety;
- g. Loss of enjoyment of life;
- h. Infection and sepsis;
- i. Injuries to her body;
- j. Loss of dignity;
- k. Hospitalization;
- l. Underwent medical procedures which otherwise she would not have to undergo;
- m. Death;
- n. Medical expenses; and
- o. In such and further ways as discovery and trial shall prove.

63. The Plaintiff will show that this action is brought pursuant to the Statutory Provisions for the Survival Actions, pursuant to South Carolina Code of Laws and pursuant to the Common Laws of the State of South Carolina. Further, this action is brought on behalf of heirs of the Estate of the deceased, Margaret Hensley, pursuant to the Laws of the State. The heirs include, but are not limited to, Terry Putman and Kevin Hensley.

FIRST CAUSE OF ACTION
(Negligence as to All Defendants)

64. Plaintiff restates and re-alleges each paragraph previously pleaded as if repeated verbatim.

65. Defendants were negligent, careless, reckless, grossly negligent, willful and wanton in the following particulars:

- a. In failing to properly treat, evaluate, and obtain diagnostic measures at the appropriate times to care for Margaret Hensley;
- b. In failing to timely obtain appropriate and necessary consultations by specialists and/or other qualified physicians for the care, evaluation, and treatment of Margaret Hensley;
- c. In failing to timely and properly communicate about the care, symptoms, and treatment of Margaret Hensley among the treating and referring physicians and related medical staff;
- d. In failing to provide proper wound care;
- e. In failing to timely and appropriately monitor Margaret Hensley's nutritional and hydrational status;
- f. In failing to timely and appropriately implement intervention in a patient/resident at risk for and with obvious nutritional and hydrational decline;
- g. In failing to provide the most basic care which does not require medical training or education, but is care that if not provided, will lead to suffering and decline in health as it did in this case;
- h. In negligently hiring, retaining, and supervising staff at the Defendants' facility;

- i. In failing to provide adequate staffing, adequately paid and adequately trained staff at their facilities to care for residents such as Margaret Hensley, and with full knowledge of such inadequate staff and practices which put patients such as Margaret Hensley at risk;
- j. In having License Practical Nurses practice outside the scope of their field;
- k. In failing to provide proper, comprehensive, and timely assessments and evaluations outlining all factors for Margaret Hensley;
- l. In failing to properly design, adhere to or modify an appropriate care plan;
- m. In failing to timely and appropriately implement intervention in a patient/resident with obvious decline;
- n. In failing to properly monitor, evaluate and treat Margaret Hensley's skin conditions, pressure injuries, and skin wounds and in failing to timely notify the physicians and family about such wounds/injuries and the worsening thereof;
- o. In failing to properly assess and appreciate the severity of the wounds;
- p. In failing to have and implement appropriate infection control to prevent the spread of infection;
- q. In failing to timely turn and reposition Margaret Hensley;
- r. In failing to provide sufficient food, supplements, and fluids.

- s. In failing to have and/or implement adequate and effective policies, procedures, staff and equipment to adequately monitor, supervise and treat Margaret Hensley;
- t. In failing to follow and comply with Defendants' own policies and procedures directed at the care and treatment of the patients;
- u. In failing to properly staff, fund, operate and manage the facility to the extent that resident care was affected and caused injuries to Margaret Hensley;
- v. In negligently administering and operating the Defendants' nursing home;
- w. In failing to comply with the applicable State, and Federal Statutes and Regulations designed to protect persons such as Margaret Hensley;
- x. In failing to adequately provide care as a reasonable and prudent nursing home would do under the same or similar circumstances; and
- y. In such other and further ways as Discovery and Trial shall prove.

66. As a direct and proximate result of the Defendants' acts and/or omissions, Plaintiff's decedent, Margaret Hensley, suffered injuries and damages as set forth herein and above.

FOR A SECOND CAUSE OF ACTION
(Ordinary Negligence as to All Defendants)

67. Plaintiff restates and re-alleges each and every paragraph previously pled herein as if repeated verbatim.

68. Defendants were negligent, careless, reckless, grossly negligent, willful, and wanton in failing to provide ordinary and basic care in the following particulars:

- a. In failing to provide basic assistance with feeding and hydration;
- b. In failing to turn and reposition Margaret Hensley; and
- c. In failing to provide the most basic care which does not require medical training or education but is care that, if not provided, will lead to suffering and decline in health as it did in the case at hand.

69. As a direct and proximate result of the Defendants' acts and/or omissions, Margaret Hensley suffered injuries and damages as set forth herein and above.

FOR A THIRD CAUSE OF ACTION
(Negligence *per se* as to All Defendants)

70. Plaintiff restates and re-alleges each paragraph previously pled as if repeated verbatim.

71. The conduct of the Defendants is governed by The Adult Protection Act of South Carolina Code §43-35-5, *et seq*, The Bill of Rights for Residents of Long Term Care Facilities at South Carolina Code §44-81-10, *et seq*, South Carolina Department of Health and Environmental Control Regulations at Regulation 61-17, *et seq*, as well as similar protective Federal Regulations and Statutes by 42 U.S.C. §1396(r), *et seq*, and 42 C.F.R. §483, *et seq*.

72. The Statutes and Regulations set out above were enacted for the benefit and protection of a class of the public, of which Margaret Hensley was a member at all times relevant to this action. The Defendants violated these Statutes and Regulations in their failure to properly care for Margaret Hensley and other similarly situated patients at their facility.

73. As a direct and proximate result of the violation of these Statutes and Regulations by the Defendants, which constitutes negligence *per se*, Margaret Hensley suffered injuries and damages as set forth above.

FOR A FOURTH CAUSE OF ACTION
(Corporate Negligence as to All Defendants)

74. Plaintiff restates and re-alleges each paragraph previously pleaded as if repeated verbatim.

75. The Defendants were negligent, careless, grossly negligent, reckless, willful, wanton, and intentional in their failure to provide White Oak Estates with adequate and proper management, funding, staffing, and supplies necessary to provide for the appropriate care for residents such as Margaret Hensley and provide care within the standard of care.

76. That these Defendants, especially those other than White Oak Estates, exercised sufficient control over White Oak Estates and divested White Oak Estates of the necessary monies, finances, staff, and supplies to provide care to the residents within the standard of care and care that met the federal and state regulations and statutes which applied to White Oak Estates.

77. That Defendants other than White Oak Estates did this through a complex corporate scheme whereby such funds were divested from White Oak Estates which were necessary for resident/patient care and were siphoned from the facility through a central cash management system where the income for the facility was swept up into a central account for the corporate Defendants, whereby other monies from White Oak Estates were siphoned from the facility through exorbitant rent, exorbitant management fees, and other exorbitant monies taken by the corporate Defendants from White Oak Estates. That

these monies were divested from the facility with the full knowledge that such money was necessary for resident care.

78. As a direct and proximate result of the corporate Defendants' acts and/or omissions, Plaintiff has suffered injuries and damages as set forth hereinabove.

WHEREFORE, Plaintiff prays for judgment against all Defendants in the following particulars:

For actual, punitive and special damages in an amount to be determined by the trier of fact;

For the costs and disbursements of this action;

For the attorneys' fees and costs; and

For such other and further relief as this Court deems just and proper.

Plaintiff respectfully requests a Jury Trial.

CHRISTIAN & CHRISTIAN
Attorneys at Law
Post Office Box 332
Greenville, South Carolina 29602
(864) 232-7363

s/Matthew W. Christian
Matthew W. Christian
S.C. Bar No.: 70516
Attorney for Plaintiff

Greenville, South Carolina
Date: November 2, 2020

STATE OF SOUTH CAROLINA	)	
	)	IN THE COURT OF COMMON PLEAS
COUNTY OF SPARTANBURG	)	
Terry Putman, Individually and as Personal	)	
Representative of the Estate of Margaret	)	
Hensley,	)	
	)	
Plaintiff,	)	ANSWER OF DEFENDANTS TO
	)	PLAINTIFF'S COMPLAINT
v.	)	(WRONGFUL DEATH ACTION)
	)	
White Oak Estates, Inc., White Oak	)	C.A. No.: 2021-CP-42-03818
Management, Inc., and White Oak	)	
Manor, Inc.,	)	
	)	
Defendant(s).	)	

Subject to and reserving all rights pursuant to the “NOTICE OF MOTION AND MOTION TO DISMISS AND COMPEL ARBITRATION OR, ALTERNATIVELY, TO STAY THE ACTION PENDING ARBITRATION (“Motion to Compel Arbitration”) filed by Defendants White Oak Estates, Inc. (“White Oak Estates”), White Oak Management, Inc. (“White Oak Management”), and White Oak Manor, Inc. (“White Oak Manor”) (collectively, when necessary or appropriate, “Defendants”), Defendants, answering Plaintiff’s Complaint, state as follows:

1. All allegations contained in Plaintiff’s Complaint that are not hereinafter admitted, qualified, or otherwise explained are denied.

FOR A FIRST DEFENSE

2. Defendants are without sufficient information upon which to form a belief as to the allegations contained in Paragraph 1 of the Complaint and the same are, therefore, denied. Defendants specifically deny that Plaintiff brings this action appropriately in this court and assert that Plaintiff’s claims must be arbitrated for the reasons set forth in Defendants’ Motion to Compel Arbitration and any future memoranda, affidavit(s), and arguments that may be submitted or supplemented in support of the same.

3. Defendants admit so much of Paragraph 2 as alleges that White Oak Estates is a

business organized and existing under the laws of the State of South Carolina. Defendants further admit that White Oak Estates employs nurses and related staff to provide healthcare services to residents of White Oak Estates. Defendants deny that White Oak Estates employs physicians and therapists to provide healthcare services to residents of White Oak Estates. Defendants admit that White Oak Estates operates a skilled nursing facility in the State of South Carolina. Defendants admit that White Oak Estates is a skilled nursing facility that holds itself out to be competent and qualified to perform the services that it is licensed to perform. Defendants admit that White Oak Estates does business in Spartanburg County, South Carolina. All remaining allegations of this paragraph are denied.

4. Defendants admit so much of Paragraph 3 as alleges that White Oak Management does business in Spartanburg County, South Carolina. All remaining allegations of this paragraph are denied.

5. Defendants admit so much of Paragraph 4 as alleges that White Oak Manor does business in Spartanburg County, South Carolina. All remaining allegations of this paragraph are denied.

6. Defendants deny the allegations of Paragraph 5.

7. The allegations of Paragraphs 6 through 35 state legal conclusions, which require no response. To the extent a response is required, Defendants admit that they operate in compliance with all applicable state and federal regulations. All remaining allegations of these paragraphs are denied.

8. In response to the allegations of Paragraph 36, Defendants crave reference to the original cost reports submitted by or on behalf of White Oak Estates and deny all allegations set forth in this Paragraph that are inconsistent therewith. Defendants deny all remaining allegations of this Paragraph.

9. Defendants deny the allegations of Paragraphs 37 through 43, and demand strict proof thereof.

10. Defendants admit so much of Paragraphs 44 through 60 as alleges that Margaret Hensley was admitted to White Oak Estates on or about August 29, 2017. In further response to the allegations contained in these Paragraphs, Defendants crave reference to Margaret Hensley's medical records and deny all allegations set forth in these Paragraphs that are inconsistent therewith.

11. Defendants deny the allegations of Paragraphs 61 and 62.

12. The allegations of Paragraph 63 contain legal conclusions, which require no response. To the extent a response is required, the same are denied.

13. In response to the allegations of Paragraph 64, Defendants reallege and incorporate the allegations set forth above.

14. Defendants deny the allegations of Paragraphs 65 and 66, including all subparts thereof.

15. In response to the allegations of Paragraph 67, Defendants reallege and incorporate the allegations set forth above.

16. Defendants deny the allegations of Paragraphs 68 and 69, including all subparts thereof.

17. In response to the allegations of Paragraph 70, Defendants reallege and incorporate the allegations set forth above.

18. The allegations of Paragraphs 71 and 72 set forth legal conclusions, which require no response. To the extent a response is required, Defendants admit that they operate in compliance with all applicable state and federal regulations. All remaining allegations of these Paragraphs are denied.

19. Defendants deny the allegations of Paragraph 73.

20. In response to the allegations of Paragraph 74, Defendants reallege and incorporate the allegations set forth above.

21. Defendants deny the allegations of Paragraphs 75 through 78.

22. Defendants deny Plaintiff's prayer for relief.

FOR A SECOND DEFENSE

23. Defendants hereby reallege and incorporate the allegations set forth above to the extent they are consistent with this defense.

24. At the time of Margaret Hensley's admission to White Oak Estates, a Resident and Facility Admission Agreement and Arbitration Agreement was signed, expressly indicating agreement to submit any controversies or disputes to binding arbitration. Thus, this case should be dismissed or stayed and submitted to binding arbitration pursuant to Rules 12(b)(1), 12(b)(2), 12(b)(3), 12(b)(6), SCRCF and all other relevant State and Federal law.

FOR A THIRD DEFENSE

25. Defendants hereby reallege and incorporate the allegations set forth above to the extent they are consistent with this defense.

26. One or more of Plaintiff's causes of action fail(s) to state facts sufficient to constitute a cause of action and should be dismissed.

FOR A FOURTH DEFENSE

27. Defendants hereby reallege and incorporate the allegations set forth above to the extent they are consistent with this defense.

28. At all times relevant to Plaintiff's claims, White Oak Estates operated as a "nursing home" within the meaning of the South Carolina Noneconomic Damage Award Act of 2005, S.C. Code Ann. § 15-32-200, et seq.

29. Plaintiff's recovery against all Defendants, if any, is limited by and subject to the provisions of the South Carolina Noneconomic Damage Award Act of 2005, S.C. Code Ann. § 15-32-200, et seq.

FOR A FIFTH DEFENSE

30. Defendants hereby reallege and incorporate the allegations set forth above to the extent they are consistent with this defense.

31. Plaintiff's claim for punitive damages against Defendants and any award of punitive damages against Defendants would violate those clauses of the United States Constitution and the South Carolina Constitution relating to privileges and immunities, due process, and equal protection.

FOR A SIXTH DEFENSE

32. Defendants hereby reallege and incorporate the allegations set forth above to the extent they are consistent with this defense.

33. Defendants reserve their rights arising under S. C. Code Ann. § 15-32-520 as to all issues described therein.

FOR A SEVENTH DEFENSE

34. Defendants hereby reallege and incorporate the allegations set forth above to the extent they are consistent with this defense.

35. Defendants plead the limitations on punitive damages as set forth in S. C. Code Ann. § 15-32-530 as a defense.

FOR AN EIGHTH DEFENSE

36. Defendants hereby reallege and incorporate the allegations set forth above to the extent they are consistent with this defense.

37. At all times relevant to the matters set forth in the Complaint, Defendants complied

with generally accepted applicable standards of care, and as a result thereof Defendants are in no way liable to Plaintiff for the matters set forth in the Complaint.

FOR A NINTH DEFENSE

38. Defendants hereby reallege and incorporate the allegations set forth above to the extent they are consistent with this defense.

39. In the alternative, Defendants plead negligence on the part of Plaintiff, or on the part of some other party other than Defendants, as a complete or partial bar to Plaintiff's claims for damages, and would further allege that any award of damages should be reduced completely, or in part, on account of Plaintiff's and/or some other third party's proportionate negligence.

FOR A TENTH DEFENSE

40. Defendants hereby reallege and incorporate the allegations set forth above to the extent they are consistent herewith.

41. Any injuries or damages alleged by Plaintiff may have been caused, in whole or in part, by Margaret Hensley's pre-existing, genetic, and/or environmental conditions, diseases, and/or illnesses unrelated to any act or omission by Defendants.

WHEREFORE, having fully answered Plaintiff's Complaint, Defendants pray that the same be dismissed, that Defendants be granted their costs and disbursements in this action, and for such other and further relief as this Court deems just and proper.

s/Joshua T. Thompson
Joshua T. Thompson, Esq.
BOULIER THOMPSON & BARNES, LLC
P.O. Drawer 6470
Spartanburg, South Carolina 29304
Phone: (864) 606-9610
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Attorney for Defendants

February 19, 2021

Spartanburg, South Carolina

IN THE EVENT THAT THE COURT ELECTS NOT TO DISMISS THIS MATTER OR
COMPEL THE PARTIES TO SUBMIT THIS MATTER TO ARBITRATION,
DEFENDANTS DEMAND A JURY TRIAL.

STATE OF SOUTH CAROLINA	)	
	)	IN THE COURT OF COMMON PLEAS
COUNTY OF SPARTANBURG	)	
Terry Putman, Individually and as Personal Representative of the Estate of Margaret Hensley,	)	
	)	
Plaintiff,	)	ANSWER OF DEFENDANTS TO
	)	PLAINTIFF'S COMPLAINT
v.	)	(SURVIVAL ACTION)
	)	
White Oak Estates, Inc., White Oak Management, Inc., and White Oak Manor, Inc.,	)	C.A. No.: 2021-CP-42-03819
	)	
Defendant(s).	)	

Subject to and reserving all rights pursuant to the “NOTICE OF MOTION AND MOTION TO DISMISS AND COMPEL ARBITRATION OR, ALTERNATIVELY, TO STAY THE ACTION PENDING ARBITRATION (“Motion to Compel Arbitration”) filed by Defendants White Oak Estates, Inc. (“White Oak Estates”), White Oak Management, Inc. (“White Oak Management”), and White Oak Manor, Inc. (“White Oak Manor”) (collectively, when necessary or appropriate, “Defendants”), Defendants, answering Plaintiff’s Complaint, state as follows:

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2. Defendants are without sufficient information upon which to form a belief as to the allegations contained in Paragraph 1 of the Complaint and the same are, therefore, denied. Defendants specifically deny that Plaintiff brings this action appropriately in this court and assert that Plaintiff’s claims must be arbitrated for the reasons set forth in Defendants’ Motion to Compel Arbitration and any future memoranda, affidavit(s), and arguments that may be submitted or supplemented in support of the same.

3. Defendants admit so much of Paragraph 2 as alleges that White Oak Estates is a

business organized and existing under the laws of the State of South Carolina. Defendants further admit that White Oak Estates employs nurses and related staff to provide healthcare services to residents of White Oak Estates. Defendants deny that White Oak Estates employs physicians and therapists to provide healthcare services to residents of White Oak Estates. Defendants admit that White Oak Estates operates a skilled nursing facility in the State of South Carolina. Defendants admit that White Oak Estates is a skilled nursing facility that holds itself out to be competent and qualified to perform the services that it is licensed to perform. Defendants admit that White Oak Estates does business in Spartanburg County, South Carolina. All remaining allegations of this paragraph are denied.

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FOR A SECOND DEFENSE

23. Defendants hereby reallege and incorporate the allegations set forth above to the extent they are consistent with this defense.

24. At the time of Margaret Hensley's admission to White Oak Estates, a Resident and Facility Admission Agreement and Arbitration Agreement was signed, expressly indicating agreement to submit any controversies or disputes to binding arbitration. Thus, this case should be dismissed or stayed and submitted to binding arbitration pursuant to Rules 12(b)(1), 12(b)(2), 12(b)(3), 12(b)(6), SCRCF and all other relevant State and Federal law.

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FOR A SIXTH DEFENSE

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33. Defendants reserve their rights arising under S. C. Code Ann. § 15-32-520 as to all issues described therein.

FOR A SEVENTH DEFENSE

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37. At all times relevant to the matters set forth in the Complaint, Defendants complied

with generally accepted applicable standards of care, and as a result thereof Defendants are in no way liable to Plaintiff for the matters set forth in the Complaint.

FOR A NINTH DEFENSE

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39. In the alternative, Defendants plead negligence on the part of Plaintiff, or on the part of some other party other than Defendants, as a complete or partial bar to Plaintiff's claims for damages, and would further allege that any award of damages should be reduced completely, or in part, on account of Plaintiff's and/or some other third party's proportionate negligence.

FOR A TENTH DEFENSE

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41. Any injuries or damages alleged by Plaintiff may have been caused, in whole or in part, by Margaret Hensley's pre-existing, genetic, and/or environmental conditions, diseases, and/or illnesses unrelated to any act or omission by Defendants.

WHEREFORE, having fully answered Plaintiff's Complaint, Defendants pray that the same be dismissed, that Defendants be granted their costs and disbursements in this action, and for such other and further relief as this Court deems just and proper.

s/Joshua T. Thompson
Joshua T. Thompson, Esq.
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Attorney for Defendants

February 19, 2021

Spartanburg, South Carolina

IN THE EVENT THAT THE COURT ELECTS NOT TO DISMISS THIS MATTER OR
COMPEL THE PARTIES TO SUBMIT THIS MATTER TO ARBITRATION,
DEFENDANTS DEMAND A JURY TRIAL.

STATE OF SOUTH CAROLINA	)	
	)	IN THE COURT OF COMMON PLEAS
COUNTY OF SPARTANBURG	)	
Terry Putnam, Individually and as	)	
Personal Representative of the Estate	)	
Of Margaret Hensley,	)	
	)	DEFENDANTS' NOTICE OF AND MOTION
Plaintiff,	)	TO DISMISS, COMPEL ARBITRATION,
	)	AND FOR A PROTECTIVE ORDER OR,
v.	)	ALTERNATIVELY, TO STAY THE
	)	ACTION PENDING ARBITRATION
White Oak Estates, Inc.; White Oak	)	
Management, Inc.; and White Oak	)	C.A. Number: 2020-CP-42-03818
Manor, Inc.,	)	C.A. Number: 2020-CP-42-03819
	)	
Defendants.	)	
_____	)	

TO: PLAINTIFF AND HER ATTORNEY MATTHEW W. CHRISTIAN

YOU WILL PLEASE TAKE NOTICE that Defendants White Oak Estates, Inc., White Oak Management, Inc., and White Oak Manor, Inc. (collectively, "Defendants") through their undersigned attorneys, will move on the tenth (10th) day after service of this Motion, or as soon thereafter as this matter can be heard, for an Order dismissing Plaintiff's Complaint and compelling arbitration on all claims pursuant to Rule 12(b)(1), (2), (3) and (6), SCRCF, Rule 26(c), SCRCF, the Federal Arbitration Act (9 U.S.C. § 1, et seq.), and all applicable statutory and case law.

More particularly, this Motion is based on the terms and provisions of the arbitration clause found in the Resident and Facility Admission Agreement and Arbitration Agreement (Exhibit 1 to the Affidavit of Karen Baker, which is attached hereto as Exhibit A), executed at or around the time of Margaret Hensley's admission to White Oak Estates, Inc. in August 2017. The Resident and Facility Admission Agreement and incorporated Arbitration Agreement expressly provide that all disputes between the parties, their heirs, their successors, and their assigns will be resolved by binding arbitration. The Resident and Facility Admission Agreement and incorporated Arbitration

Agreement also provide that Plaintiff may not file suit against White Oak Management, Inc. and White Oak Manor, Inc.

Further, because this matter is required to be submitted to binding arbitration, Defendants respectfully request that this Court stay and protect Defendants from any requirement to file any further responsive pleading, respond to any motions filed by Plaintiff, or respond to any discovery served by Plaintiff, including but not limited to Plaintiff's First Set of Interrogatories to Defendant White Oak Estates, Inc., Plaintiff's First Requests for Production to Defendant White Oak Estates, Inc., Plaintiff's First Set of Interrogatories to Defendant White Oak Management, Inc., Plaintiff's First Requests for Production to Defendant White Oak Management, Inc., Plaintiff's First Set of Interrogatories to Defendant White Oak Manor, Inc., and Plaintiff's First Requests for Production to Defendant White Oak Manor, Inc., all of which were served on or about December 22, 2020.

Alternatively, Defendants request that these proceedings be stayed pending the outcome of arbitration pursuant to Section 3 of the Federal Arbitration Act.

In support of this Motion, Defendants will rely on all attachments filed herewith, including the Affidavit of Karen Baker (attached hereto as Exhibit A), the Affidavit of Sonia Crisp (attached hereto as Exhibit B), and any memoranda of law or exhibits that it might file before the hearing of the Motion.

s/Joshua T. Thompson
Joshua T. Thompson, Esq.
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P.O. Drawer 6470
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Attorney for Defendants

February 19, 2021
Spartanburg, South Carolina

EXHIBIT A

STATE OF SOUTH CAROLINA	)	
	)	IN THE COURT OF COMMON PLEAS
COUNTY OF SPARTANBURG	)	
Terry Putman, Individually and as	)	
Personal Representative of the Estate	)	
Of Margaret Hensley,	)	AFFIDAVIT OF KAREN BAKER
	)	
Plaintiff,	)	
	)	
v.	)	
	)	
White Oak Estates, Inc.; White Oak	)	C.A. Number: 2020-CP-42-03818
Management, Inc.; and White Oak	)	C.A. Number: 2020-CP-42-03819
Manor, Inc.,	)	
	)	
Defendants.	)	
	)	

PERSONALLY APPEARED BEFORE ME, Karen Baker, who being duly sworn,
deposes and states as follows:

(1) I am over the age of 18 and make this affidavit based on my own personal knowledge and review of information and documents available to me.

(2) At the time of Margaret Hensley's admission to White Oak Estates, Inc. in August 2017, I served as the Business Office Assistant for White Oak Estates, Inc. I continue to be employed by White Oak Estates, Inc. presently.

(3) As the Business Office Assistant for White Oak Estates, Inc. at the time of Margaret Hensley's admission in August 2017, I have knowledge of and was involved in the facility admissions process.

(4) Copies of the Resident and Facility Admission Agreement, Arbitration Agreement, and Resident Representative Agreement related to Margaret Hensley's August 2017 admission to White Oak Estates, Inc. are attached to my Affidavit as Exhibit 1. These documents have been maintained by White Oak Estates, Inc. in the regular course of business.

(5) I executed the Resident and Facility Admission Agreement, Arbitration Agreement, and Resident Representative Agreement attached as Exhibit 1 on behalf of White Oak Estates, Inc. and was authorized to do so in my position as Business Office Assistant.

FURTHER AFFIANT SAYETH NOT.

By: Karen Baker
Karen Baker

SWORN to before me this

18 day of Feb, 2021.

Beverly Villalobos
Notary Public for South Carolina

My Commission Expires: Oct 21, 2024

EXHIBIT 1



RESIDENT AND FACILITY
ADMISSION AGREEMENT

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RESIDENT AND FACILITY ADMISSION AGREEMENT**PLEASE READ CAREFULLY AND ASK ANY QUESTIONS**

This Agreement is made by and between White Oak Estates (hereinafter called "Facility") and Resident and his/her Resident Representative and/or the individual who has access to Resident's income and financial resources available to pay for nursing care (hereinafter called "Resident Representative") for the provision of nursing services for Margaret Hensley (hereinafter called "Resident").

Resident and/or Resident Representative affirm that the information provided during the admission process is true and correct to the best of their knowledge, and acknowledge that the submission of any false information may constitute grounds to terminate this Agreement.

Identification of Resident Representative (if applicable):

The Resident Representative is anyone authorized by the Resident or by law to act on the Resident's behalf. Please check the type and scope of authority for anyone other than the Resident who signs this Agreement.

TYPE (Check one)

- ☐ General POA*
- ☒ Durable POA*
- ☒ Durable POA w/ Healthcare*
- ☐ Guardianship / Conservatorship*
- ☐ Healthcare POA*
- ☐ Other: _____

SCOPE (check all that apply)

- ☐ Routine health care
- ☐ Unlimited health care
- ☐ Limited access to income / finance
- ☐ Authorized to accept income and control financial resources of Resident

*** Must provide copies of any and/or all documents checked above**

The Resident Representative, by signing this Agreement, acknowledges acceptance of the duties and responsibilities of this role.

The Resident Representative will not incur personal financial liability except for breach of duty or contract related to the misuse of Resident's resources or the failure to use those resources to pay for the Resident's care.

PRELIMINARY STATEMENTS:

Resident individually or by and through Resident's Resident Representative has considered appropriate care settings and is desirous of receiving care at the Facility.

Facility is a licensed nursing facility and will provide the services set forth below in accordance with the applicable standards of care, none of which cause the Facility to become an insurer nor guarantor of the health and safety of the Resident, or for that matter, the insurer or guarantor of the Resident's personal property.

NOW, THEREFORE, in consideration of the prompt payment by the Resident (and the applicable state, federal, or private insurance program) of the charges made to the Resident's account in accordance with the charge structure of the Facility, and in further consideration of the mutual covenants and promises herein, the parties agree as follows:

2. PROVISION OF SERVICES

2.1. Care and Services. The Facility offers, at the Daily Rate, the following services: room accommodations, food services, licensed routine nursing services, social services, activities, housekeeping services, laundering of linens and towels, routine hair care, and resident trust fund services.

2.2. Ancillary Services and Supplies. The Facility shall make available at an additional charge, unless included in the Daily Rate, the following items and services: therapy services, medical supplies, laboratory services, pharmaceuticals, beauty/barbershop, guest meals, and toiletries for personal comfort, grooming, or hygiene, and transportation. All items and services not included in the Daily Rate, such as Medicare A or Medicaid, will be billed to the applicable payor. The Resident is responsible for all non-covered items and services, co-payments or deductible amounts, according to the Facility's Rate Schedule, as amended from time-to-time. Items and services not included in the Daily Rate will be updated periodically upon notice to residents.

2.3. Services of Other Providers. The services of outside providers such as a licensed physician, optometrist, podiatrist and/or dentist, a registered pharmacist for the provision of medications, rehabilitation therapies and diagnostic services, i.e., laboratory, x-ray and/or ambulance services, are available at the Facility or under arrangement. These services are available under guidelines and procedures established by the Facility and may be utilized by Resident at his or her own expense unless covered by another pay source. The Facility retains the right to control the source of supply of any items and contract services used within the Facility. Resident or Resident Representative has exercised freedom of choice by applying for admission to Facility and thereby agrees and contracts with Facility to provide said supply items and contract services as requested. The place of purchase for pharmaceutical items is within Resident's freedom of choice subject to the Facility's policy for Resident drugs.

2.4. Role of Attending Physician and Medical Director. The Resident shall obtain the services of a qualified physician who will provide medical care during the Resident's stay at the Facility. The Resident is free to receive care from any licensed physician who agrees to submit credentials to the Facility and adhere to the Facility's policies and procedures. If the attending physician does not meet facility and/or federal requirements, then the Facility may seek alternate coverage after discussion with you and/or your representative. You and/or your representative's choice of physician will be honored if the physician meets the requirements. The Resident elects medical group of casher as the attending physician(s). DAP (initials). The Facility is not obligated to provide Resident with any medicines, treatments, special diets or equipment without specific orders or directions from Resident's attending physician. In the event Resident's attending physician is unavailable, the Facility's Medical Director / Designee may issue appropriate orders. Resident is responsible to pay for all services or equipment ordered by Resident's attending physician or the Facility's Medical Director / Designee for Resident's care unless covered by Medicare / Medicaid or other third-party insurer.

2.5. Room Assignments. The Facility makes room and bed assignments according to availability and/or in accordance with the Resident's physical and psychosocial wellbeing, as well as resident choice when able including same sex couples. Resident acknowledges that bed assignments may be changed in order to provide a proper environment for all residents. Resident and family / Resident Representative will be notified of any room changes.

3. CHARGES

3.1. Recurring / Periodic Charges for Care and Services. Resident shall pay the Daily Rate, specified in the Rate Schedule in effect at the time the service is rendered, for routine nursing services provided to Resident. The Daily Rate may be changed from time-to-time in accordance with the provisions of Section 4.3. Charges for a resident whose payor source is other than Medicare Part A or Medicaid will begin on the designated admission date or actual admission, whichever is earlier; charges for a resident whose payor source is Medicare Part A or Medicaid will begin no earlier than the date of admission.

3.2. Additional Charges for Ancillary Services and Supplies. Resident shall pay for other services and supplies provided by or through the Facility which are not covered by the Daily Rate as set forth in the Rate Schedule in effect at the time such ancillary services or supplies are rendered. Any items ordered by a physician, which are not identified on the Rate Schedule, will be provided at charges identified by the Facility. The charges for ancillary services and supplies are subject to change from time-to-time.

3.3. Charges for Outside and Non-Facility Services. In addition to the Facility's charges, Resident shall pay all fees and costs for goods or services furnished to or for Resident by anyone other than the Facility as described in Section 2.3 (Services of Other Providers) unless otherwise covered in full by Medicare or Medicaid or another third-party payor. Resident or Resident Representative is obligated to pay such fees and costs whether the goods and services are furnished by a person or provider made available by the Facility, or by a person or provider selected by Resident, and whether the goods or services are provided at the Facility or elsewhere. These fees and costs are not included in the Daily Rate. Fees for professional services rendered by a physician are not included in the

Daily Rate and will be charged directly to the Resident by the physician.

4. PERIODIC BILLINGS AND PAYMENT DUE DATE

4.1. Monthly Statements and Other Billings. Prepayment for one (1) month of the basic monthly rate is required at the time of admission. The Facility will mail Resident or Resident Representative on or about the fifth (5th) day of the month a billing statement reflecting charges for care and services for the upcoming month and charges for ancillary services and supplies which were incurred in the prior month. Statements are due and payable upon receipt of the Monthly Statement.

Resident expecting Medicare coverage specifically understands that Medicare co-insurance is the responsibility of the Resident. Payment of co-insurance is required. Payment for Medicare services is not expected until services are rendered.

4.2. Failure to Pay and Cost of Collection. Failure to pay an account at the Facility when due is a breach of this Agreement and will allow Facility to discharge Resident upon giving a thirty (30) day written notice, during which thirty (30) day period the breach may be cured by payment of the account in full.

In the event the Facility initiates legal action, which may include the appointment of a Special Conservator for the resident, to collect payments due from the Resident under this Agreement, and the Facility is successful, the Resident and/or Resident Representative shall be responsible for reimbursing the Facility for all costs and expenses thereby incurred, including reasonable attorneys' fees.

4.3. Modification of Charges. The Facility reserves the right to change the Rate Schedule reflecting the amount of any of its charges or how and when charges are computed, billed or become due. The Facility shall provide sixty (60) days advance written notice of any such changes.

4.4. Obligations of Resident's Estate and Assignment of Property. Resident and Resident Representative acknowledge the charges for services provided under this Agreement remain owed until paid. In the event of Resident's discharge for any reason, including death, this Agreement shall operate as an assignment, transfer and conveyance to the Facility of so much of Resident's property as is equal in value to the amount of any unpaid obligations under this Agreement. This assignment shall be an obligation of Resident's estate and may be enforced against the Resident's estate.

4.5. Change in Contact Information. Resident and/or Resident Representative agree to notify the Facility within ten (10) days of any change in Resident Representative's contact information.

5. MEDICARE / MEDICAID PROGRAMS

5.1. Participation in Programs. The Facility currently participates in the South Carolina / North Carolina Medicaid program and the federal Medicare program. The Facility reserves the right to withdraw from the Medicaid or Medicare programs at any time in accordance with law.

5.2. Actions of Medicaid and Medicare Agencies. The South Carolina / North Carolina Department of Health and Human Services ("DHHS") is responsible for administering benefits under the Medicaid program. The Centers for Medicare and Medicaid Services ("CMS"), of the United States Department of Health and Human Services, is responsible for administering the Medicare program through an intermediary. Resident acknowledges that the Facility is not responsible for, and has made no representations regarding, the actions or decisions of DHHS, CMS or the Medicare intermediary in administering the programs.

5.3. Medicaid Benefits.

5.3.1. Obligations of Resident. Resident is obligated to make full and complete disclosure regarding all financial resources and income during the application process. Failure to identify all resources and income, or the submission of false information, may result in the termination of this Agreement. Resident is obligated to notify the Facility when Resident's resources available to satisfy the Resident's financial obligations under this Agreement are no longer sufficient to pay all the Facility charges for Resident's care and services or when directed to do so by the Facility. Resident shall provide any documentation requested by the County Medicaid Office. Upon Facility's request, Resident shall execute an authorization for Facility to assist the Resident in securing Medicaid benefits, pursuing a hardship waiver, and bringing Resident's account current. In the event Resident applies for Medicaid benefits, Resident shall continue to pay and apply all of Resident's available resources toward the fulfillment of Resident's financial obligations under this Agreement while the Medicaid application is pending an eligibility determination by DHHS.

5.3.2. Recurring Liability Amount. For residents approved for Medicaid benefits, the Facility will accept payment from the State of South Carolina / North Carolina and, if applicable, the Resident's Recurring Liability Amount as determined by DHHS as payment in full only for those services covered by the Medicaid program. Resident remains obligated to pay such Recurring Liability Amount on a monthly basis. Services not covered by Medicaid are identified in the Rate Schedule and Resident remains obligated to pay for such services. If Resident plans to apply for Medicaid, then the Resident will have an estimated monthly Recurring Liability in the amount of \$ 30 less until the State determines the amount of Resident's income to be paid to the Facility. Once the approved Recurring Liability amount has been set by Medicaid, any differences must be paid or adjusted. The Recurring Liability amount is due to the Facility by the fifth (5th) day of the month. JKP (initials)

5.3.3. Determination of Eligibility. Resident and Resident Representative are obligated to cooperate fully in any Medicaid eligibility determination or re-determination process. In the event that Resident's eligibility for Medicaid benefits is denied, interrupted or terminated due to the failure of Resident or Resident Representative to cooperate in the Medicaid application, re-determination or appeal process, the Resident and Resident Representative shall be liable for the Daily Rate plus charges for ancillary services and supplies during any period of ineligibility, and the Facility may terminate this Agreement.

5.3.4. Authorization to Apply for and/or Appeal (Medicaid). In the event of Resident's incapacity and in situations where Resident's resources are depleted or appear to be depleted to the extent that Resident can no longer pay privately for nursing care, and it appears that Resident has become or will become eligible for Medicaid benefits to cover the cost of Resident's continued stay in the Facility; and if there is no other legal representative of Resident known to the Facility or other friend or relative known to the Facility who is authorized and/or is available or willing to act on Resident's behalf, after the Facility has made a good faith effort to identify such persons; then Resident hereby authorizes the Facility to request, file and/or apply for Medicaid benefits on behalf of Resident for the limited purpose of assisting Resident to secure payment through the Medicaid program for Resident's continued stay in the Facility. In the event the application for Medicaid benefits filed on behalf of the Resident is denied, or in the event Medicaid benefits are granted and subsequently discontinued, Resident hereby authorizes the Facility to file on Resident's behalf an appeal of any such denial of Medicaid eligibility or discontinuance of Medicaid benefits, and to take such actions to secure Resident's Medicaid benefits as the Facility deems reasonably necessary or appropriate and consistent with law. Resident warrants and represents that the financial information disclosed in the admission process is true and accurate and may be relied on by the Facility in pursuing Medicaid benefits on behalf of Resident.

5.3.5. Authorization to File a Hardship Waiver with DHHS on Behalf of Resident.

If DHHS' application of a transfer of assets penalty operates to deprive Resident of medical care such that Resident's life would be in danger, or would deprive Resident of food, clothing or shelter, or the necessities of life, then in the event of Resident's incapacity, inability or unwillingness to act, and if there is no other Resident Representative of Resident known to the Facility or any other friend or relative known to the Facility who is authorized and/or is promptly available or willing to act timely on behalf of Resident, then Resident authorizes Facility to file a Hardship Waiver with DHHS on Resident's behalf.

5.4. Medicare Part A and Part B Benefits. To the extent that Resident is a beneficiary under either Medicare Part A or Medicare Part B insurance and the nursing services or ancillary services or supplies ordered by a physician are covered by such insurance, the Facility or other provider will bill the charges for the covered services or supplies to the Medicare program. The Resident is responsible for and shall pay any co-insurance or deductible amounts under Medicare Part A or Part B insurance. The Facility shall accept payment from the Medicare intermediary as payment in full only for those services deemed to be covered in full under the Medicare Part A or the Medicare Part B program. Services not covered by Medicare are identified in the Rate Schedule.

5.5. Medicare Part B Payment Limitations: Therapy Caps.

5.5.1. General. Effective January 1, 2006, CMS imposed payment limitations on covered therapy services provided to individuals who are eligible beneficiaries under Medicare Part B. Under this financial limitation, Medicare will pay an annual capped amount for physical and speech therapy (combined) and an annual capped amount for occupational therapy. The capped amounts are revised by CMS annually. Facility shall provide Resident and/or Resident Representative with notice of the current capped amounts as appropriate.

5.5.2. Resident's Responsibility to Pay for Therapy Services Beyond the Capped

Amounts. Resident is responsible to pay the charges for all medically necessary therapy services in excess of the annual capped amounts, unless such therapy services are covered in whole or in part by private insurance or another government reimbursement program. In the event that another government reimbursement program or available third-party payor or insurance program denies coverage for therapy services provided to Resident after exhaustion of the annual capped amount, then Resident or Resident Representative shall remain responsible to pay all fees and costs for all such therapy services. If Resident is not eligible for Medicaid, then failure to pay for therapy services rendered above the capped amount shall be grounds for termination and discharge from Facility pursuant to Section 10 of this Agreement.

5.5.3. Exception Requests.

5.5.3.1. Automatic Exceptions. Medicare beneficiaries may be automatically exempted from the annual therapy caps for certain conditions or complexities that have a direct and significant impact on the need for the course of therapy being provided and the additional treatment is medically necessary.

5.5.3.2. Manual Exceptions. Medicare beneficiaries not automatically exempted from the annual therapy caps are entitled to request an exception to the annual therapy caps, for up to fifteen (15) additional treatment days. In the event that Resident has exhausted the annual capped amount, and is not automatically exempted from the therapy caps, then the following shall apply:

5.5.3.2.1. Resident and/or Resident Representative may submit an exception request to the applicable CMS Medicare contractor; or

5.5.3.2.2. In the event of Resident's incapacity, and if there is no other legal representative of Resident known to the Facility or any other friend or relative known to the Facility who is authorized and/or is promptly available or willing to act timely on behalf of Resident, then Resident authorizes Facility to submit an appropriate exception request to the applicable CMS Medicare contractor.

5.5.3.2.3. If the exception request is granted, then therapy services provided to Resident shall be covered by Medicare for the number of additional treatments approved. Once the additional approved treatments have been exhausted, Resident shall be responsible to pay all fees and costs for additional therapy services provided as noted in Section 5.5.2.

5.5.3.2.4. If the exception request is denied, then Resident shall be responsible to pay all fees and costs for additional therapy services provided as noted in Section 5.5.2.

5.6. Medicare Part D Prescription Drug Benefits.

5.6.1. Enrollment in Medicare Part D Plan. If Resident is an eligible beneficiary under the Medicare Part D insurance program and has enrolled or has been mandatorily enrolled in a Medicare Part D Prescription Drug or Medicare Advantage Plan ("PDP"), Resident shall advise Facility in writing of Resident's chosen PDP upon admission. In the event that Resident becomes an eligible beneficiary under Medicare Part D after admission or subsequently chooses to enroll in a PDP following admission, Resident shall notify Facility in writing of Resident's chosen PDP prior to enrollment in the PDP. Resident shall advise Facility if Resident elects to change PDPs, and shall provide written notice of such election, including the name/identity of the newly selected PDP prior to the effective date of the change in the PDP. DAF (initial)

5.6.2. Resident's Responsibility to Pay for Pharmaceuticals. Resident is responsible to pay the charges for all prescription and other drugs or medications while a resident in Facility, except to the extent that such drugs and medications are covered in whole or in part by an applicable government reimbursement program. Some or all of the charges for prescription drugs and other drugs and medications may be covered by certain benefits available through Medicare Part D or other private insurance or governmental insurance/benefit programs, including Medicare Part A or B. In the event that coverage for any prescription drug, supply, medication or pharmaceutical provided to Resident is denied by any applicable governmental reimbursement program or other potentially available third-party payor or insurance program, then Resident or Resident Representative shall remain responsible to pay for all such prescription drugs, supplies, other medications or pharmaceuticals.

5.6.3. Actions of Medicare Part D Plan. Facility is not responsible for and has made no representations regarding the actions or decisions of any PDP, including, but not limited to, decisions relating to the establishment of the PDP formulary, denial of coverage issues, or contractual arrangements between the PDP and the Resident, and with respect to any decisions made by the PDP relating to any long term care pharmacy provider that may be under contract with Facility.

5.6.4. Dually Eligible Residents. If Resident becomes eligible for Medicaid at any time during Resident's stay at Facility, and also qualifies for benefits under the Medicare Program, then Resident shall be **required** to enroll in a PDP (unless covered by private insurance) to ensure coverage of Resident's prescription drug needs. Resident and/or Resident Representative shall take all necessary action to enroll Resident in a PDP, and shall advise Facility of such enrollment upon Resident's acceptance into the PDP. Resident acknowledges that should Resident fail to select a PDP, then CMS will assign Resident to a PDP. Resident shall provide written notice to Facility of the name of the Resident's PDP and the effective date of enrollment.

5.6.5. Billing and Resident Cost Sharing Obligations. To the extent that Resident is a beneficiary under Medicare Part D, and the pharmacy prescriptions and/or services ordered by a physician are covered by Medicare Part D, then the Pharmaceutical Provider (as required by law) shall bill the charges for the covered services to the

Resident's PDP. Resident is responsible for and shall pay any and all cost-sharing amounts applicable under Medicare Part D insurance. Facility shall not be responsible to pay for any fees or cost-sharing amounts, including co-insurance and deductibles, relating to the provision of covered Medicare Part D pharmaceuticals to Resident. To the extent that Resident may qualify as a "subsidy eligible individual" who would be entitled to a reduction or elimination of some or all the cost-sharing or premium amounts under the Medicare Part D benefit, Resident and/or Resident Representative has the sole responsibility to apply for such benefits.

5.6.6. Authorization to Request and/or Appeal Coverage Determinations. In the event that Resident is denied coverage under Resident's PDP for pharmaceutical services or supplies prescribed by Resident's attending physician, then the following shall apply:

5.6.6.1. Resident and/or Resident Representative may independently (i) request an exception from Resident's PDP to cover non-formulary or non-covered Medicare Part D drugs that are otherwise needed or required by Resident; (ii) file a request for a re-determination of any coverage denial issued by Resident's PDP; (iii) file an appeal with the appropriate agency and judicial tribunals to challenge any denial of a request for re-determination.

5.6.6.2. In the event of Resident's incapacity, and if there is no other legal representative of Resident known to the Facility or any other friend or relative known to the Facility who is authorized and/or is promptly available or willing to act timely on behalf of Resident, or if Resident's physician is unable or unwilling to act on behalf of Resident, then Resident authorizes Facility to (i) request an exception from Resident's PDP to cover non-formulary or non-covered Medicare Part D drugs that are otherwise needed or required by Resident; (ii) file a request for a re-determination of any coverage denial issued by Resident's PDP; (iii) file an appeal with the appropriate agency and judicial tribunals to challenge any denial of a request for re-determinations.

5.6.6.3. In the event of an initial denial of coverage by the Resident's PDP, then pending the outcome of an exception request, a request for re-determination, or an appeal, and in the event that Resident's attending physician fails to prescribe a clinically and reasonably acceptable substitute prescription medication, resident authorizes Facility Medical Director / Designee to prescribe a clinically and reasonably acceptable substitute prescription medication which is covered by Resident's PDP, if such clinically and reasonably acceptable substitute is available.

5.6.6.4. If a request for exception (filed by Resident, Facility or any other Resident Representative) is ultimately denied following either reconsideration by the PDP or appeal to an appropriate tribunal, and if the requested pharmaceuticals are deemed medically necessary by Resident's physician, and no reasonably acceptable substitute, as determined by Facility's Medical Director / Designee, from the formulary of Resident's PDP exists, then Facility shall make arrangements to provide the requested pharmaceuticals to Resident. In any such situation, Resident shall be responsible to pay all fees and costs for the non-covered pharmaceuticals, consistent with the requirements of this Section.

5.6.6.5. No Effect on Medicare Part A Covered Nursing Services. Resident's Medicare Part D prescription drug benefits do not apply while the Resident's stay in Facility is covered under Medicare Part A. While Resident is in Facility on a Medicare Part A stay, Resident's pharmaceutical needs generally are covered by the Medicare Part A program.

5.7. Non-Covered Services. Resident is and remains obligated to pay the Facility for services and supplies not covered by the Medicaid or the Medicare programs.

6. MANAGED CARE ORGANIZATIONS.

6.1. Participation in Managed Care Organizations. The Facility is an authorized provider of skilled nursing services to members of certain managed care organizations (MCOs). The MCOs for whom the Facility is an authorized provider are listed on Attachment "B".

6.2. Enrollment in a Managed Care Organization. Resident or Resident Representative shall notify the Facility in writing prior to enrolling with an MCO or switching Resident's MCO enrollment.

6.3. Actions of Managed Care Organization. Resident acknowledges that an MCO for whom the Facility is not an authorized provider may not approve payment for services provided by the Facility. Resident acknowledges that the Facility is not responsible for and has made no representations regarding the actions or decisions of any MCO for whom the Facility is an authorized provider, including decisions relating to a denial of coverage.

6.4. Obligations of Resident. The Facility will accept payment from the MCO as payment in full only for those services and supplies covered by the MCO. Resident is responsible for any co-payments or other costs assigned to Resident under the specific terms of the managed care plan. Resident also shall pay for any services or supplies not covered by the MCO under the specific terms of the managed care plan. Co-payments and other costs assigned to Resident and charges for services or supplies not covered by the specific terms of the managed care plan are identified in the Rate Schedule. Managed care plans typically require pre-authorization of services by the MCO. If Resident chooses to have services which the MCO refuses to pre-authorize, Resident shall pay the Facility for those services. Resident shall pay the Facility in a timely manner for all non-covered services retroactive to the date of the initial delivery of services.

6.5. Withdrawal from Participation in the MCO. The Facility reserves the right to terminate its contractual relationship and its status as a network or authorized provider with one or more of the listed MCOs at any time in accordance with law and the terms of the applicable agreement. In the event that the Facility terminates its contractual relationship with the MCO in which Resident is enrolled, Resident may convert his or her coverage to a health plan for which the Facility is an authorized provider or transfer to a facility that is an authorized provider for Resident's MCO. The Facility shall provide thirty (30) days advance notice of its decision to withdraw as a participating provider from Resident's MCO so Resident and the MCO can coordinate a transfer to another facility.

6.6. Notice of Change in Insurance Coverage. Resident and/or Resident Representative shall notify the Facility immediately of any change in Resident's insurance status or coverage made by the insurance carrier including, but not limited to, being dropped by the insurance carrier for any reason, or a decrease or increase in insurance benefits. Resident and/or Resident Representative shall give the Facility notice before Resident is unable to meet Resident's insurance premium or before Resident implements an increase, decrease or termination from insurance coverage.

7. DURABLE FINANCIAL POWER-OF-ATTORNEY.

Resident shall submit, as appropriate, to Facility, no later than the date of admission, a durable Power-of-Attorney executed by Resident as Principal designating someone other than the Facility or a representative or affiliate of Facility as Agent, for the limited purpose of financial decisions and payment of services. In the event Resident fails to designate an Agent under a Power-of-Attorney, Resident shall be responsible to pay for any guardianship proceedings related to the appointment of someone or a legal entity to make decisions on behalf of Resident, if and when Resident lacks capacity to make such decisions as determined by Facility.

8. THIRD-PARTY PAYMENTS.

8.1. Eligibility for Third-Party Payments. Resident may be or may become eligible to receive financial assistance, reimbursement, or other benefits from third parties, such as private insurance, employee benefit plans, Medicaid under the South Carolina / North Carolina Medicaid Program, Medicare benefits, managed care coverage, supplementary medical or other health insurance, supplemental security income insurance, or old-age survivors' or disability insurance. It is the responsibility of the Resident and/or Resident Representative to apply for these benefits. If Resident is or becomes eligible to receive payments from any third parties for Resident's stay and care, the Facility reserves the right to collect such payments directly from the third-party source. The Resident and Resident Representative shall at all times cooperate fully with the Facility and each third-party payor to secure payment. Cooperation includes providing information; signing and delivering documents; and assigning to the Facility (to the extent permitted by law) any payments for the Resident from federal or state governmental assistance programs or any other reimbursements or benefits to the extent of all amounts due the Facility.

8.2. Assignment of Payments. Resident irrevocably authorizes the Facility to make claims and to take other actions to secure for the Facility receipt of third-party payments to reimburse the Facility for its charges for the stay and care of Resident. To the fullest extent permitted by law, as security for payment of the Facility's charges, Resident hereby assigns to the Facility all of Resident's rights to any third-party payments now or subsequently payable to the extent of all charges due under this Agreement. Resident or Resident Representative promptly shall endorse and turn over to the Facility any payments received from third parties to the extent necessary to satisfy the charges under this Agreement. Resident or Resident Representative shall sign any necessary documents to forward third-party payments directly from the payor to the Facility.

8.3. Insurance. The Facility will bill Medicare and Medicaid for any services rendered to Resident by the Facility. The Facility may, at its discretion, bill Resident's private / supplemental insurance carrier for services rendered to Resident by the Facility. In the event of an initial or subsequent denial of coverage by the Resident's insurance carrier, Resident shall pay the Facility timely for all non-covered services retroactive to the date of the initial delivery of services, so long as such payment obligation is consistent with the regulations governing the Facility's participation in the Medicare and Medicaid Programs. JAP (initial)

8.3.1. The fact that the Facility submits a claim for payment does not relieve the Resident from liability for the cost of care for any days determined by the Program Administrators of the particular insurance coverage as non-covered, or for the Resident's portion of the liability as determined by the appropriate Program Administrators. **Pre-certification of insurance, if required, is the responsibility of the Resident.**

9. PERSONAL FINANCES.

9.1. Personal Funds Management. Resident is responsible to provide his or her personal funds, and Resident has the right to manage his or her personal funds. Resident may authorize the Facility, in writing, on a document provided by the Facility, to hold Resident's personal funds, and may revoke at any time the Facility's authorization by providing the Facility with a written notice signed and dated by Resident or Resident Representative. If Resident authorizes the Facility to hold Resident's personal funds, the Facility shall hold, safeguard and account for Resident's personal funds in accordance with applicable provisions in the Admission Handbook. If the Facility has been appointed by the Social Security Administration as Representative Payee for the Resident's funds, then the Facility, and not the Resident's Resident Representative, if any, shall have control over the Resident's funds. The Facility shall follow the policies and procedures as set forth by the Social Security Administration.

9.2. Refunds of Personal Funds. Any personal funds or valuables of Resident held by the Facility will be refunded, subject to deductions for payment of any outstanding bills or other amounts due the Facility, such as any costs incurred by Facility to repair Resident's room for damages caused by Resident, within thirty (30) days after Resident's discharge or death. In the event of Resident's death, such refund will be made to the Resident's estate in accordance with state law.

9.3. Refunds of Prepayments or Overpayments. Any prepayments or overpayments made by Resident and held by the Facility will be refunded, subject to deductions for payment of any outstanding bills or other amounts due the Facility, after all claims have been adjudicated. In the event of Resident's death, such refund will be made to the Resident's estate in accordance with state law. No interest shall accrue on any funds required to be refunded under this Agreement.

10. TERMINATION, TRANSFER OR DISCHARGE.

10.1. Resident Initiated. This Agreement remains in full force and effect until discharge of Resident regardless of payment source changes. The Facility requests a three (3) day advance written or oral notification of an impending discharge.

10.2. Facility Initiated. The Facility may terminate this Agreement and Resident's stay and transfer or discharge Resident if:

10.2.1. The transfer or discharge is necessary to meet Resident's welfare and Resident's needs cannot be met in the Facility;

10.2.2. Resident's health has improved sufficiently so that Resident no longer needs the services provided by the Facility;

10.2.3. The safety or health of individuals in the Facility is or otherwise would be endangered;

10.2.4. Resident has failed, after notice, to pay for (or to have paid or treated as paid under the Medicare or Medicaid Programs) charges for Resident's care and stay at the Facility; or

10.2.5. The Facility ceases to operate.

10.3. Notice and Waiver of Notice. The Facility will notify Resident and Resident Representative at least thirty (30) days in advance of transfer or discharge, except in situations when appropriate plans that are acceptable to the Resident can be implemented earlier, and except in cases of emergencies, including those situations described in subparagraphs 10.2.1, 10.2.2, and 10.2.3 above, or when the Resident has not resided in the Facility for at least thirty (30) days. Then notice will be provided as soon as practicable.

10.4. Withdrawal Against Advice. In the event Resident withdraws from the Facility against the advice of his/her attending physician and/or without approval of the Facility, all of Facility's responsibilities for the care of Resident are terminated.

11. FACILITY RULES, REGULATIONS, POLICIES AND PROCEDURES.

Resident shall comply fully with all governmental laws and regulations, the provisions of this Agreement, and the Facility's rules, regulations, policies and procedures as published in the Facility's Admission Handbook or other documents or publications made available by the Facility. The Facility reserves the right to amend or change its rules, regulations, policies and procedures. The Facility's rules, regulations, policies and procedures shall not be construed as imposing contractual obligations on the Facility or granting any contractual rights to Resident, and are subject to change from time-to-time.

12. PERSONAL AND OTHER PROPERTY.

12.1. Responsibility for Maintenance and Loss. Resident is responsible for furnishing and maintaining his or her own clothing and other items of property as needed or desired. Seasonal items and clothing must be removed timely to assure the safety and comfort of the Resident. If damage or loss occurs to Resident's property, the Facility will investigate each incident of loss or damage. The Facility discourages the possession of valuables and will provide a lockbox upon request.

12.2. Disposition and Storage Upon Resident's Death. Upon the Resident's death, Facility shall contact Resident's Resident Representative and arrange for the disposition of the Resident's personal property. Facility is authorized to transfer Resident's personal property to the Resident Representative. The Resident Representative must acknowledge, in writing, the receipt of the personal property transferred to his or her custody by Facility. Facility, in its sole discretion, may move and place Resident's personal property into storage at Facility's expense. If property held in storage is not claimed within thirty (30) days, Facility shall donate or discard all unclaimed property.

12.3. Disposition and Storage Upon Resident's Transfer or Discharge. If Resident's personal property is not claimed or removed by the Resident Representative following Resident's transfer or discharge, the Facility shall move and place Resident's personal property in storage until claimed. If Resident's personal property remains unclaimed after a thirty (30) day period in storage, the Facility may dispose of Resident's property. The Facility is not responsible for any damages incurred to Resident's property if storage becomes necessary.

12.4. Damage to Room or Facility Property. Resident or Resident's estate is responsible for any damages caused to the Facility property beyond normal wear and tear, and shall pay for the repair and replacement of damaged property, based on the actual charge or cost to the Facility for such repair or replacement.

13. RESIDENT RECORDS.

Resident consents to the release of Resident's personal and medical records maintained by the Facility for treatment, payment and operations as determined reasonably necessary by the Facility. Any such release may be to the Facility's employees, agents and to other health care providers from whom the Resident receives services, to third-party payors of health care services, to any MCO in which Resident may be enrolled, or to others deemed reasonably necessary by the Facility for purposes of treatment, payment and operations. Release of records for other purposes shall be done in accordance with applicable laws, with a specific authorization from the Resident where required. Authorized agents of the state or federal government, including the Long Term Care Ombudsman, may obtain Resident's records without the written consent or authorization of Resident. Resident has the right to access his/her own records.

14. TREATMENT AUTHORIZATION.

Resident authorizes the Facility to provide care and treatment consistent with the terms of this Agreement. Resident also authorizes the Facility to obtain all necessary clinical and/or financial information from the hospital or nursing facility from which Resident may be transferring.

15. DEATH OF RESIDENT.

Upon admission, Resident is required to designate a funeral home. This designation will remain in effect until otherwise notified in writing. In the event of Resident's death, the Facility shall notify the person(s) designated by Resident. The Facility is authorized to arrange for the transfer of Resident's body to the designated funeral home. Resident's estate is responsible for the payment of all costs associated with the transfer and funeral expenses.

Resident shall notify the Facility of any changes of the person(s) or funeral home to be notified in the event of death.

16. CAPACITY OF RESIDENT AND GUARDIANSHIP.

If Resident is, or becomes, unable to understand or communicate, and is determined by Resident's Physician or the Facility's Medical Director / Designee after admission to be incapacitated, the Facility shall have the right, in the absence of Resident's prior designation of an authorized legal representative, or upon the unwillingness or inability of the legal representative to act, to commence a legal proceeding to adjudicate Resident incapacitated and to have a court appoint a guardian for Resident. The cost of the legal proceedings, including attorneys' fees, shall be paid by Resident or Resident's estate.

17. CLINICAL ISSUES RELATED TO AGING:

17.1. The Resident has been advised of the high risks and consequences associated with aging and impaired physical condition, including (but not limited to):

17.1.1. A high risk of skin breakdown and development of pressure ulcers secondary to significant time confined to bed or inability or unwillingness to eat and/or drink.

17.1.2. The risk of significant weight loss and dehydration if the Resident's physical condition is currently chronic or hereinafter deteriorates, which may diminish Resident's nutritional and hydration input.

17.1.3. The enhanced risk of falls and subsequent bruises, cuts or fractures, which then increases the already high risk of pressure ulcers.

17.1.4. The goal of the Facility is to strive for a restraint-free environment, and processes are implemented to pursue this goal. These processes recognize and protect the Resident's rights and ensure that restraints are safe and appropriate if they must be used.

17.1.5. The above risks, and others, are inherent with the aging process. We urge the Resident and all family members to further acquaint themselves with the risk issues inherent with aging and an impaired physical condition.

18. REPORTING COMPLAINTS.

If Resident and/or Resident Representative believe(s) that Resident is being mistreated in any way or Resident's rights have been violated by staff or another resident, Resident or Resident Representative shall make his/her complaint known to Facility Grievance Official (Social Service Director), Facility Administrator, or any staff member in accordance with the Grievance Procedure reflected in the Admission Handbook. This notice requirement is not intended to preclude Resident and/or Resident Representative from filing a complaint with any appropriate governmental regulatory agency at any time.

19. MISCELLANEOUS PROVISIONS.

19.1. **Governing Law.** This Agreement shall be governed by and construed in accordance with the laws of the State of South Carolina / North Carolina.

19.2. **Severability.** The various provisions of this Agreement shall be severable one from another. If any provision of this Agreement is found by a court or administrative body of proper jurisdiction and authority to be invalid, the other provisions shall remain in full force and effect as if the invalid provision had not been a part of this Agreement.

19.3. **Captions.** The captions used in connection with the sections and subsections of this Agreement are inserted only for the purpose of reference. Such captions shall not be deemed to govern, limit, modify, or in any manner affect the scope, meaning or intent of the provisions of this Agreement, nor shall such captions be given any legal effect.

19.4. **Entire Agreement.** This Agreement, the Resident Representative Agreement, the Arbitration Agreement, and the admission documentation represent the entire Agreement and understanding between the parties and supersedes, merges and replaces, all prior negotiations, offers, warranties and previous representations, understandings or agreements, oral or written, between the parties.

19.5. **Modifications.** The Facility reserves the right to modify unilaterally the terms of this Agreement to conform to subsequent changes in law, regulation or operations. To the extent reasonably possible, the Facility will give Resident and Resident's Resident Representative thirty (30) days advance written notice of any such modifications. Resident may not modify this Agreement except by a writing signed by the Facility.

19.6. **Waiver of Provisions.** The Facility reserves the right to waive any obligation of Resident under the provisions of this Agreement in its sole and absolute discretion. No term, provision or obligation of this Agreement shall be deemed to have been waived by the Facility unless such waiver is in writing by the Facility. Any waiver by the Facility shall not be deemed a waiver of any other term, provision or obligation of this Agreement, and the other obligations of Resident and this Agreement shall remain in full force and effect.

20. ACKNOWLEDGMENTS.

20.1. **Rate Schedule.** Resident acknowledges the receipt of a copy of the Rate Schedule and the opportunity to ask questions about the Facility's charges.

20.2. **Resident's Rights.** Resident acknowledges being informed orally and in writing of Resident's Rights and further acknowledges having an opportunity to ask questions about those rights. The Notice of Rights of Nursing Facility Residents is subject to change from time-to-time and shall not be construed as imposing any contractual obligations on the Facility or granting any contractual rights to Resident.

20.3. **Advance Directives.** Resident acknowledges being informed, orally and in writing, of the Facility's policy on advance directives and medical treatment decisions.

20.4. **Bed Hold Policy – Readmission.** Resident acknowledges being informed orally

of the Facility's policy on readmission and bed hold. Resident further acknowledges having received in writing a copy of the readmission bed hold policy, and an opportunity to ask questions.

20.5. Agreement. Resident acknowledges that he/she has read and understands the terms of this Agreement, that the terms have been explained to him/her by a representative of the Facility, and that he or she has had an opportunity to ask questions about this Agreement, and has received a copy of this Agreement.

20.6. Smoke-Free / Tobacco-Free Policy. Resident acknowledges that he/she has read and understands that this Facility and campus are smoke-free and tobacco-free. The terms have been explained by a representative of the Facility and he/she has had an opportunity to ask questions and has received a copy of the Smoke-free /Tobacco-free Policy.

20.7. Camera Policy. Resident acknowledges that he/she has read and understands the Facility camera policy and that the terms have been explained by a representative of the Facility and he/she has had an opportunity to ask questions and has received a copy of the camera policy.

20.8. Safe Resident Handling Program. Resident acknowledges that he/she has received an oral explanation and a copy of the safe resident handling program policy and procedures. Resident further acknowledges having an opportunity to ask questions about this policy.

20.9. Physical Device Policy. Resident acknowledges that he/she has read and understands the Facility physical device policy and that the terms have been explained by a representative of the Facility and he/she has had an opportunity to ask questions and has received a copy of the physical device policy.

20.10. Admission Handbook. Resident acknowledges the receipt of a copy of the Admission Handbook and the opportunity to ask questions about Facility's policies contained in the Admission Handbook. The Admission Handbook is subject to change from time-to-time and shall not be construed as imposing any contractual obligations on the Facility or granting any contractual rights to Resident.

20.11. Consent to Care. Resident hereby consents to all routine care and services rendered in accordance with physician's orders. Resident also consents to student care from universities or other academic programs which are under contract with the facility unless the facility receives from the Resident/Resident Representative a signed document of denial of student services. (Revised 10/2010)

20.12. Participation in Care Plan. Resident is encouraged to participate in the care planning process and has the right to see and review his/her Care Plan. Approval of the Resident Care Plan is the preferred manner in which consent for most treatment is obtained. There are certain specific procedures for which an individual consent form will be provided.

20.13. Consent to Photograph. Resident consents to pictures taken for identification purposes only.

20.14. Contents of Personal Medical Records. Resident understands and agrees that the designated record set concerning Resident is and will continue to be the property of the Facility, provided that Facility will not disclose the same to any person or party other than the Resident except as outlined in the Privacy Practices Notice. The designated record set is defined as the medical record in its entirety and the financial record including itemized charges. The following items are specifically excluded from the designated record set: incident reports, QA/QI reports, tracking forms, resident care assignment forms, shift to shift report forms, admission waiting list and financial "work papers."

20.15. Notification of Facility Symbols. Resident / Resident Representative hereby acknowledge being informed of the use of signs and symbols which may be observed in this facility. For the resident's safety and comfort, the facility may post on a doorway leading into a resident's room a symbol for type of lift device to be used or a star alerting staff to a potential fall risk. Other symbols may be used from time to time which may designate and alert staff to a specific need. You or your Resident Representative may opt out of having symbols posted by signing a waiver of release from use of facility designated symbols.

20.16. Competency. Resident declares that he or she retains capacity and is competent, has never been adjudged or determined to lack capacity or competence, and knows of no petition pending to adjudicate his or her lack of capacity or competence. Alternatively, if the Resident has been or should be deemed to lack capacity or competence, then Resident's Resident Representative declares that he or she has been given authority by the Resident when competent to ask on behalf of the Resident, and/or is qualified to act as Resident's surrogate by reason of special care and concern for the Resident, familiarity with the Resident's personal values, reasonable availability, and willingness to serve.

20.17. Scope of Care. Resident acknowledges that routine nursing services do not include: continuous one-on-one care or CNA services when required by Resident's Care plan; care for certain high acuity conditions, such as ventilator dependent care; dialysis services; treatment for drug and alcohol conditions; or psychiatric care.

20.18. Health Information Exchange / Regional Health Information Organization. Federal and state laws may permit us to participate in organizations with other healthcare providers, insurers, and/or health care industry participants and their subcontractors in order for these individuals and entities to share your health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of your health records; decreasing the time needed to access your information; aggregating and comparing your information for quality improvement purposes; and such other purposes as may be permitted by law. Information may be shared if you are an inmate or under custody of law which is necessary for your health or the health and safety of others.

21. ARBITRATION.

WITH REGARD TO ALL CLAIMS ARISING BETWEEN THE FACILITY AND RESIDENT/ RESIDENT REPRESENTATIVE, ARBITRATION (PURSUANT TO THE

FEDERAL ARBITRATION ACT) IS MANDATORY (SUBJECT TO THE "OPT OUT" PROVISIONS SET FORTH IN PARAGRAPH 17 OF THE ARBITRATION AGREEMENT), BINDING AND FINAL. THE EXACT TERMS FOR ARBITRATION ARE SET FORTH IN A SEPARATE DOCUMENT OF EVEN/ RECENT DATE, ENTITLED, "ARBITRATION AGREEMENT" AND ARE INCORPORATED HEREIN BY REFERENCE.

22. BINDING EFFECT.

This Agreement shall be binding upon all parties hereto and upon their respective heirs, personal representatives, successors and assigns.

IN WITNESS WHEREOF, the parties, intending to be legally bound hereby, have signed this Agreement this ____ day of _____, 20__.

RESIDENT / RESIDENT REPRESENTATIVE:

Margaret Hensley
Printed Resident Name

Signature / Date

Terry Putman
Printed Resident Representative

Terry Putman 8/26/17
Signature / Date

Daughter & POA
Relationship

FACILITY STAFF / WITNESS:

White Oak White Oak Estates, Inc.

Date: 8/29/17

By: KAREN BAKER POA
Staff Printed Name and Title

[Signature]
Staff Signature / Witness



ARBITRATION AGREEMENT

ARBITRATION AGREEMENT
(Pursuant to the FEDERAL ARBITRATION ACT only)
 (Effective January 1, 2017)

FOR VALUABLE CONSIDERATION the parties hereto (White Oak White Oak Estates
 ("the Facility"), and Margaret Hensley
 ("the Resident")), agree to arbitrate ALL claims that may arise between them.

Specifically, the parties hereto agree as follows:

1. When reference is made in this Agreement to "the Resident," reference is made to the person identified above. When reference is made to "the Facility," reference is made to the specific White Oak Facility at which the Resident resides. When reference is made to "the Resident Representative," reference is made to anyone signing this Agreement in behalf of the Resident. When reference is made to "ALL" claims, "all claims" is intended to include not only all claims between the Resident and the Facility, as well as claims between the Resident's heirs/beneficiaries, but also all other claims that allegedly exist between the Resident and all other "White Oak" entities, including specifically White Oak Manor, Inc. and White Oak Management, Inc.
2. All claims arising between the parties hereto will be resolved by arbitration and will be subject to the terms and provisions of this Agreement. As indicated above, this Agreement is subject to the Federal Arbitration Act only. Furthermore, although entered into by and between only the parties identified above, this Agreement also makes it such that no separate action or claims may be asserted against the Facility, or any other "White Oak" entities, nor against their officers, directors, shareholders or employees.
3. If either party to this Agreement (or any other agreements entered into between the parties hereto on or about the date hereof, the terms and provisions of which are specifically incorporated herein by reference) believes that he, she or it (hereinafter referred to as the "first party") has a claim against the other party (hereinafter referred to as the "second party"), the first party shall give the second party written notice thereof. That claim may be resolved by mutual agreement. If it is, that will conclude permanently everything arising between them prior to the date of resolution. If it is not, the parties will proceed as set forth below.
4. Within a reasonable period of time after giving written notice of a claim or claims, the first party will provide the second party, in writing, with the name of an arbitrator of the first party's choosing. If the first party is the Resident, or the Resident Representative, that party may choose, as that party's arbitrator, anyone that party wishes, provided the person chosen may not be anyone signing this Agreement, a family member, or anyone who will give testimony or provide an affidavit or other written statement at the hearing provided for below. The arbitrator chosen need not be an attorney.
5. Within ninety (90) days of receipt of written notice of the first party's choice of an arbitrator, the second party will likewise choose an arbitrator and shall give the first party

written notice thereof. If the second party is the Facility, it may not choose anyone associated with the Facility as a shareholder, officer, director, or employee, or anyone who will give testimony or provide an affidavit or other written statement for presentation at the hearing.

6. Within ninety (90) days of the second party's notification to the first party of the second party's choice of an arbitrator, or as soon thereafter as reasonably possible, the two (2) arbitrators shall confer/meet and attempt to agree upon a third arbitrator. In choosing a third arbitrator, they will be limited to choosing an attorney who is certified by the Bar Association of the state in which the Facility is located to be a mediator/arbitrator and who has substantial prior experience in mediating/arbitrating nursing home claims. In the event the two (2) arbitrators cannot agree on the third arbitrator, the two (2) arbitrators will meet, and flip a coin. The arbitrator chosen by the Facility will flip the coin. The arbitrator chosen by the Resident, while the coin is in the air, will call either heads or tails. The arbitrator "winning" the coin toss will pick the third arbitrator. The choice of the third arbitrator will be both final and binding on the parties. That arbitrator must, within thirty (30) days of being given notice of having been chosen as the third arbitrator, agree to participate in this matter as the third arbitrator, and affirm that he/she meets the requirements set forth above, and will be both fair and impartial in rendering his/her decision. If the third arbitrator so chosen does not agree to participate, the process of selecting a third arbitrator will begin again, with the procedure set forth above again followed.

7. Within ninety (90) days of the determination of the third arbitrator, or as soon thereafter as the parties may determine, a hearing ("the hearing") shall be held at a mutually convenient location before a board consisting of the three (3) arbitrators. At the hearing each side may present whatever evidence that side deems appropriate. This "evidence" may be presented in any reasonable manner, and need not conform to the normal rules of evidence utilized in a court of law. All testimony will, however, be under oath. Furthermore, to the extent reasonably possible, "hearsay," as traditionally defined, will not be allowed/received. Medical records, and other records generated by the Facility during the ordinary course of business, however, and other medical records, whose authenticity is not questioned, generated by other healthcare providers, shall be admissible, and shall not be deemed to constitute hearsay.

8. At the hearing each party may, but need not, be represented by an attorney. In other words, should the Resident wish to be represented by a family member, or someone other than an attorney, subject to the limitations set forth in paragraph 3 above, he/she may.

9. Each party will be responsible for paying his/her/its own arbitrator. As indicated below, the expense of the third arbitrator will be paid by the "non-prevailing party." Payment will be made within thirty (30) days of the arbitration panel's decision.

10. Each party shall promptly provide the other party with copies of all documents upon which the producing party intends to rely at the hearing. Under all circumstances, all such documents shall be made available to the other party at least ten (10) days prior to the hearing. If they are not, they will not be admissible at the hearing unless a majority of the arbitrators determine that, in fairness, they should be admissible.

11. Prior to the hearing, depositions may be taken. If a dispute arises regarding these depositions, the number that may be taken, their length, etc., it will be resolved by a majority of the arbitrators. Under all circumstances, this decision, and all other decisions so made will be both final and binding.

12. All time limits set forth herein may, by mutual agreement, or by a majority of the arbitrators, be extended or otherwise modified.

13. At least twenty-four (24) hours prior to the hearing, each party will submit in writing to the other party that party's demand/offer of settlement. At the hearing each party will, in writing, provide the arbitrators with that party's best demand/offer. When the arbitrators make their decision, they will be limited to selecting the demand/offer made by one of the parties. In other words, the arbitrators will not have the option of splitting the difference between the final demand and the final offer made by the parties, or by choosing any other amount other than one of the two (2) amounts demanded/offered by the parties. This decision by the arbitrators will be both final and binding, will be in writing, and will be signed by at least two (2) of the arbitrators. THE ARBITRATORS ACKNOWLEDGE THAT JUST BECAUSE THE FACILITY MAKES AN OFFER DOES NOT MEAN THAT THE FACILITY CONSIDERS ITSELF RESPONSIBLE FOR THE RESIDENT'S INJURIES/DAMAGES. IN FACT, BY MAKING AN OFFER IT IS PROBABLE THAT THE FACILITY IS MERELY TRYING TO INCREASE THE CHANCES THAT THE DIFFERENCES BETWEEN THE PARTIES CAN BE RESOLVED WITHOUT THE NEED FOR ACTUAL ARBITRATION, OR THAT THE FACILITY IS TRYING TO INCREASE THE CHANCES THAT A MAJORITY OF THE ARBITRATORS WILL SELECT THE FACILITY'S OFFER AS OPPOSED TO THE RESIDENT'S DEMAND.

14. When a final determination is made by a majority of the arbitrators, they shall also award the "prevailing party," as defined herein, reimbursement for all reasonable costs and expenses associated with the arbitration, including the third arbitrator's fees, the costs of depositions, and any other costs associated with the hearing, but excluding attorney's fees and the charges of that party's own arbitrator. In other words, each party will be responsible for paying his/her/its own attorney and arbitrator. For purposes of this Agreement, "the prevailing party" shall be the party whose final offer/demand was chosen by a majority of the arbitrators.

15. An award against the Facility will be paid within ninety (90) days after the arbitrators make their decision and notify the Facility in writing of that decision. Upon payment, the Facility, as well as all other "White Oak" entities, will be deemed to be released and forever discharged from all claims between the parties.

16. In the event payment is not timely made by the Facility, judgment against the Facility may be entered of record in any County in which the facility is located, and will accrue interest therefrom at the applicable statutory rate until payment is made.

17. At the time of signing this Agreement, the Resident/the Resident Representative acknowledges having received a copy; having been told that he/she has the right to have this Agreement reviewed by his/her attorney both prior to and after signing it; and having been

advised that he/she has thirty (30) days in which to "opt out" of this Agreement and no longer be bound. To opt out, the Resident/Resident Representative must give the Facility's administrator written notice thereof. **TIME IS OF THE ESSENCE.** By initialing here, the undersigned acknowledges having been explained this paragraph and understanding what it means.

DAD (INITIALS)

18. If signed below by the Resident, the Resident intends to indicate that he/she believes himself/herself to be mentally competent and, in signing this Agreement, to be doing so freely and voluntarily. If signed by the Resident Representative, he/she intends to indicate that he/she believes that he/she has the legal right to sign this Agreement in behalf of the Resident and thereby bind the Resident, as well as the Resident's heirs/beneficiaries to the terms and provisions of not only this Agreement, but also the terms and provisions set forth in the Admission Agreement of recent date herewith. Furthermore, if signed by the Resident Representative, the undersigned intends to indicate that he/she believes the Resident would be incapable of understanding the terms and provisions set forth herein, or has indicated to the undersigned that he/she does not want to be bothered with signing this Agreement, or for that matter any other agreements between the Resident and the Facility, including the Admission Agreement. Finally, by signing below the Resident Representative intends to indicate that to the best of his/her knowledge and belief, no other family members of the Resident would object to or take issue with the undersigned signing, in behalf of the Resident, this Agreement.

19. To the extent that any questions arise that are not covered by this Agreement, they will be resolved by a majority of the arbitrators. That decision will be both final and binding.

20. In the event any portion of this Agreement is determined to be invalid or unenforceable, the remainder will nevertheless continue in full force and effect and be binding upon the parties hereto, and upon their respective heirs, personal representatives, successors and assigns.

21. The within Arbitration Agreement constitutes the entire agreement by and between the parties hereto with regard to the resolution of issues/disputes which may arise between them. Regardless, under all circumstances it shall be considered along with the Admission Agreement also entered into by and between the parties hereto. In other words, these two (2) Agreements, and any other agreement signed at or about the time the Resident is admitted into the Facility involved, shall be considered together, and will all be construed as dealing with the healthcare that the Facility is to provide the Resident.

22. The within Arbitration Agreement incorporates all representations supposedly made at or before being signed and may not be modified or otherwise amended except by subsequent written agreement.

23. Although this Agreement provides for Arbitration as the sole method of resolving disputes/issues that arise between the parties hereto, nothing herein contained shall be construed to reduce, diminish, or have any affect upon the substantive rights the Resident may have pursuant to law. However, the applicable statute of limitations remains in full force and effect.

24. By signing below, the Resident/Resident Representative certifies that:

- (a) The terms and provisions of this Agreement were satisfactorily explained, and any questions were satisfactorily answered.
- (b) He/she was given sufficient time to read this Agreement.
- (c) He/she was given, at the time he/she signed this Agreement, a copy, as well as a copy of all other agreements entered into with the Facility.
- (d) This Agreement was entered into freely and voluntarily.
- (e) He/she was told that admission into the facility was not contingent upon this Agreement being signed.
- (f) He/she was told to contact an attorney if he/she had any questions whatsoever that were not satisfactorily answered or that he/she did not fully understand.
- (g) All representations set forth above are accurate and correct. Furthermore, the undersigned acknowledges that if the representations set forth above are not accurate and correct, he/she will indemnify and hold harmless the Facility with regard to any untrue and/or inaccurate representations.

25. The within Agreement shall be binding upon the parties hereto, and upon their respective heirs, successors and assigns.

IN WITNESS WHEREOF, the undersigned have hereunto caused their hands and seals to be affixed as of this 24 day of Aug, 2017.

RESIDENT / RESIDENT REPRESENTATIVE:

Margaret Hensley
Printed Resident Name

Signature / Date

Terry H. Putman
Printed Resident Representative

Terry H. Putman 8/24/17
Signature / Date

Daughter & POA
Relationship

FACILITY STAFF / WITNESS:

White Oak White Oak Estates, Inc. Date: 8/24/17
By: Karen Baker BA
Staff Printed Name and Title Staff Signature / Witness



RESIDENT
REPRESENTATIVE
AGREEMENT

RESIDENT REPRESENTATIVE AGREEMENT
PLEASE READ CAREFULLY AND ASK ANY QUESTIONS

This Resident Representative Agreement (hereinafter referred to as "Agreement") is made between White Oak Estates {Facility Name}, (hereinafter referred to as the "Facility") and Terry H. Putman, the legal representative or representative individual (hereinafter referred to as "Resident Representative") of the Resident, Hensley Margaret (hereinafter referred to as "Resident").

WHEREAS, Resident Representative and Facility enter into this Agreement to facilitate the provision of care to the Resident.

WHEREAS, the Resident Representative may be the Guardian/Conservator, the Agent under a valid Power of Attorney, or any person authorized by the Resident to serve as Resident's Resident Representative.

WHEREAS, Facility shall discuss and consult with the Resident Representative regarding pertinent decisions related to Resident's stay and care at the Facility.

THEREFORE, Facility and Resident Representative agree to the following terms and conditions:

1. Resident Representative affirms that the information and related documents provided during the admission process are true and correct to the best of his or her knowledge. Resident Representative acknowledges that the submission of any false information, misrepresentation or lack of disclosure may result in the termination of the Resident and Facility Admission Agreement (hereinafter referred to as "Admission Agreement") and may result in the discharge of the Resident from the Facility at the Resident and/or Resident Representative's expense.

2. If the Resident selects a Resident Representative, then said Resident Representative shall sign this Agreement, the Admission Agreement and the Arbitration Agreement in recognition of this designation with the intent to be legally bound by this Agreement, the Admission Agreement and the Arbitration Agreement (subject, however, to the opt-out provisions of the Arbitration Agreement). The Resident Representative shall be obligated to fulfill the duties on behalf of the Resident imposed by the Admission Agreement in accordance with the law governing fiduciary duties. Facility may petition a court to appoint a Guardian / Conservator and take other legal action if Facility reasonably believes that the Resident's needs are not being properly met or the duties imposed by the Admission Agreement are not being fulfilled by the Resident Representative. Resident, Resident's estate, or Resident Representative shall pay the cost of such Guardianship/Conservatorship proceedings, including attorneys' fees.

3. Resident Representative affirms that he or she has access to Resident's income and resources and that Resident's income and resources are available to pay for Resident's care in the Facility. DNP (initials). The Resident Representative shall provide payment from Resident's income and resources for such care. Resident Representative shall apply Resident's income and resources to the costs and charges incurred during Resident's stay unless and until such costs are paid by private insurance or other benefits such as Medicare or Medicaid. When the Resident's financial resources warrant it, Resident Representative shall take any and all actions necessary and appropriate to initiate, make and conclude application for Medicaid benefits on behalf of the Resident, including providing all necessary documentation, complying with deadlines and pursuing all necessary appeals. Resident Representative shall utilize Resident's income and resources only for Resident and shall not utilize any of Resident's income or resources for Resident Representative's benefit nor transfer any of Resident's real property except for proceeds at no less than fair market value for the benefit of Resident.

Resident Representative affirms that he or she does not have access to Resident's income and resources, but that Resident's income and resources are available to pay for Resident's care in the Facility. _____ (initials). The Resident Representative shall provide payment from Resident's income and resources for such care. Resident Representative shall apply Resident's income and resources to the costs and charges incurred during Resident's stay unless and until such costs are paid by private insurance or other benefits such as Medicare or Medicaid. When the Resident's financial resources warrant it, Resident Representative shall take any and all actions necessary and appropriate to initiate, make and conclude application for Medicaid benefits on behalf of the Resident, including providing all necessary documentation, complying with deadlines and pursuing all necessary appeals. Resident Representative shall utilize Resident's income and resources only for Resident and shall not utilize any of Resident's income or resources for Resident Representative's benefit nor transfer any of Resident's real property except for proceeds at no less than fair market value for the benefit of Resident.

4. Resident Representative is obligated to pay Facility from Resident's financial resources for services and supplies provided to Resident in accordance with the Admission Agreement. If the Resident Representative withholds or misappropriates Resident's financial resources for personal use or gifts, or otherwise does not use the Resident's financial resources to fulfill Resident's financial obligations to Facility for services and supplies provided to Resident in accordance with the Admission Agreement, then Resident Representative shall be held liable for payment, but only up to the amount of the Resident's financial resources, and Facility will apply to become representative/designated payee for available income.

5. If Resident becomes unable to pay the charges for nursing facility care due to the depletion of Resident's financial resources, Resident Representative shall timely assist Resident in the preparation, completion and submission of Resident's application for Medicaid benefits, and if applicable, file an appeal of a determination of ineligibility. Assistance provided by Facility in the preparation, completion or submission of an application for Medicaid benefits does not relieve Resident or Resident Representative of these obligations. Resident Representative shall provide all information and documentation requested by the Medicaid Office. Upon Facility's request, Resident Representative shall execute an authorization for

Facility to obtain Resident's financial information for the purposes of securing Medicaid benefits, pursuing a hardship waiver, and bringing Resident's account current. If Resident is determined to be ineligible for Medicaid as a result of Resident Representative's failure to meet the obligations set forth in this Agreement, then Facility may terminate the Admission Agreement for non-payment, and Resident may be discharged for non-payment. Resident Representative shall be liable for any losses sustained by Facility as a result of failure to meet contractual obligations.

6. In the event Resident applies for Medicaid benefits, Resident Representative shall pay the applicable Recurring Liability Amount to Facility on a monthly basis. The Recurring Liability Amount is determined by the Department of Health and Human Services ("DHHS") and described in the Admission Agreement. Resident Representative may request the Facility, to the extent permitted by law, to apply as representative / designated payee for any income available to Resident.

7. Resident Representative is obligated to pay Facility for all losses or damages incurred by Facility resulting from the failure of the Resident Representative to fulfill his/her duties under the Admission Agreement and/or this Agreement. In the event that Facility initiates any legal actions or proceedings to collect payments due from Resident and Resident Representative under this Agreement, or to enforce Resident Representative's obligations under the Admission Agreement, then Resident and Resident Representative shall pay all damages, attorneys' fees and costs incurred by Facility in pursuing the enforcement of Resident's and/or Resident Representative's financial or other obligations under the Admission Agreement and/or this Agreement. Such damages, fees, and costs may include, in the discretion of Facility, an amount equivalent to revenue lost by Facility due to Resident Representative's failure to timely submit or complete a Medicaid application or to cooperate with DHHS in the Medicaid eligibility determination.

8. Resident Representative understands that if he or she fulfills his or her obligation under the Admission Agreement and/or this Agreement, he or she shall not be held personally liable for the Resident's charges. This Agreement shall not be construed or operate as a third party guaranty.

9. Resident Representative is obligated to perform all provisions in the Admission Agreement related to Resident Representative.

10. This Agreement shall bind the Resident Representative, his or her executors, heirs, administrators and assigns and the benefits shall inure to Facility, its successors and assigns.

11. Resident Representative acknowledges he or she has reviewed this Resident Representative Agreement and understands the information set forth herein.

IN WITNESS WHEREOF, the parties, intending to be legally bound hereby, have signed this Resident Representative Agreement on this 24 day of Aug, 2017.

RESIDENT / RESIDENT REPRESENTATIVE:

Hensley, Margaret
Printed Resident Name

Signature / Date

Terry H. Putman
Printed Resident Representative

Terry H. Putman 8/24/17
Signature / Date

Daughter + POA
Relationship

FACILITY STAFF / WITNESS:

White Oak White Oak Estates, Inc.

Date: 8/24/17

By: KAREN BAKER BMA
Staff Printed Name and Title

[Signature]
Staff Signature / Witness

EXHIBIT B

STATE OF SOUTH CAROLINA	)	
	)	IN THE COURT OF COMMON PLEAS
COUNTY OF SPARTANBURG	)	
 Terry Putman, Individually and as	)	
Personal Representative of the Estate	)	
Of Margaret Hensley,	)	AFFIDAVIT OF SONIA A. CRISP
	)	
Plaintiff,	)	
	)	
v.	)	
	)	
White Oak Estates, Inc.; White Oak	)	C.A. Number: 2020-CP-42-03818
Management, Inc.; and White Oak	)	C.A. Number: 2020-CP-42-03819
Manor, Inc.,	)	
	)	
Defendants.	)	
_____	)	

PERSONALLY APPEARED BEFORE ME, Sonia A. Crisp, who being duly sworn,
deposes and states as follows:

(1) I am over the age of 18 and make this affidavit based on my own personal knowledge and review of information and documents available to me.

(2) I hold a dual nursing home and community resident care administrator's license issued by the State of South Carolina. I am the Administrator of White Oak Estates, Inc. ("White Oak Estates"). In this role, I have knowledge of operations and the facility admissions process.

(3) There is no written notice from Margaret Hensley, Terry Putman, or anyone else, in Ms. Hensley's file maintained at White Oak Estates seeking to opt out of or rescind the Arbitration Agreement attached to Karen Baker's Affidavit as Exhibit 1.

(4) During the period of Ms. Hensley's 2017 residency at White Oak Estates, White Oak Estates' staff communicated with prospective residents and/or their families who lived outside of South Carolina. This continues to be true at the present time.

(5) During the period of Ms. Hensley's 2017 residency at White Oak Estates, White

Oak Estates' staff communicated with existing residents' family members and/or representatives who lived outside of South Carolina. This continues to be true at the present time.

(6) During the period of Ms. Hensley's 2017 residency at White Oak Estates to the present, a variety of companies have been used directly or indirectly in providing goods and services for the care of residents at White Oak Estates, including Ms. Hensley. Many of these goods and services were received from vendors based outside of South Carolina. For example, see the following chart:

<u>Company/Vendor</u>	<u>State Where Based</u>	<u>Service/Good Supplied</u>
U.S. Foods	Illinois	food supplies
PFG	Virginia	food supplies
IFH (Institution Food House)	North Carolina	food supplies
S&D Coffee	North Carolina	food supplies
Mobilex USA	Maryland	imaging services
American Health Associates	Florida	lab services

(7) During the period of Ms. Hensley's 2017 residency at White Oak Estates to the present, White Oak Estates has maintained 88 short- and long-term care beds, which are certified by and participate in the Medicare and Medicaid programs.

(8) Medicare is a federally administered program. During Ms. Hensley's 2017 residency at White Oak Estates, White Oak Estates received payments from Medicare.

(9) The South Carolina Medicaid Program is partially funded by the federal government. During Ms. Hensley's 2017 residency at White Oak Estates, White Oak Estates received payments from Medicaid.

(10) During Ms. Hensley's 2017 residency, White Oak Estates' requests for private insurance payments for services rendered to residents of White Oak Estates were sent by U.S. Mail to various private insurances companies located outside of the State of South Carolina, and

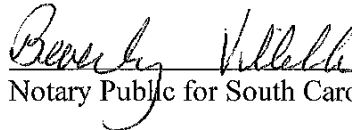
insurance payments were issued by these insurance companies.

FURTHER AFFIANT SAYETH NOT.

By:


Sonia A. Crisp

SWORN to before me this
18 day of Feb, 2021.


Notary Public for South Carolina

My Commission Expires: Oct. 21, 2024

STATE OF SOUTH CAROLINA	)	
	)	IN THE COURT OF COMMON PLEAS
COUNTY OF SPARTANBURG	)	
Terry Putnam, Individually and as	)	
Personal Representative of the Estate	)	
Of Margaret Hensley,	)	
	)	DEFENDANTS' MEMORANDUM IN
Plaintiff,	)	SUPPORT OF MOTION TO DISMISS,
	)	COMPEL ARBITRATION, AND FOR A
	)	PROTECTIVE ORDER OR,
v.	)	ALTERNATIVELY, TO STAY THE ACTION
	)	PENDING ARBITRATION
White Oak Estates, Inc.; White Oak	)	
Management, Inc.; and White Oak	)	
Manor, Inc.,	)	
	)	C.A. Number: 2020-CP-42-03818
Defendants.	)	C.A. Number: 2020-CP-42-03819
	)	

On August 29, 2017, Margaret Hensley (“Ms. Hensley”) was admitted to Defendant White Oak Estates, Inc. by her daughter and durable power of attorney Terry Putnam (“Plaintiff”) for the third time in five years. In preparation for Ms. Hensley’s admission—and also for the third time in five years, Plaintiff elected to sign merged admission and arbitration agreements requiring claims against Defendants be submitted to binding arbitration. Plaintiff now brings claims that are clearly subject to this willing agreement to arbitrate. As such, Defendants respectfully request that Plaintiff’s Complaint be dismissed and/or stayed and for the Court to compel arbitration pursuant to the merged Admission and Arbitration Agreements, Rule 12(b)(1), (2), (3) and (6), SCRCF, the Federal Arbitration Act (9 U.S.C. § 1, *et seq.*), and all applicable statutory and case law.¹ Concomitantly, pursuant to Rule 26(c), SCRCF, Defendants respectfully request protection from being required to answer Plaintiff’s written discovery served in this improperly-filed action.

BACKGROUND

On October 7, 2011, Ms. Hensley executed a Durable Power of Attorney naming Plaintiff

¹ This Memorandum in Support addresses Plaintiff’s claims in C/A No.: 2020-CP-42-03818 and C/A No.: 2020-CP-42-03819. The allegations are the same in both actions. The only difference between the actions is that -03818 alleges a wrongful death action and -03819 alleges a survival action.

as her agent (the “POA”). (See Exhibit 1 – filed Durable Power of Attorney.) The POA granted Plaintiff all lawfully delegated powers not specifically limited in the POA (Ex. 1 at p. 1). The powers specifically included the powers to arbitrate (Ex. 1 at p. 3); to provide a place of residence, health care, and custodial care (Ex. 1 at p. 6); to employ health care personnel (Ex. 1 at p. 8); and to arrange for hospitalizations and other care (Ex. 1 at p. 8). Within the POA, Ms. Hensley expressly provided that all actions taken by Plaintiff pursuant to the POA “shall be binding on me, my estate and my personal representative” (Ex. 1 at p. 12).

In November 2012 and May 2014, Plaintiff exercised her POA powers to admit Ms. Hensley to White Oak Estates for care. On each occasion, Plaintiff executed merged admission and arbitration agreements. (See Exhibit 2 – November 2012 Admission Agreement, November 2012 Arbitration Agreement, May 2014 Admission Agreement, and May 2014 Arbitration Agreement.) These agreements demonstrate Plaintiff’s familiarity with White Oak Estates and its admissions process as well as Plaintiff’s willingness to agree to arbitration.

Pertinent to the present claims, Hensley was admitted to White Oak Estates on August 29, 2017 for short term rehab following a twelve-day hospitalization at Spartanburg Medical Center during which she underwent a surgical repair for a right femur fracture. (See Exhibit 3 – excerpts from White Oak Estates medical record.)

Days prior to Ms. Hensley’s admission to White Oak Estates, while Ms. Hensley was still securely hospitalized at Spartanburg Medical Center, Plaintiff executed a merged Resident Facility Admission Agreement, Arbitration Agreement, and Resident Representative Agreement (the “Merged Agreements”) as part of the process for having Ms. Hensley admitted to White Oak Estates. (See Exhibit 4 – August 2017 Resident and Facility Admission Agreement, Arbitration Agreement, and Resident Representative Agreement.)

The Admission Agreement defines White Oak Estates as the “Facility” and Ms. Hensley

as the “Resident” (Ex. 4, Admission Agreement, p. 1). Within the Admission Agreement, Plaintiff, as Ms. Hensley’s daughter and Power of Attorney, agreed that the Admission “Agreement, the Resident Representative Agreement, and Arbitration Agreement, and the admission documentation represent the entire Agreement and understanding between the parties....” (Ex. 4, Admission Agreement, p. 16). Likewise, Plaintiff agreed that all claims between the parties were subject to arbitration pursuant to the Federal Arbitration Act (the “FAA”) and was pointed to the Arbitration Agreement which was incorporated by reference (Ex. 4, Admission Agreement, p. 18 – 19). Further, Plaintiff acknowledged that Ms. Hensley’s obligations under the Admission Agreement “shall be binding upon all parties hereto and upon their respective heirs, personal representatives, successors and assigns” (Ex. 4, Admission Agreement, p. 19). Finally, Plaintiff agreed that she had the opportunity to read the Admission Agreement, ask questions about it, and have it explained to her (Ex. 4, Arbitration Agreement, p. 17).

Turning to the merged Arbitration Agreement, Plaintiff again executed this document as Ms. Hensley’s daughter and POA “for valuable consideration” (Ex. 4, Arbitration Agreement, p. 1, 5). Plaintiff agreed that the Arbitration Agreement would be pursuant to the FAA (Ex. 4, Arbitration Agreement, p. 1). The Arbitration Agreement reiterated that it “shall be considered” along and together with the Admission Agreement (Ex. 4, Arbitration Agreement, ¶ 21). Likewise, the Arbitration Agreement noted that all claims between Ms. Hensley, her heirs and beneficiaries, White Oak Estates, and all other White Oak entities would be subject to binding arbitration (Ex. 4, Arbitration Agreement, ¶¶ 1, 2).

Next, Plaintiff agreed to the process for arbitration, including selection of arbitrators, discovery, and the arbitration hearing (Ex. 4, Arbitration Agreement, ¶¶ 3 - 16). Likewise, Plaintiff agreed that the Arbitration Agreement had been explained to her, that she the right to seek legal counsel before signing the Arbitration Agreement, that she had thirty days to opt out of the

Arbitration Agreement on Ms. Hensley's behalf, and that she freely and voluntarily executed the Arbitration Agreement (Ex. 4, Arbitration Agreement, ¶¶ 17, 24). Plaintiff also again agreed that the decision to arbitrate would be binding on Ms. Hensley and her heirs, beneficiaries, successors, and assigns (Ex. 4, Arbitration Agreement, ¶¶ 18, 25).

Karen Baker, an employee of White Oak Estates, was authorized to and did execute the Merged Agreements on behalf of White Oak Estates. (See Exhibit 5 - Affidavit of Karen Baker, at ¶ 5 (without internal exhibit).)

Based on the merged Admission Agreement, Ms. Hensley was admitted to White Oak Estates and received skilled nursing care until her discharge on September 23, 2017.

On November 2, 2020, Plaintiff commenced actions 2020-CP-42-03818 and 2020-CP-42-03819, both alleging claims of negligence against all Defendants related to the care that Ms. Hensley received at White Oak Estates. Defendants simultaneously filed Answers and Motions to Compel Arbitration on February 19, 2021. Because these claims expressly fall within the scope of the arbitration provision at issue, the Court should dismiss the Plaintiff's action, or stay these proceedings, and compel this matter to binding arbitration.

ARGUMENT

I. Federal and State Law Favor Enforcing Arbitration.

As an initial matter, both Federal and South Carolina law favor arbitrating disputes. See O'Neil v. Hilton Head Hosp., 115 F.3d 272, 273 (4th Cir. 1997) ("The FAA embodies a strong federal policy in favor of arbitration, and, accordingly, there is a strong presumption in favor of the validity of arbitration agreements."); Toler's Cove Homeowners Ass'n, Inc. v. Trident Const. Co., 355 S.C. 605, 612, 586 S.E.2d 581, 585 (2003) ("Furthermore, it is the policy of this state to favor arbitration of disputes.").

For this reason, both Federal and South Carolina courts have held that any doubts over

arbitrability should be resolved in favor of compelling arbitration. See Moses H. Cone Mem'l Hosp. v. Mercury Constr. Corp., 460 U.S. 1, 24 – 25 (1983) (“The Arbitration Act establishes that, as a matter of federal law, any doubts concerning the scope of arbitrable issues should be resolved in favor of arbitration, whether the problem at hand is the construction of the contract language itself or an allegation of waiver, delay, or a like defense to arbitrability.”); Towles v. United HealthCare Corp., 338 S.C. 29, 41, 524 S.E.2d 839, 846 (Ct. App. 1999) (“[A]ny doubts concerning the scope of arbitrable issues should be resolved in favor of arbitration, whether the problem at hand is the construction of the contract language itself or an allegation of waiver, delay, or a like defense to arbitrability.”).

II. The Federal Arbitration Act governs the Merged Agreements and compels arbitration.

Viewed through the lens of presumed enforceability outlined above, the merged Admission and Arbitration Agreements, by their terms and by law, are governed by the FAA, 9 U.S.C. §§ 1-16. See Ex. 4, Admission Agreement, p. 18 – 19 and Arbitration Agreement, p. 1; Dean v. Heritage Healthcare of Ridgeway, LLC, 408 S.C. 371, 381, 759 S.E.2d 727, 732 (2014) (skilled nursing facility admission agreements and residencies implicate interstate commerce, and thus are governed by the FAA).

Pursuant to the FAA, any written provision in “a contract evidencing a transaction involving commerce” providing that disputes be settled by arbitration is “valid, irrevocable, and enforceable.” 9 U.S.C. § 2. The language of the Act is mandatory and requires the enforcement of all arbitration agreements. The FAA provides, in pertinent part, as follows:

The court shall hear the parties, and upon being satisfied that the making of the agreement for arbitration or the failure to comply therewith is not in issue, *the court shall make an order directing the parties to proceed to arbitration in accordance with the terms of the agreement.*

9 U.S.C. § 4 (emphasis added). “By its terms, the act leaves no place for the exercise of discretion by a... court, but instead mandates that... courts shall direct the parties to proceed to arbitration on issues as to which an arbitration agreement has been signed.” Dean Witter Reynolds, Inc. v. Byrd, 470 U.S. 213, 218 (1985).

Under the FAA, a party seeking arbitration must only show two things in order to compel arbitration: (1) that a written agreement to arbitrate exists, and (2) that the written agreement is contained within a contract involving interstate commerce. 9 U.S.C. § 2. As discussed herein, the Merged Agreements satisfy both requirements, meaning Plaintiff’s claims should be dismissed and compelled to arbitration.

(a) The Merged Agreements form a valid written agreement to arbitrate.

i. Plaintiff, as Ms. Hensley’s authorized agent, executed a clear and valid contract requiring arbitration.

As set forth in the Background section, Ms. Hensley executed an October 7, 2011 Durable Power of Attorney naming Plaintiff her agent (Ex. 1 at p. 1). Through the POA, Ms. Hensley gave Plaintiff the broadest lawful powers available to an agent and specifically authorized Plaintiff to agree to arbitration, provide places for residential and health care, employ health care personnel, and arrange for hospitalizations and similar care (Ex. 1 at p. 1, 3, 6, 8). Likewise, Ms. Hensley specifically authorized Plaintiff to bind Ms. Hensley, her estate, and her personal representative (Ex. 1 at p. 12).

Against this backdrop, White Oak Estates presented Plaintiff with merged Admission and Arbitration Agreements² which offered Ms. Hensley inpatient nursing care and related services.

² As set forth in the Background section, Plaintiff expressly agreed within the Admission Agreement and the Arbitration Agreement that those agreements constituted the entirety of the agreement between the parties, were to be considered together, and were incorporated within each other (Ex. 4, Admission Agreement, p. 16, 18 -19 and Arbitration Agreement, ¶ 21). Even if this were not the case, the merged Admission and Arbitration Agreements would still be construed together because they relate to the same subject matter—Ms. Hensley’s admission to and care at White Oak Estates. See, e.g., Klutts Resort Realty, Inc. v. DownRound Dev. Corp., 268 S.C. 80, 232 S.E.2d 20 (1977)

(Ex. 4 at p. 2). Even for non-signatories, admission can serve as the direct benefit which supports arbitration where the admission and arbitration are governed by the same agreement as they are in these cases. See, e.g., Hodge v. UniHealth Post-Acute Care of Bamberg, LLC, 422 S.C. 544, 558, 813 S.E.2d 292, 299–300 (Ct. App. 2018) (“Restated, when a signatory seeks to enforce an arbitration agreement against a nonsignatory, the doctrine prevents the nonsignatory from averring he or she is not bound to the arbitration agreement when he or she receives a direct benefit from a contract that contains an arbitration clause.”)

Beyond the offering of admission, the Merged Agreements expressly state that Plaintiff acknowledged “valuable consideration” was given for her agreement to bind Ms. Hensley, her heirs, and her beneficiaries to arbitration (Ex. 4, Arbitration Agreement, p. 1)³. This consideration included, but was not limited to, a quicker resolution of the claims; the ability to choose any individual to represent the resident/claimant at the arbitration (or to represent oneself), thereby avoiding attorneys’ fees; relaxed standards for presentation of evidence; the ability to choose an arbitrator; and payment within ninety days of an arbitration award being made (Ex. 4, Arbitration Agreement, ¶¶ 4 – 5, 7 - 8, 15). See, e.g., AT&T Mobility LLC v. Concepcion, 563 U.S. 333, 344–45 (2011) (“The point of affording parties discretion in designing arbitration processes is to allow for efficient, streamlined procedures tailored to the type of dispute.... And the informality of arbitral proceedings is itself desirable, reducing the cost and increasing the speed of dispute

(Courts in South Carolina construe contemporaneous instruments together; if there are any provisions in one instrument limiting, explaining, or otherwise affecting the provisions of another, they will be given effect between the parties so that the whole agreement as actually made may be effectuated.); Plaza Dev. Serv. v. Joe Hardin Builder, Inc., 294 S.C. 430, 365 S.E.2d 231 (Ct. App. 1988) (Even when instruments are entered into by the same parties at different times but relate to the same subject matter, the instruments will be construed together to determine the entire agreement between the parties.)

³ See S.C. Dep’t of Transp. v. M & T Enterprises of Mt. Pleasant, LLC, 379 S.C. 645, 655, 667 S.E.2d 7, 13 (Ct. App. 2008) (“When a contract is unambiguous, clear, and explicit, it must be construed according to the terms the parties have used, to be taken and understood in their plain, ordinary, and popular sense.”)

resolution.”)

In exchange for this valuable consideration, Plaintiff agreed that Ms. Hensley would pay for the services provided to her and that Ms. Hensley, her personal representative, her heirs, and her beneficiaries would engage in arbitration to settle any disputes (Ex. 4, Admission Agreement, p. 2, 18 – 19 and Arbitration Agreement, ¶¶ 1, 2). Plaintiff, as Ms. Hensley’s lawfully empowered agent, freely and voluntarily accepted the offer by executing the Merged Agreements which reminded her of the opportunity to engage counsel, her ability to ask questions, her ability to have the Agreements explained, and her ability to withdraw her agreement to arbitration within thirty days (Ex. 4, Admission Agreement, p. 17, Arbitration Agreement, ¶¶ 17, 24).

The Arbitration Agreement, by its plain language, specifically said that binding arbitration would be required for all claims between Ms. Hensley, her heirs, her beneficiaries, White Oak Estates, White Oak Manor, Inc. and White Oak Management, Inc. (Ex. 4, Arbitration Agreement, ¶¶ 1, 2, 25), those being the exact type of claims that Plaintiff now raises in the above-captioned actions. The Arbitration Agreement also provided Plaintiff a clear framework for arbitration, including the selection of arbitrators, discovery, and the arbitration hearing (Ex. 4, Arbitration Agreement, ¶¶ 3 – 16). A duly authorized White Oak Estates employee executed the document on behalf of White Oak Estates (Ex. 5 at ¶ 5). Finally, though she had the option, Plaintiff did not withdraw her agreement to arbitrate. (See Exhibit 6 – Affidavit of Sonia A. Crisp, ¶ 3.)

Just as any other competent adult entering a contract, Plaintiff, Ms. Hensley, her heirs, her successors, and her assigns are held to the merged Admission and Arbitration Agreements. See J.B. Colt Co. v. Britt, 129 S.C. 226, 123 S.E. 845, 847 (1924) (a person who enters a valid contract is, “of course, bound by the terms and conditions thereof”); Regions Bank v. Schmauch, 354 S.C. 648, 663, 582 S.E.2d 432, 440 (Ct. App. 2003) (“A person signing a document is responsible for reading the document and making sure of its contents. Every contracting party

owes a duty to the other party to the contract and to the public to learn the contents of a document before he signs it.”); Maw v. McAlister, 252 S.C. 280, 285, 166 S.E.2d 203, 205 (1969) (“The duty on the part of one who signs a written instrument to exercise reasonable care to protect himself requires that he read the contract which he signs....”).

ii. Plaintiff’s claims in both lawsuits are encompassed within the scope of the merged Admission and Arbitration Agreement.

Not only did Plaintiff execute a valid agreement requiring binding arbitration, but the Estate’s claims are squarely governed by the merged Admission and Arbitration Agreements. The Admission and Arbitration Agreements conspicuously state that “all claims” between Ms. Hensley, her personal representative, her heirs, her beneficiaries, White Oak Estates, White Oak Manor, Inc., and White Oak Management, Inc. will be submitted to arbitration (Ex. 4, Admission Agreement, p. 18 – 19 and Arbitration Agreement, ¶¶ 1 – 2).

“All claims” certainly includes the negligence claims alleged in 2020-CP-42-03818 and -03819. Plaintiff’s survival action, -03819, raises claims on behalf of Ms. Hensley for negligence. Plaintiff expressly chose to obligate Ms. Hensley and her heirs and beneficiaries to the merged Admission and Arbitration Agreements. Further, Ms. Hensley’s Estate is bound by the Merged Agreements because a survival action is a product of Ms. Hensley’s alleged conscious pain and suffering. See Rutland v. S.C. Dep’t of Trans., 390 S.C. 78, 83, 700 S.E.2d 451, 454 (Ct. App. 2010), aff’d as modified sub nom. Rutland v. S.C. Dep’t of Transp., 400 S.C. 209, 734 S.E.2d 142 (2012) (“The test of a survival action in South Carolina is whether the decedent suffered conscious pain and suffering.”).

Likewise, Plaintiff’s wrongful death action, -03818, raises claims on behalf of Ms. Hensley’s Estate based on negligence. Again, these claims expressly fall within the scope of the Merged Agreements. Ms. Hensley’s POA authorized Plaintiff to bind Ms. Hensley, her Estate, and

her personal representative (Ex. 1 at p. 12). Plaintiff then exercised that authority to expressly bind Ms. Hensley and her heirs, her personal representatives, successors, assigns, and beneficiaries to the requirements of the Merged Agreements (Ex. 4, Admission Agreement, p. 18 – 19 and Arbitration Agreement, ¶¶ 1 – 2).

Plaintiff as Ms. Hensley’s agent had the ability to obligate Ms. Hensley’s wrongful death beneficiaries to arbitration because South Carolina’s Wrongful Death Statute is a derivative action. See S.C. Code Ann. § 15-51-10 (The South Carolina Wrongful Death Act requires, as a condition of any suit, that the decedent herself, had she lived, could have “maintain[ed] an action and recover[ed] damages.”); Estate of Stokes v. Pee Dee Family Physicians, LLP, 389 S.C. 343, 347 (2010) (“[O]ur law has remained steadfast to the principle of limiting the right of recovery under the wrongful death statute to those cases in which the party injured would have been entitled to recover if death had not ensued.” (cataloguing cases)); Rish v. Seaboard Air Line Ry., 90 S.E. 704, 704-05 (S.C. 1916) (“The [Wrongful Death Act] gives a right of action where none existed before, and limited the right of recovery to those cases in which the party injured would have been entitled to recover if death had not ensued.”)

Although the case law in South Carolina has not directly addressed the issue at hand, the court has not been hesitant to prohibit wrongful death actions in which the decedent had in some way barred herself from pursuing the underlying cause of action. In Price v. Richmond & D.R. Co., 33 S.C. 556, 12 S.E. 413 (1889), the court determined that a release executed by the decedent prior to his death prevented a wrongful death action brought by the decedent's wife. The Court’s decision was premised upon the limiting language of the wrongful death statute. The Price Court held that if the defendant in some way deprived himself of the right to pursue a cause of action, “his administrator is, likewise, [also] barred of his right of action.” Id. at 560, 12 S.E. at 413. Furthermore, the court in Reed v. Northeastern R. Co., 37 S.C. 42, 16 S.E. 289 (1892) affirmed

the Price holding and found that "[a]nything that would have defeated [the decedent's] recovery would defeat that in behalf of his family in case he failed to survive." Reed at 53, 16 S.E. at 291.

In Quattlebaum v. Carey Canada, Inc., 685 F. Supp. 939 (D.S.C. 1988), the South Carolina District Court interpreted the Wrongful Death statute, and held that a survivor cannot bring an action under the wrongful death statute to recover for the same wrong sued upon earlier by the decedent, if the personal injury statute of limitations has expired, but the specific wrongful death limitations period has not expired. This clearly establishes that Wrongful Death cause of action is wholly derivative. The District Court, sitting in diversity, examined the issue as the highest court of South Carolina would if confronted with the same situation. It then traced the history of wrongful death claims starting with Lord Campbell's Act. It further held that the same defenses that would have been available to use against the decedent, had he lived, were also available against those asserting the wrongful death claim.

Based on the legal nature of a wrongful death claim, the South Carolina Supreme Court has found that like here, where a decedent or her agent executes an arbitration agreement in connection with the decedent's admission to a nursing home, wrongful death actions brought by the personal representative can be subject to binding arbitration. Dean, 408 S.C. 371, 759 S.E.2d 727 at n. 3. District Courts in South Carolina interpreting Dean have found that statutory beneficiaries are subject to arbitration. See, e.g., THI of S.C. at Magnolia Manor-Inman, LLC v. Gilbert, 2015 WL 1268185, at *3 (D.S.C. Mar. 19, 2015) ("Additionally, the South Carolina Supreme Court made clear in Dean that, under South Carolina law, an arbitral agreement is still indeed binding on a decedent's estate for a claim in wrongful death.")

- iii. **White Oak Management, Inc. and White Oak Manor, Inc. may enforce the Merged Agreements even though they are not signatories to the same.**

Primarily, Plaintiff is required to arbitrate her claims against White Oak Management and

White Oak Manor because she freely and voluntarily agreed to do so when she signed the Arbitration Agreement: “When reference is made to ‘ALL’ claims, ‘all claims’ is intended to include not only all claims between the Resident and the Facility, as well as claims between the Resident’s heirs/beneficiaries, but also all other ‘White Oak’ entities, including specifically White Oak Manor, Inc. and White Oak Management, Inc.” (Ex. 4, Arbitration Agreement, ¶ 1). Therefore, Plaintiff agreed that “this Agreement also makes it such that no separate action or claims may be asserted against the Facility, or any other “White Oak” entities...” (Ex. 4, Arbitration Agreement, ¶ 2).

Even if Plaintiff had not contractually obligated Ms. Hensley, her heirs, and her beneficiaries to pursue arbitration against White Oak Management and White Oak Manor, those entities still would be entitled to compel arbitration. Though White Oak Management and White Oak Manor are not signatories to the merged Admission and Arbitration Agreements, Plaintiff alleges in both actions that these Defendants were involved in and responsible for Ms. Hensley’s care provided at White Oak Estates and alleges causes of action against these Defendants based on the care provided to Ms. Hensley at White Oak Estates. Likewise, as evident through White Oak Management and White Oak Manor joining in the Motions to Dismiss and Compel Arbitration, White Oak Management and White Oak Manor agree to participate in binding arbitration as envisioned by the merged Admission and Arbitration Agreements. In such circumstances, South Carolina law recognizes that White Oak Management and White Oak Manor have the right to seek arbitration notwithstanding the fact that they are not a signatory to the Merged Agreements.

In S.C. Pub. Serv. Authority v. Great Western Coal, et al., the plaintiff contracted with Great Western Coal for the provision of coal. 312 S.C. 559, 437 S.E.2d 22 (Ct. App. 1993). The contract contained an arbitration clause. The plaintiff later brought suit against Great Western

Coal, its president, and another employee, alleging that they had increased coal prices while lowering quality. Id. at 561, 437 S.E.2d at 23 – 24. Defendant president, a non-signatory to the contract, filed a motion to dismiss and compel arbitration. Id. at 561, 437 S.E.2d at 24. The trial judge denied defendant president’s motion because he did not sign the contract in his individual capacity, and defendant president appealed. Id. at 563, 437 S.E.2d at 24 – 25.

The Court of Appeals reasoned that “a party should not be allowed to avoid an arbitration agreement by naming nonsignatory parties in his complaint, or signatory parties in their individual capacity because this would nullify the rule requiring arbitration.” Id. at 563, 437 S.E.2d at 24 - 25, citing Arnold v. Arnold Corp., 920 F.2d 1269 (6th Cir. 1990). The Court of Appeals further reasoned that “when the nonsignatory parties are willing to submit to arbitration, the case should be arbitrated.” Id. The Court of Appeals therefore, concluded, that the defendant president was seeking arbitration and held that the trial judge erred in denying the same simply because the defendant president did not sign the contract. Id.

Great Western Coal is directly on point. Just like Great Western Coal’s president, White Oak Management and White Oak Manor are not signatories to the Merged Agreements in question, but the claims against White Oak Management and White Oak Manor arise out of and relate to the relationship between Ms. Hensley and White Oak Estates. Also, like Great Western Coal’s president, White Oak Management and White Oak Manor join in the Motions to Dismiss and Compel Arbitration and thus agree to submit to binding arbitration.

Plaintiff cannot avoid the merged Admission and Arbitration Agreements’ provisions by naming non-signatories. Likewise, Plaintiff cannot rely on the relationship created between Ms. Hensley and White Oak Estates when the Merged Agreements benefit her and repudiate those Agreements when they work to Plaintiff’s alleged disadvantage. White Oak Management and White Oak Manor thus are entitled to seek enforcement of the Merged Agreements.

iv. The Merged Agreements are not unconscionable.

As set forth above, anyone who enters into a written contract has a duty to read the contract which she signs. Maw, 252 S.C. at 284-285, 166 S.E.2d at 204. Likewise, anyone who is capable of reading and understanding, but fails to read a contract before signing is bound by the terms thereof. Sims v. Tyler, 276 S.C. 640, 643, 281 S.E.2d 229, 230 (1981). Furthermore, arbitration clauses are not unconscionable and will be enforced if a person who can read fails to read the contract, regardless of whether he was advised of the arbitration terms by the contracting party. Munoz v. Green Tree Fin. Corp., 343 S.C. 531, 541, 542 S.E.2d 360, 365 (2001) (holding the plaintiff's failure to read an arbitration provision did not render it unconscionable even though the plaintiffs claimed they were not advised of those terms). Additionally, "inequality of bargaining power alone will not invalidate an arbitration agreement." Id.

As set forth in the Background section, Plaintiff had previously admitted Ms. Hensley to White Oak in November 2012 and May 2014. Each time, Plaintiff executed merged admission and arbitration agreements. Though the wording of these agreements may have been revised over the years, Plaintiff was familiar with White Oak Estates, the White Oak Estates admission process, and the arbitration provisions contained within White Oak Estates admission documents when she was asked to execute the merged August 2017 Admission and Arbitration Agreements. Likewise, Plaintiff's past conduct demonstrated her willingness to agree to optional arbitration provisions on behalf of her mother. Finally, Plaintiff was presented with the merged August 2017 Admission and Arbitration Agreements days before Ms. Hensley's admission to White Oak Estates while Ms. Hensley was still securely hospitalized at Spartanburg Medical Center.

Within the August 2017 Admission Agreement, Plaintiff agreed that all claims between the parties were subject to arbitration pursuant to the Federal Arbitration Act and was pointed to the Arbitration Agreement which was incorporated by reference (Ex. 4, Admission Agreement, p. 18

– 19). Further, Plaintiff agreed that she had the opportunity to read the Admission Agreement, ask questions about it, and have it explained to her (Ex. 4, Arbitration Agreement, p. 17). Likewise, within the Arbitration Agreement, Plaintiff agreed that the Arbitration Agreement had been explained to her, that she the right to seek legal counsel before signing it, that she had thirty days to opt out of it on Ms. Hensley’s behalf, and that she freely and voluntarily executed it (Ex. 4, Arbitration Agreement, ¶¶ 17, 24).

Simply, Plaintiff was familiar with what she was doing, given ample notice of what she was being asked to sign, and given the opportunity to reflect on her agreement to arbitrate and rescind it. Still, she executed the Merged Agreements and did not rescind her consent to binding arbitration. The Merged Agreements, therefore, are not unconscionable and should be enforced by this Court.

(b) The Merged Agreements involves interstate commerce.

The FAA applies to written arbitration agreements which evidence a transaction involving interstate commerce. 9 U.S.C. § 2. In the present matter, the Merged Agreements expressly note that the FAA governs, and Plaintiff accepted this term of the agreement (Ex. 4, Admission Agreement, p. 18 – 19; Ex. 4, Arbitration Agreement, p. 1).

Even if this were not the case, the requirement is broadly construed so as to be coextensive with congressional power to regulate under the Commerce Clause. Comanche Indian Tribe of Okla. v. 49, LLC, 391 F.3d 1129, 1132 (10th Cir. 2004). The interstate commerce requirement under the FAA includes contracts relating to interstate commerce. Id. This requirement is met if “in the aggregate the economic activity in question would represent ‘a general practice...subject to federal control.’” Citizens Bank v. Alafabco, Inc., 539 U.S. 52 (2003) (citation omitted).

The interstate commerce requirement under the FAA is met in the present case on multiple grounds. In addition to the Arbitration Agreement expressly noting that it is governed by the FAA,

Defendants have established interstate commerce through the Affidavit of Sonia A. Crisp (Ex. 6). At the time of Ms. Hensley's residency (1) White Oak Estates received payments from Medicare, Medicaid, and private insurers from other states; (2) food served at White Oak Estates came from companies based in numerous other states; (3) imaging services at White Oak Estates were provided by a company based in Maryland; and (4) White Oak Estates communicated with prospective residents and/or residents' family members who lived outside of South Carolina (Ex. 6). In Dean, the South Carolina Supreme Court found that sufficient to establish interstate commerce. Particularly, the Dean Court found that a nursing home residency agreement implicated interstate commerce by requiring the facility to provide the resident with food and medical supplies which were instruments of interstate commerce. Id. at 381-82, 759 S.E.2d at 732-733.

Through both Plaintiff's express agreement that the FAA applies to the Merged Agreements and through the provision of services from across state lines, the FAA's interstate commerce requirement is satisfied in the present case.

III. If not dismissed, the FAA at a minimum requires that these actions be stayed while the parties submit to binding arbitration.

Should the Court elect not to dismiss these two actions while the parties submit to binding arbitration, Defendants would alternatively request that these proceedings be stayed pending completion of arbitration. The FAA requires a stay under the following circumstances:

If any suit or proceeding be brought in any of the courts of the United States upon any issue referable to arbitration under an agreement in writing for such arbitration, the court in which such suit is pending, upon being satisfied that the issue involved in such suit or proceeding is referable to arbitration under such an agreement, shall on application of one of the parties stay the trial of action until such arbitration has been had in accordance with the terms of the agreement[.]

9 U.S.C. § 3.

Accordingly, in the alternative to dismissal, Defendants respectfully request that the Court

stay all judicial proceedings pending arbitration in accordance with the arbitration clause. See Stokes v. Metropolitan Life Ins. Co., 351 S.C. 606, 612, 571 S.E.2d 711, 715 (Ct. App. 2002) (holding “the FAA clearly requires a court stay ‘any suit or proceeding’ pending the arbitration of ‘any issue referable to arbitration under an agreement in writing for such arbitration’ upon the application of one of the parties” (internal citation omitted)); 9 U.S.C. § 3.

IV. Defendants are Entitled to Protection from Responding to Plaintiff’s Written Discovery.

On December 22, 2020, Plaintiff served a First Set of Interrogatories to Defendant White Oak Estates, Inc., First Requests for Production to White Oak Estates, Inc., a First Set of Interrogatories to White Oak Management, Inc., First Requests for Production to White Oak Management, Inc., a First Set of Interrogatories to White Oak Manor, Inc., and First Requests for Production to White Oak Manor, Inc. Defendants object to these discovery requests because this case is subject to arbitration, making these civil actions and the discovery requests served in them improper. Defendants, therefore, are entitled to an order from this Court that Defendants are not required to respond to Plaintiff’s discovery requests pursuant to Rule 26(c), SCRPC.

CONCLUSION

Plaintiff, as Ms. Hensley’s legally authorized agent, freely bound Ms. Hensley, her estate, her personal representative, her heirs, and her beneficiaries to arbitrate any claims against Defendants. Defendants, therefore, respectfully request that Plaintiff’s Complaint be dismissed and/or stayed and for the Court to compel arbitration pursuant to the merged Admission and Arbitration Agreements, Rule 12(b)(1), (2), (3) and (6), SCRPC, the Federal Arbitration Act (9 U.S.C. § 1, et seq.), and all applicable statutory and case law.

s/Joshua T. Thompson
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Attorney for Defendants

March 15, 2021

Spartanburg, South Carolina

**DURABLE POWER OF ATTORNEY
OF
MARGARET S. HENSLEY**

**ARTICLE I
INTRODUCTION**

Introductory Provision. I, **Margaret S. Hensley**, hereby appoint **Terry H. Putman** and **Kevin S. Hensley** to serve as my agents, each of whom are individually referred to herein as my "Agent," to exercise alone or jointly the powers and discretions set forth below.

No Person Under Age 18 May Serve as Agent. Notwithstanding any provision herein to the contrary, no person named as Agent herein may serve until such person has attained the age of eighteen (18).

Designator of Person to Fill Agent Vacancy. If at any time no one shall be serving as my Agent under this power of attorney, then my agent shall be such person as may be appointed by **Patrick M Tesner** who shall fill such vacancy in a written instrument that shall be acknowledged before a notary public, and shall be attached to this power of attorney with the signature of such appointee indicating acceptance. Patrick M. Tesner may appoint himself as the agent.

Statement of Intent to Create Durable Power of Attorney Under State Statute. By this instrument I intend to create a Durable Power of Attorney under South Carolina law.

Revocation of Prior Powers of Attorney. I hereby revoke all powers of attorney, general and/or limited, heretofore created by me as principal and terminate all agency relationships created thereunder, including those of all successor Agents named therein, if any, except that powers granted by me on forms provided by financial institutions granting the right to write checks on, deposit funds to, and withdraw funds from accounts to which I am a signatory or granting access to a safe deposit box shall not be revoked and shall continue in full force and effect.

Agent Authorization. All persons named as Agents, or Alternate Agents herein who have succeeded to the office of Agent, are granted the powers and discretions described in the following provisions.

Delegation of All Powers Lawful to Delegate. I herewith delegate to my Agent each and every power that I may lawfully delegate, subject only to those limitations specifically set forth in this instrument.

DEE-2011-36146
Recorded 13 Pages on 10/17/2011 12:27:39 PM
Recording Fee: \$24.00 Documentary Stamps: \$0.00
Office of Register of Deeds, Spartanburg, S.C.
Dorothy Earle, Register



ARTICLE II ASSET POWERS

Introduction. My Agent is authorized in my Agent's sole and absolute discretion from time to time and at any time, with respect to any and all of my property and interests in property, real, personal, intangible, and mixed, as follows:

(1) **Power to Sell.** My Agent is authorized to sell any and every kind of property that I may own now or hereafter acquire, real, personal, intangible, and/or mixed, on such terms and conditions and security as my Agent shall deem appropriate and to grant options with respect to sales thereof.

(2) **Power to Buy.** My Agent is authorized to buy every kind of property, real, personal, intangible, and/or mixed, on such terms and conditions as my Agent shall deem appropriate.

(3) **Power to Invest.** My Agent is authorized to invest and reinvest all or any part of my property in any property or interests, including undivided interests, in property, real, personal, intangible, and/or mixed, wherever located.

(4) **Power to Manage Real Property.** With respect to real property, including but not limited to any real property I may hereafter acquire or receive and my personal residence, my Agent is authorized to lease, sublease, release; to eject and remove tenants or other persons. My Agent is authorized to mortgage and/or convey by deed of trust or otherwise encumber any real property now or hereafter owned by me, whether acquired by me or for me by my Agent.

(5) **Power to Manage Personal Property.** With respect to personal property, my Agent is authorized to buy, collect, receive, manage, lease, protect, insure, alter, improve, mortgage, pledge, sell, or transfer any such personal property, whether owned currently or hereinafter acquired by me.

(6) **Power to Operate Businesses.** My Agent is authorized to continue the operation of any business, corporation, partnership, limited liability company, proprietorship, or other entity owned by me, including all things relating to the management, operation, financing, and sale of any such business.

(7) **Power to Exercise Rights in Securities.** My Agent is authorized to exercise all rights with respect to corporate securities which I now own or may hereafter acquire.

(8) **Power to Demand and Receive.** My Agent is authorized to demand, arbitrate, settle, sue for, collect, receive, deposit, expend for my benefit, reinvest, or make such other appropriate disposition of as my Agent deems appropriate, all cash, rights to the payment of cash, property, real, personal, intangible, and/or mixed, debts, dues rights, accounts, legacies, bequests, devises, dividends, annuities, rights, and/or benefits to which I am now or may in the future become entitled.

(9) **Power to Exercise Elective Share Rights.** My Agent is authorized to elect to take against any will and conveyances of my deceased spouse and/or any other person, if appropriate,

and to retain any property which I have the right to elect to retain, as my Agent deems appropriate.

(10) **Power with Respect to Employment Benefits and Retirement Accounts.** My Agent is authorized to create and contribute to an employee benefit plan for my benefit; to elect my retirement; to select any payment option; to make voluntary contributions; to make "roll-overs" of plan benefits into other retirement plans; to apply for and receive payments and benefits; to waive rights given to non-employee spouses under state or federal law; to borrow money and purchase assets from such plans; to make and change beneficiary designations; and to consent and/or waive consent in connection with the designation of beneficiaries. These provisions apply to Individual Retirement Accounts as well as Roth Retirement Accounts.

(11) **Power with Respect to Bank Accounts.** My Agent is authorized to establish accounts of all kinds, including checking and savings, for me with financial institutions of any kind, including but not limited to banks and thrift institutions; to make deposits to and write checks on or make withdrawals from and grant security interests in all accounts in my name or with respect to which I am authorized signatory; to negotiate, endorse, or transfer any checks or other instruments with respect to any such accounts; and to contract for any services rendered by any bank or financial institution.

(12) **Power with Respect to Safe-Deposit Boxes.** My Agent is authorized to contract with any institution for the maintenance of a safe-deposit box; to have access to all safe-deposit boxes in my name or with respect to which I am a signatory; to add to and remove from the contents of any such safe deposit box; and to terminate box leases.

(13) **Power with Respect to Legal and Other Actions.** My Agent is authorized to institute, supervise, prosecute, defend, intervene in, abandon, compromise, arbitrate, settle, dismiss, and appeal from any and all legal, equitable, judicial, or administrative hearings, actions, suits, proceedings, attachments, arrests, or distresses involving me in any way.

(14) **Power to Manage Membership Plans and Accounts.** My Agent is authorized to open, manage, use, transfer, gift, and close on my behalf membership plans and accounts.

(15) **Power to Borrow Money.** My Agent is authorized to borrow money from any lender for my account on such terms and conditions and security as my Agent shall deem appropriate; and to borrow money on any life insurance policies owned by me on my life.

(16) **Power to Create, Fund, Amend, and Terminate Trusts.** My Agent is authorized to execute, amend, fund, withdraw, and terminate a revocable trust agreement with such trustee or trustees as my Agent shall select, which trust shall provide that all income and principal shall be paid to me, to some person for my benefit, or applied for my benefit in such amounts as I or my Agent shall request or as the trustee or trustees shall determine, and that on my death any remaining income and principal shall be paid to my personal representative.

(17) **Power to Fund Trusts Created by the Principal.** My Agent is authorized to transfer from time to time and at any time to the trustee or trustees of any revocable trust

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agreement created by me before or after the execution of this instrument any and all of my cash, real or personal property of all kinds, or interests in property.

(18) **Power to Withdraw Funds from Trusts.** My Agent is authorized to request, withdraw, and/or receive the income or corpus of any trust over which I may have a right of withdrawal and to exercise or let lapse any power of withdrawal.

(19) **Power to Renounce and Resign from Fiduciary Positions.** My Agent is authorized to renounce any fiduciary position to which I have been or may be appointed or elected, and any office or position to which I have been or may be elected or appointed; to resign any such positions; to file an accounting with a court of competent jurisdiction or settle on an informal method as my Agent shall deem appropriate.

(20) **Power to Disclaim, Renounce, Release, or Abandon Property Interests.** My Agent is authorized to renounce, disclaim, release, or abandon any property or interest in property or powers to which for any reason and by any means I may become entitled, whether by gift, testate or intestate succession, including the right to alter, amend, revoke, or terminate, and to exercise any right to claim an elective share in any estate or under any will.

(21) **Power with Respect to Insurance.** My Agent is authorized to purchase, maintain, surrender, collect, or cancel life insurance or annuities, hospital insurance, medical insurance, Medicare supplement insurance, custodial care insurance, long-term care insurance, and disability income insurance for me or any of my dependents, and liability insurance on assets of mine against loss or damage.

(22) **Power with Respect to Taxes.** My Agent is authorized to represent me in all tax matters; to prepare, sign, and file federal, state, and/or local income, gift, and other tax returns of all kinds, and any power of attorney form appointing an agent required by the Internal Revenue Service and/or any state and/or local taxing authority.

(23) **Power to Oversee Qualified State Tuition Plans.** My Agent is authorized to create, fund, modify, and terminate one or more qualified state tuition plans created under section 529 of the Internal Revenue Code.

(24) **Power to Make Gifts.** My Agent is authorized to make gifts or other transfers without consideration either outright or in trust (including the forgiveness of indebtedness and the completion of any charitable pledges I may have made) to such person or organization as my Agent shall select; to consent to the splitting of gifts under section 2513 of the Internal Revenue Code; to pay any gift tax that may arise by reason of such gift. Provided, however, that if this Power of Attorney shall permit an Agent to make gifts to a group of individuals, which includes the Agent, the amount of such gift to the Agent shall be limited to the greater of Five Thousand Dollars (\$5,000.00) or five percent (5%) of the aggregate value of the Principal's assets effected by this Power of Attorney as of the date of the gift.

(25) **Power to Provide Support to Others.** My Agent is authorized to support and/or continue to support any person whom I have undertaken to support or to whom I may owe an

obligation of support, in the same manner and in accordance with the same standard of living as I may have provided in the past; provided, however, that if at any time that my Agent shall act under this clause I am legally separated or divorced from my spouse, any support provided to such spouse by my Agent shall be limited to such support as may be required by law.

(26) **Power to Make Loans.** My Agent is authorized to lend, renew, or extend money and property at such interest rate, if any, and on such terms and conditions, and with such security, if any, as my Agent may deem appropriate.

(27) **Power to Engage in Estate and Long Term Care Planning.** To engage in estate and long term care planning in furtherance of achieving asset preservation based on all relevant factors, including, but not limited to: the value and nature of my property; my foreseeable obligations and need for maintenance; minimization of taxes, including income, estate, inheritance, generation skipping transfer, and gift taxes; and eligibility for a benefit, a program, or assistance under a statute or government regulation. Property transfers made pursuant to the authority granted herein shall, for all purposes, be deemed to have been "in my best interest" if such transfers are made in accordance with the provisions of this section and made in the context of estate planning, financial planning, Medicaid planning, long term care planning and/or asset preservation planning pursuant to the recommendations of an attorney-at-law experienced in such matters. My agent may take any action necessary to effectuate the foregoing, including to qualify me for Social Security benefits, Supplemental Security Income, Veterans benefits, Medicaid, or any other government benefit program. Such actions may include, but shall not be limited to, the following: convert non-exempt resources into exempt resources; divest me of assets; if I am married, my Agent may take actions to protect my income and my assets, whether owned by me alone or by us together as husband and wife, so that my spouse's impoverishment because of my health care costs can be avoided, by whatever lawful methods might be available; sign a Spousal Refusal; sign an Assignment of Support; sign an application for Medical Assistance or any other government benefit program; serve as representative payee; make home improvements and additions to my family residence; pay off, partly or in full, any encumbrance on my family residence; purchase a family residence, if I do not own a family residence; purchase a more expensive family residence; transfer, pursuant to the then-existing exemptions from imposition of a transfer penalty period, the family residence or any other asset to a spouse or other qualifying individual, who does not need long-term health or nursing care; if I am married, divide community property assets equally or unequally between my spouse and me; and attend and represent me at Fair Hearings.

(28) **Power to Care for Pets.** My Agent is authorized to take possession of my pets and maintain them in the standard of care and health as I cared for them. In exercising such authority, my Agent is authorized to expend or otherwise use reasonable amounts of my funds as may be necessary or appropriate to provide for the health, care, exercise, and welfare of such pets including, but not limited to, veterinary care, food, toys, and kennel fees.

ARTICLE III CARE AND CONTROL OF THE PERSON

Introduction. My Agent is authorized in my Agent's sole and absolute discretion from time to time and at any time, with respect to the control and management of my person, as follows:

(1) **Power to Provide for Principal's Support.** My Agent is authorized to do all acts necessary for maintaining my customary standard of living, to provide a place of residence, to provide normal domestic help, and to provide clothing, transportation, medicine, food, health care, custodial care, and incidentals, as my Agent shall deem appropriate.

(2) **Power to Provide for Personal Care.** My Agent may make all decisions related to my personal care, including but not limited to, providing for my food and clothing, transportation, recreation, entertainment, and other activities of daily life.

(3) **Power to Provide for Recreation and Travel.** To provide opportunities for me to engage in recreational and sports activities, including travel, as my health permits.

(4) **Power to Provide for Spiritual or Religious Needs.** My Agent is authorized to provide for the presence of religious clergy, and to maintain my memberships in religious organizations.

(5) **Power to Provide for Companionship.** To provide for such companionship for me as will meet my needs and preferences at a time when I am disabled or otherwise unable to arrange for such companionship myself.

(6) **Power to Make Advance Funeral Arrangements.** To make advance arrangements for my funeral and burial, including the purchase of a burial plot and marker, and such other related arrangements as my Agent shall deem appropriate; if I have not previously done so myself.

(7) **Power to Make Anatomical Gifts Effective at Death.** To make anatomical gifts of any of my organs, tissues, or body parts which will take effect at my death to such persons and organizations as my Agent shall deem appropriate and to execute such papers and do such acts as shall be necessary or appropriate.

(8) **Power to Change Domicile.** My Agent is authorized to establish a new residency or domicile for me, as my Agent shall deem appropriate.

(9) **Designation of Agent as HIPAA Personal Representative.** This Durable Power of Attorney authorizes my Agent to act on my behalf pertaining to me and my property. Some of these decisions also deal with decisions that relate to my health and health care matters. I therefore grant and confirm that my Agent also shall be treated as a "personal representative" under the Health Insurance Portability and Accountability Act of 1996 and its regulations (including 45 C.F.R. § 164.502(g)(2)) for all purposes relating to my "protected health information." My Agent is authorized to request and receive all "protected health information"

and all other types of my medical records and information from my doctors, hospitals, and any other medical facility or provider.

ARTICLE IV HEALTH CARE

My Agent is authorized in my Agent's sole and absolute discretion from time to time and at any time to exercise the authority described below relating to matters involving my health and medical care.

The Agent, as my "personal representative," shall have powers granted by all applicable state and federal law, including the Health Insurance Portability and Accountability Act ("HIPAA"). The information disclosed by any such health care provider is subject to further disclosure and may thereafter no longer be protected by such privacy rules. This authorization shall remain in effect until the earlier of its revocation by me or my death.

(1) Power of Access and Disclosure of Medical Records and Other Personal Information. To request, receive, and review any information, including both verbal or written, regarding my personal affairs or my physical or medical health, including medical and hospital records and any "protected health information" as defined by the Health Insurance Portability and Accountability Act ("HIPAA"), and to execute any releases or other documents that may be required to obtain such information, and to disclose or deny such information to such persons, organizations, firms, or corporations as my Agent shall deem appropriate. The Agent shall have powers granted by all applicable state and federal law, including HIPAA. For such purposes, I do hereby designate my Agent as my "personal representative" with all the authority granted to such person under HIPAA. The Agent may grant releases to hospital staff, physicians, and other health care providers who act in reliance on instructions given by my Agent or who render written opinions to the Agent from all liability for damages. This authorization is intended to provide my health care providers with the authorization necessary to allow each of them to disclose such general medical information and protected health information regarding me to the above designated agents. The information disclosed by any such health care provider pursuant to this authorization is subject to further disclosure and use by such designated agents and may thereafter no longer be protected by such privacy rules. This authorization shall remain in effect until the earlier of its revocation by me or my death.

(2) Psychiatric Records. My Agent is authorized to request, receive, and review any information, including, both verbal or written, regarding my psychiatric or mental health, including psychiatric records, psychiatric notes, and hospital records and any "protected health information" as defined by the Health Insurance Portability and Accountability Act ("HIPAA"), and to execute any releases or other documents that may be required to obtain such information, and to disclose or deny such information to such persons, organizations, firms, or corporations as my Agent shall deem appropriate. The Agent shall have powers granted by all applicable state and federal law including HIPAA. For such purposes, I do hereby designate my Agent as my "personal representative" with all the authorities granted to such person under HIPAA. The Agent may grant releases to hospital staff, physicians, and other health care providers who act in reliance on instructions given by my Agent or who render written opinions to the Agent from all liability for damages. This authorization is intended to provide my health care providers with the

authorization necessary to allow each of them to disclose such general psychiatric information and protected health information regarding me to the above designated agents. The information disclosed by any such health care provider pursuant to this authorization is subject to further disclosure and use by such designated agents and may thereafter no longer be protected by such privacy rules. This authorization shall remain in effect until the earlier of its revocation by me or my death.

(3) Power to Obtain Medical Records to Determine Incapacity. When it is necessary or appropriate to inquire about the physical or mental health of the Principal and notwithstanding any condition precedent otherwise contained in the document, the Agent is authorized to request, receive, and review any information, verbal or written, regarding the Principal's physical or mental health, including medical and hospital records. The Agent may execute any releases or other documents that may be required to obtain such information and to disclose such information to such persons, organizations, firms, or corporations as my Agent shall deem appropriate. The Agent shall have powers granted by all applicable state and federal law, including the Health Insurance Portability and Accountability Act ("HIPAA"). For such purposes, I do hereby designate my Agent as my "personal representative" with all the authorities granted to such person under HIPAA. The Agent may grant releases to hospital staff, physicians, and other health care providers who act in reliance on instructions given by my Agent or who render written opinions to the Agent from all liability for damages. This authorization is intended to provide my health care providers with the authorization necessary to allow each of them to disclose such general medical information and protected health information regarding me to the above designated agents. The information disclosed by any such health care provider pursuant to this authorization is subject to further disclosure and use by such designated agents and may thereafter no longer be protected by such privacy rules. This authorization shall remain in effect until the earlier of its revocation by me or my death.

(4) Power to Employ and Discharge Health Care Personnel. My Agent is authorized to employ, compensate, and discharge health care personnel as my Agent shall deem necessary.

(5) Power to Give, Withhold, or Withdraw Consent to Health Care Treatment. My Agent is authorized to give, withhold, withdraw, or modify consent to any health care procedures, tests, or treatments, including surgery; to arrange for my hospitalization or other care; to summon emergency medical personnel and seek emergency treatment for me, as my Agent shall deem appropriate; to give, withhold, withdraw, or modify consents for procedures and care.

(6) Power to Give or Withhold Consent to Psychiatric Treatment. My Agent is authorized to arrange, on the execution of a certificate by two independent psychiatrists who have examined me and in whose opinions I am in immediate need of hospitalization because of mental disorder, alcoholism, or drug abuse, for my voluntary admission to an appropriate hospital or institution for treatment of the diagnosed problem; to arrange for my treatment; and to revoke, modify, withdraw or change consent to such treatment.

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(7) **Power to Maintain Me in My Residence.** My Agent is authorized to take whatever steps are necessary or advisable to enable me to remain in my personal residence as long as it is reasonable under the circumstances to maintain me in my residence.

(8) **Power to Exercise My Health Care Right of Privacy.** My Agent is authorized to exercise all state and federal rights that I may have, including but not limited to my right of privacy to make decisions regarding my health care.

(9) **Power to Authorize Relief from Pain.** My Agent is authorized to consent to the administration of pain-relieving drugs of any kind, or other surgical or health care procedures calculated to relieve my pain, even though such drugs or procedures may lead to permanent physical damage, addiction, or even hasten the moment of, but not intentionally cause, my death.

(10) **Power to Grant Releases.** My Agent is authorized to grant releases to hospital staff, physicians, and other health care providers who act in reliance on instructions given by my Agent from all liability for damages suffered or to be suffered by me.

ARTICLE V INCIDENTAL POWERS

In connection with the exercise of the powers herein described, my Agent is fully authorized and empowered to perform any acts and things and to execute and deliver any documents, instruments, affidavits, certificates, and papers necessary or appropriate to such exercise or exercises.

(1) **Resort to Courts.** My Agent is authorized to seek on my behalf and at my expense a declaratory judgment, mandatory injunction, or suit for damages from any court of competent jurisdiction.

(2) **Hire and Fire Any Personnel.** My Agent is Authorized to employ, compensate, and discharge such domestic, health care, and professional personnel including lawyers, accountants, doctors, nurses, brokers, financial consultants, advisors, consultants, companions, servants, and employees as my Agent deems appropriate.

(3) **Sign Documents and Incur Costs in Implementing the Agent's Instructions.** My Agent is authorized to sign, execute, endorse, seal, acknowledge, deliver, and file or record instruments and documents appropriate to effectuate the powers delegated herein; to incur costs on my behalf and to promptly pay such costs, and to expend my funds and to liquidate my property or to borrow money to produce such funds needed.

(4) **Power to Do Miscellaneous Acts.** My Agent is authorized to open, read, respond to, and redirect my mail; to represent me before the U.S. Postal Service; to establish, cancel, continue, or initiate my membership in organizations and associations; to take and give or deny custody of all of my important documents; to execute documents on my behalf; and to house or provide for housing, support, and maintenance of any animals that I may own or to transfer such animals to some person or persons willing to care for them.

ARTICLE VI THIRD PARTY RELIANCE

Third Party Reliance. For the purpose of inducing all persons and entities, including but not limited to any physician, hospital, nursing home, health care provider, bank, broker, custodian, insurer, lender, transfer agent, taxing authority, governmental agency, or other party to act in accordance with the instructions of my Agent as authorized in this instrument, I hereby represent, warrant, and agree that: i) if this instrument is revoked or amended for any reason, I and my estate will hold any person or entity harmless from any loss suffered, or liability incurred by such person in acting in accordance with the instructions of my Agent acting under this instrument prior to the receipt by such person of actual written notice of any such revocation or amendment; ii) the powers conferred on my Agent may be exercised by my Agent alone and my Agent's signature or act under the authority granted in this instrument may be accepted by persons as fully authorized by me; iii) no person who relies in good faith on the authority of my Agent under this instrument shall incur any liability to me; iv) no person who relies on any affidavit or certificate under penalties of perjury that this instrument specifically authorizes my Agent to execute and deliver to such person shall incur any liability to me; v) all persons from whom my Agent may request information regarding me are released from any legal liability whatsoever to me, my estate, or my personal representative for complying with my Agent's requests; and vi) I hereby authorize all physicians and psychiatrists who have treated me, and all other providers of health care, including hospitals, to release to my Agent all information or photocopies of any records which my Agent may request and I hereby waive all privileges which may be applicable to such information and records.

ARTICLE VII RESTRICTION ON POWERS

Restriction on Powers. Notwithstanding any provision herein to the contrary, my Agent shall: i) have no power or authority whatsoever with respect to any interest in or incidents of ownership in any policy of insurance I may own on the life of my Agent; ii) have no power or authority whatsoever with respect to (a) any irrevocable trust created by my Agent as to which I am a trustee or a beneficiary, or (b) any asset given to me by my Agent; iii) be prohibited from (a) appointing, assigning, or designating any of my assets, interests, or rights directly or indirectly to my Agent, my Agent's estate, my Agent's creditors, or the creditors of my Agent's estate, (b) exercising any powers of appointment I may hold in favor of my Agent, my Agent's estate, my Agent's creditors, or the creditors of my Agent's estate, (c) disclaiming assets to which I would otherwise be entitled if the effect of such disclaimer is to pass assets directly or indirectly to my Agent or his or her estate, or (d) using my assets to discharge any of my Agent's legal obligations, including any obligation of support which my Agent may owe to others, excluding those whom I am legally obligated to support; iv) be prohibited from exercising any discretionary fiduciary powers that I now hold or may hereafter acquire; and v) avoid disrupting the dispositive provisions of any estate plan of mine known to my Agent.

ARTICLE VIII DURABILITY PROVISION

Immediate Power. This power of attorney shall not be affected by my subsequent disability or incapacity, or lapse of time.

ARTICLE IX ADMINISTRATIVE PROVISIONS

Introduction. The following provisions shall apply:

(1) **Nomination of Agent as Conservator and Guardian for Principal.** To the extent that I am permitted by law to do so, I herewith nominate and appoint my Agent to serve as my guardian, conservator, and/or in any similar representative capacity, if such an appointment is necessary.

(2) **Waiver of Acts of Omission and Commission.** My Agent (and my Agent's estate and Personal Representative), acting in good faith, are hereby released and forever discharged from any and all civil liability and from all claims or demands of all kinds whatsoever by me or my estate and Personal Representative arising out of the acts or omissions of my Agent, except for willful misconduct or gross negligence.

(3) **Waiver of Duty to Produce Income, Authority for Transactions between Agent as Agent and Agent as Individual and Eligibility of Agent to Serve in Other Fiduciary Capacities for Principal.** My Agent shall have no responsibility to make my property productive of income, to increase the value of my estate or to diversify my investments. My Agent shall have no liability for entering into transactions authorized by this instrument with my Agent in my Agent's individual capacity as long as my Agent believes in good faith that such transactions are in my best interests or the best interests of my estate and those persons interested in my estate. My Agent shall be eligible to serve in all other fiduciary capacities, for me or my benefit (but not in my place where I may serve as a fiduciary for others), including but not limited to serving as Trustee, Guardian, Conservator, Committee, Personal Representatives.

(4) **No Duty to Monitor Health.** My Agent shall have no responsibility to monitor on any regular basis the state of my physical health or mental capacity to determine if any actions need be taken under this instrument.

(5) **Severability.** If any part of any provision of this instrument shall be invalid or unenforceable under applicable law, such part shall be ineffective to the extent of such invalidity only, without in any way affecting the remaining parts of such provision or the remaining provisions of this instrument.

(6) **This Instrument Unaffected by Lapse of Time.** This power of attorney shall be legally unaffected by reason of lapse of time or staleness.

(7) **Agent Authorized to Sign Power of Attorney Forms.** In carrying out the authorizations set forth in this instrument, if in the sole opinion of my Agent it is necessary or convenient for my Agent to sign my name, as Principal, on forms of powers of attorney (the "Forms") required by governmental agencies, corporations or other entities in transactions with me, my Agent is authorized to execute such Forms, and to appoint an agent or other person on the Forms to represent me.

(8) **Agent Authorized to Employ Principal's Attorney.** The Principal requests and authorizes the Agent to employ the attorney who prepared this power of attorney or other attorneys employed by the Principal in connection with the Principal's estate plan and business matters and hereby (a) waives any and all conflicts of interest that might arise through such employment, (b) authorizes all such attorneys to make full disclosure of the Principal's estate plan and business to the Agent and (c) authorizes such attorneys to accept such employment.

(9) **Revocation and Amendment.** This instrument may be amended or revoked by me at any time by the execution by me of a written instrument of revocation or amendment delivered to my Agent and to all Alternate Agents.

(10) **Agent's Resignation and Selection of Substitute.** If my Agent desires to resign as my Agent, and there is no successor Agent named in this instrument who is willing and able to serve as my Agent, and I am incapacitated at the time of such resignation, then on such resignation my Agent is authorized and empowered to appoint a substitute Agent to act and serve as my Agent, such appointment to be made in a written instrument that shall be (i) signed by my Agent, (ii) delivered to my substitute Agent, and (iii) attached to this instrument.

(11) **Agent's Death, Incapacity, or Resignation and Selection of Substitute.** At any time after my incapacity, my Agent at any time may appoint a future successor Agent to act and serve as my Agent in the event that my Agent shall die or become mentally incapacitated or shall resign prior to my death, and my Agent at any time during my Agent's service as Agent may also revoke any such appointment theretofore made by my Agent, provided, however, that my Agent may not revoke, modify or supersede any appointment of a successor Agent made by me in this power of attorney. Any appointment made by my Agent shall be made in a written instrument that shall (i) specify the event or events on which such substitution shall become effective, (ii) be signed by my Agent, (iii) be delivered to my substitute Agent, and (iv) be attached to this instrument.

(12) **Counterpart Originals.** If this instrument has been executed in multiple counterpart originals, each such counterpart original shall have equal force and effect.

(13) **Photocopies.** My Agent is authorized to make photocopies of this instrument as frequently and in such quantity as my Agent shall deem appropriate. Each photocopy shall have the same force and effect as any original.

(14) **Binding Effect.** This instrument and actions taken by my Agent properly authorized hereunder shall be binding on me, my estate and my Personal Representative.

7th IN WITNESS WHEREOF, I have executed this Power of Attorney this the 7th day of October, 2011, and I have directed that photographic copies of this power be made which shall have the same force and effect as an original.

Margaret S. Hensley
MARGARET S. HENSLEY, PRINCIPAL

ATTESTATION

The foregoing Durable Power of Attorney was this the 7th day of October, 2011, signed, sealed, published and declared by the said Principal as and for the Principal's Durable Power of Attorney in our presence, and at the Principal's request and in the Principal's presence, and in the presence of each other, have hereunto subscribed our names as witnesses on the above date.

Paul R. Bullard of Spartanburg, S.C.
Arthur H. McQueen of Spartanburg, S.C.
STATE OF SOUTH CAROLINA)
COUNTY OF SPARTANBURG) PROBATE

PERSONALLY appeared the undersigned witness and made oath that She saw the within named Principal duly authorized, sign, seal and as the Principal's act and deed deliver the within Durable Power of Attorney and that deponent with the other witness whose name is subscribed above witnessed the execution thereof.

Paul R. Bullard

SWORN to before me this

7th day of October, 20 11

Arthur H. McQueen
Notary Public for South Carolina

My Commission Expires: 12/27/2012

ORIGINAL



RESIDENT AND FACILITY
ADMISSION AGREEMENT

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RESIDENT AND FACILITY ADMISSION AGREEMENT
PLEASE READ CAREFULLY AND ASK ANY QUESTIONS

This Agreement is made by and between White Oak Estates (hereinafter called "Facility") and Resident and his/her Authorized Representative and/or the individual who has access to Resident's income and financial resources available to pay for nursing care (hereinafter called "Authorized Representative") for the provision of nursing services for Margaret S. Hersley (hereinafter called "Resident").

Resident and/or Authorized Representative affirm that the information provided during the admission process is true and correct to the best of their knowledge, and acknowledge that the submission of any false information may constitute grounds to terminate this Agreement.

Identification of Authorized Representative (if applicable):

The Authorized Representative is anyone authorized by the Resident or by law to act on the Resident's behalf. Please check the type and scope of authority for anyone other than the Resident who signs this Agreement.

TYPE (Check one)

- ☐ General POA*
- ☐ Durable POA*
- ☒ Durable POA w/ Healthcare*
- ☐ Guardianship / Conservatorship*
- ☐ Healthcare POA*
- ☐ Other: _____

SCOPE (check all that apply)

- ☐ Routine health care
- ☒ Unlimited health care
- ☐ Limited access to income / finance
- ☒ Authorized to accept income and control financial resources of Resident

*** Must provide copies of any and/or all documents checked above**

The Authorized Representative, by signing this Agreement, acknowledges acceptance of the duties and responsibilities of this role.

The Authorized Representative will not incur personal financial liability except for breach of duty or contract related to the misuse of Resident's resources or the failure to use those resources to pay for the Resident's care.

PRELIMINARY STATEMENTS:

Resident individually or by and through Resident's Authorized Representative has considered appropriate care settings and is desirous of receiving care at the Facility.

Facility is a licensed nursing facility and will provide the services set forth below in accordance with the applicable standards of care, none of which cause the Facility to become an insurer nor guarantor of the health and safety of the Resident, or for that matter, the insurer or guarantor of the Resident's personal property.

NOW, THEREFORE, in consideration of the prompt payment by the Resident (and the applicable state, federal, or private insurance program) of the charges made to the Resident's account in accordance with the charge structure of the Facility, and in further consideration of the mutual covenants and promises herein, the parties agree as follows:

2. PROVISION OF SERVICES

2.1. Care and Services. The Facility offers, at the Daily Rate, the following services: room accommodations, food services, licensed routine nursing services, social services, activities, housekeeping services, laundering of linens and towels, routine hair care, and resident trust fund services.

2.2. Ancillary Services and Supplies. The Facility shall make available at an additional charge, unless included in the Daily Rate, the following items and services: therapy services, medical supplies, laboratory services, pharmaceuticals, beauty/barbershop, guest meals, and toiletries for personal comfort, grooming, or hygiene, and transportation. All items and services not included in the Daily Rate, such as Medicare A or Medicaid, will be billed to the applicable payor. The Resident is responsible for all non-covered items and services, co-payments or deductible amounts, according to the Facility's Rate Schedule, as amended from time-to-time. Items and services not included in the Daily Rate will be updated periodically upon notice to residents.

2.3. Services of Other Providers. The services of outside providers such as a licensed physician, optometrist, podiatrist and/or dentist, a registered pharmacist for the provision of medications, rehabilitation therapies and diagnostic services, i.e., laboratory, x-ray and/or ambulance services, are available at the Facility or under arrangement. These services are available under guidelines and procedures established by the Facility and may be utilized by Resident at his or her own expense unless covered by another pay source. The Facility retains the right to control the source of supply of any items and contract services used within the Facility. Resident or Authorized Representative has exercised freedom of choice by applying for admission to Facility and thereby agrees and contracts with Facility to provide said supply items and contract services as requested. The place of purchase for pharmaceutical items is within Resident's freedom of choice subject to the Facility's policy for Resident drugs.

2.4. Role of Attending Physician and Medical Director. The Resident shall obtain the services of a qualified physician who will provide medical care during the Resident's stay at the Facility. The Resident is free to receive care from any licensed physician who agrees to submit credentials to the Facility and adhere to the Facility's policies and procedures. The Resident elects Dr. Win as the attending physician(s). DWP (initials). The Facility is not obligated to provide Resident with any medicines, treatments, special diets or equipment without specific orders or directions from Resident's attending physician. In the event Resident's attending physician is unavailable, the Facility's Medical Director / Designee may issue appropriate orders. Resident is responsible to pay for all services or equipment ordered by Resident's attending physician or the Facility's Medical Director / Designee for Resident's care unless covered by Medicare / Medicaid or other third-party insurer.

2.5. Room Assignments. The Facility makes room and bed assignments according to availability and/or in accordance with the Resident's physical and psychosocial wellbeing. Resident acknowledges that bed assignments may be changed in order to provide a proper environment for all residents. Resident and family / Authorized Representative will be notified of any room changes.

3. CHARGES

3.1. Recurring / Periodic Charges for Care and Services. Resident shall pay the Daily Rate, specified in the Rate Schedule in effect at the time the service is rendered, for routine nursing services provided to Resident. The Daily Rate may be changed from time-to-time in accordance with the provisions of Section 4.3. Charges for a resident whose payor source is other than Medicare Part A or Medicaid will begin on the designated admission date or actual admission, whichever is earlier; charges for a resident whose payor source is Medicare Part A or Medicaid will begin no earlier than the date of admission.

3.2. Additional Charges for Ancillary Services and Supplies. Resident shall pay for other services and supplies provided by or through the Facility which are not covered by the Daily Rate as set forth in the Rate Schedule in effect at the time such ancillary services or supplies are rendered. Any items ordered by a physician, which are not identified on the Rate Schedule, will be provided at charges identified by the Facility. The charges for ancillary services and supplies are subject to change from time-to-time.

3.3. Charges for Outside and Non-Facility Services. In addition to the Facility's charges, Resident shall pay all fees and costs for goods or services furnished to or for Resident by anyone other than the Facility as described in Section 2.3 (Services of Other Providers) unless otherwise covered in full by Medicare or Medicaid or another third-party payor. Resident or Authorized Representative is obligated to pay such fees and costs whether the goods and services are furnished by a person or provider made available by the Facility, or by a person or provider selected by Resident, and whether the goods or services are provided at the Facility or elsewhere. These fees and costs are not included in the Daily Rate. Fees for professional services rendered by a physician are not included in the Daily Rate and will be charged directly to the Resident by the physician.

4. PERIODIC BILLINGS AND PAYMENT DUE DATE

- 4.1. Monthly Statements and Other Billings.** Prepayment for one (1) month of the basic monthly rate is required at the time of admission. The Facility will mail Resident or Authorized Representative on or about the tenth (10th) day of the month a billing statement reflecting charges for care and services for the upcoming month and charges for ancillary services and supplies which were incurred in the prior month. Statements are due and payable upon receipt of the Monthly Statement.

Resident expecting Medicare coverage specifically understands that Medicare co-insurance is the responsibility of the Resident. Payment of co-insurance is required. Payment for Medicare services is not expected until services are rendered.

- 4.2. Failure to Pay and Cost of Collection.** Failure to pay an account at the Facility when due is a breach of this Agreement and will allow Facility to discharge Resident upon giving a thirty (30) day written notice, during which thirty (30) day period the breach may be cured by payment of the account in full.

In the event the Facility initiates legal action to collect payments due from the Resident under this Agreement, and the Facility is successful, the Resident and/or Authorized Representative shall be responsible for reimbursing the Facility for all costs and expenses thereby incurred, including reasonable attorneys' fees.

- 4.3. Modification of Charges.** The Facility reserves the right to change the Rate Schedule reflecting the amount of any of its charges or how and when charges are computed, billed or become due. The Facility shall provide thirty (30) days advance written notice of any such changes.

- 4.4. Obligations of Resident's Estate and Assignment of Property.** Resident and Authorized Representative acknowledge the charges for services provided under this Agreement remain owed until paid. In the event of Resident's discharge for any reason, including death, this Agreement shall operate as an assignment, transfer and conveyance to the Facility of so much of Resident's property as is equal in value to the amount of any unpaid obligations under this Agreement. This assignment shall be an obligation of Resident's estate and may be enforced against the Resident's estate.

- 4.5. Change in Contact Information.** Resident and/or Authorized Representative agree to notify the Facility within ten (10) days of any change in Authorized Representative's contact information.

5. MEDICARE / MEDICAID PROGRAMS

- 5.1. Participation in Programs.** The Facility currently participates in the South Carolina / North Carolina Medicaid program and the federal Medicare program. The Facility reserves the right to withdraw from the Medicaid or Medicare programs at any time in accordance with law.

5.2. Actions of Medicaid and Medicare Agencies. The South Carolina / North Carolina Department of Health and Human Services ("DHHS") is responsible for administering benefits under the Medicaid program. The Centers for Medicare and Medicaid Services ("CMS"), of the United States Department of Health and Human Services, is responsible for administering the Medicare program through an intermediary. Resident acknowledges that the Facility is not responsible for, and has made no representations regarding, the actions or decisions of DHHS, CMS or the Medicare intermediary in administering the programs.

5.3. Medicaid Benefits.

5.3.1. Obligations of Resident. Resident is obligated to make full and complete disclosure regarding all financial resources and income during the application process. Failure to identify all resources and income, or the submission of false information, may result in the termination of this Agreement. Resident is obligated to notify the Facility when Resident's resources available to satisfy the Resident's financial obligations under this Agreement are no longer sufficient to pay all the Facility charges for Resident's care and services or when directed to do so by the Facility. Resident shall provide any documentation requested by the County Medicaid Office. Upon Facility's request, Resident shall execute an authorization for Facility to assist the Resident in securing Medicaid benefits, pursuing a hardship waiver, and bringing Resident's account current. In the event Resident applies for Medicaid benefits, Resident shall continue to pay and apply all of Resident's available resources toward the fulfillment of Resident's financial obligations under this Agreement while the Medicaid application is pending an eligibility determination by DHHS.

5.3.2. Recurring Liability Amount. For residents approved for Medicaid benefits, the Facility will accept payment from the State of South Carolina / North Carolina and, if applicable, the Resident's Recurring Liability Amount as determined by DHHS as payment in full only for those services covered by the Medicaid program. Resident remains obligated to pay such Recurring Liability Amount on a monthly basis. Services not covered by Medicaid are identified in the Rate Schedule and Resident remains obligated to pay for such services. If Resident plans to apply for Medicaid, then the Resident will have an **estimated** monthly Recurring Liability in the amount of \$ ^{Total Income} ~~255430~~ until the State determines the amount of Resident's income to be paid to the Facility. Once the approved Recurring Liability amount has been set by Medicaid, any differences must be paid or adjusted. The Recurring Liability amount is due to the Facility by the fifth (5th) day of the month. JHP (initials)

5.3.3. Determination of Eligibility. Resident and Authorized Representative are obligated to cooperate fully in any Medicaid eligibility determination or re-determination process. In the event that Resident's eligibility for Medicaid benefits is denied, interrupted or terminated due to the failure of Resident or Authorized Representative to cooperate in the Medicaid application, re-determination or appeal process, the Resident and Authorized Representative shall be liable for the Daily Rate plus charges for ancillary services and supplies during any period of ineligibility, and the Facility may terminate this Agreement.

5.3.4. Authorization to Apply for and/or Appeal (Medicaid). In the event of Resident's incapacity and in situations where Resident's resources are depleted or appear to be depleted to the extent that Resident can no longer pay privately for nursing care, and it appears that Resident has become or will become eligible for Medicaid benefits to cover the cost of Resident's continued stay in the Facility; and if there is no other legal representative of Resident known to the Facility or other friend or relative known to the Facility who is authorized and/or is available or willing to act on Resident's behalf, after the Facility has made a good faith effort to identify such persons; then Resident hereby authorizes the Facility to request, file and/or apply for Medicaid benefits on behalf of Resident for the limited purpose of assisting Resident to secure payment through the Medicaid program for Resident's continued stay in the Facility. In the event the application for Medicaid benefits filed on behalf of the Resident is denied, or in the event Medicaid benefits are granted and subsequently discontinued, Resident hereby authorizes the Facility to file on Resident's behalf an appeal of any such denial of Medicaid eligibility or discontinuance of Medicaid benefits, and to take such actions to secure Resident's Medicaid benefits as the Facility deems reasonably necessary or appropriate and consistent with law. Resident warrants and represents that the financial information disclosed in the admission process is true and accurate and may be relied on by the Facility in pursuing Medicaid benefits on behalf of Resident.

5.3.5. Authorization to File a Hardship Waiver with DHHS on Behalf of Resident. If DHHS' application of a transfer of assets penalty operates to deprive Resident of medical care such that Resident's life would be in danger, or would deprive Resident of food, clothing or shelter, or the necessities of life, then in the event of Resident's incapacity, inability or unwillingness to act, and if there is no other Authorized Representative of Resident known to the Facility or any other friend or relative known to the Facility who is authorized and/or is promptly available or willing to act timely on behalf of Resident, then Resident authorizes Facility to file a Hardship Waiver with DHHS on Resident's behalf.

5.4. Medicare Part A and Part B Benefits. To the extent that Resident is a beneficiary under either Medicare Part A or Medicare Part B insurance and the nursing services or ancillary services or supplies ordered by a physician are covered by such insurance, the Facility or other provider will bill the charges for the covered services or supplies to the Medicare program. The Resident is responsible for and shall pay any co-insurance or deductible amounts under Medicare Part A or Part B insurance. The Facility shall accept payment from the Medicare intermediary as payment in full only for those services deemed to be covered in full under the Medicare Part A or the Medicare Part B program. Services not covered by Medicare are identified in the Rate Schedule.

5.5. Medicare Part B Payment Limitations: Therapy Caps.

5.5.1. General. Effective January 1, 2006, CMS imposed payment limitations on covered therapy services provided to individuals who are eligible beneficiaries under Medicare Part B. Under this financial limitation, Medicare will pay an annual capped amount for physical and speech therapy (combined) and an annual capped amount for occupational therapy. The capped amounts are revised by CMS

annually. Facility shall provide Resident and/or Authorized Representative with notice of the current capped amounts as appropriate.

5.5.2. Resident's Responsibility to Pay for Therapy Services Beyond the Capped Amounts. Resident is responsible to pay the charges for all medically necessary therapy services in excess of the annual capped amounts, unless such therapy services are covered in whole or in part by private insurance or another government reimbursement program. In the event that another government reimbursement program or available third-party payor or insurance program denies coverage for therapy services provided to Resident after exhaustion of the annual capped amount, then Resident or Authorized Representative shall remain responsible to pay all fees and costs for all such therapy services. If Resident is not eligible for Medicaid, then failure to pay for therapy services rendered above the capped amount shall be grounds for termination and discharge from Facility pursuant to Section 10 of this Agreement.

5.5.3. Exception Requests.

5.5.3.1. Automatic Exceptions. Medicare beneficiaries may be automatically exempted from the annual therapy caps for certain conditions or complexities that have a direct and significant impact on the need for the course of therapy being provided and the additional treatment is medically necessary.

5.5.3.2. Manual Exceptions. Medicare beneficiaries not automatically exempted from the annual therapy caps are entitled to request an exception to the annual therapy caps, for up to fifteen (15) additional treatment days. In the event that Resident has exhausted the annual capped amount, and is not automatically exempted from the therapy caps, then the following shall apply:

5.5.3.2.1. Resident and/or Authorized Representative may submit an exception request to the applicable CMS Medicare contractor; or

5.5.3.2.2. In the event of Resident's incapacity, and if there is no other legal representative of Resident known to the Facility or any other friend or relative known to the Facility who is authorized and/or is promptly available or willing to act timely on behalf of Resident, then Resident authorizes Facility to submit an appropriate exception request to the applicable CMS Medicare contractor.

5.5.3.2.3. If the exception request is granted, then therapy services provided to Resident shall be covered by Medicare for the number of additional treatments approved. Once the additional approved treatments have been exhausted, Resident shall be responsible to pay all fees and costs for additional therapy services provided as noted in Section 5.5.2.

5.5.3.2.4. If the exception request is denied, then Resident shall be responsible to pay all fees and costs for additional therapy services provided as noted in Section 5.5.2.

5.6. Medicare Part D Prescription Drug Benefits.

5.6.1. Enrollment in Medicare Part D Plan. If Resident is an eligible beneficiary under the Medicare Part D insurance program and has enrolled or has been mandatorily enrolled in a Medicare Part D Prescription Drug or Medicare Advantage Plan ("PDP"), Resident shall advise Facility in writing of Resident's chosen PDP upon admission. In the event that Resident becomes an eligible beneficiary under Medicare Part D after admission or subsequently chooses to enroll in a PDP following admission, Resident shall notify Facility in writing of Resident's chosen PDP prior to enrollment in the PDP. Resident shall advise Facility if Resident elects to change PDPs, and shall provide written notice of such election, including the name/identity of the newly selected PDP prior to the effective date of the change in the PDP. JHP (initial)

5.6.2. Resident's Responsibility to Pay for Pharmaceuticals. Resident is responsible to pay the charges for all prescription and other drugs or medications while a resident in Facility, except to the extent that such drugs and medications are covered in whole or in part by an applicable government reimbursement program. Some or all of the charges for prescription drugs and other drugs and medications may be covered by certain benefits available through Medicare Part D or other private insurance or governmental insurance / benefit programs, including Medicare Part A or B. In the event that coverage for any prescription drug, supply, medication or pharmaceutical provided to Resident is denied by any applicable governmental reimbursement program or other potentially available third-party payor or insurance program, then Resident or Authorized Representative shall remain responsible to pay for all such prescription drugs, supplies, other medications or pharmaceuticals.

5.6.3. Actions of Medicare Part D Plan. Facility is not responsible for and has made no representations regarding the actions or decisions of any PDP, including, but not limited to, decisions relating to the establishment of the PDP formulary, denial of coverage issues, or contractual arrangements between the PDP and the Resident, and with respect to any decisions made by the PDP relating to any long term care pharmacy provider that may be under contract with Facility.

5.6.4. Dually Eligible Residents. If Resident becomes eligible for Medicaid at any time during Resident's stay at Facility, and also qualifies for benefits under the Medicare Program, then Resident shall be **required** to enroll in a PDP (unless covered by private insurance) to ensure coverage of Resident's prescription drug needs. Resident and/or Authorized Representative shall take all necessary action to enroll Resident in a PDP, and shall advise Facility of such enrollment upon Resident's acceptance into the PDP. Resident acknowledges that should Resident fail to select a PDP, then CMS will assign Resident to a PDP. Resident shall provide written notice to Facility of the name of the Resident's PDP and the effective date of enrollment.

5.6.5. Billing and Resident Cost Sharing Obligations. To the extent that Resident is a beneficiary under Medicare Part D, and the pharmacy prescriptions and/or services ordered by a physician are covered by Medicare Part D, then the Pharmaceutical Provider (as required by law) shall bill the charges for the covered services to the Resident's PDP. Resident is responsible for and shall pay any and all cost-sharing amounts applicable under Medicare Part D insurance. Facility shall not be responsible to pay for any fees or cost-sharing amounts, including co-insurance and deductibles, relating to the provision of covered Medicare Part D pharmaceuticals to Resident. To the extent that Resident may qualify as a "subsidy eligible individual" who would be entitled to a reduction or elimination of some or all the cost-sharing or premium amounts under the Medicare Part D benefit, Resident and/or Authorized Representative has the **sole responsibility** to apply for such benefits.

5.6.6. Authorization to Request and/or Appeal Coverage Determinations. In the event that Resident is denied coverage under Resident's PDP for pharmaceutical services or supplies prescribed by Resident's attending physician, then the following shall apply:

5.6.6.1. Resident and/or Authorized Representative may independently (i) request an exception from Resident's PDP to cover non-formulary or non-covered Medicare Part D drugs that are otherwise needed or required by Resident; (ii) file a request for a re-determination of any coverage denial issued by Resident's PDP; (iii) file an appeal with the appropriate agency and judicial tribunals to challenge any denial of a request for re-determination.

5.6.6.2. In the event of Resident's incapacity, and if there is no other legal representative of Resident known to the Facility or any other friend or relative known to the Facility who is authorized and/or is promptly available or willing to act timely on behalf of Resident, or if Resident's physician is unable or unwilling to act on behalf of Resident, then Resident authorized Facility to (i) request an exception from Resident's PDP to cover non-formulary or non-covered Medicare Part D drugs that are otherwise needed or required by Resident; (ii) file a request for a re-determination of any coverage denial issued by Resident's PDP; (iii) file an appeal with the appropriate agency and judicial tribunals to challenge any denial of a request for re-determinations.

5.6.6.3. In the event of an initial denial of coverage by the Resident's PDP, then pending the outcome of an exception request, a request for re-determination, or an appeal, and in the event that Resident's attending physician fails to prescribe a clinically and reasonably acceptable substitute prescription medication, resident authorizes Facility Medical Director / Designee to prescribe a clinically and reasonably acceptable substitute prescription medication which is covered by Resident's PDP, if such clinically and reasonably acceptable substitute is available.

5.6.6.4. If a request for exception (filed by Resident, Facility or any other authorized representative) is ultimately denied following either reconsideration by the PDP or appeal to an appropriate tribunal, and if the requested pharmaceuticals are deemed medically necessary by Resident's physician, and

no reasonably acceptable substitute, as determined by Facility's Medical Director / Designee, from the formulary of Resident's PDP exists, then Facility shall make arrangements to provide the requested pharmaceuticals to Resident. In any such situation, Resident shall be responsible to pay all fees and costs for the non-covered pharmaceuticals, consistent with the requirements of this Section.

5.6.6.5. No Effect on Medicare Part A Covered Nursing Services. Resident's Medicare Part D prescription drug benefits do not apply while the Resident's stay in Facility is covered under Medicare Part A. While Resident is in Facility on a Medicare Part A stay, Resident's pharmaceutical needs generally are covered by the Medicare Part A program.

5.7. Non-Covered Services. Resident is and remains obligated to pay the Facility for services and supplies not covered by the Medicaid or the Medicare programs.

6. MANAGED CARE ORGANIZATIONS.

6.1. Participation in Managed Care Organizations. The Facility is an authorized provider of skilled nursing services to members of certain managed care organizations (MCOs). The MCOs for whom the Facility is an authorized provider are listed on Attachment "B".

6.2. Enrollment in a Managed Care Organization. Resident or Authorized Representative shall notify the Facility in writing prior to enrolling with an MCO or switching Resident's MCO enrollment.

6.3. Actions of Managed Care Organization. Resident acknowledges that an MCO for whom the Facility is not an authorized provider may not approve payment for services provided by the Facility. Resident acknowledges that the Facility is not responsible for and has made no representations regarding the actions or decisions of any MCO for whom the Facility is an authorized provider, including decisions relating to a denial of coverage.

6.4. Obligations of Resident. The Facility will accept payment from the MCO as payment in full only for those services and supplies covered by the MCO. Resident is responsible for any co-payments or other costs assigned to Resident under the specific terms of the managed care plan. Resident also shall pay for any services or supplies not covered by the MCO under the specific terms of the managed care plan. Co-payments and other costs assigned to Resident and charges for services or supplies not covered by the specific terms of the managed care plan are identified in the Rate Schedule. Managed care plans typically require pre-authorization of services by the MCO. If Resident chooses to have services which the MCO refuses to pre-authorize, Resident shall pay the Facility for those services. Resident shall pay the Facility in a timely manner for all non-covered services retroactive to the date of the initial delivery of services.

6.5. Withdrawal from Participation in the MCO. The Facility reserves the right to terminate its contractual relationship and its status as a network or authorized provider with one or more of the listed MCOs at any time in accordance with law and the terms of the applicable agreement. In the event that the Facility terminates its contractual relationship with the MCO in which Resident is enrolled, Resident may convert his or her coverage to a health plan for which the Facility is an authorized provider or transfer to a facility that is an authorized provider for Resident's MCO. The Facility shall provide thirty (30) days advance notice of its decision to withdraw as a participating provider from Resident's MCO so Resident and the MCO can coordinate a transfer to another facility.

6.6. Notice of Change in Insurance Coverage. Resident and/or Authorized Representative shall notify the Facility immediately of any change in Resident's insurance status or coverage made by the insurance carrier including, but not limited to, being dropped by the insurance carrier for any reason, or a decrease or increase in insurance benefits. Resident and/or Authorized Representative shall give the Facility notice before Resident is unable to meet Resident's insurance premium or before Resident implements an increase, decrease or termination from insurance coverage.

7. DURABLE FINANCIAL POWER-OF-ATTORNEY.

Resident shall submit, as appropriate, to Facility, no later than the date of admission, a durable Power-of-Attorney executed by Resident as Principal designating someone other than the Facility or a representative or affiliate of Facility as Agent, for the limited purpose of financial decisions and payment of services. In the event Resident fails to designate an Agent under a Power-of-Attorney, Resident shall be responsible to pay for any guardianship proceedings related to the appointment of someone or a legal entity to make decisions on behalf of Resident, if and when Resident lacks capacity to make such decisions as determined by Facility.

8. THIRD-PARTY PAYMENTS.

8.1. Eligibility for Third-Party Payments. Resident may be or may become eligible to receive financial assistance, reimbursement, or other benefits from third parties, such as private insurance, employee benefit plans, Medicaid under the South Carolina / North Carolina Medicaid Program, Medicare benefits, managed care coverage, supplementary medical or other health insurance, supplemental security income insurance, or old-age survivors' or disability insurance. It is the responsibility of the Resident and/or Authorized Representative to apply for these benefits. If Resident is or becomes eligible to receive payments from any third parties for Resident's stay and care, the Facility reserves the right to collect such payments directly from the third-party source. The Resident and Authorized Representative shall at all times cooperate fully with the Facility and each third-party payor to secure payment. Cooperation includes providing information; signing and delivering documents; and assigning to the Facility (to the extent permitted by law) any payments for the Resident from federal or state governmental assistance programs or any other reimbursements or benefits to the extent of all amounts due the Facility.

8.2. Assignment of Payments. Resident irrevocably authorizes the Facility to make claims and to take other actions to secure for the Facility receipt of third-party payments to reimburse the Facility for its charges for the stay and care of Resident. To the fullest extent permitted by law, as security for payment of the Facility's charges, Resident hereby assigns to the Facility all of Resident's rights to any third-party payments now or subsequently payable to the extent of all charges due under this Agreement. Resident or Authorized Representative promptly shall endorse and turn over to the Facility any payments received from third parties to the extent necessary to satisfy the charges under this Agreement. Resident or Authorized Representative shall sign any necessary documents to forward third-party payments directly from the payor to the Facility.

8.3. Insurance. The Facility will bill Medicare and Medicaid for any services rendered to Resident by the Facility. The Facility may, at its discretion, bill Resident's private / supplemental insurance carrier for services rendered to Resident by the Facility. In the event of an initial or subsequent denial of coverage by the Resident's insurance carrier, Resident shall pay the Facility timely for all non-covered services retroactive to the date of the initial delivery of services, so long as such payment obligation is consistent with the regulations governing the Facility's participation in the Medicare and Medicaid Programs. DJP (initial)

8.3.1. The fact that the Facility submits a claim for payment does not relieve the Resident from liability for the cost of care for any days determined by the Program Administrators of the particular insurance coverage as non-covered, or for the Resident's portion of the liability as determined by the appropriate Program Administrators. **Pre-certification of insurance, if required, is the responsibility of the Resident.**

9. PERSONAL FINANCES.

9.1. Personal Funds Management. Resident is responsible to provide his or her personal funds, and Resident has the right to manage his or her personal funds. Resident may authorize the Facility, in writing, on a document provided by the Facility, to hold Resident's personal funds, and may revoke at any time the Facility's authorization by providing the Facility with a written notice signed and dated by Resident or Authorized Representative. If Resident authorizes the Facility to hold Resident's personal funds, the Facility shall hold, safeguard and account for Resident's personal funds in accordance with applicable provisions in the Admission Handbook. If the Facility has been appointed by the Social Security Administration as Representative Payee for the Resident's funds, then the Facility, and not the Resident's Authorized Representative, if any, shall have control over the Resident's funds. The Facility shall follow the policies and procedures as set forth by the Social Security Administration.

9.2. Refunds of Personal Funds. Any personal funds or valuables of Resident held by the Facility will be refunded, subject to deductions for payment of any outstanding bills or other amounts due the Facility, such as any costs incurred by Facility to repair Resident's room for damages caused by Resident, within thirty (30) days after Resident's discharge or death. In the event of Resident's death, such refund will be made to the Resident's estate in accordance with state law.

9.3. Refunds of Prepayments or Overpayments. Any prepayments or overpayments made by Resident and held by the Facility will be refunded, subject to deductions for payment of any outstanding bills or other amounts due the Facility, after all claims have been adjudicated. In the event of Resident's death, such refund will be made to the Resident's estate in accordance with state law. No interest shall accrue on any funds required to be refunded under this Agreement.

10. TERMINATION, TRANSFER OR DISCHARGE.

10.1. Resident Initiated. This Agreement remains in full force and effect until discharge of Resident regardless of payment source changes. The Facility requests a three (3) day advance written or oral notification of an impending discharge.

10.2. Facility Initiated. The Facility may terminate this Agreement and Resident's stay and transfer or discharge Resident if:

10.2.1. The transfer or discharge is necessary to meet Resident's welfare and Resident's needs cannot be met in the Facility;

10.2.2. Resident's health has improved sufficiently so that Resident no longer needs the services provided by the Facility;

10.2.3. The safety or health of individuals in the Facility is or otherwise would be endangered;

10.2.4. Resident has failed, after notice, to pay for (or to have paid or treated as paid under the Medicare or Medicaid Programs) charges for Resident's care and stay at the Facility; or

10.2.5. The Facility ceases to operate.

10.3. Notice and Waiver of Notice. The Facility will notify Resident and Authorized Representative at least thirty (30) days in advance of transfer or discharge, except in situations when appropriate plans that are acceptable to the Resident can be implemented earlier, and except in cases of emergencies, including those situations described in subparagraphs 10.2.1, 10.2.2, and 10.2.3 above, or when the Resident has not resided in the Facility for at least thirty (30) days. Then only such notice as is reasonable under the circumstances shall be provided.

10.4. Withdrawal Against Advice. In the event Resident withdraws from the Facility against the advice of his/her attending physician and/or without approval of the Facility, all of Facility's responsibilities for the care of Resident are terminated.

11. FACILITY RULES, REGULATIONS, POLICIES AND PROCEDURES.

Resident shall comply fully with all governmental laws and regulations, the provisions of this Agreement, and the Facility's rules, regulations, policies and procedures as published in the Facility's Admission Handbook or other documents or publications made available by the

Facility. The Facility reserves the right to amend or change its rules, regulations, policies and procedures. The Facility's rules, regulations, policies and procedures shall not be construed as imposing contractual obligations on the Facility or granting any contractual rights to Resident, and are subject to change from time-to-time.

12. PERSONAL AND OTHER PROPERTY.

12.1. Responsibility for Maintenance and Loss. Resident is responsible for furnishing and maintaining his or her own clothing and other items of property as needed or desired. Seasonal items and clothing must be removed timely to assure the safety and comfort of the Resident. The Facility is not responsible for the personal property / valuables or items belonging to the Resident. If damage or loss occurs to Resident's property, the Facility will investigate each incident of loss or damage.

12.2. Disposition and Storage Upon Resident's Death. Upon the Resident's death, Facility shall contact Resident's Authorized Representative and arrange for the disposition of the Resident's personal property. Facility is authorized to transfer Resident's personal property to the Authorized Representative. The Authorized Representative must acknowledge, in writing, the receipt of the personal property transferred to his or her custody by Facility. Facility, in its sole discretion, may move and place Resident's personal property into storage at Facility's expense. If property held in storage is not claimed within thirty (30) days, Facility shall donate or discard all unclaimed property.

12.3. Disposition and Storage Upon Resident's Transfer or Discharge. If Resident's personal property is not claimed or removed by the Authorized Representative following Resident's transfer or discharge, the Facility shall move and place Resident's personal property in storage until claimed. If Resident's personal property remains unclaimed after a thirty (30) day period in storage, the Facility may dispose of Resident's property. The Facility is not responsible for any damages incurred to Resident's property if storage becomes necessary.

12.4. Damage to Room or Facility Property. Resident or Resident's estate is responsible for any damages caused to the Facility property beyond normal wear and tear, and shall pay for the repair and replacement of damaged property, based on the actual charge or cost to the Facility for such repair or replacement.

13. RESIDENT RECORDS.

Resident consents to the release of Resident's personal and medical records maintained by the Facility for treatment, payment and operations as determined reasonably necessary by the Facility. Any such release may be to the Facility's employees, agents and to other health care providers from whom the Resident receives services, to third-party payors of health care services, to any MCO in which Resident may be enrolled, or to others deemed reasonably necessary by the Facility for purposes of treatment, payment and operations. Release of records for other purposes shall be done in accordance with applicable laws, with a specific authorization from the Resident where required. Authorized agents of the state or federal government, including the Long Term Care Ombudsman, may obtain Resident's records without the written consent or authorization of Resident.

14. TREATMENT AUTHORIZATION.

Resident authorizes the Facility to provide care and treatment consistent with the terms of this Agreement. Resident also authorizes the Facility to obtain all necessary clinical and/or financial information from the hospital or nursing facility from which Resident may be transferring.

15. DEATH OF RESIDENT.

Upon admission, Resident is required to designate a funeral home. This designation will remain in effect until otherwise notified in writing. In the event of Resident's death, the Facility shall notify the person(s) designated by Resident. The Facility is authorized to arrange for the transfer of Resident's body to the designated funeral home. Resident's estate is responsible for the payment of all costs associated with the transfer and funeral expenses. Resident shall notify the Facility of any changes of the person(s) or funeral home to be notified in the event of death.

16. CAPACITY OF RESIDENT AND GUARDIANSHIP.

If Resident is, or becomes, unable to understand or communicate, and is determined by Resident's Physician or the Facility's Medical Director / Designee after admission to be incapacitated, the Facility shall have the right, in the absence of Resident's prior designation of an authorized legal representative, or upon the unwillingness or inability of the legal representative to act, to commence a legal proceeding to adjudicate Resident incapacitated and to have a court appoint a guardian for Resident. The cost of the legal proceedings, including attorneys' fees, shall be paid by Resident or Resident's estate.

17. CLINICAL ISSUES RELATED TO AGING:

17.1. The Resident has been advised of the high risks and consequences associated with aging and impaired physical condition, including (but not limited to):

17.1.1. A high risk of skin breakdown and development of pressure ulcers secondary to significant time confined to bed or inability or unwillingness to eat and/or drink.

17.1.2. The risk of significant weight loss and dehydration if the Resident's physical condition is currently chronic or hereinafter deteriorates, which may diminish Resident's nutritional and hydration input.

17.1.3. The enhanced risk of falls and subsequent bruises, cuts or fractures, which then increases the already high risk of pressure ulcers.

17.1.4. The goal of the Facility is to strive for a restraint-free environment, and processes are implemented to pursue this goal. These processes recognize and protect the Resident's rights and ensure that restraints are safe and appropriate if they must be used.

17.1.5. The above risks, and others, are inherent with the aging process. We urge the

Resident and all family members to further acquaint themselves with the risk issues inherent with aging and an impaired physical condition.

18. REPORTING COMPLAINTS.

If Resident and/or Authorized Representative believe(s) that Resident is being mistreated in any way or Resident's rights have been violated by staff or another resident, Resident or Authorized Representative shall make his/her complaint known to Facility Administrator, in accordance with the Grievance Procedure reflected in the Admission Handbook and provide Facility with sixty (60) days to resolve the complaint satisfactorily to Resident and/or Authorized Representative before the Resident / Authorized Representative may pursue arbitration (or legal action for claims involving less than \$25,000.00). This notice requirement is not intended to preclude Resident and/or Authorized Representative from filing a complaint with any appropriate governmental regulatory agency at any time.

19. MISCELLANEOUS PROVISIONS.

19.1. Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the State of South Carolina / North Carolina.

19.2. Severability. The various provisions of this Agreement shall be severable one from another. If any provision of this Agreement is found by a court or administrative body of proper jurisdiction and authority to be invalid, the other provisions shall remain in full force and effect as if the invalid provision had not been a part of this Agreement.

19.3. Captions. The captions used in connection with the sections and subsections of this Agreement are inserted only for the purpose of reference. Such captions shall not be deemed to govern, limit, modify, or in any manner affect the scope, meaning or intent of the provisions of this Agreement, nor shall such captions be given any legal effect.

19.4. Entire Agreement. This Agreement, the Authorized Representative Agreement, the Arbitration Agreement, and the admission documentation represent the entire Agreement and understanding between the parties and supersedes, merges and replaces, all prior negotiations, offers, warranties and previous representations, understandings or agreements, oral or written, between the parties.

19.5. Modifications. The Facility reserves the right to modify unilaterally the terms of this Agreement to conform to subsequent changes in law, regulation or operations. To the extent reasonably possible, the Facility will give Resident and Resident's Authorized Representative thirty (30) days advance written notice of any such modifications. Resident may not modify this Agreement except by a writing signed by the Facility.

19.6. Waiver of Provisions. The Facility reserves the right to waive any obligation of Resident under the provisions of this Agreement in its sole and absolute discretion. No term, provision or obligation of this Agreement shall be deemed to have been waived by the Facility unless such waiver is in writing by the Facility. Any waiver by the Facility shall not be deemed a waiver of any other term, provision or obligation of this Agreement, and the other obligations of Resident and this Agreement shall remain in full force and effect.

20. ACKNOWLEDGMENTS.

- 20.1. **Rate Schedule.** Resident acknowledges the receipt of a copy of the Rate Schedule and the opportunity to ask questions about the Facility's charges.
- 20.2. **Resident's Rights.** Resident acknowledges being informed orally and in writing of Resident's Rights and further acknowledges having an opportunity to ask questions about those rights. The Notice of Rights of Nursing Facility Residents is subject to change from time-to-time and shall not be construed as imposing any contractual obligations on the Facility or granting any contractual rights to Resident.
- 20.3. **Advance Directives.** Resident acknowledges being informed, orally and in writing, of the Facility's policy on advance directives and medical treatment decisions.
- 20.4. **Bed Hold Policy – Readmission.** Resident acknowledges being informed orally of the Facility's policy on readmission and bed hold. Resident further acknowledges having received in writing a copy of the readmission bed hold policy, and an opportunity to ask questions.
- 20.5. **Agreement.** Resident acknowledges that he/she has read and understands the terms of this Agreement, that the terms have been explained to him/her by a representative of the Facility, and that he or she has had an opportunity to ask questions about this Agreement, and has received a copy of this Agreement.
- 20.6. **Smoke-Free / Tobacco-Free Policy.** Resident acknowledges that he/she has read and understands that this Facility and campus are smoke-free and tobacco-free. The terms have been explained by a representative of the Facility and he/she has had an opportunity to ask questions and has received a copy of the Smoke-free /Tobacco-free Policy.
- 20.7. **Camera Policy.** Resident acknowledges that he/she has read and understands the Facility camera policy and that the terms have been explained by a representative of the Facility and he/she has had an opportunity to ask questions and has received a copy of the camera policy.
- 20.8. **Get a Lift Safe Resident Handling Program.** Resident acknowledges that he/she has received an oral explanation and a copy of the safe resident handling program policy and procedures. Resident further acknowledges having an opportunity to ask questions about this policy.
- 20.9. **Physical Device Policy.** Resident acknowledges that he/she has read and understands the Facility physical device policy and that the terms have been explained by a representative of the Facility and he/she has had an opportunity to ask questions and has received a copy of the physical device policy.
- 20.10. **Admission Handbook.** Resident acknowledges the receipt of a copy of the Admission Handbook and the opportunity to ask questions about Facility's policies

contained in the Admission Handbook. The Admission Handbook is subject to change from time-to-time and shall not be construed as imposing any contractual obligations on the Facility or granting any contractual rights to Resident.

- 20.11. **Consent to Care.** Resident hereby consents to all routine care and services rendered in accordance with physician's orders. Resident also consents to student care from universities or other academic programs which are under contract with the facility unless the facility receives from the Resident/Authorized Representative a signed document of denial of student services.(Revised 10/2010)
- 20.12. **Participation in Care Plan.** Resident is encouraged to participate in the care planning process. Approval of the Resident Care Plan is the preferred manner in which consent for most treatment is obtained. There are certain specific procedures for which an individual consent form will be provided.
- 20.13. **Consent to Photograph.** Resident consents to pictures taken for identification purposes only.
- 20.14. **Contents of Personal Medical Records.** Resident understands and agrees that the designated record set concerning Resident is and will continue to be the property of the Facility, provided that Facility will not disclose the same to any person or party other than the Resident except as outlined in the Privacy Practices Notice. The designated record set is defined as the medical record in its entirety and the financial record including itemized charges. The following items are specifically excluded from the designated record set: incident reports, QA/QI reports, tracking forms, resident care assignment forms, shift to shift report forms, admission waiting list and financial "work papers."
- 20.15. **Notification of Facility Symbols.** Resident / Authorized Representative hereby acknowledge being informed of the use of signs and symbols which may be observed in this facility. For the resident's safety and comfort, the facility may post on a doorway leading into a resident's room a symbol for type of lift device to be used or a star alerting staff to a potential fall risk. Other symbols may be used from time to time which may designate and alert staff to a specific need. You or your Authorized Representative may opt out of having symbols posted by signing a waiver of release from use of facility designated symbols.
- 20.16. **Competency.** Resident declares that he or she retains capacity and is competent, has never been adjudged or determined to lack capacity or competence, and knows of no petition pending to adjudicate his or her lack of capacity or competence. Alternatively, if the Resident has been or should be deemed to lack capacity or competence, then Resident's Authorized Representative declares that he or she has been given authority by the Resident when competent to ask on behalf of the Resident, and/or is qualified to act as Resident's surrogate by reason of special care and concern for the Resident, familiarity with the Resident's personal values, reasonable availability, and willingness to serve.
- 20.17. **Scope of Care.** Resident acknowledges that routine nursing services do not include: continuous one-on-one care or CNA services when required by Resident's Care

plan; care for certain high acuity conditions, such as ventilator dependent care; dialysis services; treatment for drug and alcohol conditions; or psychiatric care.

21. ARBITRATION.

WITH REGARD TO ALL MONETARY CLAIMS ARISING BETWEEN THE FACILITY AND RESIDENT / AUTHORIZED REPRESENTATIVE, TO THE EXTENT THAT THEY ARE FOR MORE THAN \$25,000.00, ARBITRATION (PURSUANT TO THE FEDERAL ARBITRATION ACT) IS MANDATORY (SUBJECT TO THE "OPT OUT" PROVISIONS SET FORTH IN PARAGRAPH 16 OF THE ARBITRATION AGREEMENT), BINDING AND FINAL. THE EXACT TERMS FOR ARBITRATION ARE SET FORTH IN A SEPARATE DOCUMENT OF EVEN / RECENT DATE, ENTITLED "ARBITRATION AGREEMENT" AND ARE INCORPORATED HEREIN BY REFERENCE. WITH REGARD TO ANY NONMONETARY CLAIM, OR ANY CLAIM FOR LESS THAN \$25,000.00, ARBITRATION SHALL NOT BE REQUIRED.

22. BINDING EFFECT.

This Agreement shall be binding upon all parties hereto and upon their respective heirs, personal representatives, successors and assigns.

IN WITNESS WHEREOF, the parties, intending to be legally bound hereby, have signed this Agreement this 15 day of Nov, 2012

RESIDENT / AUTHORIZED REPRESENTATIVE:

Margaret S. Hensley
Printed Resident Name

Signature / Date

Terry Putman
Printed Authorized Representative

Terry Putman 11/15/12
Signature / Date

daughter (POA)
Relationship

FACILITY STAFF / WITNESS:

White Oak Estates, Inc. Date: 11-15-12

By: Susan Moon, BOM
Staff Printed Name and Title

Susan Moon Heather Turner
Staff Signature / Witness

ORIGINAL



ARBITRATION AGREEMENT

ARBITRATION AGREEMENT
(Pursuant to the **FEDERAL ARBITRATION ACT** only)

PLEASE READ CAREFULLY

FOR VALUABLE CONSIDERATION, the receipt and sufficiency of which is hereby acknowledge, the parties hereto, White Oak Estates ("the Facility"), and Margaret S. Hensley ("the Resident"), AGREE TO ARBITRATE ALL MONETARY CLAIMS that may arise between them (with the exception of monetary claims of less than \$25,000.00).

Specifically, the parties hereto agree as follows:

1. All monetary claims between the parties of \$25,000.00 or more will be resolved by arbitration and will be subject to the terms and provisions of this Agreement.
2. If one party to the Admission Agreement between the parties hereto believes he, she or it (hereinafter referred to as the "first party") has a monetary claim of more than \$25,000.00 against the other party (hereinafter referred to as the "second party"), the first party shall give the second party written notice thereof. That claim may be resolved by mutual agreement. If it is, that will conclude permanently that claim, and any other claims that arise on or before the date the claim is resolved. If the claim is not resolved by mutual agreement, then the parties will proceed as subsequently set forth herein.
3. Within thirty (30) days of giving written notice of a claim, the first party will identify in writing an arbitrator of that party's choosing. That party may choose, as that party's arbitrator, anyone that party wishes, provided the person chosen may not be a party to this Agreement, or someone who will give testimony, or provide an affidavit or other written statement for presentation at the hearing provided for below. Further, if the party is the Facility, it may not choose as an arbitrator anyone associated with the Facility as a shareholder, officer, director, or employee.
4. Within thirty (30) days of receipt of written notice of the first party's choice of an arbitrator, the second party will likewise choose an arbitrator, whomever that party wishes, subject to the same restrictions on potential arbitrators set forth in paragraph 3, above, and shall give the first party written notice thereof.
5. Within thirty (30) days of the second party's notification of that party's choice of an arbitrator, the two (2) arbitrators shall confer/meet and attempt to agree upon a third arbitrator. In choosing a third arbitrator, they will be limited to choosing someone who is certified by the Bar Association of the state in which the Facility is located, to be a mediator/arbitrator, and who has substantial prior experience in mediating/arbitrating nursing home claims. In the event the two (2) arbitrators cannot agree on a third arbitrator, then either side may apply to the American Arbitration Association to seek appointment of the third arbitrator. The choice made by the American Arbitration Association will be final and binding so long as the person chosen has substantial prior

experience in mediating/arbitrating nursing home claims, and can be expected to be both fair and impartial.

6. Within ninety (90) days of the determination of the third arbitrator, a hearing ("the hearing") shall be held at a mutually convenient location before a board consisting of the three (3) arbitrators. At the hearing each side may present whatever evidence that side deems appropriate. This "evidence" may be presented in any reasonable manner, and need not conform to the normal rules of evidence utilized in a court of law. All testimony will, however, be under oath.

7. At the arbitration hearing, each party may, but need not, be represented by an attorney. In other words, should the Resident wish to be represented by a family member, subject to the limitations set forth in paragraph 3 above, that is permissible.

8. Subject to paragraph 13 below, each party shall be responsible for paying that party's own arbitrator. Furthermore, prior to the actual arbitration hearing, each party will pay one-half (1/2) of the fees and costs associated with the third arbitrator and the hearing.

9. Each party shall promptly provide the other party with copies of all documents upon which the producing party intends to rely at the hearing. Under all circumstances, all such documents shall be made available to the other party at least ten (10) days prior to the hearing. If not, they will not, under any circumstances, be admissible at the hearing.

10. Prior to the hearing, depositions may be taken by the parties. If a dispute arises regarding these depositions, the number that may be taken, their length, etc., it will be resolved by a majority of the arbitrators. Under all circumstances, this decision by a majority of the arbitrators, and any other decisions made by a majority of the arbitrators, will be both final and binding.

11. All time limits set forth herein may, by mutual agreement or by a majority of the arbitrators, be extended or otherwise modified. Furthermore, all other issues that may arise between the parties hereto will likewise be resolved by a majority of the arbitrators.

12. At least ten (10) days prior to the hearing, each party shall submit in writing to the other party that party's best demand/offer of settlement. The parties may continue to negotiate up to and even through the actual hearing. At the hearing, each party shall provide, in writing, the arbitrators with that party's best offer/demand. When the arbitrators make their decision, they will be limited to selecting one of the two (2) figures presented by the parties. That determination will be both final and binding, will be in writing, and will be signed by at least two (2) of the arbitrators.

13. When a determination is made by a majority of the arbitrators, they shall also award the "prevailing party," as defined herein, reimbursement by the other party of all reasonable costs and expenses associated with the arbitration, such as the third arbitrator's fees, travel expenses, witness fees, deposition expenses, and other costs associated with the hearing, but excluding attorneys' fees. Each party will be responsible

for paying that party's own attorney. For purposes of this paragraph, "the prevailing party" shall be the party whose final offer or demand submitted at the hearing is the amount ultimately awarded by a majority of the arbitrators.

14. An award against the Facility will be paid within thirty (30) days after the arbitrators make their decision and notify the Facility in writing of that decision. Upon payment, the Facility, as well as all other "White Oak" facilities, including specifically White Oak Manor, Inc. and White Oak Management, Inc., and their respective shareholders, directors, officers and employees, will be deemed to be released and forever discharged from any and all other claims arising prior to the date of the hearing.

15. In the event payment is not made by the Facility within thirty (30) days of written notification of the arbitrators' decision, judgment against the Facility may be entered of record in any County in which it does business, and will accrue interest at the applicable statutory rate until payment is made.

16. At the time of signing this Agreement, the Resident/Authorized Representative/Attorney-in-Fact acknowledges having received a copy; having been told that he/she has the right to have this Agreement reviewed by an attorney of his/her own choosing prior to signing it; and having been advised that, beginning seven (7) days from date hereof, and for another ten (10) days thereafter, he/she has the right to "opt out" of this Agreement, and no longer be bound by it. In the event the party signing below determines to opt out, he/she must give the Facility written notice thereof within the time provided. TIME IS OF THE ESSENCE. If written notification of the Resident/Authorized Representative/Attorney-in-Fact having opted out of this Agreement is not received within the time frame set forth, the within Agreement will remain and continue in full force and effect. By initialing here, the undersigned acknowledges having specifically read this paragraph. SNP (initials)

17. If signed below by the Resident, the Resident intends to indicate that he/she believes himself/herself to be mentally competent and, in signing this Agreement, is doing so freely and voluntarily. If instead of the Resident, it is the Authorized Representative/Attorney-in-Fact signing below for the Resident, he/she has the legal right to execute this document in behalf of the Resident, and to thereby bind the Resident, as well as the Resident's heirs/beneficiaries; that so far as he/she knows, other than himself/herself, no one else has the legal right to act in behalf of the Resident and that no one else is an attorney-in-fact for the Resident pursuant to any Power of Attorney; and that all representations set forth in this paragraph are accurate.

18. Except as may be required by law, neither party hereto nor any arbitrator may disclose the determination made by the arbitrators without the prior written consent of the other party, or by court order.

19. To the extent that any questions arise that are not covered by this Agreement, they will be resolved by a majority of the arbitrators. That decision will be both final and binding.

20. In the event any portion of this Agreement is determined to be invalid or unenforceable, the remainder will nevertheless continue in full force and effect and be binding upon the parties hereto, and upon their respective heirs, personal representatives, successors or assigns.

21. The within Arbitration Agreement constitutes the entire agreement by and between the parties hereto; incorporates all representations supposedly made at or before being signed by the undersigned; and may not be modified or otherwise amended except by subsequent written agreement entered into by and between all parties hereto. This Agreement shall be governed by the Federal Arbitration Act and, to the extent not inconsistent therewith, the laws of the state where the Facility is located.

22. This Agreement provides for Arbitration as the sole method of resolving disputes of \$25,000.00 or more. However, nothing herein contained shall be construed to reduce, diminish, or have any affect upon the substantive rights either party hereto may have by virtue of either statute or case law.

23. By signing below, the undersigned certifies and affirms that he/she has been given sufficient time to read this Agreement, and that any questions that the undersigned had, if any, were satisfactorily answered.

IN WITNESS WHEREOF, the undersigned have hereunto caused their hands and seals to be affixed as of this 15 day of Nov, 2012.

RESIDENT / AUTHORIZED REPRESENTATIVE:

Margaret S. Hensley
Printed Resident Name

Signature / Date

Terry Putman
Printed Authorized Representative

Terry Putman 11/15/12
Signature / Date

daughter (POA)
Relationship

FACILITY STAFF / WITNESS:

White Oak Estates, Inc. Date: 11-15-12

By: Susan Morn BOM
Staff Printed Name and Title

Susan Morn Heather Turner
Staff Signature / Witness

ORIGINAL



RESIDENT AND FACILITY
ADMISSION AGREEMENT

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RESIDENT AND FACILITY ADMISSION AGREEMENT
PLEASE READ CAREFULLY AND ASK ANY QUESTIONS

This Agreement is made by and between White Oak Estates (hereinafter called "Facility") and Resident and his/her Authorized Representative and/or the individual who has access to Resident's income and financial resources available to pay for nursing care (hereinafter called "Authorized Representative") for the provision of nursing services for Margaret S. Hensley (hereinafter called "Resident").

Resident and/or Authorized Representative affirm that the information provided during the admission process is true and correct to the best of their knowledge, and acknowledge that the submission of any false information may constitute grounds to terminate this Agreement.

Identification of Authorized Representative (if applicable):

The Authorized Representative is anyone authorized by the Resident or by law to act on the Resident's behalf. Please check the type and scope of authority for anyone other than the Resident who signs this Agreement.

TYPE (Check one)

- ☐ General POA*
- ☐ Durable POA*
- ☒ Durable POA w/ Healthcare*
- ☐ Guardianship / Conservatorship*
- ☐ Healthcare POA*
- ☐ Other: _____

SCOPE (check all that apply)

- ☐ Routine health care
- ☒ Unlimited health care
- ☐ Limited access to income / finance
- ☒ Authorized to accept income and control financial resources of Resident

*** Must provide copies of any and/or all documents checked above**

The Authorized Representative, by signing this Agreement, acknowledges acceptance of the duties and responsibilities of this role.

The Authorized Representative will not incur personal financial liability except for breach of duty or contract related to the misuse of Resident's resources or the failure to use those resources to pay for the Resident's care.

PRELIMINARY STATEMENTS:

Resident individually or by and through Resident's Authorized Representative has considered appropriate care settings and is desirous of receiving care at the Facility.

Facility is a licensed nursing facility and will provide the services set forth below in accordance with the applicable standards of care, none of which cause the Facility to become an insurer nor guarantor of the health and safety of the Resident, or for that matter, the insurer or guarantor of the Resident's personal property.

NOW, THEREFORE, in consideration of the prompt payment by the Resident (and the applicable state, federal, or private insurance program) of the charges made to the Resident's account in accordance with the charge structure of the Facility, and in further consideration of the mutual covenants and promises herein, the parties agree as follows:

2. PROVISION OF SERVICES

2.1. Care and Services. The Facility offers, at the Daily Rate, the following services: room accommodations, food services, licensed routine nursing services, social services, activities, housekeeping services, laundering of linens and towels, routine hair care, and resident trust fund services.

2.2. Ancillary Services and Supplies. The Facility shall make available at an additional charge, unless included in the Daily Rate, the following items and services: therapy services, medical supplies, laboratory services, pharmaceuticals, beauty/barbershop, guest meals, and toiletries for personal comfort, grooming, or hygiene, and transportation. All items and services not included in the Daily Rate, such as Medicare A or Medicaid, will be billed to the applicable payor. The Resident is responsible for all non-covered items and services, co-payments or deductible amounts, according to the Facility's Rate Schedule, as amended from time-to-time. Items and services not included in the Daily Rate will be updated periodically upon notice to residents.

2.3. Services of Other Providers. The services of outside providers such as a licensed physician, optometrist, podiatrist and/or dentist, a registered pharmacist for the provision of medications, rehabilitation therapies and diagnostic services, i.e., laboratory, x-ray and/or ambulance services, are available at the Facility or under arrangement. These services are available under guidelines and procedures established by the Facility and may be utilized by Resident at his or her own expense unless covered by another pay source. The Facility retains the right to control the source of supply of any items and contract services used within the Facility. Resident or Authorized Representative has exercised freedom of choice by applying for admission to Facility and thereby agrees and contracts with Facility to provide said supply items and contract services as requested. The place of purchase for pharmaceutical items is within Resident's freedom of choice subject to the Facility's policy for Resident drugs.

2.4. Role of Attending Physician and Medical Director. The Resident shall obtain the services of a qualified physician who will provide medical care during the Resident's stay at the Facility. The Resident is free to receive care from any licensed physician who agrees to submit credentials to the Facility and adhere to the Facility's policies and procedures. The Resident elects ECP PA - Dr. Allan as the attending physician(s). JHP (initials). The Facility is not obligated to provide Resident with any medicines, treatments, special diets or equipment without specific orders or directions from Resident's attending physician. In the event Resident's attending physician is unavailable, the Facility's Medical Director / Designee may issue appropriate orders. Resident is responsible to pay for all services or equipment ordered by Resident's attending physician or the Facility's Medical Director / Designee for Resident's care unless covered by Medicare / Medicaid or other third-party insurer.

2.5. Room Assignments. The Facility makes room and bed assignments according to availability and/or in accordance with the Resident's physical and psychosocial wellbeing. Resident acknowledges that bed assignments may be changed in order to provide a proper environment for all residents. Resident and family / Authorized Representative will be notified of any room changes.

3. CHARGES

3.1. Recurring / Periodic Charges for Care and Services. Resident shall pay the Daily Rate, specified in the Rate Schedule in effect at the time the service is rendered, for routine nursing services provided to Resident. The Daily Rate may be changed from time-to-time in accordance with the provisions of Section 4.3. Charges for a resident whose payor source is other than Medicare Part A or Medicaid will begin on the designated admission date or actual admission, whichever is earlier; charges for a resident whose payor source is Medicare Part A or Medicaid will begin no earlier than the date of admission.

3.2. Additional Charges for Ancillary Services and Supplies. Resident shall pay for other services and supplies provided by or through the Facility which are not covered by the Daily Rate as set forth in the Rate Schedule in effect at the time such ancillary services or supplies are rendered. Any items ordered by a physician, which are not identified on the Rate Schedule, will be provided at charges identified by the Facility. The charges for ancillary services and supplies are subject to change from time-to-time.

3.3. Charges for Outside and Non-Facility Services. In addition to the Facility's charges, Resident shall pay all fees and costs for goods or services furnished to or for Resident by anyone other than the Facility as described in Section 2.3 (Services of Other Providers) unless otherwise covered in full by Medicare or Medicaid or another third-party payor. Resident or Authorized Representative is obligated to pay such fees and costs whether the goods and services are furnished by a person or provider made available by the Facility, or by a person or provider selected by Resident, and whether the goods or services are provided at the Facility or elsewhere. These fees and costs are not included in the Daily Rate. Fees for professional services rendered by a physician are not included in the Daily Rate and will be charged directly to the Resident by the physician.

4. PERIODIC BILLINGS AND PAYMENT DUE DATE

- 4.1. Monthly Statements and Other Billings.** Prepayment for one (1) month of the basic monthly rate is required at the time of admission. The Facility will mail Resident or Authorized Representative on or about the tenth (10th) day of the month a billing statement reflecting charges for care and services for the upcoming month and charges for ancillary services and supplies which were incurred in the prior month. Statements are due and payable upon receipt of the Monthly Statement.

Resident expecting Medicare coverage specifically understands that Medicare co-insurance is the responsibility of the Resident. Payment of co-insurance is required. Payment for Medicare services is not expected until services are rendered.

- 4.2. Failure to Pay and Cost of Collection.** Failure to pay an account at the Facility when due is a breach of this Agreement and will allow Facility to discharge Resident upon giving a thirty (30) day written notice, during which thirty (30) day period the breach may be cured by payment of the account in full.

In the event the Facility initiates legal action to collect payments due from the Resident under this Agreement, and the Facility is successful, the Resident and/or Authorized Representative shall be responsible for reimbursing the Facility for all costs and expenses thereby incurred, including reasonable attorneys' fees.

- 4.3. Modification of Charges.** The Facility reserves the right to change the Rate Schedule reflecting the amount of any of its charges or how and when charges are computed, billed or become due. The Facility shall provide thirty (30) days advance written notice of any such changes.

- 4.4. Obligations of Resident's Estate and Assignment of Property.** Resident and Authorized Representative acknowledge the charges for services provided under this Agreement remain owed until paid. In the event of Resident's discharge for any reason, including death, this Agreement shall operate as an assignment, transfer and conveyance to the Facility of so much of Resident's property as is equal in value to the amount of any unpaid obligations under this Agreement. This assignment shall be an obligation of Resident's estate and may be enforced against the Resident's estate.

- 4.5. Change in Contact Information.** Resident and/or Authorized Representative agree to notify the Facility within ten (10) days of any change in Authorized Representative's contact information.

5. MEDICARE / MEDICAID PROGRAMS

- 5.1. Participation in Programs.** The Facility currently participates in the South Carolina / North Carolina Medicaid program and the federal Medicare program. The Facility reserves the right to withdraw from the Medicaid or Medicare programs at any time in accordance with law.

5.2. Actions of Medicaid and Medicare Agencies. The South Carolina / North Carolina Department of Health and Human Services ("DHHS") is responsible for administering benefits under the Medicaid program. The Centers for Medicare and Medicaid Services ("CMS"), of the United States Department of Health and Human Services, is responsible for administering the Medicare program through an intermediary. Resident acknowledges that the Facility is not responsible for, and has made no representations regarding, the actions or decisions of DHHS, CMS or the Medicare intermediary in administering the programs.

5.3. Medicaid Benefits.

5.3.1. Obligations of Resident. Resident is obligated to make full and complete disclosure regarding all financial resources and income during the application process. Failure to identify all resources and income, or the submission of false information, may result in the termination of this Agreement. Resident is obligated to notify the Facility when Resident's resources available to satisfy the Resident's financial obligations under this Agreement are no longer sufficient to pay all the Facility charges for Resident's care and services or when directed to do so by the Facility. Resident shall provide any documentation requested by the County Medicaid Office. Upon Facility's request, Resident shall execute an authorization for Facility to assist the Resident in securing Medicaid benefits, pursuing a hardship waiver, and bringing Resident's account current. In the event Resident applies for Medicaid benefits, Resident shall continue to pay and apply all of Resident's available resources toward the fulfillment of Resident's financial obligations under this Agreement while the Medicaid application is pending an eligibility determination by DHHS.

5.3.2. Recurring Liability Amount. For residents approved for Medicaid benefits, the Facility will accept payment from the State of South Carolina / North Carolina and, if applicable, the Resident's Recurring Liability Amount as determined by DHHS as payment in full only for those services covered by the Medicaid program. Resident remains obligated to pay such Recurring Liability Amount on a monthly basis. Services not covered by Medicaid are identified in the Rate Schedule and Resident remains obligated to pay for such services. If Resident plans to apply for Medicaid, then the Resident will have an **estimated** monthly Recurring Liability in the amount of \$ ^{Total Income} ~~2,559.30~~ until the State determines the amount of Resident's income to be paid to the Facility. Once the approved Recurring Liability amount has been set by Medicaid, any differences must be paid or adjusted. The Recurring Liability amount is due to the Facility by the fifth (5th) day of the month. JAP (initials)

5.3.3. Determination of Eligibility. Resident and Authorized Representative are obligated to cooperate fully in any Medicaid eligibility determination or re-determination process. In the event that Resident's eligibility for Medicaid benefits is denied, interrupted or terminated due to the failure of Resident or Authorized Representative to cooperate in the Medicaid application, re-determination or appeal process, the Resident and Authorized Representative shall be liable for the Daily Rate plus charges for ancillary services and supplies during any period of ineligibility, and the Facility may terminate this Agreement.

5.3.4. Authorization to Apply for and/or Appeal (Medicaid). In the event of Resident's incapacity and in situations where Resident's resources are depleted or appear to be depleted to the extent that Resident can no longer pay privately for nursing care, and it appears that Resident has become or will become eligible for Medicaid benefits to cover the cost of Resident's continued stay in the Facility; and if there is no other legal representative of Resident known to the Facility or other friend or relative known to the Facility who is authorized and/or is available or willing to act on Resident's behalf, after the Facility has made a good faith effort to identify such persons; then Resident hereby authorizes the Facility to request, file and/or apply for Medicaid benefits on behalf of Resident for the limited purpose of assisting Resident to secure payment through the Medicaid program for Resident's continued stay in the Facility. In the event the application for Medicaid benefits filed on behalf of the Resident is denied, or in the event Medicaid benefits are granted and subsequently discontinued, Resident hereby authorizes the Facility to file on Resident's behalf an appeal of any such denial of Medicaid eligibility or discontinuance of Medicaid benefits, and to take such actions to secure Resident's Medicaid benefits as the Facility deems reasonably necessary or appropriate and consistent with law. Resident warrants and represents that the financial information disclosed in the admission process is true and accurate and may be relied on by the Facility in pursuing Medicaid benefits on behalf of Resident.

5.3.5. Authorization to File a Hardship Waiver with DHHS on Behalf of Resident. If DHHS' application of a transfer of assets penalty operates to deprive Resident of medical care such that Resident's life would be in danger, or would deprive Resident of food, clothing or shelter, or the necessities of life, then in the event of Resident's incapacity, inability or unwillingness to act, and if there is no other Authorized Representative of Resident known to the Facility or any other friend or relative known to the Facility who is authorized and/or is promptly available or willing to act timely on behalf of Resident, then Resident authorizes Facility to file a Hardship Waiver with DHHS on Resident's behalf.

5.4. Medicare Part A and Part B Benefits. To the extent that Resident is a beneficiary under either Medicare Part A or Medicare Part B insurance and the nursing services or ancillary services or supplies ordered by a physician are covered by such insurance, the Facility or other provider will bill the charges for the covered services or supplies to the Medicare program. The Resident is responsible for and shall pay any co-insurance or deductible amounts under Medicare Part A or Part B insurance. The Facility shall accept payment from the Medicare intermediary as payment in full only for those services deemed to be covered in full under the Medicare Part A or the Medicare Part B program. Services not covered by Medicare are identified in the Rate Schedule.

5.5. Medicare Part B Payment Limitations: Therapy Caps.

5.5.1. General. Effective January 1, 2006, CMS imposed payment limitations on covered therapy services provided to individuals who are eligible beneficiaries under Medicare Part B. Under this financial limitation, Medicare will pay an annual capped amount for physical and speech therapy (combined) and an annual capped amount for occupational therapy. The capped amounts are revised by CMS

annually. Facility shall provide Resident and/or Authorized Representative with notice of the current capped amounts as appropriate.

5.5.2. Resident's Responsibility to Pay for Therapy Services Beyond the Capped

Amounts. Resident is responsible to pay the charges for all medically necessary therapy services in excess of the annual capped amounts, unless such therapy services are covered in whole or in part by private insurance or another government reimbursement program. In the event that another government reimbursement program or available third-party payor or insurance program denies coverage for therapy services provided to Resident after exhaustion of the annual capped amount, then Resident or Authorized Representative shall remain responsible to pay all fees and costs for all such therapy services. If Resident is not eligible for Medicaid, then failure to pay for therapy services rendered above the capped amount shall be grounds for termination and discharge from Facility pursuant to Section 10 of this Agreement.

5.5.3. Exception Requests.

5.5.3.1. Automatic Exceptions. Medicare beneficiaries may be automatically exempted from the annual therapy caps for certain conditions or complexities that have a direct and significant impact on the need for the course of therapy being provided and the additional treatment is medically necessary.

5.5.3.2. Manual Exceptions. Medicare beneficiaries not automatically exempted from the annual therapy caps are entitled to request an exception to the annual therapy caps, for up to fifteen (15) additional treatment days. In the event that Resident has exhausted the annual capped amount, and is not automatically exempted from the therapy caps, then the following shall apply:

5.5.3.2.1. Resident and/or Authorized Representative may submit an exception request to the applicable CMS Medicare contractor; or

5.5.3.2.2. In the event of Resident's incapacity, and if there is no other legal representative of Resident known to the Facility or any other friend or relative known to the Facility who is authorized and/or is promptly available or willing to act timely on behalf of Resident, then Resident authorizes Facility to submit an appropriate exception request to the applicable CMS Medicare contractor.

5.5.3.2.3. If the exception request is granted, then therapy services provided to Resident shall be covered by Medicare for the number of additional treatments approved. Once the additional approved treatments have been exhausted, Resident shall be responsible to pay all fees and costs for additional therapy services provided as noted in Section 5.5.2.

5.5.3.2.4. If the exception request is denied, then Resident shall be responsible to pay all fees and costs for additional therapy services provided as noted in Section 5.5.2.

5.6. Medicare Part D Prescription Drug Benefits.

5.6.1. Enrollment in Medicare Part D Plan. If Resident is an eligible beneficiary under the Medicare Part D insurance program and has enrolled or has been mandatorily enrolled in a Medicare Part D Prescription Drug or Medicare Advantage Plan ("PDP"), Resident shall advise Facility in writing of Resident's chosen PDP upon admission. In the event that Resident becomes an eligible beneficiary under Medicare Part D after admission or subsequently chooses to enroll in a PDP following admission, **Resident shall notify Facility in writing of Resident's chosen PDP prior to enrollment in the PDP. Resident shall advise Facility if Resident elects to change PDPs, and shall provide written notice of such election, including the name/identity of the newly selected PDP prior to the effective date of the change in the PDP.** DNP (initial)

5.6.2. Resident's Responsibility to Pay for Pharmaceuticals. Resident is responsible to pay the charges for all prescription and other drugs or medications while a resident in Facility, except to the extent that such drugs and medications are covered in whole or in part by an applicable government reimbursement program. Some or all of the charges for prescription drugs and other drugs and medications may be covered by certain benefits available through Medicare Part D or other private insurance or governmental insurance / benefit programs, including Medicare Part A or B. In the event that coverage for any prescription drug, supply, medication or pharmaceutical provided to Resident is denied by any applicable governmental reimbursement program or other potentially available third-party payor or insurance program, then Resident or Authorized Representative shall remain responsible to pay for all such prescription drugs, supplies, other medications or pharmaceuticals.

5.6.3. Actions of Medicare Part D Plan. Facility is not responsible for and has made no representations regarding the actions or decisions of any PDP, including, but not limited to, decisions relating to the establishment of the PDP formulary, denial of coverage issues, or contractual arrangements between the PDP and the Resident, and with respect to any decisions made by the PDP relating to any long term care pharmacy provider that may be under contract with Facility.

5.6.4. Dually Eligible Residents. If Resident becomes eligible for Medicaid at any time during Resident's stay at Facility, and also qualifies for benefits under the Medicare Program, then Resident shall be **required** to enroll in a PDP (unless covered by private insurance) to ensure coverage of Resident's prescription drug needs. Resident and/or Authorized Representative shall take all necessary action to enroll Resident in a PDP, and shall advise Facility of such enrollment upon Resident's acceptance into the PDP. Resident acknowledges that should Resident fail to select a PDP, then CMS will assign Resident to a PDP. Resident shall provide written notice to Facility of the name of the Resident's PDP and the effective date of enrollment.

5.6.5. Billing and Resident Cost Sharing Obligations. To the extent that Resident is a beneficiary under Medicare Part D, and the pharmacy prescriptions and/or services ordered by a physician are covered by Medicare Part D, then the Pharmaceutical Provider (as required by law) shall bill the charges for the covered services to the Resident's PDP. Resident is responsible for and shall pay any and all cost-sharing amounts applicable under Medicare Part D insurance. Facility shall not be responsible to pay for any fees or cost-sharing amounts, including co-insurance and deductibles, relating to the provision of covered Medicare Part D pharmaceuticals to Resident. To the extent that Resident may qualify as a "subsidy eligible individual" who would be entitled to a reduction or elimination of some or all the cost-sharing or premium amounts under the Medicare Part D benefit, Resident and/or Authorized Representative has the **sole responsibility** to apply for such benefits.

5.6.6. Authorization to Request and/or Appeal Coverage Determinations. In the event that Resident is denied coverage under Resident's PDP for pharmaceutical services or supplies prescribed by Resident's attending physician, then the following shall apply:

5.6.6.1. Resident and/or Authorized Representative may independently (i) request an exception from Resident's PDP to cover non-formulary or non-covered Medicare Part D drugs that are otherwise needed or required by Resident; (ii) file a request for a re-determination of any coverage denial issued by Resident's PDP; (iii) file an appeal with the appropriate agency and judicial tribunals to challenge any denial of a request for re-determination.

5.6.6.2. In the event of Resident's incapacity, and if there is no other legal representative of Resident known to the Facility or any other friend or relative known to the Facility who is authorized and/or is promptly available or willing to act timely on behalf of Resident, or if Resident's physician is unable or unwilling to act on behalf of Resident, then Resident authorizes Facility to (i) request an exception from Resident's PDP to cover non-formulary or non-covered Medicare Part D drugs that are otherwise needed or required by Resident; (ii) file a request for a re-determination of any coverage denial issued by Resident's PDP; (iii) file an appeal with the appropriate agency and judicial tribunals to challenge any denial of a request for re-determinations.

5.6.6.3. In the event of an initial denial of coverage by the Resident's PDP, then pending the outcome of an exception request, a request for re-determination, or an appeal, and in the event that Resident's attending physician fails to prescribe a clinically and reasonably acceptable substitute prescription medication, resident authorizes Facility Medical Director / Designee to prescribe a clinically and reasonably acceptable substitute prescription medication which is covered by Resident's PDP, if such clinically and reasonably acceptable substitute is available.

5.6.6.4. If a request for exception (filed by Resident, Facility or any other authorized representative) is ultimately denied following either reconsideration by the PDP or appeal to an appropriate tribunal, and if the requested pharmaceuticals are deemed medically necessary by Resident's physician, and

no reasonably acceptable substitute, as determined by Facility's Medical Director / Designee, from the formulary of Resident's PDP exists; then Facility shall make arrangements to provide the requested pharmaceuticals to Resident. In any such situation, Resident shall be responsible to pay all fees and costs for the non-covered pharmaceuticals, consistent with the requirements of this Section.

5.6.6.5. No Effect on Medicare Part A Covered Nursing Services. Resident's Medicare Part D prescription drug benefits do not apply while the Resident's stay in Facility is covered under Medicare Part A. While Resident is in Facility on a Medicare Part A stay, Resident's pharmaceutical needs generally are covered by the Medicare Part A program.

5.7. Non-Covered Services. Resident is and remains obligated to pay the Facility for services and supplies not covered by the Medicaid or the Medicare programs.

6. MANAGED CARE ORGANIZATIONS.

6.1. Participation in Managed Care Organizations. The Facility is an authorized provider of skilled nursing services to members of certain managed care organizations (MCOs). The MCOs for whom the Facility is an authorized provider are listed on Attachment "B".

6.2. Enrollment in a Managed Care Organization. Resident or Authorized Representative shall notify the Facility in writing prior to enrolling with an MCO or switching Resident's MCO enrollment.

6.3. Actions of Managed Care Organization. Resident acknowledges that an MCO for whom the Facility is not an authorized provider may not approve payment for services provided by the Facility. Resident acknowledges that the Facility is not responsible for and has made no representations regarding the actions or decisions of any MCO for whom the Facility is an authorized provider, including decisions relating to a denial of coverage.

6.4. Obligations of Resident. The Facility will accept payment from the MCO as payment in full only for those services and supplies covered by the MCO. Resident is responsible for any co-payments or other costs assigned to Resident under the specific terms of the managed care plan. Resident also shall pay for any services or supplies not covered by the MCO under the specific terms of the managed care plan. Co-payments and other costs assigned to Resident and charges for services or supplies not covered by the specific terms of the managed care plan are identified in the Rate Schedule. Managed care plans typically require pre-authorization of services by the MCO. If Resident chooses to have services which the MCO refuses to pre-authorize, Resident shall pay the Facility for those services. Resident shall pay the Facility in a timely manner for all non-covered services retroactive to the date of the initial delivery of services.

6.5. Withdrawal from Participation in the MCO. The Facility reserves the right to terminate its contractual relationship and its status as a network or authorized provider with one or more of the listed MCOs at any time in accordance with law and the terms of the applicable agreement. In the event that the Facility terminates its contractual relationship with the MCO in which Resident is enrolled, Resident may convert his or her coverage to a health plan for which the Facility is an authorized provider or transfer to a facility that is an authorized provider for Resident's MCO. The Facility shall provide thirty (30) days advance notice of its decision to withdraw as a participating provider from Resident's MCO so Resident and the MCO can coordinate a transfer to another facility.

6.6. Notice of Change in Insurance Coverage. Resident and/or Authorized Representative shall notify the Facility immediately of any change in Resident's insurance status or coverage made by the insurance carrier including, but not limited to, being dropped by the insurance carrier for any reason, or a decrease or increase in insurance benefits. Resident and/or Authorized Representative shall give the Facility notice before Resident is unable to meet Resident's insurance premium or before Resident implements an increase, decrease or termination from insurance coverage.

7. DURABLE FINANCIAL POWER-OF-ATTORNEY.

Resident shall submit, as appropriate, to Facility, no later than the date of admission, a durable Power-of-Attorney executed by Resident as Principal designating someone other than the Facility or a representative or affiliate of Facility as Agent, for the limited purpose of financial decisions and payment of services. In the event Resident fails to designate an Agent under a Power-of-Attorney, Resident shall be responsible to pay for any guardianship proceedings related to the appointment of someone or a legal entity to make decisions on behalf of Resident, if and when Resident lacks capacity to make such decisions as determined by Facility.

8. THIRD-PARTY PAYMENTS.

8.1. Eligibility for Third-Party Payments. Resident may be or may become eligible to receive financial assistance, reimbursement, or other benefits from third parties, such as private insurance, employee benefit plans, Medicaid under the South Carolina / North Carolina Medicaid Program, Medicare benefits, managed care coverage, supplementary medical or other health insurance, supplemental security income insurance, or old-age survivors' or disability insurance. It is the responsibility of the Resident and/or Authorized Representative to apply for these benefits. If Resident is or becomes eligible to receive payments from any third parties for Resident's stay and care, the Facility reserves the right to collect such payments directly from the third-party source. The Resident and Authorized Representative shall at all times cooperate fully with the Facility and each third-party payor to secure payment. Cooperation includes providing information; signing and delivering documents; and assigning to the Facility (to the extent permitted by law) any payments for the Resident from federal or state governmental assistance programs or any other reimbursements or benefits to the extent of all amounts due the Facility.

8.2. Assignment of Payments. Resident irrevocably authorizes the Facility to make claims and to take other actions to secure for the Facility receipt of third-party payments to reimburse the Facility for its charges for the stay and care of Resident. To the fullest extent permitted by law, as security for payment of the Facility's charges, Resident hereby assigns to the Facility all of Resident's rights to any third-party payments now or subsequently payable to the extent of all charges due under this Agreement. Resident or Authorized Representative promptly shall endorse and turn over to the Facility any payments received from third parties to the extent necessary to satisfy the charges under this Agreement. Resident or Authorized Representative shall sign any necessary documents to forward third-party payments directly from the payor to the Facility.

8.3. Insurance. The Facility will bill Medicare and Medicaid for any services rendered to Resident by the Facility. The Facility may, at its discretion, bill Resident's private / supplemental insurance carrier for services rendered to Resident by the Facility. In the event of an initial or subsequent denial of coverage by the Resident's insurance carrier, Resident shall pay the Facility timely for all non-covered services retroactive to the date of the initial delivery of services, so long as such payment obligation is consistent with the regulations governing the Facility's participation in the Medicare and Medicaid Programs. DAP (initial)

8.3.1. The fact that the Facility submits a claim for payment does not relieve the Resident from liability for the cost of care for any days determined by the Program Administrators of the particular insurance coverage as non-covered, or for the Resident's portion of the liability as determined by the appropriate Program Administrators. **Pre-certification of insurance, if required, is the responsibility of the Resident.**

9. PERSONAL FINANCES.

9.1. Personal Funds Management. Resident is responsible to provide his or her personal funds, and Resident has the right to manage his or her personal funds. Resident may authorize the Facility, in writing, on a document provided by the Facility, to hold Resident's personal funds, and may revoke at any time the Facility's authorization by providing the Facility with a written notice signed and dated by Resident or Authorized Representative. If Resident authorizes the Facility to hold Resident's personal funds, the Facility shall hold, safeguard and account for Resident's personal funds in accordance with applicable provisions in the Admission Handbook. If the Facility has been appointed by the Social Security Administration as Representative Payee for the Resident's funds, then the Facility, and not the Resident's Authorized Representative, if any, shall have control over the Resident's funds. The Facility shall follow the policies and procedures as set forth by the Social Security Administration.

9.2. Refunds of Personal Funds. Any personal funds or valuables of Resident held by the Facility will be refunded, subject to deductions for payment of any outstanding bills or other amounts due the Facility, such as any costs incurred by Facility to repair Resident's room for damages caused by Resident, within thirty (30) days after Resident's discharge or death. In the event of Resident's death, such refund will be made to the Resident's estate in accordance with state law.

- 9.3. Refunds of Prepayments or Overpayments.** Any prepayments or overpayments made by Resident and held by the Facility will be refunded, subject to deductions for payment of any outstanding bills or other amounts due the Facility, after all claims have been adjudicated. In the event of Resident's death, such refund will be made to the Resident's estate in accordance with state law. No interest shall accrue on any funds required to be refunded under this Agreement.

10. TERMINATION, TRANSFER OR DISCHARGE.

- 10.1. Resident Initiated.** This Agreement remains in full force and effect until discharge of Resident regardless of payment source changes. The Facility requests a three (3) day advance written or oral notification of an impending discharge.

- 10.2. Facility Initiated.** The Facility may terminate this Agreement and Resident's stay and transfer or discharge Resident if:

10.2.1. The transfer or discharge is necessary to meet Resident's welfare and Resident's needs cannot be met in the Facility;

10.2.2. Resident's health has improved sufficiently so that Resident no longer needs the services provided by the Facility;

10.2.3. The safety or health of individuals in the Facility is or otherwise would be endangered;

10.2.4. Resident has failed, after notice, to pay for (or to have paid or treated as paid under the Medicare or Medicaid Programs) charges for Resident's care and stay at the Facility; or

10.2.5. The Facility ceases to operate.

- 10.3. Notice and Waiver of Notice.** The Facility will notify Resident and Authorized Representative at least thirty (30) days in advance of transfer or discharge, except in situations when appropriate plans that are acceptable to the Resident can be implemented earlier, and except in cases of emergencies, including those situations described in subparagraphs 10.2.1, 10.2.2, and 10.2.3 above, or when the Resident has not resided in the Facility for at least thirty (30) days. Then only such notice as is reasonable under the circumstances shall be provided.

- 10.4. Withdrawal Against Advice.** In the event Resident withdraws from the Facility against the advice of his/her attending physician and/or without approval of the Facility, all of Facility's responsibilities for the care of Resident are terminated.

11. FACILITY RULES, REGULATIONS, POLICIES AND PROCEDURES.

Resident shall comply fully with all governmental laws and regulations, the provisions of this Agreement, and the Facility's rules, regulations, policies and procedures as published in the Facility's Admission Handbook or other documents or publications made available by the

Facility. The Facility reserves the right to amend or change its rules, regulations, policies and procedures. The Facility's rules, regulations, policies and procedures shall not be construed as imposing contractual obligations on the Facility or granting any contractual rights to Resident, and are subject to change from time-to-time.

12. PERSONAL AND OTHER PROPERTY.

12.1. Responsibility for Maintenance and Loss. Resident is responsible for furnishing and maintaining his or her own clothing and other items of property as needed or desired. Seasonal items and clothing must be removed timely to assure the safety and comfort of the Resident. The Facility is not responsible for the personal property / valuables or items belonging to the Resident. If damage or loss occurs to Resident's property, the Facility will investigate each incident of loss or damage.

12.2. Disposition and Storage Upon Resident's Death. Upon the Resident's death, Facility shall contact Resident's Authorized Representative and arrange for the disposition of the Resident's personal property. Facility is authorized to transfer Resident's personal property to the Authorized Representative. The Authorized Representative must acknowledge, in writing, the receipt of the personal property transferred to his or her custody by Facility. Facility, in its sole discretion, may move and place Resident's personal property into storage at Facility's expense. If property held in storage is not claimed within thirty (30) days, Facility shall donate or discard all unclaimed property.

12.3. Disposition and Storage Upon Resident's Transfer or Discharge. If Resident's personal property is not claimed or removed by the Authorized Representative following Resident's transfer or discharge, the Facility shall move and place Resident's personal property in storage until claimed. If Resident's personal property remains unclaimed after a thirty (30) day period in storage, the Facility may dispose of Resident's property. The Facility is not responsible for any damages incurred to Resident's property if storage becomes necessary.

12.4. Damage to Room or Facility Property. Resident or Resident's estate is responsible for any damages caused to the Facility property beyond normal wear and tear, and shall pay for the repair and replacement of damaged property, based on the actual charge or cost to the Facility for such repair or replacement.

13. RESIDENT RECORDS.

Resident consents to the release of Resident's personal and medical records maintained by the Facility for treatment, payment and operations as determined reasonably necessary by the Facility. Any such release may be to the Facility's employees, agents and to other health care providers from whom the Resident receives services, to third-party payors of health care services, to any MCO in which Resident may be enrolled, or to others deemed reasonably necessary by the Facility for purposes of treatment, payment and operations. Release of records for other purposes shall be done in accordance with applicable laws, with a specific authorization from the Resident where required. Authorized agents of the state or federal government, including the Long Term Care Ombudsman, may obtain Resident's records without the written consent or authorization of Resident.

14. TREATMENT AUTHORIZATION.

Resident authorizes the Facility to provide care and treatment consistent with the terms of this Agreement. Resident also authorizes the Facility to obtain all necessary clinical and/or financial information from the hospital or nursing facility from which Resident may be transferring.

15. DEATH OF RESIDENT.

Upon admission, Resident is required to designate a funeral home. This designation will remain in effect until otherwise notified in writing. In the event of Resident's death, the Facility shall notify the person(s) designated by Resident. The Facility is authorized to arrange for the transfer of Resident's body to the designated funeral home. Resident's estate is responsible for the payment of all costs associated with the transfer and funeral expenses. Resident shall notify the Facility of any changes of the person(s) or funeral home to be notified in the event of death.

16. CAPACITY OF RESIDENT AND GUARDIANSHIP.

If Resident is, or becomes, unable to understand or communicate, and is determined by Resident's Physician or the Facility's Medical Director / Designee after admission to be incapacitated, the Facility shall have the right, in the absence of Resident's prior designation of an authorized legal representative, or upon the unwillingness or inability of the legal representative to act, to commence a legal proceeding to adjudicate Resident incapacitated and to have a court appoint a guardian for Resident. The cost of the legal proceedings, including attorneys' fees, shall be paid by Resident or Resident's estate.

17. CLINICAL ISSUES RELATED TO AGING:

17.1. The Resident has been advised of the high risks and consequences associated with aging and impaired physical condition, including (but not limited to):

17.1.1. A high risk of skin breakdown and development of pressure ulcers secondary to significant time confined to bed or inability or unwillingness to eat and/or drink.

17.1.2. The risk of significant weight loss and dehydration if the Resident's physical condition is currently chronic or hereinafter deteriorates, which may diminish Resident's nutritional and hydration input.

17.1.3. The enhanced risk of falls and subsequent bruises, cuts or fractures, which then increases the already high risk of pressure ulcers.

17.1.4. The goal of the Facility is to strive for a restraint-free environment, and processes are implemented to pursue this goal. These processes recognize and protect the Resident's rights and ensure that restraints are safe and appropriate if they must be used.

17.1.5. The above risks, and others, are inherent with the aging process. We urge the

Resident and all family members to further acquaint themselves with the risk issues inherent with aging and an impaired physical condition.

18. REPORTING COMPLAINTS.

If Resident and/or Authorized Representative believe(s) that Resident is being mistreated in any way or Resident's rights have been violated by staff or another resident, Resident or Authorized Representative shall make his/her complaint known to Facility Administrator, in accordance with the Grievance Procedure reflected in the Admission Handbook and provide Facility with sixty (60) days to resolve the complaint satisfactorily to Resident and/or Authorized Representative before the Resident / Authorized Representative may pursue arbitration (or legal action for claims involving less than \$25,000.00). This notice requirement is not intended to preclude Resident and/or Authorized Representative from filing a complaint with any appropriate governmental regulatory agency at any time.

19. MISCELLANEOUS PROVISIONS.

19.1. Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the State of South Carolina / North Carolina.

19.2. Severability. The various provisions of this Agreement shall be severable one from another. If any provision of this Agreement is found by a court or administrative body of proper jurisdiction and authority to be invalid, the other provisions shall remain in full force and effect as if the invalid provision had not been a part of this Agreement.

19.3. Captions. The captions used in connection with the sections and subsections of this Agreement are inserted only for the purpose of reference. Such captions shall not be deemed to govern, limit, modify, or in any manner affect the scope, meaning or intent of the provisions of this Agreement, nor shall such captions be given any legal effect.

19.4. Entire Agreement. This Agreement, the Authorized Representative Agreement, the Arbitration Agreement, and the admission documentation represent the entire Agreement and understanding between the parties and supersedes, merges and replaces, all prior negotiations, offers, warranties and previous representations, understandings or agreements, oral or written, between the parties.

19.5. Modifications. The Facility reserves the right to modify unilaterally the terms of this Agreement to conform to subsequent changes in law, regulation or operations. To the extent reasonably possible, the Facility will give Resident and Resident's Authorized Representative thirty (30) days advance written notice of any such modifications. Resident may not modify this Agreement except by a writing signed by the Facility.

19.6. Waiver of Provisions. The Facility reserves the right to waive any obligation of Resident under the provisions of this Agreement in its sole and absolute discretion. No term, provision or obligation of this Agreement shall be deemed to have been waived by the Facility unless such waiver is in writing by the Facility. Any waiver by the Facility shall not be deemed a waiver of any other term, provision or obligation of this Agreement, and the other obligations of Resident and this Agreement shall remain in full force and effect.

20. ACKNOWLEDGMENTS.

- 20.1. **Rate Schedule.** Resident acknowledges the receipt of a copy of the Rate Schedule and the opportunity to ask questions about the Facility's charges.
- 20.2. **Resident's Rights.** Resident acknowledges being informed orally and in writing of Resident's Rights and further acknowledges having an opportunity to ask questions about those rights. The Notice of Rights of Nursing Facility Residents is subject to change from time-to-time and shall not be construed as imposing any contractual obligations on the Facility or granting any contractual rights to Resident.
- 20.3. **Advance Directives.** Resident acknowledges being informed, orally and in writing, of the Facility's policy on advance directives and medical treatment decisions.
- 20.4. **Bed Hold Policy -- Readmission.** Resident acknowledges being informed orally of the Facility's policy on readmission and bed hold. Resident further acknowledges having received in writing a copy of the readmission bed hold policy, and an opportunity to ask questions.
- 20.5. **Agreement.** Resident acknowledges that he/she has read and understands the terms of this Agreement, that the terms have been explained to him/her by a representative of the Facility, and that he or she has had an opportunity to ask questions about this Agreement, and has received a copy of this Agreement.
- 20.6. **Smoke-Free / Tobacco-Free Policy.** Resident acknowledges that he/she has read and understands that this Facility and campus are smoke-free and tobacco-free. The terms have been explained by a representative of the Facility and he/she has had an opportunity to ask questions and has received a copy of the Smoke-free /Tobacco-free Policy.
- 20.7. **Camera Policy.** Resident acknowledges that he/she has read and understands the Facility camera policy and that the terms have been explained by a representative of the Facility and he/she has had an opportunity to ask questions and has received a copy of the camera policy.
- 20.8. **Get a Lift Safe Resident Handling Program.** Resident acknowledges that he/she has received an oral explanation and a copy of the safe resident handling program policy and procedures. Resident further acknowledges having an opportunity to ask questions about this policy.
- 20.9. **Physical Device Policy.** Resident acknowledges that he/she has read and understands the Facility physical device policy and that the terms have been explained by a representative of the Facility and he/she has had an opportunity to ask questions and has received a copy of the physical device policy.
- 20.10. **Admission Handbook.** Resident acknowledges the receipt of a copy of the Admission Handbook and the opportunity to ask questions about Facility's policies

contained in the Admission Handbook. The Admission Handbook is subject to change from time-to-time and shall not be construed as imposing any contractual obligations on the Facility or granting any contractual rights to Resident.

- 20.11. Consent to Care.** Resident hereby consents to all routine care and services rendered in accordance with physician's orders. Resident also consents to student care from universities or other academic programs which are under contract with the facility unless the facility receives from the Resident/Authorized Representative a signed document of denial of student services. (Revised 10/2010)
- 20.12. Participation in Care Plan.** Resident is encouraged to participate in the care planning process. Approval of the Resident Care Plan is the preferred manner in which consent for most treatment is obtained. There are certain specific procedures for which an individual consent form will be provided.
- 20.13. Consent to Photograph.** Resident consents to pictures taken for identification purposes only.
- 20.14. Contents of Personal Medical Records.** Resident understands and agrees that the designated record set concerning Resident is and will continue to be the property of the Facility, provided that Facility will not disclose the same to any person or party other than the Resident except as outlined in the Privacy Practices Notice. The designated record set is defined as the medical record in its entirety and the financial record including itemized charges. The following items are specifically excluded from the designated record set: incident reports, QA/QI reports, tracking forms, resident care assignment forms, shift to shift report forms, admission waiting list and financial "work papers."
- 20.15. Notification of Facility Symbols.** Resident / Authorized Representative hereby acknowledge being informed of the use of signs and symbols which may be observed in this facility. For the resident's safety and comfort, the facility may post on a doorway leading into a resident's room a symbol for type of lift device to be used or a star alerting staff to a potential fall risk. Other symbols may be used from time to time which may designate and alert staff to a specific need. You or your Authorized Representative may opt out of having symbols posted by signing a waiver of release from use of facility designated symbols.
- 20.16. Competency.** Resident declares that he or she retains capacity and is competent, has never been adjudged or determined to lack capacity or competence, and knows of no petition pending to adjudicate his or her lack of capacity or competence. Alternatively, if the Resident has been or should be deemed to lack capacity or competence, then Resident's Authorized Representative declares that he or she has been given authority by the Resident when competent to ask on behalf of the Resident, and/or is qualified to act as Resident's surrogate by reason of special care and concern for the Resident, familiarity with the Resident's personal values, reasonable availability, and willingness to serve.
- 20.17. Scope of Care.** Resident acknowledges that routine nursing services do not include: continuous one-on-one care or CNA services when required by Resident's Care

plan; care for certain high acuity conditions, such as ventilator dependent care; dialysis services; treatment for drug and alcohol conditions; or psychiatric care.

21. ARBITRATION.

WITH REGARD TO ALL MONETARY CLAIMS ARISING BETWEEN THE FACILITY AND RESIDENT / AUTHORIZED REPRESENTATIVE, TO THE EXTENT THAT THEY ARE FOR MORE THAN \$25,000.00, ARBITRATION (PURSUANT TO THE FEDERAL ARBITRATION ACT) IS MANDATORY (SUBJECT TO THE "OPT OUT" PROVISIONS SET FORTH IN PARAGRAPH 16 OF THE ARBITRATION AGREEMENT), BINDING AND FINAL. THE EXACT TERMS FOR ARBITRATION ARE SET FORTH IN A SEPARATE DOCUMENT OF EVEN / RECENT DATE, ENTITLED "ARBITRATION AGREEMENT" AND ARE INCORPORATED HEREIN BY REFERENCE. WITH REGARD TO ANY NONMONETARY CLAIM, OR ANY CLAIM FOR LESS THAN \$25,000.00, ARBITRATION SHALL NOT BE REQUIRED.

22. BINDING EFFECT.

This Agreement shall be binding upon all parties hereto and upon their respective heirs, personal representatives, successors and assigns.

IN WITNESS WHEREOF, the parties, intending to be legally bound hereby, have signed this Agreement this 19th day of May, 2014.

RESIDENT / AUTHORIZED REPRESENTATIVE:

Margaret S. Hensley
Printed Resident Name

Signature / Date

Terry H. Putman
Printed Authorized Representative

Terry H Putman 5/19/14
Signature / Date

Daughter POA
Relationship

FACILITY STAFF / WITNESS:

White Oak Estates, Inc. Date: 5-19-14

By: Susan Mon Bm
Staff Printed Name and Title

Susan Mon
Staff Signature / Witness

ORIGINAL



ARBITRATION
AGREEMENT

ARBITRATION AGREEMENT
(Pursuant to the FEDERAL ARBITRATION ACT only)

PLEASE READ CAREFULLY

FOR VALUABLE CONSIDERATION, the receipt and sufficiency of which is hereby acknowledge, the parties hereto, White Oak Estates ("the Facility"), and Margaret S. Hensley ("the Resident"), AGREE TO ARBITRATE ALL MONETARY CLAIMS that may arise between them (with the exception of monetary claims of less than \$25,000.00).

Specifically, the parties hereto agree as follows:

1. All monetary claims between the parties of \$25,000.00 or more will be resolved by arbitration and will be subject to the terms and provisions of this Agreement.
2. If one party to the Admission Agreement between the parties hereto believes he, she or it (hereinafter referred to as the "first party") has a monetary claim of more than \$25,000.00 against the other party (hereinafter referred to as the "second party"), the first party shall give the second party written notice thereof. That claim may be resolved by mutual agreement. If it is, that will conclude permanently that claim, and any other claims that arise on or before the date the claim is resolved. If the claim is not resolved by mutual agreement, then the parties will proceed as subsequently set forth herein.
3. Within thirty (30) days of giving written notice of a claim, the first party will identify in writing an arbitrator of that party's choosing. That party may choose, as that party's arbitrator, anyone that party wishes, provided the person chosen may not be a party to this Agreement, or someone who will give testimony, or provide an affidavit or other written statement for presentation at the hearing provided for below. Further, if the party is the Facility, it may not choose as an arbitrator anyone associated with the Facility as a shareholder, officer, director, or employee.
4. Within thirty (30) days of receipt of written notice of the first party's choice of an arbitrator, the second party will likewise choose an arbitrator, whomever that party wishes, subject to the same restrictions on potential arbitrators set forth in paragraph 3, above, and shall give the first party written notice thereof.
5. Within thirty (30) days of the second party's notification of that party's choice of an arbitrator, the two (2) arbitrators shall confer/meet and attempt to agree upon a third arbitrator. In choosing a third arbitrator, they will be limited to choosing someone who is certified by the Bar Association of the state in which the Facility is located, to be a mediator/arbitrator, and who has substantial prior experience in mediating/arbitrating nursing home claims. In the event the two (2) arbitrators cannot agree on a third arbitrator, then either side may apply to the American Arbitration Association to seek appointment of the third arbitrator. The choice made by the American Arbitration Association will be final and binding so long as the person chosen has substantial prior

experience in mediating/arbitrating nursing home claims, and can be expected to be both fair and impartial.

6. Within ninety (90) days of the determination of the third arbitrator, a hearing ("the hearing") shall be held at a mutually convenient location before a board consisting of the three (3) arbitrators. At the hearing each side may present whatever evidence that side deems appropriate. This "evidence" may be presented in any reasonable manner, and need not conform to the normal rules of evidence utilized in a court of law. All testimony will, however, be under oath.

7. At the arbitration hearing, each party may, but need not, be represented by an attorney. In other words, should the Resident wish to be represented by a family member, subject to the limitations set forth in paragraph 3 above, that is permissible.

8. Subject to paragraph 13 below, each party shall be responsible for paying that party's own arbitrator. Furthermore, prior to the actual arbitration hearing, each party will pay one-half (1/2) of the fees and costs associated with the third arbitrator and the hearing.

9. Each party shall promptly provide the other party with copies of all documents upon which the producing party intends to rely at the hearing. Under all circumstances, all such documents shall be made available to the other party at least ten (10) days prior to the hearing. If not, they will not, under any circumstances, be admissible at the hearing.

10. Prior to the hearing, depositions may be taken by the parties. If a dispute arises regarding these depositions, the number that may be taken, their length, etc., it will be resolved by a majority of the arbitrators. Under all circumstances, this decision by a majority of the arbitrators, and any other decisions made by a majority of the arbitrators, will be both final and binding.

11. All time limits set forth herein may, by mutual agreement or by a majority of the arbitrators, be extended or otherwise modified. Furthermore, all other issues that may arise between the parties hereto will likewise be resolved by a majority of the arbitrators.

12. At least ten (10) days prior to the hearing, each party shall submit in writing to the other party that party's best demand/offer of settlement. The parties may continue to negotiate up to and even through the actual hearing. At the hearing, each party shall provide, in writing, the arbitrators with that party's best offer/demand. When the arbitrators make their decision, they will be limited to selecting one of the two (2) figures presented by the parties. That determination will be both final and binding, will be in writing, and will be signed by at least two (2) of the arbitrators.

13. When a determination is made by a majority of the arbitrators, they shall also award the "prevailing party," as defined herein, reimbursement by the other party of all reasonable costs and expenses associated with the arbitration, such as the third arbitrator's fees, travel expenses, witness fees, deposition expenses, and other costs associated with the hearing, but excluding attorneys' fees. Each party will be responsible

for paying that party's own attorney. For purposes of this paragraph, "the prevailing party" shall be the party whose final offer or demand submitted at the hearing is the amount ultimately awarded by a majority of the arbitrators.

14. An award against the Facility will be paid within thirty (30) days after the arbitrators make their decision and notify the Facility in writing of that decision. Upon payment, the Facility, as well as all other "White Oak" facilities, including specifically White Oak Manor, Inc. and White Oak Management, Inc., and their respective shareholders, directors, officers and employees, will be deemed to be released and forever discharged from any and all other claims arising prior to the date of the hearing.

15. In the event payment is not made by the Facility within thirty (30) days of written notification of the arbitrators' decision, judgment against the Facility may be entered of record in any County in which it does business, and will accrue interest at the applicable statutory rate until payment is made.

16. At the time of signing this Agreement, the Resident/Authorized Representative/Attorney-in-Fact acknowledges having received a copy; having been told that he/she has the right to have this Agreement reviewed by an attorney of his/her own choosing prior to signing it; and having been advised that, beginning seven (7) days from date hereof, and for another ten (10) days thereafter, he/she has the right to "opt out" of this Agreement, and no longer be bound by it. In the event the party signing below determines to opt out, he/she must give the Facility written notice thereof within the time provided. **TIME IS OF THE ESSENCE.** If written notification of the Resident/Authorized Representative/Attorney-in-Fact having opted out of this Agreement is not received within the time frame set forth, the within Agreement will remain and continue in full force and effect. By initialing here, the undersigned acknowledges having specifically read this paragraph. JRP (initials)

17. If signed below by the Resident, the Resident intends to indicate that he/she believes himself/herself to be mentally competent and, in signing this Agreement, is doing so freely and voluntarily. If instead of the Resident, it is the Authorized Representative/Attorney-in-Fact signing below for the Resident, he/she has the legal right to execute this document in behalf of the Resident, and to thereby bind the Resident, as well as the Resident's heirs/beneficiaries; that so far as he/she knows, other than himself/herself, no one else has the legal right to act in behalf of the Resident and that no one else is an attorney-in-fact for the Resident pursuant to any Power of Attorney; and that all representations set forth in this paragraph are accurate.

18. Except as may be required by law, neither party hereto nor any arbitrator may disclose the determination made by the arbitrators without the prior written consent of the other party, or by court order.

19. To the extent that any questions arise that are not covered by this Agreement, they will be resolved by a majority of the arbitrators. That decision will be both final and binding.

20. In the event any portion of this Agreement is determined to be invalid or unenforceable, the remainder will nevertheless continue in full force and effect and be binding upon the parties hereto, and upon their respective heirs, personal representatives, successors or assigns.

21. The within Arbitration Agreement constitutes the entire agreement by and between the parties hereto; incorporates all representations/supposedly made at or before being signed by the undersigned; and may not be modified or otherwise amended except by subsequent written agreement entered into by and between all parties hereto. This Agreement shall be governed by the Federal Arbitration Act and, to the extent not inconsistent therewith, the laws of the state where the Facility is located.

22. This Agreement provides for Arbitration as the sole method of resolving disputes of \$25,000.00 or more. However, nothing herein contained shall be construed to reduce, diminish, or have any affect upon the substantive rights either party hereto may have by virtue of either statute or case law.

23. By signing below, the undersigned certifies and affirms that he/she has been given sufficient time to read this Agreement, and that any questions that the undersigned had, if any, were satisfactorily answered.

IN WITNESS WHEREOF, the undersigned have hereunto caused their hands and seals to be affixed as of this 19th day of May, 2014.

RESIDENT / AUTHORIZED REPRESENTATIVE:

Margaret S. Hensley
Printed Resident Name

Signature / Date

Terry H. Putman
Printed Authorized Representative

Terry H Putman 5/19/14
Signature / Date

Daughter / POA
Relationship

FACILITY STAFF / WITNESS:

White Oak Estates, Inc. Date: 5-19-14

By: Susan Moon, BOM
Staff Printed Name and Title

Susan Moon
Staff Signature / Witness

FACE SHEET

White Oak Estates Inc.

Page 1 of 2
9/13/17 12:39 PM
RI6100A

ELECTRONICALLY FILED - 2021 Mar 15 4:52 PM - SPARTANBURG - COMMON PLEAS - CASE#2020CP4203818

MARGARET S HENSLEY Preferred Name: MARGARET 		Res No.: 2684 Loc: 2 211 A Ph: (864) 574-0726 Sex: F	Admit Date: 9/21/11 1:37 pm ReAdmitted: 8/29/17 1:33 pm Discharged: Discharge Status: D.O.B.:	Admitted From: 4 Readmitted From: 4 Discharged To: SSN:

MEDICAL INFORMATION		
Med Record no: 2684 Height: 64 in. Admit Weight: 149.6 lbs. Primary Phys: HARBER, JAMES (864) 560-8777 MEDICAL GROUP OF THE CAROLINAS SPARTANBURG, SC 29307 Alternate Phys: Referring Phys: QL Hospital stay: Spartanburg Regional Hosp From/Thru: 8/17/17 thru 8/29/17 Rehab Potential:	Allergies: atenolol Augmentin cefuroxime axetil diclofenac sodium Lyrca Macrobid metformin Penicillins pregabalin Sulfa (Sulfonamide Antibiotics)	Admit Dx: S72.91XD Unsp fracture of right femur, subs for clos fx w routn heal Discharge Dx: Current Dx: S72.91XD Unsp fracture of right femur, subs for clos fx w routn heal Z48.01 Encounter for change or removal of surgical wound dressing G47.00 Insomnia, unspecified M62.81 Muscle weakness (generalized) See next page for additional diagnoses

Admitted with: ☐ Catheter present ☐ Contractures ☐ Restraint Orders ☐ Pressure Sores (other than Stage I) ☒ Received pneumococcal vaccine ☐ Received Influenza immunization ☐ In facility	

DEMOGRAPHICS	SERVICE PROVIDERS and PREFERENCES
Marital Status: Widowed County: SPARTANBURG Race: White, not of Hispa Primary Lang: English Religion: Christian: Methodi Birthplace: ASHEVILLE, NC Occupation: PAYROLL CLERK ☒ U.S. Citizen ☐ Military Srv.	Hospital: Spartanburg Regional Hos (864) 560-6000 Funeral Home: Floyd Mortuary (864) 582-5451

BILLING INFORMATION	
A/R Type: MRA CMG: RUC Resources: Medicare #: Ancillary A/R Type: MRB Medicaid #: Ancillary Co-ins A/R Type: IXB Ins: AARP Grp: Pol: Ins: Grp: Pol: Recurring Room Chg: ☒ Adv Bill ☐ Resident is Self Responsible TrustFund: ☒ Apply Interest ☒ Max Balance Reminder	Part D Plan: AARP MedicareRx Preferred (PDP) Effective: 1/01/06 RxBIN: RxPCN: Cardholder ID: Group No: PDPIND Issuer: 80840

RESPONSIBLE PARTY	SECOND CONTACT	THIRD CONTACT
TERRY PUTMAN 	TRACIE HENSLEY 	KEVIN HENSLEY
Relationship: Daughter Phone: (Day) (Eve) (Cell)	Relationship: Daughter in Law Phone: (Day) (Eve) (Cell)	Relationship: Son Phone: (Day) (Eve) (Cell)

ADDITIONAL INFORMATION
Is Facility Rep Payee (Yes or No): No

FACE SHEET

White Oak Estates Inc.

Page 2 of 2
9/13/17 12:39 PM
RI6100A

MARGARET S HENSLEY
Preferred Name: MARGARET

Res No.: 2684

Admit Date: 9/21/11 1:37 pm

Admitted From: 4

Loc: 2 211 A

ReAdmitted: 8/29/17 1:33 pm

Readmitted From: 4

Ph: (864) 574-0726

Discharged:

Discharged To:

Sex: F

Discharge Status:

D.O.B.: [REDACTED]

SSN: [REDACTED]

ADDITIONAL CURRENT DIAGNOSES

R26.2 Difficulty in walking, not elsewhere classified
R26.89 Other abnormalities of gait and mobility
R27.8 Other lack of coordination
Z74.09 Other reduced mobility
R41.841 Cognitive communication deficit
M62.838 Other muscle spasm
R60.9 Edema, unspecified
R52 Pain, unspecified
E11.9 Type 2 diabetes mellitus without complications
I10 Essential (primary) hypertension
E03.9 Hypothyroidism, unspecified
K21.9 Gastro-esophageal reflux disease without esophagitis
M81.0 Age-related osteoporosis w/o current pathological fracture
Z79.01 Long term (current) use of anticoagulants
I48.91 Unspecified atrial fibrillation
J45.909 Unspecified asthma, uncomplicated
D64.9 Anemia, unspecified
E78.5 Hyperlipidemia, unspecified

ELECTRONICALLY FILED - 2021 Mar 15 4:52 PM - SPARTANBURG - COMMON PLEAS - CASE#2020CP4203818

PATIENT: HENSLEY, MARGARET [REDACTED]
CREATED BY: James Harber, MD
DOS: 8/29/2017
COMPANY: MGC Senior Health

FACILITY: WHITE OAK ESTATES
GPM MRN: [REDACTED] DID: [REDACTED]
CONTACT: 864-560-8777

HISTORY AND PHYSICAL HISTORY

Code Status: Full Scope of Treatment

Chief Complaint / Nature of Presenting Problem: New admission H&P

History Of Present Illness: PER DC SUMMARY:

Principal Problem:

Closed displaced spiral fracture of shaft of right femur (CMS/HCC)

Active Problems:

Asthma

Atrial fibrillation (CMS/HCC)

HTN (hypertension), benign

Type 2 diabetes mellitus without complication (CMS/HCC)

Pressure sore on buttocks

Primary osteoarthritis involving multiple joints

Femur fracture, right (CMS/HCC)

Fall

Type 2 diabetes mellitus without complication (CMS/HCC)

HCAP (healthcare-associated pneumonia)

Femur fracture

- s/p R femur ORIF POD #10
- pt advised nwb 6-12 weeks
- Hb steady at 8.5 CBC pending
- continue to monitor
- pain controlled on norco 7.5 mg

#supratherapeutic INR

- INR 3.2 this am. On warfarin 0.5 mg. Did not receive this am due to elevated levels, will hold and check INR tmrw am.

Leukocytosis

- patient afebrile, Blood cultures negative 3 days, and sputum culture not collected. Levofloxacin given 1 time PO dose 500 mg for duration of coverage
- WBC 13 --> 14.7 --> 11.5 ctm

Urine retention

- patient has foley in place. in and out cath very painful, causing pt a great deal of distress
- nursing reports very swollen and irritate

Persistent A fib

- not anticoagulated (h/o duodenal ulcer w/ melena in 2012, risk for falls)
- started warfarin per ortho, but INR 6.9 so was stopped. This was likely due to interaction with ciprofloxacin
- INR yesterday 3.9 --> 2.8 --> 2.5
- Restarted warfarin for post op DVT ppx, per ortho normogram. Goal INR 2-3
- rate controlled on metoprolol, will continue

Type 2 DM

- last A1C 8.7 (3/2017), rechecking A1C
- holding home glipizide

PATIENT: HENSLEY, MARGARET [REDACTED]
CREATED BY: James Harber, MD
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CONTACT: 864-560-8777

- pt reports having poor appetite, not eating well
- nutrition consulted, supplements provided
- FSBS qACHS, with SSI

Hypothyroid

- TSH 5.646 (3/2017)
- continue home synthroid

Osteoporosis

- vitamin D deficiency noted (13.2 in 3/2017)
- extensive past prednisone use
- Continue home Evista, may need bisphosphonate started

HTN

- normotensive since admission
- continue metoprolol 25 daily

89 yo female admitted to WOE SNF for STR after above hospitalization. She is in her room in be at the time of my evaluation but in good spirits and reports no major issues or complaints.

Medication List: Current MAR is reviewed and approved or ammended per orders as appropriate at the time of this evaluation

Allergy List: Augmentin

Lyrice
Macrobid
Metformin
PCN
Sulfa

Past Medical History:

Asthma
Atrial fibrillation (CMS/HCC)
Atrial premature beats
Cervical spondylosis
Diabetes mellitus with skin ulcer (CMS/HCC)
History of cellulitisARM
History of recurrent UTIs
History of shingles
HTN (hypertension), benign
Hypothyroidism
Left hip pain
Mass in neck
Myalgia
Non-rheumatic tricuspid valve insufficiency
Nontoxic single thyroid nodule
Open wound of breast, without mention of complicationRIGHT
Osteoarthritis, hip, bilateral
Osteoporosis, senile
Other and unspecified hyperlipidemia
Pelvic pain in female
Pneumonia, organism unspecified
Pressure sore on buttocks

PATIENT: HENSLEY, MARGARET ([REDACTED])
CREATED BY: James Harber, MD
DOS: 8/29/2017
COMPANY: MGC Senior Health

FACILITY: WHITE OAK ESTATES
GPM MRN: [REDACTED] DID: [REDACTED]
CONTACT: 864-560-8777

Right hip pain
SOB (shortness of breath)
Type II or unspecified type diabetes mellitus without mention of complication, not stated as uncontrolled
Vitamin D deficiency

Past Surgical History:

TOTAL ABDOMINAL HYSTERECTOMY W/ BILATERAL SALPINGOOPHORECTOMY
REVISION TOTAL HIP ARTHROPLASTY Right 201182 - 83y
PARTIAL HIP ARTHROPLASTY Left 201384 - 85y
BREAST LUMPECTOMY Right
APPENDECTOMY

Social History: Former smoker
No EtOH or illicit use reported

Family History: Colon Ca
CAD

REVIEW OF SYSTEMS

General: No c/o voiced per Complete 12 point ROS other than as stated in HPI.
No complaints of acute or chronic pain currently that is not well controlled

VITAL SIGNS/CONSTITUTIONAL

Pulse: 72 BPM; **Blood Pressure:** 129/80; **O2 Saturation:** 98 Room Air; **Temperature:** 98.7 Fahrenheit;
Respiratory Rate: 18 Breaths per minute;

PHYSICAL EXAM

General: Awake and alert, cooperative with exam.
NAD

Eyes: Conjunctivae and lids appear normal.
Pupils equal, round, and normally reactive to light.
EOM intact

Ears/Nose/Mouth/Throat: Ears normal to inspection and palpation
Hearing grossly intact.
Pharynx is not injected. Mouth without lesions.
Nares without lesions noted
Tongue protrudes in midline

Neck: Symmetrical with no elevation of the jugular venous pulsation.
Trachea midline.
No thyroid enlargement, tenderness, or mass.

Respiratory: Normal respiratory effort.
Clear to auscultation, bilaterally A&P

Cardiovascular: S1 S2, irregularly irregular
No murmurs, rubs, or gallops.

Arterial: Distal pulses palpable in BUE and BLE
Extremities well perfused, warm and dry

Edema/Varicosities of Extremities: No BLE edema noted

Chest: No chest deformity.

Gastrointestinal: Abdomen is soft, nontender, and without masses.

PATIENT: HENSLEY, MARGARET [REDACTED]
CREATED BY: James Harber, MD
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CONTACT: 864-560-8777

Bowel sounds active.

Genitourinary: Foley in place, clear yellow urine

Lymphatics: No palpable adenopathy.

Musculoskeletal: RLE s/p ORIF R LE

Skin: Inspection: No rashes or ulcers noted on exposed areas of skin
See full body audit results from nursing

Neurological: Cranial nerves: CNs III-XII are grossly intact.

Sensation grossly normal to touch

No tremor or cerebral signs noted.

No focal changes noted

Psychiatric: Judgment/insight: Appropriate.

Oriented to person, place, month and year.

Appears to possess Decisional Capacity

LABS/RADIOLOGY/TESTS

Labs:

8/29/2017 06:22

White Blood Cell(WBC)Count: 14.1 (H)

Red Blood Cell (RBC) Count: 2.59 (L)

Hemoglobin: 7.4 (L)

HEMATOCRIT: 23.0 (L)

MCV: 89.1

MCH: 28.7

MCHC: 32.2 (L)

RDW: 16.9 (H)

Platelets: 347

8/28/2017 03:17

Sodium: 139

Potassium: 4.8

Chloride: 104

CO2: 28.4

Anion Gap: 7

BUN: 23

BUN/Creatinine Ratio: 23

Creatinine, Ser: 1.00

Glucose: 151 (H)

Calcium: 8.5 (L)

Estimated GFR-African American: >60

Estimated GFR-Other: 52

Modified Cockcroft-Gault Crcl: 34 (L)

Osmolality Calc: 284

DIAGNOSIS, ASSESSMENT AND PLAN

Assessment:

CPT Codes:

99306

PATIENT: HENSLEY, MARGARET [REDACTED]
CREATED BY: James Harber, MD [REDACTED]
DOS: [REDACTED]
COMPANY: MGC Senior Health

FACILITY: WHITE OAK ESTATES
GPM MRN: [REDACTED] DID: [REDACTED]
CONTACT: 864-560-8777

ICD Codes:

821.00 / S72.91XA: Closed right femoral fracture
NWB per orthopedics
follow up as directed
V54.81 / Z47.1: Aftercare following joint replacement
PT/OT evaluation and treatment
285.9 / D64.9: Postoperative anemia
monitor Hgb
250.01 / E10.9: Type I diabetes mellitus
continue current treatment and monitor
715.98 / M19.90: Osteoarthritis NOS-other site
V57.89 / Z51.89: Other specified rehabilitation procedure
427.31 / I48.2: Chronic atrial fibrillation
rate controlled and anticoagulated with warfarin for DVT prophylaxis only per DC notes, goal INR 1.8
401.9 / I10: Hypertension
continue current treatment and monitor
244.9 / E03.9: Hypothyroidism
continue current treatment and monitor

***** Document e-signed by James Harber, MD on Sep 12 2017 10:35AM EDT *****
MGC - Palliative Care



RESIDENT AND FACILITY
ADMISSION AGREEMENT

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RESIDENT AND FACILITY ADMISSION AGREEMENT**PLEASE READ CAREFULLY AND ASK ANY QUESTIONS**

This Agreement is made by and between White Oak Estates (hereinafter called "Facility") and Resident and his/her Resident Representative and/or the individual who has access to Resident's income and financial resources available to pay for nursing care (hereinafter called "Resident Representative") for the provision of nursing services for Margaret Hensley (hereinafter called "Resident").

Resident and/or Resident Representative affirm that the information provided during the admission process is true and correct to the best of their knowledge, and acknowledge that the submission of any false information may constitute grounds to terminate this Agreement.

Identification of Resident Representative (if applicable):

The Resident Representative is anyone authorized by the Resident or by law to act on the Resident's behalf. Please check the type and scope of authority for anyone other than the Resident who signs this Agreement.

TYPE (Check one)	SCOPE (check all that apply)
☐ General POA*	☐ Routine health care
☒ Durable POA*	☐ Unlimited health care
☒ Durable POA w/ Healthcare*	☐ Limited access to income / finance
☐ Guardianship / Conservatorship*	☐ Authorized to accept income and control financial resources of Resident
☐ Healthcare POA*	
☐ Other: _____	

*** Must provide copies of any and/or all documents checked above**

The Resident Representative, by signing this Agreement, acknowledges acceptance of the duties and responsibilities of this role.

The Resident Representative will not incur personal financial liability except for breach of duty or contract related to the misuse of Resident's resources or the failure to use those resources to pay for the Resident's care.

PRELIMINARY STATEMENTS:

Resident individually or by and through Resident's Resident Representative has considered appropriate care settings and is desirous of receiving care at the Facility.

Facility is a licensed nursing facility and will provide the services set forth below in accordance with the applicable standards of care, none of which cause the Facility to become an insurer nor guarantor of the health and safety of the Resident, or for that matter, the insurer or guarantor of the Resident's personal property.

NOW, THEREFORE, in consideration of the prompt payment by the Resident (and the applicable state, federal, or private insurance program) of the charges made to the Resident's account in accordance with the charge structure of the Facility, and in further consideration of the mutual covenants and promises herein, the parties agree as follows:

2. PROVISION OF SERVICES

2.1. Care and Services. The Facility offers, at the Daily Rate, the following services: room accommodations, food services, licensed routine nursing services, social services, activities, housekeeping services, laundering of linens and towels, routine hair care, and resident trust fund services.

2.2. Ancillary Services and Supplies. The Facility shall make available at an additional charge, unless included in the Daily Rate, the following items and services: therapy services, medical supplies, laboratory services, pharmaceuticals, beauty/barbershop, guest meals, and toiletries for personal comfort, grooming, or hygiene, and transportation. All items and services not included in the Daily Rate, such as Medicare A or Medicaid, will be billed to the applicable payor. The Resident is responsible for all non-covered items and services, co-payments or deductible amounts, according to the Facility's Rate Schedule, as amended from time-to-time. Items and services not included in the Daily Rate will be updated periodically upon notice to residents.

2.3. Services of Other Providers. The services of outside providers such as a licensed physician, optometrist, podiatrist and/or dentist, a registered pharmacist for the provision of medications, rehabilitation therapies and diagnostic services, i.e., laboratory, x-ray and/or ambulance services, are available at the Facility or under arrangement. These services are available under guidelines and procedures established by the Facility and may be utilized by Resident at his or her own expense unless covered by another pay source. The Facility retains the right to control the source of supply of any items and contract services used within the Facility. Resident or Resident Representative has exercised freedom of choice by applying for admission to Facility and thereby agrees and contracts with Facility to provide said supply items and contract services as requested. The place of purchase for pharmaceutical items is within Resident's freedom of choice subject to the Facility's policy for Resident drugs.

2.4. Role of Attending Physician and Medical Director. The Resident shall obtain the services of a qualified physician who will provide medical care during the Resident's stay at the Facility. The Resident is free to receive care from any licensed physician who agrees to submit credentials to the Facility and adhere to the Facility's policies and procedures. If the attending physician does not meet facility and/or federal requirements, then the Facility may seek alternate coverage after discussion with you and/or your representative. You and/or your representative's choice of physician will be honored if the physician meets the requirements. The Resident elects medical group of casher as the attending physician(s). DAP (initials). The Facility is not obligated to provide Resident with any medicines, treatments, special diets or equipment without specific orders or directions from Resident's attending physician. In the event Resident's attending physician is unavailable, the Facility's Medical Director / Designee may issue appropriate orders. Resident is responsible to pay for all services or equipment ordered by Resident's attending physician or the Facility's Medical Director / Designee for Resident's care unless covered by Medicare / Medicaid or other third-party insurer.

2.5. Room Assignments. The Facility makes room and bed assignments according to availability and/or in accordance with the Resident's physical and psychosocial wellbeing, as well as resident choice when able including same sex couples. Resident acknowledges that bed assignments may be changed in order to provide a proper environment for all residents. Resident and family / Resident Representative will be notified of any room changes.

3. CHARGES

3.1. Recurring / Periodic Charges for Care and Services. Resident shall pay the Daily Rate, specified in the Rate Schedule in effect at the time the service is rendered, for routine nursing services provided to Resident. The Daily Rate may be changed from time-to-time in accordance with the provisions of Section 4.3. Charges for a resident whose payor source is other than Medicare Part A or Medicaid will begin on the designated admission date or actual admission, whichever is earlier; charges for a resident whose payor source is Medicare Part A or Medicaid will begin no earlier than the date of admission.

3.2. Additional Charges for Ancillary Services and Supplies. Resident shall pay for other services and supplies provided by or through the Facility which are not covered by the Daily Rate as set forth in the Rate Schedule in effect at the time such ancillary services or supplies are rendered. Any items ordered by a physician, which are not identified on the Rate Schedule, will be provided at charges identified by the Facility. The charges for ancillary services and supplies are subject to change from time-to-time.

3.3. Charges for Outside and Non-Facility Services. In addition to the Facility's charges, Resident shall pay all fees and costs for goods or services furnished to or for Resident by anyone other than the Facility as described in Section 2.3 (Services of Other Providers) unless otherwise covered in full by Medicare or Medicaid or another third-party payor. Resident or Resident Representative is obligated to pay such fees and costs whether the goods and services are furnished by a person or provider made available by the Facility, or by a person or provider selected by Resident, and whether the goods or services are provided at the Facility or elsewhere. These fees and costs are not included in the Daily Rate. Fees for professional services rendered by a physician are not included in the

Daily Rate and will be charged directly to the Resident by the physician.

4. PERIODIC BILLINGS AND PAYMENT DUE DATE

4.1. Monthly Statements and Other Billings. Prepayment for one (1) month of the basic monthly rate is required at the time of admission. The Facility will mail Resident or Resident Representative on or about the fifth (5th) day of the month a billing statement reflecting charges for care and services for the upcoming month and charges for ancillary services and supplies which were incurred in the prior month. Statements are due and payable upon receipt of the Monthly Statement.

Resident expecting Medicare coverage specifically understands that Medicare co-insurance is the responsibility of the Resident. Payment of co-insurance is required. Payment for Medicare services is not expected until services are rendered.

4.2. Failure to Pay and Cost of Collection. Failure to pay an account at the Facility when due is a breach of this Agreement and will allow Facility to discharge Resident upon giving a thirty (30) day written notice, during which thirty (30) day period the breach may be cured by payment of the account in full.

In the event the Facility initiates legal action, which may include the appointment of a Special Conservator for the resident, to collect payments due from the Resident under this Agreement, and the Facility is successful, the Resident and/or Resident Representative shall be responsible for reimbursing the Facility for all costs and expenses thereby incurred, including reasonable attorneys' fees.

4.3. Modification of Charges. The Facility reserves the right to change the Rate Schedule reflecting the amount of any of its charges or how and when charges are computed, billed or become due. The Facility shall provide sixty (60) days advance written notice of any such changes.

4.4. Obligations of Resident's Estate and Assignment of Property. Resident and Resident Representative acknowledge the charges for services provided under this Agreement remain owed until paid. In the event of Resident's discharge for any reason, including death, this Agreement shall operate as an assignment, transfer and conveyance to the Facility of so much of Resident's property as is equal in value to the amount of any unpaid obligations under this Agreement. This assignment shall be an obligation of Resident's estate and may be enforced against the Resident's estate.

4.5. Change in Contact Information. Resident and/or Resident Representative agree to notify the Facility within ten (10) days of any change in Resident Representative's contact information.

5. MEDICARE / MEDICAID PROGRAMS

5.1. Participation in Programs. The Facility currently participates in the South Carolina / North Carolina Medicaid program and the federal Medicare program. The Facility reserves the right to withdraw from the Medicaid or Medicare programs at any time in accordance with law.

5.2. Actions of Medicaid and Medicare Agencies. The South Carolina / North Carolina Department of Health and Human Services ("DHHS") is responsible for administering benefits under the Medicaid program. The Centers for Medicare and Medicaid Services ("CMS"), of the United States Department of Health and Human Services, is responsible for administering the Medicare program through an intermediary. Resident acknowledges that the Facility is not responsible for, and has made no representations regarding, the actions or decisions of DHHS, CMS or the Medicare intermediary in administering the programs.

5.3. Medicaid Benefits.

5.3.1. Obligations of Resident. Resident is obligated to make full and complete disclosure regarding all financial resources and income during the application process. Failure to identify all resources and income, or the submission of false information, may result in the termination of this Agreement. Resident is obligated to notify the Facility when Resident's resources available to satisfy the Resident's financial obligations under this Agreement are no longer sufficient to pay all the Facility charges for Resident's care and services or when directed to do so by the Facility. Resident shall provide any documentation requested by the County Medicaid Office. Upon Facility's request, Resident shall execute an authorization for Facility to assist the Resident in securing Medicaid benefits, pursuing a hardship waiver, and bringing Resident's account current. In the event Resident applies for Medicaid benefits, Resident shall continue to pay and apply all of Resident's available resources toward the fulfillment of Resident's financial obligations under this Agreement while the Medicaid application is pending an eligibility determination by DHHS.

5.3.2. Recurring Liability Amount. For residents approved for Medicaid benefits, the Facility will accept payment from the State of South Carolina / North Carolina and, if applicable, the Resident's Recurring Liability Amount as determined by DHHS as payment in full only for those services covered by the Medicaid program. Resident remains obligated to pay such Recurring Liability Amount on a monthly basis. Services not covered by Medicaid are identified in the Rate Schedule and Resident remains obligated to pay for such services. If Resident plans to apply for Medicaid, then the Resident will have an estimated monthly Recurring Liability in the amount of \$ 30 less until the State determines the amount of Resident's income to be paid to the Facility. Once the approved Recurring Liability amount has been set by Medicaid, any differences must be paid or adjusted. The Recurring Liability amount is due to the Facility by the fifth (5th) day of the month. JKP (initials)

5.3.3. Determination of Eligibility. Resident and Resident Representative are obligated to cooperate fully in any Medicaid eligibility determination or re-determination process. In the event that Resident's eligibility for Medicaid benefits is denied, interrupted or terminated due to the failure of Resident or Resident Representative to cooperate in the Medicaid application, re-determination or appeal process, the Resident and Resident Representative shall be liable for the Daily Rate plus charges for ancillary services and supplies during any period of ineligibility, and the Facility may terminate this Agreement.

5.3.4. Authorization to Apply for and/or Appeal (Medicaid). In the event of Resident's incapacity and in situations where Resident's resources are depleted or appear to be depleted to the extent that Resident can no longer pay privately for nursing care, and it appears that Resident has become or will become eligible for Medicaid benefits to cover the cost of Resident's continued stay in the Facility; and if there is no other legal representative of Resident known to the Facility or other friend or relative known to the Facility who is authorized and/or is available or willing to act on Resident's behalf, after the Facility has made a good faith effort to identify such persons; then Resident hereby authorizes the Facility to request, file and/or apply for Medicaid benefits on behalf of Resident for the limited purpose of assisting Resident to secure payment through the Medicaid program for Resident's continued stay in the Facility. In the event the application for Medicaid benefits filed on behalf of the Resident is denied, or in the event Medicaid benefits are granted and subsequently discontinued, Resident hereby authorizes the Facility to file on Resident's behalf an appeal of any such denial of Medicaid eligibility or discontinuance of Medicaid benefits, and to take such actions to secure Resident's Medicaid benefits as the Facility deems reasonably necessary or appropriate and consistent with law. Resident warrants and represents that the financial information disclosed in the admission process is true and accurate and may be relied on by the Facility in pursuing Medicaid benefits on behalf of Resident.

5.3.5. Authorization to File a Hardship Waiver with DHHS on Behalf of Resident.

If DHHS' application of a transfer of assets penalty operates to deprive Resident of medical care such that Resident's life would be in danger, or would deprive Resident of food, clothing or shelter, or the necessities of life, then in the event of Resident's incapacity, inability or unwillingness to act, and if there is no other Resident Representative of Resident known to the Facility or any other friend or relative known to the Facility who is authorized and/or is promptly available or willing to act timely on behalf of Resident, then Resident authorizes Facility to file a Hardship Waiver with DHHS on Resident's behalf.

5.4. Medicare Part A and Part B Benefits. To the extent that Resident is a beneficiary under either Medicare Part A or Medicare Part B insurance and the nursing services or ancillary services or supplies ordered by a physician are covered by such insurance, the Facility or other provider will bill the charges for the covered services or supplies to the Medicare program. The Resident is responsible for and shall pay any co-insurance or deductible amounts under Medicare Part A or Part B insurance. The Facility shall accept payment from the Medicare intermediary as payment in full only for those services deemed to be covered in full under the Medicare Part A or the Medicare Part B program. Services not covered by Medicare are identified in the Rate Schedule.

5.5. Medicare Part B Payment Limitations: Therapy Caps.

5.5.1. General. Effective January 1, 2006, CMS imposed payment limitations on covered therapy services provided to individuals who are eligible beneficiaries under Medicare Part B. Under this financial limitation, Medicare will pay an annual capped amount for physical and speech therapy (combined) and an annual capped amount for occupational therapy. The capped amounts are revised by CMS annually. Facility shall provide Resident and/or Resident Representative with notice of the current capped amounts as appropriate.

5.5.2. Resident's Responsibility to Pay for Therapy Services Beyond the Capped

Amounts. Resident is responsible to pay the charges for all medically necessary therapy services in excess of the annual capped amounts, unless such therapy services are covered in whole or in part by private insurance or another government reimbursement program. In the event that another government reimbursement program or available third-party payor or insurance program denies coverage for therapy services provided to Resident after exhaustion of the annual capped amount, then Resident or Resident Representative shall remain responsible to pay all fees and costs for all such therapy services. If Resident is not eligible for Medicaid, then failure to pay for therapy services rendered above the capped amount shall be grounds for termination and discharge from Facility pursuant to Section 10 of this Agreement.

5.5.3. Exception Requests.

5.5.3.1. Automatic Exceptions. Medicare beneficiaries may be automatically exempted from the annual therapy caps for certain conditions or complexities that have a direct and significant impact on the need for the course of therapy being provided and the additional treatment is medically necessary.

5.5.3.2. Manual Exceptions. Medicare beneficiaries not automatically exempted from the annual therapy caps are entitled to request an exception to the annual therapy caps, for up to fifteen (15) additional treatment days. In the event that Resident has exhausted the annual capped amount, and is not automatically exempted from the therapy caps, then the following shall apply:

5.5.3.2.1. Resident and/or Resident Representative may submit an exception request to the applicable CMS Medicare contractor; or

5.5.3.2.2. In the event of Resident's incapacity, and if there is no other legal representative of Resident known to the Facility or any other friend or relative known to the Facility who is authorized and/or is promptly available or willing to act timely on behalf of Resident, then Resident authorizes Facility to submit an appropriate exception request to the applicable CMS Medicare contractor.

5.5.3.2.3. If the exception request is granted, then therapy services provided to Resident shall be covered by Medicare for the number of additional treatments approved. Once the additional approved treatments have been exhausted, Resident shall be responsible to pay all fees and costs for additional therapy services provided as noted in Section 5.5.2.

5.5.3.2.4. If the exception request is denied, then Resident shall be responsible to pay all fees and costs for additional therapy services provided as noted in Section 5.5.2.

5.6. Medicare Part D Prescription Drug Benefits.

5.6.1. Enrollment in Medicare Part D Plan. If Resident is an eligible beneficiary under the Medicare Part D insurance program and has enrolled or has been mandatorily enrolled in a Medicare Part D Prescription Drug or Medicare Advantage Plan ("PDP"), Resident shall advise Facility in writing of Resident's chosen PDP upon admission. In the event that Resident becomes an eligible beneficiary under Medicare Part D after admission or subsequently chooses to enroll in a PDP following admission, Resident shall notify Facility in writing of Resident's chosen PDP prior to enrollment in the PDP. Resident shall advise Facility if Resident elects to change PDPs, and shall provide written notice of such election, including the name/identity of the newly selected PDP prior to the effective date of the change in the PDP. DAF (initial)

5.6.2. Resident's Responsibility to Pay for Pharmaceuticals. Resident is responsible to pay the charges for all prescription and other drugs or medications while a resident in Facility, except to the extent that such drugs and medications are covered in whole or in part by an applicable government reimbursement program. Some or all of the charges for prescription drugs and other drugs and medications may be covered by certain benefits available through Medicare Part D or other private insurance or governmental insurance/benefit programs, including Medicare Part A or B. In the event that coverage for any prescription drug, supply, medication or pharmaceutical provided to Resident is denied by any applicable governmental reimbursement program or other potentially available third-party payor or insurance program, then Resident or Resident Representative shall remain responsible to pay for all such prescription drugs, supplies, other medications or pharmaceuticals.

5.6.3. Actions of Medicare Part D Plan. Facility is not responsible for and has made no representations regarding the actions or decisions of any PDP, including, but not limited to, decisions relating to the establishment of the PDP formulary, denial of coverage issues, or contractual arrangements between the PDP and the Resident, and with respect to any decisions made by the PDP relating to any long term care pharmacy provider that may be under contract with Facility.

5.6.4. Dually Eligible Residents. If Resident becomes eligible for Medicaid at any time during Resident's stay at Facility, and also qualifies for benefits under the Medicare Program, then Resident shall be **required** to enroll in a PDP (unless covered by private insurance) to ensure coverage of Resident's prescription drug needs. Resident and/or Resident Representative shall take all necessary action to enroll Resident in a PDP, and shall advise Facility of such enrollment upon Resident's acceptance into the PDP. Resident acknowledges that should Resident fail to select a PDP, then CMS will assign Resident to a PDP. Resident shall provide written notice to Facility of the name of the Resident's PDP and the effective date of enrollment.

5.6.5. Billing and Resident Cost Sharing Obligations. To the extent that Resident is a beneficiary under Medicare Part D, and the pharmacy prescriptions and/or services ordered by a physician are covered by Medicare Part D, then the Pharmaceutical Provider (as required by law) shall bill the charges for the covered services to the

Resident's PDP. Resident is responsible for and shall pay any and all cost-sharing amounts applicable under Medicare Part D insurance. Facility shall not be responsible to pay for any fees or cost-sharing amounts, including co-insurance and deductibles, relating to the provision of covered Medicare Part D pharmaceuticals to Resident. To the extent that Resident may qualify as a "subsidy eligible individual" who would be entitled to a reduction or elimination of some or all the cost-sharing or premium amounts under the Medicare Part D benefit, Resident and/or Resident Representative has the sole responsibility to apply for such benefits.

5.6.6. Authorization to Request and/or Appeal Coverage Determinations. In the event that Resident is denied coverage under Resident's PDP for pharmaceutical services or supplies prescribed by Resident's attending physician, then the following shall apply:

5.6.6.1. Resident and/or Resident Representative may independently (i) request an exception from Resident's PDP to cover non-formulary or non-covered Medicare Part D drugs that are otherwise needed or required by Resident; (ii) file a request for a re-determination of any coverage denial issued by Resident's PDP; (iii) file an appeal with the appropriate agency and judicial tribunals to challenge any denial of a request for re-determination.

5.6.6.2. In the event of Resident's incapacity, and if there is no other legal representative of Resident known to the Facility or any other friend or relative known to the Facility who is authorized and/or is promptly available or willing to act timely on behalf of Resident, or if Resident's physician is unable or unwilling to act on behalf of Resident, then Resident authorizes Facility to (i) request an exception from Resident's PDP to cover non-formulary or non-covered Medicare Part D drugs that are otherwise needed or required by Resident; (ii) file a request for a re-determination of any coverage denial issued by Resident's PDP; (iii) file an appeal with the appropriate agency and judicial tribunals to challenge any denial of a request for re-determinations.

5.6.6.3. In the event of an initial denial of coverage by the Resident's PDP, then pending the outcome of an exception request, a request for re-determination, or an appeal, and in the event that Resident's attending physician fails to prescribe a clinically and reasonably acceptable substitute prescription medication, resident authorizes Facility Medical Director / Designee to prescribe a clinically and reasonably acceptable substitute prescription medication which is covered by Resident's PDP, if such clinically and reasonably acceptable substitute is available.

5.6.6.4. If a request for exception (filed by Resident, Facility or any other Resident Representative) is ultimately denied following either reconsideration by the PDP or appeal to an appropriate tribunal, and if the requested pharmaceuticals are deemed medically necessary by Resident's physician, and no reasonably acceptable substitute, as determined by Facility's Medical Director / Designee, from the formulary of Resident's PDP exists, then Facility shall make arrangements to provide the requested pharmaceuticals to Resident. In any such situation, Resident shall be responsible to pay all fees and costs for the non-covered pharmaceuticals, consistent with the requirements of this Section.

5.6.6.5. No Effect on Medicare Part A Covered Nursing Services. Resident's Medicare Part D prescription drug benefits do not apply while the Resident's stay in Facility is covered under Medicare Part A. While Resident is in Facility on a Medicare Part A stay, Resident's pharmaceutical needs generally are covered by the Medicare Part A program.

5.7. Non-Covered Services. Resident is and remains obligated to pay the Facility for services and supplies not covered by the Medicaid or the Medicare programs.

6. MANAGED CARE ORGANIZATIONS.

6.1. Participation in Managed Care Organizations. The Facility is an authorized provider of skilled nursing services to members of certain managed care organizations (MCOs). The MCOs for whom the Facility is an authorized provider are listed on Attachment "B".

6.2. Enrollment in a Managed Care Organization. Resident or Resident Representative shall notify the Facility in writing prior to enrolling with an MCO or switching Resident's MCO enrollment.

6.3. Actions of Managed Care Organization. Resident acknowledges that an MCO for whom the Facility is not an authorized provider may not approve payment for services provided by the Facility. Resident acknowledges that the Facility is not responsible for and has made no representations regarding the actions or decisions of any MCO for whom the Facility is an authorized provider, including decisions relating to a denial of coverage.

6.4. Obligations of Resident. The Facility will accept payment from the MCO as payment in full only for those services and supplies covered by the MCO. Resident is responsible for any co-payments or other costs assigned to Resident under the specific terms of the managed care plan. Resident also shall pay for any services or supplies not covered by the MCO under the specific terms of the managed care plan. Co-payments and other costs assigned to Resident and charges for services or supplies not covered by the specific terms of the managed care plan are identified in the Rate Schedule. Managed care plans typically require pre-authorization of services by the MCO. If Resident chooses to have services which the MCO refuses to pre-authorize, Resident shall pay the Facility for those services. Resident shall pay the Facility in a timely manner for all non-covered services retroactive to the date of the initial delivery of services.

6.5. Withdrawal from Participation in the MCO. The Facility reserves the right to terminate its contractual relationship and its status as a network or authorized provider with one or more of the listed MCOs at any time in accordance with law and the terms of the applicable agreement. In the event that the Facility terminates its contractual relationship with the MCO in which Resident is enrolled, Resident may convert his or her coverage to a health plan for which the Facility is an authorized provider or transfer to a facility that is an authorized provider for Resident's MCO. The Facility shall provide thirty (30) days advance notice of its decision to withdraw as a participating provider from Resident's MCO so Resident and the MCO can coordinate a transfer to another facility.

6.6. Notice of Change in Insurance Coverage. Resident and/or Resident Representative shall notify the Facility immediately of any change in Resident's insurance status or coverage made by the insurance carrier including, but not limited to, being dropped by the insurance carrier for any reason, or a decrease or increase in insurance benefits. Resident and/or Resident Representative shall give the Facility notice before Resident is unable to meet Resident's insurance premium or before Resident implements an increase, decrease or termination from insurance coverage.

7. DURABLE FINANCIAL POWER-OF-ATTORNEY.

Resident shall submit, as appropriate, to Facility, no later than the date of admission, a durable Power-of-Attorney executed by Resident as Principal designating someone other than the Facility or a representative or affiliate of Facility as Agent, for the limited purpose of financial decisions and payment of services. In the event Resident fails to designate an Agent under a Power-of-Attorney, Resident shall be responsible to pay for any guardianship proceedings related to the appointment of someone or a legal entity to make decisions on behalf of Resident, if and when Resident lacks capacity to make such decisions as determined by Facility.

8. THIRD-PARTY PAYMENTS.

8.1. Eligibility for Third-Party Payments. Resident may be or may become eligible to receive financial assistance, reimbursement, or other benefits from third parties, such as private insurance, employee benefit plans, Medicaid under the South Carolina / North Carolina Medicaid Program, Medicare benefits, managed care coverage, supplementary medical or other health insurance, supplemental security income insurance, or old-age survivors' or disability insurance. It is the responsibility of the Resident and/or Resident Representative to apply for these benefits. If Resident is or becomes eligible to receive payments from any third parties for Resident's stay and care, the Facility reserves the right to collect such payments directly from the third-party source. The Resident and Resident Representative shall at all times cooperate fully with the Facility and each third-party payor to secure payment. Cooperation includes providing information; signing and delivering documents; and assigning to the Facility (to the extent permitted by law) any payments for the Resident from federal or state governmental assistance programs or any other reimbursements or benefits to the extent of all amounts due the Facility.

8.2. Assignment of Payments. Resident irrevocably authorizes the Facility to make claims and to take other actions to secure for the Facility receipt of third-party payments to reimburse the Facility for its charges for the stay and care of Resident. To the fullest extent permitted by law, as security for payment of the Facility's charges, Resident hereby assigns to the Facility all of Resident's rights to any third-party payments now or subsequently payable to the extent of all charges due under this Agreement. Resident or Resident Representative promptly shall endorse and turn over to the Facility any payments received from third parties to the extent necessary to satisfy the charges under this Agreement. Resident or Resident Representative shall sign any necessary documents to forward third-party payments directly from the payor to the Facility.

8.3. Insurance. The Facility will bill Medicare and Medicaid for any services rendered to Resident by the Facility. The Facility may, at its discretion, bill Resident's private / supplemental insurance carrier for services rendered to Resident by the Facility. In the event of an initial or subsequent denial of coverage by the Resident's insurance carrier, Resident shall pay the Facility timely for all non-covered services retroactive to the date of the initial delivery of services, so long as such payment obligation is consistent with the regulations governing the Facility's participation in the Medicare and Medicaid Programs. JAP (initial)

8.3.1. The fact that the Facility submits a claim for payment does not relieve the Resident from liability for the cost of care for any days determined by the Program Administrators of the particular insurance coverage as non-covered, or for the Resident's portion of the liability as determined by the appropriate Program Administrators. **Pre-certification of insurance, if required, is the responsibility of the Resident.**

9. PERSONAL FINANCES.

9.1. Personal Funds Management. Resident is responsible to provide his or her personal funds, and Resident has the right to manage his or her personal funds. Resident may authorize the Facility, in writing, on a document provided by the Facility, to hold Resident's personal funds, and may revoke at any time the Facility's authorization by providing the Facility with a written notice signed and dated by Resident or Resident Representative. If Resident authorizes the Facility to hold Resident's personal funds, the Facility shall hold, safeguard and account for Resident's personal funds in accordance with applicable provisions in the Admission Handbook. If the Facility has been appointed by the Social Security Administration as Representative Payee for the Resident's funds, then the Facility, and not the Resident's Resident Representative, if any, shall have control over the Resident's funds. The Facility shall follow the policies and procedures as set forth by the Social Security Administration.

9.2. Refunds of Personal Funds. Any personal funds or valuables of Resident held by the Facility will be refunded, subject to deductions for payment of any outstanding bills or other amounts due the Facility, such as any costs incurred by Facility to repair Resident's room for damages caused by Resident, within thirty (30) days after Resident's discharge or death. In the event of Resident's death, such refund will be made to the Resident's estate in accordance with state law.

9.3. Refunds of Prepayments or Overpayments. Any prepayments or overpayments made by Resident and held by the Facility will be refunded, subject to deductions for payment of any outstanding bills or other amounts due the Facility, after all claims have been adjudicated. In the event of Resident's death, such refund will be made to the Resident's estate in accordance with state law. No interest shall accrue on any funds required to be refunded under this Agreement.

10. TERMINATION, TRANSFER OR DISCHARGE.

10.1. Resident Initiated. This Agreement remains in full force and effect until discharge of Resident regardless of payment source changes. The Facility requests a three (3) day advance written or oral notification of an impending discharge.

10.2. Facility Initiated. The Facility may terminate this Agreement and Resident's stay and transfer or discharge Resident if:

10.2.1. The transfer or discharge is necessary to meet Resident's welfare and Resident's needs cannot be met in the Facility;

10.2.2. Resident's health has improved sufficiently so that Resident no longer needs the services provided by the Facility;

10.2.3. The safety or health of individuals in the Facility is or otherwise would be endangered;

10.2.4. Resident has failed, after notice, to pay for (or to have paid or treated as paid under the Medicare or Medicaid Programs) charges for Resident's care and stay at the Facility; or

10.2.5. The Facility ceases to operate.

10.3. Notice and Waiver of Notice. The Facility will notify Resident and Resident Representative at least thirty (30) days in advance of transfer or discharge, except in situations when appropriate plans that are acceptable to the Resident can be implemented earlier, and except in cases of emergencies, including those situations described in subparagraphs 10.2.1, 10.2.2, and 10.2.3 above, or when the Resident has not resided in the Facility for at least thirty (30) days. Then notice will be provided as soon as practicable.

10.4. Withdrawal Against Advice. In the event Resident withdraws from the Facility against the advice of his/her attending physician and/or without approval of the Facility, all of Facility's responsibilities for the care of Resident are terminated.

11. FACILITY RULES, REGULATIONS, POLICIES AND PROCEDURES.

Resident shall comply fully with all governmental laws and regulations, the provisions of this Agreement, and the Facility's rules, regulations, policies and procedures as published in the Facility's Admission Handbook or other documents or publications made available by the Facility. The Facility reserves the right to amend or change its rules, regulations, policies and procedures. The Facility's rules, regulations, policies and procedures shall not be construed as imposing contractual obligations on the Facility or granting any contractual rights to Resident, and are subject to change from time-to-time.

12. PERSONAL AND OTHER PROPERTY.

12.1. Responsibility for Maintenance and Loss. Resident is responsible for furnishing and maintaining his or her own clothing and other items of property as needed or desired. Seasonal items and clothing must be removed timely to assure the safety and comfort of the Resident. If damage or loss occurs to Resident's property, the Facility will investigate each incident of loss or damage. The Facility discourages the possession of valuables and will provide a lockbox upon request.

12.2. Disposition and Storage Upon Resident's Death. Upon the Resident's death, Facility shall contact Resident's Resident Representative and arrange for the disposition of the Resident's personal property. Facility is authorized to transfer Resident's personal property to the Resident Representative. The Resident Representative must acknowledge, in writing, the receipt of the personal property transferred to his or her custody by Facility. Facility, in its sole discretion, may move and place Resident's personal property into storage at Facility's expense. If property held in storage is not claimed within thirty (30) days, Facility shall donate or discard all unclaimed property.

12.3. Disposition and Storage Upon Resident's Transfer or Discharge. If Resident's personal property is not claimed or removed by the Resident Representative following Resident's transfer or discharge, the Facility shall move and place Resident's personal property in storage until claimed. If Resident's personal property remains unclaimed after a thirty (30) day period in storage, the Facility may dispose of Resident's property. The Facility is not responsible for any damages incurred to Resident's property if storage becomes necessary.

12.4. Damage to Room or Facility Property. Resident or Resident's estate is responsible for any damages caused to the Facility property beyond normal wear and tear, and shall pay for the repair and replacement of damaged property, based on the actual charge or cost to the Facility for such repair or replacement.

13. RESIDENT RECORDS.

Resident consents to the release of Resident's personal and medical records maintained by the Facility for treatment, payment and operations as determined reasonably necessary by the Facility. Any such release may be to the Facility's employees, agents and to other health care providers from whom the Resident receives services, to third-party payors of health care services, to any MCO in which Resident may be enrolled, or to others deemed reasonably necessary by the Facility for purposes of treatment, payment and operations. Release of records for other purposes shall be done in accordance with applicable laws, with a specific authorization from the Resident where required. Authorized agents of the state or federal government, including the Long Term Care Ombudsman, may obtain Resident's records without the written consent or authorization of Resident. Resident has the right to access his/her own records.

14. TREATMENT AUTHORIZATION.

Resident authorizes the Facility to provide care and treatment consistent with the terms of this Agreement. Resident also authorizes the Facility to obtain all necessary clinical and/or financial information from the hospital or nursing facility from which Resident may be transferring.

15. DEATH OF RESIDENT.

Upon admission, Resident is required to designate a funeral home. This designation will remain in effect until otherwise notified in writing. In the event of Resident's death, the Facility shall notify the person(s) designated by Resident. The Facility is authorized to arrange for the transfer of Resident's body to the designated funeral home. Resident's estate is responsible for the payment of all costs associated with the transfer and funeral expenses.

Resident shall notify the Facility of any changes of the person(s) or funeral home to be notified in the event of death.

16. CAPACITY OF RESIDENT AND GUARDIANSHIP.

If Resident is, or becomes, unable to understand or communicate, and is determined by Resident's Physician or the Facility's Medical Director / Designee after admission to be incapacitated, the Facility shall have the right, in the absence of Resident's prior designation of an authorized legal representative, or upon the unwillingness or inability of the legal representative to act, to commence a legal proceeding to adjudicate Resident incapacitated and to have a court appoint a guardian for Resident. The cost of the legal proceedings, including attorneys' fees, shall be paid by Resident or Resident's estate.

17. CLINICAL ISSUES RELATED TO AGING:

17.1. The Resident has been advised of the high risks and consequences associated with aging and impaired physical condition, including (but not limited to):

17.1.1. A high risk of skin breakdown and development of pressure ulcers secondary to significant time confined to bed or inability or unwillingness to eat and/or drink.

17.1.2. The risk of significant weight loss and dehydration if the Resident's physical condition is currently chronic or hereinafter deteriorates, which may diminish Resident's nutritional and hydration input.

17.1.3. The enhanced risk of falls and subsequent bruises, cuts or fractures, which then increases the already high risk of pressure ulcers.

17.1.4. The goal of the Facility is to strive for a restraint-free environment, and processes are implemented to pursue this goal. These processes recognize and protect the Resident's rights and ensure that restraints are safe and appropriate if they must be used.

17.1.5. The above risks, and others, are inherent with the aging process. We urge the Resident and all family members to further acquaint themselves with the risk issues inherent with aging and an impaired physical condition.

18. REPORTING COMPLAINTS.

If Resident and/or Resident Representative believe(s) that Resident is being mistreated in any way or Resident's rights have been violated by staff or another resident, Resident or Resident Representative shall make his/her complaint known to Facility Grievance Official (Social Service Director), Facility Administrator, or any staff member in accordance with the Grievance Procedure reflected in the Admission Handbook. This notice requirement is not intended to preclude Resident and/or Resident Representative from filing a complaint with any appropriate governmental regulatory agency at any time.

19. MISCELLANEOUS PROVISIONS.

19.1. **Governing Law.** This Agreement shall be governed by and construed in accordance with the laws of the State of South Carolina / North Carolina.

19.2. **Severability.** The various provisions of this Agreement shall be severable one from another. If any provision of this Agreement is found by a court or administrative body of proper jurisdiction and authority to be invalid, the other provisions shall remain in full force and effect as if the invalid provision had not been a part of this Agreement.

19.3. **Captions.** The captions used in connection with the sections and subsections of this Agreement are inserted only for the purpose of reference. Such captions shall not be deemed to govern, limit, modify, or in any manner affect the scope, meaning or intent of the provisions of this Agreement, nor shall such captions be given any legal effect.

19.4. **Entire Agreement.** This Agreement, the Resident Representative Agreement, the Arbitration Agreement, and the admission documentation represent the entire Agreement and understanding between the parties and supersedes, merges and replaces, all prior negotiations, offers, warranties and previous representations, understandings or agreements, oral or written, between the parties.

19.5. **Modifications.** The Facility reserves the right to modify unilaterally the terms of this Agreement to conform to subsequent changes in law, regulation or operations. To the extent reasonably possible, the Facility will give Resident and Resident's Resident Representative thirty (30) days advance written notice of any such modifications. Resident may not modify this Agreement except by a writing signed by the Facility.

19.6. **Waiver of Provisions.** The Facility reserves the right to waive any obligation of Resident under the provisions of this Agreement in its sole and absolute discretion. No term, provision or obligation of this Agreement shall be deemed to have been waived by the Facility unless such waiver is in writing by the Facility. Any waiver by the Facility shall not be deemed a waiver of any other term, provision or obligation of this Agreement, and the other obligations of Resident and this Agreement shall remain in full force and effect.

20. ACKNOWLEDGMENTS.

20.1. **Rate Schedule.** Resident acknowledges the receipt of a copy of the Rate Schedule and the opportunity to ask questions about the Facility's charges.

20.2. **Resident's Rights.** Resident acknowledges being informed orally and in writing of Resident's Rights and further acknowledges having an opportunity to ask questions about those rights. The Notice of Rights of Nursing Facility Residents is subject to change from time-to-time and shall not be construed as imposing any contractual obligations on the Facility or granting any contractual rights to Resident.

20.3. **Advance Directives.** Resident acknowledges being informed, orally and in writing, of the Facility's policy on advance directives and medical treatment decisions.

20.4. **Bed Hold Policy – Readmission.** Resident acknowledges being informed orally

of the Facility's policy on readmission and bed hold. Resident further acknowledges having received in writing a copy of the readmission bed hold policy, and an opportunity to ask questions.

- 20.5. **Agreement.** Resident acknowledges that he/she has read and understands the terms of this Agreement, that the terms have been explained to him/her by a representative of the Facility, and that he or she has had an opportunity to ask questions about this Agreement, and has received a copy of this Agreement.
- 20.6. **Smoke-Free / Tobacco-Free Policy.** Resident acknowledges that he/she has read and understands that this Facility and campus are smoke-free and tobacco-free. The terms have been explained by a representative of the Facility and he/she has had an opportunity to ask questions and has received a copy of the Smoke-free /Tobacco-free Policy.
- 20.7. **Camera Policy.** Resident acknowledges that he/she has read and understands the Facility camera policy and that the terms have been explained by a representative of the Facility and he/she has had an opportunity to ask questions and has received a copy of the camera policy.
- 20.8. **Safe Resident Handling Program.** Resident acknowledges that he/she has received an oral explanation and a copy of the safe resident handling program policy and procedures. Resident further acknowledges having an opportunity to ask questions about this policy.
- 20.9. **Physical Device Policy.** Resident acknowledges that he/she has read and understands the Facility physical device policy and that the terms have been explained by a representative of the Facility and he/she has had an opportunity to ask questions and has received a copy of the physical device policy.
- 20.10. **Admission Handbook.** Resident acknowledges the receipt of a copy of the Admission Handbook and the opportunity to ask questions about Facility's policies contained in the Admission Handbook. The Admission Handbook is subject to change from time-to-time and shall not be construed as imposing any contractual obligations on the Facility or granting any contractual rights to Resident.
- 20.11. **Consent to Care.** Resident hereby consents to all routine care and services rendered in accordance with physician's orders. Resident also consents to student care from universities or other academic programs which are under contract with the facility unless the facility receives from the Resident/Resident Representative a signed document of denial of student services. (Revised 10/2010)
- 20.12. **Participation in Care Plan.** Resident is encouraged to participate in the care planning process and has the right to see and review his/her Care Plan. Approval of the Resident Care Plan is the preferred manner in which consent for most treatment is obtained. There are certain specific procedures for which an individual consent form will be provided.
- 20.13. **Consent to Photograph.** Resident consents to pictures taken for identification purposes only.

20.14. Contents of Personal Medical Records. Resident understands and agrees that the designated record set concerning Resident is and will continue to be the property of the Facility, provided that Facility will not disclose the same to any person or party other than the Resident except as outlined in the Privacy Practices Notice. The designated record set is defined as the medical record in its entirety and the financial record including itemized charges. The following items are specifically excluded from the designated record set: incident reports, QA/QI reports, tracking forms, resident care assignment forms, shift to shift report forms, admission waiting list and financial "work papers."

20.15. Notification of Facility Symbols. Resident / Resident Representative hereby acknowledge being informed of the use of signs and symbols which may be observed in this facility. For the resident's safety and comfort, the facility may post on a doorway leading into a resident's room a symbol for type of lift device to be used or a star alerting staff to a potential fall risk. Other symbols may be used from time to time which may designate and alert staff to a specific need. You or your Resident Representative may opt out of having symbols posted by signing a waiver of release from use of facility designated symbols.

20.16. Competency. Resident declares that he or she retains capacity and is competent, has never been adjudged or determined to lack capacity or competence, and knows of no petition pending to adjudicate his or her lack of capacity or competence. Alternatively, if the Resident has been or should be deemed to lack capacity or competence, then Resident's Resident Representative declares that he or she has been given authority by the Resident when competent to ask on behalf of the Resident, and/or is qualified to act as Resident's surrogate by reason of special care and concern for the Resident, familiarity with the Resident's personal values, reasonable availability, and willingness to serve.

20.17. Scope of Care. Resident acknowledges that routine nursing services do not include: continuous one-on-one care or CNA services when required by Resident's Care plan; care for certain high acuity conditions, such as ventilator dependent care; dialysis services; treatment for drug and alcohol conditions; or psychiatric care.

20.18. Health Information Exchange / Regional Health Information Organization. Federal and state laws may permit us to participate in organizations with other healthcare providers, insurers, and/or health care industry participants and their subcontractors in order for these individuals and entities to share your health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of your health records; decreasing the time needed to access your information; aggregating and comparing your information for quality improvement purposes; and such other purposes as may be permitted by law. Information may be shared if you are an inmate or under custody of law which is necessary for your health or the health and safety of others.

21. ARBITRATION.

WITH REGARD TO ALL CLAIMS ARISING BETWEEN THE FACILITY AND RESIDENT/ RESIDENT REPRESENTATIVE, ARBITRATION (PURSUANT TO THE

FEDERAL ARBITRATION ACT) IS MANDATORY (SUBJECT TO THE "OPT OUT" PROVISIONS SET FORTH IN PARAGRAPH 17 OF THE ARBITRATION AGREEMENT), BINDING AND FINAL. THE EXACT TERMS FOR ARBITRATION ARE SET FORTH IN A SEPARATE DOCUMENT OF EVEN/ RECENT DATE, ENTITLED, "ARBITRATION AGREEMENT" AND ARE INCORPORATED HEREIN BY REFERENCE.

22. BINDING EFFECT.

This Agreement shall be binding upon all parties hereto and upon their respective heirs, personal representatives, successors and assigns.

IN WITNESS WHEREOF, the parties, intending to be legally bound hereby, have signed this Agreement this ____ day of _____, 20__.

RESIDENT / RESIDENT REPRESENTATIVE:

Margaret Hensley
Printed Resident Name

Signature / Date

Terry Putman
Printed Resident Representative

Terry Putman 8/26/17
Signature / Date

Daughter & POA
Relationship

FACILITY STAFF / WITNESS:

White Oak White Oak Estates, Inc.

Date: 8/29/17

By: KAREN BAKER POA
Staff Printed Name and Title

[Signature]
Staff Signature / Witness



ARBITRATION AGREEMENT

ARBITRATION AGREEMENT
(Pursuant to the FEDERAL ARBITRATION ACT only)
 (Effective January 1, 2017)

FOR VALUABLE CONSIDERATION the parties hereto (White Oak White Oak Estates
 ("the Facility"), and Margaret Hensley
 ("the Resident"), agree to arbitrate ALL claims that may arise between them.

Specifically, the parties hereto agree as follows:

1. When reference is made in this Agreement to "the Resident," reference is made to the person identified above. When reference is made to "the Facility," reference is made to the specific White Oak Facility at which the Resident resides. When reference is made to "the Resident Representative," reference is made to anyone signing this Agreement in behalf of the Resident. When reference is made to "ALL" claims, "all claims" is intended to include not only all claims between the Resident and the Facility, as well as claims between the Resident's heirs/beneficiaries, but also all other claims that allegedly exist between the Resident and all other "White Oak" entities, including specifically White Oak Manor, Inc. and White Oak Management, Inc.
2. All claims arising between the parties hereto will be resolved by arbitration and will be subject to the terms and provisions of this Agreement. As indicated above, this Agreement is subject to the Federal Arbitration Act only. Furthermore, although entered into by and between only the parties identified above, this Agreement also makes it such that no separate action or claims may be asserted against the Facility, or any other "White Oak" entities, nor against their officers, directors, shareholders or employees.
3. If either party to this Agreement (or any other agreements entered into between the parties hereto on or about the date hereof, the terms and provisions of which are specifically incorporated herein by reference) believes that he, she or it (hereinafter referred to as the "first party") has a claim against the other party (hereinafter referred to as the "second party"), the first party shall give the second party written notice thereof. That claim may be resolved by mutual agreement. If it is, that will conclude permanently everything arising between them prior to the date of resolution. If it is not, the parties will proceed as set forth below.
4. Within a reasonable period of time after giving written notice of a claim or claims, the first party will provide the second party, in writing, with the name of an arbitrator of the first party's choosing. If the first party is the Resident, or the Resident Representative, that party may choose, as that party's arbitrator, anyone that party wishes, provided the person chosen may not be anyone signing this Agreement, a family member, or anyone who will give testimony or provide an affidavit or other written statement at the hearing provided for below. The arbitrator chosen need not be an attorney.
5. Within ninety (90) days of receipt of written notice of the first party's choice of an arbitrator, the second party will likewise choose an arbitrator and shall give the first party

written notice thereof. If the second party is the Facility, it may not choose anyone associated with the Facility as a shareholder, officer, director, or employee, or anyone who will give testimony or provide an affidavit or other written statement for presentation at the hearing.

6. Within ninety (90) days of the second party's notification to the first party of the second party's choice of an arbitrator, or as soon thereafter as reasonably possible, the two (2) arbitrators shall confer/meet and attempt to agree upon a third arbitrator. In choosing a third arbitrator, they will be limited to choosing an attorney who is certified by the Bar Association of the state in which the Facility is located to be a mediator/arbitrator and who has substantial prior experience in mediating/arbitrating nursing home claims. In the event the two (2) arbitrators cannot agree on the third arbitrator, the two (2) arbitrators will meet, and flip a coin. The arbitrator chosen by the Facility will flip the coin. The arbitrator chosen by the Resident, while the coin is in the air, will call either heads or tails. The arbitrator "winning" the coin toss will pick the third arbitrator. The choice of the third arbitrator will be both final and binding on the parties. That arbitrator must, within thirty (30) days of being given notice of having been chosen as the third arbitrator, agree to participate in this matter as the third arbitrator, and affirm that he/she meets the requirements set forth above, and will be both fair and impartial in rendering his/her decision. If the third arbitrator so chosen does not agree to participate, the process of selecting a third arbitrator will begin again, with the procedure set forth above again followed.

7. Within ninety (90) days of the determination of the third arbitrator, or as soon thereafter as the parties may determine, a hearing ("the hearing") shall be held at a mutually convenient location before a board consisting of the three (3) arbitrators. At the hearing each side may present whatever evidence that side deems appropriate. This "evidence" may be presented in any reasonable manner, and need not conform to the normal rules of evidence utilized in a court of law. All testimony will, however, be under oath. Furthermore, to the extent reasonably possible, "hearsay," as traditionally defined, will not be allowed/received. Medical records, and other records generated by the Facility during the ordinary course of business, however, and other medical records, whose authenticity is not questioned, generated by other healthcare providers, shall be admissible, and shall not be deemed to constitute hearsay.

8. At the hearing each party may, but need not, be represented by an attorney. In other words, should the Resident wish to be represented by a family member, or someone other than an attorney, subject to the limitations set forth in paragraph 3 above, he/she may.

9. Each party will be responsible for paying his/her/its own arbitrator. As indicated below, the expense of the third arbitrator will be paid by the "non-prevailing party." Payment will be made within thirty (30) days of the arbitration panel's decision.

10. Each party shall promptly provide the other party with copies of all documents upon which the producing party intends to rely at the hearing. Under all circumstances, all such documents shall be made available to the other party at least ten (10) days prior to the hearing. If they are not, they will not be admissible at the hearing unless a majority of the arbitrators determine that, in fairness, they should be admissible.

11. Prior to the hearing, depositions may be taken. If a dispute arises regarding these depositions, the number that may be taken, their length, etc., it will be resolved by a majority of the arbitrators. Under all circumstances, this decision, and all other decisions so made will be both final and binding.

12. All time limits set forth herein may, by mutual agreement, or by a majority of the arbitrators, be extended or otherwise modified.

13. At least twenty-four (24) hours prior to the hearing, each party will submit in writing to the other party that party's demand/offer of settlement. At the hearing each party will, in writing, provide the arbitrators with that party's best demand/offer. When the arbitrators make their decision, they will be limited to selecting the demand/offer made by one of the parties. In other words, the arbitrators will not have the option of splitting the difference between the final demand and the final offer made by the parties, or by choosing any other amount other than one of the two (2) amounts demanded/offered by the parties. This decision by the arbitrators will be both final and binding, will be in writing, and will be signed by at least two (2) of the arbitrators. THE ARBITRATORS ACKNOWLEDGE THAT JUST BECAUSE THE FACILITY MAKES AN OFFER DOES NOT MEAN THAT THE FACILITY CONSIDERS ITSELF RESPONSIBLE FOR THE RESIDENT'S INJURIES/DAMAGES. IN FACT, BY MAKING AN OFFER IT IS PROBABLE THAT THE FACILITY IS MERELY TRYING TO INCREASE THE CHANCES THAT THE DIFFERENCES BETWEEN THE PARTIES CAN BE RESOLVED WITHOUT THE NEED FOR ACTUAL ARBITRATION, OR THAT THE FACILITY IS TRYING TO INCREASE THE CHANCES THAT A MAJORITY OF THE ARBITRATORS WILL SELECT THE FACILITY'S OFFER AS OPPOSED TO THE RESIDENT'S DEMAND.

14. When a final determination is made by a majority of the arbitrators, they shall also award the "prevailing party," as defined herein, reimbursement for all reasonable costs and expenses associated with the arbitration, including the third arbitrator's fees, the costs of depositions, and any other costs associated with the hearing, but excluding attorney's fees and the charges of that party's own arbitrator. In other words, each party will be responsible for paying his/her/its own attorney and arbitrator. For purposes of this Agreement, "the prevailing party" shall be the party whose final offer/demand was chosen by a majority of the arbitrators.

15. An award against the Facility will be paid within ninety (90) days after the arbitrators make their decision and notify the Facility in writing of that decision. Upon payment, the Facility, as well as all other "White Oak" entities, will be deemed to be released and forever discharged from all claims between the parties.

16. In the event payment is not timely made by the Facility, judgment against the Facility may be entered of record in any County in which the facility is located, and will accrue interest therefrom at the applicable statutory rate until payment is made.

17. At the time of signing this Agreement, the Resident/the Resident Representative acknowledges having received a copy; having been told that he/she has the right to have this Agreement reviewed by his/her attorney both prior to and after signing it; and having been



advised that he/she has thirty (30) days in which to "opt out" of this Agreement and no longer be bound. To opt out, the Resident/Resident Representative must give the Facility's administrator written notice thereof. **TIME IS OF THE ESSENCE.** By initialing here, the undersigned acknowledges having been explained this paragraph and understanding what it means.

DAD (INITIALS)

18. If signed below by the Resident, the Resident intends to indicate that he/she believes himself/herself to be mentally competent and, in signing this Agreement, to be doing so freely and voluntarily. If signed by the Resident Representative, he/she intends to indicate that he/she believes that he/she has the legal right to sign this Agreement in behalf of the Resident and thereby bind the Resident, as well as the Resident's heirs/beneficiaries to the terms and provisions of not only this Agreement, but also the terms and provisions set forth in the Admission Agreement of recent date herewith. Furthermore, if signed by the Resident Representative, the undersigned intends to indicate that he/she believes the Resident would be incapable of understanding the terms and provisions set forth herein, or has indicated to the undersigned that he/she does not want to be bothered with signing this Agreement, or for that matter any other agreements between the Resident and the Facility, including the Admission Agreement. Finally, by signing below the Resident Representative intends to indicate that to the best of his/her knowledge and belief, no other family members of the Resident would object to or take issue with the undersigned signing, in behalf of the Resident, this Agreement.

19. To the extent that any questions arise that are not covered by this Agreement, they will be resolved by a majority of the arbitrators. That decision will be both final and binding.

20. In the event any portion of this Agreement is determined to be invalid or unenforceable, the remainder will nevertheless continue in full force and effect and be binding upon the parties hereto, and upon their respective heirs, personal representatives, successors and assigns.

21. The within Arbitration Agreement constitutes the entire agreement by and between the parties hereto with regard to the resolution of issues/disputes which may arise between them. Regardless, under all circumstances it shall be considered along with the Admission Agreement also entered into by and between the parties hereto. In other words, these two (2) Agreements, and any other agreement signed at or about the time the Resident is admitted into the Facility involved, shall be considered together, and will all be construed as dealing with the healthcare that the Facility is to provide the Resident.

22. The within Arbitration Agreement incorporates all representations supposedly made at or before being signed and may not be modified or otherwise amended except by subsequent written agreement.

23. Although this Agreement provides for Arbitration as the sole method of resolving disputes/issues that arise between the parties hereto, nothing herein contained shall be construed to reduce, diminish, or have any affect upon the substantive rights the Resident may have pursuant to law. However, the applicable statute of limitations remains in full force and effect.

24. By signing below, the Resident/Resident Representative certifies that:

- (a) The terms and provisions of this Agreement were satisfactorily explained, and any questions were satisfactorily answered.
- (b) He/she was given sufficient time to read this Agreement.
- (c) He/she was given, at the time he/she signed this Agreement, a copy, as well as a copy of all other agreements entered into with the Facility.
- (d) This Agreement was entered into freely and voluntarily.
- (e) He/she was told that admission into the facility was not contingent upon this Agreement being signed.
- (f) He/she was told to contact an attorney if he/she had any questions whatsoever that were not satisfactorily answered or that he/she did not fully understand.
- (g) All representations set forth above are accurate and correct. Furthermore, the undersigned acknowledges that if the representations set forth above are not accurate and correct, he/she will indemnify and hold harmless the Facility with regard to any untrue and/or inaccurate representations.

25. The within Agreement shall be binding upon the parties hereto, and upon their respective heirs, successors and assigns.

IN WITNESS WHEREOF, the undersigned have hereunto caused their hands and seals to be affixed as of this 24 day of Aug, 2017.

RESIDENT / RESIDENT REPRESENTATIVE:

Margaret Hensley
Printed Resident Name

Signature / Date

Terry H. Putman
Printed Resident Representative

Terry H. Putman 8/24/17
Signature / Date

Daughter & POA
Relationship

FACILITY STAFF / WITNESS:

White Oak White Oak Estates, Inc. Date: 8/24/17
By: Karen Baker BA
Staff Printed Name and Title Staff Signature / Witness



RESIDENT
REPRESENTATIVE
AGREEMENT

RESIDENT REPRESENTATIVE AGREEMENT
PLEASE READ CAREFULLY AND ASK ANY QUESTIONS

This Resident Representative Agreement (hereinafter referred to as "Agreement") is made between White Oak Estates {Facility Name}, (hereinafter referred to as the "Facility") and Terry H. Putman, the legal representative or representative individual (hereinafter referred to as "Resident Representative") of the Resident, Hensley Margaret (hereinafter referred to as "Resident").

WHEREAS, Resident Representative and Facility enter into this Agreement to facilitate the provision of care to the Resident.

WHEREAS, the Resident Representative may be the Guardian/Conservator, the Agent under a valid Power of Attorney, or any person authorized by the Resident to serve as Resident's Resident Representative.

WHEREAS, Facility shall discuss and consult with the Resident Representative regarding pertinent decisions related to Resident's stay and care at the Facility.

THEREFORE, Facility and Resident Representative agree to the following terms and conditions:

1. Resident Representative affirms that the information and related documents provided during the admission process are true and correct to the best of his or her knowledge. Resident Representative acknowledges that the submission of any false information, misrepresentation or lack of disclosure may result in the termination of the Resident and Facility Admission Agreement (hereinafter referred to as "Admission Agreement") and may result in the discharge of the Resident from the Facility at the Resident and/or Resident Representative's expense.

2. If the Resident selects a Resident Representative, then said Resident Representative shall sign this Agreement, the Admission Agreement and the Arbitration Agreement in recognition of this designation with the intent to be legally bound by this Agreement, the Admission Agreement and the Arbitration Agreement (subject, however, to the opt-out provisions of the Arbitration Agreement). The Resident Representative shall be obligated to fulfill the duties on behalf of the Resident imposed by the Admission Agreement in accordance with the law governing fiduciary duties. Facility may petition a court to appoint a Guardian / Conservator and take other legal action if Facility reasonably believes that the Resident's needs are not being properly met or the duties imposed by the Admission Agreement are not being fulfilled by the Resident Representative. Resident, Resident's estate, or Resident Representative shall pay the cost of such Guardianship/Conservatorship proceedings, including attorneys' fees.

3. Resident Representative affirms that he or she has access to Resident's income and resources and that Resident's income and resources are available to pay for Resident's care in the Facility. DNP (initials). The Resident Representative shall provide payment from Resident's income and resources for such care. Resident Representative shall apply Resident's income and resources to the costs and charges incurred during Resident's stay unless and until such costs are paid by private insurance or other benefits such as Medicare or Medicaid. When the Resident's financial resources warrant it, Resident Representative shall take any and all actions necessary and appropriate to initiate, make and conclude application for Medicaid benefits on behalf of the Resident, including providing all necessary documentation, complying with deadlines and pursuing all necessary appeals. Resident Representative shall utilize Resident's income and resources only for Resident and shall not utilize any of Resident's income or resources for Resident Representative's benefit nor transfer any of Resident's real property except for proceeds at no less than fair market value for the benefit of Resident.

Resident Representative affirms that he or she does not have access to Resident's income and resources, but that Resident's income and resources are available to pay for Resident's care in the Facility. _____ (initials). The Resident Representative shall provide payment from Resident's income and resources for such care. Resident Representative shall apply Resident's income and resources to the costs and charges incurred during Resident's stay unless and until such costs are paid by private insurance or other benefits such as Medicare or Medicaid. When the Resident's financial resources warrant it, Resident Representative shall take any and all actions necessary and appropriate to initiate, make and conclude application for Medicaid benefits on behalf of the Resident, including providing all necessary documentation, complying with deadlines and pursuing all necessary appeals. Resident Representative shall utilize Resident's income and resources only for Resident and shall not utilize any of Resident's income or resources for Resident Representative's benefit nor transfer any of Resident's real property except for proceeds at no less than fair market value for the benefit of Resident.

4. Resident Representative is obligated to pay Facility from Resident's financial resources for services and supplies provided to Resident in accordance with the Admission Agreement. If the Resident Representative withholds or misappropriates Resident's financial resources for personal use or gifts, or otherwise does not use the Resident's financial resources to fulfill Resident's financial obligations to Facility for services and supplies provided to Resident in accordance with the Admission Agreement, then Resident Representative shall be held liable for payment, but only up to the amount of the Resident's financial resources, and Facility will apply to become representative/designated payee for available income.

5. If Resident becomes unable to pay the charges for nursing facility care due to the depletion of Resident's financial resources, Resident Representative shall timely assist Resident in the preparation, completion and submission of Resident's application for Medicaid benefits, and if applicable, file an appeal of a determination of ineligibility. Assistance provided by Facility in the preparation, completion or submission of an application for Medicaid benefits does not relieve Resident or Resident Representative of these obligations. Resident Representative shall provide all information and documentation requested by the Medicaid Office. Upon Facility's request, Resident Representative shall execute an authorization for

Facility to obtain Resident's financial information for the purposes of securing Medicaid benefits, pursuing a hardship waiver, and bringing Resident's account current. If Resident is determined to be ineligible for Medicaid as a result of Resident Representative's failure to meet the obligations set forth in this Agreement, then Facility may terminate the Admission Agreement for non-payment, and Resident may be discharged for non-payment. Resident Representative shall be liable for any losses sustained by Facility as a result of failure to meet contractual obligations.

6. In the event Resident applies for Medicaid benefits, Resident Representative shall pay the applicable Recurring Liability Amount to Facility on a monthly basis. The Recurring Liability Amount is determined by the Department of Health and Human Services ("DHHS") and described in the Admission Agreement. Resident Representative may request the Facility, to the extent permitted by law, to apply as representative / designated payee for any income available to Resident.

7. Resident Representative is obligated to pay Facility for all losses or damages incurred by Facility resulting from the failure of the Resident Representative to fulfill his/her duties under the Admission Agreement and/or this Agreement. In the event that Facility initiates any legal actions or proceedings to collect payments due from Resident and Resident Representative under this Agreement, or to enforce Resident Representative's obligations under the Admission Agreement, then Resident and Resident Representative shall pay all damages, attorneys' fees and costs incurred by Facility in pursuing the enforcement of Resident's and/or Resident Representative's financial or other obligations under the Admission Agreement and/or this Agreement. Such damages, fees, and costs may include, in the discretion of Facility, an amount equivalent to revenue lost by Facility due to Resident Representative's failure to timely submit or complete a Medicaid application or to cooperate with DHHS in the Medicaid eligibility determination.

8. Resident Representative understands that if he or she fulfills his or her obligation under the Admission Agreement and/or this Agreement, he or she shall not be held personally liable for the Resident's charges. This Agreement shall not be construed or operate as a third party guaranty.

9. Resident Representative is obligated to perform all provisions in the Admission Agreement related to Resident Representative.

10. This Agreement shall bind the Resident Representative, his or her executors, heirs, administrators and assigns and the benefits shall inure to Facility, its successors and assigns.

11. Resident Representative acknowledges he or she has reviewed this Resident Representative Agreement and understands the information set forth herein.

IN WITNESS WHEREOF, the parties, intending to be legally bound hereby, have signed this Resident Representative Agreement on this 24 day of Aug, 2017.

RESIDENT / RESIDENT REPRESENTATIVE:

Hensley, Margaret
Printed Resident Name

Signature / Date

Terry H. Putman
Printed Resident Representative

Terry H. Putman 8/24/17
Signature / Date

Daughter + POA
Relationship

FACILITY STAFF / WITNESS:

White Oak White Oak Estates, Inc.

Date:

By: KAREN BAKER BMA
Staff Printed Name and Title

[Signature]
Staff Signature / Witness

STATE OF SOUTH CAROLINA	)	
	)	IN THE COURT OF COMMON PLEAS
COUNTY OF SPARTANBURG	)	
Terry Putman, Individually and as	)	
Personal Representative of the Estate	)	
Of Margaret Hensley,	)	AFFIDAVIT OF KAREN BAKER
	)	
Plaintiff,	)	
	)	
v.	)	
	)	
White Oak Estates, Inc.; White Oak	)	C.A. Number: 2020-CP-42-03818
Management, Inc.; and White Oak	)	C.A. Number: 2020-CP-42-03819
Manor, Inc.,	)	
	)	
Defendants.	)	
	)	

PERSONALLY APPEARED BEFORE ME, Karen Baker, who being duly sworn,
deposes and states as follows:

(1) I am over the age of 18 and make this affidavit based on my own personal knowledge and review of information and documents available to me.

(2) At the time of Margaret Hensley's admission to White Oak Estates, Inc. in August 2017, I served as the Business Office Assistant for White Oak Estates, Inc. I continue to be employed by White Oak Estates, Inc. presently.

(3) As the Business Office Assistant for White Oak Estates, Inc. at the time of Margaret Hensley's admission in August 2017, I have knowledge of and was involved in the facility admissions process.

(4) Copies of the Resident and Facility Admission Agreement, Arbitration Agreement, and Resident Representative Agreement related to Margaret Hensley's August 2017 admission to White Oak Estates, Inc. are attached to my Affidavit as Exhibit 1. These documents have been maintained by White Oak Estates, Inc. in the regular course of business.

(5) I executed the Resident and Facility Admission Agreement, Arbitration Agreement, and Resident Representative Agreement attached as Exhibit 1 on behalf of White Oak Estates, Inc. and was authorized to do so in my position as Business Office Assistant.

FURTHER AFFIANT SAYETH NOT.

By: Karen Baker
Karen Baker

SWORN to before me this

18 day of Feb, 2021.

Beverly Villalva
Notary Public for South Carolina

My Commission Expires: Oct 21, 2024

STATE OF SOUTH CAROLINA	)	
	)	IN THE COURT OF COMMON PLEAS
COUNTY OF SPARTANBURG	)	
 Terry Putman, Individually and as	)	
Personal Representative of the Estate	)	
Of Margaret Hensley,	)	AFFIDAVIT OF SONIA A. CRISP
	)	
Plaintiff,	)	
	)	
v.	)	
	)	
White Oak Estates, Inc.; White Oak	)	C.A. Number: 2020-CP-42-03818
Management, Inc.; and White Oak	)	C.A. Number: 2020-CP-42-03819
Manor, Inc.,	)	
	)	
Defendants.	)	
_____	)	

PERSONALLY APPEARED BEFORE ME, Sonia A. Crisp, who being duly sworn, deposes and states as follows:

(1) I am over the age of 18 and make this affidavit based on my own personal knowledge and review of information and documents available to me.

(2) I hold a dual nursing home and community resident care administrator's license issued by the State of South Carolina. I am the Administrator of White Oak Estates, Inc. ("White Oak Estates"). In this role, I have knowledge of operations and the facility admissions process.

(3) There is no written notice from Margaret Hensley, Terry Putman, or anyone else, in Ms. Hensley's file maintained at White Oak Estates seeking to opt out of or rescind the Arbitration Agreement attached to Karen Baker's Affidavit as Exhibit 1.

(4) During the period of Ms. Hensley's 2017 residency at White Oak Estates, White Oak Estates' staff communicated with prospective residents and/or their families who lived outside of South Carolina. This continues to be true at the present time.

(5) During the period of Ms. Hensley's 2017 residency at White Oak Estates, White

Oak Estates' staff communicated with existing residents' family members and/or representatives who lived outside of South Carolina. This continues to be true at the present time.

(6) During the period of Ms. Hensley's 2017 residency at White Oak Estates to the present, a variety of companies have been used directly or indirectly in providing goods and services for the care of residents at White Oak Estates, including Ms. Hensley. Many of these goods and services were received from vendors based outside of South Carolina. For example, see the following chart:

<u>Company/Vendor</u>	<u>State Where Based</u>	<u>Service/Good Supplied</u>
U.S. Foods	Illinois	food supplies
PFG	Virginia	food supplies
IFH (Institution Food House)	North Carolina	food supplies
S&D Coffee	North Carolina	food supplies
Mobilex USA	Maryland	imaging services
American Health Associates	Florida	lab services

(7) During the period of Ms. Hensley's 2017 residency at White Oak Estates to the present, White Oak Estates has maintained 88 short- and long-term care beds, which are certified by and participate in the Medicare and Medicaid programs.

(8) Medicare is a federally administered program. During Ms. Hensley's 2017 residency at White Oak Estates, White Oak Estates received payments from Medicare.

(9) The South Carolina Medicaid Program is partially funded by the federal government. During Ms. Hensley's 2017 residency at White Oak Estates, White Oak Estates received payments from Medicaid.

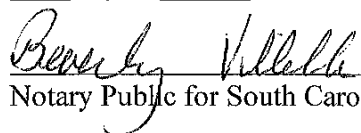
(10) During Ms. Hensley's 2017 residency, White Oak Estates' requests for private insurance payments for services rendered to residents of White Oak Estates were sent by U.S. Mail to various private insurances companies located outside of the State of South Carolina, and

insurance payments were issued by these insurance companies.

FURTHER AFFIANT SAYETH NOT.

By: 
Sonia A. Crisp

SWORN to before me this
18 day of Feb, 2021.


Notary Public for South Carolina

My Commission Expires: Oct. 21, 2024

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF SPARTANBURG	)	C.A. No.: 2020-CP-42-03818 &
	)	2020-CP-42-03819
	)	
Terry Putman, Individually and as	)	
Personal Representative of the Estate	)	
of Margaret Hensley,	)	
	)	
Plaintiff,	)	PLAINTIFF'S MEMORANDUM
	)	IN OPPOSITION TO
v.	)	DEFENDANTS' MOTION TO
	)	DISMISS, COMPEL ARBITRATION,
White Oak Estates, Inc., White Oak	)	AND FOR A PROTECTIVE ORDER
Management, Inc., and White Oak	)	OR, ALTERNATIVELY, TO STAY
Manor, Inc.,	)	THE ACTION PENDING
	)	ARBITRATION
Defendant(s).	)	
	)	

BACKGROUND

This is a wrongful death and survival action case involving nursing home negligence and corporate negligence resulting in the death of Margaret Hensley (hereinafter "Decedent"). Terry Putman (hereinafter "Daughter") was Decedent's daughter and serves as the Personal Representative of Decedent's estate. Decedent was admitted to the Defendants' facility at White Oak Estates, Inc. (hereinafter "White Oak") on or about August 29, 2017 for short-term rehabilitation after undergoing a hip arthroplasty. White Oak is a skilled nursing facility owned, controlled, and operated by Defendants White Oak Management, Inc. and White Oak Manor, Inc.

At the time of admission to White Oak, Decedent had an articulating brace for her leg to help keep it immobile as a result of her hip surgery. An abrasion/discoloration existed near the area of the brace on the right lower leg at the time of admission. No care plan was ever enacted with regards to this abrasion/discoloration on the right lower leg

and right lower medial calf/leg. By September 11, 2017, the area on the right inner calf had become unstageable and the right lower extremity wound continued to worsen and deteriorate. Despite the worsening of the wound, Decedent would go multiple days without nurses charting in the departmental notes/nursing notes. Further, none of these notes mentioned the right lower extremity wound on her calf/shin area.

When Decedent went to a follow-up appointment with her orthopaedic surgeon on September 12, 2017, it was discovered that the wound had deteriorated while at the Defendants' facility to the extent that the orthopaedic surgeon made a referral to the wound care center and gave further orders for wound care to be conducted at White Oak. Decedent continued to show signs and symptoms of deterioration in her wound and began to show signs and symptoms of infection as a result of her wound. The records reflect that on September 20, 2017, she felt bad all over secondary to wound treatment earlier and complained of pain all over. Further, on September 20th, the records reflect that Defendants communicated to Decedent's physicians that there were no complications with her wound.

The wound continued to deteriorate and by September 23rd, Decedent's white blood cell count was at 24.9, reflective of sepsis and significant infection. Finally, Decedent was transferred to Spartanburg Regional Medical Center where she was admitted with altered mental status, tachycardia, hypoxia, and sepsis. The records also noted that the hospital determined medical management instead of amputation was the appropriate course for Decedent and also noted that she had developed A-fib RVR in response to the sepsis. Unfortunately, despite the admission to the ICU, Decedent's condition continued to deteriorate from her sepsis and leg wound infection and Decedent

died on September 25, 2017. That further, in addition to the wound mentioned hereinabove, Decedent also suffered with multiple other areas of skin breakdown, bedsores, pressure ulcers, and weight loss during her admission as a result of the substandard poor care at the Defendants' facility. In addition to the clinical neglect, Defendants were also negligent by having nurses conduct out of scope assessments, understaffing the facility, and underfunding the facility.

As a result of Decedent's injuries and death, Daughter, as Personal Representative of Decedent's estate, filed and served two Notices of Intent to File Suit against the Defendants on June 9, 2020. Each Notice of Intent attached proposed complaints and affidavits alleging Defendants failed to provide adequate care to Decedent resulting in her death. The parties engaged in the mandatory pre-suit mediation on September 29, 2020. However, mediation was unsuccessful.

Daughter then filed the complaints for wrongful death and survival action on November 2, 2020 and served Defendants. Daughter's complaints state claims of nursing home negligence, ordinary negligence and corporate negligence as to White Oak and its related corporate entities/Co-Defendants. Daughter contends that not only was there clinical negligence, but there was also corporate negligence as a result of the intentional underfunding and understaffing of the facility where Decedent was a resident caused by the parent, management, and affiliated companies of the facility, all of which owned, controlled, directed, managed, and affected the resident care at the facility. On February 19, 2021, Defendants filed this motion.

Defendants' motion seeks to compel arbitration based on an arbitration agreement allegedly signed by Terry Putman at the time of Decedent's admission to White Oak. In

response to Defendants' motion, Plaintiff submits this Memorandum in Opposition together with attached exhibits. A copy of Terry Putman's Affidavit is attached hereto as Exhibit A.

BRIEF SUMMARY OF ARGUMENTS

- I. The Arbitration Agreement is Unenforceable Because it is Unconscionable.**
- II. The Arbitration Agreement is Unenforceable Because it Lacks Consideration.**
- III. The Arbitration Agreement is Unenforceable Because it is Illegal.**
- IV. The Arbitration Agreement Does Not Apply to the Wrongful Death Action.**
- V. The Arbitration Agreement Does Not Apply to Defendants White Oak Management, Inc. and White Oak Manor, Inc.**

ARGUMENT

The party seeking to enforce an agreement to arbitrate has the burden of establishing the existence of a valid arbitration agreement. See Aiken v. World Finance Corp. of S.C., 373 S.C. 144, 149, 644 S.E.2d 705, 708 (2007); MBNA America Bank, N.A. v. Christianson, 377 S.C. 210, 659 S.E.2d 209 (S.C. Ct. App. 2008). It is well established that "where one party denies the existence of an arbitration agreement raised by an opposing party, a court must immediately determine whether the agreement exists in the first place. If no agreement is found to exist, the court must deny any application to arbitrate. Simpson v. MSA of Myrtle Beach, Inc., 373 S.C. 14, 644 S.E.2d 663, 667 (S.C. 2007) (internal citation omitted). Whether a valid arbitration agreement exists is a matter for judicial determination. York v. Dodgeland of Columbia, Inc., 406 S.C. 67, 78, 749 S.E.2d 139, 144 (Ct. App. 2013).

Whether the parties agreed to arbitration is a question of substantive state law. Simpson v. MSA of Myrtle Beach, Inc., 373 S.C. 14, 644 S.E.2d 663, 668 (S.C. 2007) (“General contract principles of state law apply in a court’s evaluation of the enforceability of an arbitration clause.”). Arbitration agreements must satisfy the basic tenets and requirements of contract law. Towles v. United Healthcare Corp., 338 S.C. 29, 37, 524 S.E.2d 839, 844, (Ct. App. 1999). Section 2 of the Federal Arbitration Act dictates that arbitration agreements are enforceable except “upon such grounds as exist at law or equity for the revocation of any contract”. 9 U.S.C. §2. The courts, not arbitrators, are charged with deciding certain “gateway matters” including whether the parties have a valid arbitration agreement or whether the arbitration clause applies to a certain type of controversy. New Hope Missionary Baptist Church v. Paragon Builders, 379 S.C. 620, 629, 667 S.E.2d 1, 5 (Ct. App. 2008). Thus, unless there is a valid, irrevocable, and enforceable contract, the Federal Arbitration Act does not even apply.

Further, the party seeking enforcement of the agreement bears the burden to prove a valid arbitration agreement exists that is enforceable, knowing, voluntary, and intentional. See Aiken v. World Finance Corp. of S.C., 373 S.C. 144, 149 (2007); MBNA America Bank, N.A. v. Christianson, 377 S.C. 210, 659 S.E.2d 209 (Ct. App. 2008); Hinson-Barr, Inc. v. Pinckard, 292 S.C. 267, 268, 356 S.E.2d 115, 116 (1986). “A motion to compel arbitration pursuant to the FAA is ‘akin to the burden on summary judgment.’” Thomas v. Progressive Leasing, Civ. No. 17-1249, 2017 WL 4805235, at *2 (D. Md. Oct. 25, 2017)(internal quotation marks omitted) (quoting Galloway v. Santander Consumer USA, Inc., 819 F.3d 79, 85 (4th Cir. 2016)). Therefore, the burden is on the moving party to demonstrate the absence of any genuine dispute of material fact, Adickes

v. S.H. Kress & Co., 398 U.S. 144, 157 (1970), and that the movant is “entitled to judgment [compelling arbitration] as a matter of law.” Burrell v. 911 Restoration Franchise Inc., 2017 WL 5517383, at *3 (D. Md. November 17, 2017) (citing Fed. R. Civ. P. 56(a)). The arbitration agreement at issue in this particular case with White Oak is not valid to begin with and Defendants cannot meet their burden of proof. Therefore, the inquiry should go no further as to White Oak. However, even if the Court finds that the parties had a valid arbitration agreement, the agreement applies only to the survival action and only to Defendant White Oak.

I. The Arbitration Agreement is Unenforceable Because it is Unconscionable.

In South Carolina, unconscionability is defined as the absence of meaningful choice on the part of one party due to one-sided contract provisions, together with terms that are so oppressive that no reasonable person would make them, and no fair and honest person would accept them. Carolina Care Plan, Inc. v. United HealthCare Servs., Inc., 361 S.C. 544, 554, 606 S.E.2d 752, 757 (2004). If a court as a matter of law finds any clause of a contract to have been unconscionable at the time it was made, the court may refuse to enforce the agreement. S.C. Code Ann. § 36-2-302(1) (2003). In analyzing claims of unconscionability in the context of arbitration agreements, the Fourth Circuit has instructed courts to focus generally on whether the arbitration clause is geared towards achieving an unbiased decision by a neutral decision-maker. See Hooters of Am., Inc. v. Phillips, 173 F.3d 933, 938 (4th Cir.1999). It is under this general rubric that courts must determine whether a contract is unconscionable due to both an absence of meaningful choice and oppressive, one-sided terms.

Absence of meaningful choice on the part of one party generally speaks to the fundamental fairness of the bargaining process in the contract at issue. See Carlson v. General Motors Corp., 883 F.2d 287, 295 (4th Cir.1989). In determining whether a contract was "tainted by an absence of meaningful choice," Id. at 295, courts should take into account the nature of the injuries suffered by the plaintiff; whether the plaintiff is a substantial business concern; the relative disparity in the parties' bargaining power; the parties' relative sophistication; whether there is an element of surprise in the inclusion of the challenged clause; and the conspicuousness of the clause. Id. at 293. See also Holler v. Holler, 364 S.C. 256, 269, 612 S.E.2d 469, 476 (Ct.App.2005) ("A determination whether a contract is unconscionable depends upon all the facts and circumstances of a particular case." (quoting 17 A Am.Jur.2d Contracts§ 279 (2004))); see also Simpson v. MSA of Myrtle Beach, Inc., 373 S.C. 14, 25, 644 S.E.2d 663, 669 (2007).

The choice of a nursing home is made in the midst of a crisis brought on by a precipitous deterioration in health status, disability level, or the loss of a care giver or spouse.¹ The need to find a placement arises quickly² and nursing home admissions are often unplanned; there is little time to investigate options or to wait for an opening at a nursing home of choice.³ Time pressure significantly impairs the ability to seek and

¹ See, e.g., Podolosky v. First Healthcare Corp., 58 Cal.Rptr. 2d 89, 101 (Cal. Ct. App. 1996) (citing Donna Ambrogi, *Legal Issues in Nursing Home Admissions*, 18 Law Med. & Health Care 254, 258 (1990)); see also Marshall B. Kapp, *The "Voluntary" Status of Nursing Facility Admissions: Legal, Practical, and Public Policy Implications*, 24 N.E. J. on Crim. & Civ. Confinement. 1, 3 (1998) (stating that an older person's move to a nursing home also follows a period of acute hospitalization, when their care giving family is unable to adequately manage the demands of home care).

² In the 1980's, the government changed the way hospitals were paid for their Medicare patients; since the change, hospital discharge planning occurs "quicker and sicker." Linda S. Whitton, *Navigating the Hazards of the Eldercare Continuum*, 6 J. Mental Health and Aging 145, 150 (2000). See also Maureen Armour, *A Nursing Home's Good Faith Duty "to" Care: Redefining A Fragile Relationship Using the Law of Contract*, 39 St. Louis L.J. 217, 222 (1994).

³ Denise Ashbugh Vlosky, et al., "Say-so" as a Predictor of Nursing Home Readiness, 93 J. of Family & Consumer Science 59 (2001).

carefully consider alternatives.⁴ Daughter and her family had no choice or time in making such a decision. Many facilities lack a coherent admissions process, adding to the chaos surrounding the admission of a resident.⁵ Residents and their family members do not have time to read and deliberate on the terms of the agreement. An arbitration clause is not part of the core transaction involved in a contract for medical care or service.⁶ It is not, therefore, likely to get much attention from the non-drafting party.⁷ Daughter's affidavit reflects all of the factors reflecting the procedural unconscionability in the process of the Defendants requiring Daughter's signature to the Arbitration Agreement. Exhibit A.

The Honorable Judge Diane Goodstein found an arbitration agreement unconscionable in a similar circumstance in Rawl v. West Ashley Rehab (Exhibit B) based on the following facts that also apply to the circumstances in this case:

1. Resident lacked a meaningful choice and the terms in the Arbitration Agreement are oppressive, one-sided terms;
2. Upon admission the standard Arbitration Agreement form was presented on a take-it-or leave it basis;
3. Resident did not contribute to the drafting of the Arbitration Agreement;
4. Resident did not possess the bargaining power to negotiate the terms of

⁴ Potential residents and their family members can experience panic when they feel there is insufficient time to consider different facilities, and they may choose a facility they would not have chosen if they had more time to weigh their options. Whitton, *supra*, at 150.

⁵ Donna Ambrogi & Frances Leonard, *The Impact of Nursing Home Admission Agreements on Resident Autonomy*, 28 *The Gerontologist* 82, 83-88 (1988).

⁶ See Stanley D. Henderson, *Contractual Problems in the Enforcement of Agreements to Arbitrate Medical Malpractice*, 58 VA. L. REV. 947, 987 (1972) ("The arbitration provision, viewed from the perspective of the patient, is indeed subsidiary to the primary exchange of medical services for an undertaking of payment.")

⁷ The drafting party, on the other hand, has a great deal of information about these repetitive transactions and a great deal of incentive to prepare form contracts so that they are optimal from the drafter's perspective. Melvin Aaron Eisenberg, *The Limits of Cognition and the Limits of Contract*, 47 *Stan.L.Rev.* 211, 243 (1995).

the Arbitration Agreement;

5. An inherent disparity in bargaining power between the parties to the transaction;
6. The Arbitration Agreement was inconspicuous;
7. The injuries include wrongful death; and
8. Resident did not have sufficient time to allow any meaningful explanation of the terms and significance of the alleged arbitration agreement, considering the number and complexity of admission documents other than that alleged arbitration agreement.

The terms of the Arbitration Agreement are unfair, and no person would voluntarily agree to them. The Arbitration Agreement at issue in this case is fundamentally and substantively unfair on numerous levels. First, the Arbitration Agreement provides that three arbitrators will be on the panel to hear the case. However, two of the arbitrators do not have to be attorneys or have any education or experience in matters dealing with the subject matter or legal issues. Arbitration Agreement, pages 1-2, ¶ 4-6. Additionally, the arbitrator may be anyone that the party knows at the time with very limited exceptions. If the arbitrator chosen by Daughter and the arbitrator chosen by Defendants cannot agree to a third arbitrator, the third arbitrator will be determined by a coin toss wherein the winner of the coin toss gets to determine the third arbitrator. Arbitration Agreement, page 2, ¶ 6. The essential result is that the party prevailing on a matter of luck/coin toss will most likely win all discovery disputes, evidentiary concerns, and arbitration proceeding as the majority of the arbitrators will be anyone chosen by the winner of the coin toss. No party would agree to these fundamentally unfair principles

regarding the Arbitration Agreement rendering the result to a matter of chance and luck. Further, not having two of the arbitrators even possibly neutral or having any type of knowledge or education on the subject matter or legal field creates a fundamental unfairness.

Additionally, the Arbitration Agreement allows for extensive delays in the process when the entire purpose of arbitration is to promote efficiency and timeliness. The facility in this particular situation would have ninety (90) days/three months to name their arbitrator after the Plaintiff named the arbitrator. Arbitration Agreement, page 102, ¶ 5-6. Further, after the second arbitrator is chosen, another ninety (90) days/three months would pass before the third arbitrator is chosen. The third arbitrator would then have thirty (30) days to notify the parties as to whether or not he/she would agree to arbitrate the proceedings. Arbitration Agreement, page 2, ¶ 6. Therefore, a minimum of seven (7) months would pass before the parties could even begin the arbitration process. This is antithetical to the entire premise of arbitration and is further evidence of the unconscionability.

Third, the Arbitration Agreement provides that the decision regarding the outcome of the arbitration shall be made by the majority of the arbitrators picking an offer/demand made separately by both of the parties twenty-four (24) hours prior to the hearing. The arbitrators have no discretion to award any different decision other than one of the offers or demands given by each of the parties. Arbitration Agreement, page 3, ¶ 13. Finally, whoever the non-prevailing party is (the party whose offer/demand is not chosen by the majority of the arbitrators) will be required to pay all of the prevailing party's costs and expenses including, but not limited to, the third arbitrator's fees, costs

of deposition, and any other costs associated with the hearing. Arbitration Agreement, page 2, ¶ 9; page 3, ¶ 19.

As a result, the cost of arbitration far outweighs the cost of proceeding in Court and therefore the agreement is unconscionable. Also, the costs of the arbitration must be paid by the parties including the Estate of Margaret Hensley which contains no money or assets. Exhibit A. Plaintiff did not and does not have the financial wherewithal to pay or prepay arbitration fees or pay the opposing side's costs should the majority not pick her demand at the resolution. The amount of money that it would cost to begin and proceed through the arbitration process, including hearing, exceeds that available to the Plaintiff.

Although the costs of arbitration may be a basis for determining that an agreement to arbitrate is substantially unconscionable, since Green Tree the issue of the prohibitive costs of arbitration has developed into a separate defense to the enforcement of an arbitration agreement. See Zephyr Haven, 122 So.3d at 921–22. “[W]here ‘a party seeks to invalidate an arbitration agreement on the ground that arbitration would be prohibitively expensive, that party bears the burden of showing the likelihood of incurring such costs.’ ” Id. at 921 (quoting Green Tree, 531 U.S. at 92, 121 S.Ct. 513). In determining whether the costs of arbitration in a fee splitting arrangement are so prohibitive as to render the agreement unenforceable because it denies the plaintiff access to the arbitral forum, a case-by-case analysis is appropriate. Id. at 922. The focus is on the claimant's ability to pay the arbitration fees and costs, the expected cost differential between arbitration and litigating in court, and whether the cost differential is so substantial as to deter the bringing of the claims. Id. In order to invalidate the arbitration agreement, the plaintiff, at an evidentiary hearing, must show the expected cost of arbitrating the specific claim is greater than litigating it and that the cost of arbitration would be prohibitively expensive. Id.

Fi-Tampa, LLC v. Kelly-Hall, 135 So.3d 563 (Fla. App., 2014)

An arbitration agreement may be substantively unconscionable if the fees and costs to arbitrate are so excessive as to “deny a potential litigant the opportunity to vindicate his or her rights.” [Cite omitted] Green Tree Fin. Corp. Ala. v. Randolph, 531 U.S. 79, 81, 121 S.Ct. 513, 148 L.Ed.2d 373 (2000) (holding that excessive arbitration costs may preclude litigants from effectively vindicating their rights). The party seeking to invalidate

an arbitration agreement on such grounds has the burden of proving that arbitration would be prohibitively expensive. [cites omitted] Whether arbitration is prohibitively expensive is a question of fact that depends on the unique circumstances of each case. See Harrington, 119 P.3d at 1055 (explaining that “the Supreme Court adopted a case-by-case approach to determining whether fees imposed under an arbitration agreement deny a potential litigant the opportunity to vindicate his or her rights”) (citing Randolph, 531 U.S. at 92, 121 S.Ct. 513). In determining whether arbitration costs are prohibitively expensive, courts have considered several factors. First, the party seeking to invalidate the arbitration agreement must present evidence concerning the cost to arbitrate. [cite omitted]. This evidence cannot be speculative; it must be based on specific facts showing with reasonable certainty the likely costs of arbitration. [cite omitted] see also Phillips v. Assocs. Home Equity Servs., Inc., 179 F.Supp.2d 840, 847 (N.D.Ill.2002) (party must make “a reasonable, good faith effort to estimate” arbitration costs). Second, a party must make a specific, individualized showing as to why he or she would be financially unable to bear the costs of arbitration. This evidence must consist of more than conclusory allegations stating a person is unable to pay the costs of arbitration. Rather, parties must show that based on their specific income/assets, they are unable to pay the likely costs of arbitration. Third, a court must consider whether the arbitration agreement or the applicable arbitration rules referenced in the arbitration agreement permit a party to waive or reduce the costs of arbitration based on financial hardship. Id. (holding an arbitration agreement was not substantively unconscionable because, in part, the agreement provided that any claim or dispute would be resolved under the American Arbitration Rules (“AAA”); the applicable AAA rules provided for waiver or reduction in arbitration fees based on “extreme hardship”); Jones v. Gen. Motors Corp., 640 F.Supp.2d 1124, 1134 (D.Ariz.2009) (finding arbitration fee not substantively unconscionable under Arizona law in part because arbitration rules referenced in arbitration agreement provided for waiver and deferral of fees based on financial hardship). We conclude there is reasonable evidence to support the trial court's finding that “[i]n this particular case, Plaintiff has established that he has a fixed, limited income that would make it extremely difficult, if not impossible, to pay to arbitrate the claim.”

Clark v. Renaissance W., LLC, 232 Ariz. 510, 307 P.3d 77, 666 Ariz. Adv. Rep. 29 (Ariz. App., 2013). (Exhibit C).

Therefore, based on all of the factors hereinabove, the Arbitration Agreement should not be enforced because it is unconscionable.

II. The Arbitration Agreement is Unenforceable Because it Lacks Consideration.

It is axiomatic that every contract in South Carolina must be supported by mutual consideration in order to be valid and enforceable. “The necessary elements in a contract are an offer, acceptance, and valuable consideration.” Sauner v. Pub. Serv. Auth. of SC, 354 S.C. 397, 406, 581 S.E.2d 161, 166 (2003). It is well settled that to be valid and enforceable, a contract must have valuable consideration. Benya v. Gamble, 282 S.C. 624, 628, 321 S.E.2d 57, 60 (Ct. App. 1984). Because an arbitration agreement is a contract to be treated like any other, it is only enforceable if it contains bargained for consideration and mutuality of obligations. No bargained for consideration or mutuality of obligations exists for the arbitration agreements or waiver of jury trial provisions.

Consideration consists of “some right, interest, profit, or benefit accruing to one party or some forbearance, detriment, loss, or responsibility given, suffered, or undertaken by the other”. Prestwick Golf Club, Inc. v. Prestwick Ltd. Partnership, 331 S.C. 385, 389, 403 S.E.2d 184, 186 (Ct. App. 1998). Our appellate courts have held in multiple cases that nursing home arbitration agreements and arbitration agreements generally do not merge. See Coleman v. Mariner Health Care, Inc., 755 S.E.2d 450, 407 S.C. 346 (S.C. 2014); Thompson, 416 S.C. at 55, 784, S.E.2d at 686; Hodge, 422 S.C. at 563, 813 S.E.2d at 302. Therefore, any consideration that is afforded through the admission agreement does not apply to the arbitration agreement. As a result, the arbitration agreement must have its own identifiable consideration given for its formation. The separate arbitration agreement reflects that it is voluntary where it states it is not a condition of admission to the facility. Therefore, it is not required as part of the Admission Agreement. The Defendants’ expected reasoning and arguments in this case are flawed. The Defendants may argue that the Arbitration Agreement is voluntary and

not mandatory and is a separate agreement yet somehow merged with the Admission Agreement and therefore, the consideration necessary for the Admission Agreement which was to provide care suddenly becomes consideration for the Arbitration Agreement. That reasoning is circular and is incorrect. Other South Carolina courts agree. See Holmes, Royston, Williams, St. Aubin, and Nanney Orders at Exhibits D, E, F, G, and H.

Reviewing the Arbitration Agreement reveals that there is no mention of consideration anywhere in the Arbitration Agreement. While Defendants may argue that the Arbitration Agreement is a bilateral contract and consideration is provided through the exchanging of promises to enter into each, our South Carolina Supreme Court held long ago otherwise:

“A promise may constitute the consideration for another promise. But a promise is not a good consideration for a promise unless there is absolutely **mutuality of the engagement**, so that each party has the right to hold the other to a positive agreement. **In case the promise of one of the parties imposes no legal duty of the party making it, such promise furnishes no consideration for a promise.**”

International Shoe Company v. Herndon, 135 S.C. 138, 203, 133, S.E. 202 (1926)(emphasis added)(quoting Elliott on Contracts Volume I Section 231).

While Defendants may argue that both parties are waiving a right to jury trial, and instead, all disputes between the parties should be resolved through binding arbitration or non-jury trial, the reality is the obligation and resulting detriment falls only on the resident.

The Defendants’ position in the most simple explanation is that Plaintiff promised to Defendant that if a dispute or transgression arose, then she would move for arbitration

and Defendant promised to Plaintiff that if a dispute or transgression arose, then it would move for arbitration. However, each of these promises by the parties must rely on the assumption that a dispute or transgression could arise.

However, a dispute or transgression cannot arise against Defendants because **no duty is owed by the resident to the nursing home facility.** The resident's only obligation is to pay bills which happens to be exclusively related and used as consideration for the Admission Agreement, not the Arbitration Agreement and therefore, the two agreements do not merge. On the other hand, Defendants have a legal duty to provide care and treatment to their residents. In the most basic terms, a resident has no duty to the facility. As a result, there are not mutually exchanged promises as consideration for this arbitration agreement because the parties do not have mutual obligations or duties to each other. The Defendants are the only parties to benefit from the arbitration agreement and no consideration was offered to Decedent. Defendants cannot meet their required burden of proof to establish any lack of issue as to the contract for arbitration to be valid and enforceable and cannot provide the Court with any convincing argument or evidence of consideration. Therefore, the Arbitration Agreement fails as a matter of law and should not be enforced.

III. The Arbitration Agreement is Unenforceable Because it is Illegal.

Defendants may argue this agreement merged with the Admission Agreement but under South Carolina case law, that could only occur if they were not optional. If they were not optional and the Arbitration Agreement was required as a condition of admission to the facility, then it violates federal regulations. While the Arbitration Agreement states it is not required as a condition for admission, the Admission

Agreement explicitly states otherwise when it notes, “Arbitration...is mandatory (subject to the ‘opt out’ provisions set forth in Paragraph 17 of the Arbitration Agreement)”. Arbitration Agreement at p. 5, ¶ 24; Admission Agreement at p. 19, ¶ 21. Further, the Admission Agreement (which was required to be signed for admission) includes a provision for arbitration that cannot be excluded in the Admission Agreement. Admission Agreement, p. 18, ¶ 21.

Federal regulations require Medicare and Medicaid certified facilities to accept Medicare/Medicaid reimbursement rates as payment in full. See 42 C.F.R. §489.30; 42 C.F.R. §447.15. Moreover, such facilities, in the case of an individual who is entitled to medical assistance, must “not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the state plan...any other consideration as a precondition of admitting (or expediting the admission of) the individual to the facility or as a requirement for the individual’s continued stay at the facility”. 42 USC §1396r(c)(5)(A)(iii).

An illegal contract is unenforceable. Berkebile v. Outen, 426 S.E.2d 760, 762 n. 2 (1993). “The general rule is that courts will not enforce a contract which is violative of public policy, statutory law, or provisions of the Constitution.” Id. If the agreements merged, then they were not optional and were a mandatory term to the Admission Agreement and was, in part, illegal consideration for admission and an illegal required pre-condition to admission as Decedent and Daughter had no way to decline the waiver of jury trial provision and were required to sign the Admission Agreement which contained the provisions. Other South Carolina courts have agreed and refused to enforce the arbitration agreements and waiver of jury trial provisions for these exact reasons. See

Boozer and Holmes Orders at Exhibits G and D. As a result, the arbitration provision is unenforceable as it is an illegal provision to the Admission Agreement under the above-referenced Medicare regulation.

IV. The Arbitration Agreement Does Not Apply to the Wrongful Death Action.

South Carolina law is clear that a wrongful death claim exists for the statutory beneficiaries and that such claims are distinct and separate from those brought under survival claims. Bennett v. Spartanburg Railway Gas and Electric Co., 97 S.C. 27, 81 S.E. 189 (1914). The alleged Arbitration Agreement with White Oak by its own terms is an agreement between “White Oak Estates (‘The Facility’), and Margaret Hensley (‘the Resident’).” Therefore, any purported agreement to arbitrate any claims was clearly (by the terms of the contract which was drafted by the Defendants) only on behalf of Decedent and the facility.

However, even if Decedent had agreed to arbitration, she did not have the legal authority to bind her statutory beneficiaries who are not parties to the Arbitration Agreement. The signatories to the agreement are Daughter as “Resident Representative” on behalf of Decedent and Karen Baker on behalf of White Oak. No other parties are parties to this agreement. The scope of these agreement does not include the statutory beneficiaries’ claims. Other South Carolina courts have agreed that arbitration agreements do not reach the wrongful death beneficiaries’ claims in these circumstances. See Exhibits E, G, H, I, J, K, and L, Royston, Boozer, Coleman, Young, Joyner, Testerman, and Wilson Orders.

However, while Defendants would like to contend that the agreement covers the statutory beneficiaries’ claims, which they do not, the problem with this contention is that

Decedent/Daughter had no authority to waive the statutory beneficiaries' claims. The arguments given under this section regarding not reaching the wrongful death claims equally applies to the waiver of jury trial agreement.

Defendants may erroneously contend that the South Carolina Supreme Court has held that arbitration agreements are binding as to the wrongful death claims. Defendants may rely on Dean v. Heritage Healthcare of Ridgeway, LLC, 408 S.C. 371, 759 S.E.2d 727 (2014) for this proposition. To the contrary, in a footnote, the Dean Court indicated that a court may not refuse to compel arbitration "simply because a wrongful death claim is involved". However, the Supreme Court has been clear that a court may find a wrongful death claim not covered by an arbitration agreement - not because it is a wrongful death claim, but because of state law contract defenses such as a person(s) not being a party or signatory to the contract. In the present case, the statutory beneficiaries clearly are not parties/signatories to the contract. This is the exact type of basis courts have upheld invalidating an arbitration agreement.

While dealing with a separate arbitration issue in a nursing home case and finding the arbitration agreement to be unenforceable, the Court of Appeals in Hodge v. Uni-Health Post-Acute Care of Bamberg, Opinion No. 5541 (S.C. Ct. App. March 7, 2018), recognized the separateness of the statutory beneficiaries/estate's claims from those of the patient/resident. In discussing the Maryland court's case of Dickerson, the Court noted that the nursing home was attempting "to use equitable estoppel against [the patient's] estate based on actions that [Son] took *in her individual capacity*. The fact that [Son] is *now the Personal Representative for [the patient's] [e]state* is of no moment; we will not hold this circumstance against [the patient's] [e]state. Simply put, [the patient's]

[e]state is the plaintiff in this case, and Respondent has alleged no conduct on the part of [the patient's] [e]state, or by [Son] in *her capacity as Personal Representative* of [the patient's] [e]state....” Hodge quoting Dickerson v. Longoria, 995 A.2d. 721, 743 (Md. 2010). As recognized in this discussion, actions taken by Son in her *individual capacity* will not be held against the estate and as the Court noted, the estate may well have other beneficiaries or creditors.

Defendants may further incorrectly assert other cases hold that the statutory beneficiaries are bound as third-party beneficiaries. The Defendants may cite Pearson v. Hilton Head Hosp., 400 S.C. 281, 733 S.E.2d 597 (Ct. App. 2012). In Pearson, the Plaintiff who sought to avoid the arbitration agreement had filed suit for a breach of the very contract that contained the arbitration clause. In the present case, no claim for breach of contract has been made whatsoever. Further, the Plaintiff in Pearson personally received direct benefits from the contract. Here, the statutory beneficiaries personally received zero benefit from any contract.

Defendants insist that Decedent had the power to waive the right to a jury trial on a claim that did not exist when the arbitration agreement was presented but never belonged to him and covered injuries suffered exclusively by other people. Wilson v. Willis, 926 S.C. 326, 827 S.E.2d 167 (2019), provides the specific times when a contract may be enforced against a non-party and the Defendants would have the burden of proving each of the elements of one of those instances where such a contract may be enforced against a non-party. Defendants cannot prove these elements existed with regards to this specific case.

The statutory beneficiaries' claim is much more akin to the claims of the non-signatory Plaintiffs in Wilson v. Willis, 926 S.C. 326, 827 S.E.2d 167 (2019), where the South Carolina Supreme Court held the non-signatories could not be bound by the arbitration agreement. Much like the non-signatories in Wilson, the statutory beneficiaries in the instant case are not attempting to exploit or receive a direct benefit from the agreement and were not even aware of the existence of the arbitration provision. Defendants confuse the benefit Decedent received from admission and attempt to argue the statutory beneficiaries received a benefit personally from the admission. That argument is without merit.

As the Wilson Court notes, "Equitable estoppel is ultimately a theory designed to prevent injustice, and it should be used sparingly. See Hirsch v. Amper Fin. Servs., LLC, 71 A.3d 849, 852 (N.J. 2013)(observing equitable estoppel should be used sparingly to compel arbitration and noting 'it is more properly viewed as a shield to prevent injustice rather than a sword to compel arbitration'); 28 Am.Jr.2d Estoppel and Waiver §29 (2011)(stating equitable estoppel should be used with restraint and only in exceptional circumstances)."

Further confirming the separateness of each statutory beneficiary's claim from that of the survival action, a Federal District Court in South Carolina has analyzed this issue under the South Carolina Non-Economic Awards Act of 2005. Diane Boyle as Personal Representative of the Estate of John Francis Boyle v. United States of America, United States District Court for the District of South Carolina, Beaufort Division (2009). In Boyle, the Court concluded that the wrongful death beneficiaries' claims were separate and distinct claims for purposes of stacking damage caps and for purposes of being

individual claimants. See Exhibit M, Boyle Order. Further, at least one other South Carolina court judge has come to the same conclusion. See Wilson v. Amisub Order at Exhibit N. These analyses confirm that the wrongful death claimants have separate and distinct claims apart from that of the survival action. As such, Daughter or Decedent were incapable of waiving the statutory beneficiaries' right to a trial by jury.

Many other states have come to this same conclusion, Daniels v. Sunrise Senior Living, Inc., 212 Cal.App 4th 674, 151 Cal.Rptr.3d 273 (Cal.App.4 Dist, 2013) (Wrongful Death claims not bound to arbitration), Lawrence v. Beverly Manor, 273 S.W.3d 525 (Mo. 2009) (Wrongful Death claimants not bound by arbitration agreement.) The only signatures to the agreement with White Oak were Daughter for "Resident Representative" and Karen Baker for "Facility Staff/Witness". Therefore, the only parties executing this Agreement were Daughter purportedly on behalf of Decedent and an employee as an agent for White Oak. Defendants would contend that this agreement is binding on the non-signatory statutory beneficiaries simply because the Arbitration Agreement allegedly states such.

However, as the Supreme Court of Kentucky said regarding binding non-signatory wrongful death beneficiaries in Ping v. Beverly Enterprises, Inc.:

[A]s interesting as life might be if we could bind one another to contracts merely by referring to each other in them, we are not persuaded that a non-signatory who receives no substantive benefit under a contract may be bound to the contract's procedural provisions, including arbitration clauses, merely by being referred to in the contract. It is one thing to say that a third party for whose substantive benefit a contract is made may not enforce his or her rights under the contract without also abiding by the contract's other terms. That is the general third-party beneficiary rule discussed above. It may even be that tort claims by such a directly

benefitting third-party are appropriately subjected the contract's arbitration provisions, at least where the tort and contract are significantly intertwined. See, In re Weekley Homes, L.P., 180 S.W. 3d 127 (Tex. 2005) (negligent repair claim by homeowner's Son against contractor was subject to repair contract's arbitration clause because Son, although a non-party, was direct and principal beneficiary under the contract). It is something else entirely, however, to say that incidental beneficiaries of a contract-individuals or entities with no substantive rights under the contract and no direct benefits-may have their tort claims against the parties swept up into the contract's arbitration provisions merely by being mentioned in the contract as potential claimants. This is what Beverly purports to do. Arbitration is a matter of contract, however, it is something the contracting parties, or their proxies, must agree to. It is not something that one party may simply impose upon another. Howsam v. Dean Witter Reynolds, Inc., 537 U.S. 79, 83, 123 S. Ct. 588, 154 L. Ed.2d 491 (2002) ("[A]rbitration is a matter of contract and a party cannot be required to submit to arbitration any dispute which he has not agreed so to submit", Citation and internal quotation marks omitted.) Since Beverly's theory would allow just that, i.e., would allow one party merely by referring to someone else in an arbitration clause to thereby bind that other person to arbitration as a "third party beneficiary" of the arbitration agreement, we reject it out of hand.

Ping v. Beverly Enterprises, Inc., 376 S.W.3d 581, 599-600 (KY 2012).

Defendants are left to argue the wrongful death claim actually belongs to Decedent's estate rather than the statutorily designated beneficiaries. However, this argument incorrectly lumps together the wrongful death claims and the survival of tort claims Decedent had against Defendants at the time of her death. The differences with these claims begin with the statutes themselves.

The wrongful death claims are separate claims apart from the Decedent's claims. According to South Carolina's Wrongful Death Act:

“Whenever the death of a person shall be caused by the wrongful act, negligent or the fault of another and the act, negligent or the fault is such as would, if death had not ensued, had entitled party injured to maintain an action and recover damages in respect thereof, the person who would have been liable, if death had not ensued shall be liable to an action for damages.”

South Carolina Code Annotated §15-51-10 (1977)

The wrongful death beneficiaries are as follows:

“Every such action shall be for the benefit of the wife, or husband and child or children of the person whose death shall have been so caused, and, if there be no such wife, husband, child or children, then for the benefit of the parent or parents, and if there be none, for the benefit of the heirs or the person whose death shall have been so caused.”

South Carolina Code Annotated §15-51-20 (Supp. 2001)

The general element of damages recoverable are pecuniary loss, mental shock and suffering, wounded feelings, grief and sorrow, loss of companionship, and deprivation of the use and comfort of the Decedent, society, including the loss of her experience, knowledge, and judgment in managing the affairs of herself and her beneficiaries. Self v. Goodrich, 300 S.C. 349, 351, 387 S.E.2d. 713, 714 S.C. (Ct. App. 1989). Damages are paid to these beneficiaries because a wrongful death claim is directed at their losses suffered as a result of the Decedent’s absence. Scott v. Porter, 340 S.C. 158, 168, 530 S.E.2d 389, 394 (Ct. App. 2000)(citing F.P. Hubbard & R.L. Felix, The South Carolina Law of Torts 610 (2d ed 1997). In contrast, the legislature positions the survival statute in a completely different code chapter. The wrongful death claim is a distinct claim warranting its own designation (Chapter 51). The survival statute is classified within an existing chapter (Chapter 5) identifying the proper “parties” for pursuing legal claims.

The wrongful death claim is a separate claim from the claims a decedent might bring on his own behalf under the survival statute. In Bennett v. Spartanburg Railway Gas and Electric Company, 97 S.C. 27, 81 S.E. 189 (1914), the Supreme Court held that wrongful death and survival actions are different claims for different injuries. The Court stated “necessarily, therefore, there must be separate verdicts and separate judgments, there should be separate actions.” Id. at 31. See also Strickland v. Southern Ry Co., 111 S.C. 248, 97 S.E. 695 (1918) (Supreme Court Affirmed Appeal from Circuit Court’s ruling noting that survival claims are independent of wrongful death claims), Claussen v. Brothers, 148 S.C. 1, 145 S.E. 539 (1928) (discussing the difference between survival and wrongful death claims as being independent of each other).

In Grainger v. Greenville S&A Railway Co., the South Carolina Supreme Court traced the divergent tracks that wrongful death and survival claims have taken over their development. Grainger v. Greenville S&A Railway Co., 101 S.C. 399, 85 S.E. 968 (1915). In that case, the trial court had dismissed the survival action because the decedent’s administrator (equivalent to the modern “Personal Representative”) had previously recovered on a wrongful death claim. Id. at 968. When the legislature recognized this abnormality, it responded by creating the predecessor to the modern survival statute. Id. citing 1912 Code §3693. Grainger held this legislative history conclusively established wrongful death and survival actions are distinct and independent. Id. The claims are distinct because “the beneficiaries, the cause of action, the measure of damages, are all different.” Grainger 85 S.E. at 969. Our courts have further held that judgement in a wrongful death claim does not have preclusive effect on survival claims. 229 S.C. at 611-12 93 S.E.2d at 914. Further, the law is clear that in

wrongful death claims, the personal representative “functions under two separate and distinct trusteeships”. Id. In other words, while it is the personal representative’s name in the caption for the wrongful death claim, “it is clear...the real parties to the action were the beneficiaries.” Claussen v. Brothers, 148 S.C. 1, 145 S.E. 539, 541 (1928).

Further, as early as 1907, our Supreme Court recognized a wrongful death action is not the survival of an action which the deceased had in his lifetime but is a “new cause of action”. Osteen v. Southern Ry., Carolina Division, 76 S.C. 368, 57 S.E. 196, 200 (1907). Claussen held a wrongful death claim is “not a continuation” of any claim the decedent had before her death. 145 S.E. at 540. A wrongful death claim is “independent” of claims the decedent had during her life and “wholly different” than any other claim available at her death. Wellman v. Bethea, 243 F. 222 (E.D.S.C. 1917). Our court continues to recognize the distinctiveness of the two actions and that the wrongful death statute created a new cause of action that did not exist at common law and only accrues at the decedent’s death as the wrongful death claim is subject to its own statute of limitations. Weaver v. Lentz, 348 S.C. 672, 678, 561 S.E.2d 360, 363 (Ct. App. 2002).

It is true that our Supreme Court reaffirmed that a claim under the Wrongful Death Act lies in the decedent’s estate only when the decedent possessed the right of recovery at his death. Estate of Stokes ex rel. Spell v. Pee Dee Family Physicians, L.L.P., 389 S.C. 343, 699 S.E. 2d 143 (2010). This rule, however, does not dictate the conclusion that a wrongful death claim is wholly derivative of the decedent’s claim. Instead, the rule provides that if the defendant has a defense that would completely bar the decedent’s claim had the decedent survived, then the wrongful death beneficiaries may not bring a claim under the statute. For instance, in Stokes, the statute of limitations had run on the

decedent's claim, and the wrongful death beneficiaries were accordingly totally barred from pursuing their claims under the statute. The Supreme Court cited the following from United States District Court case of Quattlebaum v. Carey Canada, Inc., 685 F. Supp. 939 (D.S.C. 1988): "anything that would have *defeated the decedent's recovery* had he survived the accident, (such as contributory negligence, a valid release, or similar acts on his part." (Emphasis added). The Court held Quattlebaum was correctly decided and adheres to the principle that that a decedent's estate may maintain an action only when the decedent would have been entitled to maintain an action had he survived." Estate of Stokes ex rel. Spell v. Pee Dee Family Physicians, L.L.P., 389 S.C. 343, 143, 146, 699 S.E.2d (S.C. 2010) at 146.

White Oak has never asserted that the claims here are completely barred or that Decedent's recovery has been "defeated" by operation of law, such as by the running of the statute of limitations or the execution of a release. Instead, what White Oak asserts is that Decedent may not bring a claim in court but must pursue his remedies in arbitration or non-jury. Thus, neither Stokes nor the wrongful death statute operate to cut off the statutory beneficiaries' rights, even if the claims had been subject to arbitration. See also Carter v. SSC Odin Operating Co., LLC, 2012 IL 113204, ¶57, 976 N.E.2d 344, 359 (IL 2012) (noting the defendants overstated the significance of the derivative nature of a wrongful death action, and stating "Although a wrongful-death action is dependent upon the decedent's entitlement to maintain an action for his or her injury, had death not ensued, neither the Wrongful Death Act nor this court's case law suggests that this limitation on the cause of action provides a basis for dispensing with basic principles of contract law in deciding who is bound by an arbitration agreement"). Additionally, the

legal provisions holding that an individual may prevent a wrongful death claim by ignoring or settling a personal injury suit during his life do not mean the individual may control the manner in which the wrongful death claim will be resolved should he *choose to leave it intact*.

The Pennsylvania Superior Court recently in Pisano v. Extended Homes, Inc., operating under the fictitious name Belaire Health 84 Rehabilitation Center, 2013 PA Super 232, 77 A.3d 651, 662 (PA 2013) affirmed the trial court decision that the nursing home arbitration agreement did not apply to the statutory beneficiaries' wrongful death claim. The Court noted the wrongful death and survival actions are not derivative of each other but are flowing from the same underlining tortious conduct. Like the South Carolina statute, Pennsylvania's wrongful death statute provides that the right of action exists only for the benefit of the spouse, children, parents, or parents of the deceased. Id. at 656. The Pennsylvania Court further held that since the wrongful death claim is independent of the survival action and because the wrongful death statute does not characterize the wrongful death claim as that of a third-party beneficiary, that the trial court properly refused to compel arbitration to the non-signatory wrongful death beneficiaries who were not parties to the arbitration agreement and in this case, would include the waiver of jury trial as well.

Likewise, in Bybee v. Abdulla, M.D., 189. P.3d 40, 2008 UT 35 (Utah, 2008), the Supreme Court of Utah held that an agreement to arbitrate that was signed by the decedent cannot extend to the statutory beneficiaries of a wrongful death claim. The Utah Supreme Court noted that certain defenses from the decedent's personal injury action may be raised against the heirs of a wrongful death action such as comparative

negligence and statutes of limitations as key common characteristics. However, as the Supreme Court of Utah noted, both of these defenses go to the viability of the underlying personal injury action. The Court further stated that “by contract, an agreement to bind heirs to arbitrate disputes does not implicate the viability of underlying claims.” Id. at 47, citing Horwich v. Superior Court, 21 Cal. 4th 272, 87 Cal. Rptr. 2d 222, 980 P. 2d 927, 935 (1999). The Utah Supreme Court went on to note that “we have never intended to suggest, however, that because Decedent is the master of his claim he may by contract expose his unwilling heirs to any imaginable defense.” Bybee v. Abdulla, M.D. at 46. The Utah Supreme Court further held that the defenses against the decedent’s claim which are less likely to be found enforceable against the heirs’ claims in a wrongful death action “are contract provisions that purport to affect the rights of heirs that do not affect the existence of the decedent’s personal injury claim during his lifetime. The arbitration agreement...falls squarely within this category and is, therefore, unenforceable against the heir.” Id. at 47.

The Court of Appeals in Washington in Woodall v. Avalon Care Center-Federal Way, LLC, 155 Wn. App. 919, 231 P. 3d 1252 (Wash. App. Div. 1 2010) held that “arbitration is a matter of contract and a party cannot be required to submit to arbitration any dispute which he [or she] has not agreed so to submit.” Id. quoting Satomi Owners Association v. Satomi, LLC, 167 Wash. 2d 781, 225 P.3d 213 (2009). The Washington Court of Appeals further noted that the wrongful death claims asserted in that case were not on behalf of the estate just as South Carolina’s wrongful death claims are not on behalf of the estate. The Washington Court of Appeals further discussed the Supreme Court of Ohio’s ruling in Peters v. Columbus Steel Casting Co., 115 Ohio St.3d 134, 873

N.E.2d 1258 (2007), wherein the Supreme Court of Ohio held that the wrongful death claim of a spouse who was Administrator of her husband's estate was not subject to the decedent's arbitration agreement. The Washington Court of Appeals in discussing Peters, stated "In sum, the decedent's agreement was an agreement 'to arbitrate his claims against the company,' and thus the provision in the agreement binding the decedent's heirs applied to a survival action. But the decedent could not 'restrict his beneficiaries to arbitration of their wrongful death claims because he held no right to those claims.'" Woodall v. Avalon Care Center - Federal Way, LLC at 929. In the Washington Court of Appeals' analysis, the Court concluded that the wrongful death beneficiaries could not be bound to the arbitration agreement which they did not sign.

Because the statutory beneficiaries have separate and independent claims and were not covered by the scope of this agreement nor were parties to this agreement, the Arbitration Agreement drafted by White Oak cannot reach the claims of the wrongful death statutory beneficiaries. Many other South Carolina courts agree as well.

V. The Arbitration Agreement Does Not Apply to Defendants White Oak Management, Inc. and White Oak Manor, Inc.

The Arbitration Agreement clearly states that it is between "White Oak Estates ('the Facility') and Margaret Hensley ('the Resident')". The only signatories to the Agreement were Daughter as "Resident Representative" and Karen Baker for "White Oak Estates", the facility. No other entity or individual is identified as a party to the agreement at any point in the Arbitration Agreement. Defendants White Oak Management, Inc. and White Oak Manor, Inc. are not identified as parties to the Arbitration Agreement.

South Carolina law is very clear in that White Oak's Co-Defendants are not third-party beneficiaries to either of these contracts. South Carolina courts have held that third-party non-signatories should only be included in arbitration agreements in exceptionally limited circumstances. Wilson v. Willis, 926 S.C. 326, 827 S.E.2d 167 (2019). Further, "South Carolina contract law carries a presumption that an individual who is not a party to a contract lacks privity to enforce it". Trancik v. USAA Insurance Company, 354 S.C. 549, 553, 581 S.E.2d 858, 861 (Ct. App. 2003). "It is to be observed that the presumption is that the parties contract for their own benefit and not for that of others not parties to the contract." Ancrum v. Camden Water, Light and Ice Company, 82 S.C. 284, 295, 64 S.E. 151, 155 (1909). The rule of contract interpretation is to ascertain and give legal effect to the intentions of the parties as determined by the contract language. Schulmeyer v. State Farm Fire and Casualty Company, 353 S.C. 492, 495, 579 S.E.2d 132, 134 (2003). Generally, courts do not have the authority to alter a contract by construction or make new contracts for the parties and words cannot be read into a contract which give an intent not expressed within the contract. Gilstrap v. Culpepper, 283 S.C. 83, 86, 320 S.E.2d 445, 447 (1984). Only if a contract is made for the benefit of the third person and the contracting parties intended to create a direct, rather than incidental or consequential benefit to the third person, can the third person make a claim based on the contract. Windsor Green Owners Association v. Allied Signal, Inc., 362 S.C. 12, 17, 605 S.E.2d 750, 752 (Ct. App. 2004).

As a result, Defendants White Oak Management, Inc. and White Oak Manor, Inc. are unable to carry their burden to overcome the presumption that the contract was only

intended for the benefit of the parties to the contract. Therefore, the Arbitration Agreement does not extend to these Defendants.

CONCLUSION

The Arbitration Agreement is not enforceable for the reasons set forth hereinabove. Furthermore, if the Court were to find that the arbitration provisions were enforceable, then the arbitration provisions do not extend to the wrongful death claims nor do they include the Co-Defendants White Oak Management, Inc. and White Oak Manor, Inc. Therefore, for the reasons set forth hereinabove, Defendants Motion to Compel Arbitration, Stay of Action, and for a Protective Order or Alternatively, to Stay the Action Pending Arbitration should be denied.

Respectfully submitted,

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Attorneys at Law
Post Office Box 332
Greenville, South Carolina 29602
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s/Matthew W. Christian
Matthew W. Christian
S.C. Bar No.: 70516
Attorney for Plaintiff

Greenville, South Carolina
Date: March 15, 2021

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF SPARTANBURG	)	C.A. No.: 2020-CP-42-03818 &
	)	2020-CP-42-03819
	)	
Terry Putman, Individually and as	)	
Personal Representative of the Estate	)	
of Margaret Hensley,	)	
	)	
Plaintiff,	)	AFFIDAVIT OF
	)	TERRY PUTMAN
	)	
v.	)	
	)	
White Oak Estates, Inc., White Oak	)	
Management, Inc., and White Oak	)	
Manor, Inc.,	)	
	)	
Defendant(s).	)	
	)	

PERSONALLY appeared before me, the undersigned, who being duly sworn, hereby states and attests that the following is true and correct:

1. I am a citizen and resident of Spartanburg County, South Carolina.
2. My mother, Margaret Hensley, was admitted to White Oak Estates, a skilled nursing facility/nursing home, on or about August 29, 2017.
3. That on or about the time of my mother's admission and during her entire admission, I was a citizen and resident of Spartanburg County, South Carolina.
4. That admission to the facility was very stressful for both the family and for my mother. That further, my mother was transitioning from an inpatient admission to the hospital where she had been admitted for inpatient care. That it was during this hospitalization and right before admission to White Oak Estate that I was required to sign the admission documents for White Oak Estates where she was to transition for long-term care.



5. That at no point in time did any representative of White Oak Estates ever alert me to the alleged arbitration agreement or explain it to me.

6. That I was advised and led to believe I was required to sign the alleged arbitration agreement for Margaret Hensley's admission to White Oak Estates.

7. Margaret Hensley was not competent and was never aware that I had signed the arbitration agreement.

8. When I signed the alleged arbitration and admission agreement, no one from the facility explained the arbitration provisions to me.

9. That my brother, Kevin Hensley, who is also a statutory beneficiary, was unaware that I was signing the Arbitration Agreement.

10. That the Estate of Margaret Hensley has no assets or income to be able to pay for the arbitration costs as set forth in the agreement.

11. That personally, I do not have the financial ability to pay for the arbitration costs as set forth in the agreement.

12. Had I been aware of any alleged arbitration agreement and its effect, I would not have signed it.

Date: 03/15/2021

Terry Putman
Terry Putman

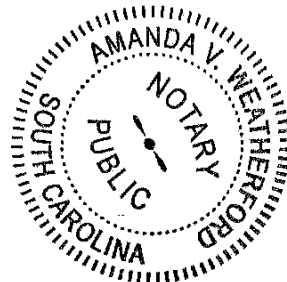
SWORN to and subscribed before me this

15th day of March, 2021

Amanda Weatherford

NOTARY PUBLIC FOR SOUTH CAROLINA

MY COMMISSION EXPIRES: 1-25-27



IN THE STATE OF SOUTH CAROLINA)
COUNTY OF CHARLESTON)

IN THE COURT OF COMMON PLEAS
FOR THE NINTH JUDICIAL CIRCUIT
CASE NO: 2017-CP-10-5984

VICTOR RAWL as Personal
Representative of the ESTATE OF VERA
BROWN,

Plaintiff,

v.

WEST ASHLEY REHABILITATION
AND NURSING CENTER-
CHARLESTON, SC, LLC d/b/a
HEARTLAND OF WEST ASHLEY
REHAB AND NURSING CENTER,

Defendant.

ORDER DENYING DEFENDANT'S MOTION
TO DISMISS AND COMPEL ARBITRATION

This matter came before the court on March 21, 2018 on Defendant's Motion to Dismiss and Compel Arbitration. For the reasons set forth below, Defendant's Motion to Dismiss and Compel Arbitration is **DENIED**.

BACKGROUND FACTS

Vera Brown was admitted to Defendant's facility on August 25, 2014. Upon admission, Ms. Brown was asked to sign admission paperwork as well as the Arbitration Agreement, which was separate from the admission paperwork. The Arbitration Agreement was not necessary for admission. Additionally, there was no bargain for exchange nor consideration in Ms. Brown's agreement to the Arbitration Agreement. Ms. Brown passed away approximately four (4) days after her admission into Defendant's facility, while under Defendant's care.

LEGAL ANALYSIS

While there is a presumption in favor of arbitration agreements, this presumption only applies where there is a valid arbitration agreement. EEOC v. Waffle House, 534 U.S. 279, 293-294, 122 S.Ct. 754, 764, 151 L.Ed.2d 755 (4th Cir. 2014); Toler's Cove Homeowners Ass'n v.



Trident Constr. Co., Inc., 355 S.C. 605, 612, 586 D.E.2d 581 (2003). However, not all arbitration clauses are enforceable. Unless the parties have contracted otherwise, the FAA applies in federal and state courts to any arbitration agreement. Simpson v. MSA of Myrtle Beach, Inc., 373 S.C. 14, 644 S.E.2d 663 (2007). While federal law preempts state laws that would invalidate arbitration agreements on most public policy grounds, the FAA looks to state law to decide the threshold questions of contract formation. Munoz v. Green Tree Fin. Corp., 343 S.C. 531, 542 S.E.2d 360, 364 (2001); Towles v. United Healthcare Corp., 338 S.C. 29, 37, 524 S.E.2d 839, 844 (Ct. App. 1999) (“the court should apply ‘ordinary state-law principles that govern the formation of contracts.’”). Therefore, arbitration agreements guided by the FAA are subject to the same defenses applicable to all other contracts. Rent-A-Center, West, Inc. v. Jackson, 561 U.S. 63, 130 S. Ct 2772, 2776, 177 L.Ed.2d 403 (2010) Simpson, 373 S.C at 14, 644 S.E.2d at 663 (“general contract principles of state law apply in a court’s evaluation of the enforceability of an arbitration clause.”).

A. The Arbitration Agreement lacks valuable consideration and is unenforceable where there was no additional consideration in Plaintiff’s agreement to the Arbitration Agreement and future promises are not valuable consideration.

The necessary elements of a contract are an offer, acceptance, and valuable consideration. Sauner v. Pub. Serv. Auth. of S.C., 581 S.E.2d 161, 166 (S.C. 2003) “Valuable consideration to support a contract may consist of some right, interest, profit or benefit accruing to one party or some forbearance, detriment, loss or responsibility given, suffered or undertaken by the other.” Plantation A.D., LLC v. Gerald Builders of Conway, Inc., 386 S.C. 198, 206, 687 S.E.2d 714, 718 (Ct. App. 2009) (quoting Prestwick Golf Club, Inc. v. Prestwick Ltd. P’ship., 331 S.C. 385, 389, 503 S.E.2d 184, 186 (Ct.App.1998)). Where a contract lacks valuable consideration, the contract will be deemed unenforceable.

Our courts have held that where there is a mutual promise to arbitrate, there must be additional consideration. See Riedman Corp. v. Jarosh, 290 S.C. 252, 253, 349 S.E.2d 404, 405 (1986); see also O'Neil v. Hilton Head Hosp., 115 F.3d 272, 274-5 (4th Cir. 1997). However, in determining whether adequate consideration exists in a contract, or arbitration agreement under the FAA guided by principles of contract law, our courts must examine and stay within the confines of the four corners of the instrument. State Acc. Fund v. S.C. Second Injury Fund, 388 S.C. 67, 76, 693 S.E.2d 441, 445 (Ct. App. 2010) (quoting McPherson v. J.E. Sirrine & Co., 206 S.C. 183, 204, 33 S.E.2d 501, 509 (1945)). Therefore, our courts must assess whether the arbitration agreement itself contains sufficient consideration in the form of a mutual exchange of promises to arbitrate.

In the case at hand, it is clear that the Arbitration Agreement lacks valuable consideration. Paragraph 3 of the Arbitration Agreement states that the FAA applies to the Agreement. Therefore, we must look at state law to decide the threshold question of contract formation and whether consideration exists. Munoz, 343 S.C. at 542 S.E.2d 360, 364; Towles, 338 S.C. at 37, 524 S.E.2d at 844; Rent-A-Center, West, Inc., 561 U.S. at 130 S. Ct. at 2776, 177 L.Ed.2d 403; Simpson, 373 S.C. at 14, 644 S.E.2d at 663. Upon admission Ms. Brown was asked to sign the admission paperwork. Ms. Brown then signed the Arbitration Agreement separate from the admission paperwork. Having already signed the admission paperwork there was no additional consideration in agreeing to the Arbitration Agreement. In fact, the Arbitration Agreement states “[t]he patient will receive services in this center whether or not this agreement is signed.” Neither party gained a right, interest, profit or benefit by agreeing to the Arbitration Agreement. Plantation, 386 S.C. at 206, 687 S.E.2d at 718. Additionally, neither party suffered a forbearance, detriment, loss or responsibility given, suffered or undertaken by the other the party,

when agreeing to the Arbitration Agreement. *Id.* Finally, viewing the Arbitration Agreement itself there is no mention of consideration. The court is required to make its assessment by viewing only the four-corners of the Arbitration Agreement, and cannot go beyond the confines of the Arbitration Agreement itself. Consequently, where the Arbitration Agreement is guided by the FAA and principles of contract law - the Arbitration Agreement is unenforceable where the Arbitration Agreement lacks valuable consideration.

B. Plaintiff's agreement to the Arbitration Agreement was unconscionable in the absence of meaningful choice on part of Plaintiff due to the one-sided contract provisions, the relative disparity in the parties' bargaining power, and the Defendants relative sophistication over Plaintiff's decedent.

In South Carolina, unconscionability is defined as the absence of meaningful choice on the part of one party due to one-sided contract provisions, together with terms that are so oppressive that no reasonable person would make them and no fair and honest person would accept them. Carolina Care Plan, Inc. v. United HealthCare Servs., Inc., 361 S.C. 544, 554, 606 S.E.2d 752, 757 (2004). If a court as a matter of law finds any clause of a contract to have been unconscionable at the time it was made, the court may refuse to enforce the agreement. S.C. Code Ann. § 36-2-302(1) (2003).

In analyzing claims of unconscionability in the context of arbitration agreements, the Fourth Circuit has instructed courts to focus generally on whether the arbitration clause is geared towards achieving an unbiased decision by a neutral decision-maker. See Hooters of Am., Inc. v. Phillips, 173 F.3d 933, 938 (4th Cir.1999). It is under this general rubric that courts must determine whether a contract is unconscionable due to both an absence of meaningful choice and oppressive, one-sided terms.

Absence of meaningful choice on the part of one party generally speaks to the fundamental fairness of the bargaining process in the contract at issue. See Carlson v. General

Motors Corp., 883 F.2d 287, 295 (4th Cir.1989). In determining whether a contract was “tainted by an absence of meaningful choice,” id. at 295, courts should take into account the nature of the injuries suffered by the plaintiff; whether the plaintiff is a substantial business concern; the relative disparity in the parties' bargaining power; the parties' relative sophistication; whether there is an element of surprise in the inclusion of the challenged clause; and the conspicuousness of the clause. Id. at 293. See also Holler v. Holler, 364 S.C. 256, 269, 612 S.E.2d 469, 476 (Ct.App.2005) (“A determination whether a contract is unconscionable depends upon all the facts and circumstances of a particular case.” (quoting 17A Am.Jur.2d Contracts § 279 (2004))).

In the case at hand, it is clear that the Arbitration Agreement is unconscionable because Vera Brown lacked absence of meaningful choice and the terms in the Arbitration Agreement are oppressive, one-sided terms. Vera Brown was admitted into Defendants' facility on August 25, 2014. She passed away at Defendants' facility four (4) days later on August 29, 2014. Upon admission the standard Arbitration Agreement form was presented to an ill Vera Brown on a take-it-or leave it basis. Ms. Brown did not contribute to the drafting of the Arbitration Agreement or possess the bargaining power to negotiate the terms of the Arbitration Agreement. See Lackey v. Green Tree Fin. Corp., 330 S.C. 388, 394, 498 S.E.2d 898, 901 (Ct. App. 1998) (recognizing a contract of adhesion is generally thought of as a standard form contract, offered on a take-it-or-leave-it basis, containing non-negotiable terms). Nevertheless, finding a contract to be one of adhesion is merely the beginning point in the analysis of whether the contract is unconscionable. Lackey, 330 S.C. at 395, 498 S.E.2d at 902.

Absence of meaningful choice on the part of one party generally speaks to the fundamental fairness of the bargaining process in the contract at issue. Simpson v. MSA of Myrtle Beach, Inc., 373 S.C. 14, 25, 644 S.E.2d 663, 669 (2007). In determining whether there

is an absence of a meaningful choice, courts consider the relative disparity in the parties' bargaining power; the parties' relative sophistication; the nature of the injuries suffered by the plaintiff; whether the plaintiff is a substantial business concern; whether there is an element of surprise in the inclusion of the challenged clause; and the conspicuousness of the clause. Id.

In the case at hand, there was an inherent disparity in bargaining power between the parties as this was a transaction between an ill patient who died four (4) days after executing the Arbitration Agreement and a commercial entity. Vera Brown was transferred from the hospital via ambulance to Defendants' facility with diagnosis that included chronic kidney disease, Anemia, dementia, urinary tract infection, upper respiratory disease, acute kidney failure, congestive heart failure, hypertension, weakness, and difficulty in walking. She was also marked as a fall risk.

Furthermore, the arbitration agreement was inconspicuously buried in the admission paperwork and "hastily" presented to Ms. Brown for her signature. This is evident by the "x's" where Ms. Brown was asked to print and sign her name, and date. Moreover, Vera Brown's injuries include death as this is a wrongful death claim.

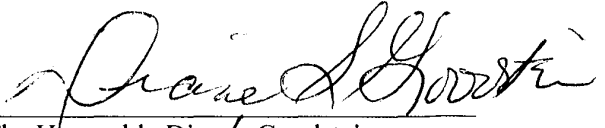
Moreover, we must also consider the otherwise inconspicuous nature of the arbitration clause in light of its consequences. The loss of the right to a jury trial is an obvious result of arbitration. However, this particular arbitration clause also required Vera Brown to forego certain remedies that were otherwise required by statute. While certain phrases are in bold, the arbitration clauses in their entirety are written in the standard small print, and embedded in paragraphs one (1) through fourteen (14). The Court cannot ignore the inconspicuous nature of these provisions, which was drafted by the superior party, and which functioned to contract away certain significant rights and remedies otherwise available to Ms. Brown by law.

Therefore, this Court denies Defendant's Motion to Dismiss and Compel Arbitration where the Arbitration Agreement is guided under the FAA and principles of contract law because the Arbitration Agreement lacks valuable consideration and was unconscionable.

IT IS THEREFORE ORDERED that Defendant's Motion to Dismiss and Compel Arbitration is **DENIED**.

IT IS SO ORDERED!

Dated this 27 day of April 2018


The Honorable Diane Goodstein
Presiding Judge, Ninth Judicial Circuit

**232 Ariz. 510
307 P.3d 77
666 Ariz. Adv. Rep. 29**

**John H. CLARK, a single man,
Plaintiff/Appellee,
v.
RENAISSANCE WEST, LLC, a foreign
limited liability company doing
business in Arizona as Springdale
West; Renaissance West Realty, LLC,
Defendants/Appellants.**

No. 1 CA–CV 12–0692.

**Court of Appeals of Arizona,
Division 1, Department D.**

July 30, 2013.

[307 P.3d 78]

Hornstein & Bennett PLLC by Gail R. Hornstein, James G. Bennett, Scottsdale, Attorneys for Appellants.

Udall Shumway PLC by H. Micheal Wright, Lincoln M. Wright, Mesa, Attorneys for Appellee.

OPINION

GOULD, Judge.

¶ 1 This appeal examines whether the trial court erred in ruling that an arbitration agreement was substantively unconscionable because the cost to arbitrate was prohibitively high. For the following reasons, we affirm.

Facts and Procedural Background

¶ 2 After having surgery for a hip fracture, eighty-eight-year-old John H. Clark (“Plaintiff”) was admitted into Springdale West, a skilled nursing facility owned by Renaissance West, LLC and Renaissance West Realty, LLC (collectively, “Defendants”).



Three days later, he signed an arbitration agreement (the “Agreement”) which required Plaintiff to arbitrate all disputes with the facility.

¶ 3 After his discharge, Plaintiff filed a complaint against Defendants in Superior

[307 P.3d 79]

Court, which included claims for medical negligence and abuse and neglect of a vulnerable adult pursuant to Arizona Revised Statutes (“A.R.S.”) section 46–455, *et seq.* The claims were based on Plaintiff’s allegation that while he was at Defendants’ facility, he was neglected by nursing staff and consequently developed a severe pressure ulcer on his back that tunneled to the bone and required medical treatment and long-term care.

¶ 4 Defendants moved to dismiss and to compel arbitration. The court held an evidentiary hearing at which Plaintiff’s expert testified that based on the complex nature of Plaintiff’s claims, it would cost Plaintiff approximately \$22,800 in arbitrator’s fees to arbitrate the case. Plaintiff testified that he was retired and lived on a fixed income, and that based on the likely amount of arbitrator’s fees, he could not afford to arbitrate his claims.

¶ 5 After the evidentiary hearing, the trial court ruled that the Agreement was substantively unconscionable and therefore unenforceable as a matter of law. The court based this finding in part on its determination that Plaintiff’s limited income would make it extremely difficult, if not impossible, for Plaintiff to pay the arbitrator’s fees necessary to arbitrate his case.¹ Accordingly, the trial court denied Defendants’ motion to dismiss and to compel arbitration.

¶ 6 Defendants timely appealed. We have jurisdiction over the order denying the

-1-



motion to compel arbitration pursuant to A.R.S. § 12-2101.01(A)(1).

Discussion

¶ 7 Whether a contract is unconscionable is a question of law that we review de novo. *Maxwell v. Fid. Fin. Servs., Inc.*, 184 Ariz. 82, 88-89, 907 P.2d 51, 57-58 (1995). However, we defer to any factual findings made by the trial court, unless such findings are clearly erroneous. *Harrington v. Pulte Home Corp.*, 211 Ariz. 241, 247, 252, ¶¶ 16, 40, 119 P.3d 1044, 1050, 1055 (App.2005).

¶ 8 An unconscionable contract is unenforceable. *Id.* at 252, ¶ 39, 119 P.3d at 1055; *see also* A.R.S. § 12-1501 (arbitration agreements are not enforceable on “such grounds as exist at law or in equity for the revocation of any contract”). There are two types of contractual unconscionability: substantive and procedural. *Nelson v. Rice*, 198 Ariz. 563, 567, 12 P.3d 238, 242 (App.2000). Procedural unconscionability addresses the fairness of the bargaining process, which “is concerned with ‘unfair surprise,’ fine print clauses, mistakes or ignorance of important facts or other things that mean bargaining did not proceed as it should.” *Maxwell*, 184 Ariz. at 88-89, 907 P.2d at 57-58 (quoting Dan B. Dobbs, 2 *Law of Remedies* § 10.7, at 706 (2d ed.1993)).² In contrast, substantive unconscionability addresses the fairness of the terms of the contract itself. *Id.* at 88, 907 P.2d at 58. A contract may be substantively unconscionable when the terms of the contract are so one-sided as to be overly oppressive or unduly harsh to one of the parties. *Harrington*, 211 Ariz. at 252, ¶ 39, 119 P.3d at 1055; *Maxwell*, 184 Ariz. at 88, 907 P.2d at 58.

¶ 9 An arbitration agreement may be substantively unconscionable if the fees and costs to arbitrate are so excessive as to “deny a potential litigant the opportunity to vindicate his or her rights.” *Harrington*, 211 Ariz. at 252, ¶ 43, 119 P.3d at 1055; *see also*

[307 P.3d 80]

Green Tree Fin. Corp. -Ala. v. Randolph, 531 U.S. 79, 81, 121 S.Ct. 513, 148 L.Ed.2d 373 (2000) (holding that excessive arbitration costs may preclude litigants from effectively vindicating their rights). The party seeking to invalidate an arbitration agreement on such grounds has the burden of proving that arbitration would be prohibitively expensive. *Harrington*, 211 Ariz. at 252, ¶ 43, 119 P.3d at 1055; *Randolph*, 531 U.S. at 90, 121 S.Ct. 513. Whether arbitration is prohibitively expensive is a question of fact that depends on the unique circumstances of each case. *See Harrington*, 211 Ariz. at 252, ¶ 43, 119 P.3d at 1055 (explaining that “the Supreme Court adopted a case-by-case approach to determining whether fees imposed under an arbitration agreement deny a potential litigant the opportunity to vindicate his or her rights”) (citing *Randolph*, 531 U.S. at 92, 121 S.Ct. 513).

¶ 10 In determining whether arbitration costs are prohibitively expensive, courts have considered several factors. First, the party seeking to invalidate the arbitration agreement must present evidence concerning the cost to arbitrate. *Randolph*, 531 U.S. at 91-92, 121 S.Ct. 513; *Harrington*, 211 Ariz. at 252, ¶¶ 41-44, 119 P.3d at 1055. This evidence cannot be speculative; it must be based on specific facts showing with reasonable certainty the likely costs of arbitration. *Randolph*, 531 U.S. at 91-92, 121 S.Ct. 513; *Harrington*, 211 Ariz. at 252, ¶¶ 41-44, 119 P.3d at 1055; *see also Phillips v. Assocs. Home Equity Servs., Inc.*, 179 F.Supp.2d 840, 847 (N.D.Ill.2002) (party must make “a reasonable, good faith effort to estimate” arbitration costs).

¶ 11 Second, a party must make a specific, individualized showing as to why he or she would be financially unable to bear the costs of arbitration. *Id.* at ¶ 47. This evidence must consist of more than conclusory allegations stating a person is unable to pay

the costs of arbitration. *Id.* Rather, parties must show that based on their specific income/assets, they are unable to pay the likely costs of arbitration. *Id.*

¶ 12 Third, a court must consider whether the arbitration agreement or the applicable arbitration rules referenced in the arbitration agreement permit a party to waive or reduce the costs of arbitration based on financial hardship. *Id.* at ¶¶ 47, 49 (holding an arbitration agreement was not substantively unconscionable because, in part, the agreement provided that any claim or dispute would be resolved under the American Arbitration Rules (“AAA”); the applicable AAA rules provided for waiver or reduction in arbitration fees based on “extreme hardship”); *Jones v. Gen. Motors Corp.*, 640 F.Supp.2d 1124, 1134 (D.Ariz.2009) (finding arbitration fee not substantively unconscionable under Arizona law in part because arbitration rules referenced in arbitration agreement provided for waiver and deferral of fees based on financial hardship).

¶ 13 We conclude there is reasonable evidence to support the trial court's finding that “[i]n this particular case, Plaintiff has established that he has a fixed, limited income that would make it extremely difficult, if not impossible, to pay to arbitrate the claim.”

Cost to Arbitrate

¶ 14 At the hearing, Plaintiff's expert Jeffrey Victor testified about the amount of arbitrator's fees Plaintiff would likely incur to arbitrate his case. Victor testified that arbitrators in the Phoenix area typically charge between \$300 and \$475 per hour, and that arbitrators with expertise in medical malpractice usually charge at least \$400 per hour. An exhibit containing three arbitrators' billing statements showing rates of \$380–400 per hour was admitted at the hearing. Regarding how long the hearing would likely

take, Victor also testified that due to the complex nature of Plaintiff's claims, it was likely that Plaintiff would need to call between five and seven experts, as well as several witnesses, including two to three members of the nursing staff, the administrator of the facility, the wound nurse, the attending physician, the treating wound surgeon, a specialist in geriatric or internal medicine, a nursing expert, a nursing home expert, Plaintiff, and Plaintiff's nephew. Accordingly, Plaintiff provided evidence it would likely take at least five days for the arbitration hearing (assuming eight hours per day).

[307 P.3d 81]

¶ 15 Because the Agreement required that three arbitrators be appointed if the parties could not agree on a single arbitrator,³ and to split the arbitration fees regardless of who prevailed, Victor testified that it would cost Plaintiff approximately \$22,800 in arbitrators' fees alone to arbitrate his claims.

¶ 16 Defendants argue that Victor's testimony was speculative and that he lacked the foundation to testify because Defendants had not yet filed an answer, making it impossible for Victor to know with certainty what issues would be litigated in the arbitration. However, any lack of certainty about the exact cost of this arbitration goes to the weight, not the admissibility or evidentiary foundation of Victor's testimony. *See Faber v. Menard, Inc.*, 367 F.3d 1048, 1054 (8th Cir.2004) (instructing the party seeking to avoid arbitration to “present specific evidence of *likely* arbitrator's fees and its financial ability to pay those fees so that the court can determine whether the arbitral forum is accessible to the party”) (emphasis added). On this record, the trial court properly concluded that while “the amount of discovery necessary to prepare for an arbitration hearing, the number of witnesses who would be called to testify and the length of the hearing are all difficult to predict at this

early stage of the process,” it is reasonable to infer “from the evidence and statements of counsel and the Court’s experience as a judicial officer in similar cases ... that this type of case is expensive to litigate.”

¶ 17 Defendants also argued that Victor was not qualified to testify about the amount of time needed to arbitrate Plaintiff’s claims because he had not actually represented a client in a medical malpractice arbitration. We note, however, that Victor had practiced law for nearly thirty years, had been dealing with long-term care cases for twelve years, and that approximately ten to twelve of his cases had involved arbitration agreement issues. Again, Defendants’ argument goes to the weight of Victor’s testimony, not its foundation or admissibility. *See City of Phoenix v. Brown*, 88 Ariz. 60, 64, 352 P.2d 754, 756 (1960) (explaining that the lack of the highest degree of skill or qualification of an expert witness goes to the weight of his testimony rather than to its admissibility).

Plaintiff’s Ability to Pay

¶ 18 Plaintiff testified that he was retired, living on a fixed income, ⁴ and did not have any financial resources such as savings or stocks. Plaintiff further testified that a portion of his monthly income consisted of veteran’s assistance that is provided to veterans who are “hard pressed for money.” Based on his financial situation, Plaintiff stated he would be unable to pay the arbitrators’ fees needed to arbitrate his case. We conclude this evidence supports the trial court’s factual finding that arbitration would be cost-prohibitive for Plaintiff.

¶ 19 Defendants contend that Plaintiff’s income, which Defendants estimate to be \$55,560 per year, was sufficient to pay the estimated \$22,800 in arbitration costs. However, as explained above, the trial court is in the best position to evaluate witness credibility and demeanor, and we therefore defer to the trial court’s factual findings

absent a clear abuse of discretion (and there was no such abuse here).

Waiver or Reduction in Fees

¶ 20 Finally, unlike *Harrington*, the Agreement does not provide for a reduction or waiver of Plaintiff’s fees based on financial hardship. The Agreement simply states the parties will “contribute equally to payment of the fees charged by the Arbitrator or Arbitrators.” Moreover, the Agreement is not subject to any arbitration rules, such as AAA, that provide for waiver/reduction of fees based on financial hardship.⁵

[307 P.3d 82]

Agreement Unconscionable

¶ 21 Because we defer to the trial court’s findings of fact absent clear error, *Harrington*, 211 Ariz. at 247, ¶ 16, 119 P.3d at 1050, we conclude there is reasonable evidence supporting the trial court’s determination that Plaintiff would be unable to afford to arbitrate his claims. As a result, the Agreement effectively precludes Plaintiff from obtaining redress for any of his claims, and is therefore substantively unconscionable and unenforceable. *See id.* at 252, ¶ 42, 119 P.3d at 1055 (“The Court has made it clear that arbitration is appropriate only ‘[s]o long as the prospective litigant effectively may vindicate’ his or her rights in the arbitral forum.”) (quoting *Gilmer v. Interstate/Johnson Lane Corp.*, 500 U.S. 20, 28, 111 S.Ct. 1647, 114 L.Ed.2d 26 (1991)).⁶

Conclusion

¶ 22 For the foregoing reasons, we affirm.

CONCURRING: MARGARET H. DOWNIE, and PATRICIA A. OROZCO, Judges.

Notes:

^{1.} The court also reasoned the Agreement was substantively unconscionable because the terms of the Agreement were one-sided, requiring mandatory arbitration for the types of claims a patient could bring against the facility, but not for the types of claims the facility could bring against a patient.

^{2.} The trial court found the Agreement was not procedurally unconscionable, and Plaintiff has not challenged that finding on appeal. Thus, Defendants' arguments referencing the fact the Agreement was a separate document from other admission paperwork and was conspicuously written in bold print and large type are largely irrelevant, because while these facts may be relevant to procedural unconscionability, they do not bear on substantive unconscionability. For the same reason, Defendants' arguments referencing the fact the Agreement was not a "take it or leave it" agreement or a pre-condition to admittance to the facility, and that it could have been rescinded within thirty days of signature primarily relate to procedural unconscionability.

^{3.} Plaintiff's assertion that three arbitrators would be necessary was not challenged by Defendants in their briefs on appeal. *See State Farm Mut. Auto. Ins. Co. v. Novak*, 167 Ariz. 363, 370, 807 P.2d 531, 538 (App.1990) (failing to develop an argument properly results in waiver on appeal).

^{4.} Plaintiff's total monthly income was \$4,630, which consisted of the following: \$1,717 in social security; \$1,200 from a pension; and \$1,703 in "veteran's assistance." Plaintiff testified that apart from his monthly income, he had no other financial resources.

^{5.} We note that parties not subject to arbitration may request a waiver or deferral of court fees and costs based on financial hardship if they litigate in court. *See* A.R.S. 12-302(C) (deferral); A.R.S. 12-302(D) (waiver).

^{6.} Having determined that the Agreement was substantively unconscionable, we need not reach Plaintiff's argument that the Agreement would also contravene the purposes of the Adult Protective Services Act, A.R.S. § 46-455.

FORM 4**STATE OF SOUTH CAROLINA
COUNTY OF BEAUFORT
IN THE COURT OF COMMON PLEAS****JUDGMENT IN A CIVIL CASE****CASE NO. 2017-CP-07-02636**

JOSEPH HOLMES, as Personal Representative of the ESTATE
OF DAVID HOLMES
PLAINTIFF(S)

BAYVIEW MANOR, LLC, d/b/a BAYVIEW MANOR; EPIC
GROUP, LP; and EPIC GENERAL, LLC
DEFENDANT(S)

Submitted by: Eric M. Poulin

Attorney for : ☒ Plaintiff ☐ Defendant
or
☐ Self-Represented Litigant

DISPOSITION TYPE (CHECK ONE)

- ☐ **JURY VERDICT.** This action came before the court for a trial by jury. The issues have been tried and a verdict rendered.
- ☒ **DECISION BY THE COURT.** This action came to trial or hearing before the court. The issues have been tried or heard and a decision rendered.
- ☐ **ACTION DISMISSED** (*CHECK REASON*): ☐ Rule 12(b), SCRCP; ☐ Rule 41(a), SCRCP (Vol. Nonsuit); ☐ Rule 43(k), SCRCP (Settled); ☐ Other
- ☐ **ACTION STRICKEN** (*CHECK REASON*): ☐ Rule 40(j), SCRCP; ☐ Bankruptcy; ☐ Binding arbitration, subject to right to restore to confirm, vacate or modify arbitration award; ☐ Other
- ☐ **DISPOSITION OF APPEAL TO THE CIRCUIT COURT** (*CHECK APPLICABLE BOX*):
☐ Affirmed; ☐ Reversed; ☐ Remanded; ☐ Other

NOTE: ATTORNEYS ARE RESPONSIBLE FOR NOTIFYING LOWER COURT, TRIBUNAL, OR ADMINISTRATIVE AGENCY OF THE CIRCUIT COURT RULING IN THIS APPEAL.

IT IS ORDERED AND ADJUDGED: ☒ See attached order (formal order to follow) ☐ Statement of Judgment by the Court: Defendants' Motion for Non-Jury Trial is DENIED.

ORDER INFORMATION

This order ☐ ends ☒ does not end the case.

Additional Information for the Clerk :

INFORMATION FOR THE JUDGMENT INDEX

Complete this section below when the judgment affects title to real or personal property or if any amount should be enrolled. If there is no judgment information, indicate "N/A" in one of the boxes below.

Judgment in Favor of (List name(s) below)	Judgment Against (List name(s) below)	Judgment Amount To be Enrolled (List amount(s) below)
		\$
		\$
		\$

If applicable, describe the property, including tax map information and address, referenced in the order:



The judgment information above has been provided by the submitting party. Disputes concerning the amounts contained in this form may be addressed by way of motion pursuant to the SC Rules of Civil Procedure. Amounts to be computed such as interest or additional taxable costs not available at the time the form and final order are submitted to the judge may be provided to the clerk.
Note: Title abstractors and researchers should refer to the official court order for judgment details.

Circuit Court Judge	Judge Code	Date
For Clerk of Court Office Use Only		
This judgment was entered on the day of , 20 and a copy mailed first class or placed in the appropriate attorney's box on this day of , 20 to attorneys of record or to parties (when appearing pro se) as follows:		
Eric M. Poulin / Stefan B. Feidler	W. McElhaney White	
32 Ann Street	101 West St. John Street, Suite 200	
Charleston, SC 29403	Spartanburg, SC 29306	
ATTORNEY(S) FOR THE PLAINTIFF(S)	ATTORNEY(S) FOR THE DEFENDANT(S)	
	CLERK OF COURT	

STATE OF SOUTH CAROLINA
COUNTY OF BEAUFORT

)
)

IN THE COURT OF COMMON PLEAS
FOR THE 14TH JUDICIAL CIRCUIT

CASE NO: 2017-CP-07-02636

JOSEPH HOLMES, as Personal
Representative of the ESTATE OF DAVID
HOLMES,

Plaintiff(s),

v.

BAYVIEW MANOR, LLC, d/b/a
BAYVIEW MANOR; EPIC GROUP, LP;
and EPIC GENERAL, LLC,

Defendant(s).

ORDER DENYING DEFENDANTS'
MOTION FOR NON JURY TRIAL

THIS MATTER is before the Court on Defendants' Motion for Non-Jury Trial.

Arguments were held on April 25, 2018 in the Beaufort County Courthouse. Present at the call of the case was attorney Eric M. Poulin, representing the Plaintiff, and attorney W. McElhaney White, representing the Defendants. For the following reasons, Defendants' Motion is respectfully **DENIED**.

BACKGROUND

The Decedent, David Holmes, was a resident of Defendants' long term care facility. Decedent was first admitted on December 2, 2014, and re-admitted on February 17, 2015. Decedent was incompetent during both admissions. At each admission, Decedent's family signed an Admission Agreement.¹ The Admission Agreements contained the following provision:

¹ Plaintiff argues that the family members lacked authority to sign these Admission Agreements to the extent they contain jury waiver clauses. However, because the Court finds this waiver was invalid and unenforceable in the first instance, it is not necessary to discuss the issues of authority or agency.

Waiver of Jury Trial: (Please read carefully)

Resident hereby knowingly, voluntarily, and intentionally waives the right to trial by jury with respect to any litigation, including any counterclaim which Resident may assert, arising from or relating to this Agreement or any other document connected with this Agreement, or arising out of or relating to any of the said documents or any relationship between the Facility and Resident, including the Resident's admission itself, or any other course of conduct, course of dealing statements (whether verbal or written) or actions of the facility or Resident.

Resident represents and warrants that the waiver contained in this Paragraph has been freely and voluntarily made after reviewing the same, or having had an opportunity to review the same, with counsel of Resident's choice.

The Admission Agreements also contained an Arbitration Clause which states that arbitration is "Optional" and allows the person signing to decline by marking an "X." At each admission, the family declined arbitration by marking an "X." Upon Decedent's death, his Estate brought this medical negligence action against the Defendants and requested a jury trial. Defendants now seek to invoke the jury waiver clause of the Admission Agreements, and seek an order setting this case for non-jury disposition.

LAW

An illegal contract is unenforceable. Berkebile v. Outen, 311 S.C. 50, 53 n. 2, 426 S.E.2d 760, 762 n. 2 (1993). "The general rule is that courts will not enforce a contract which is violative of public policy, statutory law, or provisions of the Constitution." Id. Federal regulations require Medicare and Medicaid certified facilities to accept Medicare/Medicaid reimbursement rates as payment in full. See 42 C.F.R. § 489.30; 42 C.F.R. § 447.15. Moreover, such facilities, in the case of an individual who is entitled to medical assistance, must "not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under

the state plan...any other consideration as a precondition of admitting (or expediting the admission of) the individual to the facility or as a requirement for the individual's continued stay at the facility." 42 U.S.C. § 1396r(c)(5)(A)(iii).

Finally, it is well settled that to be valid and enforceable, a contract must be supported by valuable consideration. Benya v. Gamble, 282 S.C. 624, 628, 321 S.E.2d 57, 60 (Ct.App.1984)("[a] contract exists where there is an agreement between two or more persons upon sufficient consideration either to do or not to do a particular act."). Consideration may consist of "some right, interest, profit or benefit accruing to one party or some forbearance, detriment, loss or responsibility given, suffered or undertaken by the other." Prestwick Golf Club, Inc. v. Prestwick Ltd. P'ship, 331 S.C. 385, 389, 503 S.E.2d 184, 186 (Ct.App.1998).

ANALYSIS

In the instant case, it is undisputed that Decedent was a Medicare and Medicaid beneficiary while residing at Defendants' facility and that the facility was billing and accepting payment from Medicare and Medicaid for Decedent's care.² Therefore, the question of enforceability turns, in part, on whether the jury waiver provision was a mandatory part of the Admission Agreement and a required pre-condition to admission. During arguments, counsel for Defendants was unable or unwilling to take a position on this issue. However, in light of the following analysis, the Court finds that this provision is unenforceable in either case.

If the jury waiver provision was a required pre-condition to admission, then this requirement was a clear violation of Federal Law. 42 U.S.C. § 1396r(c)(5)(A)(iii) prohibits a

² During the hearing, counsel for Defendants stated his belief that Decedent was Medicare eligible but only "Medicaid pending" during his stay. However, Mr. White has since confirmed that Decedent was, in fact, Medicaid eligible during his stay.

facility such as Defendants' from soliciting or accepting "any other consideration" as a condition to admission outside of the Medicaid payments when admitting a patient in Decedent's position. By requiring Decedent's family to waive his right to a jury trial as a condition of admission, Defendants' were requiring and accepting consideration in addition to Medicaid payments. Therefore, the jury waiver clause would be unenforceable due to its illegality.

Alternatively, if the jury waiver was not a precondition to admission, then it fails for lack of consideration. As noted, the waiver, as written, works only in one direction. When asked during arguments what the consideration for the waiver might be, counsel for Defendants argued only that the admission was the consideration for the waiver. When pushed on whether any additional consideration was present (separate and apart from the admission and care) counsel agreed there was none. Here, Defendants cannot have it both ways. They cannot, on the one hand, argue that the waiver was not consideration for the admission but, on the other, argue that the admission was valuable consideration for the waiver. For the waiver to be enforceable as a non-pre-condition to admission, it must be supported by some other valuable consideration, which it is not.

CONCLUSION

Therefore, we are left with a clause that, if a pre-condition to admission, is unenforceable under the doctrines of illegality; if not a precondition to admission, void for lack of consideration. For these reasons, Defendants' Motion for Non-Jury trial is respectfully **DENIED.**

IT IS SO ORDERED!

Dated this ____ day of May, 2018
Walterboro, S.C.

The Honorable Perry M. Buckner, III
Presiding Judge, 14th Judicial Circuit



Beaufort Common Pleas

Case Caption: David Holmes Estate Of , plaintiff, et al VS Bayview Manor Llc ,
defendant, et al
Case Number: 2017CP0702636
Type: Order/Jury Trial

It is so Ordered

s/ Perry M Buckner III 2122

STATE OF SOUTH CAROLINA
COUNTY OF GREENVILLE

IN THE COURT OF COMMON PLEAS
C.A. No.: 2019-CP-23-00473

Estate of Patricia Royston, by and through the
appointed Personal Representative, Marianne
McCoig, Individually, and on behalf of the
statutory beneficiaries,

Plaintiffs,

**ORDER DENYING DEFENDANTS'
MOTION TO DISMISS, COMPEL
ARBITRATION AND STAY COURT
PROCEEDINGS**

vs.

Hunt Valley Holdings, LLC a/k/a
Fundamental Long Term Care Holdings,
LLC; Fundamental Clinical and Operational
Services, LLC; Fundamental Administrative
Services, LLC; and THI of South Carolina at
Magnolia Place at Greenville, LLC d/b/a
Magnolia Place-Greenville,

Defendants.

This matter came before the Court on Defendants' Motion to Dismiss and Compel Arbitration. After reviewing the parties' submissions and arguments, the Court finds no valid arbitration contract between Ms. Royston and Defendants because: (1) the Arbitration Agreement is not signed by both parties and was produced, unsigned, by the Plaintiff during discovery, and (2) the parties on the Arbitration Agreement are not those parties specifically listed in the lawsuit. Accordingly, the Defendants' motion is **DENIED**.



FACTUAL BACKGROUND

This matter arises out of two civil actions --- a Survival Action and a Wrongful Death action. Both actions involve allegations of corporate negligence and nursing home neglect resulting in the alleged wrongful death of Patricia Royston.

Magnolia Place-Greenville (“Facility”) is owned and operated by Hunt Valley Holdings, LLC, formerly known as Fundamental Long Term Care Holdings, Inc. The claims are brought against the nursing home facility THI of South Carolina at Magnolia Place at Greenville, LLC d/b/a Magnolia Place – Greenville, as well as Fundamental Clinical and Operational Services, LLC, Fundamental Administrative Services, LLC, and Hunt Valley Holdings, LLC a/k/a Fundamental Long Term Care Holdings, LLC, these latter three entities being hereinafter referred to as the “Corporate Defendants.”

Marianne McCoig was Patricia's daughter and now serves as the personal representative of Patricia's estate. Patricia was admitted as a short-term resident into the Facility on December 19, 2016. The Arbitration Agreement was allegedly provided to Patricia, but the facility claims they are not in possession of it, and the copy Plaintiffs produced was not signed by the facility. There is no evidence the Arbitration Agreement was signed by Patricia Royston during the admission process and provided to Defendants. Defendants acknowledge the copy at issue was not signed by any Facility representative.

Ms. McCoig initiated the current action on January 31, 2019. The Complaint alleges wrongful death and survival claims arising from Defendants' failure to monitor and supervise Patricia's safety and well-being while at the Facility. On July 26, 2019, Defendants filed a Motion to Dismiss, Compel Arbitration, and Stay Court Proceedings.

LEGAL STANDARD

In order to compel arbitration, the Facility bears the burden to prove a valid and enforceable arbitration contract. Not all arbitration clauses are per se enforceable. Aiken v. World Finance Corp. of S.C., 373 S.C. 144, 149, 644 S.E.2d 705, 708 (2007); MBNA America Bank, N.A. v. Christianson, 377 S.C. 210, 659 S.E.2d 209 (Ct. App. 2008). Courts interpret a jury trial waiver narrowly and construe contract ambiguities against the Facility as the party that drafted the Arbitration Agreement. WDI Meredith & Co. v. Am. Telesis, Inc., 359 S.C. 474, 480, 597 S.E.2d 885 (Ct. App. 2004). Simpson v. MSA of Myrtle Beach, Inc., 373 S.C. 14, 644 S.E.2d 663, 668 (2007). Whether the parties agreed to arbitrate is a question of substantive state law. In Chassereau v. Global Sun Pools, Inc., the Supreme Court stated:

Although we are constrained to resolve all doubts in favor of arbitration, this is not an absolute truism intended to replace careful judicial analysis. While actions taken in an arrangement such as the one entered into by these parties might have the potential to generate several legal claims and causes of action, we have no doubt that Chassereau did not intend to agree to arbitrate the claims she asserts in the instant case. Accordingly, we hold that these claims are not covered by the arbitration agreement at issue in the instant case.

373 S.C. 168, 644 S.E.2d 718, 720-21 (2007) (emphasis added).

While the Federal Arbitration Act (“FAA”) includes a presumption favoring arbitration, it only applies *after* the court finds there is a valid, enforceable arbitration agreement. 9 U.S.C. § 4 (“The court shall make an order directing the parties to proceed to arbitration” but only “upon being satisfied that the making of the agreement...is not in issue”).¹ The FAA looks to state law to decide the threshold questions of contract formation.² Therefore, arbitration agreements guided

¹ See also EEOC v. Waffle House, 534 U.S. 279, 293-294, 122 S.Ct. 754, 764, 151 L.Ed.2d 755 (4th Cir. 2014); Toler's Cove Homeowners Ass'n v. Trident Constr. Co., Inc., 355 S.C. 605, 612, 586 S.E.2d 581 (2003).

² Munoz v. Green Tree Fin. Corp., 343 S.C. 531, 542 S.E.2d 360, 364 (2001); Towles v. United Healthcare Corp., 338 S.C. 29, 37, 524 S.E.2d 839, 844 (Ct. App. 1999) (“the court should apply ‘ordinary state-law principles that govern the formation of contracts.’”).

by the FAA are subject to the same defenses applicable to all other contracts.³ The judicial inquiry may include an examination of contractual defects such as lack of mutual assent and want of consideration, as well as other grounds existing at law or equity, including fraud, duress, and unconscionability.⁴

LEGAL ANALYSIS

The Facility's motion to compel arbitration is effectively a motion to enforce a contract. In the ordinary course, a nursing home resident who alleges injury would bring her claims before the Court as Plaintiff has done here and the nursing home would mount its defense in the same forum. A valid contract to arbitrate their disputes is the only way for the parties to opt out of the litigation process. The Court finds the Facility had no such contract with Ms. Royston. The "Arbitration Agreement" on which the Facility's motion relies is invalid because it is not signed by both parties, and the parties on the Arbitration Agreement are not those parties specifically listed in this lawsuit.

A. The Arbitration Agreement is not a valid and enforceable agreement because it was not signed by the party seeking its enforcement.

The Arbitration Agreement is a separate document from the Admission Agreement with the Facility. At the bottom of the Arbitration Agreement there were lines provided for the resident and an agent of Facility to sign, date, and print their names. While not dated, Ms. Royston allegedly signed at the signature line reserved for "Resident/Representative Signature". A signature line existed for Facility to execute the agreement as well. A blank was provided for the facility to sign as "Authorized Agent of Facility", and a separate blank for the agent to print his/her

³ Rent-A-Center, West, Inc. v. Jackson, 561 U.S. 63, 130 S. Ct 2772, 2776, 177 L.Ed.2d 403 (2010) Simpson, 373 S.C at 14, 644 S.E.2d at 663 ("general contract principles of state law apply in a court's evaluation of the enforceability of an arbitration clause.").

⁴ See Sydnor v. Conesco Fin. Servicing Corp., 252 F.3d.302, 205 (4th Cir.2001).

name and title. At no time did anyone from Facility ever sign and execute the agreement on behalf of Facility. It is also interesting to note that the only agreement in the record, or known to exist, was found in her personal effects and produced by the Plaintiff in discovery. The Defendant did not have a copy in its possession. That leaves outstanding the question of whether the Plaintiff ever delivered to the Defendant her signed copy. As previously noted, the Facility bears the burden of proving that a valid arbitration agreement exists and was executed.

Because the facility did not sign the agreement, there is no indicia of mutual assent as required for a valid enforceable arbitration agreement. See Rodarte v. Univ. of S.C., 419 S.C. 592, 603, 799 S.E.2d 912, 917-18 (2017) (quoting Laser Supply & Servs., Inc. v. Orchard Park Assocs., 382 S.C. 326, 334, 676 S.E.2d 139, 143-44 (Ct. App. 2009) (noting South Carolina law requires court to consider only “objective manifestations of the parties’ assent at the time the contract was made”)). The alleged agreement by its express terms, “**THE PARTIES CONFIRM THAT EACH OF THEM UNDERSTANDS THAT EACH HAS WAIVED THE RIGHT TO TRIAL BEFORE A JUDGE OR JURY AND THAT EACH CONSENTS TO ALL OF THE TERMS OF THE VOLUNTARY AGREEMENT.**,” requires both parties to sign and confirm in writing that they are waiving their right to a jury trial and consenting to the terms of the agreement by affixing their signatures. The Arbitration Agreement itself references the parties’ intention to select arbitration, however, there is no party signature on behalf of Facility and its affiliates. The fact that there is a signature line for “Authorized Agent of Facility” and that it is left blank further indicates that there was no mutual assent. See Baier v. Darden Restaurants, 420 S.W.3d 733, 739 (Mo. Ct. App. 2014).

B. The parties on the Arbitration Agreement are not those parties specifically listed in this lawsuit.

All Defendants are all related entities⁵ of the nursing home and have a significant relationship in the ownership, operation, and management of the nursing home, and derive significant economic benefits from its revenue.

In Hawthorne v. Fundamental et al., these same Defendants moved to compel arbitration on behalf of the Corporate Defendants stating that “The arbitration agreement contractually **is enforceable by each of the moving defendants as either a parent company, agent or as an employee of the facility and legally is enforceable by these defendants under the circumstances** and Pennsylvania law in any event. In addition, Defendants argued that Patricia and his estate equitably are estopped from arguing that the arbitration agreement is not binding and enforceable **by each of the defendants.**” Hawthorne v. Fundamental et al., No. 2:12cv1826 (2013).

Furthermore, Plaintiff’s claims against Defendants are based on a theory of unified operation and control. Each is alleged to have participated in exactly the same wrongful conduct. Agency law extends the right to enforce an arbitration award against agents, sister corporations, subsidiaries, and parent/ownership entities of a contracting party “where the interests of such parties are directly related to, if not congruent with, those of a signatory.” Pritzker v. Merrill Lynch, Pierce, Fenner & Smith, Inc., 7 F.3d 1110, 1112 (3d Cir. 1993) (citing Isidor Paiwonsky Associates, Inc. v. Sharp Properties, 998 F.2d 145, 155 (3d Cir. 1993)). Plaintiff alleges each Corporate Defendant is a parent entity, agent or employee of the Facility that shares a congruent interest. Plaintiff thus presumptively would be able to enforce any judgment from the proceeding against the Corporate Defendant and, in turn, each can rely on the principles of agency law and the broad scope of the FAA to compel and participate in the Arbitration Agreement. Id. (“Where the parties to such a clause unmistakably intend to arbitrate all controversies, which might arise

⁵ Related entity is an industry term that means the entities are have common ownership, management, and control.

between them, their agreement should be applied to claims against agents or entities related to the signatories.”); Sharp Properties, 998 F.2d at 155 (“Applying Barrowclough [v. Kidder, Peabody & Co.], 752 F.2d 923 (3d Cir. 1985)]’s logic here, because Bared’s and ARI’s interests are directly related, if not in fact congruent, it can fairly be assumed that within the arbitration proceedings ARI advanced arguments protective of Bared’s interests. There is, therefore, no reason to conclude that the Federal Arbitration Act’s overarching policy favoring the enforcement of arbitration awards does not apply to this case.”).

It is also worth noting that at the beginning of the Arbitration Agreement in question where the parties are identified the Facility has listed itself as “Magnolia Place of Greenville.” (Emphasis added). In actuality the Facility’s correct title would be Magnolia Place – Greenville which is the name THI of South Carolina at Magnolia Place at Greenville, LLC is doing business as. It is up to the drafter of the Arbitration Agreement to be able to sufficiently and correctly identify themselves as a party of the Arbitration Agreement. Failure to do so must be construed against the drafting the party.

CONCLUSION

For the foregoing reasons, Defendants’ Motion to Dismiss and Compel Arbitration or Alternatively, to Compel Arbitration and Stay Proceedings, is DENIED.

AND IT IS SO ORDERED

Signature to Follow



Greenville Common Pleas

Case Caption: Patricia Royston , plaintiff, et al vs. Hunt Valley Holdings LLC ,
defendant, et al
Case Number: 2019CP2300473
Type: Order/Other

So Ordered

s/ Robin B. Stilwell 2158

Electronically signed on 2019-10-09 10:23:56 page 8 of 8

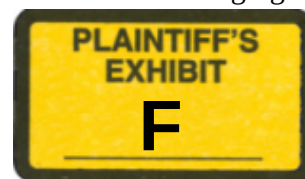
STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF RICHLAND	)	CIVIL ACTION NO.: 2020-CP-40-02181
	)	(Wrongful Death)
Sybil B. Williams, as Personal Representative	)	
of the Estate of Michael L. Boler,	)	
	)	
Plaintiff,	)	ORDER DENYING
	)	MOTION TO DISMISS AND / OR STAY AND
	)	COMPEL ARBITRATION
v.	)	
	)	
PruittHealth-Columbia, LLC, United Health	)	
Services, Inc., PruittHealth Consulting	)	
Services, Inc., PruittHealth Therapy Services,	)	
Inc., PruittHealth, Inc., and Neil Pruitt, Jr.,	)	
	)	
Defendants.	)	

This matter came before this Court on July 13, 2020 for a hearing on Defendants' Motion to Dismiss and/or Stay and Compel Arbitration. Plaintiff Sybil B. Williams, as Personal Representative of the Estate of Michael L. Boler, was represented by Neil E. Alger and Defendants were represented by Josh S. Whitley. Both parties fully briefed the motion and presented this Court with memorandums of law and numerous exhibits for the Court's consideration. For the reasons set forth below, Defendants' Motion to Dismiss and/or Stay and Compel Arbitration is **DENIED**.

18

BACKGROUND

Defendants operate a nursing home in Richland County, South Carolina. In late July and early August of 2018, Mr. Boler developed edema and was hospitalized. He ultimately passed away on September 3, 2018 from his injuries and cardiac arrest. Plaintiff, Sybil B. Williams, brought these Wrongful Death and Survival actions on behalf of the Estate of Mr. Michael L. Boler. The parties have completed the notice of intent process which included exchanging



records and initial interrogatories. Plaintiff then proceeded with filing of the Summons and Complaint in the Court of Common Pleas in Richland County. After receiving service of the Summons and Complaint, Defendants filed this Motion to Dismiss in lieu of filing an answer. No additional discovery has been served or exchanged by either party.

Defendants seek to enforce an arbitration agreement that was signed by Mr. Boler's sister, Plaintiff. Importantly, at the time of admission and prior to the execution of the documents on July 19, 2018, no legal guardianship, health care power of attorney, or durable power of attorney had been executed by Mr. Boler. Despite a lack of express authority, Defendants assert that the arbitration agreement is enforceable based on federal presumptions and agency theory. Plaintiff challenges the validity of that agreement on numerous grounds, and argues that Defendants have relied on erroneous assumptions and failed to meet their burdens.

LEGAL ANALYSIS

Defendants have moved to dismiss Plaintiff's Complaint and compel arbitration pursuant to the arbitration agreement that was signed and executed along with admission paperwork by Mr. Michael L. Boler's sister, Mrs. Sybil B. Williams. Plaintiff has raised basic contractual defenses. First, that the agreement is not binding because Mrs. Sybil B. Williams lacked the proper authority to sign the arbitration agreement on Mr. Michael L. Boler's behalf. And second, even if Mrs. Sybil B. Williams did have such authority, the agreement is not valid and enforceable because of a lack of consideration and mutuality under the circumstances.

Defendants argued that the Federal Arbitration Act (“FAA”) is to be applied and judicially favored. Defendants also argued that federal and state policy generally favors compelling arbitration. However, Defendants’ arguments assume that a valid, enforceable arbitration agreement exists between the parties. By arguing these positions, Defendants have placed the proverbial cart before the horse.

Courts are bound to interpret arbitration contracts within the familiar structures of contractual interpretation. Arbitration agreements must satisfy the basic tenets and requirements of contract law. *Towles v. United Healthcare Corp.*, 338 S.C. 29, 37, 524 S.E.2d 839, 844 (Ct. App. 1999). "[A]rbitration is a matter of contract, and our evaluation of the enforceability of an arbitration agreement is guided by general principles of contract law." *Grant v. Magnolia Manor-Greenwood, Inc.*, 383 S.C. 125, 130, 678 S.E.2d 435, 438 (2009) (citing, *Munoz v. Green Tree Fin. Corp.*, 343 S.C. 531, 538, 542 S.E.2d 360, 364 (2001)). This is a threshold contract inquiry that precedes any FAA implications.

In recognition of its contractual origins and limitations, Section 2 of the FAA dictates that arbitration agreements "shall be valid, irrevocable, and enforceable, *save upon such grounds as exist at law or in equity for the revocation of any contract.*" 9 U.S.C. § 2. (emphasis added). Justice Scalia succinctly stated that, "[i]f a party challenges the validity under § 2 of the precise agreement to arbitrate at issue, the federal court must consider the challenge before ordering compliance with that agreement under § 4." *Rent-A-Center, West, Inc. v. Jackson*, 561 U.S. 63, 71, 130 S.Ct. 2772, 2778 (2010). Thus, unless there is a valid, irrevocable, and enforceable contract, the substantive law of the FAA is not even applicable. "[B]efore referring a dispute to an arbitrator, the court determines whether a valid arbitration agreement exists." *Henry Schein, Inc. v. Archer & White Sales, Inc.*, 139 S.Ct. 524, 530 (2019) (citing 9 U.S.C. § 2).¹

¹ Both South Carolina and Fourth Circuit case law have applied this principle. "[I]f a party challenges the validity under [9 U.S.C.] § 2 of the precise agreement to arbitrate at issue, the federal court must consider the challenge before ordering compliance with that agreement. . . ." *Minnieland Private Day Sch., Inc. v. Applied Underwriters Captive Risk Assurance Co., Inc.*, 867 F.3d 449, 455 (4th Cir. 2017) (quoting *Rent-A-Center, West, Inc. v. Jackson*, 561 U.S. 63, 71 (2010)); *York v. Dodgeland of Columbia, Inc.*, 406 S.C. 67, 78, 749 S.E.2d 139, 144 (Ct. App. 2013) (citing *Partain v. Upstate Auto. Grp.*, 386 S.C. 488, 491, 689 S.E.2d 602, 603 (2010)) ("Whether a valid arbitration agreement exists is a matter for judicial determination.").

Accordingly, this Court retains its jurisdiction to perform an inquiry into the law and facts relating to the threshold question of the validity and enforceability of these contracts.

Furthermore, the party seeking judicial enforcement of a contract bears the burden of persuasion, i.e. that a valid and enforceable agreement was signed in a knowing, voluntary and intentional capacity. *See Aiken v. World Finance Corp. of S.C.*, 373 S.C. 144, 149 (2007); *MBNA America Bank, N.A. v. Christianson*, 377 S.C. 210, 659 S.E.2d 209 (Ct. App. 2008); *Hinson-Barr, Inc. v. Pinckard*, 292 S.C. 267, 268, 356 S.E.2d 115, 116 (1986). "A motion to compel arbitration pursuant to the FAA is 'akin to the burden on summary judgment.'" *Thomas v. Progressive Leasing*, Civ. No. 17-1249, 2017 WL 4805235, at *2 (D. Md. Oct. 25, 2017) (internal quotation marks omitted) (quoting *Galloway v. Santander Consumer USA, Inc.*, 819 F.3d 79, 85 (4th Cir. 2016)). Therefore, the burden is on the moving party to demonstrate the absence of any genuine dispute of material fact, *Adickes v. S.H. Kress & Co.*, 398 U.S. 144, 157 (1970), and that the movant is "entitled to judgment [compelling arbitration] as a matter of law." *Burrell v. 911 Restoration Franchise Inc.*, 2017 WL 5517383, at *3 (D. Md. November 17, 2017) (citing Fed. R. Civ. P. 56(a)). Thus, in this instance, the burden is on Defendants to prove that there are no questions of fact relating to the formation of this contract, i.e. the arbitration agreement. This burden has not been met by Defendants and for that reason their motion to dismiss is denied.

A. MRS. SYBIL B. WILLIAMS DID NOT HAVE THE LEGAL AUTHORITY TO GIVE AWAY MR. MICHAEL L. BOLER'S RIGHT TO A JURY TRIAL.

As a preliminary matter, this case is nearly identical to the factual scenario presented in *Hodge v. UniHealth Post-Acute Care of Bamberg, LLC*, in which another nursing home's motion to compel arbitration was denied. *Hodge*, 422 S.C 544, 813 S.E.2d 292 (Ct. App. 2018) *reh'g denied* (May 2, 2018), *cert. denied* (Aug. 21, 2018). In *Hodge*, Mrs. Mable Hodge's husband

executed various documents relating to her admission including an arbitration agreement despite her being of sound mind. The arbitration agreement and admission agreement were very similar to the agreements in question in this matter. The nursing home filed motions to dismiss and compel arbitration, or alternatively, to stay proceedings and compel arbitration. The nursing home also sought jurisdictional discovery such as the husband's deposition. The Court of Appeals affirmed the circuit court's denial of all motions and requests.

The *Hodge* Court recognized that “[t]he relationship of agency between a husband and wife is governed by the same rules which apply to other agencies[,] . . . [and] no presumption arises from the mere fact of the marital relationship” *Bankers Tr. of S.C. v. Bruce*, 283 S.C. 408, 423, 323 S.E.2d 523, 532 (Ct. App. 1984). Ostensibly, the same could be said about the relationship between siblings. “Agency is the fiduciary relationship that arises when one person (a ‘principal’) manifests assent to another person (an ‘agent’) that the agent shall act on the principal's behalf and subject to the principal's control.” *Hodge*, 422 S.C. at 564 (internal citations omitted).

The *Hodge* Court thoroughly examined agency scenarios in the context of arbitration agreements and nursing homes and, along with a majority of other jurisdictions, concluded that even if a family member or personal representative is given authority to make healthcare decisions concerning medical treatment, admission into medical facilities, and finances, such authority does not extend to non-healthcare decisions such as signing an arbitration agreement. *Hodge*, 422 S.C. at 568 (citing *Dickerson v. Longoria*, 995 A.2d 721, 739 (Md. Ct. App. 2010).

This same rationale had been adopted prior to *Hodge* by the S.C. Court of Appeals in *Thompson v. Pruitt Corp.*, 416 S.C. 43, 784 S.E.2d 679 (Ct. App. 2016). In *Thompson*, the court determined “the authority conveyed by a principal to an agent to handle finances or make health care decisions does not encompass executing an agreement to resolve legal claims by arbitration,

thereby waiving the principal's right of access to the courts and to a jury trial.” *Id.* at 55, 784 S.E.2d at 686. The facts of *Thompson* are very similar to *Hodge* and the present case, except for the slight difference that a mother’s son was signing the arbitration agreement because his mother was not mentally competent. Nonetheless, the court concluded that the son did not have authority under either common law agency or Adult Health Care Consent Act. *Id.* at 48-49, 56, 784 S.E.2d at 682, 686. That position was reaffirmed but also distinguished by the Court of Appeals in *Hodge*:

Further, *because Mable was competent*, unlike the patient in *Thompson* for whom the family members were allowed to sign medical forms under the Adult Health Care Consent Act, *no argument can be made the Adult Health Care Consent Act gave Husband the right to sign medical forms*. Similarly, Husband did not have Mable's health care power of attorney. Moreover, even if Husband had authority to handle finances or make health care decisions, as Appellants contend is evidenced by Husband signing past healthcare documents, this court has held the authority conveyed by a principal to an agent to handle finances or make health care decisions does not encompass executing an agreement to resolve legal claims by arbitration, thereby waiving the principal's right of access to the courts and to a jury trial.

Hodge, 422 S.C. at 574, 813 S.E.2d at 308 (internal citations omitted) (emphasis added).

This Court will follow the holdings of both *Thompson* and *Hodge*. Most simplistically, Defendants’ arguments fail under the *Thompson* analysis because a Health Care Power of Attorney does not provide the requisite authority to enter into arbitration agreements. But furthermore, Plaintiff presented numerous records which indicate that Mr. Boler was of sound mind, alert, oriented, follows commands, and comprehends. Equally as importantly, none of the assessments at the time of admission indicate that Mr. Boler had any disorientation, memory problems, incompetency, or altered mental state. Accordingly, this Court finds that Mr. Boler was competent and of sound mind at admission, and accordingly, any healthcare power of attorney would be rendered ineffective.

Lastly, this Court considered and rejected Defendants’ argument that Ms. Williams was an implied agent with apparent authority. “To establish apparent authority, the proponent must show (1) the purported principal consciously or impliedly represented another to be his agent; (2) the proponent relied on the representation; and (3) there was a change of position to the [proponent’s] detriment.” *Id.* at 571-72, 813 S.E.2d at 307 (citations omitted). “Either the principal must intend to cause the third person to believe that the agent is authorized to act for him, or he should realize that his conduct is likely to create such belief.” *Id.* at 572, 813 S.E.2d at 307 (quoting *Froneberger v. Smith*, 406 S.C. 37, 47, 748 S.E.2d 625, 630 (Ct. App. 2013)).

Defendants have offered no evidence that Mr. Boler consciously or implicitly represented anyone to be his agent at any time. “Moreover, an agency may not be established solely by the declarations and conduct of *an alleged agent*.” *Id.* (emphasis added). Directly to that point, Defendants’ only evidence that could possibly exhibit some form of factual inference of agency is the Arbitration checklist, but those inferences fail because the document exclusively contains the declarations of the alleged agent, Mrs. Williams, not the purported principal, Mr. Boler.

Defendants’ suggest that because Mr. Boler provided a Living Will and Healthcare Power of Attorney about a month after his admission, this is “entirely consistent with the principal/resident conferring authority at the time of admission.” (Def. Memo. p.6, n.3). But this inference is not consistent because it was untimely. Even more so, Defendants must acknowledge that Mr. Boler only conveyed a Living Will and Healthcare Power of Attorney; *not a Durable Power of Attorney*. Circumstantially, this inference of not obtaining a Durable Power of Attorney is equally as important as any inference obtained by the execution of a Living Will and Healthcare Power of Attorney. Mr. Boler and Mrs. Williams could have obtained a durable power of attorney within that same time frame and they did not do so. Accordingly, Mrs. Williams never obtained full authority to sign away Mr. Boler’s right to a jury trial.

B. THE ARBITRATION AGREEMENT IS NOT ENFORCEABLE BECAUSE OF A LACK OF CONSIDERATION AND MUTUALITY OF PROMISES.

"The necessary elements of a contract are an offer, acceptance, and valuable consideration." *Sauner v. Pub. Serv. Auth. of S.C.*, 354 S.C. 397, 406, 581 S.E.2d 161, 166 (2003). To be legally enforceable, a contract must have an offer, acceptance, consideration, and mutual assent or meeting of the minds on all material terms. It is well settled that to be valid and enforceable, a contract must be supported by valuable consideration. *Benya v. Gamble*, 282 S.C. 624, 628, 321 S.E.2d 57, 60 (Ct. App. 1984). "Valuable consideration to support a contract may consist of some right, interest, profit or benefit accruing to one party or some forbearance, detriment, loss or responsibility given, suffered or undertaken by the other." *Plantation A.O., LLC v. Gerald Builder of Conway, Inc.*, 386 S.C. 198, 206, 687 S.E.2d 714, 718 (Ct. App. 2009) (citation omitted). Consideration is a promise to do something that a party has no legal obligation to do or to forbear from doing something it has a legal right to do. A valid contract requires that both sides provide consideration. An arbitration agreement is simply a contract and therefore, is only enforceable if it contains bargained for consideration and a mutuality of obligations between its parties. These essential contract formation requirements are not met here.

The S.C. Supreme Court and Court of Appeals have reviewed nearly identical admission and arbitration documents as exist in this present matter and held resoundingly that the admission agreements and arbitration agreements do not merge. *See Coleman v. Mariner Health Care, Inc.* 407 S.C. 346, 352-54, 755 S.E.2d 450, 453-54 (2014); *Thompson*, 416 S.C. at 55, 784 S.E.2d at 686; *Hodge*, 422 S.C. at 563, 813 S.E.2d at 302. Thus, any consideration that is afforded through the admission agreement is not applicable, nor credited to the arbitration agreement. Therefore, the arbitration agreement must have its own specific consideration attributed to its formation.

Standing on its own, there is no mention of consideration anywhere in the arbitration agreement. Defendants have argued that the arbitration agreement is a bilateral contract and consideration is provided through the exchanging of promises to enter into arbitration. (Def. Memo. p. 7). However, the S.C. Supreme Court held long ago:

A promise may constitute the consideration for another promise. But a promise is not a good consideration for a promise unless there is absolutely *mutuality of the engagement*, so that each party has the right to hold the other to a positive agreement. *In case the promise of one of the parties impose no legal duty upon the party making it, such promise furnishes no consideration for a promise.*

Int'l Shoe Co. v. Herndon, 135 S.C. 138, 203, 133 S.E. 202 (1926) (emphasis added) (quoting Elliott on Contracts, vol. 1, § 231). Although Defendants have stated that “each of the parties is waiving the right to trial by jury, and instead, any dispute between the parties shall be resolved through binding arbitration,” the reality is that the obligation and resulting detriment falls exclusively on the resident. *Id.*

To explain requires simplifying Defendants’ proposition of mutual promises. In the most basic explanation, Plaintiff promised to Defendant that if a dispute or transgression arose, then she would move for arbitration, and Defendant promised to Plaintiff that if a dispute or transgression arose, then it would move for arbitration. However, each of these promises by the parties rely on the predicate assumption that a dispute or transgression could arise.

But, a dispute or transgression cannot arise against Defendants because *no duty is owed by the resident to the nursing home facility*. The only obligation of a resident is to pay his bills which happens to be exclusively related and used as consideration for the admission agreement, not the arbitration agreement; the two agreements do not merge. Whereas, Defendants have a legal duty to provide care and treatment to their residents. Simply put, a resident has no duty to the facility. There are not mutually exchanged promises as consideration for this arbitration

agreement because the parties do not have mutual obligations or duties to each other. Defendants exclusively benefit from this contract and no consideration was offered to Mr. Boler. Defendants have not met their persuasive burden and are unable to provide this Court with any convincing argument or evidence of consideration, and therefore, the arbitration agreement fails as a matter of contract and law.

C. NEITHER JURISDICTIONAL DISCOVERY, NOR A SUMMARY TRIAL IS APPROPRIATE.

Defendants are incorrect in asserting that pursuant to the FAA and *Dean v. Heritage Healthcare of Ridgeway, LLC* this Court is required to compel jurisdictional discovery and perform a summary trial. Defendants rely on the following footnote from *Dean* in which the Supreme Court stated:

We are concerned that, according to the Record, the patient did not sign either the residency agreement or the [a]greement on her own behalf, despite being competent at the time, nor did Respondent possess a health care power of attorney to sign either contract on the patient's behalf. The parties did not address this issue on appeal, and Respondent's only argument that this issue should serve as an additional sustaining ground was located in a cursory footnote in her brief. Accordingly, we merely note that, on remand, the circuit court must engage in a full inquiry into this matter prior to any attempt to enforce the [a]greement.

Dean v. Heritage Healthcare of Ridgeway, LLC, 408 S.C. 371, 388 n.13, 759 S.E.2d 727, 736 n.13 (2014). Without any further explanation or legal reasoning, Defendants extrapolate this statement by the Supreme Court and incorporate it with § 4 of the FAA which provides that when “the making of the arbitration agreement . . . [is] in issue, the court shall proceed summarily to the trial thereof.” 9 U.S.C. § 4.

But as previously mentioned, the FAA is not even relevant to this inquiry. Thus, unless there is a valid, irrevocable, and enforceable contract, the substantive law of the FAA is not even applicable.

Dean provides and the S.C. Court of Appeals has interpreted this footnote to support the position that the trial court retains jurisdiction to make an inquiry into the arbitration agreement's origination, validity, and execution so that any contractual defenses may be asserted. The Court in *Hodge* noted this precedent and employed this inquiry. *Hodge*, 422 S.C. at 574, 813 S.E.2d at 308 (denying arbitration without a summary trial or jurisdictional discovery). Although it may appear that this Court is negating one inquiry under the FAA for the sake of another contractual inquiry under state law, the legal basis for that distinction is pivotal. By performing a proper, state law inquiry on the validity of the contract, this Court is requiring Defendants to come forward and meet their burden of establishing the validity and enforceability of the arbitration agreement. *See id.*

Mr. Boler is deceased – he can offer no further testimony as to his manifestations of authority. Defendants have failed to offer any articulable discovery that would benefit the specific state law contractual inquiries that are presented to this Court. To be clear, Defendants' Memorandum in Support of their motion categorically requests "limited jurisdictional discovery" with no specificity. This discovery request is akin to a motion to compel, yet Defendants have offered no explanation of what discovery they are seeking or how such discovery would answer the factual inquiries in this case. This vague assertion by Defendants is unsupported by the facts of this case and the state law inquiries that are presented to this Court.

Rule 26, SCRCRCP, provides:

Parties may obtain discovery by one or more of the following methods: depositions upon oral examination or written questions; written interrogatories; production of documents or things or permission to enter upon land or other property, for inspection and other purposes; physical and mental examinations; and requests for admissions. The frequency or intent of use of discovery methods set forth in subdivision (a) shall be limited by the court if it determines that: (i) the discovery sought is unreasonably cumulative or duplicative, or is obtainable from some other source

that is more convenient, less burdensome, or less expensive; (ii) the party seeking discovery has had ample opportunity by discovery in the action to obtain the information sought; or (iii) the discovery is unreasonably burdensome or expensive taking into account the needs of the case, the amount in controversy, limitations on the parties' resources, and the importance of the issues at stake in the litigation.

Considering Rule 26, SCRCP, and agency law in tandem, the only probative and relevant information to the arbitration inquiries before this Court relate to Mr. Boler's written, spoken, or other conduct that may establish agency on his behalf. However, Mr. Boler is deceased and unavailable to offer any testimony. Defendants' insistence on taking Ms. Williams deposition is unconvincing. Mrs. William's deposition could only reveal that she was an unauthorized agent. This is consistent with the holding in *Klippel v. Mid-Carolina Oil, Inc.*, 303 S.C. 127, 130-31, 399 S.E.2d 163, 165 (Ct. App. 1990), in which the circuit court granted summary judgment to respondents who, along with the alleged agent, had denied in their affidavits an alleged agent was actually their agent. The court held that even though the purported agent stated in a deposition he was respondents' agent, because no other affidavits or depositions corroborated that claim, no question of fact was presented as to agency, and the court affirmed the grant of summary judgment to respondents. *Id.* at 130, 399 S.E.2d at 165. The court observed "statements made by an agent concerning the existence or extent of his authority are insufficient standing alone to establish agency." *Id.* In *Snell v. Parlette*, the South Carolina Supreme Court determined "[t]he testimony of [a purported agent who signed an agreement on behalf of ten relatives] that she was acting as the agent of her ten nonresident relatives is entitled to some weight, but is insufficient without more to establish an agency relationship." 273 S.C. 317, 322-23, 256 S.E.2d 410, 413 (1979). Furthermore, "it is the duty of one dealing with an agent to use due care to ascertain the scope of the agent's authority." *Hodge*, 422 S.C. at 565-66, 813 S.E.2d at 304 (citations omitted).

Both parties exchanged records during the notice of intent stage of these proceedings, and both parties are in possession of all material facts relating to this inquiry. The parties are already in possession of all available evidence that would reveal facts relevant to the alleged apparent authority conferred by Mr. Boler and of consideration between the parties. There is no additional discovery available that would assist these parties in determining agency and for that reason, Defendants' request for additional discovery is denied.

CONCLUSION

After careful consideration of the arguments of counsel, memorandum of law, applicable law, and for the reasons set forth above, it is ordered that Defendants' Motion to Dismiss and/or Stay and Compel Arbitration is DENIED.

THEREFORE Defendants motion is denied.

IT IS SO ORDERED.

Honorable Robert E. Hood
Fifth Judicial Circuit

December _____, 2020
Richland, South Carolina



Richland Common Pleas

Case Caption: Sybil B Williams , plaintiff, et al vs Pruitthealth Columbia Llc ,
defendant, et al
Case Number: 2020CP4002181
Type: Order/Other

So Ordered

s/ R.E. Hood #2164

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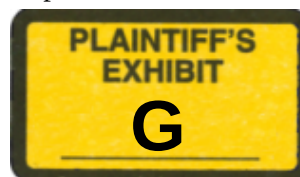
STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	SEVENTH JUDICIAL CIRCUIT
COUNTY OF SPARTANBURG	)	CASE NO. 2019-CP-42-03236
 RITA ST. AUBIN,	)	
as personal representative of the	)	
Estate of Irene Ramsey,	)	
	)	
Plaintiff,	)	
	)	
vs.	)	ORDER REGARDING DEFENDANTS'
	)	MOTION TO COMPEL ARBITRATION
	)	AND STAY ACTION
THI OF SOUTH CAROLINA AT CAMP	)	
CARE, LLC d/b/a Lake Emory Post Acute	)	
Care; THI OF SOUTH CAROLINA, LLC;	)	
HUNT VALLEY HOLDINGS, LLC; THI	)	
OF BALTIMORE, INC.; and CASEY	)	
CADDELL, as Officer/Manager of THI of	)	
South Carolina at Camp Care, LLC d/b/a	)	
Lake Emory Post Acute Care,	)	
	)	
Defendants.	)	

Hearing Date:	December 18 th , 2019, at 2:30 p.m.
Hearing Judge:	Grace Gilchrist Knie
Counsel for Plaintiff:	Stefan Bjorn Feidler
Counsel for Defendants:	Russell G. Hines
Court Reporter:	Michael R. Watts

This matter was before the Court on Wednesday, December 18th, 2019, at 2:30 p.m., in Spartanburg County, SC, the Seventh Judicial Circuit upon Defendants' Motion to Compel Arbitration. Attorney Stefan Bjorn Feidler of the Anastopoulos Law Firm, LLC, was present representing the interests of the Plaintiff. Attorney Russell G. Hines of Young Clement Rivers was present representing the interests of the Defendants. Michael R. Watts was the Court Reporter.

PROCEDURAL BACKGROUND:

This matter began with the filing of a Summons and Complaint on September 10th, 2019, asserting the causes of action of negligence/gross negligence, negligence per se, breach of



contract, fraud/misrepresentation/spoliation, violation of the South Carolina Unfair Trade Practices Act, elder abuse, corporate negligence, breach of fiduciary duty, unjust enrichment, alter ego/piercing the corporate veil, amalgamation of interests, conversion, a survival action under S.C. Code Ann. § 15-5-90, and a wrongful death action under S.C. Code Ann. § 15-51-10. An Affidavit of Service was filed September 18th, 2019, certifying that the Summons and Complaint were served on Lynanne Gares, Litigation Management Services Leader, for Defendant Hunt Valley Holdings, LLC on September 12th, 2019. An Affidavit of Service was filed September 18th, 2019 certifying that the Summons and Complaint were served on Lynanne Gares, Litigation Management Services Leader, for Defendant THI of Baltimore, Inc. on September 12th, 2019. An Affidavit of Service was filed September 18th, 2019, certifying that the Summons and Complaint were served on Trey Williams, Billing Administrator, for Defendant THI of South Carolina, LLC on September 12th, 2019. An Affidavit of Service was filed September 18th, 2019 certifying that the Summons and Complaint were served on Trey Williams, Billing Administrator for Defendant THI of South Carolina at Camp Care, LLC d/b/a Lake Emory Post Acute Care on September 12th, 2019.

Defendant THI of South Carolina, LLC filed an Answer to the Complaint on October 14th, 2019. Defendant Hunt Valley Holdings, LLC filed an Answer to the Complaint on October 14th, 2019. Defendant THI of Baltimore, Inc. filed an Answer to the Complaint on October 14th, 2019. Defendant Casey Caddell filed an Answer to the Complaint on October 14th, 2019. Defendant THI of South Carolina at Camp Care, LLC d/b/a Lake Emory Post Acute Care filed an Answer to the Complaint on October 14th, 2019.

Defendant THI of South Carolina at Camp Care, LLC d/b/a Lake Emory Post Acute Care filed a Motion to Stay the Action and Compel Arbitration on October 28th, 2019. Defendant Hunt

Valley Holdings, LLC filed a Motion to Stay on October 28th 2019. Defendant THI of Baltimore, Inc. filed a Motion to Stay on October 28th, 2019. Defendant THI of South Carolina, LLC filed a Motion to Stay on October 28th, 2019. Defendant Casey Caddell filed a Motion to Stay the Action and Compel Arbitration on December 9th, 2019.

FACTUAL BACKGROUND:

This is a professional negligence case involving Irene Ramsey (hereinafter “Ms. Ramsey”), who was admitted to Defendant’s facility for rehabilitative purposes after suffering a fall at home resulting in a fractured femur. After admission, Ms. Ramsey suffered an additional fall at Defendant’s facility. Plaintiff alleges that this fall was caused by Defendant’s negligence and proximately caused Ms. Ramsey’s death. Plaintiff filed this action shortly thereafter. Defendant subsequently filed the present Motion to Dismiss and Compel arbitration.

On February 6, 2017, Rita St. Aubin executed the Admission Agreement and Arbitration Agreement on behalf of Irene Ramsey. The Admission Agreement and Arbitration Agreement were two separate agreements. This separation is evidenced by several factors. For instance, the Agreements are separately numbered and separately titled; and the Admission Agreement provided an opt-out option where either party could terminate the Admission Agreement, while the Arbitration Agreement did not provide such a provision. Further, the Arbitration Agreement itself does not contain language stating that it is voluntary and not a precondition to admission. As discussed below, material terms in the Arbitration Agreement are vague or missing. Specifically, the Arbitration Agreement fails to state where or how the parties shall choose the arbitration from a “panel” or who is responsible for the arbitration fees. At the hearing, the parties agreed the Federal Arbitration Act (“FAA”) governs the Arbitration Agreement.

LEGAL ANALYSIS AND FINDINGS:

The Arbitration Agreement that is the subject of this Motion is governed by the FAA. There is a presumption in favor of the enforcement of arbitration agreements. However, this presumption only applies where there is a valid arbitration agreement. EEOC v. Waffle House, Inc., 534 U.S. 279, 293-294, 122 S. Ct. 754, 764, 151 L.Ed.2d 755 (2002); Toler's Cove Homeowners Ass'n, Inc., v. Trident Constr. Co., Inc., 355 S.C. 605, 612, 586 S.E.2d 581 (2003). Where the FAA does apply, the Arbitration Agreement is subject to the same defenses applicable to all other contracts as discussed below. Rent-A-Center, West, Inc. v. Jackson, 561 U.S. 63, 130 S.Ct. 2772, 2776, 177 L.Ed.2d 403 (2010).

This Court also interprets jury trial waivers narrowly and construes contract ambiguities against the Defendant as the drafter of the Arbitration Agreement. See WDI Meredith & Co. v. American Telesis, Inc., 359 S.C. 474, 480, 597 S.E.2d 885 (Ct. App. 2004); Simpson v. MSA of Myrtle Beach, Inc., 373 S.C. 14, 644 S.E.2d 663, 668 (2007). Whether the parties agreed to arbitrate is a question of substantive state law. The South Carolina Supreme Court has stated “[a]lthough we are constrained to resolve all doubts in favor of arbitration, this is not an absolute truism intended to replace careful judicial analysis.” Chassereau v. Global Sun Pools, Inc., 373 S.C. 168, 644 S.E.2d 718, 720-21 (2007). Where the FAA looks to state law to decide the threshold questions of contract formation, the Arbitration Agreement is subject to the same defenses applicable to other contracts. Consequently, this Court’s inquiry included an examination of contractual defects such as lack of mutual assent, consideration, ambiguity, vagueness, and unconscionability to determine the enforceability of the Arbitration Agreement.

As a threshold matter, this Court notes that Plaintiff first argued the Arbitration Agreement was an involuntary precondition to admission in violation of federal law, because of language in

the Admission Agreement coupled with the failure to state in the Arbitration Agreement that the agreement was voluntary and not a pre-condition to admission. Berkebile v. Outen, 311 S.C. 50, 53, 426 S.E.2d 760, 762 (1993); See 42 C.F.R. § 489.30; 42 C.F.R. § 447.15; 42 U.S.C. § 1396r(c)(5)(A)(iii). The Court finds this argument unpersuasive.

I. Material Terms of the Arbitration Agreement are Vague, Indefinite, and Omitted

The Court finds the Arbitration Agreement at issue is, at best, ambiguous. Moreover, material terms of the Arbitration Agreement are vague and indefinite, and in some respects completely omitted, requiring this Court to find the Arbitration Agreement unenforceable. Indeed, an agreement that omits material terms may be determined to be unenforceable for indefiniteness. In Grant v. Magnolia Manor-Greenwood, Inc., our South Carolina Supreme Court spoke to the proof required to establish an enforceable agreement to arbitrate:

Arbitration is a matter of contract, and our evaluation of the enforceability of an arbitration agreement is guided by general principles of contract law. Munoz v. Green Tree Fin. Corp., 343 S.C. 531, 538, 542 S.E.2d 360, 364 (2001). The parties to an arbitration agreement are at liberty to choose the terms under which they will arbitrate. Dowling v. Home Buyers Warranty Corp., II, 311 S.C. 233, 236, 428 S.E.2d 709, 710 (1993). In order to have a valid and enforceable contract, there must be a meeting of the minds between the parties with regard to all essential and material terms of the contract. Player vs. Chandler, 299 S.C. 101, 105, 382 S.E.2d 891 (1989). An agreement that omits material terms may be determined to be unenforceable for indefiniteness. Lindsay v. Lindsay, 491 S.E.2d 583 (S.C. App. 1997); Ellis v. Taylor, 449 S.E.2d (S.C. App. 1994).

383 S.C. 125, 678 S.E.2d 435 (2009).

“Ordinarily, a court will not supply omitted terms to an agreement, and an agreement where the parties did not agree to essential terms will simply not be enforced.” Id. In the case at hand, even if the contract was validly executed, this Court finds there was not a “meeting of the minds” as to the essential terms of arbitration.

Specifically, the arbitration agreement is silent as to what “panel” the arbitrator is to be chosen from or who pays for arbitration. The choice of an arbitrator is an important, essential, and material term of an agreement to arbitrate, and to say otherwise undermines the purpose of the arbitration process. Without a designated process to select an arbitrator from a “panel” to choose from, or any indication of what that “panel” would be or who it includes, the Court would be forced to fill in the parties’ alleged contract with an arbitrator selection clause. Again, the Arbitration Agreement that is the subject of this motion simply states that the “parties shall select an arbitration from a panel having experience and knowledge of the health care industry” and, if the parties cannot reach a mutual decision on the selection of an arbitrator, the parties agree that an arbitrator shall be selected by the Court. The process for doing so is vague and indefinite.

Even if the court assumes that the Arbitration Agreement did clearly provide direction to the parties as to where or what the “panel” is to choose the arbitrator from, the Arbitration Agreement remains vague to other material terms as well. Specifically, the Arbitration Agreement does not indicate who is to pay for the arbitrator’s fees. There can be no doubt that this is a material and essential term of the Arbitration Agreement. This is important for two (2) reasons. First, even if the Court assumes the Arbitration Agreement is enforceable, the parties would have to, once again, ask the Court to add terms outside of the Arbitration Agreement as to who pays for the arbitration itself. This Court declines to do so. Second, had language regarding payment of arbitration fees been included in the Arbitration Agreement it could have potentially been considered additional consideration.

Simply put, the parties cannot be bound to act on a promise that does not exist. If the Court found the Arbitration Agreement enforceable, the parties would then have to make arrangements and additional agreements outside of the Arbitration Agreement to begin the arbitration process or

ask the Court to create those terms. Due to the vagueness and indefiniteness of the Arbitration Agreement's provisions and the lack of a "meeting of the minds" as to these essential terms, there is no enforceable contract.

Consequently, the Court finds that, because the Arbitration Agreement is vague, contains indefinite terms, omits essential and material terms, and lacks valid consideration, the Arbitration Agreement is unenforceable.

II. The Arbitration Agreement Lacks Valuable Consideration Necessary to Form an Enforceable Contract

Plaintiff argued the Admission Agreement is unenforceable due to lack of valid consideration. The Court agrees it is axiomatic that every contract in South Carolina be supported by mutual consideration in order to be valid and enforceable. Defendant argued the Arbitration Agreement was not involuntary and instead made in consideration of admission. However, as discussed below, this does not constitute effective consideration to make the Arbitration Agreement enforceable.

While federal law preempts state laws that would invalidate arbitration agreements on most public policy grounds, the FAA looks to state law to decide the threshold questions of contract formation. Munoz v. Green Tree Financial Corp., 343 S.C. 531, 542 S.E.2d 360, 364 (2001); Towles v. United Healthcare Corp., 338 S.C. 29, 37, 524 S.E.2d 839, 844 (Ct. App. 1999) ("the court should apply 'ordinary state-law principles that govern the formation of contracts.'"). Therefore, arbitration agreements guided by the FAA are subject to the same defenses applicable to all other contracts. Rent-A-Center, West, Inc., 561 U.S. at 63, 130 S.Ct. at 2776; Simpson, 373 S.C. at 14, 644 S.E.2d at 663 ("general contract principles of state law apply in a court's evaluation of the enforceability of an arbitration clause."). The necessary elements of a contract are an offer,

acceptance, and valuable consideration. Sauner v. Public Service Authority of S.C., 354 S.C. 397, 581 S.E.2d 161, 166 (2003). “Valuable consideration to support a contract may consist of some right, interest, profit or benefit accruing to one party or some forbearance, detriment, loss or responsibility given, suffered or undertaken by the other.” Plantation A.D., LLC v. Gerald Builders of Conway, Inc., 386 S.C. 198, 206, 687 S.E.2d 714, 718 (Ct. App. 2009) (quoting Prestwick Golf Club, Inc. v. Prestwick Ltd. P'ship., 331 S.C. 385, 389, 503 S.E.2d 184, 186 (Ct. App. 1998)). Where a contract lacks valuable consideration, the contract will be deemed unenforceable.

Our courts have held that where there is a mutual promise to arbitrate, there must be additional consideration. See Reidman Corp. v. Jarosh, 290 S.C. 252, 253, 349 S.E.2d 404, 405 (1986). However, in determining whether adequate consideration exists in a contract, or arbitration agreement under the FAA guided by principles of contract law, our courts must examine and stay within the confines of the four corners of the instrument. State Accident Fund v. S.C. Second Injury Fund, 388 S.C. 67, 76, 693 S.E.2d 441, 445 (Ct. App. 2010) (internal citations omitted). Ms. St. Aubin was asked to sign the Admission paperwork upon Ms. Ramsey’s presentation to the facility. Ms. St. Aubin was also asked to sign the separate Arbitration Agreement. Having already signed the admission paperwork, there was no additional consideration in agreeing to the Arbitration Agreement itself. Therefore, neither party gained a right, interest, profit, or benefit by agreeing to the Arbitration Agreement. Additionally, neither party suffered a forbearance, detriment, loss or responsibility given, suffered, or undertaken by the other party when agreeing to the Arbitration Agreement. Finally, viewing the Arbitration Agreement itself within its four corners, there is no mention of consideration. Therefore, after analyzing the four corners of the Arbitration Agreement itself, this Court finds no valuable consideration exists. As such, the Arbitration Agreement is unenforceable.

CONCLUSION:

The Court acknowledges and appreciates the amount of research and preparation for the hearing by all counsel, as well as, the professionalism of all counsel in their presentations to the Court. After consideration of the record, arguments of counsel, memorandum of counsel, and the applicable law, and for the reasons set forth above, it is Ordered that Defendant THI of South Carolina at Camp Care, LLC d/b/a Lake Emory Post Acute Care's Motion to Compel Arbitration is denied; and

It is further ordered that Defendants THI of South Carolina, LLC, Hunt Valley Holdings, LLC, THI of Baltimore, Inc., and Casey Caddell as Officer/Manager of THI of South Carolina at Camp Care, LLC d/b/a Lake Emory Post Acute Care's Motions to Stay Action are denied, as those Motions are now moot.

IT IS SO ORDERED.

/s/Grace Gilchrist Knie
Honorable Grace Gilchrist Knie
Resident Judge, Seventh Judicial Circuit

January 8th, 2020
Spartanburg, South Carolina



Spartanburg Common Pleas

Case Caption: Irene Ramsey VS Thi Of South Carolina At Camp Care, Llc ,
defendant, et al
Case Number: 2019CP4203236
Type: Order/Other

IT IS SO ORDERED.

S/GRACE GILCHRIST KNIE - 2760

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ELECTRONICALLY FILED - 2020 Jan 09 4:45 PM - SPARTANBURG - COMMON PLEAS - CASE#2019CP4203236
ELECTRONICALLY FILED - 2021 Mar 15 12:49 PM - SPARTANBURG - COMMON PLEAS - CASE#2020CP4203818

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
COUNTY SPARTANBURG	)	SEVENTH JUDICIAL CIRCUIT
	)	
Betty Nanney, by and through her	)	
Attorney-In-Fact, Leslie Nanney,	)	CIVIL ACTION NO.: 2019-CP-42-03075
	)	
Plaintiffs,	)	Order regarding Defendants' Motion to
	)	Compel Arbitration
vs.	)	
	)	
THI of South Carolina at Spartanburg, LLC	)	
d/b/a Magnolia Manor-Spartanburg, Rusty	)	
Flathmann, Laura Anne Winn, and Olishia	)	
Gaffney,	)	
	)	
Defendants.	)	
_____	)	

Hearing Date:	December 16 th , 2019, at 2:30 p.m.
Hearing Judge:	Grace Gilchrist Knie
Counsel for Plaintiffs:	Raymond Paul Mullman, Jr., Gary W. Poliakoff, & Edward John Waelde
Counsel for Defendants:	Russell G. Hines
Court Reporter:	Sandy Satterwhite

This matter was before the Court on Monday, December 16th, 2019, at 2:30 p.m., in Spartanburg County, SC, the Seventh Judicial Circuit upon Defendants' Motion to Compel Arbitration. Attorneys Raymond Paul Mullman, Jr., Gary W. Poliakoff, and Edward John Waelde of Poliakoff & Associates, P.A. were present representing the interests of the Plaintiffs. Attorney Russell G. Hines of Young Clement Rivers was present representing the interests of the Defendants. Sandy Satterwhite was the Court Reporter.

PROCEDURAL BACKGROUND:

This matter began with the filing of a Summons and Complaint on September 4th, 2019, asserting the causes of action of negligence/recklessness, neglect of a vulnerable adult, and negligent administration arising from Defendants' failure to monitor and supervise Ms. Nanney's



safety and well-being while at the Facility. An Expert Affidavit was filed September 4th, 2019. A Proof of Service filed September 17th, 2019, certified that a recorded copy of the Summons and Complaint and Expert Affidavit were deposited in the United States Mail to the Registered Agent, Corporation Service Company, for THI of South Carolina at Spartanburg, LLC. An Acceptance of Service was filed September 17th, 2019, acknowledging receipt of the Summons and Complaint by Attorney D. Jay Davis, Jr. on behalf of Defendant Laura Anne Winn. An Acceptance of Service was filed September 17th, 2019, acknowledging receipt of the Summons and Complaint by Attorney D. Jay Davis, Jr. on behalf of Defendant Olishia Gaffney. An Acceptance of Service was filed September 17th, 2019, acknowledging receipt of the Summons and Complaint by Attorney D. Jay Davis, Jr. on behalf of Defendant Rusty Flathmann.

Defendant THI of South Carolina at Spartanburg, LLC d/b/a Magnolia Manor-Spartanburg filed an Answer to the Complaint on October 9th, 2019. Defendant Laura Anne Winn filed a Motion to Dismiss the Plaintiff's Complaint on October 11th, 2019. Defendant Rusty Flathmann filed an Answer to Plaintiff's Complaint on October 11th, 2019. Defendant Olishia Gaffney filed an Answer to Plaintiff's Complaint on October 11th, 2019. Defendant THI of South Carolina at Spartanburg, LLC d/b/a Magnolia Manor-Spartanburg filed a Motion to Dismiss Plaintiff's Complaint, Motion to Compel Arbitration, and Motion to Stay State Court Proceedings on November 11th, 2019. Defendant Rusty Flathmann filed a Motion to Dismiss Plaintiff's Complaint, Motion to Compel Arbitration, and Motion to Stay State Court Proceedings on November 11th, 2019. Defendant Olishia Gaffney filed a Motion to Dismiss Plaintiff's Complaint, Motion to Compel Arbitration, and Motion to Stay State Court Proceedings on November 11th, 2019. The parties were before the Court on Monday, December 16th, 2019, to take up these Motions.

FACTUAL BACKGROUND:

This matter arises out of a nursing home neglect case where alleging that Ms. Nanney was injured as a result of Defendants' negligence fracturing her hip. Ms. Nanney was admitted into the Facility on October 28, 2016. Defendant has represented that agreeing to arbitrate was not a prerequisite to admission at the Facility or a condition of admission. It is undisputed that Betty Nanney did not sign the Arbitration Agreement, despite being lucid and competent. No power of attorney existed at the time of the admission into the nursing home on October 28, 2016. Leslie Nanney is Ms. Nanney's daughter. Betty Nanney granted Power of Attorney to Leslie Nanney on June 23, 2017, approximately eight months after admission. Neither Betty nor Leslie Nanney signed the Arbitration Agreement. Kaileb Horn (Kaileb), Ms. Nanney's son, signed the Arbitration Agreement. At no point in time did Kaileb Horn have Power of Attorney or any other legal authority that would have given Kaileb the legal authority to bind Ms. Nanney to arbitration. Plaintiff's provided an affidavit from Kaileb that stated: "My mother was not in the room and could not and did not make any indication or statement that I was her agent or power of attorney during the admission process. The admission process was quick and occurred while my mother was already transferred into her room." Defendants did not offer any evidence to contradict the affidavit. Defendants did not provide an affidavit from Kris Milner, the signatory for the nursing home, to support the Motion to Dismiss. The basis of apparent authority is representations made by the principal to the third party and reliance by the third party on those representations. In this case, there is no evidence of apparent authority and Defendants did not rely on any representation as a condition of admission.

BURDEN OF PROOF:

Defendant carries the burden to prove a valid and enforceable arbitration contract. Not all arbitration clauses are per se enforceable.¹ Courts interpret a jury trial waiver narrowly and construe contract ambiguities against Defendant who drafted the Arbitration Agreement.² Whether the parties agreed to arbitrate is a question of substantive state law.³ In Chassereau v. Global Sun Pools, Inc., 644 S.E.2d 718 (S.C. 2007), the Supreme Court stated:

Although we are constrained to resolve all doubts in favor of arbitration, this is not an absolute truism intended to replace careful judicial analysis. While actions taken in an arrangement such as the one entered into by these parties might have the potential to generate several legal claims and causes of action, we have no doubt that Chassereau did not intend to agree to arbitrate the claims she asserts in the instant case. Accordingly, we hold that these claims are not covered by the arbitration agreement at issue in the instant case.

Thus, the presumption favoring arbitration only applies after this Court finds there is a valid, enforceable arbitration agreement.⁴ The mandatory language in the Federal Arbitration Act (“FAA”) only applies in instances where a valid arbitration agreement has been well established. This is self-evident from the FAA provisions: “The court shall make an order directing the parties to proceed to arbitration” but only “upon being satisfied that the making of the agreement...is not in issue.” 9 U.S.C. § 4. The FAA looks to state law to decide the threshold questions of contract formation.⁵ Therefore, arbitration agreements guided by the FAA are subject to the same defenses

¹ See Aiken v. World Finance Corp. of S.C., 373 S.C. 144, 149, 644 S.E.2d 705, 708 (2007); MBNA America Bank, N.A. v. Christianson, 377 S.C. 210, 659 S.E.2d 209 (S.C. Ct. App. 2008).

² Nat’l Acceptance Co., 381 F.Supp. at 271).

³ Simpson v. MSA of Myrtle Beach, Inc., 373 S.C. 14, 644 S.E.2d 663, 668 (S.C. 2007)(“General contract principles of state law apply in a court’s evaluation of the enforceability of an arbitration clause.”).

⁴ EEOC v. Waffle House, 534 U.S. 279, 293-294, 122 S.Ct. 754, 764, 151 L.Ed.2d 755 (4th Cir. 2014); Toler’s Cove Homeowners Ass’n v. Trident Constr. Co., Inc., 355 S.C. 605, 612, 586 S.E.2d 581 (2003).

⁵ Munoz v. Green Tree Fin. Corp., 343 S.C. 531, 542 S.E.2d 360, 364 (2001); Towles v. United Healthcare Corp., 338 S.C. 29, 37, 524 S.E.2d 839, 844 (Ct. App. 1999) (“the court should apply ‘ordinary state-law principles that govern the formation of contracts.’”).

applicable to all other contracts.⁶ The judicial inquiry may include an examination of contractual defects such as lack of mutual assent and want of consideration, as well as other grounds existing at law or equity, including fraud, duress, and unconscionability.⁷ In short, pro-arbitration policy does not validate a contract lacking the building blocks of a binding contract.

LEGAL ANALYSIS:

Defendants' motion to compel arbitration is effectively a motion to enforce a contract. Defendants had no such contract with Ms. Nanney. The "Arbitration Agreement" on which Defendants' motion relies is invalid because there can be no contract without the mutual assent of its proposed parties. Ms. Nanney never assented to the Arbitration Agreement and did not empower anyone else to assent on her behalf.

A. Signatory Had No Legal Authority.

"The first element of a contract is that the parties have the capacity to contract... Further, capacity to contract relates to the status of the person rather than to circumstances surrounding the contract." (17 C.J.S. Contracts §32). Kaileb Horn did not have that authority. Defendants have produced no evidence indicating that Kaileb Horn had authority to enter a contract on Ms. Nanney's behalf or to waive Ms. Nanney's right to a jury trial.

For agency situations, the legal burden is on the party asserting that an agency exists.⁸ In this case, Defendant must show all necessary elements of an agency relationship are "clearly established" by the facts. Id. A party dealing with an agent has a duty to use due care to ascertain the scope of the agent's authority to act. Id. An agency may not, however, be established solely

⁶ Rent-A-Center, West, Inc. v. Jackson, 561 U.S. 63, 130 S. Ct 2772, 2776, 177 L.Ed.2d 403 (2010) Simpson, 373 S.C at 14, 644 S.E.2d at 663 ("general contract principles of state law apply in a court's evaluation of the enforceability of an arbitration clause.").

⁷ See Sydnor v. Conseco Fin. Servicing Corp., 252 F.3d.302, 205 (4th Cir.2001).

⁸ Frasier v. Palmetto Homes of Florence, Inc., 323 S.C. 240, 244, 473 S.E.2d 865, 867 (Ct. App. 1996).

by the declarations and conduct of an alleged agent.⁹ South Carolina law requires that to prove apparent authority the Defendants must show: 1) that the purported principal consciously or impliedly represented to another to be his agent, 2) that there was reliance upon the representation, and 3) that there was a change of position to the relying party's detriment. Cownburn v. Leventis, 366 S.C. 39, 619 S.E.2d 448 (Ct. App. 2005). The basis of apparent authority is representations made by the principal to the third party and reliance by the third party on those representations. Young v. S.C. Department of Disabilities and Special Needs, 374 S.C. 360, 367, 649 S.E.2d 488, 491 (2007). The proper focus in determining a claim of apparent authority is not on the relationship between the principal and the agent but that between the principal and the third party. Vereen v. Liberty Life Insurance Company, 306 S.C. 423, 412, S.E.2d 425 (Ct. App. 1991). Defendant has failed to provide any evidence beyond Kaileb Horn's signature to suggest he was Ms. Nanney's agent. The fact that Kaileb signed documents so that Ms. Nanney could be admitted to the facility and receive medical care in no way indicates a manifestation of authority by Ms. Nanney to waive her right to a jury trial or agree to arbitration. There has been no evidence that Ms. Nanney ever manifested any form of assent establishing Kaileb as her agent.

Kaileb was one of Ms. Nanney's children. He was not Ms. Nanney's attorney-in-fact. He had no legal authority to enter contracts on Ms. Nanney's behalf. The Supreme Court of South Carolina has held that a surrogate without proper legal authority cannot bind a person to arbitration.

The scope of Sister's authority to consent to "decisions concerning Decedent's health care" extended to the admission agreement, which was the basis upon which Facility agreed to provide health care and Sister agreed to pay for it. The separate arbitration agreement concerned neither health care nor payment, but instead provided an optional method for dispute resolution between Facility and Decedent or Sister should issues arise in the future. Under the Act, Sister did not have the capacity to bind Decedent to this voluntary

⁹ Muller v. Myrtle Beach Golf & Yacht Club, 303 S.C. 137, 142-143, 399 S.B.2d at 433 (Ct. App. 1990) overruled on other grounds by Myrtle Beach Hosp., Inc. v. City of Myrtle Beach, 341 S.C. 1, 532 S.E.2d 868 (2000)).

arbitration agreement. We therefore affirm the circuit court's holding that the Act did not confer authority on Sister to execute a document which involved neither health care nor financial terms for payment of such care.

Coleman v. Mariner Health Care, Inc., 407 S.C. 346, 353-54, 755 S.E.2d 450, 454 (2014).

In Coleman, the circuit court refused to compel arbitration because the sister of a nursing home resident who signed the arbitration and admission agreements lacked authority to bind her sister to the arbitration agreement. In affirming the circuit court's order, the Supreme Court found that, although the South Carolina Adult Healthcare Consent Act gave the sister authority to make 'healthcare decisions' on behalf of her sister, consent for medical treatment is not the same as binding an incompetent person to a legally binding contract such as an arbitration agreement. Coleman, 407 S.C. at 352, 755 S.E.2d at 453-54. The court reasoned that the Act extends authority to surrogates to make traditional healthcare decisions and financial decisions that arise out of those decisions. Id. Kaileb had no legal authority to sign the Arbitration Agreement, and Defendant knew or should have known this fact. Since Kaileb lacked legal authority to enter into a contract; the arbitration agreement is void and unenforceable.

B. Equitable estoppel, ratification and third-party beneficiary theories do not apply.

Arbitration contracts concerning interstate commerce are governed by the FAA but its provisions apply state law to enforceability questions such as the application of equitable estoppel. 9 U.S.C. § 2 (requiring enforcement of arbitration contract "save upon such grounds as exist at law or in equity for the revocation of any contract"). The FAA does not "alter background principles of state contract law regarding the scope of agreements (including the question of who is bound by them)." Arthur Anderson LLP v. Carlisle, 556 U.S. 624, 630 (2009). Arthur Andersen specifically applied this principle to equitable estoppel arguments. Id. at 632 (noting question on remand was "whether the relevant state contract law recognizes equitable estoppel").

Defendants argued that Ms. Nanney should be estopped from denying the validity of the Arbitration Agreement because Ms. Nanney accepted the benefits of the Admission Agreement and, therefore, should not be able to repudiate the alleged Arbitration Agreement. However, Defendant's argument fails because it depends on Defendants' faulty merger argument, and Ms. Nanney did not receive a benefit from the Arbitration Agreement.

Defendants allege Plaintiff is equitably estopped from opposing enforcement of the Arbitration Agreement. Equitable estoppel is a contract defense for which the asserting party "bears the burden of establishing all the elements." Kelly v. Logan, Jolley & Smith, 383 S.C. 626, 638, 682 S.E.2d 1,7 (Ct. App. 2009). Equitable estoppel requires proof that the party to be estopped (1) acted in a way amounting to a false representation; (2) intended that such conducted be acted on by the other party; and (3) had actual or constructive knowledge of the real facts. Strickland v. Strickland, 375 S.C. 76, 84, 650 S.E.2d 465, 470 (2007). The party asserting estoppel must (1) lack knowledge and the means of knowledge of the truth of the facts in question; (2) rely on the conduct of the party estopped; and (3) make a prejudicial change in position in reliance on conduct of the party to be estopped. Id.

In the case at hand, Defendants have not established the elements required to prove equitable estoppel. First, there is no evidence Defendants lacked knowledge Kaileb was not authorized to bind Ms. Nanney to the Arbitration Agreement. Additionally, Kaileb did not have power of attorney over Ms. Nanney nor did Defendant produce evidence that Ms. Nanney represented the same to Defendant. The affidavit of Kaileb Horn states that Ms. Nanney, while lucid, was unable to make verbal representation. Defendants have produced no evidence that Ms. Nanney made any representation of any agency of Kaileb.

Defendants argued Ms. Nanney created an agency relationship to support arbitration because she accepted admission. Defendants then argued Kaileb is estopped from denying authority to bind Ms. Nanney to arbitration because he does not deny authority to admit Ms. Nanney to the Facility. Finding merger would be a prerequisite to accepting Defendant's arguments, but Coleman and its progeny rejected similar merger arguments.

The Admission Agreement and Arbitration Agreement are separate contracts that do not merge. See Hodge v. UniHealth Post-Acute Care of Bamberg, LLC, 422 S.C. 544, 573-74, 813 S.E.2d 292, 308 (Ct. App. 2018) (cert. denied Aug. 21, 2018); Thompson v. Pruitt Corp., 416 S.C. 43, 55, 784 S.E.2d 679, 686 (Ct. App. 2016); Coleman v. Mariner Health Care, Inc., 407 S.C. 346, 352, 755 S.E.2d 450 (2014) (Coleman refused to apply the merger doctrine because language in the contracts "recognize[d] the 'separateness' of the admission and arbitration agreements." 407 S.C. at 355, 755 S.E.2d at 455. Thompson and Hodge applied Coleman and provided further examples of factors demonstrating "separateness" and preventing merger. 416 S.C. at 52, 784 S.E.2d at 684; 422 S.C. at 563, 813 S.E.2d at 302.

As discussed above briefly, there were two separate agreements signed on the day of the admission, and they were not merged. By their own terms, the Admission Agreement indicated an intent that the common law doctrine of merger not apply. The Admission Agreement's "Entire Agreement"¹⁰ provision shows that one contract constituted "the entire agreement and understanding between the parties" concerning admission to the Facility and prohibits merging the two separate agreements. An admission contract with an "Entirety of Agreement" provision is separate "on its face" from an arbitration contract where the provision identifies the two contracts

¹⁰ "I/we hereby acknowledge that I/we have read this page and all preceding pages and acknowledge that this Agreement represents the entire agreement and understanding between the parties and supersedes all previous representations, understandings or agreements, oral or written, between the parties and may not be amended except by written agreement of the parties."

distinctly—i.e. “this [Admission] Agreement *or* in the Arbitration Agreement.” Coleman, 407 S.C. at 355, 755 S.E.2d at 455 (emphasis added). Even if the “Entire Agreement” clause creates an ambiguity as to merger, the law is clear that any ambiguity must be construed against the drafter, in this case, Defendants.¹¹ Since there was no merger here, Defendants’ equitable estoppel argument must be denied. See Coleman, 407 S.C. at 355–56, 755 S.E.2d at 455 (rejecting estoppel argument by finding no merger).

As in Hodge, the separate contracts here have separate signature pages and separate pagination—i.e. the Admission Agreement ends with “Page 12 of 12” while the Arbitration Agreement is a separate document. As in Thompson, the arbitration agreement announces its independence with its “Arbitration Agreement” title.

The arbitration and admission contracts have different pagination with different signature pages and the arbitration contract has “Arbitration Agreement” at the top its first page, these factors further indicate the parties’ intent for it to stand by itself as an independent contract.” Thompson, 416 S.C. at 53 n. 1, 784 S.E.2d at 685 n. 1; Hodge, 422 S.C. at 562-63, 813 S.E.2d at 302. Separateness is further demonstrated when the nursing home makes clear that agreeing to arbitrate is not required to gain admission to the home. Thompson, 416 S.C. at 53, 784 S.E.2d at 685; Hodge, 422 S.C. at 562-63, 813 S.E.2d at 302.

The Facility cannot meet its burden to prove merger. The Admission Agreement and Arbitration Agreement are distinct and should not be construed as a unit. So long as the admission and arbitration contracts are separate documents, any alleged misrepresentations made by a resident’s family member when signing the contracts would not equitably estop the resident’s attorney-in-fact from challenging the family member’s authority to bind the resident to arbitration.

¹¹ See Davis v. KB Home of S.C., Inc., 394 S.C. 116, 713 S.E.2d 799 (Ct.App.2011) fn. 4.

A family member who signs an arbitration contract without legal authority to bind the resident acts in her individual capacity and his misrepresentations, if any, would have no bearing on claims against the home by the resident even if the misrepresenting family member is also the attorney-in-fact for the resident. Thompson, 416 S.C. 43, 62, 784 S.E.2d 679 (Ct. App. 2016) (finding nursing home “may not hold [resident’s] estate responsible for any possible misrepresentations Son or Daughter may have made in their individual capacities”).

Therefore, Defendants cannot prove merger of the Admission Agreement and Arbitration Agreement. Defendants can also not claim to have been misled and cannot rely on equitable estoppel if they, by the exercise of reasonable diligence, could have acquired knowledge to determine the truth of facts in questions.¹² Furthermore, Defendants had the capacity to determine whether Kaileb had authority to sign the Arbitration Agreement on Ms. Nanney’s behalf. Defendants are a sophisticated business entity frequently interacting with residents and their families during the nursing home admission. Defendants are familiar with the legal concepts of guardianship and powers-of-attorney and had the ability to ask Kaileb for any power of attorney documentation.

Defendants then argued Ms. Nanney’s admission to the Facility was the required “direct benefit.” In doing so, Defendant tied its estoppel argument to the merger argument. See Coleman, 407 S.C. at 355, 755 S.E.2d at 455 (noting nursing home’s “equitable estoppel argument is premised on [the home’s] contention that, under state law, the admission agreements and the [arbitration agreements] merged”). Admission can be the “direct benefit” that forces Plaintiff to arbitrate only if admission and arbitration are governed by the same contract. For the reasons

¹² See Binkley v. Rabon Creek Watershed Conservation Dist. of Fountain Inn, 348 S.C. 58, 70-71, 558 S.E.2d 902, 908-909 (Ct. App. 2001).

outlined above, the two contracts are separate, they do not merge, and Ms. Nanney's admission does not support equitable estoppel.

Precedent is decisive on this point. Citing International Paper, the Court of Appeals held in Thompson that any benefit of admission "is of no moment" for the application of equitable estoppel to a separate arbitration contract. 416 S.C. at 59-60, 784 S.E.2d at 688; see also Coleman, 407 S.C. at 354-55, 755 S.E.2d at 455. Hodge cited and reaffirmed Thompson's estoppel analysis. 422 S.C. at 558-59, 813 S.E.2d at 300. Since admission is unavailable as a "direct benefit" to support estoppel, Defendants would be required to point to some benefit Ms. Nanney received from the Arbitration Agreement alone. However, Ms. Nanney derived no benefit from the Arbitration Agreement. Hodge, 422 S.C. at 563, 813 S.E.2d at 302 (finding family members, resident, and resident's estate "received no benefit from the Arbitration Agreement"). In sum, Defendants cannot meet their burden to prove merger. The Admission Agreement and Arbitration Agreement are distinct and should not be construed as a unit.

Defendants then argued ratification of her continued residency in Defendants' facility. To establish a ratification of the Arbitration Agreement Defendants must show (1) acceptance by the principal of the benefits of the agent's acts, (2) the principal's full knowledge of the facts, and (3) circumstances or an affirmative election demonstrating the principal's intent to accept the unauthorized arrangement. Lincoln v. Aetna Gas. & Sur. Co., 300 S.C 188, 191, 386 S.E.2d 801, 803 (Ct. App. 1989).

This argument fails for several reasons. First, Ms. Nanney's presence alone cannot constitute an affirmative representation. See Hodge where the court rejected the notion that a nursing home resident represents her/her family member has authority to enter an arbitration agreement on the resident's behalf simply by failing to object to the family member's signature.

422 S.C. at 573-74, 813 S.E.2d at 308 (noting home argued resident “represented” her husband had authority by “allowing him to procure her admission” but still finding “no evidence . . . that [the resident], as the principal, represented husband was her agent”).

Defendants argued Ms. Nanney accepted the benefits of the contracts. It is doubtful that the resident received a benefit from the Arbitration Agreement. Hodge was skeptical of the notion that admission was a benefit to the resident considering Complaint allegations that the nursing home’s acts during the admission caused the resident’s death. 422 S.C. at 563, 813 S.E.2d at 303 (“we find it difficult to find [resident] benefitted even from being admitted”).

However, the only alleged benefit Defendants cited is admission itself, a benefit Defendants have admitted to be separate from arbitration. Defendants never attempt to explain what supposed benefit of the independent Arbitration Agreement Ms. Nanney derived during her time as a resident in Defendants’ facility. The Court of Appeals’ ruling in Thompson speaks directly on this point, i.e., “any possible benefit emanating from the [arbitration agreement] alone is offset by the [arbitration agreement’s] requirement that [resident] waive her right to access the courts and her right to a jury trial.” 416 S.C. at 60, 784 S.E.2d at 688.

Defendants then made a broader argument that it would be manifestly inequitable for Plaintiff to pursue a tort claim based on the Admission Agreement while denying Kaileb’s authority to sign the Arbitration Agreement. The Adult Health Care Consent Act does provide statutory authority for family members to make an incapacitated loved one’s health care decisions, but leaves the conferral of authority to arbitrate for powers of attorney or other legal instruments outlined in the probate code. Coleman, 407 S.C. at 353, 755 S.E.2d at 454 (finding statutory power to make “health care” decisions limited to nursing home admission and related financial decisions).

Lastly, Defendants claimed that the agreement is enforceable under a theory of third-party beneficiary. See Thompson, 416 S.C. at 57, 784 S.E.2d at 687 (holding as to the arbitration agreement between the appellants and Son in his individual capacity, a third-party beneficiary to an arbitration agreement cannot be required to arbitrate a claim unless the third party is attempting to enforce the contract containing the arbitration agreement.) With no valid underlying contract, there could be no third-party beneficiary. First, Plaintiff's action sounds solely in tort. There is no breach of contract claim asserted. Plaintiff's pleading does not specifically refer to any written contract or necessarily rely upon the language of any written contract. Plaintiff's tort claims presumably are based on common law and statutory or regulatory duties imposed by law. Second, as discussed above, the Arbitration Agreement is a separate and distinct agreement from the Admission Agreement. Plaintiff does not rely upon the terms of the Arbitration Agreement to establish her tort claims.

C. Lack of consideration and mutuality.

The Arbitration Agreement is not a valid and enforceable agreement due to a lack of consideration and mutuality. Every contract must contain an offer, acceptance, and valuable consideration.¹³ “Valuable consideration to support a contract may consist of some right, interest, profit or benefit accruing to one party or some forbearance, detriment, loss or responsibility given, suffered or undertaken by the other.”¹⁴ Where a contract lacks valuable consideration, the contract must fail. Courts have held that where there is a mutual promise to arbitrate, there must be additional consideration. However, in determining whether adequate consideration exists in a contract, the Court must examine and stay within the confines of the four corners of the

¹³ Sauner v. Pub. Serv. Auth. of S.C., 581 S.E.2d 161, 166 (S.C. 2003).

¹⁴ Plantation A.D., LLC v. Gerald Builders of Conway, Inc., 386 S.C. 198, 206, 687 S.E.2d 714, 718 (Ct. App. 2009) (quoting Prestwick Golf Club, Inc. v. Prestwick Ltd. P'ship., 331 S.C. 385, 389, 503 S.E.2d 184, 186 (Ct.App.1998)).

instrument.¹⁵ Therefore, the Court must assess whether the contract itself contains sufficient consideration in the form of a mutual exchange of promises to arbitrate. Here, the Arbitration Agreement does not contain the required consideration. There is no direct benefit to nursing home residents from a pre-admission arbitration contract separate from the Admission Agreement. Admission can be the direct benefit that forces Plaintiff to arbitrate only if admission and arbitration are governed by the same contract. In this case, even assuming Kaileb had authority, there is no valuable consideration in agreeing to the Arbitration Agreement. The one-page agreement contains no benefit or detriment to the parties. Therefore, the Arbitration Agreement lacks consideration. Moreover, Defendant was prohibited from asking or receiving any consideration from Ms. Nanney. “Facilities must “not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the state plan...any other consideration as a precondition of admitting (or expediting the admission of) the individual to the facility or as a requirement for the individual’s continued stay at the facility.” 42 U.S.C. § 1396r(c)(5)(A)(iii). Any nursing home facility that accepts Medicare or Medicaid funds for resident care is expressly forbidden from accepting any other money, benefit or other consideration as a precondition for admitting a patient to the facility or as a requirement for continued stay in a facility.

In the instant case, it is undisputed Ms. Nanney was a Medicare and Medicaid beneficiary while residing at the Facility and the Facility was billing and accepting payment from Medicare and Medicaid for Ms. Nanney’s care. Therefore, the question of enforceability turns, in part, on whether the jury waiver provision was a mandatory part of the Admission Agreement and a required pre-condition to admission. Defendant has admitted the Arbitration Agreement was not a

¹⁵ State Acc. Fund v. S.C. Second Injury Fund, 388 S.C. 67, 76, 693 S.E.2d 441, 445 (Ct. App. 2010) (quoting McPherson v. J.E. Sirrine & Co., 206 S.C. 183, 204, 33 S.E.2d 501, 509 (1945)).

condition of admission, thus, there is no separate consideration offered for the arbitration agreement.

D. No meeting of the minds due to missing material terms.

A valid contract under South Carolina law requires a meeting of the minds between the parties with regard to all essential and material terms of the agreement.¹⁶ The forum chosen for the arbitration to take place is an essential and material term. A contract lacking material terms may be found unenforceable for indefiniteness.¹⁷ Here there was no meeting of the minds as to (1) the choice of arbitrator; (2) the rules of evidence; or (3) allowance of pre-hearing discovery. The choice of an arbitrator is an important, essential, and material term of an agreement to arbitrate. No rules for arbitration were included in or attached to the Arbitration Agreement. The parties cannot now arbitrate this dispute without the presence of an agreed-upon arbitrator chosen by this Court. But, “ordinarily, a court will not supply omitted terms to an agreement, and an agreement where the parties did not agree to essential terms will simply not be enforced.”¹⁸ As a result, the promise that the dispute “shall be resolved by arbitration, as provided by the South Carolina Alternate Dispute Resolution/Mediation Rules” is moot and ineffective. The choice of arbitral forum also dictates the rules of arbitration and the rights of the parties including, but not limited to, presentation of evidence, scheduling, deadlines, discovery issues, costs, expenses, and appeals. None of this was negotiated or discussed by the parties. No agreement or meeting of the minds to material terms exists.

¹⁶ Player v. Chandler, 299 S.C. 101, 105, 1989 (citing Hughes v. Edwards, 265 S.C.529 (1975)).

¹⁷ Lindsay v. Lindsay, 491 S.E.2d 583 (S.C. App. 1997).

¹⁸ Lindsay v. Lindsay, 491 S.E.2d 583 (S.C. App. 1997).

E. The Arbitration Agreement should not be enforced because it is both procedurally and substantively unconscionable.

In South Carolina, unconscionability is defined as the absence of meaningful choice on the part of one party due to one-sided contract provisions, together with terms that are so oppressive that no reasonable person would make them and no fair and honest person would accept them. Carolina Care Plan, Inc. v. United HealthCare Servs., Inc., 361 S.C. 544, 554, 606 S.E.2d 752, 757 (2004). If the Court as a matter of law finds any clause of a contract to have been unconscionable at the time it was made, the Court may refuse to enforce the agreement. S.C. Code Ann. § 36-2-302(1) (2003). In analyzing claims of unconscionability in the context of arbitration agreements, the Fourth Circuit has instructed courts to focus generally on whether the arbitration clause is geared towards achieving an unbiased decision by a neutral decision-maker. See Hooters of Am., Inc. v. Phillips, 173 F.3d 933, 938 (4th Cir.1999). It is under this general rubric that courts must determine whether a contract is unconscionable due to both an absence of meaningful choice and oppressive, one-sided terms.

Absence of meaningful choice on the part of one party generally speaks to the fundamental fairness of the bargaining process in the contract at issue. See Carlson v. General Motors Corp., 883 F.2d 287, 295 (4th Cir.1989). In determining whether a contract was "tainted by an absence of meaningful choice," Id. at 295, courts should take into account the nature of the injuries suffered by the plaintiff; whether the plaintiff is a substantial business concern; the relative disparity in the parties' bargaining power; the parties' relative sophistication; whether there is an element of surprise in the inclusion of the challenged clause; and the conspicuousness of the clause. Id. at 293. See also Holler v. Holler, 364 S.C. 256, 269, 612 S.E.2d 469, 476 (Ct.App.2005) ("A determination whether a contract is unconscionable depends upon all the facts and circumstances of a particular

case." (quoting 17A Am.Jur.2d Contracts§ 279 (2004))); see also Simpson v. MSA of Myrtle Beach, Inc., 373 S.C. 14, 25, 644 S.E.2d 663, 669 (2007).

CONCLUSION:

The Court acknowledges and appreciates the amount of research and preparation for the hearing by all parties, as well as, the professionalism of all parties in their presentations to the Court. In conclusion, in order to prevail in its motion, the Defendant Facility must show a valid and enforceable arbitration agreement between Ms. Nanney and the Facility to prevail on its motion. After consideration of the record, arguments of the parties, and the applicable law, the Court finds that Defendants did not meet this burden. After reviewing the parties' submissions and arguments, the Court finds no valid arbitration contract between Ms. Nanney and the Facility exists because: (1) Kaileb Horn did not have legal authority to bind Betty Nanney to the Arbitration Agreement; (2) there is a lack of consideration and mutuality under the circumstances; and (3) the affirmative defenses of equitable estoppel, ratification, and third-party beneficiary do not apply under the circumstances. Accordingly, for the foregoing reasons, Defendants' Motions to Dismiss and Compel Arbitration, or Alternatively, to Compel Arbitration and Stay Proceedings, are denied.

IT IS SO ORDERED.

/s/Grace Gilchrist Knie
 Honorable Grace Gilchrist Knie
 Resident Judge, Seventh Judicial Circuit

January 5th, 2020
 Spartanburg, South Carolina



Spartanburg Common Pleas

Case Caption: Betty Nanney , plaintiff, et al VS Thi Of South Carolina At
Spartanburg, Llc , defendant, et al
Case Number: 2019CP4203075
Type: Order/Other

IT IS SO ORDERED.

S/GRACE GILCHRIST KNIE - 2760

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ELECTRONICALLY FILED - 2021 Mar 15 12:49 PM - SPARTANBURG - COMMON PLEAS - CASE#2020CP4203818

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF GREENVILLE	)	C.A. No.: 2019-CP-23-00545 &
	)	2019-CP-23-00546
	)	
Janet King, Individually and as	)	
Personal Representative of the Estate	)	
of Hartford Parks Boozer, Jr.,	)	
	)	
Plaintiff,	)	
	)	ORDER
v.	)	
	)	
Emericare, Inc. d/b/a Emeritus at	)	
Greenville d/b/a Brookdale Greenville;	)	
Emerical, Inc.; Brookdale Senior	)	
Living, Inc.; Emeritus Senior Living;	)	
Emeritus Corporation a/k/a Brookdale	)	
Southpointe Drive; Bre Knight SH SC	)	
Owner, LLC; HCP MA3 South	)	
Carolina, LP; and Welltower, Inc. f/k/a	)	
Health Care REIT, Inc.,	)	
	)	
Defendant(s).	)	
	)	

This matter came before the Court in Greenville County on July 22, 2019 on Defendants' Motion to Dismiss or, in the Alternative, Motion to Compel Arbitration and Stay Proceedings.

This matter arises out of civil actions for wrongful death and survival actions involving allegations of nursing home and assisted living facility abuse and neglect and corporate negligence with allegations of understaffing, underfunding, undertraining, and corporate mismanagement. Both parties submitted briefs/memoranda as well as exhibits in support of their positions. Having listened to oral arguments from counsel and having reviewed the parties' legal memoranda and exhibits and for the reasons set forth more fully



below, the Court hereby denies the Defendants' Motion to Dismiss or, in the Alternative, Motion to Compel Arbitration and Stay Proceedings.

BACKGROUND

Plaintiff Janet King (hereinafter "Daughter") was the daughter and is the Personal Representative of the Estate of Hartford Parks Boozer, Jr. (hereinafter "Decedent"), a resident/patient at Defendants' assisted living facility and skilled nursing facility. The assisted living facility was Emeritus Corporation a/k/a Brookdale Southpointe Drive (hereinafter "Brookdale Southpointe"), an assisted living facility which Plaintiff contends was owned, controlled, and operated by Brookdale Senior Living, Inc., Welltower, Inc. f/k/a Healthcare REIT, Inc., and Emeritus Senior Living. Decedent was admitted to Brookdale Southpointe on or about September 24, 2015, at which time an arbitration agreement was signed.

Plaintiff alleges that Decedent suffered with numerous falls during the admission which resulted in a brain injury and transfer to the hospital on December 28, 2016. Decedent was discharged from the hospital to the skilled nursing facility, Emericare Inc. d/b/a Emeritus at Greenville d/b/a Brookdale Greenville (hereinafter "Brookdale Greenville") on January 3, 2017 for short-term rehabilitation at which time an arbitration agreement was signed by Daughter Brookdale Greenville. Plaintiff alleges that Decedent suffered with additional falls at Brookdale Greenville resulting in further brain injury and was shortly thereafter discharged to Brookdale Southpointe again where he suffered from further falls on the night of admission resulting in another brain bleed and was discharged back to the hospital on January 24, 2017, for his injuries. He suffered until he succumbed

to his injuries and died on February 10, 2017. Defendants vehemently deny Plaintiff's allegations.

Defendants filed this Motion to Dismiss and Compel Arbitration on May 15, 2019. For the reasons stated hereinbelow, Defendants' Motion is denied as to the Motion to Compel Arbitration for any claims related to the Brookdale Greenville admission and granted as to any survival action claims only for Brookdale Southpointe. All wrongful death action claims against the Brookdale Southpointe Defendants are also denied.

LEGAL ANALYSIS AND CONCLUSION

The party seeking to enforce an agreement to arbitrate has the burden of establishing the existence of a valid arbitration agreement. See Aiken v. World Finance Corp. of S.C., 373 S.C. 144, 149, 644 S.E.2d 705, 708 (2007); MBNA America Bank, N.A. v. Christianson, 377 S.C. 210, 659 S.E.2d 209 (S.C. Ct. App. 2008). It is well established that "where one party denies the existence of an arbitration agreement raised by an opposing party, a court must immediately determine whether the agreement exists in the first place. If no agreement is found to exist, the court must deny any application to arbitrate." Simpson v. MSA of Myrtle Beach, Inc., 373 S.C. 14, 644 S.E.2d 663, 667 (S.C. 2007) (internal citation omitted). Whether a valid arbitration agreement exists is a matter for judicial determination. York v. Dodgeland of Columbia, Inc., 406 S.C. 67, 78, 749 S.E.2d 139, 144 (Ct. App. 2013). Whether the parties agreed to arbitration is a question of substantive state law. Simpson v. MSA of Myrtle Beach, Inc., 373 S.C. 14, 644 S.E.2d 663, 668 (S.C. 2007) ("General contract principles of state law apply in a court's evaluation of the enforceability of an arbitration clause.").

I. The Arbitration Agreement with Brookdale Greenville is Unenforceable in its Entirety Because There was no Mutual Assent and Meeting of the Minds.

The arbitration agreement with Brookdale Greenville was included within the Admission Agreement with Brookdale Greenville. Page 16 of the agreement provides for the signature line for both the resident and the facility. On January 4, 2017, Daughter signed at the signature line reserved for “Resident Representative Signature”. A signature line existed for the facility to execute the agreement as well. A blank was provided for the facility to sign as “Provider Representative”, a separate blank for the Provider Representative to print his/her name, and a third blank for the Provider Representative to date when the facility executed the agreement on its own behalf.

At no time did anyone from Brookdale Greenville ever sign and execute the agreement on behalf of the facility. As previously noted, Brookdale Greenville bears the burden of proving that a valid arbitration agreement exists and was executed. Arbitration cannot be compelled in the absence of an express agreement to arbitrate. EEOC v. Waffle House, Inc., 534 U.S. 279 (2002); Emlenton Area Municipal Authority v. Miles, 548 A.2d 623, 625 (Pa. Super. 1988). The touchstone of any valid contract is mutual consideration. The issue whether the parties agree to arbitrate is generally one for the court, not for the arbitrators.

Because the facility did not sign the agreement, there is no indicia of mutual assent as required for a valid enforceable arbitration agreement. The alleged agreement by its express terms requires both parties to sign and confirm in writing that they are waiving their right to a jury trial and consenting to the terms of the agreement by affixing their signatures. The arbitration provision itself references the “signatories to this arbitration

provision” and references “the parties’ decision to select arbitration”, however, there is no party signature on behalf of Brookdale Greenville and its affiliates. The fact that there is a signature line for “Provider Representative” and that it is left blank further indicates that there was no mutual assent. See Baier v. Darden Restaurants, 420 S.W.3d 733, 739 (Mo. Ct. App. 2014).

As the Pennsylvania Superior Court noted in Bair v. Manor Care of Elizabethton, PA, LLC, et al., 108 A3d 94 (2015), the issue is not necessarily just whether or not the arbitration agreement was signed by the parties sought to be bound but whether there was a meeting of the minds, that is, whether the parties agreed in a clear and unmistakable manner to arbitrate their disputes. Id. at 97. The Court concluded that the parties did not agree in a clear and unmistakable manner to arbitrate the disputes due to the lack of signature on behalf of the nursing home facility. As the Court noted, by failing to affix its signature, the facility did not consent to arbitrate. Absent mutual assent at the time of the creation of the agreement, there was no enforceable agreement to arbitrate. Id. at 98. As the Pennsylvania Court noted, “it is not just the lack of the signature of the nursing home facility that is problematic but the fact that there was not mutual assent of the parties to the alleged contract. It is not the resident’s consent that is the problem, it is Manor Care’s failure to fill in essential terms and sign the agreement that fell short in manifesting its consent to arbitrate”. Id. at 98.

South Carolina law requires that “in order to have a valid and enforceable contract, there must be a meeting of the minds between the parties with regard to all essential and material terms of the agreement.” Grant v. Magnolia Manor-Greenwood, Inc., 383 S.C. 125, 678 S.E.2d 435 (2009) citing Player v. Chandler, 299 S.C. 101, 105, 382 S.E.2d 891

(1989). Parties cannot be said to have a meeting of the minds on matters which are indefinite, vague, uncertain, and even incomprehensible. “Vagueness of expression, indefiniteness, and uncertainty as to any of the essential terms of an agreement have often been held to prevent the creation of an enforceable contract”. Reed v. Boykin, 282 S.C. 614, 320 S.E.2d 68 (S.C. App., 1984). Because Brookdale Greenville never indicated its assent to the terms of the agreement, failed to complete all of the necessary portions of the agreement, failed to fill in the necessary blanks, and otherwise failed to come to agreement on the material terms of the agreement by signing the agreement, the arbitration agreement is unenforceable as to Brookdale Greenville.

II. The Brookdale Greenville Arbitration Agreement is Unenforceable Because it is Illegal Consideration for the Admission Agreement.

Plaintiff’s Affidavit submitted for the Motion states that Plaintiff was not aware of the arbitration provision nor explained the arbitration provision in the Admission Agreement. No evidence was presented by the Defendants to indicate otherwise. The Admission Agreement contained the arbitration provision with no opportunity for the Plaintiff to decline the arbitration agreement. There was not a separate signature page for the arbitration agreement. As a result, the arbitration provision was required as a condition of admission to the facility. This requirement for admission to the facility is a violation of federal regulations.

Federal regulations require Medicare and Medicaid certified facilities to accept Medicare/Medicaid reimbursement rates as payment in full. See 42 C.F.R. §489.30; 42 C.F.R. §447.15. Moreover, such facilities, in the case of an individual who is entitled to

medical assistance, must “not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the state plan...any other consideration as a precondition of admitting (or expediting the admission of) the individual to the facility or as a requirement for the individual’s continued stay at the facility”. 42 USC §1396r(c)(5)(A)(iii).

An illegal contract is unenforceable. Berkebile v. Outen, 426 S.E.2d 760, 762 n. 2 (1993). “The general rule is that courts will not enforce a contract which is violative of public policy, statutory law, or provisions of the Constitution.” Id. In the instant case, it is undisputed that Decedent was a Medicare beneficiary while residing at Defendants’ facility. Further, there is no doubt that the arbitration provision was a mandatory term to the Admission Agreement and was, in part, illegal consideration for admission and an illegal required pre-condition to admission as Decedent and Daughter had no way to decline the arbitration provision and were required to sign the Admission Agreement which contained the arbitration provision and is therefore, unenforceable.

III. The Brookdale Greenville and Brookdale Southpointe Arbitration Agreements are Unenforceable Against Decedent’s Wrongful Death Statutory Beneficiaries.

It is the conclusion and order of this Court that the Arbitration Agreement of Brookdale Greenville is unenforceable in its entirety for the above-stated reasons. However, even if there was a meeting of the minds and no illegal consideration, the Arbitration Agreements as to both Brookdale Greenville and Brookdale Southpointe are unenforceable against the Decedent’s wrongful death statutory beneficiaries under South Carolina contract law defenses. The Arbitration Agreements neither cover the wrongful

death statutory beneficiaries' claims within the scope of the agreement nor were the Arbitration Agreements signed by an individual who had authority to bind the statutory beneficiaries.

South Carolina law is clear that a wrongful death claim exists for the statutory beneficiaries and that such claims are distinct and separate from those brought under survival claims. Bennett v. Spartanburg Railway Gas and Electric Co., 97 S.C. 27, 81 S.E. 189 (1914). The alleged arbitration agreement with Brookdale Southpointe by its own terms is an agreement between "Park Booser ('Resident', 'you', or 'your') and "Emeritus Corporation d/b/a Brookdale Southpointe Drive ('The Company', 'us', 'we', or 'our')". The alleged admission agreement/arbitration agreement with Brookdale Greenville by its own terms is an agreement between "Emericare, Inc. d/b/a Brookdale Greenville AL/MC/SNF (SC) a licensed Nursing Care Institution located at 1306 Pelham Road, Greenville SC 29615 (the 'Provider', 'us', 'we', or 'our') and "H P BOOZER (the 'Resident', 'you', or 'your') and/or (Name of 'Resident Representative') on behalf of Resident". Even if Decedent had agreed to arbitration, he did not have the legal authority to bind his statutory beneficiaries who are not parties to the Arbitration Agreements. The signatories to the agreements are Daughter as representative of Decedent and the agent for Brookdale Southpointe (no signature for Brookdale Greenville). No other persons are parties to these agreements. The scope of the agreements does not include the statutory beneficiaries' claims.

However, even if the Arbitration Agreements did contemplate the wrongful death statutory beneficiaries' claims, Decedent and/or Daughter had no authority to waive the statutory beneficiaries' claims. Daughter signed the Arbitration Agreements in her

individual capacity in a representative capacity of Decedent only. As the Hodge court noted, actions taken by Daughter in her *individual capacity* will not be held against the estate as the estate has other beneficiaries and may have other creditors. Moreover, the wrongful death claim is not based on the contract or agreement to arbitrate with the facility. The statutory beneficiaries received no benefit from any contract which Decedent may have entered into with the Defendants. See Wilson v. Willis, No. 27879, 2019 S.C. LEXIS 27.

Further confirming the separateness of each statutory beneficiary's claim from that of the survival action, a Federal District Court in South Carolina has analyzed this issue under the South Carolina Non-Economic Awards Act of 2005. Diane Boyle as Personal Representative of the Estate of John Francis Boyle v. United States of America, 944 F.Supp.2d 577 (D.S.C. 2012). In Boyle, the Court concluded that the wrongful death beneficiaries' claims were separate and distinct claims for purposes of stacking damage caps and for purposes of being individual claimants. This analysis supports the contention that the wrongful death claimants have separate and distinct claims apart from that of the survival action.

Many other states have come to this same conclusion, Daniels v. Sunrise Senior Living, Inc., 212 Cal.App 4th 674, 151 Cal.Rptr.3d 273 (Cal.App.4 Dist, 2013) (Wrongful Death claims not bound to arbitration), Lawrence v. Beverly Manor, 273 S.W.3d 525 (Mo. 2009) (Wrongful Death claimants not bound by arbitration agreement.) As previously discussed, the only parties executing these agreements were Daughter purportedly on behalf of Decedent and an employee as an agent for Brookdale Southpointe. (No signature for Brookdale Greenville.) Defendants would contend that these agreements are binding

on the non-signatory statutory beneficiaries simply because it contends the Arbitration Agreements say so.

However, as the Supreme Court of Kentucky said regarding binding non-signatory wrongful death beneficiaries in Ping v. Beverly Enterprises, Inc.:

[A]s interesting as life might be if we could bind one another to contracts merely by referring to each other in them, we are not persuaded that a non-signatory who receives no substantive benefit under a contract may be bound to the contract's procedural provisions, including arbitration clauses, merely by being referred to in the contract. It is one thing to say that a third party for whose substantive benefit a contract is made may not enforce his or her rights under the contract without also abiding by the contract's other terms. That is the general third-party beneficiary rule discussed above. It may even be that tort claims by such a directly benefitting third-party are appropriately subjected the contract's arbitration provisions, at least where the tort and contract are significantly intertwined. See, In re Weekley Homes, L.P., 180 S.W. 3d 127 (Tex. 2005) (negligent repair claim by homeowner's Son against contractor was subject to repair contract's arbitration clause because Son, although a non-party, was direct and principal beneficiary under the contract). It is something else entirely, however, to say that incidental beneficiaries of a contract-individuals or entities with no substantive rights under the contract and no direct benefits-may have their tort claims against the parties swept up into the contract's arbitration provisions merely by being mentioned in the contract as potential claimants. This is what Beverly purports to do. Arbitration is a matter of contract, however, it is something the contracting parties, or their proxies, must agree to. It is not something that one party may simply impose upon another. Howsam v. Dean Witter Reynolds, Inc., 537 U.S. 79, 83, 123 S. Ct. 588, 154 L. Ed.2d 491 (2002) (“[A]rbitration is a matter of contract and a party cannot be required to submit to arbitration any dispute which he has not agreed so to submit”, Citation and internal quotation marks omitted.) Since Beverly's theory would allow just that, i.e., would allow one party merely by referring to someone else in an arbitration clause to thereby bind that other person to

arbitration as a “third party beneficiary” of the arbitration agreement, we reject it out of hand.

Ping v. Beverly Enterprises, Inc., 376 S.W.3d 581, 599-600 (KY 2012).

Likewise, Brookdale Southpointe and Brookdale Greenville’s mentioning of “any spouse, children, heir, representatives, agents, executors, administrators, successors, family members, or other persons claiming through the Resident, or other person claiming through the Resident’s estate, whether such third parties make a claim in a resident representative capacity or in a personal capacity. Any claims or grievances against the Community or the Community’s corporate parent, subsidiaries, affiliates, employees, officers, or directors” as being bound by the Arbitration Agreement does not make it so. It is no more than an *ipse elixir* which Defendants expect this Court to embrace. The law simply does not permit a party to cut off the rights of a non-signatory to an agreement who receives no benefit thereunder.

The wrongful death claims are separate claims apart from the Decedent’s claims.

According to South Carolina’s Wrongful Death Act:

“Whenever the death of a person shall be caused by the wrongful act, negligent or the fault of another and the act, negligent or the fault is such as would, if death had not ensued, had entitled party injured to maintain an action and recover damages in respect thereof, the person who would have been liable, if death had not ensued shall be liable to an action for damages.”

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South Carolina Code Annotated §15-51-10 (1977)

The wrongful death beneficiaries are as follows:

“Every such action shall be for the benefit of the wife, or husband and child or children of the person whose death shall have been so caused, and, if there be no such wife, husband, child or children, then for the benefit of the parent or parents, and if there be none, for the benefit of

the heirs or the person whose death shall have been so caused.”

South Carolina Code Annotated §15-51-20 (Supp. 2001)

The general element of damages recoverable are pecuniary loss, mental shock and suffering, wounded feelings, grief and sorrow, loss of companionship, and deprivation of the use and comfort of the Decedent, society, including the loss of his experience, knowledge, and judgment in managing the affairs of himself and his beneficiaries. Self v. Goodrich, 300 S.C. 349, 351, 387 S.E.2d. 713, 714 S.C. (Ct. App. 1989).

The wrongful death claim is a separate claim from the claims a decedent might bring on his own behalf under the survival statute. In Bennett v. Spartanburg Railway Gas and Electric Company, 97 S.C. 27, 81 S.E. 189 (1914), the Supreme Court held that wrongful death and survival actions are different claims for different injuries. The Court stated “necessarily, therefore, there must be separate verdicts and separate judgments, there should be separate actions.” Id. at 31. See also Strickland v. Southern Ry Co., 111 S.C. 248, 97 S.E. 695 (1918) (Supreme Court Affirmed Appeal from Circuit Court’s ruling noting that survival claims are independent of wrongful death claims), Claussen v. Brothers, 148 S.C. 1, 145 S.E. 539 (1928) (discussing the difference between survival and wrongful death claims as being independent of each other).

The Pennsylvania Superior Court in Pisano v. Extended Homes, Inc., operating under the fictitious name Belaire Health 84 Rehabilitation Center, 2013 PA Super 232, 77 A.3d 651, 662 (PA 2013) affirmed the trial court decision that the nursing home arbitration agreement did not apply to the statutory beneficiaries’ wrongful death claim. The Court noted the wrongful death and survival actions are not derivative of each other but are flowing from the same underlining tortious conduct. Like the South Carolina statute,

Pennsylvania's wrongful death statute provides that the right of action exists only for the benefit of the spouse, children, parents, or parents of the deceased. *Id.* at 656. The Pennsylvania Court further held that since the wrongful death claim is independent of the survival action and because the wrongful death statute does not characterize the wrongful death claim as that of a third-party beneficiary, that the trial court properly refused to compel arbitration to the non-signatory wrongful death beneficiaries who were not parties to the arbitration agreement.

Likewise, in Bybee v. Abdulla, M.D., 189 P.3d 40, 2008 UT 35 (Utah, 2008), the Supreme Court of Utah held that an agreement to arbitrate that was signed by the decedent cannot extend to the statutory beneficiaries of a wrongful death claim. The Utah Supreme Court noted that certain defenses from the decedent's personal injury action may be raised against the heirs of a wrongful death action such as comparative negligence and statutes of limitations as key common characteristics. However, as the Supreme Court of Utah noted, both of these defenses go to the viability of the underlying personal injury action. The Court further stated that "by contract, an agreement to bind heirs to arbitrate disputes does not implicate the viability of underlying claims." *Id.* at 47, citing Horwich v. Superior Court, 21 Cal. 4th 272, 87 Cal. Rptr. 2d 222, 980 P. 2d 927, 935 (1999). The Utah Supreme Court went on to note that "we have never intended to suggest, however, that because Decedent is the master of his claim he may by contract expose his unwilling heirs to any imaginable defense." Bybee v. Abdulla, M.D. at 46. The Utah Supreme Court further held that the defenses against the decedent's claim which are less likely to be found enforceable against the heirs' claims in a wrongful death action "are contract provisions that purport to affect the rights of heirs that do not affect the existence of the decedent's personal injury claim

during his lifetime. The arbitration agreement...falls squarely within this category and is, therefore, unenforceable against the heir.” Id. at 47.

The Court of Appeals in Washington in Woodall v. Avalon Care Center-Federal Way, LLC, 155 Wn. App. 919, 231 P. 3d 1252 (Wash. App. Div. 1 2010) held that “arbitration is a matter of contract and a party cannot be required to submit to arbitration any dispute which he [or she] has not agreed so to submit.” Id. quoting Satomi Owners Association v. Satomi, LLC, 167 Wash. 2d 781, 225 P.3d 213 (2009). The Washington Court of Appeals further noted that the wrongful death claims asserted in that case were not on behalf of the estate just as South Carolina’s wrongful death claims are not on behalf of the estate. The Washington Court of Appeals further discussed the Supreme Court of Ohio’s ruling in Peters v. Columbus Steel Casting Co., 115 Ohio St.3d 134, 873 N.E.2d 1258 (2007), wherein the Supreme Court of Ohio held that the wrongful death claim of a spouse who was Administrator of her husband’s estate was not subject to the Decedent’s arbitration agreement. The Washington Court of Appeals in discussing Peters, stated “In sum, the decedent’s agreement was an agreement ‘to arbitrate his claims against the company,’ and thus the provision in the agreement binding the decedent’s heirs applied to a survival action. But the decedent could not ‘restrict his beneficiaries to arbitration of their wrongful death claims because he held no right to those claims.” Woodall v. Avalon Care Center - Federal Way, LLC at 929. In the Washington Court of Appeals’ analysis, the Court concluded that the wrongful death beneficiaries could not be bound to the arbitration agreement which they did not sign.

Therefore, even if Daughter had actual or apparent authority/agency to execute the Arbitration Agreements, the Arbitration Agreements did not include the wrongful death

statutory beneficiaries' claims within the scope of the Arbitration Agreements, nor did Decedent and/or Daughter have authority to bind the wrongful death statutory beneficiaries' claims to the Arbitration Agreements. As a result, the Arbitration Agreements cannot reach the claims of the wrongful death statutory beneficiaries.

CONCLUSION

Therefore, based upon the foregoing reasons, the Defendants' Motion to Dismiss or, in the Alternative, Motion to Compel Arbitration and Stay Proceedings as to all claims against Brookdale Greenville are hereby denied. Further, the Motion to Compel Arbitration as to Brookdale Southpointe is granted only as to the Survival Action claims and denied as to the Wrongful Death Action claims.

IT IS SO ORDERED.

Greenville, South Carolina

Date: _____

The Honorable Edward W. Miller
Judge, Thirteenth Judicial Circuit
State of South Carolina



Greenville Common Pleas

Case Caption: Janet King , plaintiff, et al vs. Emericare Inc , defendant, et al

Case Number: 2019CP2300546

Type: Order/Other

So Ordered

s/ Edward W. Miller

Electronically signed on 2019-08-28 13:59:11 page 16 of 16

STATE OF SOUTH CAROLINA)

COUNTY OF FLORENCE)

Ann Coleman, Individually, and as Personal Representative of the Estate of Mary Brinson,
☒ Plaintiff)

v.)

Mariner Health Care, Inc. F/K/A Mariner Post-Acute Network, LLC, Mariner Health Care Management Company, Mariner Health Central, Inc., Mariner Health Group, Inc., MHC Holding Company, MHC Florida Holding Company, MHC Gulf Coast Holding Company, MHC Midamerica Holding Company, MHC Rocky Mountain Holding Company, MHC Northeast Holding Company, MHC West Holding Company, MHC Texas Holding Company, MHC Midatlantic Holding Company, Living Centers-Southeast, Inc., Grancare South Carolina, Inc., Individually And D/B/A Faith Health Care Center, Savaseniorcare Management, LLC, Savaseniorcare Administrative Services, LLC, Savaseniorcare, LLC, Savaseniorcare, Inc., National Senior Care, Inc., Palmetto Health Care, LLC, Palmetto Faith Operating, LLC, Individually And D/B/A Faith Health Care Center, Ask Holdings, LLC, Leonard Gruntesin, An Individual, Murray Forman, An Individual, Boyd P. Gentry, An Individual, Abraham Shaulson A/K/A Abraham Shavlson A/K/A A. Shawson, A/K/A Abraham Shawson, An Individual, Avi Klein, An Individual, SC Property Holdings, LLC, SC Faith, LLC, And John Does 1-26.

☐ Defendant.)

IN THE COURT OF COMMON PLEAS

CASE NO.

2010-CP-21-00836

MOTION AND ORDER INFORMATION
FORM AND COVER SHEET

FILED
 2011 MAR 25 PM 4:00
 CONNIE REEL-SHEARIN
 C.C.P. & G.S.
 FLORENCE COUNTY, SC

Plaintiff's Attorney:
 Matthew Christian, Bar No. 70516
 Address:
 1007 East Washington Street, Greenville, SC 29601
 phone: 864-232-7363 fax: 864-370-3731
 e-mail: mchristian@christiananddavis.com other:

Defendant's Attorney:
 , Bar No.
 Address:
 phone: fax:
 e-mail: other:

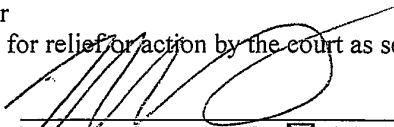
- ☐ MOTION HEARING REQUESTED (attach written motion and complete SECTIONS I and III)
☐ FORM MOTION, NO HEARING REQUESTED (complete SECTIONS II and III)
☒ PROPOSED ORDER/CONSENT ORDER (complete SECTIONS II and III)



E COPY

Shapiro

C.P & G.S.
TY, S.C.

SECTION I: Hearing Information	
Nature of Motion: Estimated Time Needed: _____ Court Reporter Needed: ☐ YES / ☐ NO	
SECTION II: Motion/Order Type	
☐ Written motion attached ☒ Form Motion/Order I hereby move for relief or action by the court as set forth in the attached proposed order.	
 Signature of Attorney for ☒ Plaintiff / ☐ Defendant	<u>March 24, 2011</u> Date submitted
SECTION III: Motion Fee	
☒ PAID – AMOUNT: 25.00 ☐ EXEMPT: (check reason)	
☐ Rule to Show Cause in Child or Spousal Support ☐ Domestic Abuse or Abuse and Neglect ☐ Indigent Status ☐ State Agency v. Indigent Party ☐ Sexually Violent Predator Act ☐ Post-Conviction Relief ☐ Motion for Stay in Bankruptcy ☐ Motion for Publication ☐ Motion for Execution (Rule 69, SCRCF) ☐ Proposed order submitted at request of the court; or, reduced to writing from motion made in open court per judge's instructions Name of Court Reporter: _____ ☐ Other: _____	
JUDGE'S SECTION ☐ Motion Fee to be paid upon filing of the attached order. ☐ Other: _____	_____ JUDGE CODE: _____ Date: _____
CLERK'S VERIFICATION	
Collected by: _____ Date Filed: _____	
☐ MOTION FEE COLLECTED: _____ ☐ CONTESTED – AMOUNT DUE: _____	

STATE OF SOUTH CAROLINA **FILED** IN THE COURT OF COMMON PLEAS

COUNTY OF FLORENCE

C.A. No.: 2010-CP-21-836

2011 MAR 25 PM 4:00
 Ann Coleman, Individually, and as Personal
 Representative of the Estate of Mary CCCP & GS
 Brinson, FLORENCE COUNTY, SC

Plaintiff,

v.

Mariner Health Care, Inc. f/k/a Mariner
 Post-Acute Network, LLC, Mariner Health
 Care Management Company, Mariner
 Health Central, Inc., Mariner Health Group,
 Inc., MHC Holding Company, MHC
 Florida Holding Company, MHC Gulf
 Coast Holding Company, MHC
 MidAmerica Holding Company, MHC
 Rocky Mountain Holding Company, MHC
 Northeast Holding Company, MHC West
 Holding Company, MHC Texas Holding
 Company, MHC MidAtlantic Holding
 Company, Living Centers-Southeast, Inc.,
 GranCare South Carolina, Inc., Individually
 and d/b/a Faith Health Care Center,
 SavaSeniorCare Management, LLC,
 SavaSeniorCare Administrative Services,
 LLC, SavaSeniorCare, LLC,
 SavaSeniorCare, Inc., National Senior Care,
 Inc., Palmetto Health Care, LLC, Palmetto
 Faith Operating, LLC, Individually and
 d/b/a Faith Health Care Center, Ask
 Holdings, LLC, Leonard Grunstein, an
 Individual, Murray Forman, an Individual,
 Boyd P. Gentry, an Individual, Abraham
 Shaulson a/k/a Abraham Shavlson a/k/a A.
 Shawson a/k/a Abraham Shawson, an
 Individual, Avi Klein, an Individual, SC
 Property Holdings, LLC, SC Faith, LLC,
 and John Does 1-26.,

Defendant(s).

**ORDER DENYING DEFENDANTS
 MARINER HEALTH CARE
 MANAGEMENT COMPANY,
 MARINER HEALTH CENTRAL, INC.,
 GRANCARE SOUTH
 CAROLINA, INC., INDIVIDUALLY
 AND d/b/a FAITH HEALTH CARE
 CENTER, MARINER HEALTH CARE,
 INC. f/k/a MARINER POST ACUTE
 NETWORK, LLC, MARINER
 HEALTH GROUP, INC., MHC
 HOLDING COMPANY, MHC
 FLORIDA HOLDING COMPANY,
 MHC GULF COAST HOLDING
 COMPANY, MHC MIDAMERICA
 HOLDING COMPANY, MHC ROCKY
 MOUNTAIN HOLDING COMPANY,
 MHC NORTHEAST HOLDING
 COMPANY, MHC WEST HOLDING
 COMPANY, MHC TEXAS HOLDING
 COMPANY, MHC MIDATLANTIC
 HOLDING COMPANY, LIVING
 CENTERS-SOUTHEAST, INC.,
 SAVASENIORCARE
 ADMINISTRATIVE SERVICES, LLC,
 SAVASENIORCARE, LLC,
 SAVASENIORCARE INC.,
 NATIONAL SENIOR CARE, INC.,
 LEONARD GRUNSTEIN, BOYD P.
 GENTRY, AND MURRAY FORMAN
 MOTION TO STAY ACTION AND
 COMPEL ARBITRATION
 (SURVIVAL ACTION)**

CERTIFIED: A TRUE COPY

Connie Reel Shearin
 CLERK OF COURT C.P. & G.S.
 FLORENCE COUNTY, S.C.

PROCEDURAL

This matter came before the Court on the motion of Defendants Mariner Health Care Management Company, Mariner Health Central, Inc., Grancare South Carolina, Inc., individually and d/b/a Faith Health Care Center, Mariner Health Care, Inc. f/k/a Mariner Post Acute Network, LLC, Mariner Health Group, Inc., MHC Holding Company, MHC Florida Holding Company, MHC Gulf Coast Holding Company, MHC MidAmerica Holding Company, MHC Rocky Mountain Holding Company, MHC Northeast Holding Company, MHC West Holding Company, MHC Texas Holding Company, MHC MidAtlantic Holding Company, Living Centers-Southeast, Inc., SavaSeniorCare Administrative Services, LLC, SavaSeniorCare, LLC, SavaSeniorCare, Inc., National Senior Care, Inc., Leonard Grunstein, Boyd P. Gentry and Murray Forman, to stay the action and compel arbitration and was heard on January 6, 2011. All parties were represented by counsel and provided oral arguments and also submitted written memoranda and exhibits supporting their positions. The Court hereby denies Defendants' Motion to Stay Action and Compel Arbitration for the reasons set forth below.

BACKGROUND

Mary Brinson, deceased, was admitted to Faith Health Care Center on June 2, 2006 where she remained until September 16, 2006. She was then readmitted to Faith Health Care Center on December 13, 2006 and resided there until December 26, 2006. When Mary Brinson was admitted on June 2, 2006, the licensee was Grancare South Carolina, Inc., and when she was admitted on December 13, 2006, the licensee was Palmetto Faith Operating, LLC.

Ann Coleman is the Personal Representative of the estate of Mary Brinson. Ann Coleman is the sister of Mary Brinson, deceased. When Mary Brinson was admitted to Faith Health Care Center on June 2, 2006 and on December 13, 2006, no one had a Power of Attorney for Mary Brinson. Furthermore, at that time no one had a conservatorship and no one had been

appointed guardian for Mary Brinson during these times. Despite the fact that Ann Coleman did not have a Power of Attorney for her sister, Faith Health Care Center requested that Ann Coleman sign an Arbitration Agreement during the admission process when Mary Brinson was admitted on both occasions. It is from the June 1, 2006, Arbitration Agreement which these Defendants seek to enforce.

DISCUSSION

1. The Arbitration Agreement is not enforceable because Ann Coleman lacked the capacity to contract on behalf of her sister.

The Arbitration Agreement is not enforceable because Ann Coleman lacked the capacity to contract on behalf of her sister. South Carolina law recognizes that arbitration agreements are contracts. The interpretation and enforcement of arbitration agreements are scrutinized using contract principles of law. The Defendants' own Admissions Agreement also recognizes that the Arbitration Agreement is a contract. It is a basic tenant of contract law that the parties to the contract must have the capacity to contract.

"The first element of a contract is that the parties have the capacity to contract... Further, capacity to contract relates to the status of the person rather than to circumstances surrounding the contract." (17 C.J.S. Contracts §32) Ann Coleman did not have that authority. Furthermore, Defendants admit that they are not aware of any Power of Attorney held by Ann Coleman on behalf of Mary Brinson at the time that the Arbitration Agreement was signed (Defendants Answers to Interrogatories—Mariner Interrogatory 24 and Grancare Interrogatory 32).

Defendants rely upon the South Carolina Adult Health Care Consent Act (S.C. Code Ann. §44-66-10 *et seq*) and the South Carolina Bill of Rights for Residents of Long-Term Care Facilities (S.C. Code Ann. §44-81-10 *et seq*) as granting authority to Ann Coleman to enter into the Arbitration Agreement on behalf of her sister, Mary Brinson. S.C. Code Ann. §44-66-30

notes that “(A) Where a patient is unable to consent, decisions concerning his health care may be made by the following persons in order of priority: ... (6) an adult sibling...of the patient...”

S.C. Code Ann. §44-66-20(1) provides the definition of “health care” as meaning “a procedure to diagnose or treat a human disease, ailment, defect, abnormality, or complaint, whether of physical or mental origin. It also includes the provision of intermediate or skilled nursing care; services for the rehabilitation of the injured, disabled, or sick persons; and the placement in or removal from a facility that provides these forms of care.” It says nothing that could be construed as conferring the ability to enter into a separate legal document waiving an individual’s rights to due process under the law for another individual. Clearly, this act does not confer legal authority to enter into contracts for another person.

It is admitted by all parties that Mary Brinson did not have the capacity to contract for herself. The Defendants admit that Ms. Brinson was incompetent by virtue of their responses to Plaintiff’s Request to Admit in addition to the fact that the medical director at the Faith Healthcare Center facility certified that Ms. Brinson was unable to consent to or make her own healthcare decisions.

While the South Carolina Adult Healthcare Consent Act does grant Ms. Coleman the authority to make “healthcare decisions” on behalf of her sister, consent for medical treatment for someone unable to consent is not the same as binding an incompetent person to a legally binding contract such as an arbitration agreement without the authority to do so.

Defendants also rely on S.C. Code Ann. §44-81-10 *et seq* to argue that Ms. Coleman has the legal authority to bind her sister to a contract and waive her sister’s rights under the law. This Court declines to adopt this application of this Act. The Bill of Rights for long-term care facilities sets out the rights given to a long term care resident or resident’s representative under the law; however, these rights are, once again, rights concerning the resident’s access to

healthcare and to be free from abuse and does not purport to grant others authority to enter into contracts for the resident. The Bill does not contemplate the resident's or the resident's representative's rights under the law for the authority or capacity to contract. The Bill defines representative as "a resident's legal guardian, committee, or next of kin or other person acting as agent of a resident who does not have a legally appointed guardian." The fact that the authors of this Bill felt it necessary to note that the resident may not have a guardian appointed under the law affirms their intentions that the Bill was designed to protect an individual's right of access to healthcare whether or not the individual has appointed a representative under the law. The Bill does not allow for an individual without any authority from the resident to be imbued with the legal authority to enter a contact waiving a resident's rights under the law.

The courts in North Carolina have recently decided an issue similar to the one at hand, finding that the authority granted by a state's Health Care Consent Act does not grant legal authority for the purpose of entering binding contracts. *Munn v. Haymount Rehabilitation & Nursing Center, Inc., et. al.*, No. COA 10-105 (NC Ct.App., Filed 21 Dec. 2010). In fact, in *Munn*, the Court specifically notes that "consent for medical care for another person who is unable to consent is a completely different issue than being an agent who has the authority to enter into a contract such as an arbitration agreement." Therefore, with similar reasoning this Court finds that Ann Coleman did not have actual authority to enter into the Arbitration Agreement on behalf of Mary Brinson.

The Defendants further argued that Ann Coleman acted as Mary Brinson's apparent agent. South Carolina case law on this issue is well established. Defendants argue that an agent's implied authority can be circumstantially provided by evidence and conduct and in doing so, rely on *Heil-Quaker v. Swindler*, 255 F.Supp. 445 (D.S.C. 1966), and *WDI Meredith & Co., v. American Telesis, Inc.*, 359 S.C. 474, 597 S.E.2d 885 (Ct.App. 2004). This reliance is

misplaced. *Heil-Quaker* and *WDI Meredith & Co.* hold that apparent agency is based upon the principal holding the agent out or allowing the agent to hold himself or herself out with the alleged authority. “Apparent authority is the authority that the principal intended the agent to have or such power that a principal holds his agent as possessing or permits him to exercise.” *Heil-Quaker v. Swindler*, 255 F.Supp. 445 (D.S.C. 1966). Because Mary Brinson was incompetent, she was incapable of granting the power to Ann Coleman and incapable of making a decision to allow Ann Coleman to hold herself out as Mary Brinson’s agent. Therefore, Mary Brinson as the principal did never and could never exercise such an intent. If a person does not possess the capacity to make their own healthcare decisions, they would not possess the capacity to convey their rights under the law to another individual. Furthermore, even if such an individual could convey such rights in such circumstances, there is no evidence that Mary Brinson exhibited such an intent.

The Defendants further rely on *WDI Meredith & Co., v. American Telesis, Inc.*, 359 S.C. 474, 597 S.E.2d 885 (Ct.App. 2004) for the proposition that “to establish apparent authority, either the principal must intend to cause the third person to believe the agent is authorized to act for him, or he should realize that his conduct is likely to create such belief”. As the court also noted in *WDI Meredith*, “an agency may not, however, be established solely by the declarations and conduct of an alleged agent.” (citing *Muller v. Myrtle Beach Golf & Yacht Club*, 303 S.C. 137, 142-143, 399 S.E.2d at 433 (Ct.App. 1990) overruled on other grounds by *Myrtle Beach Hosp., Inc. v. City of Myrtle Beach*, 341 S.C. 1, 532 S.E.2d 868 (2000)). An incompetent individual such as Mary Brinson would be unable to possess this intent or realize that any conduct would create such a belief.

The Defendants also rely on *Carraway v. Beverley Enterprises Alabama, Inc.* 978 So. 2d 27 (Aa. 2007). In this Alabama case, the Plaintiff was a brother of a resident of a nursing home

facility who executed a number of documents on his sister's behalf on her admission to the facility, including an arbitration agreement. The brother of the plaintiff did not have a Power of Attorney. Shortly after his sister's admission, a Power of Attorney was executed naming the brother as her attorney-in-fact. The fact that the sister provided a Power of Attorney shortly after her admission indicates that she was indeed competent, unlike the present case with Mary Brinson. Therefore, the sister could have allowed or exhibited the intent for her brother to be held out as her representative unlike Mary Brinson. Furthermore, in *Carraway* the sister in essence ratified the representation by the brother by shortly thereafter naming him as her power of attorney by her own decision. This court finds the reasoning of *Munn* to be on point and applicable. Therefore, since Mary Brinson, the principal, was incapable of making any decisions or demonstrating any intentions conveying any authority to Ann Coleman, Ann Coleman did not have the apparent authority to contract or to enter into a binding contractual agreement such as an arbitration agreement on behalf of Mary Brinson.

Furthermore, according to the Defendants' admission documents, they were aware that Ann Coleman did not have a Power of Attorney. The face sheet from the admissions documents as well as other documents indicate that Ann Coleman did not have any other legal oversight, durable power of attorney or healthcare proxy. The Defendants are sophisticated individuals and corporations which are accustomed to dealing with arbitration provisions and understand the implications of a Power of Attorney. (*Small v. HCF of Perrysburg, Inc.*, 159 Ohio App.3d 66, 823 N.E.2d 19 at 24 {¶29}). The Defendants cannot reasonably assert that Ann Coleman was the apparent agent of Mary Brinson when they had the knowledge to understand the meaning of a Power of Attorney and the fact that Ann Coleman did not have one. The fact that the Defendants have a form which would allow for the documentation of some form of authority indicates that they knew that there are certain requirements which much be met before an

individual can be imbued with the authority to act as an agent, and further demonstrates that they knew that none of the documents which would give Ann Coleman such authority existed at the time that Mary Brinson was admitted to their facility.

Therefore, Ann Coleman had neither actual nor apparent authority to act on behalf of Mary Brinson and to sign away her right to a jury trial by entering into the arbitration agreement. As a result, the arbitration agreement is null and void because Ann Coleman lacked the capacity and authority to ever execute it on behalf of Mary Brinson.

2. The Arbitration Agreement is not enforceable against the statutory beneficiaries.

The agreement to arbitrate explicitly specifies that it is “an agreement to arbitrate any dispute that might arise between Mary Brinson (“Resident”) and/or _____ (“Legal Representative”) and Faith Healthcare (“Facility”)...”. The agreement clearly allowed for the application of the agreement to extend to a resident’s representative and, in this instance, was not so applied. Even if so applied, in the current actions, Ann Coleman has filed both a wrongful death and a survival action. While this court finds independently that Ann Coleman lacked the authority to enter into the contract on behalf of Mary Brinson and is therefore, null and void, this court also finds that the arbitration agreement cannot be enforced because it cannot apply to statutory beneficiaries who are not parties to the agreement. This principal has been specifically upheld in other jurisdictions. (*Woodall v. Avalon Care Center-Federal Way, LLC*, 155 Wash.App. 919, 231 P.3d 1252 (2010). *Small v. HCF of Perrysburg, Inc.*, 159 Ohio App.3d 66, 823 N.E.2d 19).

While Ann Coleman did not have authority to waive the rights of Mary Brinson, even if she did, she did not have the authority to waive the right to statutory beneficiaries under the arbitration agreement at hand. South Carolina law is clear that a wrongful death claim exists for the statutory beneficiaries. Because the statutory beneficiaries are not parties to the contract, and

because the statutory beneficiaries have not conveyed any power to the signatory to the agreement, their claims could not be waived and any attempt to apply the agreement to them would be null and void.

3. The Arbitration Agreement is procedurally and substantively unconscionable and impossible to enforce.

The Defendants acted in a manner inconsistent with their own policies and procedures. The facility policy in effect at the time of Mary Brinson's admission clearly required that a member of the admissions staff explain the admissions and financial documents to the person signing them. This includes the Arbitration Agreement at issue here. Specifically, the policy states its purpose as intended to "provide an informative environment that should reduce the fears and anxieties of the resident and family during the admissions process" and requires that "the Administrator, through the Admissions Staff, is responsible for ensuring that the facility and the resident follow the established admission policy, as it may apply." Additionally, the policy requires that "the Admission staff will explain and offer an Arbitration Agreement to the resident or responsible party (emphasis added)". On the basis of the Affidavit of Ann Coleman and the admission of the Defendants that the Arbitration Agreement was presented as part of a larger admissions package, the Court finds that these documents were not explained to Ms. Coleman, nor was it made clear to her that the Arbitration Agreement was voluntary and not a requirement for Mary Brinson's admission to the facility.

Additionally, it is the finding of this Court that, even were the Arbitration Agreement valid, it can not be construed to apply to all claims at issue in the case at hand. An Arbitration Agreement, or any contract, for that matter, applies only to claims arising which would be made by someone standing in the shoes of the contractor, in this case, Mary Brinson, and cannot be construed so as to apply to those claims which may be brought on behalf of others with standing

to a claim. Claims that have been made on behalf of Ann Coleman and the other statutory beneficiaries of Mary Brinson's estate are not and were not parties to the Arbitration Agreement and cannot retroactively be joined to the contract.

Moreover, not all of the Defendants to this case have moved for arbitration—specifically, there are five defendants to the case at hand who are not currently seeking to enforce arbitration. In fact, one of these defendants, Palmetto Health Care, LLC, had previously moved for enforcement and has subsequently withdrawn its petition. Parties who are not seeking arbitration cannot be forced to arbitrate a matter any more than individuals who are not party to the agreement can. As a result, this Court is faced with the possibility that, if the Arbitration Agreement is deemed valid portions of the claims along with some of the parties would be subject to arbitration while other portions of the claims and different parties to this action would be subject to trial by jury. Should this be allowed, the very real possibility of conflicting rulings on common issues of law and fact may result.

Instructive on this issue is the matter of *Birl v. Heritage Care, LLC*, 172 Cal.App.4th 1313, 91 Cal.Rptr.3d 777. In *Birl* a case was brought by the family of a deceased patient against a hospital, physicians, and a nursing facility and the nursing facility sought to compel arbitration. Of relevance, the Court here noted that “(1) the hospital and physicians with no arbitration agreement were involved in the same transaction as the nursing facility; (2) all defendants were involved in a series of related transactions with the patient; (3) there was a possibility of conflicting rulings on common issues of law or fact; and (4) patient's family members were third parties to the patient's arbitration agreement.” In its ruling denying the nursing facility's motion to compel arbitration, California's Appellate Court noted that “the trial court properly noted the possibility of conflicting rulings on common issues of law or fact if defendant Heritage was not

joined to the court action with the other defendants...Different triers of fact in different proceedings could come to different conclusions..." *Id.* at 1321.

The Court in *Birl* also took note that the Plaintiffs in that action asserted claims "not just as successors in interest, but also individually and as surviving heirs" (*Id.* at 1321), just as Ms. Coleman has done in the cases at issue now, and that such claims for "wrongful death and emotional distress were brought by plaintiffs in their individual capacities" and not as persons who had stepped into the shoes of the decedent. It was the conclusion of the *Birl* Court that the possibility of conflicting rulings on a common issue of law or fact was real and that "different triers of fact could reach different conclusions as to which party was at fault, the cause of any injuries, and the apportionment of liability—unless all the parties are jointed to one action" (*Id.* at 1322). Based on such a finding, the Court determined that it was proper to deny the nursing facility's motion to compel arbitration.

While the circumstances of the current actions differ slightly from those of *Birl*, it remains consistent that compelling arbitration of certain claims but not of others and compelling arbitration with respect to some defendants but not others will result in the conflicting rulings as contemplated in *Birl*. Furthermore, such a division of the cases would result in an unreasonable hardship for Plaintiff, as she and the other statutory beneficiaries of Ms. Brinson's estate would be effectively forced to litigate claims arising from the same or related events in two separate forums. Therefore, to uphold the Arbitration Agreement would not only pose a potential impossibility, it is also unreasonable and unconscionable to force a Plaintiff to prosecute her claims in such a fashion, especially when this issue was not explained to her. Our Courts have discussed and recognized that it is proper to deny Arbitration Agreements with impossibility of enforcement. (*Grant v. Magnolia Manor-Greenwood, Inc.*, 383 SC 125, 678 S.E.2d 435 (S.C. 2009)).

It is the finding of this Court that the Arbitration Agreement was presented to Ms. Coleman as part of a larger admissions packet and the meaning of the Arbitration Agreement was not explained; that Ms. Coleman was not informed that her signature on the Arbitration Agreement was optional and not a prerequisite for her sister to receive care; that the current conditions are that most, but not all of the defendants are seeking to compel arbitration; and compelling arbitration of Plaintiff's claims while not compelling arbitration to some claims against other Defendants, or by statutory beneficiaries who are not seeking either arbitration or were not parties to the contract makes the Arbitration Agreement as a whole impossible, unconscionable and therefore, unenforceable.

4. The Defendants' delay has effectively nullified the agreement and waived any right the Defendants may have had to force Arbitration.

The Plaintiff's Notice of Intent was filed in July of 2009, providing the Defendants with notice of impending litigation. The Notice of Intent stage took a usual course and, in fact, was extended beyond the normal time frame due to the substantial number of defendants in the case. The parties completed the required pre-suit mediation in January of 2010 which was unsuccessful in reaching a resolution. The Plaintiff filed the Summons and Complaint in March of 2010. Defendants began filing their Answers in May of 2010, and it was at this time that Plaintiff was provided with the first notice of the existence of an Arbitration Agreement and the Defendants' allegation that the issues and incidents addressed by Plaintiff's Complaint were governed by said Arbitration Agreement only by virtue of one of the Defendants' affirmative defenses. Even in light of said notice, Defendants did not move to seek enforcement of the Arbitration Agreement until August of 2010, more than a year after they had been first placed on notice of pending litigation and had been served with the Notice of Intent to Sue. This was also well after Plaintiff had served Discovery and filed a Motion to Compel.

The Courts in South Carolina have long recognized the act of abandonment as a valid basis for an exception to a contract's enforceability:

Generally, no-damage-for-delay provisions are valid and enforceable so long as they meet ordinary rules governing the validity of contracts. *See* Annot., *Validity and Construction of "No Damage Clause" with Respect to Delay in Building or Construction Contract*, 74 A.L.R.3d 187 §2[a] (1976). A certain majority of jurisdictions, however, recognize certain exceptions to such clauses. *Id.* Among the recognized exceptions are (a) delay caused by fraud, misrepresentation, or other bad faith... (c) delay which has extended such an unreasonable length of time that the party delayed would have been justified in abandoning the contract... *U.S. f/u/b/a Williams Electric Company, Inc. v. Metric Constructors, Inc.* 325 S.C. 129, 480 S.E.2d 447 (1997).

The contract at issue here is, of course, the Arbitration Agreement. First, the Agreement does not contain a "no-damage-for-delay" provision, and, as such, had Defendants intended to rely upon the Agreement, they should have acted promptly upon the first notice of a civil action. Secondly, and being generous to Defendants, they waited a full nine months after Plaintiff's first filings to make any mention of an Arbitration Agreement and an additional three months more before moving to enforce said Agreement.

"[I]n South Carolina, there exists in every contract an implied obligation of good faith and fair dealing." *Id.* citing *Adams v. Creel*, 320 S.C. 274, 465 S.E.2d 84 (1995); *Parker v. Byrd*, 309 S.C. 189, 420 S.E.2d 850 (1992); *Tharpe v. G.E. Moore*, 254 S.C. 196, 174 S.E.2d 397 (1970). Continuing, "A number of courts recognize an exception to a no-damage clause where delays are so unreasonable in length or duration that they amount to an abandonment of the contract..." *U.S. f/u/b/a Williams Electric* at 134-135 citing 74 A.L.R.3d at 226-230 §7(i). "An abandonment need not be express but may be inferred from the conduct of the parties and attendant circumstances." *Quality Concrete Products, Inc., v. Thomason*, 253 S.C. 579, 172

S.E.2d 297 (1970). “Abandonment of a contract by one party is the giving up of the right of benefit due from the other party.” *Ro-Lo Enterprises v. Hicks Enterprises*, 294 S.C. 111, 362 S.E.2d 888 (Ct. App. 1987). “As with the above mentioned exceptions, an abandonment of the contract involves a breach of the implied obligation of good faith and fair dealing. Accordingly, we adopt this exception and find that if a party abandons the contract, they also abandon their right to rely on a no damage for delay clause.” *U.S. f/u/b/a Williams Electric* at 135. Likewise, South Carolina Courts have previously considered and found that significant delay is tantamount to abandonment and constitutes a sufficient basis to support a finding of abandonment with respect to an arbitration agreement. (See also *Evans v. Accent Manufactured Homes, Inc.*, 352 S.C. 544, 575 S.E.2d 74 (S.C. App. 2003), *Deloitte & Touche, LLP v. Unisys Corp*, 358 S.C. 179, 594 S.E.2d 523).

As previously discussed, the Arbitration Agreement the Defendants now seek to enforce does not contain a no-damage-for-delay clause, which make the performance under the Agreement an even more time-sensitive issue. The Defendants delayed almost a year before notifying Plaintiff of such an agreement and waited more than a year before moving for the enforcement of the Agreement. During the entire length of their delay, they conducted themselves in a manner consistent with parties that intended to proceed with litigation through the confines of the judicial process. It is the ruling of this Court that, the Defendants, through their actions and delay, abandoned any rights they may have been afforded to force this matter to arbitration. To allow the Defendants to now insist on adherence to the Arbitration Agreement which was the subject of the Motion before this Court, not only amounts to an unconscionable act, but it is also in disagreement with established precedent—precedent that finds contracts far more lenient on the issue of delay than the one at hand to have been abandoned in the face of acts such as those displayed by the Defendants here.

5. **Excepting GranCare South Carolina, Inc., Mariner Health Care Management Company, and Mariner Health Central, Inc., the Defendants bringing this motion have argued in a manner inconsistent with the parties who have standing to enforce an Arbitration Agreement.**

GranCare South Carolina, Inc., was the operator of Faith Healthcare Center at the time of Mary Brinson's June 2006 admission, and all of the other defendants bringing this motion have alleged elsewhere that they do not operate nursing homes, do not have any ties to Faith Healthcare Center, have never transacted business in South Carolina, do not own property in South Carolina, and have never had any influence over the operations of Faith Healthcare Center. In fact, simultaneous to the hearing of this Motion to Compel Arbitration, these same Defendants argued a Motion to Dismiss for Lack of Personal Jurisdiction. Yet despite these protestations, these Defendants have sought to enforce an Arbitration Agreement between a facility they contend they have no interest in or control over, in a state they do not transact business in, in an industry in which they do not participate, and that this Court holds no jurisdiction over them. It cannot be rationally argued that all of these Defendants are parties to this contract, while at the same time argue that they have never contracted in South Carolina, never conducted business in South Carolina or are not tied in with the operation of the nursing facility. If the Defendants' arguments were accepted as true, then they would not have standing to enforce the Arbitration Agreement and the impossibility of prosecuting the claims in two separate forums becomes even more significant as discussed hereinabove.

6. **The Defendants' argument that Mary Brinson was a third party beneficiary to the contract is illogical and premised on the rights of Ann Coleman as signatory, which said rights do not exist.**

Defendants' have sought to argue that Mary Brinson was the third party beneficiary to the Admissions and Arbitration Agreements. While this Court concedes that it was Ms. Brinson's admission into Faith Healthcare Center that was contemplated by the Admissions Agreement, the

Defendants' extension of this argument that seeks to cast Ms. Brinson as a third party beneficiary of said agreements is misplaced as it assumes that Ann Coleman had the right to contract on behalf of Ms. Brinson. As this Court has already discussed at length, while Ann Coleman did have the right under the Adult Health Care Consent Act to consent to medical treatment, she did not have the right to commit her sister to a legally binding contract that agreed to the removal of Ms. Brinson's rights under the law. Because Ann Coleman did not have the right to contract on behalf of her sister, Mary Brinson cannot possibly be a third party beneficiary as the contract itself was never valid.

7. The Defendants' argument that Plaintiff should be equitably estopped from denying the existence of an enforceable Arbitration Agreement is rejected.

As with the argument concerning the third party beneficiary status of Mary Brinson, the Court finds that the Defendants' argument with respect to the Arbitration Agreement and estoppel of the Plaintiff is, once again, misguided and assumes a premise which this Court has previously rejected.

The principle of estoppel in equity stands on the very foundation of right and fair dealing. It considers and weighs the conduct of men in their dealings with each other and gives that effect and meanings to their actions which common sense and justice dictate. The essential elements of equitable estoppel are ignorance of the party invoking the estoppel of the truth as to the facts in question and a misrepresentation or deceptive conduct of the party against whom estoppel is sought to be applied, which in fact misleads the person asserting the estoppel to rely on the misrepresentation or conduct to change his position prejudicially as a result of the reliance. *SCJur* "Estoppel" §4.

The Defendants' estoppel argument is not only misguided, it misses the true nature of estoppel. As this Court has previously discussed, it was Faith Healthcare Center's failure to explain the Arbitration Agreement in accordance with the Defendants' policies and procedures coupled with the manner in which the Arbitration Agreement was presented to Ann Coleman that

caused and contributed to Ms. Coleman not understanding the true nature of the document she was signing. The unconscionability of this process as described hereinabove serves as an additional sustaining ground for the finding that the Arbitration Agreement is not valid. The Defendants could not reasonably rely on the contract/agreement when they knew that Ann Coleman lacked the authority to enter into such a contract/agreement. The Defendants are assuming that it is the representation of the agent and not the principal that is the determinant of apparent authority and an establishment of agency when, as this Court has already discussed, it is the actions of the principal. As such, this Court rejects the Defendants' argument for equitable estoppel.

Furthermore, the Defendants have argued that Plaintiff cannot deny the validity of the Arbitration Agreement yet rely on the Admissions Agreement in alleging that the Defendants' were in breach of contract with respect to their contractual obligation to provide appropriate medical care to Mary Brinson. It is the Defendants' contention that the Arbitration Agreement and the Admissions Agreement are part of the same agreement between the parties and, as such, the Plaintiff can not disclaim the Arbitration Agreement. Defendants further argued that the Arbitration Agreement was part of the entire agreement between the parties and that the Plaintiff should not be able to argue that the Arbitration Agreement is invalid while asserting claims arising out of the relationship between the parties and that the Plaintiff should be equitably estopped from doing so. Plaintiff opposed these contentions. The errors in this argument have already been discussed. The Defendants again assume that the Arbitration Agreement and Admissions Agreement are on the same footing. As this Court has stated before, they are not. An agreement concerning the provision of health care is a far different matter than an agreement to waive legal and constitutional rights. As such, the Defendants' argument concerning estoppel is rejected.

CONCLUSION

This Court declines to enforce the Arbitration Agreement. Ann Coleman lacked the authority to bind her sister to any contract which removed her rights under the law and the Constitution. That she has the statutory authority to assist in making decisions regarding the treatment and care on behalf of her sister is irrelevant to the determination of whether she had the authority to contract on behalf of her sister in a separate legal agreement. The determination of agency is made based upon the principal and not the agent, and the Defendants' own documents demonstrate that they were aware that Mary Brinson was incapable of demonstrating any such intention or making any such representation. The Defendants cannot now reasonably argue that they thought Ms. Coleman had "apparent" authority, as they were aware of the legal requirements governing arbitration agreements.

Likewise, the Arbitration Agreement does not apply to all parties to this suit as it governs neither the claims brought on behalf of Mary Brinson's statutory beneficiaries, nor a portion of the Defendants who have not sought to force arbitration. Such circumstances give rise to the possibility of conflicting findings based on the same facts depending on the forum in which the issues are heard. These circumstances render the Arbitration Agreement unconscionable and impossible. Adding to the Agreement's unconscionability is Faith Healthcare Center's failure to adequately and appropriately inform Ms. Coleman as to the nature of the documents she was signing. She was not advised of the meaning of the Arbitration Agreement, nor was she advised that her signature on said Agreement was voluntary and that a refusal to sign would have no affect on her sister's admission to the facility.

The Arbitration Agreement was further abandoned by the Defendants through their delay. The Defendants proceeded to engage in the litigation process with Plaintiff, allowing this case to

more forward for more than a year after the filing of the Notice of Intent before they sought any enforcement of the Arbitration Agreement. South Carolina precedent is clear that, had the Defendants intended to seek enforcement of the Agreement, they should have done so at the outset of this matter, not more than a year after its genesis. And while it has been the finding of this Court in a separate Order that the Plaintiff has made a sufficient showing for jurisdiction over Defendants in this case, the myriad of issues discussed previously preclude any finding in favor of their Motion to Compel Arbitration, as they have argued inconsistent and irreconcilable positions.

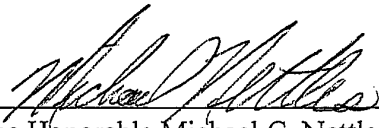
Finally, it is the belief of this Court that the Defendants' arguments concerning the third party beneficiary status of Mary Brinson and the argument concerning equitable estoppel are misguided and are rejected by the Court.

Therefore, it is the finding of this Court that the Plaintiff did not have the legal authority to execute the Arbitration Agreement on behalf of her sister; the Arbitration Agreement does not apply to all parties to this suit, giving rise to the possibility of divergent outcomes premised on the same facts; that the Arbitration Agreement itself is impossible and unconscionable; and that the Defendants abandoned the Agreement through their delay in seeking its enforcement. As such, Defendants' Motion to Stay Action and Compel Arbitration is denied in its entirety.

IT IS SO ORDERED.

Florence, South Carolina

Date: 3-18-11


The Honorable Michael G. Nettles
Twelfth Circuit of the State of South Carolina

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CONNIE RICE-SHEARIN
COURT & GS
FLORENCE COUNTY, SC

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FILED-CLERK OF COURT
 STATE OF SOUTH CAROLINA GREENVILLE COUNTY THIRTEENTH JUDICIAL CIRCUIT
 PAUL B. WICKENBARGER IN THE COURT OF COMMON PLEAS
 COUNTY OF GREENVILLE)

2014 JUL 24 PM 4 31

PATRICIA YOUNG, Individually
 and as Personal Representative of
 the Estate of Donald Young,

C. A. No. 2014-CP-23-00877

C.A. No. 2014-CP-23-00878

Plaintiff,

ORDER

vs.

NATIONAL HEALTHCARE
 CORPORATION, NHC/OP, L.P.,
 NATIONAL HEALTH
 CORPORATION, NHC-
 MAULDIN, LLC d/b/a NCH
 HEALTHCARE MAULDIN,
 CAROLINA MEDICAL
 REHABILITATION, LLC, BYUNG
 HUNG CHOE, M.D., KEITH
 SCHENTZEL, M.D., and GARY
 BARCINAS, P.A.,

Defendants.

This matter came before the Court on Defendants National Healthcare Corporation, NHC/OP, L.P., and National Health Corporation's (collectively hereinafter as "Corporate NHC Defendants") Motion to Dismiss and to Compel Arbitration and Defendant NHC-Mauldin, LLC d/b/a NCH Healthcare Mauldin's (hereinafter "NHC-Mauldin") Motion to Dismiss and to Compel Arbitration. Having listened to oral arguments from counsel and having reviewed the parties' legal memorandums, for the reasons more fully set forth below, the Court hereby grants the Motion to Compel Arbitration as to Civil Action number 2014-CP-23-00877 ("Survival Action"), but denies the Motion to Dismiss the Corporate NHC Defendants and to Compel Arbitration as to Civil Action number 2014-CP-23-00878 ("Wrongful Death Action").

AB



BACKGROUND

This matter arises out of two civil actions --- a Survival Action and a Wrongful Death action. Both actions involve allegations of nursing home negligence resulting in the death of Donald Young ("Decedent"). Patricia Young ("Plaintiff") was Decedent's spouse and serves as the personal representative of Decedent's estate.

On November 5, 2012, Decedent was admitted to NHC-Mauldin, a skilled nursing facility. National Healthcare Corporation is the parent corporation of NHC-Mauldin, and NHC/OP, L.P., and National Health Corporation are affiliate corporations. Plaintiff alleges that while the Corporate Defendants did not provide direct care or services to Decedent, they are proper Defendants in this matter because their control over NHC-Mauldin directly affected the quality of care received by Decedent.

At the time of admission, Decedent entered into an Admission and Financial Contract (the "Agreement") for the provision of health care services. As part of the Agreement, Decedent also executed an Agreement to Arbitrate ("Arbitration Agreement"). The Arbitration Agreement was also executed by Plaintiff, as an "other person signing on behalf of patient."

The Arbitration Agreement provides that the parties agree to follow the dispute resolution procedure set forth in the Arbitration Agreement. This Procedure can be summarized as follows:

1. The parties agree to follow the Grievance Procedure described in the Patient Rights Booklet for any claims or disputes arising out of or in connection with the care rendered to Mr. Young;
2. Where the amount in controversy sits within the limits for submission to South Carolina Small Claims Court, then the controversy will be submitted to

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that Court;

3. Any disputes with an amount in controversy exceeding the limits for submission to small claims court shall be resolved by binding arbitration. There are no limits on the award of actual or punitive damages in the Agreement.

Plaintiff filed the instant actions on February 18, 2014. Plaintiff has not complied with the Grievance Procedure as described in the Patient Rights Booklet for claims or disputes arising out of or in connection with Decedent's care, nor, despite the fact that the amount in controversy exceeds the limits for submission to small claims court, has Plaintiff made an attempt to arbitrate this matter as Defendants contend is required under the Arbitration Agreement.

LEGAL ANALYSIS AND CONCLUSIONS

Whether the parties agreed to arbitrate is a question of substantive state law. Simpson v. MSA of Myrtle Beach, Inc., 373 S.C. 14, 644 S.E.2d 663, 668 (S.C. 2007) ("General contract principles of state law apply in a court's evaluation of the enforceability of an arbitration clause."). The courts, not arbitrators, are charged with deciding certain "gateway matters" including whether the parties have a valid arbitration agreement or whether the arbitration clause applies to a certain type of controversy. New Hope Missionary Baptist Church v. Paragon Builders, 379 S.C. 620, 629, 667 S.E. 2d 1, 5 (Ct. App. 2008). The Court finds that the parties had a valid arbitration agreement; however, the agreement applies only to the Survival Action.

I. Survival Action Subject to Arbitration

The Survival Action is clearly within the scope of the Arbitration Agreement. The pertinent language of the Arbitration Agreement states,

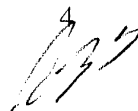
"The parties shall submit to binding arbitration all disputes... arising out of or in any way related or connected to the Patient's

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stay and the care provided at the Center, including but not limited to any disputes concerning alleged personal injury to the Patient caused by improper or inadequate care, including allegations of medical malpractice; any disputes concerning whether any statutory or regulatory provisions relating to the Patient were violated; any dispute related to Center's charges to the Patient; and any other dispute under state or federal law based on contract, tort, or statute that exceeds the state's small claims court statutory limits as later defined."

The Arbitration Agreement implicitly recognizes that injuries may occur to Decedent while he was a resident of NHC-Mauldin and that personal injuries and tort claims arising therefrom are to be governed by the Arbitration Agreement. It is clear that the intent of the Arbitration Agreement is to resolve allegations of negligence and personal injury through arbitration.

It is undisputed that Decedent and Plaintiff both signed the Arbitration Agreement and that there is nothing improper about the Arbitration Agreement on its face. In opposition to the Motion to Compel Arbitration, Plaintiff argues that the Arbitration Agreement should be deemed unconscionable due to the circumstances upon which it was executed. Specifically, Plaintiff contends that the Arbitration Agreement was just one of many documents that Decedent executed in a short period of time during the admission process, so Decedent may not have had time to fully read it. However, whether the Decedent did or did not read the Arbitration Agreement is irrelevant since it is well established that a person who signs a contract cannot avoid the effect of the document by claiming he did not read it. Regions Bank v. Schmauch, 354 S.C. 648, 663, 582 S.E.2d 432, 440 (Ct. App. 2003) ("Every contracting party owes a duty to the other party to the contract and to the public to learn the contents of a document before he signs it.") In addition, Plaintiff contends that Decedent had taken narcotic medications prior to admission that may have affected his mental status and his ability to understand the document. But, mere speculation that Decedent may have been incompetent at the time is insufficient. Plaintiff had the burden of proving Decedent's incompetence, and she failed to put forth any



evidence in support of her allegation. *See Schmauch*, 354 S.C. at 665, 582 S.E.2d at 441.

Therefore, this Court finds that Decedent knowingly entered into an agreement to arbitrate any claims that arose from his being a patient of NHC-Mauldin. As a result, this Court grants NHC-Mauldin's Motion to Dismiss the Survival Action and to Compel Arbitration pursuant to the terms of the Arbitration Agreement on all claims that were made or could have been made in the Survival Action. Further, the Court finds that the Corporate NHC Defendants were intended beneficiaries of the Arbitration Agreement; therefore, the order compelling arbitration of the Survival Action shall also apply to the Corporate NHC Defendants as the allegations against those Defendants are based on the same facts and are inherently inseparable from the claims made against NHC-Mauldin. *See Int'l Paper Co. v. Schwabedissen Maschenen & Anlagen GMBH*, 206 F.3d 411, 417 (4th Cir. 2000); *see also Pearson v. Hilton Head Hospital*, 400 S.C. 281, 733 S.E.2d 597 (S.C. Ct. App. 2012).

II. Wrongful Death Action Not Subject to Arbitration

While Decedent and NHC-Mauldin clearly intended to arbitrate any claims between them, it is less clear whether the Arbitration Agreement mandates arbitration for all claims related to Decedent's injuries and death. It appears that the question of whether a wrongful death action is subject to mandatory arbitration pursuant to the terms of a contract is one of first impression in South Carolina. Case law across many jurisdictions within the United States is split as to whether an arbitration agreement covers a wrongful death claim brought by the decedent's statutory beneficiaries who were not a party to the contract. *Compare Carter v. SSC Odin Operating Company, LLC*, 2012 IL 113204, 976 N.E.2d 344, 360, 364 Ill. Dec. 66 (Ill. 2012); *Lawrence v. Manor*, 273 S.W.3d 525, 530 (Mo. 2009); *Bybee v. Abdulla*, 2008 UT 35, 189 P.3d 40, 47, 50 (Utah 2008); *Peters v. Columbus Steel Castings Co.*, 115 Ohio St. 3d 134, 2007 Ohio 4787, 873

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N.E.2d 1258, 1262 (Ohio 2007); McFarren v. Emeritus at Canton, 2013 Ohio 3900, 997 N.E.2d 1254, 2013 WL 4822908 (Ohio App. 2013); Pisano v. Extendicare Homes, Inc., 2013 PA Super 232, 77 A.3d 651, 2013 WL 4046673 (Pa. Super. 2013); Woodall v. Avalon Care Center-Federal Way, LLC, 155 Wn. App. 919, 231 P.3d 1252, 1257-59 (Wash. App. 2010) with Graves v. B.P., 568 F.3d 221, 223 (5th Cir. 2009); Peltz ex rel. Estate of Peltz v. Sears, Roebuck & Co., 367 F.Supp.2d 711, 718-19 (E.D. Pa. 2005); Laizure v. Avante at Leesburg, Inc., 109 So. 3d 752, 762 (Fla. 2013); Ruiz v. Podolsky, 50 Cal. 4th 838, 114 Cal. Rptr. 3d 263, 237 P.3d 584, 591 n. 2 (Cal. 2010); In re Labatt Food Service, L.P., 279 S.W.3d 640, 647 (Tex. 2009); Briarcliff Nursing Home, Inc. v. Turcotte, 894 So.2d 661, 665 (Ala. 2004); Allen v. Pacheco, 71 P.3d 375, 379 (Colo. 2003); Estate of Richard Heiney v. Life Care Centers of America, Inc., 2013 Ariz. App. Unpub. LEXIS 496, 2013 WL 1846599 (Ariz. App. 2013).

This Court finds persuasive the reasoning of those jurisdictions that have held that an arbitration agreement executed by a decedent cannot bind the decedent's statutory beneficiaries who were not parties to the agreement. South Carolina law is clear that a wrongful death claim exists for the statutory beneficiaries, and that such claims are distinct and separate claims from those that are brought under the survival statute. See Bennett v. Spartanburg Railway Gas and Electric Company, 97 S.C. 27, 81 S.E. 189 (1914). The Arbitration Agreement, by its own terms, "is an agreement to arbitrate any dispute that might arise between Donald W. Young ("Patient") and NHC Healthcare Mauldin, LLC ("Center")." Decedent had the authority to bind himself and his claims to arbitration, but this Court finds he did not have the legal authority to bind his statutory beneficiaries who were not a party to the Arbitration Agreement.

NHC-Mauldin contends that the Arbitration Agreement expressly covers the statutory beneficiaries' claims, and that by signing the agreement, Decedent knowingly bound those

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claims to arbitration. However, this Court agrees with the Supreme Court of Kentucky which said regarding binding non-signatory wrongful death beneficiaries in Ping v. Beverly Enterprises, Inc.,

“[A]s interesting as life might be if we could bind one another to contracts merely by referring to each other in them, we are not persuaded that a non-signatory who receives no substantive benefit under a contract may be bound to the contract's procedural provisions, including arbitration clauses, merely by being referred to in the contract. It is one thing to say that a third party for whose substantive benefit a contract is made may not enforce his or her rights under the contract without also abiding by the contract's other terms. That is the general third-party beneficiary rule discussed above. It may even be that tort claims by such a directly benefitting third party are appropriately subjected to the contract's arbitration provisions, at least where the tort and the contract are significantly intertwined. It is something else entirely, however, to say that incidental beneficiaries of a contract—individuals or entities with no substantive rights under the contract and no direct benefits—may have their tort claims against the parties swept up into the contract's arbitration provisions merely by being mentioned in the contract as potential claimants.”

376 S.W.3d at 599-600.

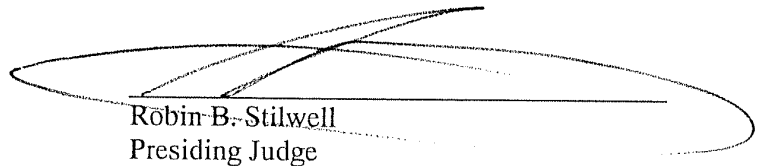
NHC-Mauldin contends that the fact that Plaintiff signed the Arbitration Agreement distinguishes this case from Ping and the other cases cited above. While it is true that Plaintiff signed the Arbitration Agreement, by its own terms, she did so on behalf of Decedent, not on her own behalf. As a result, the Court finds Plaintiff did not knowingly agree to arbitrate her claims against NHC-Mauldin. Regardless, even if the Court were inclined to agree that Plaintiff signed the Arbitration Agreement on her own behalf, Plaintiff has represented to the Court that she is not the only statutory beneficiary seeking to recover damages via the Wrongful Death action; therefore, even if her individual claims should be subject to arbitration, she did not have the authority to bind the other statutory beneficiaries' claims. As a result, they have a right to have their claims decided by a jury of their peers should the evidence so warrant.

III. Corporate NHC Defendants

The Court finds there are pending questions of fact as to whether the Corporate NHC Defendants had sufficient control over NHC-Mauldin and the care that was provided to Decedent so as to subject them to the jurisdiction of this Court. Questions regarding the Corporate NHC Defendants' level of involvement in the management of daily affairs including, employee scheduling and patient care, as well as the corporate involvement in the overall management of NHC-Mauldin must still be resolved through further discovery. Therefore, the Corporate NHC Defendants' Motion to Dismiss in the Wrongful Death action is denied at this time without prejudice. The Corporate NHC Defendants may raise the issue again at summary judgment as discovery warrants.

WHEREFORE, for the reasons stated herein, the Court grants the Motion to Dismiss the Survival Action and orders the parties to arbitrate the matter pursuant to the terms of the Arbitration Agreement. But, the Court denies the Motion to Compel Arbitration in the Wrongful Death action and also denies, without prejudice, the Motion to Dismiss the Corporate NHC Defendants.

IT IS SO ORDERED.


Robin B. Stilwell
Presiding Judge

June 26, 2014
Greenville, South Carolina

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF GREENVILLE	)	C.A. No.: 2019-CP-23-02184 &
	)	2019-CP-23-02185
	)	
Jack A. Joyner, Individually and as	)	
Personal Representative of the Estate	)	
of Dollie Alice Joyner,	)	
	)	
Plaintiff,	)	ORDER
	)	
v.	)	
	)	
NHC Healthcare/Greenville, LLC,	)	
National Healthcare Corporation,	)	
NHC/OP, L.P.,	)	
	)	
Defendant(s).	)	
	)	

This matter came before the Court in Greenville County on July 26, 2019, on Defendants' Motion to Dismiss and Motion to Compel Arbitration in regard to Plaintiff's Complaints. Present for hearing were Matthew W. Christian, Esq. of Greenville, S.C. for the Plaintiff and Andrew M. Rawl, Esq. and F. Matlock Elliott, Esq. of Greenville, S.C. for the Defendants.

This matter arises out of two civil actions involving allegations of nursing home abuse and neglect and corporate negligence with claims of underfunding, understaffing, and undertraining. Both parties submitted briefs/memoranda as well as exhibits in support of their positions. Having listened to oral arguments from counsel and having reviewed the parties' legal memoranda for the reasons more fully set forth below, the Court hereby denies the Defendants' Motion to Dismiss and Motion to Compel Arbitration.



BACKGROUND

Plaintiff Jack A. Joyner (hereinafter “Son”) was the son and is the Personal Representative of the Estate of Dollie Alice Joyner (hereinafter “Decedent”), a resident/patient at Defendants’ skilled nursing facility. The skilled nursing facility was NHC Healthcare/Greenville, LLC (hereinafter “Facility”), an entity Plaintiff contends was owned, controlled, and operated by Defendants National Healthcare Corporation and NHC/OP, L.P. Decedent was admitted to the Facility on April 27, 2016, for short-term rehabilitation after a brief hospitalization for a urinary tract infection. Plaintiff alleges that Decedent suffered from multiple preventable pressure ulcers/bedsores and inadequate care regarding nutrition and hydration resulting in infected pressure ulcers/bedsores, dehydration, and nutritional compromise, all of which Plaintiff alleges resulted in Decedent’s death. Defendants vehemently deny these allegations.

At the time of admission, Decedent and Son signed an agreement to arbitrate and waive jury trial (“Arbitration Agreement”). Plaintiff argued that the Arbitration Agreement was unenforceable in its entirety and in the alternative, if it was enforceable, that it was unenforceable as to the wrongful death actions and statutory beneficiaries. Plaintiff further argued that Defendants’ Motion to Dismiss National Healthcare Corporation and NHC/OP, L.P. should be denied because there is significant evidence that these Defendants were involved in the management, operation, oversight, budget, staffing, training, and policies and procedures at the facility.

LEGAL ANALYSIS AND CONCLUSIONS

The party seeking to enforce an agreement to arbitrate has the burden of establishing the existence of a valid arbitration agreement. See Aiken v. World Finance

Corp. of S.C., 373 S.C. 144, 149, 644 S.E.2d 705, 708 (2007); MBNA America Bank, N.A. v. Christianson, 377 S.C. 210, 659 S.E.2d 209 (S.C. Ct. App. 2008). It is well established that “where one party denies the existence of an arbitration agreement raised by an opposing party, a court must immediately determine whether the agreement exists in the first place. If no agreement is found to exist, the court must deny any application to arbitrate.” Simpson v. MSA of Myrtle Beach, Inc., 373 S.C. 14, 644 S.E.2d 663, 667 (S.C. 2007) (internal citation omitted). Whether a valid arbitration agreement exists is a matter for judicial determination. York v. Dodgeland of Columbia, Inc., 406 S.C. 67, 78, 749 S.E.2d 139, 144 (Ct. App. 2013). Whether the parties agreed to arbitration is a question of substantive state law. Simpson v. MSA of Myrtle Beach, Inc., 373 S.C. 14, 644 S.E.2d 663, 668 (S.C. 2007) (“General contract principles of state law apply in a court’s evaluation of the enforceability of an arbitration clause.”).

I. The Arbitration Agreement is Unenforceable Because There was no Meeting of the Minds and Mutual Assent by the Parties

The purported agreement to arbitrate is between “Alice Joyner (‘Patient’)” and “National Healthcare, LLC” as “(‘Center’)”. It is undisputed that the Facility’s name and licensee of the skilled nursing facility where Plaintiff was admitted was “National Healthcare/Greenville, LLC”.

Plaintiff argued that the Defendants operate under a complex corporate structure. Within that corporate structure, Plaintiff produced a corporate flowchart for the Defendants. Nowhere within the corporate flowchart is there an entity named “National Healthcare, LLC”. The entity which whom Defendants contend Decedent/Son agreed to arbitrate does not exist.

Courts have held that mutual assent and a meeting of the minds is necessary for an enforceable arbitration agreement. South Carolina law requires that in order to have a valid and enforceable contract, there must be a meeting of the minds between the parties with regard to all essential and material terms of the agreement. Grant v. Magnolia Manor-Greenwood, Inc., 383 S.C. 125, 678 S.E.2d 435 (2009) citing Player v. Chandler, 299 S.C. 101, 105, 382 S.E.2d 891 (1989). Parties cannot be said to have had a meeting of the minds on matters which are indefinite, vague, uncertain, and even incomprehensible. “Vagueness of expression, indefiniteness, and uncertainty as to any of the essential terms of an agreement have often been held to prevent the creation of an enforceable contract.” Reed v. Boykin, 282 S.C. 614, 320, S.E.2d 68 (S.C. App. 1984) *quoting* 1 CORBIN ON CONTRACTS, § 95 (1963).

The Arbitration Agreement states that “this is an agreement to arbitrate any dispute that might arise between Alice Joyner (‘Patient’) and National Healthcare, LLC (‘Center’).” The document must be construed against the Defendants as the drafting entities. Nowhere does the document identify that the Plaintiff was entering into an arbitration agreement with “National Healthcare/Greenville, LLC”, “National Healthcare Corporation”, or “NHC/OP, L.P.” within the four corners of this agreement.

The identification of the parties to the agreement are essential and integral terms to which courts may not re-write for the parties. The issue is “whether there was a meeting of the minds, that is, whether the parties agreed in clear and unmistakable manner to arbitrate their disputes”. Bair v. Manor Care of Elizabethton PA, LLC, et al., No. 435 MDA 2014, 108 A3d 94 (2015). Absent mutual assent at the time of the creation of the agreement, there can be no enforceable agreement to arbitrate. The identification

of the parties with whom the parties agreed to purportedly arbitrate is an essential and integral part/term of the purported agreement. Failure on the part of the Defendants to have the valid correct name of an existing entity results in indefinite, vague, uncertain, and even incomprehensible terms which are essential to the agreement. Therefore, Plaintiff cannot be compelled to arbitrate his claims with an entity that neither exists nor is the entity with whom the current lawsuit involves and as such, the Arbitration Agreement is unenforceable in its entirety.

B. In the Alternative, if the Arbitration Agreement was Enforceable as to the Survival Action Claim, it is Unenforceable Against Decedent’s Wrongful Death Statutory Beneficiaries.

It is the conclusion and order of this Court that the Arbitration Agreement is unenforceable for the above-stated reasons. However, even if Son had actual or apparent authority/agency to sign the Arbitration Agreement on behalf of Decedent, the Arbitration Agreement is unenforceable against the Decedent’s wrongful death statutory beneficiaries under South Carolina contract law defenses. The Arbitration Agreement neither covers the wrongful death statutory beneficiaries’ claims within the scope of the agreement nor was the Arbitration Agreement signed by an individual who had authority to bind the statutory beneficiaries.

South Carolina law is clear that a wrongful death claim exists for the statutory beneficiaries and that such claims are distinct and separate from those brought under survival claims. Bennett v. Spartanburg Railway Gas and Electric Co., 97 S.C. 27, 81 S.E. 189 (1914). The alleged Arbitration Agreement by its own terms is an agreement between “Alice Joyner (‘Patient’)” and “NHC Healthcare, LLC (‘Center’)”. Even if Decedent had agreed to arbitration, she did not have the legal authority to bind her

statutory beneficiaries who are not parties to the Arbitration Agreement. The signatories to the agreement are Decedent, Son on behalf of Decedent, and NHC Healthcare, LLC. No other persons are parties to this agreement. The scope of the agreement does not include the statutory beneficiaries' claims.

However, even if the Arbitration Agreement did contemplate the wrongful death statutory beneficiaries' claims, Decedent and/or Son had no authority to waive the statutory beneficiaries' claims. Son signed the Arbitration Agreement in his *individual capacity*. However, as the Hodge court noted, actions taken by Son in his *individual capacity* will not be held against the estate as the estate has other beneficiaries and may have other creditors. Moreover, the wrongful death claim is not based on the contract or agreement to arbitrate with the facility. The statutory beneficiaries received no benefit from any contract which Decedent may have entered into with the Defendants. See Wilson v. Willis, No. 27879, 2019 S.C. LEXIS 27.

Further confirming the separateness of each statutory beneficiary's claim from that of the survival action, a Federal District Court in South Carolina has analyzed this issue under the South Carolina Non-Economic Awards Act of 2005. Diane Boyle as Personal Representative of the Estate of John Francis Boyle v. United States of America, 944 F.Supp.2d 577 (D.S.C. 2012). In Boyle, the Court concluded that the wrongful death beneficiaries' claims were separate and distinct claims for purposes of stacking damage caps and for purposes of being individual claimants. This analysis supports the contention that the wrongful death claimants have separate and distinct claims apart from that of the survival action.

Many other states have come to this same conclusion, Daniels v. Sunrise Senior Living, Inc., 212 Cal.App 4th 674, 151 Cal.Rptr.3d 273 (Cal.App.4 Dist, 2013) (Wrongful Death claims not bound to arbitration), Lawrence v. Beverly Manor, 273 S.W.3d 525 (Mo. 2009) (Wrongful Death claimants not bound by arbitration agreement.) As previously discussed, the only parties executing this Agreement were Decedent, Son purportedly on behalf of Decedent, and an employee as an agent for NHC Healthcare, LLC. Defendants would contend that this agreement is binding on the non-signatory statutory beneficiaries simply because it contends the Arbitration Agreement says so.

However, as the Supreme Court of Kentucky said regarding binding non-signatory wrongful death beneficiaries in Ping v. Beverly Enterprises, Inc.:

[A]s interesting as life might be if we could bind one another to contracts merely by referring to each other in them, we are not persuaded that a non-signatory who receives no substantive benefit under a contract may be bound to the contract's procedural provisions, including arbitration clauses, merely by being referred to in the contract. It is one thing to say that a third party for whose substantive benefit a contract is made may not enforce his or her rights under the contract without also abiding by the contract's other terms. That is the general third-party beneficiary rule discussed above. It may even be that tort claims by such a directly benefitting third-party are appropriately subjected the contract's arbitration provisions, at least where the tort and contract are significantly intertwined. See, In re Weekley Homes, L.P., 180 S.W. 3d 127 (Tex. 2005) (negligent repair claim by homeowner's Son against contractor was subject to repair contract's arbitration clause because Son, although a non-party, was direct and principal beneficiary under the contract). It is something else entirely, however, to say that incidental beneficiaries of a contract-individuals or entities with no substantive rights under the contract and no direct benefits-may have their tort claims against the parties swept up into the contract's arbitration provisions merely by being mentioned in the contract as potential

claimants. This is what Beverly purports to do. Arbitration is a matter of contract, however, it is something the contracting parties, or their proxies, must agree to. It is not something that one party may simply impose upon another. Howsam v. Dean Witter Reynolds, Inc., 537 U.S. 79, 83, 123 S. Ct. 588, 154 L. Ed.2d 491 (2002) (“[A]rbitration is a matter of contract and a party cannot be required to submit to arbitration any dispute which he has not agreed so to submit”, Citation and internal quotation marks omitted.) Since Beverly’s theory would allow just that, i.e., would allow one party merely by referring to someone else in an arbitration clause to thereby bind that other person to arbitration as a “third party beneficiary” of the arbitration agreement, we reject it out of hand.

Ping v. Beverly Enterprises, Inc., 376 S.W.3d 581, 599-600 (KY 2012).

Likewise, Defendants’ mentioning of “agents, representatives, affiliates, fiduciaries...third party beneficiaries, heirs, executors, administrators, or any of them, and all persons, entities or corporations with whom any of the former have been, are now, or may be affiliated, arising out of or in any way related or connected to the Patient’s stay and the care provided at the Center, including but not limited to any disputes concerning alleged personal injury to the Patient caused by improper or inadequate care, including allegations of medical malpractice; any disputes concerning whether any statutory or regulatory provisions relating to the Patient were violated...”, as being bound by the Arbitration Agreement does not make it so. It is no more than an *ipse elixir* which Defendants expect this Court to embrace. The law simply does not permit a party to cut off the rights of a non-signatory to an agreement who receives no benefit thereunder.

The wrongful death claims are separate claims apart from the Decedent’s claims.

According to South Carolina’s Wrongful Death Act:

“Whenever the death of a person shall be caused by the wrongful act, negligent or the fault of another and the

act, negligent or the fault is such as would, if death had not ensued, had entitled party injured to maintain an action and recover damages in respect thereof, the person who would have been liable, if death had not ensued shall be liable to an action for damages.”

South Carolina Code Annotated §15-51-10 (1977)

The wrongful death beneficiaries are as follows:

“Every such action shall be for the benefit of the wife, or husband and child or children of the person whose death shall have been so caused, and, if there be no such wife, husband, child or children, then for the benefit of the parent or parents, and if there be none, for the benefit of the heirs or the person whose death shall have been so caused.”

South Carolina Code Annotated §15-51-20 (Supp. 2001)

The general element of damages recoverable are pecuniary loss, mental shock and suffering, wounded feelings, grief and sorrow, loss of companionship, and deprivation of the use and comfort of the Decedent, society, including the loss of her experience, knowledge, and judgment in managing the affairs of herself and her beneficiaries. Self v. Goodrich, 300 S.C. 349, 351, 387 S.E.2d. 713, 714 S.C. (Ct. App. 1989).

The wrongful death claim is a separate claim from the claims a decedent might bring on his own behalf under the survival statute. In Bennett v. Spartanburg Railway Gas and Electric Company, 97 S.C. 27, 81 S.E. 189 (1914), the Supreme Court held that wrongful death and survival actions are different claims for different injuries. The Court stated “necessarily, therefore, there must be separate verdicts and separate judgments, there should be separate actions.” Id. at 31. See also Strickland v. Southern Ry Co., 111 S.C. 248, 97 S.E. 695 (1918) (Supreme Court Affirmed Appeal from Circuit Court’s ruling noting that survival claims are independent of wrongful death claims), Claussen v.

Brothers, 148 S.C. 1, 145 S.E. 539 (1928) (discussing the difference between survival and wrongful death claims as being independent of each other).

The Pennsylvania Superior Court in Pisano v. Extended Homes, Inc., operating under the fictitious name Belaire Health 84 Rehabilitation Center, 2013 PA Super 232, 77 A.3d 651, 662 (PA 2013) affirmed the trial court decision that the nursing home arbitration agreement did not apply to the statutory beneficiaries' wrongful death claim. The Court noted the wrongful death and survival actions are not derivative of each other but are flowing from the same underlining tortious conduct. Like the South Carolina statute, Pennsylvania's wrongful death statute provides that the right of action exists only for the benefit of the spouse, children, parents, or parents of the deceased. Id. at 656. The Pennsylvania Court further held that since the wrongful death claim is independent of the survival action and because the wrongful death statute does not characterize the wrongful death claim as that of a third-party beneficiary, that the trial court properly refused to compel arbitration to the non-signatory wrongful death beneficiaries who were not parties to the arbitration agreement.

Likewise, in Bybee v. Abdulla, M.D., 189 P.3d 40, 2008 UT 35 (Utah, 2008), the Supreme Court of Utah held that an agreement to arbitrate that was signed by the decedent cannot extend to the statutory beneficiaries of a wrongful death claim. The Utah Supreme Court noted that certain defenses from the decedent's personal injury action may be raised against the heirs of a wrongful death action such as comparative negligence and statutes of limitations as key common characteristics. However, as the Supreme Court of Utah noted, both of these defenses go to the viability of the underlying personal injury action. The Court further stated that "by contract, an agreement to bind

heirs to arbitrate disputes does not implicate the viability of underlying claims.” Id. at 47, citing Horwich v. Superior Court, 21 Cal. 4th 272, 87 Cal. Rptr. 2d 222, 980 P. 2d 927, 935 (1999). The Utah Supreme Court went on to note that “we have never intended to suggest, however, that because Decedent is the master of his claim he may by contract expose his unwilling heirs to any imaginable defense.” Bybee v. Abdulla, M.D. at 46. The Utah Supreme Court further held that the defenses against the decedent’s claim which are less likely to be found enforceable against the heirs’ claims in a wrongful death action “are contract provisions that purport to affect the rights of heirs that do not affect the existence of the decedent’s personal injury claim during his lifetime. The arbitration agreement...falls squarely within this category and is, therefore, unenforceable against the heir.” Id. at 47.

The Court of Appeals in Washington in Woodall v. Avalon Care Center-Federal Way, LLC, 155 Wn. App. 919, 231 P. 3d 1252 (Wash. App. Div. 1 2010) held that “arbitration is a matter of contract and a party cannot be required to submit to arbitration any dispute which he [or she] has not agreed so to submit.” Id. quoting Satomi Owners Association v. Satomi, LLC, 167 Wash. 2d 781, 225 P.3d 213 (2009). The Washington Court of Appeals further noted that the wrongful death claims asserted in that case were not on behalf of the estate just as South Carolina’s wrongful death claims are not on behalf of the estate. The Washington Court of Appeals further discussed the Supreme Court of Ohio’s ruling in Peters v. Columbus Steel Casting Co., 115 Ohio St.3d 134, 873 N.E.2d 1258 (2007), wherein the Supreme Court of Ohio held that the wrongful death claim of a spouse who was Administrator of her husband’s estate was not subject to the Decedent’s arbitration agreement. The Washington Court of Appeals in discussing Peters,

stated “In sum, the decedent’s agreement was an agreement ‘to arbitrate his claims against the company,’ and thus the provision in the agreement binding the decedent’s heirs applied to a survival action. But the decedent could not ‘restrict his beneficiaries to arbitration of their wrongful death claims because he held no right to those claims.” Woodall v. Avalon Care Center - Federal Way, LLC at 929. In the Washington Court of Appeals’ analysis, the Court concluded that the wrongful death beneficiaries could not be bound to the arbitration agreement which they did not sign.

Therefore, even if Son had actual or apparent authority/agency to execute the Arbitration Agreement, the Arbitration Agreement did not include the wrongful death statutory beneficiaries’ claims within the scope of the Arbitration Agreement, nor did Decedent and/or Son have authority to bind the wrongful death statutory beneficiaries’ claims to the Arbitration Agreement. As a result, the Arbitration Agreement cannot reach the claims of the wrongful death statutory beneficiaries.

II. National Healthcare Corporation and NHC/OP, L.P.’s Motion to Dismiss

Defendants National Healthcare Corporation and NHC/OP, L.P. also moved independently to be dismissed from the actions pursuant to Rules 12(b)(1), (2), and (6), S.C.R.C.P. on the grounds that:

- a) These Defendants are separate and distinct legal entities from NHC Healthcare/ Greenville, LLC;
- b) The Complaint also fails to state a claim against these Defendants in that:
 - i. These Defendants do not provide care and treatment to patients at NHC Healthcare/Greenville, LLC, such as Ms. Joyner, and,

in particular, had no involvement with the allegations involving Ms. Joyner;

- ii. No act or omission of these Defendants were proximate cause of any injuries or damages to Ms. Joyner;
- iii. At no point have these Defendants exerted sufficient control over NHC Healthcare/Greenville, LLC to create a principal-agent relationship, and at no point have these Defendants expressly authorized or insisted upon any act or omission of NHC Healthcare/Greenville, LLC related to this present litigation; and
- iv. These Defendants are not liable for the tortuous acts of NHC Healthcare/Greenville, LLC.

The Court hereby denies Defendants National Healthcare Corporation and NHC/OP, L.P.'s Motions to Dismiss. Plaintiff argued and submitted significant evidence through the course of argument, brief, and exhibits that warrant the denial of these Defendants' Motion at this stage. The Court's decision is that Plaintiff has made a sufficient showing to overcome Defendants' Rule 12(b) Motions to Dismiss; however, the Court's ruling is not a dispositive determination of the Defendants' liability in this action.

CONCLUSION

Because Plaintiff has met the threshold of requirements to overcome Defendants' Rule 12(b)(1), (2), and (6) Motions to Dismiss, the Motions to Dismiss by Defendants National Healthcare Corporation and NHC/OP, L.P. are hereby denied.

Because there was no mutual assent and meeting of the minds and for the other reasons set forth hereinabove, Defendants' Motions to Compel Arbitration are denied. For the foregoing reasons and above-stated reasons, Defendants' Motion to Dismiss and Motion to Compel Arbitration ARE HEREBY DENIED.

IT IS SO ORDERED.

Greenville, South Carolina
Date: _____

The Honorable Edward W. Miller
Judge, Thirteenth Judicial Circuit
State of South Carolina



Greenville Common Pleas

Case Caption: Jack A Joyner , plaintiff, et al vs. Nhc Healthcare Greenville, Llc ,
defendant, et al
Case Number: 2019CP2302185
Type: Order/Other

So Ordered

s/ Edward W. Miller

Electronically signed on 2019-08-28 13:17:58 page 15 of 15

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF GREENVILLE	)	C.A. No.: 2019-CP-23-7282 &
	)	2019-CP-23-7283
	)	
Troy Testerman, Individually and as	)	
Personal Representative of the Estate	)	
of Donald Testerman,	)	
	)	
Plaintiff,	)	
	)	
v.	)	ORDER
	)	
Emeritus Corporation d/b/a Brookdale	)	
Greenville, Emericare, Inc., Emerical,	)	
Inc., Brookdale Senior Living, Inc.,	)	
HCP MA3 South Carolina, LP, Bre	)	
Knight SH SC Owner, LLC, Inpatient	)	
Consultants of North Carolina, P.C.,	)	
Adam L. Schendel, MSN, ACNP-BC,	)	
Jaspreet Pestana, M.D.,	)	
	)	
Defendant(s).	)	
	)	

This matter came before the Court on April 14, 2020 on Defendants' Motion to Dismiss or, in the Alternative, Motion to Compel Arbitration and Stay Proceedings.

This matter rises out of wrongful death and survival actions involving allegations of nursing home negligence and corporate negligence and allegations of understaffing, underfunding, undertraining, and corporate mismanagement. Both parties submitted briefs/memoranda as well as exhibits in support of their motions. The hearing was conducted via telephone conference with consent of all parties and pursuant to the South Carolina Supreme Court's recent Order regarding such hearings in light of the COVID-19 pandemic. Present for the Defendants were C. Stuart Mauney for Defendants Emeritus Corporation d/b/a Brookdale Greenville, Emericare, Inc., Emerical, Inc., Brookdale Senior Living, Inc., HCP MA3 South Carolina, LP, and Bre Knight SH SC Owner, LLC



and Mark Wilby for Defendants Inpatient Consultants of North Carolina, P.C., Adam L. Schendel, MSN, ACNP-BC, and Jaspreet Pestana, M.D. and Matthew Christian for the Plaintiff. Having listened to oral arguments from counsel and from having reviewed the parties' legal memoranda and exhibits, for the reasons set forth more fully below, the Court hereby grants Defendants' Motion to Dismiss or, in the Alternative, Motion to Compel Arbitration and Stay Proceedings as to the survival action as to all Defendants. The Court denies Defendants' Motion to Dismiss or, in the Alternative, Motion to Compel Arbitration and Stay Proceedings as to the wrongful death action as to all Defendants.

BACKGROUND

Troy Testerman (hereinafter "Son") was the son and is the Personal Representative of the Estate of Donald Testerman (hereinafter "Decedent"), a resident/patient at Defendants' skilled nursing facility and where Defendants Inpatient Consultants of North Carolina, P.C., Adam L. Schendel, MSN, ACNP-BC, and Jaspreet Pestana, M.D. treated Decedent.

The skilled nursing facility was Emeritus Corporation d/b/a Brookdale Greenville (hereinafter "Brookdale Greenville") which Plaintiff contends was owned, controlled, and operated by Emericare, Inc., Emerical, Inc., Brookdale Senior Living, Inc., HCP MA3 South Carolina, LP, and Bre Knight SH SC Owner, LLC.

Decedent was admitted to Brookdale Greenville on January 17, 2018 for long-term care. Plaintiff alleges that during this admission, Defendants failed to properly prevent and/or treat skin breakdown/pressure ulcers/bedsores resulting in multiple pressure ulcers/bedsores, some of which became infected and malodorous and were very

significant in size. Plaintiff further alleges Defendants failed to timely prevent and treat falls, weight loss, and infection. Additionally, Plaintiff alleges claims of understaffing and underfunding in conjunction with the corporate negligence claims. Plaintiff also alleges that as a result of these injuries, Defendants caused Decedent's death on May 8, 2018. All Defendants vehemently deny all of Plaintiff's allegations.

Defendants filed this Motion to Dismiss and Compel Arbitration on March 3, 2020 arising out of an arbitration agreement signed by Son on January 17, 2018 at Brookdale Greenville's facility in conjunction with Decedent's admission to Brookdale Greenville's facility. It is undisputed that Son held both a guardianship and a general durable power of attorney for Decedent. For the reasons stated hereinbelow, Defendants motion is denied as to the wrongful death causes of action and granted as to the survival action claims.

LEGAL ANALYSIS

The party seeking to enforce an agreement to arbitrate has the burden of establishing the existence of a valid arbitration agreement. See Aiken v. World Finance Corp. of S.C., 373 S.C. 144, 149, 644 S.E.2d 705, 708 (2007); MBNA America Bank, N.A. v. Christianson, 377 S.C. 210, 659 S.E.2d 209 (S.C. Ct. App. 2008). It is well established that "where one party denies the existence of an arbitration agreement raised by an opposing party, a court must immediately determine whether the agreement exists in the first place. If no agreement is found to exist, the court must deny any application to arbitrate." Simpson v. MSA of Myrtle Beach, Inc., 373 S.C. 14, 644 S.E.2d 663, 667 (S.C. 2007) (internal citation omitted). Whether a valid arbitration agreement exists is a matter for judicial determination. York v. Dodgeland of Columbia, Inc., 406 S.C.

67,78,749 S.E.2d 139, 144 (Ct. App. 2013). Whether the parties agreed to arbitration is a question of substantive state law. Simpson v. MSA of Myrtle Beach, Inc., 373 S.C. 14, 644 S.E.2d 663, 668 (S.C. 2007) (“General contract principles of state law apply in a court’s evaluation of the enforceability of an arbitration clause.”).

Because Son had authority under the language of the General Durable Power of Attorney to execute the agreement for arbitration, the arbitration agreement is enforceable as to Decedent’s claims in the Survival Action, However, the Arbitration Agreement is unenforceable against the Decedent’s wrongful death statutory beneficiaries under South Carolina contract law defenses. The Arbitration Agreement neither covers the wrongful death statutory beneficiaries’ claims within the scope of the agreement nor was the Arbitration Agreement signed by an individual who had authority to bind the statutory beneficiaries.

South Carolina law is clear that a wrongful death claim exists for the statutory beneficiaries and that such claims are distinct and separate from those brought under survival claims. Bennett v. Spartanburg Railway Gas and Electric Co., 97 S.C. 27, 81 S.E. 189 (1914). The alleged admission agreement/arbitration agreement with Brookdale Greenville by its own terms is an agreement between “Emericare, Inc. d/b/a Brookdale Greenville AL/MC/SNF (SC) a licensed Nursing Care Institution located at 1306 Pelham Road, Greenville SC 29615 (the ‘Provider’, ‘us’, ‘we’, or ‘our’)” and “Donald Testerman (the ‘Resident’, ‘you’, or ‘your’) and/or (Name of ‘Resident Representative’) on behalf of Resident”. Even if Decedent had agreed to arbitration, he did not have the legal authority to bind his statutory beneficiaries who are not parties to the Arbitration Agreement. The signatories to the agreement are Son as representative of Decedent and the agent for

Brookdale Greenville. No other persons are parties to these agreements. The scope of the agreement does not include the statutory beneficiaries' claims.

However, even if the Arbitration Agreement did contemplate the wrongful death statutory beneficiaries' claims, Decedent and/or Son had no authority to waive the statutory beneficiaries' claims. Son signed the Arbitration Agreement in his *individual capacity* in a representative capacity of Decedent only. As the Hodge court noted, actions taken by Son in his *individual capacity* will not be held against the estate as the estate has other beneficiaries and may have other creditors. Moreover, the wrongful death claim is not based on the contract or agreement to arbitrate with the facility. The statutory beneficiaries received no benefit from any contract which Decedent may have entered into with the Defendants. See Wilson v. Willis, No. 27879, 2019 S.C. LEXIS 27.

Further confirming the separateness of each statutory beneficiary's claim from that of the survival action, a Federal District Court in South Carolina has analyzed this issue under the South Carolina Non-Economic Awards Act of 2005. Diane Boyle as Personal Representative of the Estate of John Francis Boyle v. United States of America, 944 F.Supp.2d 577 (D.S.C. 2012). In Boyle, the Court concluded that the wrongful death beneficiaries' claims were separate and distinct claims for purposes of stacking damage caps and for purposes of being individual claimants. This analysis supports the contention that the wrongful death claimants have separate and distinct claims apart from that of the survival action.

Many other states have come to this same conclusion, Daniels v. Sunrise Senior Living, Inc., 212 Cal.App 4th 674, 151 Cal.Rptr.3d 273 (Cal.App.4 Dist, 2013) (Wrongful Death claims not bound to arbitration), Lawrence v. Beverly Manor, 273

S.W.3d 525 (Mo. 2009) (Wrongful Death claimants not bound by arbitration agreement.)

As previously discussed, the only parties executing these agreements were Son purportedly on behalf of Decedent and an employee as an agent for Brookdale Greenville. Defendants would contend that this agreement is binding on the non-signatory statutory beneficiaries simply because it contends the Arbitration Agreement says so.

However, as the Supreme Court of Kentucky said regarding binding non-signatory wrongful death beneficiaries in Ping v. Beverly Enterprises, Inc.:

[A]s interesting as life might be if we could bind one another to contracts merely by referring to each other in them, we are not persuaded that a non-signatory who receives no substantive benefit under a contract may be bound to the contract's procedural provisions, including arbitration clauses, merely by being referred to in the contract. It is one thing to say that a third party for whose substantive benefit a contract is made may not enforce his or her rights under the contract without also abiding by the contract's other terms. That is the general third-party beneficiary rule discussed above. It may even be that tort claims by such a directly benefitting third-party are appropriately subjected the contract's arbitration provisions, at least where the tort and contract are significantly intertwined. See, In re Weekley Homes, L.P., 180 S.W. 3d 127 (Tex. 2005) (negligent repair claim by homeowner's Son against contractor was subject to repair contract's arbitration clause because Son, although a non-party, was direct and principal beneficiary under the contract). It is something else entirely, however, to say that incidental beneficiaries of a contract-individuals or entities with no substantive rights under the contract and no direct benefits-may have their tort claims against the parties swept up into the contract's arbitration provisions merely by being mentioned in the contract as potential claimants. This is what Beverly purports to do. Arbitration is a matter of contract, however, it is something the contracting parties, or their proxies, must agree to. It is not something that one party may simply

impose upon another. Howsam v. Dean Witter Reynolds, Inc., 537 U.S. 79,83, 123 S. Ct. 588, 154 L. Ed.2d 491 (2002) (“[A]rbitration is a matter of contract and a party cannot be required to submit to arbitration any dispute which he has not agreed so to submit”, Citation and internal quotation marks omitted.) Since Beverly’s theory would allow just that, i.e., would allow one party merely by referring to someone else in an arbitration clause to thereby bind that other person to arbitration as a “third party beneficiary” of the arbitration agreement, we reject it out of hand.

Ping v. Beverly Enterprises, Inc., 376 S.W.3d 581, 599-600 (KY 2012).

Likewise, Brookdale Greenville’s mentioning of “any spouse, children, heir, representatives, agents, executors, administrators, successors, family members, or other persons claiming through the Resident, or other person claiming through the Resident’s estate, whether such third parties make a claim in a resident representative capacity or in a personal capacity. Any claims or grievances against the Community or the Community’s corporate parent, subsidiaries, affiliates, employees, officers, or directors” as being bound by the Arbitration Agreement does not make it so. It is no more than an *ipse elixir* which Defendants expect this Court to embrace. The law simply does not permit a party to cut off the rights of a non-signatory to an agreement who receives no benefit thereunder.

The wrongful death claims are separate claims apart from the Decedent’s claims.

According to South Carolina’s Wrongful Death Act:

“Whenever the death of a person shall be caused by the wrongful act, negligent or the fault of another and the act, negligent or the fault is such as would, if death had not ensued, had entitled party injured to maintain an action and recover damages in respect thereof, the person who would have been liable, if death had not ensued shall be liable to an action for damages.”

South Carolina Code Annotated §15-51-10 (1977)

The wrongful death beneficiaries are as follows:

“Every such action shall be for the benefit of the wife, or husband and child or children of the person whose death shall have been so caused, and, if there be no such wife, husband, child or children, then for the benefit of the parent or parents, and if there be none, for the benefit of the heirs or the person whose death shall have been so caused.”

South Carolina Code Annotated §15-51-20 (Supp. 2001)

The general element of damages recoverable are pecuniary loss, mental shock and suffering, wounded feelings, grief and sorrow, loss of companionship, and deprivation of the use and comfort of the Decedent, society, including the loss of his experience, knowledge, and judgment in managing the affairs of himself and his beneficiaries. Self v. Goodrich, 300 S.C. 349, 351, 387 S.E.2d. 713, 714 S.C. (Ct. App. 1989).

The wrongful death claim is a separate claim from the claims a decedent might bring on his own behalf under the survival statute. In Bennett v. Spartanburg Railway Gas and Electric Company, 97 S.C. 27, 81 S.E. 189 (1914), the Supreme Court held that wrongful death and survival actions are different claims for different injuries. The Court stated “necessarily, therefore, there must be separate verdicts and separate judgments, there should be separate actions.” Id. at 31. See also Strickland v. Southern Ry Co., 111 S.C. 248, 97 S.E. 695 (1918) (Supreme Court Affirmed Appeal from Circuit Court’s ruling noting that survival claims are independent of wrongful death claims), Claussen v. Brothers, 148 S.C. 1, 145 S.E. 539 (1928) (discussing the difference between survival and wrongful death claims as being independent of each other).

The Pennsylvania Superior Court in Pisano v. Extended Homes, Inc., operating under the fictitious name Belaire Health 84 Rehabilitation Center, 2013 PA Super 232, 77 A.3d 651, 662 (PA 2013) affirmed the trial court decision that the nursing home arbitration agreement did not apply to the statutory beneficiaries' wrongful death claim. The Court noted the wrongful death and survival actions are not derivative of each other but are flowing from the same underlining tortious conduct. Like the South Carolina statute, Pennsylvania's wrongful death statute provides that the right of action exists only for the benefit of the spouse, children, parents, or parents of the deceased. Id. at 656. The Pennsylvania Court further held that since the wrongful death claim is independent of the survival action and because the wrongful death statute does not characterize the wrongful death claim as that of a third-party beneficiary, that the trial court properly refused to compel arbitration to the non-signatory wrongful death beneficiaries who were not parties to the arbitration agreement.

Likewise, in Bybee v. Abdulla, M.D., 189. P.3d 40, 2008 UT 35 (Utah, 2008), the Supreme Court of Utah held that an agreement to arbitrate that was signed by the decedent cannot extend to the statutory beneficiaries of a wrongful death claim. The Utah Supreme Court noted that certain defenses from the decedent's personal injury action may be raised against the heirs of a wrongful death action such as comparative negligence and statutes of limitations as key common characteristics. However, as the Supreme Court of Utah noted, both of these defenses go to the viability of the underlying personal injury action. The Court further stated that "by contract, an agreement to bind heirs to arbitrate disputes does not implicate the viability of underlying claims." Id. at 47, citing Horwich v. Superior Court, 21 Cal. 4th 272, 87 Cal. Rptr. 2d 222, 980 P. 2d 927,

935 (1999). The Utah Supreme Court went on to note that “we have never intended to suggest, however, that because Decedent is the master of his claim he may by contract expose his unwilling heirs to any imaginable defense.” Bybee v. Abdulla, M.D. at 46. The Utah Supreme Court further held that the defenses against the decedent’s claim which are less likely to be found enforceable against the heirs’ claims in a wrongful death action “are contract provisions that purport to affect the rights of heirs that do not affect the existence of the decedent’s personal injury claim during his lifetime. The arbitration agreement...falls squarely within this category and is, therefore, unenforceable against the heir.” Id. at 47.

The Court of Appeals in Washington in Woodall v. Avalon Care Center-Federal Way, LLC, 155 Wn. App. 919, 231 P. 3d 1252 (Wash. App. Div. 1 2010) held that “arbitration is a matter of contract and a party cannot be required to submit to arbitration any dispute which he [or she] has not agreed so to submit.” Id. quoting Satomi Owners Association v. Satomi, LLC, 167 Wash. 2d 781, 225 P.3d 213 (2009). The Washington Court of Appeals further noted that the wrongful death claims asserted in that case were not on behalf of the estate just as South Carolina’s wrongful death claims are not on behalf of the estate. The Washington Court of Appeals further discussed the Supreme Court of Ohio’s ruling in Peters v. Columbus Steel Casting Co., 115 Ohio St.3d 134, 873 N.E.2d 1258 (2007), wherein the Supreme Court of Ohio held that the wrongful death claim of a spouse who was Administrator of her husband’s estate was not subject to the Decedent’s arbitration agreement. The Washington Court of Appeals in discussing Peters, stated “In sum, the decedent’s agreement was an agreement ‘to arbitrate his claims against the company,’ and thus the provision in the agreement binding the decedent’s

heirs applied to a survival action. But the decedent could not ‘restrict his beneficiaries to arbitration of their wrongful death claims because he held no right to those claims.’” Woodall v. Avalon Care Center - Federal Way, LLC at 929. In the Washington Court of Appeals’ analysis, the Court concluded that the wrongful death beneficiaries could not be bound to the arbitration agreement which they did not sign.

Therefore, even if Son had actual or apparent authority/agency to execute the Arbitration Agreement, the Arbitration Agreement did not include the wrongful death statutory beneficiaries’ claims within the scope of the Arbitration Agreement, nor did Decedent and/or Son have authority to bind the wrongful death statutory beneficiaries’ claims to the Arbitration Agreement. As a result, the Arbitration Agreement cannot reach the claims of the wrongful death statutory beneficiaries.

CONCLUSION

Therefore, based upon the foregoing reasons, the Defendants’ Motion to Dismiss or, in the Alternative, Motion to Compel Arbitration and Stay Proceedings as to the Survival Action claims against the Defendants are granted. Further, the Defendants’ Motion to Dismiss or, in the Alternative, Motion to Compel Arbitration and Stay Proceedings as to all of the wrongful death causes of action and claims are denied.

IT IS SO ORDERED.

The Honorable Robin B. Stilwell
Judge, Thirteenth Judicial Circuit

Greenville, South Carolina
Date: _____



Greenville Common Pleas

Case Caption: Troy Testerman , plaintiff, et al vs. Emeritus Corporation ,
defendant, et al
Case Number: 2019CP2307283
Type: Order/Other

So Ordered

s/ Robin B. Stilwell 2158

Electronically signed on 2020-05-07 09:23:53 page 12 of 12

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF GREENVILLE	)	C.A. No.: 2018-CP-23-00119 &
	)	2018-CP-23-00120
	)	
Marlene Wilson, Individually and as	)	
Personal Representative of the Estate	)	
of Kenneth Wilson,	)	
	)	
Plaintiff,	)	ORDER
	)	
v.	)	
	)	
NHC Healthcare/Mauldin, LLC,	)	
National Healthcare Corporation,	)	
NHC/OP, LP, Bon Secours St. Francis	)	
Health System, Inc., Bon Secours	)	
Health System, Inc.,	)	
	)	
Defendant(s).	)	
	)	

This matter came before the Court on Defendants National Healthcare Corporation' and NHC/OP, LP's (hereinafter "Nursing Home Defendants") Motion to Dismiss and to Compel Arbitration. Having listened to oral arguments from counsel and having reviewed the parties' legal memoranda for the reasons more fully set forth below, the Court hereby denies the Defendants' Motion to Dismiss and to Compel Arbitration.

BACKGROUND

This matter arises out of two civil actions – a survival action and a wrongful death action. Both actions involve allegations of nursing home negligence and corporate negligence resulting in the death of Kenneth Wilson (hereinafter "Decedent"). Marlene Wilson (hereinafter "Daughter") was Decedent's daughter and serves as Personal Representative of Decedent's estate. On April 6, 2015, Decedent was admitted to NHC Mauldin for short-term rehabilitation after undergoing a hip arthroplasty at St. Francis



Hospital. Plaintiff alleges that as a result of Nursing Home Defendants' negligence, Decedent developed necrotic and infected bedsores, became dehydrated, suffered from nutritional compromise, and developed multiple infections which went untreated, all of which Plaintiff alleges caused Decedent's injuries and death.

At the time of admission, Daughter signed an Agreement to Arbitrate and Waive Jury Trial ("Arbitration Agreement"). The Arbitration Agreement was signed by Jennifer Balon for "The Center" and by Daughter for "The Patient". The Arbitration Agreement provides that the parties agree to follow the dispute resolution procedures set forth in the Arbitration Agreement which include the waiver of a jury trial and the requirement that the parties submit to binding arbitration all disputes against each other which exceed an amount in controversy over \$7,500.00.

Plaintiff filed the Notice of Intent to File Suit on September 14, 2017. The parties engaged in the mandatory pre-suit mediation on December 28, 2017. Plaintiff then filed the Summons and Complaint on January 5, 2018 and served same. Nursing Home Defendants filed this Motion to Dismiss and to Compel Arbitration on February 28, 2018. Nursing Home Defendants contend that this Arbitration Agreement requires that this Court order that this case be dismissed and that the claims be submitted to binding arbitration in accordance with the Arbitration Agreement. Plaintiff contends that the Arbitration Agreement is unenforceable under state contract law and this Court agrees for the various reasons set forth hereinbelow.

LEGAL ANALYSIS AND CONCLUSIONS

The party seeking to enforce an agreement to arbitrate has the burden of establishing the existence of a valid arbitration agreement. See Aiken v. World Finance

Corp. of S.C., 373 S.C. 144, 149, 644 S.E.2d 705, 708 (2007); MBNA America Bank, N.A. v. Christianson, 377 S.C. 210, 659 S.E.2d 209 (S.C. Ct. App. 2008). It is well established that “where one party denies the existence of an arbitration agreement raised by an opposing party, a court must immediately determine whether the agreement exists in the first place. If no agreement is found to exist, the court must deny any application to arbitrate. Simpson v. MSA of Myrtle Beach, Inc., 373 S.C. 14, 644 S.E.2d 663, 667 (S.C. 2007) (internal citation omitted). Whether a valid arbitration agreement exists is a matter for judicial determination. York v. Dodgeland of Columbia, Inc., 406 S.C. 67, 78, 749 S.E.2d 139, 144 (Ct. App. 2013). Whether the parties agreed to arbitration is a question of substantive state law. Simpson v. MSA of Myrtle Beach, Inc., 373 S.C. 14, 644 S.E.2d 663, 668 (S.C. 2007) (“General contract principles of state law apply in a court’s evaluation of the enforceability of an arbitration clause.”).

I. Daughter had No Authority to Sign the Arbitration Agreement for Decedent

Because Decedent did not sign the Arbitration Agreement, Daughter was required to have authority to execute the Arbitration Agreement for the Arbitration Agreement to be enforceable. Daughter had no such authority. The legal consequences of an agent’s actions can only be attributed to the principal when the agent has actual or apparent authority. Charleston Registry v. Young Clement, 598 S.E.2d 717, 359 S.C. 635, 642 (Ct. App. 2004). In the present case, neither actual or apparent authority exists for Daughter.

A. No Actual Agency/Authority

While it is true that Daughter held a “Power of Attorney” on behalf of Decedent, this Power of Attorney did not confer the necessary authority to execute an arbitration agreement on Decedent’s behalf. This document is titled “Power of Attorney” and is not

identified a “General Durable Power of Attorney.” More importantly, the document does not confer sufficient authority to enter into contracts generally, to enter into releases on behalf of Decedent, to waive the constitutional right to a jury trial, nor does it include the “catch all provision giving the attorney-in-fact the authority ‘to sign any and all releases or consent required.’” Sovereign Healthcare of Tampa v. Schmitt, 195 So. 3d, 1175 (Fla. Dist. Ct. App. 2016).

The powers and authorities which Daughter held were specifically delineated in the Power of Attorney. These powers granted to Daughter the authority to make decisions regarding financial matters and decisions regarding healthcare.

This analysis is akin to that in Hodge v. UniHealth Post-Acute Care of Bamberg, 2018 S.C. App. LEXIS 13. As noted in Hodge, ““This limited range of acts performed on the [decedent]’s behalf suggest, at most, [he] may have conferred on [the personal representative] the authority to make health care and financial decisions on his behalf, but no more than that.”” Id at 29 quoting Dickerson v. Longoria, 95 A.2d 721, 743, 414 Md. 419 (2010). The Hodge court further noted that the authority to sign healthcare documents does not include the authority to sign an arbitration agreement. Hodge at 40. Our courts have held a healthcare power of attorney does not provide authority to sign an arbitration agreement. Hodge v. UniHealth Post-Acute Care of Bamberg, 2018 S.C. App. LEXIS 13; Thompson v. Pruitt Corp., 784 S.E.2d, 679, 416 S.C. 43, 55 (Ct. App. 2016), *cert. denied*, S.C. Sup. Ct. Order dated Dec. 2, 2016.

Furthermore, the South Carolina Supreme Court has held that “The authority conveyed by a principal to an agent to handle finances or make health care decisions does not encompass executing an agreement to resolve legal claims by arbitration, thereby

waiving the principal's right of access to the courts and to a jury trial." Hodge at 37 quoting Thompson at 55, 784 S.E.2d at 686. As previously indicated, this Power of Attorney did not have the "catch all" language of many general powers of attorney and does not encompass the executing of an agreement to resolve legal claims by arbitration and waiving a jury trial, but rather, deals with the limited circumstances enumerated therein of making financial or healthcare decisions for Decedent. Therefore, no actual authority existed for Daughter to sign the Arbitration Agreement.

B. No Apparent Agency/Authority NAAA

Daughter did not have apparent authority/agency to execute the Arbitration Agreement on behalf of the Decedent. Apparent authority is based on "representations made by the principal to the third party and reliance by the third party on those representations". Young v. S.C. Department of Disabilities and Special Needs, 374 S.C. 360, 367, 649, S.E.2d 488, 491 (2007). Apparent authority exists when the principal is bound by the acts of its agent after the principal has placed the agent in such a position that a person of ordinary prudence, reasonably familiar with business usages and custom is led to believe the agent has certain authority and in turn, deals with the agent based on the assumption. Muller v. Myrtle Beach Golf and Yacht Club, 303 S.C. 137, 399 S.E.2d 430 (Ct. App. 1990), *rev'd on other grounds*.

South Carolina law requires that to prove apparent authority, the Defendants must show "... (1) that the purported principal consciously or impliedly represented another to be his agent; (2) that there was reliance upon the representation; and (3) that there was a change of position to the relying party's detriment." Cowburn v. Leventis, 366 S.C. 39, 619 S.E.2d 448 (Ct. App. 2005). The basis of apparent authority is representations made

by the principal to the third party and reliance by the third party on those representations. Young v. S.C. Department of Disabilities and Special Needs, 374 S.C. 360, 367, 649 S.E.2d 488, 491 (2007). The proper focus in determining a claim of apparent authority is not on the relationship between the principal and the agent but that between the principal and the third party. Vereen v. Liberty Life Insurance, Company, 306 S.C. 423, 412 S.E.2d 425 (Ct. App. 1991). The burden of establishing agency is on the party asserting that a principal agency relationship exists.

Nursing Home Defendants have presented no evidence that Decedent represented, implicitly or explicitly, to the Nursing Home Defendants that Daughter had the authority to enter into the Arbitration Agreement on his behalf. The Affidavit presented by Plaintiff reflects that Decedent was not present when Daughter signed the Arbitration Agreement as he was still in the hospital. The Affidavit further reflects that Decedent was never aware that Daughter had signed the Arbitration Agreement and never authorized Daughter to sign such contracts or agreements. Further, based upon the Affidavit of Daughter and the records submitted as exhibits at the hearing, Decedent was confused from the effects of the anesthesia and had “moderate” mental impairment.

It should further be noted that despite the fact that Decedent’s mental impairment improved to “cognitively intact”, according to Nursing Home Defendants’ own records during his admission, Defendants never requested that Decedent sign the Arbitration Agreement personally. Further, the Arbitration Agreement does not reflect any authority which Daughter had to execute such agreement despite the Arbitration Agreement’s own requirement that any such authority be delineated.

Nursing Home Defendants must also show a detrimental change of position. It should also be noted that the Arbitration Agreement is separate from the Admissions Agreement. The facility cannot show that it changed its position for the worse as required to prove any apparent authority/agency as reflected in Hodge.

Because Decedent did not consciously or impliedly represent that Daughter was his agent and because there was no change of position by the Nursing Home Defendants, Nursing Home Defendants cannot show that Daughter had apparent authority/agency to execute the Arbitration Agreement on behalf of Decedent.

II. The Arbitration Agreement is Unenforceable Against the Decedent's Wrongful Death Statutory Beneficiaries

It is the conclusion and order of this Court that the Arbitration Agreement is unenforceable for the above-stated reasons. However, even if Daughter had actual or apparent authority/agency to sign the Arbitration Agreement on behalf of Decedent, the Arbitration Agreement is unenforceable against the Decedent's wrongful death statutory beneficiaries under South Carolina contract law defenses. The Arbitration Agreement neither covers the wrongful death statutory beneficiaries' claims within the scope of the agreement nor was the Arbitration Agreement signed by an individual who had authority to bind the statutory beneficiaries.

South Carolina law is clear that a wrongful death claim exists for the statutory beneficiaries and that such claims are distinct and separate from those brought under survival claims. Bennett v. Spartanburg Railway Gas and Electric Co., 97 S.C. 27, 81 S.E. 189 (1914). The alleged Arbitration Agreement by its own terms is an agreement between "Kenneth Wilson ('patient')" and "NHC Healthcare/Mauldin, LLC ('center')". While at some point during Decedent's admission to the facility, he might have had the authority to

bind himself and his claims to arbitration but was never given the chance. However, even if Decedent had agreed to arbitration, he did not have the legal authority to bind his statutory beneficiaries who are not parties to the Arbitration Agreement. The signatories to the agreement are Daughter on behalf of Decedent and NHC Healthcare/Mauldin, LLC. No other persons are parties to this agreement. The scope of the agreement does not include the statutory beneficiaries' claims.

However, even if the Arbitration Agreement did contemplate the wrongful death statutory beneficiaries' claims, Decedent and/or Daughter had no authority to waive the statutory beneficiaries' claims. Daughter signed the Arbitration Agreement in her *individual capacity*. However, as the Hodge court noted, actions taken by Daughter in her *individual capacity* will not be held against the estate as the estate has other beneficiaries and may have other creditors. Daughter's Affidavit reflects that other statutory beneficiaries exist in this case.

Further confirming the separateness of each statutory beneficiary's claim from that of the survival action, a Federal District Court in South Carolina has analyzed this issue under the South Carolina Non-Economic Awards Act of 2005. Diane Boyle as Personal Representative of the Estate of John Francis Boyle v. United States of America, 944 F.Supp.2d 577 (D.S.C. 2012). In Boyle, the Court concluded that the wrongful death beneficiaries' claims were separate and distinct claims for purposes of stacking damage caps and for purposes of being individual claimants. This analysis supports the contention that the wrongful death claimants have separate and distinct claims apart from that of the survival action.

Many other states have come to this same conclusion, Daniels v. Sunrise Senior Living, Inc., 212 Cal.App.4th 674, 151 Cal.Rptr.3d 273 (Cal.App.4 Dist, 2013) (Wrongful Death claims not bound to arbitration), Lawrence v. Beverly Manor, 273 S.W.3d 525 (Mo. 2009) (Wrongful Death claimants not bound by arbitration agreement.) As previously discussed, the only parties executing this Agreement were Daughter purportedly on behalf of Decedent and employee as an Agent for NHC Mauldin. NHC Mauldin would contend that this agreement is binding on the non-signatory statutory beneficiaries simply because it contends the Arbitration Agreement says so.

However, as the Supreme Court of Kentucky said regarding binding non-signatory wrongful death beneficiaries in Ping v. Beverly Enterprises, Inc.:

[A]s interesting as life might be if we could bind one another to contracts merely by referring to each other in them, we are not persuaded that a non-signatory who receives no substantive benefit under a contract may be bound to the contract's procedural provisions, including arbitration clauses, merely by being referred to in the contract. It is one thing to say that a third party for whose substantive benefit a contract is made may not enforce his or her rights under the contract without also abiding by the contract's other terms. That is the general third-party beneficiary rule discussed above. It may even be that tort claims by such a directly benefitting third-party are appropriately subjected the contract's arbitration provisions, at least where the tort and contract are significantly intertwined. See, In re Weekley Homes, L.P., 180 S.W. 3d 127 (Tex. 2005) (negligent repair claim by homeowner's daughter against contractor was subject to repair contract's arbitration clause because daughter, although a non-party, was direct and principal beneficiary under the contract). It is something else entirely, however, to say that incidental beneficiaries of a contract-individuals or entities with no substantive rights under the contract and no direct benefits-may have their tort claims against the parties swept up into the contract's arbitration provisions merely by being mentioned in the contract as potential claimants. This is

what Beverly purports to do. Arbitration is a matter of contract, however, it is something the contracting parties, or their proxies, must agree to. It is not something that one party may simply impose upon another. Howsam v. Dean Witter Reynolds, Inc., 537 U.S. 79, 83, 123 S. Ct. 588, 154 L. Ed.2d 491 (2002) (“[A]rbitration is a matter of contract and a party cannot be required to submit to arbitration any dispute which he has not agreed so to submit”, Citation and internal quotation marks omitted.) Since Beverly’s theory would allow just that, i.e., would allow one party merely by referring to someone else in an arbitration clause to thereby bind that other person to arbitration as a “third party beneficiary” of the arbitration agreement, we reject it out of hand.

Ping v. Beverly Enterprises, Inc., 376 S.W.3d 581, 599-600 (KY 2012).

Likewise, NHC-Mauldin’s mentioning of “employees, agents, representatives, affiliates, fiduciaries, medical directors, officers, directors, governing bodies, management companies, insurers, attorneys, predecessors, successors, assigns, third party beneficiaries, heirs, executors, administrators, or any of them, and all persons, entities or corporations with whom any of the former have been, are now, or may be affiliated, arising out of or in any way related or connected to the patient’s stay and the care provided at the Center”, as being bound by the Arbitration Agreement does not make it so. It is no more than an *ipse elixir* which Defendants expect this Court to embrace. The law simply does not permit a party to cut off the rights of a non-signatory to an agreement who receives no benefit thereunder.

The wrongful death claims are separate claims apart from the Decedent’s claims.

According to South Carolina’s Wrongful Death Act:

“Whenever the death of a person shall be caused by the wrongful act, negligent or the fault of another and the act, negligent or the fault is such as would, if death had not ensued, had entitled party injured to maintain an action and recover damages in respect thereof, the person

who would have been liable, if death had not ensued shall be liable to an action for damages.”

South Carolina Code Annotated §15-51-10 (1977)

The wrongful death beneficiaries are as follows:

“Every such action shall be for the benefit of the wife, or husband and child or children of the person whose death shall have been so caused, and, if there be no such wife, husband, child or children, then for the benefit of the parent or parents, and if there be none, for the benefit of the heirs or the person whose death shall have been so caused.”

South Carolina Code Annotated §15-51-20 (Supp. 2001)

The general element of damages recoverable are pecuniary loss, mental shock and suffering, wounded feelings, grief and sorrow, loss of companionship, and deprivation of the use and comfort of the Decedent, society, including the loss of his experience, knowledge, and judgment in managing the affairs of himself and his beneficiaries. Self v. Goodrich, 300 S.C. 349, 351, 387 S.E.2d. 713, 714 S.C. (Ct. App. 1989).

The wrongful death claim is a separate claim from the claims a decedent might bring on his own behalf under the survival statute. In Bennett v. Spartanburg Railway Gas and Electric Company, 97 S.C. 27, 81 S.E. 189 (1914), the Supreme Court held that wrongful death and survival actions are different claims for different injuries. The Court stated “necessarily, therefore, there must be separate verdicts and separate judgments, there should be separate actions.” Id. at 31. See also Strickland v. Southern Ry Co., 111 S.C. 248, 97 S.E. 695 (1918) (Supreme Court Affirmed Appeal from Circuit Court’s ruling noting that survival claims are independent of wrongful death claims), Claussen v. Brothers, 148 S.C. 1, 145 S.E. 539 (1928) (discussing the difference between survival and wrongful death claims as being independent of each other).

The Pennsylvania Superior Court in Pisano v. Extended Homes, Inc., operating under the fictitious name Belaire Health 84 Rehabilitation Center, 2013 PA Super 232, 77 A.3d 651, 662 (PA 2013) affirmed the trial court decision that the nursing home arbitration agreement did not apply to the statutory beneficiaries' wrongful death claim. The Court noted the wrongful death and survival actions are not derivative of each other but are flowing from the same underlining tortious conduct. Like the South Carolina statute, Pennsylvania's wrongful death statute provides that the right of action exists only for the benefit of the spouse, children, parents, or parents of the deceased. Id. at 656. The Pennsylvania Court further held that since the wrongful death claim is independent of the survival action and because the wrongful death statute does not characterize the wrongful death claim as that of a third-party beneficiary, that the trial court properly refused to compel arbitration to the non-signatory wrongful death beneficiaries who were not parties to the arbitration agreement.

Likewise, in Bybee v. Abdulla, M.D., 189 P.3d 40, 2008 UT 35 (Utah, 2008), the Supreme Court of Utah held that an agreement to arbitrate that was signed by the decedent cannot extend to the statutory beneficiaries of a wrongful death claim. The Utah Supreme Court noted that certain defenses from the decedent's personal injury action may be raised against the heirs of a wrongful death action such as comparative negligence and statutes of limitations as key common characteristics. However, as the Supreme Court of Utah noted, both of these defenses go to the viability of the underlying personal injury action. The Court further stated that "by contract, an agreement to bind heirs to arbitrate disputes does not implicate the viability of underlying claims." Id. at 47, citing Horwich v. Superior Court, 21 Cal. 4th 272, 87 Cal. Rptr. 2d 222, 980 P. 2d 927, 935 (1999). The Utah Supreme Court

went on to note that “we have never intended to suggest, however, that because Decedent is the master of his claim he may by contract expose his unwilling heirs to any imaginable defense.” Bybee v. Abdulla, M.D. at 46. The Utah Supreme Court further held that the defenses against the decedent’s claim which are less likely to be found enforceable against the heirs’ claims in a wrongful death action “are contract provisions that purport to affect the rights of heirs that do not affect the existence of the decedent’s personal injury claim during his lifetime. The arbitration agreement...falls squarely within this category and is, therefore, unenforceable against the heir.” Id. at 47.

The Court of Appeals in Washington in Woodall v. Avalon Care Center-Federal Way, LLC, 155 Wn. App. 919, 231 P. 3d 1252 (Wash. App. Div. 1 2010) held that “arbitration is a matter of contract and a party cannot be required to submit to arbitration any dispute which he [or she] has not agreed so to submit.” Id. quoting Satomi Owners Association v. Satomi, LLC, 167 Wash. 2d 781, 225 P.3d 213 (2009). The Washington Court of Appeals further noted that the wrongful death claims asserted in that case were not on behalf of the estate just as South Carolina’s wrongful death claims are not on behalf of the estate. The Washington Court of Appeals further discussed the Supreme Court of Ohio’s ruling in Peters v. Columbus Steel Casting Co., 115 Ohio St.3d 134, 873 N.E.2d 1258 (2007), wherein the Supreme Court of Ohio held that the wrongful death claim of a spouse who was Administrator of her husband’s estate was not subject to the Decedent’s arbitration agreement. The Washington Court of Appeals in discussing Peters, stated “In sum, the decedent’s agreement was an agreement ‘to arbitrate his claims against the company,’ and thus the provision in the agreement binding the decedent’s heirs applied to a survival action. But the decedent could not ‘restrict his beneficiaries to arbitration of their

wrongful death claims because he held no right to those claims.” Woodall v. Avalon Care Center - Federal Way, LLC at 929. In the Washington Court of Appeals’ analysis, the Court concluded that the wrongful death beneficiaries could not be bound to the arbitration agreement which they did not sign.

Therefore, even if Daughter had actual or apparent authority/agency to execute the Arbitration Agreement, the Arbitration Agreement did not include the wrongful death statutory beneficiaries’ claims within the scope of the Arbitration Agreement, nor did Decedent and/or Daughter have authority to bind the wrongful death statutory beneficiaries’ claims to the Arbitration Agreement. As a result, the Arbitration Agreement cannot reach the claims of the wrongful death statutory beneficiaries.

WHEREFORE, for the reasons stated herein, the Court denies Defendants’ Motion to Dismiss and Motion to Compel Arbitration.

IT IS SO ORDERED.

The Honorable Michael G. Nettles
Presiding Judge

Greenville, South Carolina
Date: _____



Greenville Common Pleas

Case Caption: Marlene Wilson , plaintiff, et al vs. NHC Healthcare/Mauldin LLC ,
defendant, et al
Case Number: 2018CP2300120
Type: Order/Other

So Ordered

s/ Michael Nettles

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
BEAUFORT DIVISION

DIANE S. BOYLE, as Personal
Representative of the Estate of
John Francis Boyle,

Plaintiff,

v.

UNITED STATES OF AMERICA,

Defendant.

Civil Action No. 9:09-939-SB

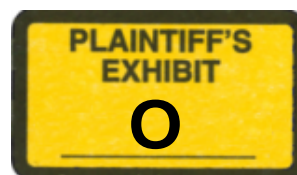
FINDINGS OF FACT
AND
CONCLUSIONS OF LAW
AS TO DAMAGES

This matter came before the Court for a non-jury trial on the Plaintiff's action brought against the United States of America pursuant to the Federal Tort Claims Act, 28 U.S.C. §§ 1346(b) and 2671-80 (hereinafter referred to as "the FTCA").¹ Carl Jacobson and Jonathan Krell represented the Plaintiff at trial, and Lee Berlinsky represented the Defendant. On March 9, 2012, the Court issued its findings of fact and conclusions of law as to liability, and the Court incorporates herein those findings of fact and conclusions of law. On March 20, 2012, the Court held a hearing on the issue of damages.

In its March 9th findings of fact and conclusions of law, the Court found that the Plaintiff met her burden of proof to establish the Defendant's liability. Specifically, the Court found it more likely than not that the Beaufort Naval Hospital mis-filled John Francis Boyle's (hereinafter referred to as "Mr. Boyle" or "the decedent") 0.5-milligram Prograf²

¹ The Plaintiff filed her amended complaint on April 13, 2009, alleging that her husband died of Tacrolimus toxicity and kidney failure due to the negligent, careless, and reckless filling and dispensing of her husband's medication by employees at the Beaufort Naval Hospital Pharmacy. (Entry 1 at 2.)

² Following his transplant, Mr. Boyle was prescribed Tacrolimus (available under the brand name "Prograf"), which is an immunosuppressant medication that helps prevent



prescription in December of 2005, and that instead of dispensing 180 0.5-milligram Prograf capsules, the Beaufort Naval Hospital negligently dispensed 180 5-milligram capsules of Prograf. (Entry 59 at 3, ¶ 11.) The Court also found from what it deemed to be the more credible evidence that Mr. Boyle's hospitalizations on February 2, 2006, February 19, 2006, and March 19, 2006, more likely than not occurred at least in part because Mr. Boyle was taking an improper daily dose of Prograf due to the December 2005 mis-fill. (*Id.* at 4, ¶ 13.) Therefore, the Court found that the Defendant breached the standard of care and that the breach proximately caused Mr. Boyle's Prograf toxicity, thereby contributing to his death. (*Id.* at 8, ¶ 9.)

Despite the foregoing, the Court also found that at some point between the December 2005 mis-fill and his final hospitalization, Mr. Boyle should have recognized that the bottle of 0.5-milligram Prograf capsules actually contained 5-milligram capsules, based on factors such as his familiarity with the medication and the differing characteristics of the dosages, including size, color, and markings. (*Id.* at 9, ¶¶ 11, 12.) Thus, in addition to finding that the Defendant was negligent, the Court also found that Mr. Boyle was negligent by failing to recognize the mis-fill at some point between December 2005 and his subsequent hospitalizations. (*Id.*, ¶ 13.) Ultimately, the Court attributed twenty-five percent of the fault to Mr. Boyle. (*Id.*)

a person's immune system from rejecting a transplanted organ. Prograf is available for oral administration as capsules in the following dosages: 0.5 milligram, 1 milligram, or 5 milligrams. The colors and sizes of 0.5-milligram capsules, 1-milligram capsules, and 5-milligram capsules are different, and they are distinguishable by sight. In addition, each capsule contains a marking identifying the dosage. Prograf is considered a narrow therapeutic index medication, which means there is a small margin of error in dosing and significant toxicity can result from a minor overdose.

FINDINGS OF FACT³

1. Mr. Boyle was born on July 3, 1934, and he was seventy-one years old at the time of his death on April 28, 2006.
2. In the mid-nineties, Mr. Boyle began suffering from renal disease secondary to autosomal dominant polycystic kidney disease.
3. In November of 2000, Mr. Boyle received a kidney transplant, and his medical records indicate that he was mostly stable from the time of his transplant until February of 2006.
4. Mr. Boyle graduated from college in 1956 and went to work in the New York City Police Department, where he worked for thirty years. In addition, Mr. Boyle was in the New York National Guard and Army Reserve for thirty years.
5. Diane S. Boyle ("Diane") was born on December 17, 1935, and she met Mr. Boyle when she was eighteen or nineteen years old. They married when she was twenty-three years old, and together they had two children, Julie Boyle Mecca ("Julie") and John C. Boyle ("John").
6. At the time of Mr. Boyle's death, Diane and Mr. Boyle had been married for forty-seven years, and from the evidence presented, it appears that they had a very loving and happy relationship. Diane testified that Mr. Boyle was a great husband, the love of her life, her best friend, and her spiritual partner.
7. When Mr. Boyle was twenty-seven years old, Diane gave birth to a daughter,

³ To the extent that the Court has made "findings of fact" that would be better expressed as "conclusions of law," and vice versa, each category is expressly incorporated into the other.

Julie. According to Julie, it was a "great family." Julie lived under the same roof with her parents until she got married at age twenty-six. In addition, her father's line of work influenced her to go work for the Department of Probation and for the District Attorney's Office. Julie particularly enjoyed it when her father spent time with her and her three children. In all, it appears from the evidence presented that Julie had a close, loving relationship with her father.

8. When Mr. Boyle was thirty years old, Diane gave birth to a son, John. In addition to being his father's namesake, John followed his father's footsteps into the police academy and the national guard. From all accounts John and his father had a close relationship; they participated in joint athletic activities and enjoyed family vacations and outings. John lived at home until he entered the police academy at age twenty-one, and even after he moved out of the house, he continued to see his father at least twice a week. John had plans to eventually move to Hilton Head to spend more time with his parents. As with Julie, it appears from the evidence that John had a close, loving relationship with his father.

9. Mr. Boyle and his family lived in one home in New York until 1995 when he and his wife moved to Hilton Head, South Carolina.

10. Mr. Boyle was an active member of both his family and his community. He was involved with his church and he served as the financial secretary and chief recruiter for the Knights of Columbus.

11. At the time of his death, Mr. Boyle was receiving police retirement income from his employment with the New York City Police Department, military retirement income, and Social Security benefits. In 2005, the last full year before his death, Mr. Boyle received

approximately \$44,050.00 in police retirement income, approximately \$16,096.00 in military retirement income, and \$17,054.00 in Social Security benefits.

CONCLUSIONS OF LAW

1. This case involves claims based on the South Carolina statutes for a "survival right of action," S.C. Code Ann. § 15-5-90, and for "wrongful act causing death," S.C. Code Ann. § 15-51-10.

2. Section 15-5-90 of the South Carolina Code (sometimes referred to as the "survival statute") provides in pertinent part: "Causes of action for and in respect to . . . any and all injuries to the person or to personal property shall survive both to and against the personal or real representative, as the case may be, of a deceased person . . . , any law or rule to the contrary notwithstanding." S.C. Code Ann. § 15-5-90.

3. Thus, the "survival statute provides that a cause of action for injuries to a person shall survive the person's death, with damages recoverable by the legal representative of the deceased." Smalls v. South Carolina Dept. of Educ., 339 S.C. 208, 216, 528 S.E.2d 682, 686 (Ct. App. 2000).

4. In a survival action, the legal representative of the deceased may recover damages for the deceased's conscious pain and suffering and medical expenses. See Baker v. Sanders, 301 S.C. 170, 391 S.E.2d 229 (1990) (finding that the South Carolina Tort Claims Act does not preclude a survival action for conscious pain and suffering and medical expenses when an injured person later dies as a result of the tortious conduct).

5. In addition, pursuant to section 15-5-100 of the South Carolina Code, funeral expenses are recoverable in a survival action. S.C. Code Ann. § 15-5-100.

6. Next, section 15-51-10 (sometimes referred to as the "wrongful death

statute") provides:

Whenever the death of a person shall be caused by the wrongful act, neglect or default of another and the act, neglect or default is such as would, if death had not ensued, have entitled the party injured to maintain an action and recover damages in respect thereof, the person who would have been liable, if death had not ensued, shall be liable to an action for damages, notwithstanding the death of the person injured, although the death shall have been caused under such circumstances as made the killing in law a felony. . . .

S.C. Code Ann. § 15-51-10.

7. Section 15-51-20 outlines the beneficiaries of a wrongful death action, stating:

Every such action shall be for the benefit of the wife or husband and child or children of the person whose death shall have been so caused, and, if there be no such wife, husband, child, or children, then for the benefit of the parent or parents, and if there be none such, then for the benefit of the heirs of the person whose death shall have been so caused. Every such action shall be brought by or in the name of the executor or administrator of such person.

Id. at § 15-51-20.

8. In a wrongful death action in South Carolina, the damages recoverable by the statutory beneficiaries of the decedent include (1) pecuniary loss, (2) mental shock and suffering, (3) wounded feelings, (4) grief and sorrow, (5) loss of companionship, and (6) deprivation of the use and comfort of the intestate's society. Knoke v. South Carolina Dept. of Parks, Recreation & Tourism, 324 S.C. 136, 141, 478 S.E.2d 256, 258 (1996).

"In a wrongful death case, the question of damages is not directed toward the value of the human life that was lost, but rather the damages sustained by the beneficiaries as a result of the death." Self v. Goodrich, 300 S.C. 349, 351, 387 S.E.2d 713, 714 (Ct. App. 1989).

9. This case also involves application of the South Carolina Noneconomic Damage Awards Act of 2005. Specifically, section 15-32-220 provides:

(A) In an action on a medical malpractice claim when final judgment is rendered against a single health care provider, the limit of civil liability for noneconomic damages of the health care provider is limited to an amount not to exceed three hundred fifty thousand dollars as for each claimant, regardless of the number of separate causes of action on which the claim is based, except as provided in subsection (E).⁴

S.C. Code Ann. § 15-32-220(A) (emphasis added).

10. Here, the parties dispute how the Court should construe the term "claimant" in section 15-32-220(A). Specifically, the Plaintiff urges the Court to find four claimants in this case: (1) the estate of Mr. Boyle in the survival action; (2) Diane Boyle in the wrongful death action; (3) Julie Boyle Mecca in the wrongful death action; and (4) John C. Boyle in the wrongful death action. In contrast, the government argues that there is only one claimant in this case: the patient, Mr. Boyle.

11. Section 15-32-210(2) of the South Carolina Code (titled "Definitions") states that "[c]laimant" means the person suffering personal injury." *Id.* at § 15-32-210(2) (emphasis added).

12. Subsection (11) then defines "[p]ersonal injury" as the following: "injuries to the person including, but not limited to, bodily injuries, mental distress or suffering, loss of wages, loss of service, loss of consortium, wrongful death, survival, and other noneconomic damages and actual economic damages." *Id.* at § 15-32-210(11) (emphasis added).

13. "Personal injury action" is defined as "an action for personal injury, including a wrongful death action pursuant to Sections 15-51-10 through 15-51-60 and a survival

⁴ Subsection (F) includes a built-in inflation valve tied to the Consumer Price Index. See S.C. Code Ann. § 15-5-220(F). Taking into consideration this built-in inflation valve, the current maximum amount recoverable is \$415,055.00.

action pursuant to Section 15-5-90(12)." *Id.* at § 15-5-90(12).

14. Subsection (9) provides that "[n]oneconomic damages" means "nonpecuniary damages arising from pain, suffering, inconvenience, physical impairment, disfigurement, mental anguish, emotional distress, loss of society and companionship, loss of consortium, injury to reputation, humiliation, other nonpecuniary damages, and any other theory of damages including, but not limited to, fear of loss, illness, or injury." *Id.* at § 15-32-210(9).

15. Although there is little guidance on how to construe the term "claimant" other than the statutory language itself, the Plaintiff provided the Court with a copy of an order issued on March 25, 2009, by South Carolina Circuit Court Judge John C. Hayes, III.⁵ In his order, Judge Hayes discusses the Noneconomic Damages Awards Act of 2005 and states:

The phrase "for each claimant" makes clear that the caps apply separately to each claimant. Therefore, if the caps apply separately for each claimant, it becomes necessary for a jury to award damages separately to each claimant.

In addition, it is conceivable that a jury could determine that one claimant deserves a larger damage award than another claimant. For example, in a case where a mother and father are suing for the wrongful death of their child, a jury could award more damages to the mother than the father because the mother was more directly involved in the caring and support of each child.

Wilson v. Amisub of South Carolina, Inc., et al., Civil Action No. 06-CP-46-2891, Order dated March 25, 2009, Exhibit A at 4.

16. Ultimately, after a great deal of consideration, the Court agrees with the

⁵ Because it is not entirely clear from the docket whether a copy of this order was formally filed with one of the Plaintiff's briefs or memoranda, the Court attaches a copy of the order hereto as Exhibit A.

Plaintiff that this case involves four claimants rather than just one. Stated simply, the Court believes that the statutory language, including the definitions set forth above, requires such a finding. First, the statute makes clear that the number of causes of action is irrelevant. See S.C. Code Ann. § 15-32-220(A). Moreover, the statute caps damages for "each claimant" and not "the claimant." Id. Although claimant means "*the* person suffering personal injury," id. at § 15-32-210(2) (emphasis added), the definition of personal injury makes clear that not only does Mr. Boyle (or more accurately, his estate) qualify as a claimant pursuant to the survival statute, but also, Diane, Julie, and John each qualify as claimants pursuant to the wrongful death statute, as they each suffered personal injury, which is defined to include (and not limited to) "mental distress or suffering, loss of wages, loss of service, loss of consortium, wrongful death, survival, and other noneconomic damages and actual economic damages." Id. at § 15-32-210(11).

17. Having resolved the foregoing issue, the Court next determines the decedent's life expectancy. According to South Carolina Code Section 19-1-500, Mr. Boyle's life expectancy was an additional twelve years (12.01 years, in fact, which would have carried Mr. Boyle to age 83.82).

18. However, Dr. Michael P. Mayes, who personally treated Mr. Boyle from September 23, 2004, until January of 2006, testified that based on his medical history Mr. Boyle likely would have lived another eight to ten years if not for the apparent Prograf overdose.

19. In contrast, the government's expert witness in the field of nephrology and transplant medicine, Dr. Anil Chandraker, who did not treat Mr. Boyle, testified that Mr. Boyle likely would have lived another five years.

20. After thoroughly considering the evidence and testimony presented, the Court finds itself more persuaded by Dr. Mayes' testimony than by Dr. Chandraker's, particularly in light of the fact that Dr. Mayes actually treated Mr. Boyle over a period of time. However, the Court notes that Dr. Chandraker presented compelling testimony regarding life expectancy studies of individuals with kidney transplants, and based in part on that information, the Court accepts the lower end of Dr. Mayes' suggested life expectancy rather than the middle or higher end. Therefore, the Court finds that Mr. Boyle had a life expectancy of eight years.

Damages in the Survival Action

21. After consideration, the Court finds that **Diane Boyle, the duly-appointed personal representative of the estate of Mr. Boyle, is entitled to \$319,412.17 in economic damages in the survival action, which consists of the following:**

- a. \$3,952.10 for Mr. Boyle's hospitalization at the Hilton Head Regional Medical Center on February 2, 2006;
- b. \$37,410.83 for Mr. Boyle's hospitalization at the Hilton Head Regional Medical Center on February 19, 2006;
- c. \$22,305.40 for Mr. Boyle's hospitalization at the Hilton Head Regional Medical Center on March 19, 2006;
- d. \$202,131.34 for Mr. Boyle's hospitalization at Emory University Hospital;
- e. \$49,259.00 for Mr. Boyle's treatment at the Emory Clinic; and
- f. \$4,353.50 in funeral expenses;

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22. The estate of Mr. Boyle is entitled to recover for the non-economic damages suffered by Mr. Boyle between the time of the mis-fill on December 6, 2005, until the date of his death on April 28, 2006, to the extent that those non-economic damages are attributable to the mis-fill.

23. The Plaintiff presented evidence showing that, towards the end of Mr. Boyle's life, he suffered from diarrhea, acute renal failure, respiratory failure, volume overload, difficulty moving, and cellulitis, among other things. At one point, in a matter of three weeks, Mr. Boyle gained twenty-five to thirty pounds due to fluid retention. Mr. Boyle was hospitalized for a total of thirty-nine days between December 6, 2005, and April 28, 2006, and he was intubated and on a respirator for three weeks. Even after being taken off the intubator and put into hospice care, Mr. Boyle was on a morphine drip for twelve days. In all, the Court has no doubt that Mr. Boyle experienced a great deal of pain and suffering, for which the Court believes the estate of Mr. Boyle is entitled to recover \$250,000.00 in noneconomic damages in the survival action.

Damages in the Wrongful Death Action

24. Diane Boyle, as a surviving spouse, and Julie and John, as surviving children, are the beneficiaries in the wrongful death action. The Court has carefully considered evidence in the record, including the testimony of the beneficiaries, and it is clear that they suffered a difficult loss.

25. With respect to the economic damages suffered by Diane Boyle, the Plaintiff presented the testimony and expert report of Dr. Oliver G. Wood, Jr., dated February 7, 2011. In this report, Dr. Wood used a life expectancy of nine years (the average of the

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eight-to-ten-year range testified to by Dr. Mayes) and came up with a total amount of economic loss of \$501,148.00.

26. The Court has great respect for Dr. Wood's calculations; however, the Court is not fully convinced by these calculations for various reasons including the following. First, Dr. Wood relied on a life expectancy of nine years whereas this Court has found Mr. Boyle's life expectancy to be eight years. Second, Dr. Wood included a \$12,000 variable supplement to Mr. Boyle's police retirement income as a yearly supplement without knowing whether the supplement was tied to market conditions or whether the supplement was to continue every year of Mr. Boyle's retirement. (See Entry 57 at 74-75.) Third, it is not clear whether the surviving spouse benefit that Diane Boyle receives (\$11,076 per year as of the time of trial) comes from a collateral or a noncollateral source because the evidence does not indicate with any certainty whether or not Mr. Boyle's military pension was reduced actuarially to provide for the benefit.

I. The Surviving Spouse's Damages

27. Ultimately, having started by considering Dr. Wood's computation of \$501,148.00, and having considered certain factors that negatively affect that computation (such as the Court's finding of a reduced life expectancy as well as the other concerns outlined in paragraph 25), the Court finds, based on all of the evidence presented, that **Diane Boyle is entitled to recover \$375,000.00 in economic damages in the wrongful death action.**

28. Next, the Court finds that Diane, who has undoubtedly suffered a great loss, is entitled to **recover \$400,000.00 in noneconomic damages in the wrongful death**

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action.

II. The Surviving Children's Damages

29. Next, the Court finds that Julie and John, the surviving children of Mr. Boyle who also have suffered from the loss of their father, are each entitled to \$200,000.00 in noneconomic damages in the wrongful death action.

CONCLUSION

Based on the foregoing, it is hereby

ORDERED that

(1) Diane Boyle, as the duly-appointed personal representative of the estate of Mr. Boyle, is entitled to \$319,412.17 in economic damages and \$250,000.00 in noneconomic damages in the survival action, to be reduced by twenty-five percent, which amounts to \$239,559.13 in economic damages and \$187,500.00 in noneconomic damages, together totaling \$427,059.13.

(2) Diane Boyle, as the surviving spouse of Mr. Boyle, is entitled to \$375,000.00 in economic damages and \$400,000.00 in noneconomic damages in the wrongful death action, to be reduced by twenty-five percent, which amounts to \$281,250.00 in economic damages and \$300,000.00 in noneconomic damages, together totaling \$581,250.00.

(3) Julie Boyle, as a surviving child of Mr. Boyle, is entitled to \$200,000.00 in noneconomic damages in the wrongful death action, to be reduced by twenty-five percent, for a total of \$150,000.00.

(4) John Boyle, as a surviving child of Mr. Boyle, is entitled to \$200,000.00 in noneconomic damages in the wrongful death action, to be reduced by twenty-five percent,

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for a total of \$150,000.00.

Altogether the total judgment in this case amounts to \$1,308,309.13.

IT IS FURTHER ORDERED that the judgment shall bear the current statutory legal rate of interest from the date of the judgment until it is satisfied.

IT IS SO ORDERED.


The Honorable Sol Blatt, Jr.
Senior United States District Judge

August 6, 2012
Charleston, South Carolina

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EXHIBIT A

"Exhibit A"
JF

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JF

STATE OF SOUTH CAROLINA
COUNTY OF YORK

Robin R. Wilson and Brice R. Wilson
Individually and as Personal
Representatives for the Estate of Sierra R.
Wilson,

Plaintiffs,

vs.

Amisub of South Carolina, Inc., d/b/a
Piedmont Healthcare System and Piedmont
Medical Center, and James R. Granger,
III, M.D.,

Defendants.

IN THE COURT OF COMMON PLEAS
C.A. No.: 06-CP-46-2891

ORDER

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CLERK OF COURT
YORK COUNTY, SC

This matter comes before the Court on five post-trial motions made by Defendant Amisub of South Carolina, Inc., d/b/a Piedmont Healthcare System and Piedmont Medical Center ("the Hospital"). This medical malpractice case was tried to verdict in front of the undersigned in York, South Carolina, during the February 9, 2009, Term of Common Pleas Court. Plaintiffs were awarded a total verdict in the amount of \$4,405,000.00.¹ Plaintiffs were represented by Kenneth Suggs, Esq. and Gerald Jowers, Esq. Defendant Hospital was represented by William Gunn, Esq., and Defendant James R. Granger, III, M.D. ("Dr. Granger") was represented by Ashby Davis, Esq. and Collie Lehn, Esq. A hearing was heard on the motions in Union, South Carolina, by the undersigned on March 16, 2009. Plaintiff was represented by Kenneth Suggs, Esq., the Hospital was represented by William Gunn, Esq., and Ashby Davis, Esq. represented Dr. Granger. For the below reasons, the Court denies the Hospital's motions.

¹ The jury found Dr. Granger not liable. The Plaintiffs have moved this Court to declare the statutory cap on noneconomic damages unconstitutional. That motion is not addressed in this Order.

Motion for New Trial Based on the Thirteenth Juror Doctrine

In Youmans ex rel. Elmore v. S.C. Dept. of Transp., 380 S.C. 263, 272, 670 S.E.2d 1, 5 (Ct. App. 2008), the Court of Appeals recently explained the purposes of the thirteenth juror doctrine:

The thirteenth juror doctrine is a vehicle by which the trial court may grant a new trial absolute when he finds that the evidence does not justify the verdict. This ruling has also been termed granting a new trial upon the facts. The effect is the same as if the jury failed to reach a verdict. The judge as the thirteenth juror "hangs" the jury. (citing Folkens v. Hunt, 300 S.C. 251, 254-55, 387 S.E.2d 265, 267 (1990)).

The Youmans Court also made clear that "[t]he 'thirteenth juror' doctrine is not used when the trial judge has found the verdict was inadequate or unduly liberal and, therefore, is not a vehicle to grant a new trial *nisi additur*." Bailey v. Peacock, 318 S.C. 13, 14-15, 455 S.E.2d 690, 692 (1995). Youmans at 273.

This Court finds that the evidence presented at trial justifies the verdict and that the verdict is neither inconsistent nor a reflection of confusion by the jury. The interpretation and reporting of both the fetal monitor strips and the complete blood count (CBC) test formed the basis for Plaintiffs' theory of negligence. Plaintiffs' expert, Dr. Jeffery King, testified that the fetal monitor strips showed recurrent late decelerations, a sign, according to him, indicating placental insufficiency. While Defendants' witnesses and expert witnesses offered a different interpretation of the fetal monitor strips, it was for the jury to decide the weight and credibility to give to the differing testimony.

Similarly, it was for the jury to decide the weight and credibility to give to the testimony regarding the CBC test. Dr. Granger testified that he could not remember whether he had the CBC test results on November 16, 2003, but that this did not impact his treatment of Mrs. Wilson. Moreover, Dr. Granger's expert, Dr. Robert Arnett, testified that obstetricians may rely

on the information given to them by nurses—in this case, the results from the fetal monitor and CBC tests—and that to do so is not a deviation from the standard of care. Based on this and other evidence and testimony offered at trial, the jury had enough evidence to reach a verdict against the Hospital but not against Dr. Granger and such a verdict is justified by the evidence and is not inconsistent or illogical.

Motion for New Trial Based on the Verdict Form

Under Rule 59(a), SCRCP, a “new trial may be granted to all or any of the parties and on all or part of the issues (1) in an action in which there has been a trial by jury, for any of the reasons for which new trials have heretofore been granted in actions at law in the courts of the State. . .”. The Hospital bases its first motion for new trial on the grounds that the Court erred in providing separate lines on the verdict form for Robin Wilson and Brice Wilson in the wrongful death cause of action. Instead, the Hospital argues the Court should have submitted a form with one line letting the probate court divide any verdict between the co-personal representatives.

Using separate lines on the verdict form complies with the South Carolina wrongful death statute and the statute regarding caps on noneconomic damages.² Section 15-51-40 of the wrongful death statute says that “the jury may give damages . . . as they may think proportioned to the injury resulting from the death to the parties respectively for whom and for whose benefit such action shall be brought.” S.C. Code Ann. § 15-51-40 (Rev. 2005) (emphasis added). That the legislature chose to use the word “respectively” indicates its desire to separate the amount of damages according to each claimant. See Matter of Decker, 322 S.C. 215, 219, 471 S.E.2d 462,

² The statute regarding noneconomic damages, section 15-32-220, was enacted by 2005 Act No. 32, which says “this act takes effect July 1, 2005, for causes of action arising after July 1, 2005.” Therefore, the caps do not apply to the damages awarded in Sierra Wilson’s survival action because that action arose on November 18, 2003. Assuming for the moment that they are constitutional, the caps do apply to the wrongful death claim, which arose in February 2008; therefore, this Court must comply with the language in that section.

463 (1995) ("A statute should be so construed that no word, clause, sentence, provision or part shall be rendered surplusage, or superfluous....") (citation omitted).

In addition, the statute dealing with caps on noneconomic damages, section 15-32-220(a), says

[i]n an action on a medical malpractice claim when final judgment is rendered against a single health care provider, the limit of civil liability for noneconomic damages of the health care provider is limited to an amount not to exceed three hundred fifty thousand dollars for each claimant, regardless of the number of separate causes of action on which the claim is based, except as provided in subsection (E).

S.C. Code Ann. § 15-32-220(a) (Supp. 2003) (emphasis added). The phrase "for each claimant" makes clear that the caps apply separately to each claimant. Therefore, if the caps apply separately for each claimant, it becomes necessary for a jury to award damages separately to each claimant.

In addition, it is conceivable that a jury could determine that one claimant deserves a larger damage award than another claimant. For example, in a case where a mother and father are suing for the wrongful death of their child, a jury could decide to award more damages to the mother than the father because the mother was more directly involved in the caring and support of the child. Such a possibility makes separate lines on a verdict form for each claimant appropriate and necessary.

Motion for New Trial Based on the Court's Note to the Jury

The Hospital also argues the Court should grant a new trial because the Court erred in its response to a request from the jury to rehear the testimony of Nurse Lisa Reynolds and, instead, wrote a note to the jury answering its question.³ In support of its argument, the Hospital cites

³ The jury's question was "[m]ay we hear Ms. Reynolds' testimony of what she reported to the doctor about the NST/CST results?" The Court's response was "[w]e have examined the testimony of Ms. Reynolds and she testified that she could not recall what she reported to Dr. Granger."

Article V, § 21 of the South Carolina Constitution, which says that "[j]udges shall not charge juries in respect to matters of fact, but shall declare the law."

This Court does not believe its handling of the jury's question regarding Nurse Reynolds' testimony constitutes grounds for a new trial. The Court gave a completely accurate response to the question asked and only responded to the question asked. More importantly, the Court's response did not comment on the facts but, rather, simply stated what Nurse Reynolds had said. It would have been unfair to the Plaintiff to direct the jury to other testimony because such an emphasis from the Court might have been misconstrued by the jury.

Article V, § 21 of the Constitution deals with jury charges not responses to jury questions. If this Court were to apply Article V, § 21 as narrowly as the Hospital seems to want, then a judge would not be allowed to comment on a question from the jury requesting pens and paper because such a comment would not deal with the law. Such a result is neither required nor contemplated under our Constitution.

The undersigned has adopted the philosophy/practice of responding to jury questions with specificity. That is, the jury poses a question, the Court answers that question. For the Court to broaden the jury's inquiry would, in the undersigned's opinion, interject the trial judge into the jury's analysis and deliberations. The Court would in essence be saying "well, you asked this, but don't you think you should consider this other thing also?" The undersigned believes to broaden the answer to a question beyond the question itself places the judge in the jury room as a thirteenth juror.

Finally, this Court's ruling on the jury's note must be considered in light of Rule 61, SCRPC. Rule 61 says that "... no error or defect in any ruling or order or anything done or omitted by the court ... is ground for granting a new trial ... unless refusal to take such action

appears to the court inconsistent with substantial justice." Rule 61, SCRCP. Writing a completely accurate response to a jury's question is not inconsistent with substantial justice and did not prejudice the Hospital.

**Motion for New Trial or in the Alternative New Trial *Nisi*
(Excessive Verdict)**

The Hospital makes its last motion for new trial on the grounds that the total verdict of \$4,405,000.00 was excessive and based upon arbitrariness, capriciousness, passion, prejudice, or other considerations not found in the evidence. The Court disagrees.

"A new trial absolute should be granted only if the verdict is so grossly excessive that it shocks the conscience of the court and clearly indicates the amount of the verdict was the result of caprice, passion, prejudice, partiality, corruption, or other improper motive" Knoke v. S.C. Dept. of Parks, Recreation, and Tourism, 324 S.C. 136, 141, 478 S.E.2d 256, 258 (1996) (citations omitted). "[T]he circuit court alone has the power to grant a new trial *nisi* when it finds the amount of the verdict to be merely inadequate or excessive. McCourt by and Through McCourt v. Abernathy, 318 S.C. 301, 308, 457 S.E.2d 603, 607 (1995). "Compelling reasons, however, must be given to justify invading the jury's province in this manner." Bailey v. Peacock, 318 S.C. 13, 14, 455 S.E.2d 690, 691, (1995)." RRR, Inc. v. Toggas, 378 S.C. 174, 183, 662 S.E.2d 438, 442-43 (Ct. App. 2008).

The verdict in this case does not shock the conscience of the Court, and the verdict is not excessive. The decedent, Sierra Wilson, lived with substantial pain and suffering that supports a verdict in her survival action of \$2,405,000.00 for her medical expenses and pain and suffering. Part of her pain and suffering included the seizures she experienced when she was only six hours old; kidney failure; the numerous operations she had; and the fact that she suffered from cerebral palsy. While the Defendants may disagree as to the cause and culpability of these problems, the

jury returned a verdict against the Hospital and the Court must analyze the reasonableness and excessiveness of the verdict in light of the jury's determination of negligence.

Similarly, the jury's award of \$1,000,000.00 each to Robin and Brice Wilson in their wrongful death action is not excessive and does not shock the conscience of the court. The jury's award was reasonable based on the evidence and testimony presented at trial regarding Robin and Brice's pain and suffering, including the fact that Sierra is the only child that Robin and Brice will be capable of having together since Robin was sterilized when Sierra was born.

Motion to Alter or Amend the Judgment by Reducing the Verdict

Pursuant to Rule 59(e), SCRC, the Hospital moves the court to alter or amend the judgment by reducing the verdict. This issue is affected by the Court's ruling on Plaintiffs' motion regarding the constitutionality of the statutory caps on non-economic damages in medical malpractice causes of action. Based on the Order issued by this Court this date, the Court finds the statutory caps constitutional and reduces the verdict in accordance with § 15-32-220(A)-(F).

The caps require reducing each of the Wilson's award to \$350,000.00 and then increasing or decreasing that amount based on the Consumer Price Index formula set forth in § 15-32-220(F). The Chief Economist at the State of South Carolina Board of Economic Advisors has informed the parties that applying subsection (F) increases the caps to \$386,650.00. Therefore, Robin Wilson's wrongful death verdict is reduced to \$386,650.00 and Brice Wilson's wrongful death verdict is reduced to \$386,650.00.

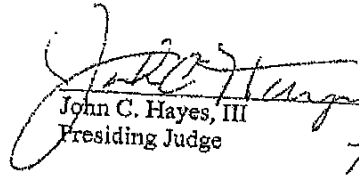
Wherefore, the Hospital's Motion for New Trial Based on the Thirteenth Juror Doctrine is DENIED; the Hospital's Motions for New Trial Based on the Verdict Form and the Court's Note to the Jury are DENIED; the Hospital's Motion for New Trial or in the Alternative New

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[Signature]

[Signature]

Trial *Nisi* is DENIED; and the Hospital's Motion to Alter or Amend the Judgment by Reducing the Verdict is GRANTED.

IT IS SO ORDERED.


John C. Hayes, III
Presiding Judge

March 25th, 2009
York, South Carolina

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STATE OF SOUTH CAROLINA
COUNTY OF YORK

IN THE COURT OF COMMON PLEAS
C.A. No.: 06-CP-46-2891

Robin R. Wilson and Brice R. Wilson
Individually and as Personal
Representatives for the Estate of Sierra R.
Wilson,

Plaintiffs,

vs.

ORDER

Amisub of South Carolina, Inc., d/b/a
Piedmont Healthcare System and Piedmont
Medical Center, and James R. Granger,
III, M.D.,

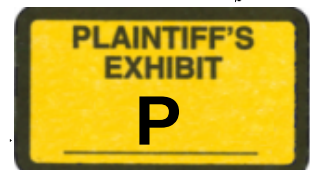
Defendants.

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YORK COUNTY, SC

This matter comes before the Court on five post-trial motions made by Defendant Amisub of South Carolina, Inc., d/b/a Piedmont Healthcare System and Piedmont Medical Center ("the Hospital"). This medical malpractice case was tried to verdict in front of the undersigned in York, South Carolina, during the February 9, 2009, Term of Common Pleas Court. Plaintiffs were awarded a total verdict in the amount of \$4,405,000.00.¹ Plaintiffs were represented by Kenneth Suggs, Esq. and Gerald Jowers, Esq. Defendant Hospital was represented by William Gunn, Esq., and Defendant James R. Granger, III, M.D. ("Dr. Granger") was represented by Ashby Davis, Esq. and Collie Lehn, Esq. A hearing was heard on the motions in Union, South Carolina, by the undersigned on March 16, 2009. Plaintiff was represented by Kenneth Suggs, Esq., the Hospital was represented by William Gunn, Esq., and Ashby Davis, Esq. represented Dr. Granger. For the below reasons, the Court denies the Hospital's motions.

¹ The jury found Dr. Granger not liable. The Plaintiffs have moved this Court to declare the statutory cap on noneconomic damages unconstitutional. That motion is not addressed in this Order.

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Motion for New Trial Based on the Thirteenth Juror Doctrine

In Youmans ex rel. Elmore v. S.C. Dept. of Transp., 380 S.C. 263, 272, 670 S.E.2d 1, 5 (Ct. App. 2008), the Court of Appeals recently explained the purposes of the thirteenth juror doctrine:

The thirteenth juror doctrine is a vehicle by which the trial court may grant a new trial absolute when he finds that the evidence does not justify the verdict. This ruling has also been termed granting a new trial upon the facts. The effect is the same as if the jury failed to reach a verdict. The judge as the thirteenth juror "hangs" the jury. (citing Folkens v. Hunt, 300 S.C. 251, 254-55, 387 S.E.2d 265, 267 (1990)).

The Youmans Court also made clear that "[t]he 'thirteenth juror' doctrine is not used when the trial judge has found the verdict was inadequate or unduly liberal and, therefore, is not a vehicle to grant a new trial *nisi additur*." Bailey v. Peacock, 318 S.C. 13, 14-15, 455 S.E.2d 690, 692 (1995). Youmans at 273.

This Court finds that the evidence presented at trial justifies the verdict and that the verdict is neither inconsistent nor a reflection of confusion by the jury. The interpretation and reporting of both the fetal monitor strips and the complete blood count (CBC) test formed the basis for Plaintiffs' theory of negligence. Plaintiffs' expert, Dr. Jeffery King, testified that the fetal monitor strips showed recurrent late decelerations, a sign, according to him, indicating placental insufficiency. While Defendants' witnesses and expert witnesses offered a different interpretation of the fetal monitor strips, it was for the jury to decide the weight and credibility to give to the differing testimony.

Similarly, it was for the jury to decide the weight and credibility to give to the testimony regarding the CBC test. Dr. Granger testified that he could not remember whether he had the CBC test results on November 16, 2003, but that this did not impact his treatment of Mrs. Wilson. Moreover, Dr. Granger's expert, Dr. Robert Arnett, testified that obstetricians may rely

on the information given to them by nurses—in this case, the results from the fetal monitor and CBC tests—and that to do so is not a deviation from the standard of care. Based on this and other evidence and testimony offered at trial, the jury had enough evidence to reach a verdict against the Hospital but not against Dr. Granger and such a verdict is justified by the evidence and is not inconsistent or illogical.

Motion for New Trial Based on the Verdict Form

Under Rule 59(a), SCRPC, a “new trial may be granted to all or any of the parties and on all or part of the issues (1) in an action in which there has been a trial by jury, for any of the reasons for which new trials have heretofore been granted in actions at law in the courts of the State. . .”. The Hospital bases its first motion for new trial on the grounds that the Court erred in providing separate lines on the verdict form for Robin Wilson and Brice Wilson in the wrongful death cause of action. Instead, the Hospital argues the Court should have submitted a form with one line letting the probate court divide any verdict between the co-personal representatives.

Using separate lines on the verdict form complies with the South Carolina wrongful death statute and the statute regarding caps on noneconomic damages.² Section 15-51-40 of the wrongful death statute says that “the jury may give damages . . . as they may think proportioned to the injury resulting from the death to the parties respectively for whom and for whose benefit such action shall be brought.” S.C. Code Ann. § 15-51-40 (Rev. 2005) (emphasis added). That the legislature chose to use the word “respectively” indicates its desire to separate the amount of damages according to each claimant. See Matter of Decker, 322 S.C. 215, 219, 471 S.E.2d 462,

² The statute regarding noneconomic damages, section 15-32-220, was enacted by 2005 Act No. 32, which says “this act takes effect July 1, 2005, for causes of action arising after July 1, 2005.” Therefore, the caps do not apply to the damages awarded in Sierra Wilson’s survival action because that action arose on November 18, 2003. Assuming for the moment that they are constitutional, the caps do apply to the wrongful death claim, which arose in February 2008; therefore, this Court must comply with the language in that section.

463 (1995) ("A statute should be so construed that no word, clause, sentence, provision or part shall be rendered surplusage, or superfluous....") (citation omitted).

In addition, the statute dealing with caps on noneconomic damages, section 15-32-220(a), says

[i]n an action on a medical malpractice claim when final judgment is rendered against a single health care provider, the limit of civil liability for noneconomic damages of the health care provider is limited to an amount not to exceed three hundred fifty thousand dollars for each claimant, regardless of the number of separate causes of action on which the claim is based, except as provided in subsection (E).

S.C. Code Ann. § 15-32-220(a) (Supp. 2008) (emphasis added). The phrase "for each claimant" makes clear that the caps apply separately to each claimant. Therefore, if the caps apply separately for each claimant, it becomes necessary for a jury to award damages separately to each claimant.

In addition, it is conceivable that a jury could determine that one claimant deserves a larger damage award than another claimant. For example, in a case where a mother and father are suing for the wrongful death of their child, a jury could decide to award more damages to the mother than the father because the mother was more directly involved in the caring and support of the child. Such a possibility makes separate lines on a verdict form for each claimant appropriate and necessary.

Motion for New Trial Based on the Court's Note to the Jury

The Hospital also argues the Court should grant a new trial because the Court erred in its response to a request from the jury to rehear the testimony of Nurse Lisa Reynolds and, instead, wrote a note to the jury answering its question.³ In support of its argument, the Hospital cites

³ The jury's question was "[m]ay we hear Ms. Reynolds' testimony of what she reported to the doctor about the NST/CST results?" The Court's response was "[w]e have examined the testimony of Ms. Reynolds and she testified that she could not recall what she reported to Dr. Granger."

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Article V, § 21 of the South Carolina Constitution, which says that "[j]udges shall not charge juries in respect to matters of fact, but shall declare the law."

This Court does not believe its handling of the jury's question regarding Nurse Reynolds' testimony constitutes grounds for a new trial. The Court gave a completely accurate response to the question asked and only responded to the question asked. More importantly, the Court's response did not comment on the facts but, rather, simply stated what Nurse Reynolds had said. It would have been unfair to the Plaintiff to direct the jury to other testimony because such an emphasis from the Court might have been misconstrued by the jury.

Article V, § 21 of the Constitution deals with jury charges not responses to jury questions. If this Court were to apply Article V, § 21 as narrowly as the Hospital seems to want, then a judge would not be allowed to comment on a question from the jury requesting pens and paper because such a comment would not deal with the law. Such a result is neither required nor contemplated under our Constitution.

The undersigned has adopted the philosophy/practice of responding to jury questions with specificity. That is, the jury poses a question, the Court answers that question. For the Court to broaden the jury's inquiry would, in the undersigned's opinion, interject the trial judge into the jury's analysis and deliberations. The Court would in essence be saying "well, you asked this, but don't you think you should consider this other thing also?" The undersigned believes to broaden the answer to a question beyond the question itself places the judge in the jury room as a thirteenth juror.

Finally, this Court's ruling on the jury's note must be considered in light of Rule 61, SCRPC. Rule 61 says that "... no error or defect in any ruling or order or anything done or omitted by the court ... is ground for granting a new trial ... unless refusal to take such action

appears to the court inconsistent with substantial justice.” Rule 61, SCRC. Writing a completely accurate response to a jury’s question is not inconsistent with substantial justice and did not prejudice the Hospital.

**Motion for New Trial or in the Alternative New Trial *Nisi*
(Excessive Verdict)**

The Hospital makes its last motion for new trial on the grounds that the total verdict of \$4,405,000.00 was excessive and based upon arbitrariness, capriciousness, passion, prejudice, or other considerations not found in the evidence. The Court disagrees.

“A new trial absolute should be granted only if the verdict is so grossly excessive that it shocks the conscience of the court and clearly indicates the amount of the verdict was the result of caprice, passion, prejudice, partiality, corruption, or other improper motive” Knoke v. S.C. Dept. of Parks, Recreation, and Tourism, 324 S.C. 136, 141, 478 S.E.2d 256, 258 (1996) (citations omitted). “[T]he circuit court alone has the power to grant a new trial *nisi* when it finds the amount of the verdict to be merely inadequate or excessive. McCourt by and Through McCourt v. Abernathy, 318 S.C. 301, 308, 457 S.E.2d 603, 607 (1995). “Compelling reasons, however, must be given to justify invading the jury’s province in this manner.” Bailey v. Peacock, 318 S.C. 13, 14, 455 S.E.2d 690, 691, (1995).” RRR, Inc. v. Toggas, 378 S.C. 174, 183, 662 S.E.2d 438, 442-43 (Ct. App. 2008).

The verdict in this case does not shock the conscience of the Court, and the verdict is not excessive. The decedent, Sierra Wilson, lived with substantial pain and suffering that supports a verdict in her survival action of \$2,405,000.00 for her medical expenses and pain and suffering. Part of her pain and suffering included the seizures she experienced when she was only six hours old; kidney failure; the numerous operations she had; and the fact that she suffered from cerebral palsy. While the Defendants may disagree as to the cause and culpability of these problems, the

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jury returned a verdict against the Hospital and the Court must analyze the reasonableness and excessiveness of the verdict in light of the jury's determination of negligence.

Similarly, the jury's award of \$1,000,000.00 each to Robin and Brice Wilson in their wrongful death action is not excessive and does not shock the conscience of the court. The jury's award was reasonable based on the evidence and testimony presented at trial regarding Robin and Brice's pain and suffering, including the fact that Sierra is the only child that Robin and Brice will be capable of having together since Robin was sterilized when Sierra was born.

Motion to Alter or Amend the Judgment by Reducing the Verdict

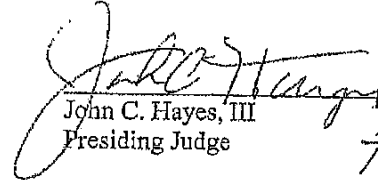
Pursuant to Rule 59(e), SCRPC, the Hospital moves the court to alter or amend the judgment by reducing the verdict. This issue is affected by the Court's ruling on Plaintiffs' motion regarding the constitutionality of the statutory caps on non-economic damages in medical malpractice causes of action. Based on the Order issued by this Court this date, the Court finds the statutory caps constitutional and reduces the verdict in accordance with § 15-32-220(A)-(F).

The caps require reducing each of the Wilson's award to \$350,000.00 and then increasing or decreasing that amount based on the Consumer Price Index formula set forth in § 15-32-220(F). The Chief Economist at the State of South Carolina Board of Economic Advisors has informed the parties that applying subsection (F) increases the caps to \$386,650.00. Therefore, Robin Wilson's wrongful death verdict is reduced to \$386,650.00 and Brice Wilson's wrongful death verdict is reduced to \$386,650.00.

Wherefore, the Hospital's Motion for New Trial Based on the Thirteenth Juror Doctrine is DENIED; the Hospital's Motions for New Trial Based on the Verdict Form and the Court's Note to the Jury are DENIED; the Hospital's Motion for New Trial or in the Alternative New

Trial *Nisi* is DENIED; and the Hospital's Motion to Alter or Amend the Judgment by Reducing the Verdict is GRANTED.

IT IS SO ORDERED.


John C. Hayes, III
Presiding Judge #8

March 25th, 2009
York, South Carolina