IN THE COURT OF COMMON PLEAS
LAKE COUNTY, OHIO

CHRISTINE PEARSON, as the Personal Representative of the Estate of GARY BANKS (deceased),	)	CASE NO. 13 CV 1703
	)	JUDGE JOSEPH GIBSON
Plaintiff,	)	PLAINTIFF'S BRIEF IN OPPOSITION TO DEFENDANTS' MOTION TO STAY PROCEEDINGS PENDING ARBITRATION.
vs.	)	
MANORCARE HEALTH SERVICES - WILLOUGHBY, et al.,	)	
Defendants.	)	

Now comes Plaintiff Christine Pearson, as the Personal Representative of the Estate of Gary Banks(deceased), by and through her attorneys, Blake A. Dickson, Mark D. Tolles, II, and Jacqueline M. Mathews of The Dickson Firm, L.L.C., and, for her Brief in Opposition to Defendants' Motion to Stay Proceedings Pending Arbitration, states as follows:

I. STATEMENT OF THE FACTS AND OF THE CASE.

Gary Banks was a mentally retarded man, who also suffered from paranoid schizophrenia and progressive quadriplegia. From 2006 until 2012, Gary Banks resided at The Gables, which is a group home for adults located in Madison, Ohio. In 2012, his progressive quadriplegia began causing him to lose his ability to walk, and he needed a mechanical lift for transfers. Since The Gables could not provide this level of care, Gary Banks had to be transferred to a different facility.

On August 7, 2012, Gary Banks was admitted to the Cleveland Clinic because of his worsening gait, which was caused by two herniated disks in his spine. On August 13, 2012, Gary Banks successfully underwent surgery.

On August 15, 2012, Gary Banks was discharged from the Cleveland Clinic and admitted to the ManorCare Health Services - Willoughby nursing home. Gary Banks brought a stuffed animal and a balloon with him to the ManorCare Health Services - Willoughby nursing home.

When Gary Banks arrived at the ManorCare Health Services - Willoughby nursing home, prior to signing any admitting documents, Courtney Laurich, LPN conducted an initial nursing assessment and received admission physician's orders for Gary Banks, which clearly indicated that Gary Banks was mentally retarded and had diagnoses of mental retardation and schizophrenia. *See*

Courtney Laurich Depo. 9:11-10:7 and 17:8-21 (December 17, 2013), relevant portions of which are attached hereto as Exhibit "A"; *see also* Gary Banks' Progress Note dated August 15, 2012, at 10:56 p.m., a copy of which is attached hereto as Exhibit "B" (The Progress Note indicates that Gary Banks, upon admission to the ManorCare Health Services - Willoughby nursing home, had diagnoses that included mental retardation and paranoid schizophrenia); *see also* Page 1 of Gary Banks' Admission Physician's Orders dated August 15, 2012, a copy of which is attached hereto as Exhibit "C" (The Admission Physician's Orders also confirm that Gary Banks has diagnoses of mental retardation, which is abbreviated as "MR", and schizophrenia).

Although it was clearly documented by Ms. Laurich as well as Gary Banks' admitting and attending physician that Mr. Banks was mentally retarded and suffered from schizophrenia, Darlene Stincic, the Admissions Coordinator, still instructed Mr. Banks to sign the admission paperwork. *See* Darlene Stincic Depo. 31:21-32:8 (December 17, 2013), relevant portions of which are attached hereto as Exhibit "D". Although the ManorCare Health Services - Willoughby nursing was aware that Gary Banks was mentally retarded and suffered from schizophrenia, neither Ms. Stincic, nor any other employee or agent of the ManorCare Health Services - Willoughby nursing home, contacted any of Gary Banks' family members, including his sister, Christine Pearson, who was his attorney-in-fact for health care decisions, to aid Mr. Banks during the admission process nor to sign any admission paperwork on his behalf. *See* Laurich Depo. 13:17-25, relevant portions of which are attached hereto as Exhibit "A"; *see also* Stincic Depo. 18:1-3, relevant portion of which are attached hereto as Exhibit "D". Instead, Ms. Stincic placed all of the admission paperwork in front of Gary Banks. Gary Banks did not read any portion of the Admission Agreement, including the arbitration clause contained therein. *See* Stincic Depo. 26: 5-6, relevant portions of which are attached hereto as Exhibit "D". Gary Banks was not told that he could have an attorney review the arbitration clause before he signed it. *See* Stincic Depo. 26:10-13, relevant portions of which are attached hereto as Exhibit "D". Ms. Stincic told Gary Banks to sign all of the admission paperwork, including the arbitration clause. Mr. Banks simply signed the admission paperwork at Ms. Stincic's direction.

Upon his admission to the ManorCare Health Services - Willoughby nursing home, it was noted that Gary Banks was at risk for skin breakdown and required assistance with his activities of daily living due to his inability to change and control his body position. However, Defendants, by

and through their employees and/or agents, did not properly reposition and treat Gary Banks in order to prevent the development of new pressure ulcers and promote the healing of pressure ulcers after they developed.

On September 19, 2012, Gary Banks went to the Cleveland Clinic's Spine Clinic for a follow-up appointment relative to his surgery. After discovering that Gary Banks had infected pressure ulcers on his sacrum and left hip, as well as additional pressure ulcers on both of his ankles, the Spine Clinic referred Mr. Banks to the Emergency Department. The sacral pressure ulcer exuded a foul smell and contained fecal matter. Gary Banks was subsequently admitted to the Cleveland Clinic, where he underwent surgical debridement of the two infected pressure ulcers.

As a direct and proximate result of the Defendants' negligence, recklessness, and/or actual malice, Gary Banks suffered from multiple pressure ulcer wounds, including infected Stage IV pressure ulcers on his sacrum and left hip that became septic and resulted in osteomyelitis; suffered a myocardial infarction due to infection-related tachycardia; and was required to undergo a diverting colostomy.

On May 25, 2013, Gary Banks died as a direct and proximate result of the Defendants' negligence, recklessness, and/or actual malice.

On August 2, 2013, Plaintiff Christine Pearson, as the Personal Representative of the Estate of Gary Banks (deceased), filed a Complaint against Defendants ManorCare Health Services - Willoughby, Manor Care of Willoughby OH, LLC, Manor Care, Inc., Manor Care of Willoughby, HCR Manor Care Services, LLC, HCR ManorCare, Inc., HCR II Healthcare, LLC, HCR III Healthcare, LLC, HCR IV Healthcare, LLC, HCR ManorCare Heartland, LLC, HCR ManorCare Operations II, LLC, Healthcare Operations Holdings, Inc., Healthcare Operations Investments, Inc., Carlyle MC Partners, LP, MC Operations Investments, Inc., TC Group V, LP, Carlyle Partners V MC Holdings, LP, Carlyle Partners V MC, LP, HCP, Inc., HCR Healthcare, LLC, and Paul A. Ormond (hereafter collectively referred to as "Defendants") asserting claims for personal injury, wrongful death, medical negligence, ordinary negligence, and violations of Ohio's Nursing Home Resident's Bill of Rights, as set forth in O.R.C. § 3721.13. Plaintiff seeks compensatory damages, punitive damages, attorney fees, and other appropriate relief.

On October 11, 2013, Defendants filed a Joint Answer to Plaintiff's Complaint and demanded a jury trial on all of Plaintiff's claims against them. Defendants also filed a Motion to Stay Proceedings Pending Arbitration pursuant to O.R.C. § 2711.02.

On October 25, 2013, Plaintiff filed a Motion for Extension of Time to Respond to Defendants' Motion to Stay Proceedings Pending Arbitration. In its November 14, 2013 Journal Entry, this Court granted Plaintiff an extension until February 12, 2014 to obtain requested information and documents from the Defendants, depose individuals involved in Gary Banks' admission to the ManorCare Health Services - Willoughby nursing home, and file her response to Defendants' Motion to Stay Proceedings Pending Arbitration.

On February 12, 2014, Plaintiff filed a Motion for Leave to File the Within Brief, Instanter, in Opposition to Defendants' Motion to Stay Proceedings Pending Arbitration, in which Plaintiff requested leave to exceed the ten (10) page limitation set forth in Lake Co. C.P.R. 3.01(A), in order to fully respond to Defendants' Motion to Stay Proceedings Pending Arbitration.

II. LAW AND ARGUMENT.

Defendants, by and through their counsel, have moved this Court to permanently stay all proceedings in this case pending arbitration of all of Plaintiff's claims in this case, pursuant to O.R.C. § 2711.02. Defendants rely upon the arbitration clause that is contained in the Admission Agreement relative to Gary Banks' admission to the ManorCare Health Services - Willoughby nursing home on August 15, 2012. However, Defendants' Motion to Stay Proceedings Pending Arbitration is without merit and should be promptly denied by this Court.

O.R.C. § 2711.02 permits a party to request a stay of proceedings when an "action is brought upon any issue referable to arbitration under an agreement in writing for arbitration". O.R.C. § 2711.02(B) states:

> If any action is brought upon any issue referable to arbitration under an agreement in writing for arbitration, the court in which the action is pending, upon being satisfied that the issue involved in the action is referable to arbitration under an agreement in writing for arbitration, shall on application of one of the parties stay the trial of the action until the arbitration of the issue has been had in accordance with the agreement, provided the applicant for the stay is not in default in proceeding with arbitration.

O.R.C. § 2711.01(A) states that arbitration clauses in written contracts are generally valid and enforceable, subject to several statutory exceptions as well as "grounds that exist at law or in equity for the revocation of any contract."

The arbitration clause contained in Defendants' Admission Agreement, relative to Gary Banks' admission to the ManorCare Health Services - Willoughby nursing home, is void, invalid, and unenforceable against the Estate of Gary Bank (deceased) and Gary Banks' next-of-kin for the following **eleven (11)** reasons:

A. Defendants' Admission Agreement unequivocally states that the Admission Agreement, including the arbitration clause contained therein, automatically terminated upon Gary Banks' discharge from the ManorCare Health Services - Willoughby nursing home, which occurred on September 19, 2012. As a result, the Admission Agreement and its arbitration clause are now void pursuant to the express language of the Admission Agreement.

B. Pursuant to O.R.C. § 2711.22(A), an arbitration agreement is not valid and enforceable until it is signed by all of the parties. The only parties listed in the alleged arbitration clause are Gary Banks and "MC Wby". Since none of the Defendants are listed in the alleged arbitration clause and none of the Defendants have signed it, none of the Defendants have any standing to enforce the arbitration clause at issue against anyone.

C. Pursuant to O.R.C. § 2711.24, an arbitration agreement is only valid and enforceable if the person executing the agreement is able to effectively communicate in spoken and written English. Gary Banks could not effectively communicate in written English due to his intellectual disabilities. Accordingly, the arbitration clause is invalid and unenforceable as a matter of law.

D. Pursuant to O.R.C. § 2711.23(A), an arbitration agreement involving a medical claim is only valid and enforceable if the agreement states that the care, diagnosis, or treatment will be provided whether or not the resident signs the arbitration agreement. Defendants' arbitration clause does not state that Gary Banks will receive care and treatment at the ManorCare Health Services - Willoughby nursing home regardless of whether he signs the arbitration clause. Accordingly, it is invalid and unenforceable as a matter of law.

E. Pursuant to O.R.C. § 2711.23(C), an arbitration agreement involving a medical claim is only valid and enforceable if the agreement states that the decision whether or not to sign the agreement is solely a matter for the

resident's determination without any influence. Defendants' arbitration clause contains no such statement and, therefore, is invalid and unenforceable as a matter of law.

F. Pursuant to O.R.C. § 2711.23(G), an arbitration agreement involving a medical claim is only valid and enforceable if it is separate from any other agreement, consent, or document. Since the arbitration clause at issue is buried in Defendants' twenty-seven (27) page Admission Agreement and is not a separate agreement, it is invalid and unenforceable as a matter of law.

G. Pursuant to the Ohio Supreme Court's decision in *Peters v. Columbus Steel Castings, Co.*, 115 Ohio St.3d 134, 2007-Ohio-4784, 873 N.E.2d 1258 (2007), wrongful death claims brought by a Decedent Gary Banks' next-of kin are not subject to arbitration based upon an arbitration clause signed by Decedent Gary Banks because he cannot compel his next-of-kin to arbitrate their wrongful death claims. Accordingly, there is no basis for this Court to stay Plaintiff's wrongful death claims.

H. In their Answer, Defendants admitted that there is no privity of contract between the parties. Therefore, the Admission Agreement, including the arbitration clause contained therein, is invalid and unenforceable by the Defendants.

I. Defendants have waived any alleged right to arbitration by actively participating in this case, including, but not limited to, the filing of an Answer and demanding a jury trial on all of the claims set forth in Plaintiff's Complaint.

J. Defendants' arbitration clause is both procedurally and substantively unconscionable and, as a result, is unenforceable.

K. Defendants' arbitration clause violates the unanimous recommendations of the American Arbitration Association, the American Bar Association, and the American Medical Association and, therefore, should not be enforced.

For all of these reasons, as further discussed below, Plaintiff respectfully requests that this Honorable Court deny Defendants' Motion to Stay Proceedings Pending Arbitration, as the arbitration clause at issue is clearly void, invalid, and unenforceable based upon Defendants' own admissions in this case, the express language of Defendants' Admission Agreement, Defendants' conduct throughout this litigation, and as a matter of law.

A. The express language of Defendant's Admission Agreement clearly states that the Admission Agreement, including its arbitration clause, automatically terminated upon Gary Banks' discharge from the ManorCare Health Services - Willoughby nursing home on September 19, 2012. As a result, the Admission Agreement and its arbitration clause is void and unenforceable.

Pursuant to its express terms, Defendants' Admission Agreement automatically terminated on September 19, 2012, when Gary Banks was discharged from the ManorCare Health Services - Willoughby nursing home. Since the agreement terminated on September 19, 2012, it was not in effect on October 11, 2013, over a year later, when the Defendants filed their Motion to Stay Proceedings Pending Arbitration.

It is well recognized that "arbitration is a creature of contract." *Motor Wheel Corp. v. Goodyear Tire & Rubber Co.*, 98 Ohio App.3d 45, 52, 647 N.E.2d 844 (8th Dist. 1994). Arbitration agreements should be "as enforceable as other contracts, but not more so." *Prima Paint Corp. v. Flood & Conklin Mfg. Co.*, 388 U.S. 395, 405 n. 12, 87 S.Ct. 1801 (1967). As a result, "the first task of a court asked to compel arbitration of a dispute is to determine whether the parties agreed to arbitrate that dispute." *Mitsubishi Motors Corp. v. Soler Chrysler-Plymouth, Inc.*, 473 U.S. 614, 626, 105 S.Ct. 3346 (1985). "When confronted with an issue of contract interpretation, the role of the court is to give effect to the intent of the parties to that agreement. The court examines the contract as a whole and presumes that the intent of the parties is reflected in the language used in the agreement." *Martin Marietta Magnesia Specialties, L.L.C. v. Pub. Utils. Comm'n of Ohio*, 129 Ohio St.3d 485, 490, 2011-Ohio-4189, 954 N.E.2d 104 (2011), citing *Westfield Ins. Co. v. Galatis*, 100 Ohio St.3d 216, 219, 2003-Ohio-5849, 797 N.E.2d 1256 (2003). "[T]he terms of a written contract are to be ascertained from the language of the agreement, and no implication inconsistent with the express terms therein may be inferred." *Belfance v. Standard Oil*, 1990 Ohio App. LEXIS 5475, at * 8 (9th Dist. 1990). "When the language of a written contract is clear, a court may look no further than the writing itself to find the intent of the parties." *Martin Marietta Magnesia Specialties, L.L.C.*, 129 Ohio St.3d at 490, citing *Westfield Ins. Co.*, 100 Ohio St.3d at 219.

"Contract provisions that are unambiguous must be construed according to the plain, express terms." *Budai v. Euclid Spiral Paper Tube Corp.*, 1997 Ohio App. LEXIS 189, at * 29 (9th Dist. 1997). "When a written contract is plain and unambiguous, it does not become ambiguous by reason

of the fact that its operation will work a hardship on one party and accord advantage to the other." *Belfance*, 1990 Ohio App. LEXIS 5475, at * 8-9.

"A court * * * is not permitted to alter a lawful contract by imputing an intent contrary to that expressed by the parties." *Westfield Ins. Co.*, 100 Ohio St.3d at 219, citing *Shifrin v. Forest City Enters., Inc.*, 64 Ohio St.3d 635, 1992-Ohio-28, 597 N.E.2d 499 (1992) and *Blosser v. Enderlin*, 113 Ohio St. 121, 148 N.E. 393, paragraph one of the syllabus (1925). "Additionally, all terms in a contract should be given effect whenever possible." *Budai*, 1997 Ohio App. LEXIS 189, at * 28-29 (emphasis in original), citing *Wadsworth Coal Co. v. Silver Creek Min. & Ry. Co.*, 40 Ohio St. 559, paragraph one of the syllabus (1884). "The contract under consideration should be construed reasonably, so as not to arrive at absurd results. *Budai*, 1997 Ohio App. LEXIS 189, at * 28, citing *Cincinnati v. Cameron*, 33 Ohio St. 336, 364 (1878). "Common words appearing in a written instrument will be given their ordinary meaning unless manifest absurdity results, or unless some other meaning is clearly evidenced from the face or overall contents of the instrument." *King v. Nationwide Ins. Co.*, 35 Ohio St.3d 208, 212, 519 N.E.2d 1380 (1988) citing *Alexander v. Buckeye Pipe Line Co.*, 53 Ohio St.2d 241, 374 N.E.2d 146, paragraph two of the syllabus (1978). "[W]here the written contract is standardized and between the parties of unequal bargaining power, an ambiguity in the writing will be interpreted strictly against the drafter and in favor of the nondrafting party." *Westfield Ins. Co.*, 100 Ohio St.3d at 220, citing *Cent. Realty Co. v. Clutter*, 62 Ohio St.2d 411, 413, 406 N.E.2d 515 (1980).

In *Martin Marietta Magnesia Specialties, L.L.C. v. Pub. Utils. Comm'n of Ohio*, 129 Ohio St.3d 485, 2011-Ohio-4189, 954 N.E.2d 104 (2011), the Ohio Supreme Court was asked to determine the termination date of special contracts between several corporations and their public utility company, Toledo Edison. The corporations contended that their special contracts "would terminate on the date that Toledo Edison ceased its collection of regulatory-transition charges, i.e., December 31, 2008", pursuant to the express terms of the contracts. *Id.* at 489. However, Toledo Edison terminated the contracts in February of 2008. Toledo Edison claimed that the parties had agreed to a termination date "that tied regulatory-transition charges to Toledo Edison's distribution sales", such that the contracts would terminate "when Toledo Edison's distribution sales reach a certain level." *Id.* at 490. Finding that the language of the contracts was clear and unambiguous and expressly stated that the contracts "shall terminate with the bill rendered for the electric usage

through the date which [the regulatory-transition charge] ceases for the [Toledo Edison] Company", the Court held that the contracts were supposed to terminate on December 31, 2008 when Toledo Edison stopped collecting its regulatory-transition charges. *Id.* The Court found that, pursuant to the express terms of the contracts, the corporations and Toledo Edison had agreed that the contracts would terminate on this date, not on some other date when Toledo Edison's distribution sales reached a certain level. Therefore, the express language of the termination clauses in the contracts controlled.

In this case, there is no dispute that the arbitration clause at issue was part of the Defendants' Admission Agreement, relative to Gary Banks' admission to the ManorCare Health Services - Willoughby nursing home. *See* Stincic Depo. 29:12-14, relevant portions of which are attached hereto as Exhibit "D". Section 6.1 of the Admission Agreement expressly states:

> This Agreement begins on the day You are admitted to the Center and **ends on the day You are discharged from the Center** unless you are readmitted within 15 days of Your discharge date. If You are re-admitted within 15 days of being discharged from the Center, this Agreement will continue in effect as of the date of Your re-admission.

See Bates-Stamped Page 2 of Gary Banks' Admission Agreement (emphasis added), a copy of which is attached hereto as Exhibit "E".

Gary Banks was discharged from the ManorCare Health Services - Willoughby nursing home September 19, 2012, and he was never readmitted to the nursing home. As a result, pursuant to Section 6.1 of the Defendants' Admission Agreement, which was drafted exclusively by the Defendants, the Admission Agreement and the arbitration clause incorporated therein, automatically terminated upon Gary Banks' discharge on September 19, 2012. Therefore, this Court should not give any effect to Defendants' Admission Agreement because it terminated on September 19, 2012 and is void.

Accordingly, there is no basis to stay any of Plaintiff's claims pursuant to Defendants' Motion to Stay Proceedings Pending Arbitration, which was filed on October 11, 2013, over one (1) year after the Admission Agreement terminated, and this Court should promptly deny Defendants' Motion to Stay Proceedings Pending Arbitration.

B. The only proper party to the alleged arbitration clause is an entity known as "MC Wby". MC Wby is not a Defendant in this case. Therefore, pursuant to O.R.C. § 2711.01(A), there is no enforceable arbitration clause between Gary Banks and any of the Defendants.

O.R.C. § 2711.01(A) defines a valid arbitration clause, in pertinent part, as "any agreement in writing between two or more persons to submit to arbitration any controversy existing between them". *See also* O.R.C. § 2711.22(A).

In this case, there is no agreement in writing between Gary Banks and any of the Defendants. None of the Defendants are parties to the alleged arbitration clause. In the second paragraph, the arbitration clause expressly states that it was "[m]ade on 8/15/12 (date) by and between the Patient Gary Banks or Patient's Legal Representative _____ (collectively referred to as "Patient") and the Center MC Wby." *See* Bates-Stamped Page 26 of Gary Banks' Admission Agreement, a copy of which is attached hereto as Exhibit "E". On the next page of the Admission Agreement, Darlene Stincic signed as "Center Representative". *Id.* at Bates-Stamped Page 27. "Center" is not defined anywhere within the arbitration clause. Defendants ManorCare Health Services - Willoughby, Manor Care of Willoughby OH, LLC, Manor Care, Inc., Manor Care of Willoughby, HCR Manor Care Services, LLC, HCR ManorCare, Inc., HCR II Healthcare, LLC, HCR III Healthcare, LLC, HCR IV Healthcare, LLC, HCR ManorCare Heartland, LLC, HCR ManorCare Operations II, LLC, Healthcare Operations Holdings, Inc., Healthcare Operations Investments, Inc., Carlyle MC Partners, LP, MC Operations Investments, Inc.,TC Group V, LP, Carlyle Partners V MC Holdings, LP, Carlyle Partners V MC, LP, HCP, Inc., HCR Healthcare, LLC, and Paul A. Ormond are not parties to the arbitration clause. The only parties to the agreement are Gary Banks and MC Wby. Pursuant to O.R.C. § 2711.01(A), there is no valid written arbitration clause to enforce between Gary Banks and the Defendants.

Accordingly, this Court must deny Defendants' Motion to Stay Proceedings Pending Arbitration.

C. Pursuant to O.R.C. § 2711.24, an arbitration agreement is only valid and enforceable if the person executing the agreement is able to effectively communicate in spoken and written English. Gary Banks could not effectively communicate in written English due to his mental disabilities. As a result, the arbitration clause is invalid and unenforceable as a matter of law.

O.R.C. § 2711.24 states, in pertinent part (emphasis added):

> To the extent it is in ten-point type and is executed in the following form, an arbitration agreement of the type stated in section 2711.23 of the Revised Code shall be presumed valid and enforceable in the absence of proof by a preponderance of the evidence * * * **that the patient executing the agreement was not able to communicate effectively in spoken and written English** or any other language in which the agreement is written * * *.

As discussed above, Gary Banks suffered from mental retardation and paranoid schizophrenia. Courtney Laurich, LPN, who conducted an initial nursing assessment, noted in her Progress Note relative to Gary Banks' admission to the ManorCare Health Services - Willoughby nursing home, that Mr. Banks had diagnoses of mental retardation and schizophrenia. *See* Courtney Laurich Depo. 17:16-19, relevant portions of which are attached hereto as Exhibit "A"; *see also* Gary Banks' Progress Note dated August 15, 2012, at 10:56 p.m., a copy of which is attached hereto as Exhibit "B". Ms. Laurich also indicated on Gary Banks' Admission Physician's Orders that he had diagnoses of mental retardation (abbreviated as "MR") and schizophrenia. *See* Page 1 of Gary Banks' Admission Physician's Orders dated August 15, 2012, a copy of which is attached hereto as Exhibit "C".

Due to his mental disabilities, Gary Banks was placed in special education classes throughout the entirety of his formal education. *See* Affidavit of Christine Pearson, at ¶ 5, a copy of which is attached hereto as Exhibit "F". He never held a job that required him to read or write and only held jobs such as packing light bulbs and cleaning churches, which did not require any reading or writing. *Id.* at ¶¶ 8-9. He could not read books, magazines, letters, or documents on his own. *Id.* at ¶ 15, a copy of which is attached hereto as Exhibit "F". He was unable to read and comprehend complex documents like the Defendants' Admission Agreement. *Id.* at ¶ 7. In fact, Darlene Stincic, the Admissions Coordinator who provided Gary Banks with the admission paperwork, testified that Mr. Banks did not read any portion of the Admission Agreement, including the arbitration clause contained therein. *See* Stincic Depo. 26:5-6, relevant portions of which are attached hereto as Exhibit "D". Yet, she still had him sign all of the admission paperwork.

It is clear that Gary Banks could not effectively communicate in written English, as required by O.R.C. § 2711.24, when he signed the Admission Agreement on August 15, 2012. Accordingly, pursuant to O.R.C. § 2711.24, his signature is invalid and the Agreement is invalid and

unenforceable as a matter of law. Therefore, this Court should promptly deny Defendants' Motion to Stay Proceedings Pending Arbitration.

D. Pursuant to O.R.C. § 2711.23(A), an arbitration agreement involving a medical claim is only valid and enforceable if the agreement states that the care, diagnosis, or treatment will be provided whether or not the resident signs the arbitration agreement. Defendants' arbitration clause does not state that Gary Banks will receive care and treatment at the ManorCare Health Services - Willoughby nursing home, even if he does not sign the arbitration clause. As a result, the arbitration clause is invalid and unenforceable as a matter of law.

O.R.C. § 2711.23(A) states (emphasis added):

> **To be valid and enforceable** any arbitration agreements * * * for controversies involving a medical, dental, chiropractic, or optometric claim that is entered into prior to a patient receiving care, diagnosis, or treatment shall include or be subject to the following conditions:
>
> (A) **The agreement shall provide that the care, diagnosis, or treatment will be provided whether or not the patient signs the agreement to arbitrate;**

The arbitration clause at issue is contained on Bates-Stamped Pages 26-27 of Defendants' Admission Agreement, which is attached hereto as Exhibit "E". In contradiction of O.R.C. § 2711.23(A), the arbitration clause does not state, in any place, that Gary Banks will receive the necessary medical care at the ManorCare Health Services - Willoughby nursing home, regardless of whether he signed the arbitration clause. Nor does it state anywhere that Gary Banks will receive the necessary medical treatment, regardless of whether he signed the arbitration clause.

This is a classic example of a contract of adhesion. Gary Banks only signed the arbitration clause because he thought he had to sign it in order to be admitted to the ManorCare Health Services - Willoughby nursing home and receive the necessary care and treatment that he needed, which could no longer be provided at The Gables group home. Without clear language stating that the provision of medical care and treatment are not dependent upon the signing of the arbitration clause, this Court, like Gary Banks (had he been able to actually read and comprehend the arbitration clause), can only presume that Gary Banks (or someone lawfully acting on his behalf) needed to sign the arbitration clause in order for him to be admitted to, and receive the necessary care and treatment, at the ManorCare Health Services - Willoughby nursing home. O.R.C. § 2711.23(A)

clearly states that such arbitration clauses are against public policy and deems such arbitration clauses invalid and unenforceable as a matter of law.

Accordingly, pursuant to O.R.C. § 2711.23(A), Defendants' arbitration clause is an invalid contract that is unenforceable as a matter of law. Therefore, this Court should promptly deny Defendants' Motion to Stay Proceedings Pending Arbitration.

E. Pursuant to O.R.C. § 2711.23(C), an arbitration agreement involving a medical claim is only valid and enforceable if the agreement states that the decision whether or not to sign the agreement is solely a matter for the resident's determination without any influence. Defendants' arbitration clause contains no such statement and, therefore, is invalid and unenforceable as a matter of law.

O.R.C. § 2711.23(C) states:

> **To be valid and enforceable** any arbitration agreements * * * for controversies involving a medical, dental, chiropractic, or optometric claim that is entered into prior to a patient receiving care, diagnosis, or treatment shall include or be subject to the following conditions:
>
> * * *
>
> (C) **The agreement shall provide that the decision whether or not to sign the agreement is solely a matter for the patient's determination without any influence;**

The arbitration clause at issue is contained on Bates-Stamped Pages 26-27 of Defendants' Admission Agreement, which is attached hereto as Exhibit "E". In contradiction of O.R.C. § 2711.23(C), the arbitration clause does not state, in any place, that the decision whether or not to sign the agreement is solely a matter for Gary Banks' determination without any influence. Gary Banks did not, and could not, read any portion of the Admission Agreement, including the arbitration clause contained therein, during the admission process. *See* Stincic Depo. 26:5-6, relevant portions of which are attached hereto as Exhibit "D". Yet, she still directed him sign the Admission Agreement, the arbitration clause, and the rest of the admission paperwork.

Accordingly, pursuant to O.R.C. § 2711.23(C), Defendants' arbitration clause is invalid and unenforceable as a matter of law. Therefore, this Court should promptly deny Defendants' Motion to Stay Proceedings Pending Arbitration.

F. Pursuant to O.R.C. § 2711.23(G), an arbitration agreement involving a medical claim is only valid and enforceable if it is separate from any other agreement, consent, or document. Since the two (2) page arbitration clause that Defendants are relying upon is buried within Defendants' twenty-seven (27) page Admission Agreement and is not a separate agreement, it is invalid and unenforceable as a matter of law.

O.R.C. § 2711.23 states, in pertinent part (emphasis added):

> **To be valid and enforceable** any arbitration agreements pursuant to sections 2711.01 and 2711.22 of the Revised Code for controversies involving a medical, dental, chiropractic, or optometric claim that is entered into prior to a patient receiving any care, diagnosis, or treatment shall include and be subject to the following conditions:
>
> * * *
>
> (G) **The arbitration agreement shall be separate from any other agreement, consent, or document;**

As noted above, Darlene Stincic, the Admissions Coordinator who provided Gary Banks with all of the paperwork during the admission process, testified that the arbitration clause is part of Defendants' Admission Agreement. *See* Stincic Depo. 29:12-14, relevant portions of which are attached hereto as Exhibit "D". They comprise one document. The arbitration clause is not a separate agreement, but is simply an attachment or addendum to the Admission Agreement. Since the arbitration clause is not separate from the Admission Agreement, it is invalid and unenforceable, pursuant to O.R.C. § 2711.23(G), as a matter of law.

Accordingly, this Court should promptly deny Defendants' Motion to Stay Proceedings Pending Arbitration.

G. Pursuant to the Ohio Supreme Court's decision in *Peters v. Columbus Steel Castings, Co.*, 115 Ohio St.3d 134, 2007-Ohio-4787, 873 N.E.2d 1258 (2007), wrongful death claims brought by a decedent's next-of-kin are not subject to arbitration.

In *Peters v. Columbus Steel Castings Co.*, 115 Ohio St.3d 134, 2007-Ohio-4787, 873 N.E.2d 1258 (2007), the Ohio Supreme Court considered the issue of "whether the personal representative of a decedent's estate is required to arbitrate a wrongful-death claim when the decedent had agreed to arbitrate all claims against the alleged tortfeasor." *Peters*, 115 Ohio St.3d at 135. In considering this issue, the Court reviewed the separate nature of survival claims and wrongful death claims. The Court stated that "when an individual is killed by the wrongful act of another, the personal

representative of the decedent's estate may bring a survival action *for the decedent's own injuries* leading to his or her death as well as a wrongful-death action *for the injuries suffered by the beneficiaries of the decedent* as a result of the death." *Peters*, 115 Ohio St.3d at 137 (emphasis in original); *see also* O.R.C. §§ 2125.02 and 2305.21, which provide separate causes of action for wrongful death claims and survival claims respectively. The Ohio Supreme Court recognized that although survival claims and wrongful death claims both relate to the same allegedly negligent acts of a defendant, and that such claims are often pursued by the same nominal party (i.e., the personal representative of the estate) in the same case, they are distinct claims that are brought by different parties in interest. *Peters*, 115 Ohio St.3d at 137, citing *Mahoning Valley Ry. Co. v. Van Alstine*, 77 Ohio St. 395, 414, 83 N.E. 601 (1908). As a result of the different nature of wrongful death claims from survival claims, the Court held that "a decedent cannot bind his or her beneficiaries to arbitrate their wrongful-death claims. The beneficiaries can agree to arbitrate these claims themselves, but they are not required to do so. Because Peter's beneficiaries did not sign the plan nor any other dispute-resolution agreement, they cannot be forced into arbitration." *Peters*, 115 Ohio St.3d at 138, citing *Thompson v. Wing*, 70 Ohio St.3d 176, 182-83, 637 N.E.2d 917 (1994). Simply put, the Court concluded that "[a]lthough we have long favored arbitration and encourage it as a cost-effective proceeding that permits parties to achieve permanent resolution of their disputes in an expedient manner, it may not be imposed on the unwilling." *Peters*, 115 Ohio St.3d at 138. The Court went on to state that "[r]equiring Peters's beneficiaries to arbitrate their wrongful-death claims without a signed arbitration agreement would be unconstitutional, inequitable, and in violation of nearly a century's worth of established precedent." *Peters*, 115 Ohio St.3d at 138-39.

The holding and reasoning in *Peters* applies to the wrongful death claims which have been brought by Plaintiff Christine Pearson on behalf of Decedent Gary Banks' next-of-kin. The wrongful death claims in this case are not subject to arbitration pursuant to the arbitration clause contained within the Admission Agreement. As a result, there is absolutely no basis for this Court to stay the wrongful death claims in this case. None of Gary Banks' next-of-kin were ever a party to the Admission Agreement and its arbitration clause, so they cannot be bound by it. Further, none of Gary Banks' next-of-kin signed any part of the Admission Agreement or the arbitration clause and their names do not appear anywhere within the agreements. It is clear that the Admission Agreement and the arbitration clause, in no way, bind Plaintiff Christine Pearson nor any of Gary Banks' other next-of-kin.

In *Skerlec v. Ganley Chevrolet, Inc.*, 2012-Ohio-5748 (8th Dist. 2012), the Eighth District Court of Appeals held that it was reversible error for a trial court to stay claims pending arbitration where some of the claims that were stayed did not fall within the arbitration agreement. In that case, the Court held that three intentional tort claims fell outside of the arbitration agreement and should not have been stayed.

Similarly, in *McFarren v. Emeritus at Canton*, 2013-Ohio-3900 (5th Dist. 2013), the Fifth District Court of Appeals held that arbitration agreements are not enforceable against a nursing home resident's next-of-kin, relative to their wrongful death claims, where the next-of kin did not sign an agreement agreeing to arbitrate their wrongful death claims. The Fifth District Court of Appeals reversed the trial court's decision that had improperly granted the defendant-appellee's motion to stay proceedings pending arbitration in that case. *Id.* at ¶ 31.

In this case, there is no question that Plaintiff's wrongful death claims do not fall within the scope of the Admission Agreement and its arbitration clause. None of Gary Banks' next-of-kin were parties to the arbitration clause signed by Gary Banks. None of Gary Banks' next-of-kin's names appear anywhere in the entire Admission Agreement or arbitration clause. As a result, it would be error for this Court to require Gary Banks' next-of-kin to arbitrate their wrongful death claims. Further, it would be error for this Court to stay Gary Banks' next of kin's wrongful death claims.

Accordingly, this Court should promptly deny Defendants' Motion to Stay Proceedings Pending Arbitration.

H. In their Answer, Defendants admit that there is no privity of contract between the parties. Since there is no privity of contract between the parties, the arbitration clause is not valid and cannot be enforced by any of the Defendants, relative to any of Plaintiff's claims in this case.

On October 11, 2013, Defendants filed a Joint Answer to Plaintiff's Complaint. In their Tenth Affirmative Defense, Defendants stated that "Plaintiff's claims fail for lack of privity of contract."

Defendants have not further described the lack of privity of contract, and it is not necessary to do so at this point in time. It is sufficient that Defendants have admitted that Plaintiff's contractual claims lack privity of contract. The only contract that the Defendants have produced in this case is the Admission Agreement, relative to Gary Banks' residency at the ManorCare Health Services - Willoughby nursing home, which contains the arbitration clause at issue. As a result, Defendants' Tenth Affirmative Defense can only be understood to mean that the Admission

Agreement pertaining to Gary Banks' residency is not binding on the parties of the within case because there is no privity of contract between Defendants and the Plaintiff. If there is no privity of contract between Defendants and the Plaintiff, as Defendants have indicated in their Joint Answer to Plaintiff's Complaint, then the Admission Agreement certainly cannot be enforced against Plaintiff, relative to any claim in this case.

Accordingly, Plaintiff respectfully requests that this Honorable Court deny Defendants' Motion to Stay Proceedings Pending Arbitration because, as the Defendants have admitted in their Answer, the Admission Agreement is unenforceable due to the fact that the parties lack privity of contract.

I. Defendants have waived any alleged right to arbitration by actively participating in this litigation by filing their Answer and demanding a jury trial on all of Plaintiff's claims.

Having actively participated in this lawsuit, Defendants have acquiesced to proceeding in a judicial forum - i.e. this case - rather than an arbitration forum. Defendants' active participation in this case supports this Court finding that Defendants have waived any alleged right to arbitration. See *Jones v. Honchell*, 14 Ohio App.3d 120, 470 N.E.2d 219 (12th Dist. 1984).

In *Hogan v. Cincinnati Fin. Corp.*, 2004-Ohio-3331, at ¶¶ 22-25 (11th Dist. 2004), the Eleventh District Court of Appeals held:

> It is well-established that the right to arbitration can be waived. See, e.g., *Griffith v. Linton (1998), 130 Ohio App. 3d 746, 751, 721 N.E.2d 146*; *Siam Feather & Forest Products Co., Inc. v. Midwest Feather Co., Inc. (S.D. Ohio 1980), 503 F. Supp. 239, 242.* "A party can waive his right to arbitrate under an arbitration clause by filing a complaint." *Glenmoore Builders, Inc. v. Kennedy, 11th Dist. No. 2001-P-0007, 2001 Ohio 8777, 2001 Ohio App. LEXIS 5449, at 9*, citing *Rock, Inc. v. Merrill Lynch, Pierce, Fenner & Smith, Inc. (1992), 79 Ohio App. 3d 126, 128, 606 N.E.2d 1054.* * * *
>
> To prove waiver, the opposing party merely needs to show: (1) that the party waiving the right knew of the existing right of arbitration and (2) that the party acted inconsistently with that right. *See, e.g., Glenmoore Builders at 10, citing ACRS, Inc. v. Blue Cross & Blue Shield of Minnesota* (1998), 131 Ohio App. 3d 450, 456, 722 N.E.2d 1040.

In this case, Defendants clearly knew of their alleged right to arbitration. They have been in possession of the Admission Agreement, which includes the arbitration clause, since Gary Banks was first admitted to the ManorCare Health Services - Willoughby nursing home on August 15,

2012. Although Defendants have filed a Motion to Stay, the Motion was not filed until October 11, 2013. Defendants waited more than two (2) months after Plaintiff filed her Complaint to assert their alleged right to arbitration, even though they had been in possession of Gary Banks' Admission Agreement for over fourteen (14) months at that time.

Defendants have clearly acted inconsistently with any alleged right to arbitration. They filed an Answer to Plaintiff's Complaint and their Answer contained a Jury Demand. By demanding a jury trial on all of the claims asserted in Plaintiff's Complaint, the Defendants have actively participated in this case, in the current forum. Further, by demanding a jury trial, the Defendants have asked this Court, the current forum, to decide the merits of Plaintiff's claims in this case. Not only have the Defendants acquiesced to having a jury trial on the merits of Plaintiff's claims, they have demanded it. In *Milling Away, LLC v. UGP Properties*, LLC, 2011-Ohio-1103, at ¶ 9 (8th Dist. 2011), the Eighth District Court of Appeals found that the filing of a counterclaim against a Plaintiff is a factor to be considered when determining whether a party has waived their right to arbitration. The Court determined that such an act is an indication that the Defendant is accepting the trial court as the forum to resolve the parties' claims. Similarly, by demanding a jury trial, the Defendants have affirmatively indicated that they are seeking this Court's jurisdiction over the resolution of all of Plaintiff's claims.

Defendants may argue that they filed a Jury Demand to preserve their right to a jury trial, the same right that they are attempting to deny to Plaintiff. However, such an argument is without merit. Defendants did not need to demand a jury trial in their Answer, in order to preserve their right to a jury trial and have a jury trial on Plaintiff's claims, in the event that this Court denies their Motion to Stay Proceedings Pending Arbitration. Plaintiff had already demanded a jury trial in her Complaint. Civ.R. 38(D) states, "A demand for trial by jury made as herein provided may not be withdrawn without the consent of the parties." Plaintiff had already demanded a jury trial on all of her claims against the Defendants in the within case. Pursuant to Civ.R. 38(D), Plaintiff cannot withdraw her jury demand at a later date without the Defendants' consent. Therefore, these claims will be tried to a jury, unless the Defendants consent to waive their right to a jury trial at a later date. Defendants had no reason to demand a jury trial in their Answer to preserve anything. However, Defendants chose to demand a jury trial and, by doing so, they have affirmatively indicated that a jury trial is the correct forum for the resolution of Plaintiff's claims. By acting inconsistently with

any alleged right to arbitration and demanding a jury trial, the Defendants have waived any alleged right to arbitration.

In *Milling Away, LLC* , at ¶¶ 8-9, the Eighth District Court of Appeals held:

> Like any other contractual right, the right to arbitration may be waived. *Rock v. Merrill Lynch, Pierce, Fenner & Smith, Inc. (1992), 79 Ohio App.3d 126, 128, 606 N.E.2d 1054*. But in light of Ohio's strong policy in favor of arbitration, waiver of the right to arbitrate is not to be lightly inferred. *Griffith v. Linton (1998), 130 Ohio App.3d 746, 751, 721 N.E.2d 146*. A party asserting waiver must prove the waiving party (1) knew of the existing right to arbitrate; and (2) acted inconsistently with that right. *Checksmart v. Morgan, 8th Dist. No. 80856, 2003 Ohio 163, ¶22*. "'The essential question is whether, based upon the totality of the circumstances, the party seeking arbitration has acted inconsistently with the right to arbitrate.'" Id., quoting *Wishnosky v. Star-Lite Bldg. & Dev. Co. (Sept. 7, 2000), 8th Dist. No. 77245, 2000 Ohio App. LEXIS 4081*.
>
> Among the factors a court may consider in determining whether the totality of circumstances supports a finding of waiver are: (1) whether the party seeking arbitration invoked the jurisdiction of the trial court by filing a complaint, counterclaim, or third-party complaint without asking for a stay of proceedings; (2) the delay, if any, by the party seeking arbitration in requesting a stay of proceedings or an order compelling arbitration; (3) the extent to which the party seeking arbitration participated in the litigation, including the status of discovery, dispositive motions, and the trial date; and (4) any prejudice to the non-moving party due to the moving party's prior inconsistent actions. *U.S. Bank, N.A. v. Wilkens, 8th Dist. No. 93088, 2010 Ohio 262, ¶31*, citing *Phillips v. Lee Homes, Inc. (Feb. 17, 1994), 8th Dist. No. 64353, 1994 Ohio App. LEXIS 596*.

As noted above, Defendants clearly knew of their alleged right to arbitration and have been in possession of the Admission Agreement and arbitration clause since Gary Banks' admission to the ManorCare Health Services - Willoughby nursing home on August 15, 2012. As discussed above, Defendants have also clearly acted inconsistently with any alleged right to arbitration. Defendants have already filed an Answer to Plaintiff's Complaint. Further, Defendants have demanded a jury trial, clearly indicating that this Court, and a jury, is the correct forum in which this case should be resolved. Defendants had months to file a Motion to Stay and assert their alleged right to arbitration. Instead, Defendants filed an Answer to Plaintiff's Complaint with a Jury Demand. The fact that Defendants' also filed a Motion to Stay is not enough to overcome all of Defendants' actions that are inconsistent with arbitration. Based upon the totality of the circumstances, Defendants clearly acted inconsistently with any alleged right to arbitrate.

Plaintiff would be prejudiced if Defendants' Motion to Stay Proceedings Pending Arbitration is granted and all of Plaintiff's claims are stayed pending arbitration. This case was

originally filed on August 2, 2013. Plaintiff has propounded written discovery requests. Plaintiff has reviewed thousands of pages of documents relative to this case. Plaintiff has engaged expert witnesses. Plaintiff would be unfairly prejudiced if this case was stayed pending arbitration on any of Plaintiff's claims.

Accordingly, this Court should promptly deny Defendants' Motion to Stay Proceedings Pending Arbitration.

J. The arbitration clause contained within Defendant's Admission Agreement is both procedurally and substantively unconscionable and, therefore, it is unenforceable.

Defendants' terminated Admission Agreement, including the arbitration clause contained therein, is not enforceable because it is both procedurally unconscionable and substantively unconscionable.

"[A]n arbitration agreement is enforceable unless grounds exist at law or in equity for revoking the agreement." *Hayes v. Oakridge Home*, 122 Ohio St.3d 63, 67, 2009-Ohio-2054, 908 N.E.2d 408 (2009), citing O.R.C. § 2711.01(A). "Unconscionability is a ground for revocation of an arbitration agreement." *Id.*, citing *Taylor Bldg. Corp. of Am. v. Benfield*, 117 Ohio St.3d 352, 2008-Ohio-938, 884 N.E.2d 12 (2008). "Unconscionability includes both 'an absence of meaningful choice on the part of one of the parties together with contract terms which are unreasonably favorable to the other party." *Id.*, quoting *Lake Ridge Academy v. Carney*, 66 Ohio St.3d 376, 383, 613 N.E.2d 183 (1993). "The party asserting unconscionability of a contract bears the burden of proving that the agreement is both procedurally and substantively unconscionable." *Id.*, citing *Ball v. Ohio State Home Servs., Inc.*, 168 Ohio App.3d 622, 2006-Ohio-4464, 861 N.E.2d 553 (9th Dist. 2006).

1. Procedural Unconscionability.

"Procedural unconscionability involves those factors bearing on the relative bargaining position of the contracting parties, e.g., 'age, education, intelligence, business acumen and experience, relative bargaining power, who drafted the contract, whether the terms were explained to the weaker party, whether alterations in the printed terms were possible, whether there were alternative sources of supply for the goods in question.'" *Small v. HCF of Perrysburg*, 159 Ohio App.3d 66, 2004-Ohio-5757, 823 N.E.2d 19 (6th Dist. 2004), quoting *Johnson v. Mobil Oil Corp.*, 415 F.Supp. 264, 268 (E.D. Mich. 1976). "Additional factors that may contribute to a finding of

procedural unconscionability include the following: 'belief by the stronger party that there is no reasonable probability that the weaker party will fully perform the contract; knowledge of the stronger party that the weaker party will be unable to receive substantial benefits from the contract; knowledge of the stronger party that the weaker party is unable reasonably to protect his interests by reason of physical or mental infirmities, ignorance, illiteracy or inability to understand the language of the agreement, or similar factors.'" *Hayes*, 122 Ohio St.3d at 68, citing *Taylor Bldg. Corp. of Am.*, 117 Ohio St.3d at 362.

In *Manley v. Personacare of Ohio*, 2007-Ohio-343, ¶ 31 (11th Dist. 2007), the Eleventh District Court of Appeals held that an arbitration agreement, signed by a nursing home resident during admission, was procedurally unconscionable. In *Manley*, the resident signed a "resident admission agreement" as well as an "alternative dispute resolution agreement between resident and facility". *Id.* at ¶ 3. The Eleventh District Court of Appeals held that the arbitration agreement was procedurally unconscionable. *Id.* at ¶ 31. The Eleventh District Court of Appeals noted that the resident, Patricia Manley, had left the hospital a week prior to her admission, went directly from the hospital to the nursing home, she did not have a friend or family member with her during her admission, she was sixty-six (66) years old, she was college educated but had no legal experience, and she did not have an attorney present when she entered into the arbitration agreement. *Id.* at ¶¶ 21-23. The Eleventh District Court of Appeals also considered Patricia Manley's cognitive impairments when finding the arbitration clause procedurally unconscionable. The Court noted that Patricia Manley was competent, however, she suffered from a "very mild cognitive impairment." *Id.* at ¶ 24. It was also noted that she had two different medical conditions, either of which could cause her confusion. *Id.* Patricia Manley also had numerous physical ailments. *Id.* at ¶ 25. After considering these factors, the Eleventh District Court of Appeals stated:

> The fact that a resident is signing an arbitration agreement contemporaneously with being admitted into a nursing home is troubling. By definition, an individual being admitted into a nursing home has a physical or mental detriment that requires them to need the assistance of a nursing home. Further, the reality is that, for many individuals, their admission to a nursing home is the final step in the road of life. As such, this is an extremely stressful time for elderly persons of diminished health. In most circumstances, it will be difficult to conclude that such an individual has equal bargaining power with a corporation that, through corporate counsel, drafted the form contract at issue.

Id. at ¶ 29. Accordingly, the Eleventh District Court of Appeals held that the arbitration clause entered into between the resident and the nursing home was procedurally unconscionable.

In *Small v. HCF of Perrysburg*, 159 Ohio App.3d 66, 71-73, 2004-Ohio-5757, 823 N.E.2d 19 (6th Dist. 2004), the Sixth District Court of Appeals held that an arbitration clause that provided for the arbitration of a nursing home resident's negligence claims was both procedurally and substantively unconscionable. The Court determined that the arbitration clause was procedural unconscionability because "[w]hen Mrs. Small signed the agreement she was under a great amount of stress. The agreement was not explained to her; she did not have an attorney present. Mrs. Small did not have any particularized legal expertise and was 69 years old on the date the agreement was signed." *Small*, 159 Ohio App.3d at 73.

The circumstances surrounding Gary Banks' signing of the arbitration clause could not have been more procedurally unconscionable. Gary Banks was under a significant amount of stress when he was admitted to the ManorCare Health Services - Willoughby nursing home. Gary Banks was moving from the group home where he had resided at for six (6) years, into a brand new facility. Gary Banks enjoyed living at The Gables group home and wanted to return there. *See* Affidavit of Christine Pearson, at ¶ 19, a copy of which is attached hereto as Exhibit "F". He did not cope well with new environments and changes. *Id.* at ¶ 18. However, his quadriplegia was progressing, causing him to be unable to walk and he was slowly losing control over his arms. This resulted in The Gables being unable to provide Gary Banks with the care that he needed. Additionally, Gary Banks had undergone spinal surgery on August 13, 2012, just two (2) days before he was admitted to the ManorCare Health Services - Willoughby nursing home.

Gary Banks' significant stress was exasperated by the fact that he had mental disabilities and was unable to comprehend the changes that were occurring. *Id.* at ¶18. In fact, Courtney Laurich, LPN noted in Gary Banks' Initial Admission Assessment that Mr. Banks has difficulties dealing with new situations. She also noted that Mr. Banks' had psychomotor retardation. *See* Section B of Gary Banks' Initial Admission Assessment dated August 15, 2012, a copy of which is attached hereto as Exhibit "G". This is further evidenced by the fact that Gary Banks, who was then 48 years old, arrived at the ManorCare Health Services - Willoughby nursing home with a balloon and a stuffed animal. *See* Inventory of Personal Effects, a copy of which is attached hereto as Exhibit "H".

Gary Banks' mental disabilities were much more severe than those of the resident in *Manley*. As discussed above, Gary Banks' admitting diagnoses included mental retardation and paranoid schizophrenia. *See, e.g.*, Page 1 of Gary Banks' Admission Physician's Orders dated August 15,

2012, a copy of which is attached hereto as Exhibit "C". Gary Banks attended special education classes when he was in school. *See* Affidavit of Christine Pearson, at ¶ 5, a copy of which is attached hereto as Exhibit "F". Gary Banks participated in jobs for adults with disabilities, including packing light bulbs and cleaning churches. *Id.* at ¶ 8. Gary Banks was unable to be employed in a position which required any type of reading or writing. *Id.* at ¶ 9. He could not read on his own. *Id.* at ¶ 15. Gary Banks could not control his own finances, and he was unable to write a check because of his mental disabilities. *Id.* at ¶¶ 13-14. He could not coordinate appointments or transportation. *Id.* at ¶¶ 10-12. Gary Banks' mental disabilities also made him unable to comprehend his own medical conditions. *Id.* at ¶ 17. In fact, when he entered the Cleveland Clinic a month prior to his admission to ManorCare Health Services - Willoughby nursing home due to his decreasing ability to walk, Gary Banks told the physician that he was at the emergency room because he "stretches a lot". *See* Cleveland Clinic History and Physical Examination, dated July 20, 2012, a copy of which is attached hereto as Exhibit "I". Gary Banks could neither read nor understand any part of the Admission Agreement and the arbitration clause due to his mental disabilities.

The ManorCare Health Services - Willoughby nursing home staff were fully aware of Gary Banks' mental disabilities, as they had performed an assessment, including a psychological assessment, prior to having him sign the Admission Agreement and the arbitration clause. *See* Laurich Depo. 9:11-21, relevant portions of which are attached hereto as Exhibit "A". This assessment made it apparent to the employees and agents involved in the admissions process that Gary Banks was developmentally disabled. *See* Laurich Depo. 9:24-10:7, relevant portions of which are attached hereto as Exhibit "A". The Nurse's Note relative to Gary Banks' admission to the ManorCare Health Services - Willoughby nursing home also indicates that Mr. Banks is mentally retarded and diagnosed with paranoid schizophrenia. *See* Gary Banks' Progress Note dated August 15, 2012, at 10:56 p.m., a copy of which is attached hereto as Exhibit "B".

Gary Banks also suffered from serious physical disabilities. Like in *Manley*, Gary Banks was not only cognitively impaired, he was also physically impaired. Gary Banks suffered from progressive quadriplegia. He was slowly losing his ability to control his body and was becoming paralyzed. Gary Banks had just undergone spinal surgery two (2) days prior to his admission to the ManorCare Health Services - Willoughby nursing home. Gary Banks was clearly both physically

and mentally impaired at the time of his admission to the Manorcare Health Services - Willoughby nursing home.

With all of this stress, and with no regard for Gary Banks' mental disabilities, the admission paperwork was placed in front of Gary Banks, and he was told that he had to sign it. Gary Banks did not have a single family member nor friend with him, with whom he could have consulted with about the agreements. *See* Stincic Depo. 18:1-3, relevant portions of which are attached hereto as Exhibit "D"; Laurich Depo. 13:17-20, relevant portions of which are attached hereto as Exhibit "A". As a result, Gary Banks, who was unable to understand the admissions process and Admission Agreement, signed the admission paperwork over the course of a few minutes, as directed by Darlene Stancic, the Admissions Coordinator at the ManorCare Health Services - Willoughby nursing home.

In terms of business acumen, Gary Banks had no experience with litigation, arbitration, nor drafting or negotiating contracts. *See* Affidavit of Christine Pearson, at ¶¶ 27-33, a copy of which is attached hereto as Exhibit "F". As noted above, he was a mentally disabled individual, and he was placed in special education classes when he attended school, which ended in 1983. *Id.* at ¶¶ 5-6. Gary Banks was much less educated than the resident in *Manley*, who had a college education. *See Manley*, 2007-Ohio-343, at ¶ 23. As noted above, Gary Banks could not read. Further, he was not an attorney. Gary Banks did not know the difference between arbitration and litigation. *See* Affidavit of Christine Pearson, at ¶¶ 27-30, a copy of which is attached hereto as Exhibit "F". He was unable to fully comprehend what arbitration was or how arbitration works. *Id.* No one at the ManorCare Health Services - Willoughby nursing home ever explained to Gary Banks the difference between litigation and arbitration. *See* Stincic Depo. 20:25-21:5, relevant portions of which are attached hereto as Exhibit "D". Gary Banks was never read the Voluntary Arbitration Program brochure which explained arbitration more fully. *See* Stincic Depo. 21:6-8, relevant portions of which are attached hereto as Exhibit "D". It is unclear whether Darlene Stincic even provided Gary Banks with the Voluntary Arbitration Program brochure. The brochure contains a place for the resident or the resident's legal representative to sign, confirming receipt of it. Ms. Stincic testified that is was her practice to have all residents sign the Voluntary Arbitration Program brochure. And the Defendants have not been able to produce a copy of Gary Banks' signature on any Voluntary Arbitration Program brochure. *See* Stincic Depo. 30:15-31:9, relevant portions of which are attached hereto as Exhibit "D".

No one at the ManorCare Health Services - Willoughby nursing home ever informed Gary Banks' sister and attorney-in-fact for health care decisions, Christine Pearson, that Gary Banks would be required to enter into an Admission Agreement, which contained an arbitration clause, when he entered the ManorCare Health Services - Willoughby nursing home. *See* Affidavit of Christine Pearson, at ¶ 24, a copy of which is attached hereto as Exhibit "F". No one told her that Gary Banks had signed any type of contract, including the Admission Agreement and the arbitration clause. *Id.* at ¶ 23. No one discussed the Admission Agreement nor the arbitration clause with her, at any time, prior to or during Gary Banks' residency. *Id.* at ¶ 25. No one asked her to be present during Gary Banks' admission to the ManorCare Health Services - Willoughby nursing home, in order to review any admission paperwork. *Id.* at ¶¶ 22 and 26. It is worth pointing out that when Gary Banks was later admitted to the Wickliffe Country Place nursing home on March 19, 2013, Christine Pearson, as Gary Banks' attorney-in-fact, declined to sign that facility's arbitration clause. *See* Wickliffe Country Place Agreement to Resolve Legal Disputes Through Arbitration, dated March 19, 2013, a copy of which is attached hereto as Exhibit "J".

Meanwhile, Defendants run a business that generates over four billion dollars in annual revenue. At the time when Gary Banks was admitted to the ManorCare Health Services-Willoughby nursing home, Defendants employed admissions personnel whose full-time job was meeting with new residents and securing their signatures on Admission Agreements which contained arbitration clauses. It is clear that the Defendants had all of the relevant experience and business acumen.

In terms of relative bargaining power, Defendants own and operate over 280 campuses across the country, including assisted living, skilled nursing home, memory care, independent living, outpatient rehabilitation, and hospice care facilities. Gary Banks was a mentally disabled man with progressing quadriplegia who was unable to care for himself and had a stuffed animal with him during his admission to the ManorCare Health Services - Willoughby nursing home. It is clear that Defendants had all of the bargaining power.

Defendants drafted the Admission Agreement, including the arbitration clause contained therein.

In terms of whether alterations to the printed terms were possible, it is clear that Gary Banks never altered one word of the arbitration clause. *See* Stincic Depo. 26:14-20, relevant portions of which are attached hereto as Exhibit "D". No one ever explained to Gary Banks that he had a choice as to whether he wanted to waive his right to a jury trial and arbitrate any possible future claims of

substandard care against the owners and operators of the ManorCare Health Services - Willoughby nursing home. The arbitration clause in this case was a boilerplate contract that was presented to Gary Banks on a take it or leave it basis. The arbitration clause was drafted by the Defendants, in its entirety, to help protect the Defendants from liability.

The terms of the Admission Agreement were never explained to Gary Banks. Instead, he was simply told to sign the Admission Agreement. *See* Stincic Depo. 22:14-23:8, relevant portions of which are attached hereto as Exhibit "D". Just like Mrs. Small in the *Small* case, no one at the ManorCare Health Services - Willoughby nursing home ever adequately explained the arbitration clause to Gary Banks, in a manner that he could understand it. *Id.* Gary Banks was not read the brochure that was supposed to explain the process of arbitration. If fact, as discussed above, there is no evidence that Gary Banks ever received such a brochure.

When Gary Banks signed the Admission Agreement, he was unable to comprehend the significance of the document or what arbitration was. *See* Affidavit of Christine Pearson, at ¶ 7, a copy of which is attached hereto as Exhibit "F". No one at the ManorCare Health Services - Willoughby nursing home ever explained to Gary Banks the difference between arbitration and litigation. *See* Stincic Depo. 22:18-23:8, relevant portions of which are attached hereto as Exhibit "D". Even if they had attempted to explain these differences, Gary Banks would not have been able to understand these complicated topics, as he was mentally disabled. *See* Affidavit of Christine Pearson, at ¶¶ 7, 27-30, a copy of which is attached hereto as Exhibit "F". No one ever explained to Gary Banks nor any member of his family that if he signed the admission paperwork that he would waived his right to a jury trial. *Id.* at ¶¶ 23-26. In fact, no one at the ManorCare Health Services - Willoughby nursing home ever mentioned arbitration to any member of Gary Banks' family, including his attorney-in-fact for health care decisions, or informed them that Gary Banks was entering into contractual agreements, on his own, without the advice or counsel of anyone but the Defendants' employees and/or agents. *Id.*

Moreover, no one ever explained to Gary Banks, nor any member of his family, that if Gary Banks was a victim of abuse or neglect at the ManorCare Heath Services - Willoughby nursing home, and if Gary Banks or his family wanted to pursue a claim, they would not be able to subpoena witnesses, conduct discovery, propound interrogatories, propound requests for production of documents, etc., so he or his family could properly pursue the claim. *Id.* In fact, Darlene Stincic, the Admissions Coordinator who had Gary Banks sign the arbitration clause, believed that Gary

Banks would be able to be heard in front of a judge during arbitration and did not know if he would be able to conduct written discovery. *See* Stincic Depo. 24:18-25:5, relevant portions of which are attached hereto as Exhibit "D". As a result, Ms. Stincic would not have been able to accurately explain arbitration, even if she had attempted to explain the process to Gary Banks. As a result, it was impossible for Gary Banks to make an informed decision. Under these circumstances, it was impossible for Gary Banks to knowingly give up his right to a jury trial and his right to conduct discovery before that jury trial.

There is no question that Defendants, the much stronger parties in this case, knew that Gary Banks, as the much weaker party, was unable to reasonably protect his interests by reason of his inability to understand the concept of arbitration and his inability to read.. Gary Banks would not receive any benefit from the arbitration clause. The arbitration clause was drafted solely to limit the liability of the Defendants.

In addition, Winston M. Ford, General Counsel for the Ohio Department of Health, explained the Ohio Department of Health's position regarding binding arbitration in long-term care and residential care facilities in a April 2, 2008 letter, a copy of which is attached hereto as Exhibit "K". In the second paragraph on Page 1 of the letter, Mr. Ford indicates that "ODH has concerns about residential care and nursing home facilities that secure waivers of the rights guaranteed under Ohio's 'Patients' Bill of Rights,' otherwise known as 'residents' rights.'" In the fourth paragraph, Mr. Ford recognizes that "R.C. 3721.13(A)(15) states that a resident has the right to exercise all 'civil rights,' which rights the resident may not waive (R.C. 3721.13(C))." Mr. Ford goes on to state that the term "civil rights" "encompasses those rights set forth in R.C. 3721.17, i.e., the right to file a grievance with the grievance committee established in R.C. 3721.12, to file a report with ODH, and to file a civil lawsuit in a court against any person or home committing the residents' rights violation." In the last full paragraph on Page 3 of the letter, Mr. Ford confirms that "ODH believes that R.C. 3721.17 *does* provide [residents with the civil right to file a claim in a court of law]." (Emphasis in original.) In the second full paragraph on Page 4 of the letter, Mr. Ford summarized the Ohio Department of Health's position: "ODH's position is that the civil rights set forth in R.C. 3721.10 to 3721.17 have been specifically enacted by the Ohio General Assembly to ensure that each resident has specific avenues for redress of alleged residents' rights violations, and that these civil rights may not be waived by the resident." The Ohio Department of Health has concluded that "the use of binding arbitration provisions and other statutory waiver clauses in resident admission

agreements benefits facilities at the expense of the residents that they are supposed to protect", and "that the only way to ensure that the civil rights of residents are protected is to enforce R.C. 3721.13(C)". *See* Page 3 of Letter from Winston M. Ford, Esq. dated April 2, 2008, a copy of which is attached hereto as Exhibit "K". As a result, the Ohio Department of Health indicated that it "would be citing facilities that require a resident to enforce his or her residents' rights through arbitration rather than a judicial forum contemplated in R.C. 3721.17". *Id.*

Accordingly, this Court should find that the arbitration clause contained within Defendants' Admission Agreement is procedurally unconscionable.

2. Substantive Unconscionability.

"Substantive unconscionability involves those factors which relate to the contract terms themselves and whether they are commercially reasonable. Because the determination of commercial reasonableness varies with the content of the contract terms at issue in any given case, no generally accepted list of factors has been developed for this category of unconscionability. However, courts examining whether a particular limitations clause is substantively unconscionable have considered the following factors: the fairness of the terms, the charge for the service rendered, the standard in the industry, and the ability to accurately predict the extent of future liability." *Small*, 159 Ohio App.3d at 71.

In *Small*, the Sixth District Court of Appeals held that an arbitration clause was substantively unconscionable where the resident or representative was given no means by which to reject the arbitration clause in an admissions agreement, despite the presence of a sentence in the agreement stating that admission is not conditioned on agreement to the arbitration clause. The Court stated that "we believe that the resident or representative is, by signing the agreement that is required for admission, for all practical purposes being required to agree to the arbitration clause." *Small*, 159 Ohio App.3d at 72.

Additionally, in *Fortune v. Castle Nursing Homes, Inc.*, 164 Ohio App.3d 689, 696, 2005-Ohio-6195, 843 N.E. 2d 1216 (5th Dist. 2005), the Fifth District Court of Appeals held that an arbitration agreement entered into between a resident and a nursing home was substantively unconscionable. In this case, the Fifth District Court of Appeals noted that the arbitration agreement required the patient to waive his or her right to a jury trial. *Id.* at 692. The Court also noted that the arbitration clause was written in the same size font as the rest of the agreement. *Id.* The Fifth District Court of Appeals also provided an example of a non-oppressive, conscionable arbitration

agreement in a medical setting. *Id.* at 696. The Court's example included that it be a stand-alone, one-page contract containing an explanation of its purpose that encouraged the patient to ask questions. *Id.*

In *Manley*, 2007-Ohio-343 at ¶ 53, Judge Mary Colleen O'Toole discussed the substantive unconscionability of nursing home arbitration clauses in her dissenting opinion. In her opinion, Judge Mary Colleen O'Toole stated that:

> The location is non-neutral. The arbitration provisions are buried near the end of the extremely long admission contract, and are presented to the resident at the time of admission. Thus a resident is required to make his or her decision regarding this vital issue at a time when, typically, they are sick and in need of care.
>
> * * *
>
> This contract gives potential residents a choice between being out on the street with no medical care, or accepting the first available bed.
>
> * * *
>
> The arbitration provision is not in compliance with industry standards. Contract provisions of the type at issue are disfavored by the American Arbitration Association, the American Bar Association, and the American Medical Association. Binding arbitration should not be used between patients and commercial healthcare providers unless the parties agree to it *after* the dispute arises. This is the only way a consumer/patient entering a nursing or healthcare facility in an ailing and diminished capacity can stand on equal footing with a large corporate entity. This would promote meaningful dispute resolution and allow both sides to enter into this agreement voluntarily and knowingly. The law favors arbitration: it abhors contracts of adhesion.
>
> The third factor of substantive unconscionability deals with the ability to properly determine future liability. It is clear that neither party to this contract could accurately predict the extent of future liability. The negligence had not occurred at the time of the signing of the contract. It was impossible to determine if Ms. Manley, at the time of admission, could be waiving her right to a wrongful death lawsuit. Certainly when she went into the nursing home she was anticipating her release.

Id. at ¶¶ 59-62.

In this case, the arbitration clause was offered to Gary Banks in the Admission Agreement on a take it or leave it basis. This is a classic contract of adhesion. There was no way for Gary Banks to indicate on the Admission Agreement or the arbitration clause that he rejected the arbitration clause. The arbitration clause, which Gary Banks could not read, does contain a provision labeled "Right to Change your Mind". However, this provision requires that the resident send notice by certified mail within thirty (30) days of admission. *See* Bates-Stamped Page 27 of

Defendants' Admission Agreement, a copy of which is attached hereto as Exhibit "E". This provision does not provide residents, including Gary Banks, any way to alter the arbitration clause at the time of admission and/or when entering into the Admission Agreement. Further, the act of sending a letter via certified mail, by a person who is entering a nursing home because they are unable to properly care for themselves and cannot walk, would be extremely difficult for many residents and almost impossible for residents such as Gary Banks, who suffer from mental retardation, paranoid schizophrenia, as well as severe physical disabilities.

Defendants' terminated Admission Agreement was a twenty-seven (27) page document. The Admission Agreement included a boilerplate arbitration clause. There is nothing in the arbitration clause that says that sometimes nursing home residents are neglected and abused. There is nothing in the clause about the benefits of a jury trial. There is nothing in the clause telling new residents about the specific rules that will be applied to the arbitration of their claims. Although the procedures provide for subpoenas, the arbitration panel cannot enforce a subpoena. It cannot force third parties to submit to a deposition, nor can the panel hold a party in contempt. A jury trial which may last two to three weeks in a nursing home case. There is no indication as to how long the arbitration will last. Obviously, the Plaintiff, the party with the burden of proof, is hurt by any time limitation when presenting her case.

In addition, each party must pay for their own attorney fees and the costs of preparing their case. There is nothing in the clause telling new residents that most nursing home cases are handled on a contingent fee basis, so the resident or his or her family do not have to pay any amount in legal fees up front or until a recovery is made.

There is no question that the arbitration clause is substantively unconscionable, as well as procedurally unconscionable. Since both prongs for the test for unconscionability have been met, Plaintiff respectfully requests that this Honorable Court deny Defendant's Motion to Stay Proceedings Pending Arbitration, as the Admission Agreement, and the arbitration clause included within it, are not enforceable as it is egregiously procedurally and substantively unconscionable.

K. The AMA, the ABA and the AAA have unanimously come out against pre-dispute arbitration clauses involving residents.

As the Court reviews the unconscionability of the arbitration clause at issue in this case, Plaintiff urges the Court to also consider that the American Medical Association, the leading national organization of doctors and other health care providers, the American Bar Association, the

leading national organization of attorneys, and the American Arbitration Association, the leading national organization of arbitrators, have all come out against arbitration clauses like the one at issue in this case.

In 1997, the American Arbitration Association, the American Bar Association and the American Medical Association, the leading associations involved in alternative dispute resolution, law, and medicine, collaborated to form a Commission on Health Care Dispute Resolution ("the Commission"). The Commission's goal was to issue, by the Summer of 1998, a Final Report on the appropriate use of alternative dispute resolution (ADR) in resolving disputes in the private managed health care environment. Their Final Report discusses the activities of the Commission from its formation in September 1997 through the date of its report, and sets forth its unanimous recommendations. The Commission issued its Final Report on July 27, 1998, a copy of which is attached hereto as Exhibit "L". That report concluded on Page 15, in Principle 3 of a section entitled, "C. A Due Process Protocol for Resolution of Health Care Disputes." that: "**The agreement to use ADR should be knowing and voluntary. Consent to use an ADR process should not be a requirement for receiving emergency care or treatment. In disputes involving patients, binding forms of dispute resolution should be used only where the parties agree to do so after a dispute arises**." (Emphasis added.)

The arbitration clause at issue in the within case clearly violates the guidelines set forth above. It should not be enforced. It cannot be over-emphasized that the American Arbitration Association, the American Bar Association and the American Medical Association, the leading associations involved in alternative dispute resolution, law, and medicine, have come together and issued a joint report which argues against the enforcement of arbitration clauses like the one at issue in this case.

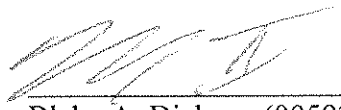
The arbitration clause in this case was signed during Gary Banks' admission and before he or his family had a claim and could evaluate how to pursue that claim. The arbitration clause was not entered into knowingly, nor was it entered into voluntarily. According to the Commission's Final Report, the arbitration clause is unconscionable and should not be enforced.

III. CONCLUSION.

For all of the reasons articulated above, Plaintiff respectfully requests that this Honorable Court promptly deny Defendants' Motion to Stay Proceedings Pending Arbitration, as there is

absolutely no basis, whatsoever, to refer any of Plaintiff's claims against any of the Defendants in this case to arbitration and to stay any proceedings in this case.

Respectfully submitted,
THE DICKSON FIRM, L.L.C.

By: 

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Attorneys for Plaintiff Christine Pearson, as the Personal Representative of the Estate of Gary Banks (deceased).

CERTIFICATE OF SERVICE

I hereby certify that a true and accurate copy of the foregoing, Plaintiff's Brief in Opposition to Defendants' Motion to Stay Proceedings Pending Arbitration, was sent by ordinary U.S. Mail this **19th day of February, 2014**, to the following:

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By: _____

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Attorneys for Plaintiff Christine Pearson, as the Personal Representative of the Estate of Gary Banks (deceased).

IN THE COURT OF COMMON PLEAS

LAKE COUNTY, OHIO

CHRISTINE PEARSON, as the
Personal Representative of
the Estate of GARY BANKS (deceased),

Plaintiff,

-vs-

JUDGE JOSEPH GIBSON
CASE NO. 13-CV-001703

MANORCARE HEALTH SERVICES
WILLOUGHBY, et al.,

Defendants.

- - - -

Deposition of COURTNEY L. LAURICH, taken as if upon cross-examination before Margaret A. Trombetta, a Registered Merit Reporter and Notary Public within and for the State of Ohio, at the offices of Reminger Company, 1400 Midland Building, 101 Prospect Avenue West, Cleveland, Ohio, at 9:02 a.m. on Tuesday, December 17, 2013, pursuant to notice and/or stipulations of counsel, on behalf of the Plaintiff in this cause.

- - - -

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COURTNEY L. LAURICH, of lawful age, called by the Plaintiff for the purpose of cross-examination, as provided by the Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

CROSS-EXAMINATION OF COURTNEY L. LAURICH

BY MR. DICKSON:

MR. DICKSON: All right. Let the record reflect that this is the deposition of Defendants Manor Care Health Services, Willoughby; Manor Care Willoughby Ohio, LLC; Manor Care, Inc.; Manor Care of Willoughby; HCR Manor Care Services, LLC; HCR Manor Care, Inc.; HCR II Healthcare, LLC; HCR III Healthcare, LLC; HCR IV Healthcare, LLC; HCR Manorcare Heartland, LLC; HCR Manorcare Operations II, LLC; Healthcare Operations Holdings, Inc; Healthcare Operations Investments, Inc.; Carlyle MC Partners LP; MC Operations Investments, Inc.; TC Group V LP; Carlyle Partners V MC Holdings LP; Carlyle Partners V MC LP; HCP, Inc; HCR Healthcare, LLC; and Paul A. Ormond, O-R-M-O-N-D.

This deposition is being taken pursuant to Ohio Civil Rule 30(B)(5) at the office of the Reminger Law firm located at 101 West Prospect Avenue, Suite 1400 in Cleveland, Ohio.

Today is Tuesday, December 17th, it's a few minutes after 9:00. This is Case Number 13-CV-1703 captioned as Christine Pearson as the personal representative of the Estate of Gary Banks, Deceased versus Manor Care Health Services, Willoughby, et al. currently pending in the Lake County Court of Common Pleas before the Honorable Judge Joseph Gibson and present is Attorney Tom Prislipsky who represents all the defendants in this case and Tom is with the Reminger firm.

Q. Ma'am, please state your name for the record.
A. Courtney L. Laurich.
Q. And who do you work for?
A. Manor Care Willoughby.
Q. And what is your title or position with them?
A. LPN nursing supervisor.
Q. All right. My name is Blake Dickson. I represent Chris Pearson and the Banks family in

that it's privileged, you know, you can just tell us and then Tom will object and he'll instruct you not to answer if it's proper.

A. Okay.

Q. So do you remember what documents you looked at?

A. I looked at the admission assessment that I did.

Q. Okay. Anything else?

A. The pain eval.

Q. Okay.

A. And nursing notes.

Q. Do you know if the assessment and evaluation that you did of Mr. Banks was done before or after he signed the admitting documents?

A. Before.

Q. Okay. And was any part of the assessment that you did of Mr. Banks relevant to his mental capacity, his mental status?

A. We did -- we do a mental status just kind of, you know, if they're alert to place, date, time, but not full on like mental status, like a mini mental eval, we don't do that.

Q. Okay.

A. We just do the baseline of how they came to us.

Q. Okay. If somebody was mentally incompetent, mentally retarded, demented, had some other

challenge that made them mentally incompetent, would that be apparent to you during your admission assessment?

MR. PRISLIPSKY: Objection to compound.

Go ahead. You can answer.

A. Yes.

Q. Okay. I'll get a little background from you in a minute.

How long have you worked for Manor Care?

A. Seven years.

Q. And how long have you been -- and you're an LPN?

A. Yes.

Q. How long have you been an LPN?

A. Nine years.

Q. In the course of your career as an LPN, not just limited to Manor Care, have you done assessments of people who were mentally incompetent for one reason or another?

A. Yes, yeah.

Q. So you deal with some nursing home residents who are demented?

A. Yes.

Q. You deal with some nursing home residents who maybe have some other mental challenge, mental

THE WITNESS: Sorry.

MR. PRISLIPSKY: That's all right. It sounded like you were getting ready to say uh-huh.

Q. What is Darlene Stincic's title, role?

A. She would have been the admissions assistant, not the -- yeah, yeah. Sorry.

Q. That's okay. And you say "would have been," is she no longer there?

A. She is no longer there.

Q. Okay. To your knowledge, was anybody else on behalf of the nursing home involved in the admission process with Mr. Banks?

A. I am not sure who everyone involved was.

Q. Do you know of anybody else who was involved?

A. No.

Q. Okay. To your knowledge, was anybody else involved in the admission process with Mr. Banks on Mr. Banks's side other than Mr. Banks?

A. No.

Q. Okay. So to the best of your knowledge, you and Miss Stincic and Mr. Banks, those are the only people that you are aware that were involved in Mr. Banks's admission to the nursing home?

A. Yes.

Q. Did you have any conversations with any of Mr. Banks's family relative to his admission?
A. I do not recall if I did, but no.
Q. Okay. Did you have any conversations with anybody else who was active on behalf of Mr. Banks relative to his admission?
A. No.
Q. Did you speak with any of his doctors or any of his past health care providers?
A. I did speak with Dr. Whitehouse who was his attending physician.
Q. And what did Dr. Whitehouse tell you?
A. I just called to confirm orders and he was familiar with the patient, followed him, and that was it.
Q. Okay. And you mentioned that information that you've gathered during the admission process would be contained in nurse's notes?
A. Yes.
Q. Where else?
A. In the initial nursing assessment.
Q. Any place else?
A. From my part, no.
Q. Okay.
A. Nowhere else.

MCHS Willoughby

- Patients
- Dashboard
- Quick Entry
- Weights and Vitals
- Physician's Orders
- Reports
- Logout
- Help

Patient Search
by: Last Name
Go
Search all Facilities

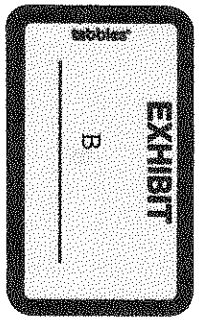
Progress Notes --- View All

Patient: Gary Banks (10639)

Views: All Notes - [Custom] - Last 8 hrs - Last 24 hrs - Last 72 hrs

Progress Notes [New] [Back] [Printable View]

	Effective Date	Type	Note	Care Plan Item or Task	Dept.	Shift Report	24 Hour Report
view	9/19/2012 12:11	Skilled Nursing	Note Text: SISTER RETURNED FROM APPT AT CCF PATIENT TO BE ADMITTED TO HOSPITAL FOR WOUND PER SISTER			N	Y
view	9/19/2012 05:22	Skilled Nursing	Note Text: ISC as ordered and yielded 450 ml. Resident attempted to urinate before st. cath but unable. Denies pain and tolerated procedure. Continues to monitor.			Y	Y
view	9/19/2012 02:28	Skilled Nursing	Note Text: A&Ox3. Resting quietly on bed but arousable. No complaints of pain nor discomforts voiced. No respiratory distress noted. No glycemic distress noted. On heparin therapy - no s/s of bleeding noted. Has slight elevated temp of 99.7 post midnight. Hydration and sponge therapy non-pharmacological interventions given with positive effects. Rechecked T 98.5 oF. No s/s of adverse reactions to atb tx noted at this time. Turned and reposition by staff. Continues to monitor. Call light within reach.			Y	Y
view	9/18/2012 22:36	Skilled Nursing	Note Text: res turned q 1 hr by staff repositioned for comfort air boots on feet to protect heels meds po without difficulty res requested pain pill for rt leg pain res strait for 300 cc of dark yellow urine res on atb for wound to coccyx no adverse reaction to meds afebrile res sister gabriel into see res res returned from appt new order for proscar for bph to start family aware of new order call light within reach of res.			N	Y
view	9/18/2012 20:08	Skin	Note Text: Patient is alert and oriented x 2, MR. Patient 48 year old admitted with dx of PVD, cervical stenosis, herniated nucleus, C3-4,			N	Y



BANKS-000344

		(SPN)	the evaluation for details.		
view	8/16/2012 02:45	Skilled Nursing	Note Text: A&Ox3. Resting quietly on bed but arousable. No complaints of pain nor discomforts voiced. No SOB noted. No respiratory distress noted. Lung sounds clear and BSx4. Abdomen soft and non-tender. No glycemic distress noted. No s/s of adverse reactions to atb tx for UTI. Afebrile. Call light within reach.	Y	Y
view	8/15/2012 22:56	Admit/Readmit	Note Text: PT. ADMITTED INTO ROOM 250-1 FROM CC MAIN CAMPUS. DX- CERVICAL STENOSIS S/P C3-4 4-5 DISKECTOMY, HTN, DM, PARANOID SCHIZOPHRENIA, DVT, IVC FILTER, PROGRESSIVE QUADPLEGIA, MILD MENTAL RETARDATION. PT. ALERT AND ORIENTED TIMES 3. FULL LIFT FOR TRANSFERS. PT. CONTINENT OF BOWEL AND BLADDER. PT. STERI STRIPS TO RIGHT NECK. PT. ON ATB THERAPY FOR UTI, NO S/S OF ADVERSE REACTIONS NOTED. RESP EVEN AND UNLABORED. PT. DENIES PAIN OR DISCOMFORT. ABD SOFT AND NON TENDER BS + X 4. BED LOW. MEDICATIONS VERIFIED WITH DR. WHITEHOUSE. MD TO BE IN TOMORROW TO SEE PT. CALL LIGHT IN REACH.	N	Y

PHYSICIAN'S ORDERS

ADMISSION PHYSICIANS ORDERS

RESIDENT _____ CENTER _____ DATE: _____

MEDICATION	HOUR
Test on admission, 0.1cc PPD intradermal, If negative repeat in 7 days and per policy. If positive, obtain chest x-ray and notify physician.	UAM
Immunization upon admission PPV 0.5ml IM once consent obtained. Last PPV Received _____	
Immunization upon admission Flu vaccine 0.5ml IM once consent obtained offered Oct 1 to March 31st. Last flu vaccine received refused	
Daily Pain Score Assess and Document PAIN q shift via NUMERIC PAIN SCALE	11-7 score 7-3 score 3-11 score
Do Not Send ↓↓ Diagnosis _____	
Do Not Send [ ] Baclofen 20MG PO TID Diagnosis MUSCLE SPASMS	UAM 2PM 10PM
Do Not Send [ ] Ciprofloxacin 500MG PO q 12hours x 4days Diagnosis UTI	9AM 9PM

** Note when completing form **
1) Enter Patient & Center Name at top of form
2) Check Do Not Send if medication not needed
3) Answer all questions listed
4) Tear off perforations
5) Fax top copy only
6) Fax all (4) pages together

Advance Directives: FULL CODE

** Diet Orders **

Type: CHOLCONTROLLED, NAS

Resident may have dietary liberties on special occasions: [ ] Yes [X] No

May have Alcohol: [ ] Yes [X] No

** Ancillary Orders **

May crush crushable meds or give liquid meds if unable to take intact solid dosage form under guidelines: [X] Yes [ ] No

Generics are used whenever possible unless stated by Physician.

FOR CONTROLLED SUBSTANCES III-V- 5 REFILLS ARE AUTHORIZED AND QUANTITY TO BE DISPENSED IS "DIRECTIONS TIMES 15 DAYS" UNLESS OTHERWISE SPECIFIED.

Continue all orders every 30 days from first three months from admission, then every 60 days thereafter unless otherwise specified.

The resident's plan of care goals and discharge plan has been reviewed and approved.

Physical Therapy: eval and tx
Occupational Therapy: eval and tx } as indicated
Speech/Dysphagia Therapy: eval and tx
Respiratory Therapy: _____

Resident is free of communicable disease including active TB.

Mental Health consult: [ ] Yes [ ] No with _____

Physiatry consult [ ] Yes [ ] No

Audiology Consult: [ ] Yes [ ] No

Dermatology consult: [ ] Yes [ ] No

verified c Dr. Whitehouse 8/15/12

ALLERGIES / SENSITIVITIES: [ ] MEDICARE [ ] MEDICAID [ ] PVT. PAY [ ] OTHER [ ] MANAGED CARE

ACE inhibitors (intolerance) Lisinopril (intolerance) NKFA

DIAGNOSIS:
S/P C3-4 C4-5 Diskectomy, C4 corpectomy, placement fibular graft and anterior cervical plate 8/13/12, cervical stenosis, schizophrenia HTN, BPH, DVT s/p IVC Filter, MR, progressive quadriplegia.

LAST	FIRST	D.O.B	GENDER	ROOM/BED	MED RECORD NO
RESIDENT: BANKS	GARY	3/21/64	M	250-1	101639

PHYSICIAN	PHYSICIAN PHONE #	SS#
Whitehouse	440-944-4076	294-58-2616 S

NURSE'S SIGNATURE: _____ DATE: 8-15-12

EXHIBIT C

IN THE COURT OF COMMON PLEAS

LAKE COUNTY, OHIO

CHRISTINE PEARSON, as the
Personal Representative of
the Estate of GARY BANKS (deceased)

Plaintiff,

-vs-

JUDGE JOSEPH GIBSON
CASE NO. 13-CV-001703

MANORCARE HEALTH SERVICES
WILLOUGHBY, et al.,

Defendants.

- - - -

Deposition of DARLENE STINCIC, taken as if upon cross-examination before Margaret A. Trombetta, a Registered Merit Reporter and Notary Public within and for the State of Ohio, at the offices of Reminger Company, 1400 Midland Building, 101 Prospect Avenue West, Cleveland, Ohio, at 9:30 a.m. on Tuesday, December 17, 2013, pursuant to notice and/or stipulations of counsel, on behalf of the Plaintiff in this cause.

- - - -

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DARLENE STINCIC, of lawful age, called by the Plaintiff for the purpose of cross-examination, as provided by the Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

CROSS-EXAMINATION OF DARLENE STINCIC

BY MR. DICKSON:

MR. DICKSON: Let the record reflect that this is the deposition of defendants Manor Care Health Services, Willoughby; Manor Care Willoughby, OH, LLC; Manor Care, Inc; Manor Care of Willoughby; HCR Manor Care Services, LLC; HCR Manorcare, Inc; HCR II Healthcare, LLC; HCR III Healthcare, LLC; HCR IV Healthcare, LLC; HCR Manorcare Heartland, LLC; HCR Manorcare Operations II, LLC; Healthcare Operations Holdings, Inc.; Healthcare Operations Investments, Inc; Carlyle MC Partners, LP; MC Operations Investments, Inc; TC Group V, LP; Carlyle Partners V MC Holdings, LP; Carlyle Partners V MC, LP; HCP, Inc.; HCR Healthcare, LLC; and Paul A. Ormond, O-R-M-O-N-D.

This deposition is being taken

pursuant to Ohio Civil Rule 30(B)(5) at the offices of Reminger Company LPA located at 101 West Prospect Avenue, Suite 1400 in Cleveland, Ohio 44115.

It's Tuesday, December 17th, 2013 and it's about 9:30. This is Case Number 13-CV-1703, the caption is Christine Pearson as the personal representative of the Estate of Gary Banks, deceased, versus Manor Care Health Services Willoughby, et al. currently pending in the Lake County Court of Common Pleas before the Honorable Judge Joseph Gibson.

Present is Attorney Tom Prislipsky of the Reminger firm who represents all of the defendants in this case.

Q. Ms. Stincic, my name is Blake Dickson. I represent Christine Pearson who is the personal representative of the Estate of Gary Banks and Gary Banks' family in this case. I'm going to ask you some questions.

Have you ever had a deposition taken before like we're doing this morning?

A. No, I haven't.

Q. Okay. So I'm going to ask you some questions.

Q. Other than Mr. Banks, anybody involved on his side in the admissions process?
A. Not that I can remember.
Q. All right. Is there anything on Exhibit 3, the financial information page, that has anything to do with arbitration?
A. No.
Q. Is there anything in the patient information handbook that has anything to do with arbitration?
A. I can't remember.
Q. Okay.

MR. PRISLIPSKY: Go ahead and take a look.

MR. DICKSON: Or if you want to stipulate. I don't think it's a hard question.

A. No.

MR. DICKSON: You can do it however you want.

MR. PRISLIPSKY: Go ahead.

A. No, I don't think so.
Q. Yes, I didn't see anything.
A. No, I don't think so.
Q. All right. Anything in the Nursing Home Bill of

question because I really don't know.
Q. Okay. In August of 2012, how long had you had the position of admissions for, of doing admissions?
A. Probably a month.
Q. Okay. And do you remember back then, you know, how typically an admission was, like did someone come in every day or was it like a once a week thing or how often did it happen?
A. Maybe two times a day, three.
Q. Were you involved in every admission?
A. I was in training.
Q. And when you did Mr. Banks's admission, were you in training?
A. Yes.
Q. Okay. To the best of your knowledge and having reviewed these documents, and please feel free to review them again if you need to, the only documents that are part of the admission packet that have to do with arbitration were the Voluntary Arbitration Program brochure that's Exhibit 7 and the first two pages of Exhibit 2 which is the Voluntary Arbitration Agreement?
A. Yes.
Q. Okay. Do you remember talking to Mr. Banks about

arbitration?
A. I don't.
Q. Okay. Do you remember seeing anybody else talk to Mr. Banks about arbitration?
A. No, I don't.
Q. Do you remember reading Mr. Banks the Voluntary Arbitration Program materials?
A. No, I don't.
Q. Do you remember reading him the Voluntary Arbitration Agreement?
A. Yes.
Q. You did read it to him?
A. Well, I did read it to him because I read it to every person.
Q. Okay. So the first two pages of Exhibit 2, the Voluntary Arbitration Agreement, you would have read to Mr. Banks. Now let me ask you this question.

Do you have a specific recollection of reading it to him or do you just remember that you read it to everybody?
A. I remember reading it to everybody.
Q. Okay. Word for word, line for line?
A. We had to, yes.
Q. Okay. And where would that have taken place?

A. In his room.
Q. Okay. So you sat down with Mr. Banks and said, I'm going to read you the Voluntary Arbitration Agreement?
A. Yes.
Q. Other than the two-page Voluntary Arbitration Agreement, is there anything else that you read to Mr. Banks?
A. I just highlighted the parts and explained it to him and if he wanted to know more, I would tell him more.
Q. Of the admission packet?
A. Yes.
Q. Okay. So the two-page Voluntary Arbitration Agreement is the only document you read page for page, line for line?
A. Yes.
Q. Okay. Other than reading this to him, do you remember explaining any part of it to him?
A. I don't remember.
Q. Other than you reading this to him, do you remember anybody else or are you aware that anybody else spoke to him in any way about arbitration?
A. I don't remember and I don't have any knowledge

of that.
Q. Did you have any conversations with any member of his family?
A. I don't recall.
Q. To your knowledge, did anybody else have any conversations relative to his admission with any member of his family?
A. To my knowledge, no.
Q. Okay. The time that you read this to him, so that would have been one occasion in his room that you read this to him?
A. Yes.
Q. Okay. Other than that occasion, any other times when you had any discussion with him about arbitration?
A. No.
Q. Okay. Have you ever been fired from a job?
MR. PRISLIPSKY: Objection.
A. No.
Q. Did you have any training relative to arbitration at Manor Care or any place else?
A. Yes.
Q. Tell me about your arbitration training.
A. It was an in-service.
Q. Okay. How long?

A. How long was the in-service?
Q. Yes. Was it like a one-hour class, a six-week course?
A. I think it was maybe, I'm guessing, maybe 30 minutes.
Q. Okay. Other than the 30 minute in-service about arbitration, any other training about arbitration?
A. No.
Q. Okay. Tell me what arbitration is.
A. Arbitration is the legal piece of the document which I explained to the resident that if something was to happen unfortunately, by signing this arbitration it's letting us -- you would have a lawyer to represent you, we would have a lawyer to represent us and it would stay out of trial.
Q. If a dispute goes to arbitration, is there a judge?
A. Yes.
Q. If a dispute goes to arbitration, can either side take depositions like we're doing today?
A. I don't know.
Q. Okay. If a dispute goes to arbitration, can one side or the other send out written questions

called interrogatories?
A. I don't know.
Q. Can one side or the other send out written requests for documents in arbitration?
A. Yes.
Q. Okay. If a dispute goes to arbitration, can either side get a jury?
A. No.
Q. Okay. What are the costs of arbitration?
A. I don't know.
Q. Is there a set of rules if a case were to go to arbitration with Manor Care?
A. I don't know.
Q. Okay. Do you know what a subpoena is?
A. Yes.
Q. If a dispute were to go to arbitration, can either side issue subpoenas?
A. Yes.
Q. To your knowledge, did Manor Care ever initiate a lawsuit against a resident?
A. Not to my knowledge.
Q. Do you remember how old Mr. Banks was?
A. No, I don't.
Q. Okay. Did you do anything to determine as part of your admissions process his mental capacity?

A. No.
Q. Okay. Did you ask him if he had any prior experience with contracts?
A. No.
Q. Did he read the Admission Agreement?
A. No.
Q. Was anyone with him when you read him the Arbitration Agreement?
A. No.
Q. Did you tell him that he could have an attorney review the Arbitration Agreement before he signed it?
A. No.
Q. Did Mr. Banks change any of the language in the Arbitration Agreement?
A. No.
Q. In your experience at Manor Care, did you ever have a resident alter any language in the Arbitration Agreement?
A. No.
Q. Did you ever have a resident not sign the Arbitration Agreement?
A. Yes.
Q. Okay. How many residents refused to sign?
A. I'd say two to three.

is defined?
A. On just this page?
Q. Any page, any part of the Arbitration Agreement.
A. It does say Admission Agreement, it has A, center, we/us or our and then it says HCR Manor Care Willoughby.
Q. Right. That's the Admission Agreement, correct?
A. Correct.
Q. Is there any place in the Arbitration Agreement where MC WBY is defined?
A. No.
Q. Okay. To your knowledge, is the Arbitration Agreement part of the Admission Agreement?
A. Yes.
Q. It is. And does it say that someplace?
A. No, it doesn't.
Q. Okay. You'd agree with me that the Arbitration Agreement is a separate two-page document?
A. Yes.
Q. And then the Admission Agreement begins over, and just so you're not confused, the actual first page of the Admission Agreement is this financial sheet which is 1 and then the Admission Agreement says 2 so that starts over with new pagination.
A. Yes.

Q. Okay. Turn to the second page of the Admission Agreement, please.

At the bottom it says, Center representative, signature of center representative, is that your signature?

A. Yes.

Q. And who were you employed by at the time?

A. HCR Manor Care in Willoughby.

Q. Okay. Do you know why the Nursing Home Residents' Bill of Rights was given to Mr. Banks?

A. It's given to every resident.

Q. Do you know why?

A. Because it's their rights. We need -- they have to know their rights.

Q. Okay. The Voluntary Arbitration Program document, which is Exhibit 7, has a section on the third page for patient signature. This one is not signed.

To your knowledge, does a signed copy exist?

A. Yes, to my knowledge it should.

Q. Well, I mean, and this happens a lot in depositions because you've done this a lot and you did it a long time ago.

Do you have a specific knowledge of Gary Banks signing this document or was it just your

practice to have the person sign?
A. It's my practice to have the person sign.
Q. But you don't have a specific memory of him signing?
A. No, I don't.
Q. Okay. And you don't remember reading the Voluntary Arbitration Program document to Mr. Banks?
A. No, I don't recall.
Q. Okay. Do you know who wrote the Voluntary Arbitration Program document?
A. No, I don't.
Q. Do you know where the information contained in it comes from?
A. No.
Q. Okay. Just flip to the second page of the Arbitration Agreement.

The only person who signed on behalf of Mr. Banks was Mr. Banks himself?
A. That's what it looks like.
Q. And you did not do anything to verify that he had the capacity to sign a document or contract?
A. Explain that a little bit more what you're talking about.
Q. Some people in nursing homes are demented or

retarded or have other challenges which means they lack the legal capacity to sign a document.

You didn't undertake anything to make sure that Mr. Banks had the capacity to sign a legal document?

A. No.

Q. And to your knowledge, did anybody?

A. Not to my knowledge.

Q. Okay. Other than reading the Arbitration Agreement to Mr. Banks, can you remember anything you told him about it or you explained to him about it?

A. I don't, but in practice doing that, I explained it very carefully to everyone.

Q. Okay. But you don't remember explaining it to him?

A. No.

Q. And in that you were in training, did anybody supervise your discussion with Mr. Banks about the Arbitration Agreement?

A. No.

Q. Was there any policy at Manor Care at the time regarding validating a person's capacity to sign a document when they were presented with an admission packet?

ADMISSION AGREEMENT

1. PARTIES, ADMISSION DATE, AND DEPOSIT

The following are parties to this Agreement:

A. Center (We, Us, Our): HCR Manor Care Willoughby
B. Patient (You, Your): Gary Banks
C. Responsible Party, if applicable (You, Your): Gary Banks

Admission Date: Aug. 15, 2012 Deposit Amount: $

2. CENTER'S RESPONSIBILITIES

We will:

A. Provide You with a basic room, board, common facilities, housekeeping, laundered bed linens, general nursing care, personal assessment, social services, and other services.
B. Apply Your deposit, if any, to Your first one or two months of Your stay at Center.
C. Refund any amounts owed to You within 30 days or within the time frame required by state law after Your discharge or transfer.

3. RESIDENT'S RIGHTS AND RESPONSIBILITIES

3.1 You have the right to:

A. Choose Your own personal physician as long as the physician is properly licensed and complies with Our policies and procedures.
B. Choose Your own pharmacy as long as the pharmacy complies with Our policies and procedures and operates in compliance with state and federal laws. In order for You to receive prescription drug coverage under Medicare Part D, the pharmacy must have a contract with the Part D plan You select.

3.2 You will:

A. Pay Us:
1. the room and board rate for all days that You reside at the Center including the day of admission. Unless you are covered under Medicaid or an insurance plan that prohibits it, We may bill You for a late fee if You do not leave the Center before 12:00 p.m. on the day of Your discharge. The late fee will reflect any charges accrued by You while in the Center after 12:00 p.m. on the day of Your discharge. If We change the room and board rate, We will notify you in writing 30 days before the change. (Room and Board Rates are listed in Attachment A).
2. all additional ancillary charges accrued by You while in the Center. (Ancillary Charges are described on Attachment B)
3. any co-insurance, deductibles or reimbursement You receive for non-covered services if You are eligible for any insurance or governmental program including Medicare, Medicaid, or Veteran's Administration.
4. Any additional or denied charges that are not covered by Your insurance company's benefit or third party payer
5. upon receipt of the bill. If We hire a collection agency or attorney to collect payment on Your account, You will pay for these collection costs including attorney fees and costs.

B. Pay other providers, including Your attending physician, directly for care they provide to You.
C. Notify Us of Your coverage under any insurance plans or government programs.

EXHIBIT
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D. Notify Us in writing within 5 days if Your coverage under any insurance plans or government programs changes while You are at the Center.
E. Assign Us the right to bill and receive money directly from Your insurance or government payor. You authorize Center and any holder of medical or other information to release such information to the Centers for Medicare and Medicaid Services and its agents and to third party payors any information needed to determine Your benefits and Our right to receive payment.
F. Pay for any damage You cause to any person or property on Center grounds.
G. Abide by our policies and procedures.

4. RESPONSIBLE PARTY'S RESPONSIBILITIES

You will:

A. Have legal access to the Patient's income or resources and deliver any documents supporting such authority to the Center.
B. Pay for all charges that Patient incurs while at the Center from the Patient's income or resources.
C. Notify Us immediately and in writing if the Patient's financial resources are depleted.
D. Secure Medicaid in a timely and proper manner.
E. Cooperate with Us by providing information about the Patient's finances.
F. Transfer and accept the Patient when it is medically appropriate to discharge the Patient from the Center.
G. Abide by Our policies and procedures.
H. Not misappropriate the Patient's income or resources or use them for the benefit of someone other than the Patient.
I. Be personally liable for the payment of all charges if You fail to fulfill Your other responsibilities under this Agreement.

5. CONSENT

You consent to allow Us to:

A. Use and disclose your health information for purposes of treatment, payment, or health care operations.
B. Treat You to maintain Your well-being.
C. Photograph you for identification purposes.

6. TERM AND TERMINATION

6.1 Term

This Agreement begins on the day You are admitted to the Center and ends on the day You are discharged from the Center unless you are readmitted within 15 days of Your discharge date. If You are re-admitted within 15 days of being discharged from the Center, this Agreement will continue in effect as of the date of Your re-admission.

6.2 Termination

A. By You:

You may terminate this Agreement:
1. immediately if you leave the Center because of emergency; or
2. by providing 7 days written notice of Your intent to leave the Center.

B. By Us:

We may terminate this Agreement and discharge You from the Center by notifying You in writing. Where legally required, We will notify you at least 30 days prior to Your transfer or discharge. In cases where the safety or health of You or other individuals in the Center may be endangered, or if other legal reasons exist, we will notify You as soon as practicable before transfer or discharge.

We can terminate the Agreement for any of the following reasons:

1. Your needs cannot be met in the Center;
2. Your health has sufficiently improved so that You no longer need Our services;
3. The safety of other individuals in the Center is endangered;
4. The health of other individuals in the Center is endangered;
5. After appropriate notice, You have failed to pay for your stay at the Center*; or
6. We cease to operate the Center.

* If the Center participates in the Medicaid program on a distinct part basis under Ohio law, We may discharge You from the Center if You reside in a non-certified Medicaid bed and You are unable to pay for Your medical care without Medicaid assistance.

7. ACKNOWLEDGMENTS

You acknowledge that You have received the following attachments:

A. Room and Board Rate – Attachment A
B. Ancillary Charges – Attachment B
C. Notice of Information Practices and Receipt of Notice of Information Practices – Attachments C-1 and C-2
D. Resident's Personal Trust Fund Agreement – Attachment D
E. SNF Medicare Determination Form – Attachment E
F. Medicare Secondary Payor Questionnaire – Attachment F
G. Summary of Limited Treatment Policy – Attachment G
H. Ohio Department of Job & Family Services – Medicaid Resource Assessment Notice – Attachment H
I. Medicare and Medicaid Information
J. Patient Information Handbook
K. Center Supplement
L. Resident Rights

By signing the Admission Agreement, You acknowledge that you have been given and have read this Agreement in its entirety, and all its attachments. You agree that all information submitted as part of Your admission to the Center is true and correct. You acknowledge that the Center relies on the accuracy of all information submitted by You or on Your behalf in determining whether to admit You to the Center.

By signing below, the parties agree to the terms of this Admission Agreement:

X Mary Barker ______________ 8/15/12 ______________
Patient Date

Darlene Stewart ______________ 8/15/12 ______________
Center Representative Date

If applicable:

______________________ ______________________
Responsible Party Date

( ) ______________________
Responsible Party's Telephone Number

000004

ATTACHMENT A

ROOM AND BOARD RATE

You will pay the following monthly rate:

Semi-Private Room:	Private Room:
3-Bed Room:	4-Bed Room:
Subacute Semi-Private Room:	Subacute Private Room:
3-Bed Room:	4-Bed Room:

ATTACHMENT B

ANCILLARY CHARGES

I. Private Pay, Third Party Payors and Managed Care Organizations

The services and supplies categorically described on this Attachment are not included in the basic Room and Board Rate. Therefore, You will be individually billed and required to pay for these items, unless covered by a third party payer or managed care organization. A complete list of ancillary items, together with the current price, is on file at the Center's business office.

Personal laundry and dry cleaning.
Personal care items, such as toothbrush, toothpaste, mouthwash, deodorant, hairbrush, Efferdent, tissues, razors, etc.
Beauty and Barber Shop services
Tobacco and smoking supplies, newspapers and periodicals
Stationary, postage, and writing implements
Radios, televisions, cable service, room telephone
Transportation for non-medical purposes and ambulance charges
Photocopies of medical records
Personal physicians and specialists
Dental services and dentures
Optometrist/Ophthalmologist services and eyeglasses
Podiatry services
Special nursing services, such as hand feeding, and care for catheters, decubiti, incontinence, isolation and dressings
Therapy services, including physical, speech, occupational, audiology and respiratory therapy
Prescription and non-prescription medication
Laboratory and x-ray tests
Oxygen and related supplies
IV Therapy and supplies
Peritoneal dialysis
Tracheotomy supplies
Ventilator rental and related supplies
Medical supplies, including but not limited to syringes, dressings, catheters, colostomy bags, tubes, surgical stockings, and all other supplies necessary for the treatment, nursing care, or well-being of the Resident
Incontinence supplies
Special equipment (for some items, a rental, rather than purchase fee is charged), such as wheelchairs, wheelchair pad, trapeze, canes, geri-chair, special mattresses, portachairs, etc.
Special, supplementary, or very low calorie prescription dietary products, including liquid for gastric and naso-gastric tubes, and any supply necessary to accomplish special feedings.

II. Medicare and Medicaid

The services and supplies categorically described below are not covered by the Medicare or Medicaid programs. If You are covered under either program, You will be individually billed for these items. A complete list of ancillary items, together with the current price, is on file at the Center's business office.

Beauty and Barber Shop services
Tobacco and smoking supplies, newspapers and periodicals
Stationary, postage, and writing implements
Radios, televisions, cable service, room telephone
Transportation for non-medical purposes and ambulance charges
Photocopies of medical records
Personal physicians and specialists
Dental services and dentures
Optometrist/Ophthalmologist services and eyeglasses
Podiatry services

If You are covered under the Medicare or Medicaid programs, any of the ancillary charges listed above shall be subject to and limited by the payment provisions of any contract or agreement between the Center and the Medicaid or Medicare programs. We will not charge You for items and services for which payment is made under Medicaid or Medicare.

ATTACHMENT C-1

NOTICE OF INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS DOCUMENT CAREFULLY.

We have summarized our responsibilities and your rights on this first page. For a complete description of our information practices, please review this entire notice.

Our Responsibilities

We are required to:

- Maintain the privacy of your health information;
- Provide you with this notice of our legal duties and information practices with respect to information we collect and maintain about you; and
- Abide by the terms of this notice.

Your Rights

You have several rights with regard to your health information. Those include the right to:

- Request that we not use or disclose your health information in certain ways;
- Request to receive communications in an alternative manner or location;
- Access and obtain a copy of your health information;
- Request an amendment to your health information; and
- An accounting of disclosures of your health information;

We reserve the right to change our information practices and to make the new provisions effective for all health information we maintain. Should our privacy practices change, we will post the changes in a physical place within our building and on our web site. A copy of the revised notice will be available after the effective date of the changes upon request.

We will not use or disclose your health information without your authorization, except as described in this notice.

If you have questions and would like additional information, you may contact Lisa Griesmer, Administrator, 440-951-5551.

Entities Covered Under This Notice

Manor Care, Inc. through its operating group HCR Manor Care, is the owner and operator of several entities which operate primarily under the Heartland, ManorCare, and Arden Court names. The following entities are part of an organized health care arrangement:

- Skilled Care Facilities – provide comprehensive health care around the clock by experienced professionals.
- Assisted Living Facilities – provide personal care assistance as needed for dressing, bathing, meal preparation and medication management for residents who live independently.
- Rehabilitation Companies – provide in-patient and out-patient therapy services for those recovering from illnesses, injuries, or disabilities.
- Home Health Care – provide health care in the home so that patients may stay at home while receiving needed care to function.
- Hospice Services – provide hospice services to assist those dealing with terminal illness.
- Medicare Part B Provider – Provides certain medical products for eligible individuals.
- Pharmacy Products and Services – provide pharmaceuticals to patients who need pharmacy services.
- Physician Services – provide management services to physician practices.

These entities are all affiliated with the same parent company, Manor Care, Inc. The entities participating in the organized health care arrangement will share health information with each other as necessary to carry out treatment, payment, or health care operations. Each entity will abide by the terms of this notice with respect to protected health information received by another participating entity.

Understanding Your Health Record

Each time you visit a medical provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves the following purposes:

Basis for planning your care and treatment

Communication among health professionals involved in your care

Legal document describing the care you received

Proof that services billed were actually provided

A tool to educate health professionals

A source of data for medical research

A source of information for public health officials who oversee the delivery of health care in the United States

A tool to measure and improve the care we give

Understanding what is in your record and how your health information is used helps you to:

Ensure its accuracy

Understand who, what, when, where, and why others may access your health information

Make informed decisions when authorizing disclosure to others.

How We Will Use or Disclose Your Health Information.

For Treatment. We will use and disclose your personal health information in providing you with treatment and services. We may disclose your personal health information to personnel who may be involved in your care, such as physicians, nurses, nurse aides, physical therapists, dietary and admissions personnel. For example, a nurse caring for you will report any change in your condition to your physician. We also may disclose personal health information to individuals who will be involved in your care after you leave the facility.

For Payment. We may use and disclose your personal health information so that we can bill and receive payment for the treatment and services you receive. For billing and payment purposes, we may disclose your personal health information to your representative, an insurance or managed care company, Medicare, Medicaid or another third party payer. For example, we may contact Medicare or your health plan to confirm your coverage or to request prior approval for a proposed treatment or service.

For Health Care Operations. We may use and disclose your personal health information for our regular health operations. These uses and disclosures are necessary to manage our operations and to monitor our quality of care. For example, we may use personal health information to evaluate our services, including the performance of our staff. We may use a photograph of you to identify you or for general programs such as posting on activity boards.

Business Associates. Outside people and entities provide some services for us. Examples of these "business associates" include our accountants, consultants and attorneys. We may disclose your health information to our business associates so that they can perform the job we've asked them to do. We require the business associates to safeguard your information so that it is protected.

Directory. Unless you notify us that you object, we may use your name, location in the facility, general condition, and religious affiliation for directory purposes. We may release information in our directory, except for your religious affiliation, to people who ask for you by name. We may provide the directory information, including your religious affiliation, to any member of the clergy.

Notification. We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, of your location and general condition. If we are unable to reach your family member or personal representative, then we may leave a message for them at the phone number that they have provided us, e.g. on an answering machine.

Communication with Family. We may disclose to a family member, other relative, close personal friend or any other person involved in your health care, health information relevant to that person's involvement in your care or payment related to your care.

Bulletin Boards/Newsletters. We may post your name and birth date on a facility bulletin board or in a facility newsletter.

Research. We may disclose information to researchers when certain conditions have been met.

Transfer of Information at Death. We may disclose health information to funeral directors, medical examiners, and coroners to carry out their duties consistent with applicable law.

Organ Procurement Organizations. Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing. We may contact you regarding your treatment, to coordinate your care, or to direct or recommend alternative treatments, therapies, health care providers or settings. In addition, we may contact you to describe a health-related product or services that may be of interest to you, and the payment for such product or service.

Fund raising. We may contact you as part of a fund-raising effort.

Food and Drug Administration (FDA). We may disclose to the FDA, or to a person or entity subject to the jurisdiction of the FDA, health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Worker's compensation. We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs established by law.

Public health. As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Correctional institution. Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Law enforcement. We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Reports. Federal law allows a member of our work force or a business associate to release your health information to an appropriate health oversight agency, public health authority or attorney, if the work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

Your Health Information Rights

You have the following rights regarding your personal health information:

Right to Request Restrictions. You have the right to request restrictions on our use or disclosure of your personal health information for treatment, payment or health care operations. You also have the right to restrict the personal health information we disclose about you to a family member, friend or other person who is involved in your care or the payment for your care.

We are not required to agree to your requested restriction (except that while you are competent you may restrict disclosures to family members or friends). If we do agree to accept your requested restriction, we will comply with your request except as needed to provide you emergency treatment.

Right of Access to Personal Health Information. You have the right to inspect and obtain a copy of your medical or billing records or other written information that may be used to make decisions about your care, subject to some limited exceptions. Such records will be provided to you in the time frames established by law. We may charge a reasonable fee for our costs in copying and mailing your requested information.

We may deny your request to inspect or receive copies in certain limited circumstances. If you are denied access to personal health information, in some cases you will have a right to request review of the denial.

Right to Request Amendment. If you believe that any health information in your record is incorrect or if you believe that important information is missing, you may request that we correct the existing information or add the missing information. Such requests must be made in writing, and must provide a reason to support the amendment.

We may deny your request for amendment in certain circumstances. If we deny your request for amendment, we will give you a written denial including the reasons for the denial and the right to submit a written statement disagreeing with the denial.

Right to an Accounting of Disclosures. You have the right to request an "accounting" of our disclosures of your personal health information. This is a listing of certain disclosures of your personal health information made by the us or by others on our behalf, but does not include disclosures for treatment, payment and health care operations or certain other exceptions.

To request an accounting of disclosures, you must submit a request in writing, stating a time period beginning after April 13, 2003 that is within six years from the date of your request. An accounting will include, if requested: the disclosure date; the name of the person or entity that received the information and address, if known; a brief description of the information disclosed; a brief statement of the purpose of the disclosure or a copy of the authorization request; or certain summary information concerning multiple similar disclosures. The first accounting provided within a 12-month period will be free; for further requests, we may charge you our costs.

Right to a Paper Copy of This Notice. You have the right to obtain a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may request of copy of this Notice at any time.

Right to Request Confidential Communications. You have the right to request that we communicate with you concerning personal health matters in a certain manner or at a certain location. For example, you can request that we contact you only at a certain phone number. We will accommodate your reasonable requests.

Right to Revoke Authorization. You may revoke an authorization to use or disclose health information, except to the extent that action has already been taken. This request must be made in writing.

For More Information or to Report a Problem

If you believe that your privacy rights have been violated, you may file a complaint in writing with us or with the Office of Civil Rights in the U.S. Department of Health and Human Services. To file a complaint with us, contact Lisa Griesmer, Administrator, 440-951-5551. We will not retaliate against you if you file a complaint.

If you have any questions about this Notice or would like further information concerning your privacy rights, please contact Lisa Griesmer, 440-951-5551.

Effective Date: April 14, 2003

HCR ManorCare

ATTACHMENT C-2

RECEIPT OF NOTICE OF INFORMATION PRACTICES

Patient's Name: Gary Banks

I acknowledge receipt of HCR Manor Care's Notice of Information Practices.

I ✓ agree ___ object to including Gary Banks location in the facility, general condition and religious affiliation (available to clergy only) in the Facility Directory.

I ✓ agree ___ object to disclosure of Gary Banks health information to a family member or close personal friend, including clergy, who is involved in my care.

Gary Banks — Name (Please Print)

X Gary Banks — Signature

Relationship to Patient

8/15/12 — Date

To be completed by Facility Personnel

A good faith effort was made to obtain written acknowledgement of the Notice of Information Practices.

✓ Written acknowledgment was obtained

___ Written acknowledgment was not obtained. Efforts to obtain receipt and reason not obtained are described below.

Completed by: — Name

Signature

ATTACHMENT D

RESIDENT'S PERSONAL TRUST FUND AGREEMENT

The undersigned hereby agree as follows:

1. We will give You a written receipt for all expenditures and deposits regarding any funds You Deposit with Us.

2. We will maintain a record of all transactions regarding Your account in accordance with generally accepted accounting principles.

3. You will have access, at any time upon request, to the above record and shall receive an itemized quarterly statement of Your account.

4. We have a surety bond to guarantee Your funds.

5. We will keep Your personal funds in separate account(s) from Our operating accounts.

6. We may keep Fifty and 00/100 Dollars ($50.00) or less in a non-interest bearing or petty cash fund for Your account. We will put any money in excess of Fifty and 00/100 Dollars ($50.00) into an interest-bearing account, with the interest to be credited to You. If We maintain an account with a bank on Your behalf, any service charges assessed by the bank will be deducted from Your personal trust fund account unless prohibited by state law.

7. You acknowledge that, upon Your disharge or death, the balance of Your account will be promptly released to You or Your Responsible Party as indicated in Our records. Upon death, the balance of the funds will be promptly conveyed to the executor or administrator of Your estate. If there is no estate, You request that the remaining funds be give to _____ at the following address:_____. If no designation is made, We will dispose Your funds in accordance with Ohio law.

8. You authorize Us to distribute or return Your money only to You or Your designated representative upon written request.

9. We have no duty to invest the money in Your account to earn income other than interest in a bank checking or similar account, or to accept a deposit which would cause the balance in Your account to exceed applicable limits of federal or state law.

10. If You receive Medicaid benefits, We will notify You when the amount in Your account reaches Two Hundred and 00/100 Dollars ($200.00) less than the social security income ("SSI") resource limit for one person and that, if the amount in the account, in addition to the value of Your other nonexempt resources, reaches the SSI resource limit for one person, You may lose eligibility for Medicaid or SSI.

You acknowledge you have received Our policies on Resident's Personal Trust Fund Accounts and have had the opportunity to read the information.

[X] You decline the opportunity to deposit funds within the center.

Date: 8/15/12

V. Mary Banks
Resident (Signature)

Responsible Party (Signature)

Darlene Stevens
Facility Representative (Signature)

[ ] You accept the opportunity to deposit funds within the center.

Date:

Resident (Signature)

Non-Employee Witness (Signature)

Responsible Party (Signature)

Facility Representative (Signature)

ATTACHMENT E

HCR ManorCare

Heartland • ManorCare • Arden Courts

SKILLED NURSING FACILITY DENIAL LETTER

I. NON-ADMISSION or CONTINUED STAY denial

SNF Name: HCR Manor Care Willoughby ADDRESS: 37603 Euclid Ave. Willoughby, OH 40494

DATE: __/__/__

TO: Name: Gary Banks RE: Beneficiary Gary Banks

Address: 731 N. Lake St. Admission Date: Aug. 15, 2012

City, State, Zip Madison, OH 44057 Patient Medical Record #: ___

I. TECHNICALLY INELIGIBLE ADMISSION

On __/__/__, we reviewed your medical information available at the time of, or prior to admission, and we believe that the service(s)_____(beneficiary name) needed did not meet the requirements for coverage under Medicare. The reason is:

- ☐ You had no 3-day hospital qualifying stay
- ☐ You have previously exhausted your 100 Medicare days coverage and remained at a Medicare skilled level of care
- ☐ You are not entitled to Medicare Part A
- ☐ Your discharge from the hospital/SNF has exceeded 30 days

If the resident is waiving Medicare benefits complete the "Voluntary Waiver of Medicare Benefits" letter

II. ADMISSION or CONTINUED STAY - SKILLED CARE DENIAL

On __/__/__, we reviewed your medical information and found that the services furnished (you)_____no longer qualified as covered under Medicare beginning __/__/__. The reason is:

☐ You have used the full 100 days of Medicare coverage allowed under the Medicare program for Skilled Nursing facility coverage.

☐ Medicare covers medically necessary skilled nursing care needed on a daily basis. You only needed oral medications, assistance with your daily activities and general supportive services. There is no evidence of medical complications or other medical reasons that required the skills of a professional nurse or therapist to safely and effectively carry out your plan of care. Therefore, we believe that your care cannot be covered under Medicare.

☐ Medicare covers medically necessary skilled care needed on a daily basis. You only needed _____. This does not require the skills of a licensed nurse to perform the service or to manage your care. Since you needed neither skilled nursing nor skilled rehabilitation on a daily basis, we believe your stay is not covered under Medicare.

☐ Medicare covers medically necessary skilled care needed on a daily basis. You only needed_____ after __/__/__. Since you no longer require skilled nursing and did not need skilled rehabilitation on a daily basis, we believe your stay beginning __/__/__ is not covered under Medicare.

☐ Medicare covers medically necessary skilled care needed on a daily basis. You needed skilled nursing care beginning __/__/__ to observe and evaluate your condition. There is no indication of further likelihood of significant changes in your care plan or of acute changes or complication in your condition. Since you no longer need skilled nursing or skilled rehabilitation services on a daily basis, we believe your stay after __/__/__ is not covered under Medicare.

☐ Medicare covers medically necessary skilled care needed on a daily basis. Because of your condition you needed a skilled nurse from __/__/__ through __/__/__ to evaluate and manage your care plan. Your condition has improved so the services you need can safely and effectively be given by non skilled persons. Since you no longer require skilled nursing and did not need skilled rehabilitation services on a daily basis, we believe your stay is not covered under Medicare after __/__/__.

☐ Medicare covers medical necessary skilled nursing or rehabilitation services you need including teaching and training activities for a reasonable time where progressive learning is demonstrated. You have learned to perform the tasks ordered by your physician by __/__/__ but the therapist continued services. Since you did not need skilled services after that date, we believe your stay is not covered under Medicare beginning __/__/__.

☐ Medicare covers medical necessary skilled nursing or rehabilitation services you need including teaching and training activities for a reasonable time where progressive learning is demonstrated. You needed only to be reminded to follow the physician's instructions. This does not require the skills of a professional nurse or therapist. Therefore, we believe that this service is not covered under Medicare.

☐ Medicare covers medically necessary skilled nursing or rehabilitation services you need including teaching and training activities for a reasonable time where progressive learning is demonstrated. You received teaching and training for a reasonable time but demonstrated you were not able, at this time, to learn or make progress to perform the activities ordered by your physician. Therefore, we believe that skilled services are not covered under Medicare after __/__/__.

☐ Medicare covers daily skilled nursing care related to the insertion, sterile irrigation and replacement of urethral catheter if the use of the catheter is reasonable and necessary for the active treatment of a disease of the urinary tract or for patients with special medical needs. Skilled nursing is not considered medically necessary when urethral catheters are used only for mere convenience or the control of incontinence. Since your catheter was inserted for convenience or the control of your incontinence. We believe that your care is not covered under Medicare.

☐ Medicare covers medically necessary skilled rehabilitation services. The medical information shows that the only therapy services you needed beginning ___/___/___ were repetitive exercises and help with walking. These do not generally require the skills or the supervision of a qualified therapist. There was no evidence of medical complications which would have required that services be performed by a qualified therapist. We believe therapy services are not covered under Medicare after ___/___/___.

☐ Medicare covers medically necessary skilled rehabilitation services when needed on a daily basis. The therapy services you received were for your overall fitness and general well-being. They did not require the skills of a qualified _____ therapist to perform and / or to supervise the services. Since you did not need skilled nursing or skilled rehabilitation services, we believe your stay is not covered under Medicare.

☐ Medicare covers medically necessary skilled rehabilitation services to establish a safe and effective program to maintain your functional abilities. This program was established and beginning ___/___/___, the _____ therapy services you received were to carry out this program. These services do not require the supervision or skills of a _____ therapist and, therefore, we believe that the services are not would not be covered under Medicare.

☐ Medicare covers medically and necessary skilled care when needed on a daily basis. The _____ (specify services) you received is/are considered a skilled service by Medicare. However based on the medical information provided, this/these service(s) is not/are not considered a specific and /or effective treatment for your condition. Since the service(s) you received was not/were not reasonable or necessary for the treatment of your condition, we believe your stay is not covered under Medicare.

☐ Medicare covers medically necessary skilled rehabilitation services when needed on a daily basis. The _____ therapy services provided was not/were not reasonable in relation to the expected improvement in your condition. In this case, since you do not need skilled nursing on a daily basis and the therapy services are not considered reasonable and necessary, we believe, your stay is not covered under Medicare.

☐ Medicare covers medically necessary skilled rehabilitation services when needed on a daily basis. While you required skilled _____ from ___/___/___ to ___/___/___, the medical information shows that the _____ therapy services after that time are not reasonable in relation to the expected improvement in your condition. In this case, since you do not need skilled nursing on a daily basis and the therapy services are not considered reasonable and necessary, we believe, your stay after ___/___/___ is not covered under Medicare.

☐ Medicare covers medically necessary skilled care when needed on a daily basis. Although _____ (service) generally requires the skills of a _____, the frequency with which the service is given must be in accordance with accepted standards of medical practice. The service(s) you received is not/are not normally needed on a daily basis. The medical information does not show medical complications which require the services to be performed on a daily basis. In this case, the services are not considered reasonable and necessary. Since you did not need skilled nursing or skilled rehabilitation on a daily basis, we believe your stay is not covered under Medicare.

This decision has not been made by Medicare. It represents ☐ our judgment that the services you needed did not meet or no longer met Medicare payment requirements. A bill will be sent to Medicare for services you received before ___/___/___. Normally, the bill submitted to Medicare does not include services provided after this date. If you want to appeal this decision, you must request that the bill submitted to Medicare include the services we determined to be non-covered. Medicare will notify you of its determination. If you disagree with that determination you may file an appeal.

III. APPEAL RIGHTS

Under a provision of the Medicare law, you do not have to pay for non-covered services determined to be custodial care or not reasonable and necessary unless you had reason to know the services were non-covered. You are considered to know that these services were non-covered effective with the date of this notice. If you have questions concerning your liability for payment for services you received prior to the date of this notice, you must request that a bill b e submitted to Medicare. We regret that this may be your first notice of the non-coverage of services under Medicare. Our efforts to contact you earlier in person or by telephone were unsuccessful. Please check one of the boxes below to indicate whether or not you want your bill submitted to Medicare and sign the notice to verify receipt.

Sincerely yours,

_____

Signature of Administrative Officer

IV. REQUEST FOR MEDICARE INTERMEDIARY REVIEW

☐ A. I do want my bill for services I continue to receive to be submitted to the Intermediary for a Medicare decision. You will be informed when the bill is submitted. If you do not receive a formal Notice of Medicare Determination within 90 days of this request you should contact:

☐ Cigna Government Services	PO Box 100140	Columbia, SC 29202-3140
☐ Novitas Solutions	PO Box 890385	Camp Hill, PA 17089-0385

☐ B. I do not want my bill for services I continue to need to be submitted to the Intermediary for a Medicare decision. I understand that I do not have Medicare rights if a bill is not submitted.

V. VERIFICATION OF RECEIPT OF NOTICE

☐ C. This acknowledges that I received this notice of non-coverage of services under Medicare on __/__/__.

X Gary Banks

Signature of Resident or person acting on resident's behalf.

If not signed by Resident indicate signer's relationship to Resident

☐ D. This is to confirm that you were advised of the non- coverage of the services under Medicare by telephone on __/__/__:

_____

Name of person contacted and relationship to the Resident

_____

Signature of Administrative Officer

cc: 1. Attending Physician

2. Patient's Financial Record

KEEP A COPY OF THIS FOR YOUR RECORDS

ATTACHMENT F

Medicare Secondary Payor (MSP) Questionnaire

Patient Name: Gary Banks

1. Is the patient receiving Black Lung (BL) benefits? Yes____ No ✓
If yes, record in #10 the date benefits began and the address where the claim should be sent.
BL is primary only for claims related to BL.
2. Are the services to be paid by a government program such as a research grant? Yes____ No ✓
Government Program will pay primary benefits for these services.
3. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for care at this facility? Yes____ No ✓
If yes, record in #10 the date benefits began and the address where the claim should be sent.
DVA is primary for these services.
4. Is the illness/injury due to a work related accident/condition? Yes____ No ✓
If yes, record in #10 the employer name and address, date and type of injury, claim number, and name and address of the worker's compensation plan.
WC is primary payer only for claims related to work related injuries or illness.
5. Is this illness/injury due to a non-work related accident or was another party responsible for an accident that caused this illness/injury? If yes, record in #10 date and type of accident that caused this illness/injury, the name and address of the liability insurer responsible for coverage, and the claim number. Liability insurer is primary payer only for those claims related to the accident. Yes____ No ✓
6. Was the illness/injury caused by an automobile accident? Yes____ No ✓
If yes, record in #10 the name and address of no-fault or liability insurer.
No-Fault insurer is primary payer only for those claims related to the accident.
7. AGE
a. Is the patient entitled to Medicare based on age (65 or older)? Yes____ No ✓
If no, move to #8. If yes, complete 7b and 7c below.
b. Is the patient or patient's spouse currently employed by an employer of 20 or more employees? Yes____ No ✓
If yes, record in #10 the employer name and address.
If no and either the patient or his/her spouse is retired, enter date of retirement in #10 below.
c. Does the patient have Group Health Plan coverage based on the patient's or spouse's current employment? Yes____ No ✓
If yes, enter the Group Health Plan data in #10 below. If no, move to Prior Stay Information.
8. DISABILITY
a. Is this patient entitled to Medicare coverage on the basis of a disability? Yes____ No ✓
If no, move to #8e. If yes, complete 8b through 8d below.
b. Is this patient or the patient's spouse or parent actively employed? Yes____ No ✓
If yes, record in #10 the employer name and address.
If no and either the patient or his/her spouse is retired, enter date of retirement in #10 below.
c. Does the patient have Group Health Plan coverage based on his own or a family member's current employment? Yes____ No ✓
d. Does the employer that sponsors the Group Health Plan employ 100 or more employees? Yes____ No ✓
If yes, enter the Group Health Plan data in #10. If no, move to Prior Stay Information.
e. Is the patient covered under the group health plan of a family member other than the spouse? Yes____ No ✓
If yes, record in #10 the family member's employer's name and address.
9. END STAGE RENAL DISEASE
a. Is this patient entitled to Medicare coverage on the basis of End Stage Renal Disease (ESRD)? Yes____ No ✓
If no, move to Prior Stay Information. If yes, complete 9b through 9f below.
b. Does the patient have Group Health Plan coverage? Yes____ No ✓
If yes, enter the Group Health Plan data in #10 & answer c. below. If no, move to 9d below.
c. Has this patient completed the ESRD 30-month coordination period? Yes____ No ✓
d. Has this patient received a kidney transplant? Yes____ No ✓
If yes, enter the date of transplant in #10 below.
e. Has this patient received maintenance dialysis treatments? Yes____ No ✓
If yes, enter the date dialysis began in #10 below.

f. If this patient participated in a self-dialysis training program, provide date training started in # below.
g. Is this patient entitled to Medicare on the basis of either ESRD and age or ESRD and disability? Yes_____ No____
h. Was this patient's initial entitlement to Medicare (including simultaneous or dual entitlement) Yes_____ No✓
based on ESRD?
i. Does the working aged or disability MSP provision apply (i.e., is the GHP primarily based on age or disability entitlement)? Yes_____ No_____

10. Name of Insurance Company or HMO Medicare
Insured's Name and Policy Number_____
Employer / Address_____
Address of Insurance Co. or HMO_____
Date benefits began_____
Date & type of injury/accident, Claim #_____

PRIOR STAY INFORMATION
Has this patient been confined to a hospital or skilled nursing facility within the last 60 days? Yes✓ No_____
If yes, complete the following information for each stay.

Hospital or SNF AO
Address_____
Admission Date_____
Discharge Date_____
By Whom Verified_____

Hospital or SNF Cumberland Glen
Address_____
Admission Date 8/7/12
Discharge Date 8/13/12
By Whom Verified_____

Name of person who supplied all of the above information Self
How is this person related to the patient?_____
What is this person's telephone number?_____
Date_____

ATTACHMENT G

LIMITED TREATMENT POLICY SUMMARY
OHIO

HCR Manor Care's policy is that all residents will be provided health care unless the attending physician enters a contrary order in the resident's medical record. The Center will act to maintain human life in accordance with accepted standards of ethical practice. Health care will be withheld only in accordance with the procedures set forth in HCR Manor Care's Limited Treatment Policy for Ohio, which is summarized below.

Competent Resident

A competent resident can refuse medical treatment, including artificial nutrition and hydration, at any time. The attending physician must, however, record complete information in the resident's medical record to demonstrate that the decision to refuse treatment was made on the basis of informed consent.

Incompetent Resident

Ohio law permits decisions to be made on behalf of an incompetent resident in several ways.

1. With Living Will.

A. General. If, when competent, the resident has executed a "declaration" in accordance with Ohio law, then life-sustaining treatment can be withheld in accordance with the resident's instructions set forth in the declaration provided that the following requirements are met. The attending physician must determine that the resident is no longer able to make informed health care decisions and that there is no reasonable possibility of regaining such capacity. The attending physician must use good faith efforts to notify any persons specified in the living will and certain family members. Notified persons have an opportunity to object to any withholding. Additionally, the resident must either be certified as being in a terminal condition, as set forth either be certified as being in a terminal condition, as set forth in Part B, below, or as being permanently unconscious, as set forth in Part C, below, as these terms are defined under Ohio law.

B. Life-Sustaining Treatment - Terminal Condition. In this situation, the attending physician may decide to withhold life-sustaining treatment if the attending and one other physician examine the resident and determine that the resident is in a terminal condition. If it is desired that artificial nutrition and hydration be withheld, the two physicians must additionally certify that artificial nutrition and hydration will not or no longer will serve to provide comfort or alleviate pain.

C. Life-Sustaining Treatment - Permanently Unconscious. In this situation, the attending physician may decide to withhold life-sustaining treatment if the attending and a physician with a pertinent specialty examine the resident and determine that the resident is in a permanently unconscious state. Artificial nutrition and hydration can only be withheld if the declaration contains a statement in capital letters, which has been initialed by the resident, that the resident desires to withhold artificial nutrition and hydration when in a permanently unconscious state. The two physicians must additionally certify that the provisions of artificial nutrition and hydration will not or no longer will serve to provide comfort or alleviate pain.

2. With Durable Power of Attorney for Health Care.

A. General. If, when competent, the resident has executed a durable power of attorney for health care in accordance with Ohio law, then life-sustaining treatment can be withheld in accordance with any instructions set

forth in the document provided that the following requirements are met. The attending physician must determine that the resident has lost the capacity to make informed decisions and there is no reasonable possibility that the resident will regain that capacity. The attending physician must believe that the attorney-in-fact is authorized to make the decision to withhold and the decision is consistent with the desires of the resident, or the desires of the resident are unknown and the decision is in the best interest of the resident. The attending physician must notify family members and afford them the requisite time to object to the withholding. Additionally, the resident must either be certified as being in a terminal condition, as set forth in Part B, below, or as being permanently unconscious, as set forth in Part C, below, as these terms are defined under Ohio law.

B. Life-Sustaining Treatment - Terminal Condition. In this situation, the attorney-in-fact may decide to withhold life-sustaining treatment if the attending and a consulting physician with a pertinent specialty examine the resident and determine that the resident is in a terminal condition. If it is desired that nutrition and hydration be withheld, the two physicians must additionally certify that nutrition and hydration will not or no longer will serve to provide comfort or alleviate pain.

C. Life-Sustaining Treatment - Permanently Unconscious. In this situation, the attorney-in-fact may decide to withhold life-sustaining treatment if the attending and a consulting physician with a pertinent specialty examine the resident and determine that the resident is in a permanently unconscious state. Nutrition and hydration can only be withheld if the durable power of attorney for health care contains a statement in capital letters, which has been initialed by the resident, that the resident desires to withhold nutrition and hydration when in a permanently unconscious state. The two physicians must additionally certify that nutrition and hydration will not or no longer will serve to provide comfort or alleviate pain.

3. Without Advance Directives.

Ohio law permits decisions to be made on behalf of a resident who has not executed a living will or durable power of attorney for health care under certain circumstances.

A. Surrogate Decisionmaker. Persons in the following order of priority may give consent to the withholding of life-sustaining treatment: (1) guardian; (2) spouse; (3) adult child or, if there is more than one, a majority of the adult children, whom the attending physician made a good faith effort and used reasonable diligence to notify and who are available within a reasonable period of time for consultation with the attending physician; (4) parents; (5) adult sibling or, if there is more than one adult sibling, a majority of the adult siblings who are available within a reasonable period of time for consultation with the attending physician; or (6) the nearest adult who is not one of the individuals described above, who is related to the resident by blood or adoption, and who is available within a reasonable period of time for consultation with the attending physician. The consent of the appropriate person must be in writing and witnessed by two qualified witnesses. The consent must be consistent with the resident's previously expressed intent regarding life-sustaining treatment, artificial nutrition or hydration; or the type of decision that the resident would have made as inferred from his or her lifestyle and character.

B. Life-Sustaining Treatment. The attending physician must determine that the resident is no longer able to make informed health care decisions and there is no reasonable possibility of regaining such capacity. The attending physician and one other physician must examine the resident and determine that either (1) the resident is in a terminal condition, or (2) the resident is currently is and for at least the immediately preceding twelve months has been in a permanently unconscious state. If it is desired that artificial nutrition and hydration be withheld from a resident with a terminal condition, then two physicians must additionally certify that artificial nutrition and hydration will not or no longer will serve to provide comfort care or alleviate pain.

C. Artificial Nutrition and Hydration - Permanent Unconsciousness. Nutrition and hydration may not be withheld from a resident in a permanently unconscious state pursuant to a request from the appropriate surrogate decisionmaker, unless the probate court of the county in which the resident is located issues an order

authorizing withholding.

d. With Legal Guardian.

Ohio law may permit a legal guardian to authorize the withholding of life-sustaining treatment. The scope of the guardian's authority will be verified by HCR Manor Care.

Additionally, Ohio law provides a procedure whereby a person receiving notice from the attending physician as to withholding treatment can object to such withholding by filing a complaint in the local probate court. The attending physician must record complete information in the resident's medical record to demonstrate that the decision of the Responsible Party to refuse treatment was made on the basis of informed consent and that all other federal and state law requirements have been satisfied.

DO NOT RESUSCITATE POLICY

CPR will be initiated without a specific physician's order or appropriate "Do Not Resuscitate Identification" when cardiac or respiratory arrest is recognized. A specific instruction is necessary if CPR is not to be initiated, except in instances in which CPR will be unsuccessful in restoring cardiac and respiratory function or when the resident has appropriate DNR Identification which identifies the person as not wanting CPR in certain instances. A valid DNRCC, DNRCC - Arrest, or other DNR Order precludes the otherwise automatic initiation of CPR.

The state of Ohio passed a law in 1998 that does two major things:

1. It provides for an identification system whereby a person can work with their physician and designate himself or herself as a person with a Do Not Resuscitate Order by using one of the state approved identifiers (i.e. form, bracelet, necklace);

2. It also provides for two types of Do Not Resuscitate Orders which will receive special protections under the law. They are known as Do Not Resuscitate-Comfort Care Orders ("DNRCC") and Do Not Resuscitate-Comfort Care - Arrest Orders ("DNRCC- Arrest"). The two orders have the same protocol of care. The difference lies in the timing of when the protocol is implemented.

If a resident is transported to the facility with a state recognized identification indicating that they are a DNRCC or DNRCC-Arrest, the facility should recognize that DNR status immediately and implement that protocol as appropriate. The facility should, however, receive a physician's order as soon as possible.

A Do Not Resuscitate Order can be entered only by the resident's attending physician, after consent has been obtained from the legal decisionmaker and the required documentation has been inserted into the resident's medical record, in accordance with HCR Manor Care's Do Not Resuscitate policy. The legal decisionmaker for a competent resident is, of course, the resident. The medical record must reflect that an informed decision was made by the competent resident after discussion of all aspects of CPR with the attending physician.

For an incompetent resident, entry of a Do Not Resuscitate order is appropriate only when the resident has either of the following physical conditions: (1) death is expected because of a terminal condition, or (2) a condition exists in which CPR would not be expected to render substantial improvement in the ultimate outcome. Additionally, the legally recognized surrogate decisionmaker must consent in writing to the entry of the Do Not Resuscitate order, and the medical record must reflect that such person made an informed decision after discussion of all aspects of the order with the attending physician. The legally recognized surrogate decisionmakers for purposes of the Do Not Resuscitate policy are the same as for a resident having no advance directives under the Limited Treatment Policy -

Ohio, described above.

Copies of the full policies are available upon request.

ATTACHMENT H

Ohio Department of Job and Family Services

Medicaid Resource Assessment Notice

Facility Name:		
Address:		
City:	State:	Zip:
County:		

- Federal regulations provide that, at the request of an institutionalized spouse or a community spouse, the State shall promptly assess and document the total value of the couple's resources that exist as of the beginning of the first continuous period of institutionalization.
- A resource assessment is a determination of the amount of countable resources a married couple owns as of the date of institutionalization of one of the spouses. This assessment allocates a portion of the resources to each spouse.
- All married persons who enter a medical institution and intend to remain for 30 days or longer are entitled to have a resource assessment completed by their local Department of Job and Family Services (CDJFS).
- If you request a resource assessment and you do not apply for Medicaid, you will be charged $50. If you request a resource assessment at the same time you apply for Medicaid, you will not be charged for the assessment. There is no charge to apply for Medicaid at any time.
- If you want a resource assessment, or if you want to apply for Medicaid, you may request that someone in your facility's social service department contact your local Department of Job and Family Services (CDJFS) on your behalf. You may also apply by contacting the CDJFS yourself or have someone else, such as a relative, friend, or attorney, apply for you. A resource assessment may be requested by you, your spouse, or a representative acting on behalf of you or your spouse.

☐ *Yes, I want the county Department of Job and Family Services (CDJFS) to complete a resource assessment.*

☑ *No, I am not requesting a resource assessment at this time.*

Resident Name (please print):	
Signature (resident or authorized representative): X Mary Banks	Date: 5/25/12

JFS 04080 (10/2005) 134

VOLUNTARY ARBITRATION AGREEMENT ("AGREEMENT")

THE PARTIES ARE WAIVING THEIR RIGHT TO A TRIAL BEFORE A JUDGE OR JURY OF ANY DISPUTE BETWEEN THEM. PLEASE READ CAREFULLY BEFORE SIGNING. THE PATIENT WILL RECEIVE SERVICES IN THIS CENTER WHETHER OR NOT THIS AGREEMENT IS SIGNED. ARBITRATION IS DESCRIBED IN THE VOLUNTARY ARBITRATION PROGRAM BROCHURE COPY, ATTACHED AND MADE PART OF THIS AGREEMENT.

Made on 8/15/12 (date) by and between the Patient Gary Banks or Patient's Legal Representative _____ (collectively referred to as "Patient") and the Center McIlroy.

1. Agreement to Arbitrate "Disputes": All claims arising out of or relating to this Agreement, the Admission Agreement or any and all past or future admissions of the Patient at this Center, or any sister Center operated by any subsidiary of HCR ManorCare, Inc.("Sister Center"), including claims for malpractice, shall be submitted to arbitration. Nothing in this Agreement prevents the Patient from filing a complaint with the Center or appropriate governmental agency or from seeking review under any applicable law of any decision to involuntarily discharge or transfer the Patient.

2. Demand for Arbitration: shall be written, sent to the other Party by certified mail, return receipt requested.

3. FAA: The Parties agree and intend that this Agreement, the Admission Agreement and the Patient's stays at the Center substantially involve interstate commerce, and stipulate that the Federal Arbitration Act ("FAA") and applicable federal case law apply to this Agreement, preempt any inconsistent State law and shall not be reverse preempted by the McCarran-Ferguson Act; United States Code Title 15, Chapter 20, or other law. Any amendment to such version of the FAA is hereby expressly waived.

4. Arbitration Panel: Three (3) arbitrators (the "Panel") shall conduct the arbitration. Each Party will select one Arbitrator, the two selected Arbitrators will select a third. Each Arbitrator must be a retired State or Federal Judge or a Member of the State Bar where the Center is located with at least 10 years of experience as an attorney. The Panel will elect a Chief Arbitrator who will be responsible for establishing and resolving issues pertaining to procedure, discovery, admissibility of evidence, or any other issue.

5. Sole Decision Maker: Except as otherwise provided in 6 below, the Panel is empowered to, and shall, resolve all disputes, including without limitation, any disputes about the making, validity, enforceability, scope, interpretation, voidability, unconscionability, preemption, severability and/or waiver of this Agreement or the Admission Agreement, as well as resolve the Parties' underlying disputes, as it is the Parties' intent to avoid involving the court system. The Panel shall not have jurisdiction to certify any person as a representative of a class of persons and, by doing so, adjudicate claims of persons not directly taking part in Arbitration.

6. Procedural Rules and Substantive Law: The Panel shall apply the State Rules of Evidence and State Rules of Civil Procedure except where otherwise stated in this Agreement. Also, the Panel shall apply, and the arbitration award shall be consistent with, the State substantive law, including statutory damage caps, for the State in which the Center is located, except as otherwise stated in this Agreement or where preempted by the FAA. The Panel's award must be unanimous and shall be served no later than 7 working days after the arbitration hearing. The award must state the Panels' findings of fact and conclusions of law, shall be marked "confidential", and must be signed by all three Arbitrators. If any damages are awarded, the award must delineate specific amounts for each type of damages awarded, i.e. economic, non-economic, etc. The failure of the Panel to issue a unanimous award creates an appealable issue, appealable to the appropriate court, in addition to those set forth in paragraph 7, below. In the event the appellate court finds a non-unanimous award invalid as against law or this Agreement, the award shall be vacated and the arbitration dismissed without prejudice. A subsequent arbitration, if any, of the same claim or claims shall remain subject to the terms of this Agreement.

7. Final with Limited Rights to Review (Appeal): The Panel's award binds the Parties. The Parties have a limited right of appeal for only the express reasons allowed by the FAA or as provided in 6, above.

8. Right to Change Your Mind: This Agreement may be cancelled by written notice sent by certified mail to the Center's Administrator within 30 calendar days of the Patient's date of admission. If alleged acts underlying the dispute occur before the cancellation date, this Agreement shall be binding with respect to those alleged acts. If not cancelled, this Agreement shall be binding on the Patient for this and all of the Patient's subsequent admissions to the Center or any Sister Center without any need for further renewal.

9. Binding on Parties & Others: The Parties intend that this Agreement shall benefit and bind the Center, its parent, affiliates, and subsidiary companies, and shall benefit and bind the Patient (as defined herein), his/her successors, spouses, children, next of kin, guardians, administrators, and legal representatives.

10. Fees and Costs: The Panels' fees and costs will be paid by the Center except in disputes over non-payment of Center charges wherein such fees and costs will be divided equally between the Parties. The Parties shall bear their own attorney fees and costs in relation to all preparation for and attendance at the arbitration hearing.

11. Confidentiality: The arbitration proceedings shall remain confidential in all respects, including all filings, deposition transcripts, discovery documents, or other materials exchanged between the Parties and the Panels' award. In addition, following receipt of the Panels' award, each Party agrees to return to the producing Party within 30 days the original and all copies of documents exchanged in discovery and at the arbitration Hearing.

12. Non-waiver of this Agreement: A waiver of the right to arbitrate a specific Dispute or series of Disputes, as described above, does not relieve any Party from the obligation to arbitrate *other* Disputes, whether asserted as independent claims or as permissive or mandatory counterclaims, unless each such claim is also individually waived. With multiple Patient admissions, the presentation of an arbitration agreement at a later admission to the Center or a Sister Center shall not constitute a waiver by the Center of a prior signed arbitration agreement.

13. Severability: Except as provided in 6, any provision contained in this Agreement is severable, and if a provision is found to be unenforceable under State or Federal law, the remaining provisions of this Agreement shall remain in force and effect. This Agreement represents the Parties' entire agreement regarding Disputes, supersedes any other agreement relating to disputes, and may only be changed in writing signed by all Parties. This Agreement shall remain in full force and effect notwithstanding the termination, cancellation or natural expiration of the Admission Agreement.

14. Health Care Decision: The Parties hereby stipulate that the decision to have the Patient move into this Center and the decision to agree to this Agreement are each a health care decision. The Parties stipulate that there are other health care facilities in this community currently available to meet the Patient's needs.

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 THIS VOLUNTARY AGREEMENT. PATIENT ACKNOWLEDGES THE RIGHT TO REVIEW THIS AGREEMENT WITH AN ATTORNEY OR FAMILY BEFORE SIGNING.

PATIENT:

Gary Banks 8/15/12
Printed Name (Date)

Gary Banks
Signature of Patient

CENTER REPRESENTATIVE

Darlene Spencer
Signature of Center Representative

PATIENT'S LEGAL REPRESENTATIVE:

Printed Name (Date)

Signature of Patient's Legal Representative[1] in his/her Representative capacity

Signature of Patient's Legal Representative in his/her Individual capacity

[1] Patient's Legal Representative should sign on both lines above containing the phrase "Patient's Legal Representative."

STATE OF OHIO)
) SS:
COUNTY OF CUYAHOGA)

Now comes Christine Pearson, and for her Affidavit, states as follows:

1. I am Gary Banks' biological sister.

2. Gary Banks was born with mental disabilities and he was diagnosed as Mentally Retarded/Developmentally Disabled ("MRDD").

3. Prior to his admission to ManorCare Health Services - Willoughby, Gary Banks had also been diagnosed with paranoid schizophrenia and MRDD.

4. I was Gary Banks' Health Care Power of Attorney from February 26, 2010 until his death.

5. Gary Banks was placed in special education classes throughout the entirety of his education.

6. Gary Banks had not received any formal education since 1983.

7. Gary Banks was unable to read or comprehend written documents due to his mental disabilities.

8. Gary Banks held odd jobs that were facilitated by The Gables. Such jobs included packing light bulbs and cleaning churches.

9. Gary Banks never held a job that required him to read or write.

10. The Gables arranged for, and provided, Gary Banks with transportation to and from his places of employment.

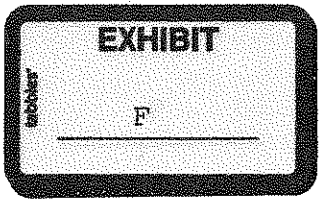
11. Gary Banks could not make appointments for himself.

12. The Gables scheduled Gary Banks' appointments and provided Gary Banks with transportation to and from his appointments.

13. The Gables and Gary Banks' family took care of his finances.

14. Although he could sign his name, Gary Banks was unable to write a check.

15. Gary Banks could not read books, magazines, letters, nor documents on his own.



16. Gary Banks was unable to conduct commercial transactions on his own because he could not properly count money, nor read or write.

17. Gary Banks was unable to discuss his medical conditions because he did not comprehend them.

18. Gary Banks did not cope well with changes and new environments.

19. Gary Banks enjoyed living at The Gables and wanted to return to live there.

20. Gary Banks was admitted to the Cleveland Clinic on August 7, 2012 and underwent a cervical corpectomy.

21. As Gary Banks' Health Care Power of Attorney, I consented to the cervical corpectomy.

22. I was not aware that Gary Banks was being discharged from Cleveland Clinic to ManorCare Health Services - Willoughby nursing home on August 15, 2012, until he was already admitted into ManorCare Health Services - Willoughby nursing home. As a result, I was not with Gary Banks during his admission to ManorCare Health Services - Willoughby nursing home.

23. I was not aware that Gary Banks had signed an Admission Agreement, that contained an arbitration clause, when he entered ManorCare Health Services - Willoughby nursing home.

24. No employee and/or agent at ManorCare Health Services - Willoughby nursing home, nor any of the Defendants, informed me that Gary Banks would be required to enter into an Admission Agreement, with an arbitration clause, when he entered ManorCare Health Services - Willoughby nursing home.

25. No employee and/or agent at ManorCare Health Services - Willoughby nursing home, nor any of the Defendants, discussed the Admission Agreement nor the arbitration clause, in any way, with me.

26. No employee and/or agent at ManorCare Health Services - Willoughby nursing home, nor any of the Defendants, asked me to be present during Gary Banks' admission to ManorCare Health Services - Willoughby in order to review any admission paperwork.

27. Gary Banks had no legal expertise.

28. Gary Banks had no experience with arbitration.

29. Gary Banks did not know what arbitration was.

30. Gary Banks did not know the difference between arbitration and litigation.

31. Gary Banks was unable to draft any type of document.

32. Gary Banks was unable to alter a legal document because he would have been unable to read the document and comprehend it.

33. Gary Banks would have signed anything he was asked to sign.

Affiant further sayeth naught.

Christine Pearson

Christine Pearson

Sworn to and subscribed before me in my presence this 11th day of February, 2014, in Beachwood, Ohio.

NOTARY PUBLIC

NOTARIAL SEAL STATE OF OHIO

MARK D. TOLLES, II
Attorney At Law
NOTARY PUBLIC
STATE OF OHIO
My Commission Has
No Expiration Date
Section 147.03 O.R.C.

Patient Name:	Gary Banks	Patient Number:	10639	Effective Date:	8/15/2012 21:29
Location:	2 250 - 1	Date of Birth:	3/21/1964	Gender:	M
Primary Language:	English	Physician:	Robert, Whitehouse		
Allergies:	ACE INHIBITORS(INTOLERANCE), LISINOPRIL(INTOLERANCE) NKFA				
Diagnosis:	NA				
Title:	Patient Admission / Readmission Screen - v4	Type:	Admission	Braden Scale for Predicting Pressure Sore Risk Score:	15.0
Braden Scale for Predicting Pressure Sore Risk Category:	Low Risk for Skin Breakdown				

1. PATIENT ADMISSION / READMISSION SCREEN

A. Vital Signs

Admitted / readmitted from:
1. 1) Hospital

Accompanied by:
2. 1) Paramedic/EMT

Attending physician notified of admission?
3. (•) a. Yes

Date / time physician notified:
4. 08/15/2012 21 00

Recent influenza vaccine:
5a. 3) Unable to determine

Date of influenza vaccine, if known:
5b.

Recent pneumococcal vaccine:
6a. 3) Unable to determine

Date of pneumococcal vaccine, if known:
6b.

Recent TB test:
7a. 3) Unable to determine

Date of TB test, if known:
7b.

TB test results:
7c. 3) Unknown

8. Most Recent Temperature — Temperature: 98.6 Date: 8/15/2012 22:59
Route: Oral

9. Most Recent Pulse — Pulse: 96 Date: 8/15/2012 22:59
Pulse Type: Regular

10. Most Recent Respiration — Respiration: 18.0 Date: 8/15/2012 22:59

11. Most Recent Blood Pressure — Blood Pressure: 105.0 / 70.0 Date: 8/15/2012 22:59
Position: Lying l/arm

12. Most Recent O2 sats — O2 sats: 98.0 (%) Date: 8/15/2012 22:59
Method: Room air

B. Mental Status

EXHIBIT
tabbies
G

Patient Name: Gary Banks Patient Number: 10639

B.	Mental Status	Inattention: Does pt. have difficulty focusing attention (easily distracted, out of touch or difficulty following what was said?) 1. a) Behavior not present Disorganized thinking: Is the patient's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)? 2. a) Behavior not present Altered level of consciousness: Does patient have altered level of consciousness e.g., vigilant-startled easily to any sound or touch; lethargic-repeatedly dozing off when being asked questions, but responds to voice or touch; stuporous-very difficult to arouse and keep aroused; comatose-could not be aroused. 3. a) Behavior not present	Psychomotor retardation: Does the patient have an unusually decreased level of activity such as sluggishness, staring into space, staying in one position, moving very slowly? 4. c) Behavior present, fluctuates (comes & goes, changes in severity) Cognitive Skills for Daily Decision Making: Made decisions regarding tasks of daily life 5. b) Modified independence: some difficulty in new situations
C.	Oral/Dental/ Hearing/Speech/Vision	9. ☑ None of the above	Check all that apply: Hearing, Speech, Vision 10. Persistent vegetative state: ◉ b. No 11. Ability to hear a) Adequate 12. Hearing aid(s) ◉ b. No 13. Speech clarity a) Clear 14. Makes self understood b) Usually understood 15. Ability to see in adequate light a) Adequate 16. Corrective lenses ◉ b. No
D.	Respiratory	Check all that apply:	7. ☑ None of the above were present
E.	Cardiovascular	Check all that apply: 4. ☑ None of the above Amputation 5a. Affected side: 4) N/A 5b. Location: 4) N/a	Pedal pulse 6a. Right 1) Strong 6b. Left 1) Strong Pedal edema 7a. Right 2) No 7b. Left 2) No
F.	Bladder & Bowel	Check all that apply: 1. Dialysis 3) Not applicable	8. ☑ None of the above 9. ☑ Bowel sounds present
G.	Functional Status	Check all that apply. Indicate the level of function that best matches the patient's abilities observed on admission.	

G.	Functional Status	Check all that apply. Indicate the level of function that best matches the patient's abilities observed on admission. I= Independent, A=Assistance, D=Dependent,	14. ☑ None of the above

U=Unkown/Not tested

1.	Ambulation	3
2.	Bed mobility	3
3.	Bathing	3
4.	Dressing	3
5.	Eating	2
6.	Toileting	2
7.	Transfer	3

H. Exit Seeking

Check all that apply.

5. [x] None of the above

I. Fluid

7. [x] None of the above

J. Fall Risk

1. [ ] History of falls
2. [ ] Syncope / dizziness / vertigo
3. [x] Unsteady gait
4. [x] Muscle weakness / numbness / tightening
5. [ ] Urinary / fecal incontinence
6. [ ] Appliances / devices in use
7. [ ] Diuretic medication
8. [ ] Psychotropic medication
9. [ ] Cardiovascular medication
10. [x] Underlying health conditions that may predispose patient to falls
11. [ ] No vitamin D prescribed, patient is >65 yrs. old

K. Pain

1. Presence of pain (•) 2. No
3. Received PRN medications? (•) 1. Yes

At any time in the last 5 days, has the patient:

2. Been on a scheduled pain medication regimen? (•) 1. Yes
4. Received non-medication intervention for pain? (•) 1. Yes
5. Does patient have a condition or disease causing or likely to cause pain / discomfort? (•) 1. Yes

L. Documentation

Include additional observations / comments not captured in the above questions

1. PT. DENIES PAIN OR DISCOMFORT AT THIS TIME

2. TREATMENTS / PROCEDURES

A. Treatments & Procedures

1. [ ] CA Chemotherapy
2. [ ] Radiation (continuing from acute care)
3. [ ] IV medications (continuing from acute care. Do Not Include flushes used to maintain patency)
4. [ ] Transfusions (within the last 14 days prior to admission to this facility)
5. [ ] Isolation (DO Not Include: standard body / fluid precautions)
6. [ ] Internal bleeding (Do Not Include: bleeds that are easily controlled such as nose bleeds, menses or small amounts of red blood cells / urinalysis)
7. [ ] Hospice
8. [x] Insulin
9. [ ] Active MDRO Infection
10. [ ] End stage prognosis

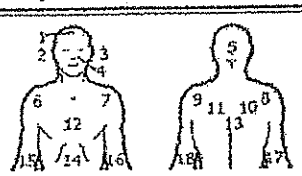
3. SKIN

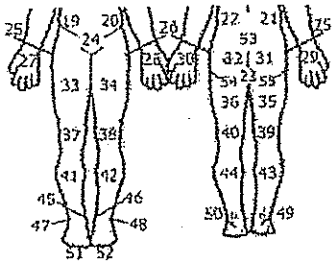
Z. Skin

Patient Name: Gary Banks Patient Number: 10639

Z. Skin

1.





Site	Description
Other (specify)	RIGHT NECK INCISION STERI STRIPS INTACT
36) Left thigh (rear)	1.4X1.3X<0.1 OPEN BLISTER DARKENED SKIN
Other (specify)	DRY SKIN BILAT FEET

4. BRADEN RISK ASSESSMENT SCALE

A.	Sensory Perception	Ability to respond meaningfully to pressure-related discomfort 3. Slightly Limited: Responds to verbal commands, but cannot always communicate discomfort or the need to be turned OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.
B.	Moisture	Degree to which skin is exposed to moisture 3. Occasionally Moist: Skin is occasionally moist, requiring an extra linen change approximately once a day.
C.	Activity	Degree of physical activity 2. Chairfast: Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.
D.	Mobility	Ability to change and control body position 2. Very Limited: Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.

Patient Name: Gary Banks Patient Number: 10639

E.	Nutrition	Usual food intake pattern, 3. Adequate: Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs
F.	Friction & Shear	2. Potential Problem: Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time

[but occasionally slides down.

SIGNED SECTIONS

Signed By	Sections	Signed Date
Courtney Laurich, [ESOF]	1, 2, 3, 4	8/15/2012

DIRECTIONS:
Mark and list items brought for the personal use of the resident/patient.
Please bring additional items to the Nurse's Station for proper handling.

INVENTORY OF PERSONAL EFFECTS

Resident's/Patient's washable clothing to be: ☐ taken home for laundering ☑ laundered at facility/community/center

QTY	ARTICLES	DATE
	Clothing / Personal Affects	
	Belts / Suspenders	
	Billfolds / Wallets	
	Blouses / Shirts	
	Brassieres	
	Cash *(see Items of Specific Value)*	
	Coats	
	Comb / Brush	
	Contact Lenses	
	Credit Cards / Debit Cards / Checks	
	Dresses	
	Furs	
	Girdles	
	Glasses	
	Gloves	
	Handkerchiefs	
	Hats	
	Hose	
	Housecoats / Robes	
	Jewelry	
	Nightgowns / Pajamas	
	Overnight Case / Luggage	
	Pocketbooks / Handbags	
	Scarfs	
	Shaving Kit / Electric Razor	
	Shoes	
	Skirts	
	Slacks	
	Slippers	
	Slips	
	Socks/Nylons	
	Sports Jackets	
	Suits	
	Sweaters	
	Sweatsuits/Warm Up Suits	
	Ties	
	Toothbrush	
	Undershirts	
	Underwear / Panties	
	Other:	
	Other:	
	Appliances / Furniture	
	Radio	
	Television / DVD / VCR	
	Assistive Devices	
	Commode	
	Crutches	
	Dentures: Upper - ☐ Full ☐ Partial Lower - ☐ Full ☐ Partial	
	GeriChair	
	Hearing Aid: Right - Make _____ Model _____ Serial # _____ Left - Make _____ Model _____ Serial # _____	
	Prosthesis	
	Walker / Cane	
	Wheelchair	
	Other:	

ITEMS OF SPECIFIC VALUE

Description	Value $	Date

ITEMS STORED IN FACILITY/COMMUNITY/CENTER SAFE

Description	Value $	Date

ACQUIRED AFTER ORIGINAL ENTRY

Date	Item	How Received

NOTES ON ARTICLES (Listing of items damaged, etc.)

Lotion Stuffed animal
Balloon

REMARKS

EXHIBIT
Witness H

ON ADMISSION / MOVE IN

I agree that the above is a correct listing of the personal belongings that I have chosen to keep in my possession while I am a resident/patient at this facility/community/center. I take full responsibility for these items and any other personal effects brought to me.

Signature of Resident / Patient / Responsible Party	Date
Gary	8.15.12
Signature of Staff	**Date**
Gary Banks	8.15.12

ON DISCHARGE / MOVE OUT

Upon discharge/move-out, personal items are sent with resident/patient or picked up by responsible party. Upon transfer, personal items are to be boxed and placed in designated storage area for safe keeping (or handled per facility/community/center policy).

Signature of Resident / Patient / Responsible Party	Date
Signature of Staff	**Date**

Resident / Patient Name: Last	First	Middle	Room Number	Resident / Patient Number	Admission Date
Banks	Gary		290	161859	8/8/12

Form # MP5413 05/06

Reorder From: MED•PASS® 800-438-6084

XPM 121154

Cleveland Clinic

59944592
599445920004
Banks, Gary
Male 3/21/1964

9500 Euclid Ave
Cleveland, OH 44195

H&P signed by Jeffrey (Res) Mullin at 07/20/12 2305

Author:	Jeffrey (Res) Mullin	Service:	Neurosurgery	Author Type:	Resident
Filed:	07/20/12 2305	Note Time:	07/20/12 2228	Note Type:	H&P

Cleveland Clinic

HISTORY AND PHYSICAL EXAMINATION

PLEASE DO NOT REMOVE FROM THE CHART OR MODIFY PRINTED COPY

Patient Name: Gary Banks
MRN: 59944592

PRIMARY CARE PHYSICIAN: Robert J Whitehouse, MD

CHIEF COMPLAINT: "stretch a lot"

HPI: This is a 48 year old male w pmhx of schizophrenia, htn, venous insufficiency, mental retardation, group home resident who presents with new MRI findings. Patient is poor history and repeatedly stated he in in hospital because he "stretches a lot". OSH notes are scant, seems patient had MRI today and was sent to ED following imaging from there admission was arranged to CCF based upon MRI. Patient recently seen by neurology at CCF for gait difficulty. Plan at that time was to obtain MRI of brain and C spine. At outpatient visit concern was for slight LUE weakness and gait difficulty, patient has been reliant upon a walker for the past few months, previously required cane.
Patient denies pain, numbness, change in bowel or bladder function.

Per chart review has been taking Ketoprofen, according to uptodate half life is Regular release: 2-4 hours; Renal impairment: Mild: 3 hours; moderate-to-severe: 5-9 hours Extended release: ~3-7.5 hours

PAST MEDICAL HISTORY: No past medical history on file.

PAST SURGICAL HISTORY: No past surgical history on file.

FAMILY HISTORY: No family history on file

SOCIAL HISTORY:
Tobacco Use: Never
Alcohol Use: Not on file

MEDICATIONS:

EXHIBIT
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Wickliffe Country Place
AGREEMENT TO RESOLVE LEGAL DISPUTES THROUGH ARBITRATION

This Agreement to Resolve Legal Disputes Through Arbitration ("Agreement") is made and entered into this day of 3/19/2013, by and between 3G Operating Company ("Wickliffe Country Place"), Gary Banks ("Resident"), and Christine Pearson ("Representative").

The parties wish to work together to resolve any legal disputes in a timely fashion and in a manner that they believe will minimize both of their legal costs. Therefore, in consideration of the mutual promises contained in this Agreement, Resident, Representative and Wickliffe Country Placehereby agree to submit disputes that represent a recognized cause of action in a court of law to binding arbitration, as follows:

A. **Disputes to Be Arbitrated.** Any legal controversy, dispute, disagreement or claim of any kind now existing or occurring in the future between the parties arising out of or in any way relating to this Agreement or the Resident's stay at Wickliffe Country Placeshall be settled by binding arbitration, including, but not limited to, all claims based on breach of contract, negligence, medical malpractice, tort, breach of statutory duty, resident's rights, and any departures from accepted standards of care. This includes claims against Wickliffe Country Place, its employees, agents, officers, directors, any parent, subsidiary or affiliate of Wickliffe Country Place.

B. **Binding Nature of Arbitration.** The decision rendered by the arbitrator shall be final and binding, and judgment on the award, if any, shall be entered in accordance with applicable law in any court having jurisdiction thereof. There shall be no appeal of the arbitrator's decision by either party. The decision of the arbitrator shall be binding on all of the parties to the arbitration, and also on their successors and assigns, including the agents and employees of Wickliffe Country Place, and all persons whose claim is derived through or on behalf of Resident, including, but not limited to, that of any parent, spouse, child, guardian, executor, administrator, legal representative, or heir of Resident.

C. **Who Will Conduct Arbitration.** The arbitration shall be conducted by National Arbitration and Mediation ("NAM"). Information regarding NAM and a copy of pertinent rules and forms may be located at NAM's website, www.namadr.com; by contacting NAM toll-free at 800-358-2550, by fax at 516-794-8518; or at 990 Stewart Avenue, Garden City, NY 11530. If the NAM process is no longer in existence at the time of the dispute, or NAM is unwilling or unable to conduct the arbitration, then the parties shall mutually agree on an alternative organization to conduct the arbitration.

D. **Costs of Arbitration.** The parties agree that all filing fees shall be shared equally by Resident and Wickliffe Country Place. Thereafter, each party agrees to be responsible for their own fees, expenses and costs as attributed to them pursuant to the NAM rules and procedures, unless ordered otherwise by the arbitrator. Each party agrees to be responsible for their own attorney fees and costs, if any.

E. **How to Request Arbitration.** Any party desiring arbitration shall file a claim with NAM. All necessary forms, rules and procedures are available through NAM, and claims may be submitted online.

F. **Rules of Arbitration.** Regardless of who conducts the arbitration, it shall be conducted in accordance with the NAM rules and procedures, which are hereby incorporated into this Agreement by reference. Except as set forth in the NAM rules and procedures, the arbitration proceedings shall follow all rules of civil procedure and evidence. Statutes of limitation and award caps that would be applicable to a comparable civil action brought in an appropriate court in the county in which Wickliffe Country Placeis located shall apply to the arbitration and any award. All claims based in whole or in part on the same incident, transaction, or related course of care and services provided by Wickliffe Country Placeto Resident shall be arbitrated in one proceeding. A claim shall be waived and forever barred if it arose prior to the date upon which notice of arbitration is received by Wickliffe Country Placeor the Resident,

EXHIBIT
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and is not presented in the arbitration proceeding.

G. Laws Governing Arbitration. The parties agree that Wickliffe Country Placeis engaged in interstate commerce and that this agreement to arbitrate disputes and the arbitration proceeding shall be governed in accordance with the Federal Arbitration Act. If for any reason there is a finding that the Federal Arbitration Act cannot be applied to this Agreement, then the parties hereby make clear their intent that their disputes/claims be resolved pursuant to Chapter 2711 of the Ohio Revised Code, and that the parties do not want their disputes/claims resolved in a judicial forum.

H. Confidentiality. Resident, Representative, and Wickliffe Country Placeagree to keep all arbitration proceedings strictly confidential, and hereby direct any organization overseeing the arbitration process, and any arbitrator to do the same. The fact that a dispute was settled or a judgment issued, and the details of the foregoing, may not be released without an express written authorization from both the Resident and Wickliffe Country Place, unless otherwise required by law.

I. Binding Effect. This Agreement shall be binding upon the parties hereto and their respective heirs, executors, administrators, successors, and permitted assigns.

J. IMPORTANT TERMS TO UNDERSTAND. By signing this Agreement, Resident and Representative acknowledge that they have been informed that: (1) This arbitration provision shall not limit in any way their right to file formal or informal complaints with Wickliffe Country Place, the state of Ohio under R.C. 3721.17, or the Federal government, including the right to challenge a proposed discharge pursuant to R.C. 3721.16 to 3721.162; (2) Agreeing to arbitrate legal disputes is not a condition of admission, and care and treatment will be provided whether or not they agree to arbitrate (if they do not wish to sign this Agreement then they are under no requirement to do so); (3) This arbitration provision does not limit their rights to bring any action that they could bring in a court of law, it merely changes the forum in which such an action must be brought; (4) Other than changing the forum for lawsuits, this Agreement does not waive any of the resident's rights as provided for in R.C. 3721.10 through 3721.17; (5) The decision whether to sign the Agreement with the arbitration provision is solely a matter for their determination without any influence; (6) They have the right to seek legal counsel regarding this arbitration provision; and (7) THE AGREEMENT WAIVES THEIR RIGHT TO A TRIAL IN COURT AND A TRIAL BY A JURY FOR ANY LEGAL CLAIMS THEY MAY HAVE AGAINST THE FACILITY.

RIGHT TO CANCEL AGREEMENT

Resident, Representative, or the Resident's spouse or the personal representative of the Resident's estate in the event of the Resident's death or incapacity, has the right to cancel this Agreement by notifying Wickliffe Country Placein writing. Such notice must be sent via certified mail to the attention of the Administrator of Wickliffe Country Place, and the notice must be post marked within thirty (30) days of the date upon which this Agreement was signed. Instead of mailing, the notice may be hand-delivered to the Administrator within the same thirty (30) day time period. The filing of a claim in a court of law within the thirty (30) days provided for above will cancel this Agreement without any further action by the Resident or Representative.

IN WITNESS WHEREOF, the parties, intending to be legally bound, have signed this Agreement as of the date first above written.

Gary Banks	Christine Pearson	Wickliffe Country Place
decline — LB	Sign. Christine Pearson	
Signature 3/19/2013	Signature 3/19/2013	Signature 3/19/2013

OHIO DEPARTMENT OF HEALTH

246 North High Street
Columbus, Ohio 43215

614/466-3543
www.odh.ohio.gov

Ted Strickland/Governor

Alvin D. Jackson, M.D./Director of Health

April 2, 2008

Jean Thompson
Executive Director
Ohio Assisted Living Association
1335 Dublin Road, Suite 221 – B
Columbus, Ohio 43215

RE: Binding Arbitration Agreements in Long-Term Care and Residential Care Facilities

Dear Ms. Thompson:

Dr. Alvin D. Jackson, Director of the Ohio Department of Health ("ODH"), received and reviewed your November 30, 2007 letter regarding the use of binding arbitration clauses in long-term and residential care admission agreements. Specifically, your letter stated that ODH's decision to cite facilities with a licensure deficiency if they enter into binding arbitration agreements with residents "is in violation of Ohio and federal law and policy." Since Dr. Jackson's receipt of your letter, I have also had the opportunity to review it, as well as the case and statutory law you presented in support of your position.

At the outset, please note that ODH has not decided to issue licensure citations to all long-term and residential care facilities that enter into binding arbitration agreements with residents. Rather, ODH has concerns about residential care and nursing home facilities that secure waivers of the rights guaranteed under Ohio's "Patients' Bill of Rights," otherwise known as "residents' rights."

Ohio's Patients' Bill of Rights was enacted in 1978 and codified in Chapter 3721 of the Revised Code. This statute sets forth a non-exhaustive list that guarantees rights relating to safety, treatment and care, privacy, and the exercise of civil rights to residents of long term and residential care facilities. (R.C. 3721.13(A)). The goal of this enactment "was not to give special treatment to residents of nursing homes [but] to restore those human rights which have been eroded by misunderstanding, administrative convenience, or neglect." *Cramer v. Auglaize Acres* (2007), 113 Ohio St.3d 266, 268, 2007-Ohio-1946, quoting Ohio Nursing Home Comm., 113th Gen. Assembly, Final Report (July 1979).

Chapter 3721 of the Revised Code contemplates that residents' rights are not just those specific rights enumerated in R.C. 3721.13, but are also all of the protections afforded to residents in accordance with R.C. 3721.10 to 3721.17. R.C. 3721.13(A)(15) states that a resident has the right to exercise all "civil rights," which rights the resident may not waive (R.C. 3721.13(C)). The term "civil rights" is not specifically defined, but it appears that civil rights encompass those

EXHIBIT
tabbies
K

rights set forth in R.C. 3721.17, i.e., the right to file a grievance with the grievance committee established in R.C. 3721.12, to file a report with ODH, and to file a civil lawsuit in a court against any person or home committing the residents' rights violation.

Over the last several years, residential care and nursing home facilities have been incorporating with greater frequency provisions that seek waiver of the facilities' Chapter 3721 statutory obligations into resident admission agreements. These waiver provisions include binding arbitration provisions that require residents to give up statutory rights set forth in R.C. 3721.17 to seek redress in an administrative or court forum for residents' rights violations.

Additionally, facilities are also incorporating other waiver provisions into resident admission agreements that relieve them from statutory obligations. Such provisions increase the resident's burden of proof; limit the facility's statutory liability; limit the facility's responsibility to provide adequate and appropriate medical treatment and nursing care; and result in the waiver of residents' rights to specified statutory remedies. Some of these agreements contain limitations that prohibit or substantially limit a resident's enforcement of statutory civil rights, irrespective of the forum used to enforce those rights. At times, the alteration of statutory residents' rights may be contained in rules of a specified arbitration forum that are not made available to a resident in advance of securing the binding arbitration agreement.

These waiver provisions, including binding arbitration agreements, raise significant public policy considerations. First, long-term and residential care admission agreements that include binding arbitration clauses and other statutory waivers are frequently contracts of adhesion, and are presented by facilities on a "take it or leave it" basis. Consequently, residents and family members are usually not given the opportunity to negotiate contractual terms. Because the placement of a resident in a long-term care facility is a hectic, stressful, and overwhelming experience, residents and their loved ones may not have the time to participate in protracted negotiations regarding the terms of admission agreements. Further, residents and family members frequently find that admission agreements are extremely lengthy and written in complicated "legalese" that can only be explained by an attorney. Few, if any, individuals have legal counsel who can review the terms of admission agreements and explain the impact of each clause and provision. Indeed, the terms of admission agreements are frequently explained by employees of the facility, who may not understand the contractual provisions or may inadvertently misrepresent the legal effect of certain terms in the agreement.

Second, waiver provisions in long-term and residential care admission agreements are often one-sided and drafted to favor the facility itself. In the case of binding arbitration agreements, many of these provisions require residents to arbitrate their disputes with the facility, but still enable the facility to sue the residents in court for non-payment of fees and other contractual breaches. Moreover, binding arbitration clauses often require the use of specific arbitrators or arbitration agencies that have been utilized by the facility in the past. Thus, a resident is unable to participate in the selection of an impartial and objective arbitrator.

Third, while binding arbitration is frequently promoted as a less expensive means of resolving disputes, this may not be applicable to nursing home and residential care facility residents. There is no evidence that binding arbitration is a less expensive or more advantageous forum for residents than that of a judicial forum. In fact, in many cases it is exactly the opposite. The

resident's filing fee alone can in some cases cost over a thousand dollars, with additional and substantial fees for requesting subpoenas or dispositive orders and filing objections. Requirements that a non-prevailing resident must pay the facility's costs and attorneys' fees are sometimes required by the arbitration rules but are not clearly specified in the arbitration agreement. These factors undoubtedly not only serve as a barrier to residents exercising their statutory rights, but also have a chilling effect on the filing of valid complaints by residents. Residents without substantial monetary resources may not be able to afford the cost of securing their residents' rights through arbitration, or afford to take the risk of having to pay the facility's attorneys' fees.

Clearly, the use of binding arbitration provisions and other statutory waiver clauses in resident admission agreements benefits facilities at the expense of the residents that they are supposed to protect. ODH believes that the only way to ensure that the civil rights of residents are protected is to enforce R.C. 3721.13(C) in cases where residential care and nursing home facilities ask residents to waive residents' rights. To that end, late last year, ODH announced at a providers' meeting that ODH would be looking more closely at admission agreements and would be citing facilities that require a resident to enforce his or her residents' rights through arbitration rather than a judicial forum contemplated in R.C. 3721.17.

In your letter, you made several arguments about ODH's announcement. First, you argued that Ohio courts have upheld arbitration provisions in skilled nursing facility admission agreements. ODH recognizes that, in the absence of unconscionability, a few Ohio courts have upheld binding arbitration agreements in the nursing home context. It is not clear, however, that the cited cases involved arbitration of alleged violations pursuant to R.C. §§ 3721.10 to R.C. 3721.17.

Second, you contended that a resident who has signed a binding arbitration agreement is not foreclosed from asserting civil rights protections outlined in R.C. 3721.17. Specifically, you argue that R.C. 3721.17 does not provide residents with the civil right to file a claim in a particular court or venue, and that any claims that residents may have under R.C. 3721.17 may be brought before the arbitrator. However, ODH believes that R.C. 3721.17 *does* provide such a civil right. As previously noted, a resident that signs a general binding arbitration agreement may not commence an action in court, which is a statutory right provided for in R.C. 3721.17(I). Further, a resident would not be able to pursue an administrative complaint with ODH because an arbitrator does not have the statutory authority to fine the facility for an asserted residents' rights violation as provided in R.C. 3721.17. Thus, residents that sign a general binding arbitration agreement would be precluded from a hearing before an ODH-appointed administrative hearing officer in the case of transfer or discharge in accordance with R.C. 3721.16 to 3701.162. The Ohio General Assembly set forth specific statutory civil rights in R.C. 3721.17 that a resident may pursue in the case of an allegation of a denial of residents' rights. Nursing homes and residential care facilities are using binding arbitration clauses and other waivers specifically designed to substantially limit those rights and subvert the purpose of the Ohio Patients' Bill of Rights.

Third, you asserted that ODH exceeded its authority by reaching its conclusion regarding binding arbitration agreements, and that ODH must promulgate administrative rules to enforce such conclusion. However, as previously stated, ODH believes that state law (specifically, R.C.

3721.13(C) and R.C. 3721.17) prevent a facility from including binding arbitration clauses in resident admission agreements. Further, there is no basis for the assertion that in general, ODH must promulgate administrative rules to make sure that its legal interpretations are "properly vetted" by the general public and legislature. Any time ODH proposes to deny, suspend or revoke a facility's license based upon the facility's non-compliance with an ODH interpretation of a statute or administrative rule, that facility is entitled to request an administrative hearing in accordance with Chapter 119 of the Ohio Revised Code. Any appeal of the Director's decision that is alleged to be arbitrary, capricious, unreasonable, or contrary to law would be appropriately reviewed by a court of competent jurisdiction.

Finally, you stated that arbitration is favored both nationally and in Ohio, and ODH's interpretation of the law is preempted by the Federal Arbitration Act (the "FAA"). It should be noted that ODH takes no position on whether arbitration agreements, binding or otherwise, are "favored" or "unfavored." Indeed, ODH recognizes that state and federal courts will generally enforce a contract between parties requiring claims to be submitted to binding arbitration. In the context of nursing homes or residential care facilities, the true issue is not whether arbitration agreements are generally favored, but: 1) whether a resident may *waive* a residents' right enumerated in R.C. Chapter 3721, which would necessarily arise in a case where a facility is seeking a broad-based binding agreement to arbitrate all claims of the resident; and 2) whether ODH may cite a home that has procured an agreement from a resident to waive such rights.

ODH's position is that the civil rights set forth in R.C. 3721.10 to 3721.17 have been specifically enacted by the Ohio General Assembly to ensure that each resident has specific avenues for redress of alleged residents' rights violations, and that these civil rights may not be waived by the resident. As such, ODH has interpreted R.C. 3721.13 to bar a resident from waiving the right to seek redress in a court of law in accordance with R.C. 3721.17. You have raised the issue of whether ODH is precluded by the FAA from citing a facility that has procured a binding arbitration agreement from a resident that waives the resident's civil right to seek redress in a court of law or administrative forum. The Federal Arbitration Act was enacted by Congress in 1925 pursuant to its power over admiralty and interstate commerce. The FAA's principal objective was to enforce arbitration agreements made by the parties to interstate commerce and maritime transactions. *Dean Witter Reynolds Inc. v. Byrd,* 470 U.S. 213, 219-220 (1985). Section 2 of the FAA, codified at 9 U.S.C. § 2, reads:

> A written provision in any maritime transaction or a contract evidencing a transaction involving commerce to settle by arbitration a controversy thereafter arising out of such contract or transaction, or the refusal to perform the whole or any part thereof, or an agreement in writing to submit to arbitration an existing controversy arising out of such a contract, transaction, or refusal, shall be valid, irrevocable, and enforceable, save upon such grounds as exist at law or in equity for the revocation of any contract.

When ODH reviewed this issue last year, court decisions that examined whether the FAA preempts state residents' rights law were mixed. Several courts addressing this specific issue found that the FAA does *not* apply to nursing home admission contracts under a variety of legal theories, some of which would require ODH to look at each arbitration agreement on a case-by-

case basis to determine whether the FAA precluded enforcement of R.C. 3721.13. However, most recently, ODH found a federal district court opinion that directly addresses the role of the state in enforcing residents' rights laws relating to non-mandatory binding arbitration agreements through licensure actions. This case, while not controlling in Ohio, supports the argument that the FAA preempts state law and therefore prohibits a state from enforcing non-waiver provisions similar to that found in R.C. 3721.13. Therefore, as a general rule, ODH will not be citing residential care or nursing home facilities that include non-mandatory binding arbitration clauses in their contracts at the time of admission to the extent that the agreement changes the *forum* where the case will be heard.

However, ODH will continue to cite facilities that seek waivers of substantive rights outlined in the residents' rights statutes (R.C. 3721.10 to 3721.17), including those waivers that increase a resident's statutory burden of proof or liability, or limit the facility's responsibility to provide adequate and appropriate medical treatment and nursing care or a reasonably secure environment for the resident's possessions. ODH also will continue to cite facilities for using resident admission agreements that require arbitration in lieu of exercising the following civil rights:

- the right to file a complaint with ODH under R.C. 3721.17; and
- the right to a hearing before an administrative hearing officer appointed by ODH and the right to any court appeals in the case of a R.C. 3721.16 to 3721.162 transfer or discharge hearing.

ODH will continue to expect any binding arbitration agreement to contain clear and concise statutory references excepting the above from arbitration. Moreover, ODH does not believe that the FAA prevents a state from prohibiting nursing homes from requiring residents to sign binding arbitration agreements as a condition of entering a Medicaid certified facility. Accordingly, if this becomes an issue in the future, ODH will address it at that time.

ODH appreciates your views on binding arbitration agreements, and will be happy to engage in further discussions on this and other waiver of residents' rights issues. If you have any questions or require additional information, please do not hesitate to contact me at (614) 466-4882.

Sincerely,

WMF

Winston M. Ford
General Counsel
Ohio Department of Health

cc: Alvin D. Jackson, M.D., Director of Health

Healthcare Due Process PROTOCOL
AMERICAN ARBITRATION ASSOCIATION
AMERICAN BAR ASSOCIATION
AMERICAN MEDICAL ASSOCIATION
COMMISSION ON HEALTH CARE DISPUTE RESOLUTION
FINAL REPORT
July 27, 1998

The views expressed herein have not yet been approved by the ABA House of Delegates or the Board of Governors of the American Bar Association and accordingly should not be construed as representing the policy of the American Bar Association. Similar approval processes are also necessary at the AAA and AMA.

I. INTRODUCTION

In the Fall of 1997, the leading associations involved in alternative dispute resolution, law, and medicine collaborated to form a Commission on Health Care Dispute Resolution (the Commission). The Commission's goal was to issue, by the Summer of 1998, a Final Report on the appropriate use of alternative dispute resolution (ADR) in resolving disputes in the private managed health care environment. This Final Report discusses the activities of the Commission from its formation in September 1997 through the date of this report, and sets forth its unanimous recommendations.

II. SUMMARY OF RECOMMENDATIONS

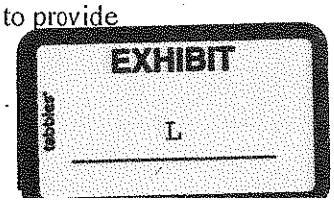
The Commission unanimously makes the following recommendations:

- Alternative dispute resolution can and should be used to resolve disputes over health care coverage and access arising out of the relationship between patients and private health plans and managed care organizations.
- Alternative dispute resolution can and should be used to resolve disputes over health care coverage and access arising out of the relationship between health care providers and private health plans and managed care organizations.
- In disputes involving patients, binding forms of dispute resolution should be used only where the parties agree to do so after a dispute arises.
- It is essential that due process protections be afforded to all participants in the ADR process.
- Review of managed health care decisions alternative dispute resolution complements the concept of internal review of determinations made by private managed health care organizations.

These findings and recommendations are articulated in detail in this Final Report. They are meant to provide guidance not only to private managed health care organizations considering the voluntary adoption of ADR programs as a form of review of plan determinations, but also to legislative and regulatory bodies considering the establishment of standards governing the use of ADR in the health plan environment.

III. FORMATION OF THE COMMISSION

In August 1997, leaders of the American Arbitration Association (AAA), American Bar Association (ABA), and American Medical Association (AMA) met in Chicago and determined to form a commission to study and make recommendations on the appropriate use of ADR in the private managed health care environment. This first time joint effort by the AAA, ABA, and AMA underscored the need to provide



the public with a fast, just, and efficient system of resolving health care disputes without having to resort to costly and time-consuming court litigation.

In forming the Commission, the convening institutions expressed the hope that as the health care environment continues to evolve, the dispute resolution models and due process safeguards developed by the Commission will be implemented by managed health care organizations across the nation to give consumers the opportunity to have a prompt resolution of their disputes, while at the same time assuring that the parties' Constitutional and other legal rights and remedies are protected. A concomitant goal was to provide guidance to legislative and related bodies who are developing systems to regulate the managed health care relationship.

Another main goal identified in the early stages of the Commission's deliberations is promoting greater awareness and understanding of the use of mediation, arbitration, and other out-of-court settlement techniques as methods for resolving disputes over health care coverage and access in the managed health care environment.

The conveners established the following objectives of the Commission: studying and making recommendations on the application of alternative dispute resolution to coverage and access issues in the managed health care arena, the development of appropriate due process standards to be applied to ADR in this context, and the development of model ADR procedures for use in managed health care relationships.

In the weeks following the Chicago organizational meeting, each institution named its representatives to the Commission, and the first working session took place on September 22, 1997, in Chicago.

Each of the convening institutions possesses expertise and guidance essential to the success of the Commission:

> The leader in conflict management since 1926, the American Arbitration Association is a not-for-profit, public service organization dedicated to the resolution of disputes through the use of negotiation, mediation, arbitration, and other voluntary dispute settlement techniques. In 1997, more than 78,000 cases were filed with the Association in a full range of matters. Through 37 offices nationwide and cooperative agreements with arbitral institutions in 38 other nations, the AAA provides a forum for the hearing of disputes, rules and procedures and a roster of impartial experts to hear and resolve cases.
>
> The American Bar Association is the world's largest voluntary professional association with more than 392,000 members. As the national voice for the legal community, the ABA's mission is to serve the public and the profession by promoting justice, professional excellence, and respect for a just rule of law.
>
> The American Medical Association is the nation's leading organization of physicians. Formed more than 150 years ago, the AMA is a partnership of physicians and their professional associations dedicated to promoting the art and science of medicine and the betterment of public health. The AMA serves its nearly 300,000 member physicians and their patients by establishing and promoting ethical, educational, and clinical

standards for the medical profession and by advocating for the highest principle of all -- integrity of the patient/physician relationship.

The Commission met as follows:

- September 22, 1997 in Chicago
- October 27, 1997 in Chicago
- December 8, 1997 in New York City
- January 12, 1998 in Washington
- March 6, 1998 in New York City
- April 29, 1998 in Washington

In the course of these meetings, the Commission accomplished the following:

- established its membership and governance
- established its mission
- identified objectives
- identified substantive areas of study
- established its methodology
- issued a press release on November 17, 1997
- identified presenters (oral and written)
- established funding for presenter reimbursement
- heard presentations
- received written submissions
- made various governmental leaders aware of the Commission's work
- issued an Interim Progress Report on January 20, 1998
- issued this Final Report on July 27, 1998

IV. MEMBERSHIP AND GOVERNANCE

The Commission is co-chaired by Jerome J. Shestack, president of the ABA, William K. Slate II, president and chief executive officer of the AAA, and Dr. Percy Wootton, president of the AMA. The Secretary and Rapporteur is George H. Friedman, Senior Vice President of the AAA. The Recording Secretary is Scott Carfello, Regional Vice President of the Chicago office of the AAA.

Each of the institutions has four representatives on the Commission, as follows:

<u>For the American Arbitration Association:</u>

Howard J. Aibel, Esq.
Thomasina Rogers, Esq.
J. Warren Wood, III, Esq.
Max Zimny, Esq.

<u>For the American Bar Association:</u>

Hon. Arlin Adams
Kimberlee K. Kovach, Esq.
Lawrence A. Manson, Esq.
Roderick B. Mathews, Esq.

For the American Medical Association:

Dr. Charles Barone
Dr. Donald Palmisano
Carter Phillips, Esq.
Ron Pollack, Esq.

A roster describing the affiliations of the Commission members appears as Exhibit I of the Appendix of this Final Report.

V. MISSION

The Commission on Health Care Dispute Resolution adopted the following mission statement:

> ... to evaluate and make recommendations as to how alternative dispute resolution should be used to provide a just, prompt, and economical means of resolving disputes over access to health care treatment, and coverage, in the private health plan/managed care environment.

VI. IDENTIFIED NEED

The determination of the three sponsoring institutions to form the Commission was prescient. In the several months that followed the creation of the Commission, the general topic of health care has become a subject of national discourse. The President's Advisory Commission on Consumer Protection and Quality (President's Advisory Commission) in March 1998 issued a final report to the President. This group, comprised of representatives from a broad base of participants in the health care process, was formed in March 1997. In its final report to the President, this Commission urges the creation of a Patient's Bill of Rights. Legislative initiatives, at both the state and federal levels, were commenced with a goal of addressing the emerging issues in health care. Parties in the health care arena engaged in a national dialogue on how to address the many issues relating to the delivery of health care in the United States. A recurrent theme in all of these efforts was a recognized need to establish fair, neutral, swift, and economical means for settling disputes among participants in managed health care relationships.

While the Commission recognized that there are a variety of other health care relationships, its primary focus was on private managed care. According to the Final Report of the President's Advisory Commission (March 1998, p. 164), some 140 million Americans are covered by some form of private (i.e., non-governmental) health insurance. Today, three-fourths of Americans with private health insurance are enrolled in some form of managed care system (*Report of Proposed Recommendations on Process for Resolving Consumer Differences with Managed Health Care Plans,* ABA Commission on Legal Problems of the Elderly, June 1998, p.1). Given the nature of these relationships, and the sheer number of covered persons, disputes are inevitable.

Alternative dispute resolution has emerged as an accepted means of resolving disputes outside of the court system. The early working hypothesis of the convening institutions and the Commission members was that ADR can and should play an important, effective role in resolving disputes among participants in private managed health care relationships. After hearing often compelling presentations about the need for appropriate means of resolving disputes quickly, fairly, and efficiently, the Commission believes this hypothesis has been borne out.

The Commissioners note that a few states have enacted some form of legislation regulating the relationships between patients and managed health care organizations, (see, for example, Ohio's Physician-Health Plan Partnership Act of 1997), providing at some point for external review of certain health plan determinations. They also observe that similar legislation has been introduced in Congress, and that the President's Advisory Commission in Chapter Ten of its *Final Report to the President* encourages independent, external review of certain claim denials.

While these myriad efforts and activities to one extent or another involve various forms of ADR as part of the internal review process, external appeals, or both, the Commissioners concluded that there was a clear need to add definition and depth to these concepts. Stated differently, as managed health care organizations move to voluntarily embrace ADR as a form of external review, and as legislative and regulatory bodies provide direction to health plans regarding the development of external review programs, guidance and information will be needed to address how best to utilize ADR in this context. It is the Commission's objective to provide such guidance by issuing this Final Report.

VII. OBJECTIVES

There was unanimity among Commission members that ADR would facilitate the resolution of disputes in the private managed health care area which are not resolved through internal review procedures offered by the managed health care organization. In view of its overall objective of promoting the prompt and fair application of ADR in the managed health care area, the Commission identified the following main objectives:

- develop model ADR procedures for use in the managed care area (in effect, a "Restatement on Health Care ADR");
- identify substantive areas in the managed health care environment that would be suitable for resolution by alternative dispute resolution. Examples discussed included a host of coverage and access issues, such as access to specific healthcare providers, access to needed treatment or necessary care, experimental treatment, medical necessity, and reasonableness of cost;
- establish due process criteria for the use of ADR to resolve health care disputes. Examples discussed included due process procedures for ADR systems, timing of the agreement to use ADR, and informed, knowing, and voluntary use of ADR.

VIII. AREAS OF STUDY

The Commission's general focus was to study and make recommendations on the applicability of alternative dispute resolution in the private managed health care environment. It identified the following general subject matters for consideration:

- access to specific health care providers
- access to needed treatment
- access to specific health care facilities
- medical necessity of treatment
- experimental treatment
- reasonableness of cost
- continuity of care
- disclosure of information to consumers
- development of drug formularies
- out-of-area coverage
- provider communication with patients

- utilization management

Given the complexity and importance of ADR in the private managed health care setting, the Commission determined not to study the applicability of ADR to medical malpractice, Medicare, specific provisions of health care insurance contracts, or general access to health care outside of the private managed health care relationship. This does not mean that the concepts articulated in this report are not applicable to other health care relationships, such as indemnity plans (i.e., those in which the patient seeks reimbursement from a health insurer for the cost of medical care received). The Commission is also aware that managed health care tort liability concepts are developing. These concepts may result in new types of civil claims that may be resolved by means of ADR, just as ADR is used today in many jurisdictions for resolving personal injury civil claims.

IX. METHODOLOGY

The Commission's method of operation was to seek oral and written presentations from a wide array of key organizations and individuals, to inform the Commission's thinking in developing specific ADR models and areas of application. Included in this pool of advisors were: health care providers, patient advocacy groups, health care insurers (managed health care organizations, health maintenance organizations, and indemnity plans), health insurance associations, public health officials and groups, elder care groups, and law and medical school faculty.

Overall, thirty-seven individuals or organizations responded orally or in writing to 79 written invitations to submit comments or other information to the Commission. A listing of these individuals/organizations appears as Exhibit II of the Appendix of this Report (Individuals and Organizations Contacted by the Commission for Written Submissions). The Commission's Secretary also corresponded with the President's Advisory Commission, advising of the work of the AAA/ABA/AMA Commission. The information was directed specifically to Secretary of Health & Human Services Donna Shalala and Secretary of Labor Alexis Herman (co-chairs), with a copy delivered to President Clinton. Also, various Congressional leaders were advised of the work of the Commission. ABA President Shestack arranged for the Commission's work to be showcased at the ABA's 1998 Annual Meeting, in the form of a program devoted to the use of ADR to resolve health care disputes.

Oral presentations were made at Commission meetings held on October 27, 1997; December 8, 1997; January 12, 1998; March 6, 1998; and April 29, 1998, by the following individuals:

Mary Ellen Bliss
Federal Affairs Action Team
American Association of Retired Persons

Chris Carey
Staff Member
House Committee on Education and the Workforce

Edward Dauer
Dean Emeritus
University of Denver College of Law

Michael Duffy
Director
Office of Consumer Affairs and Business Regulation

Massachusetts Consumer Affairs Commission
(and Boaz Yavnai - research assistant)

Elizabeth Hadley
Legislative Counsel for Health Policy
National Association of Insurance Commissioners

Matt Keast
Staff Member
Office of Congressman Charles Norwood

Kurt Lawson
ABA Section of Taxation

Len Marcus
Director - Health Care Negotiations
Harvard School of Public Health

F. William McCalpin
Chair
ABA Commission on Legal Problems of the Elderly

Julie Miller
Director - Policy Analysis
Blue Cross & Blue Shield Association

Dr. Donald Palmisano
Trustee

Ron Pollack
Executive Director
Families USA
(member of Commission)

David Richardson
President
Center for Health Dispute Resolution

Elizabeth Rolph
RAND

Dr. Clarke Russ
Institute for Conflict Resolution in Health Care
(Chair, Board of Medicine, Commonwealth of Virginia)

Grey Till
General Counsel
Blue Cross & Blue Shield of Alabama
(member of Commission)

Oral presentations were followed by questioning from the Commission and its staff. In some instances, this process was quite intense, but the intention always was to illuminate the nature of the problem and to evaluate carefully the range of realistic alternatives available.

X. ALTERNATIVE DISPUTE RESOLUTION METHODS AND MODELS

A. Introduction

As courts and administrative agencies become less accessible to civil litigants, patients, health care providers, and managed health care organizations have begun to explore ADR as a way promptly and effectively to resolve disputes. A wide range of dispute prevention and resolution procedures allow the participants to develop a fair, cost-effective, and private forum to resolve disputes.

As part of its work, the Commission reviewed a number of ADR processes which may be appropriate for the resolution of disputes and disagreements which occur among patients, families, health care providers, and managed health care organizations. The use of external, independent ADR is typically not available until after all remedies are exhausted within the managed health care organization. Usually, managed health care plans will offer some form of internal review, by which a provider or participant can challenge the plan's action. While this review can and should include some elements of ADR, the Commissioners contemplate ADR playing a role in the next step - i.e., as a form of independent external review or appeal. Based on the information adduced during the course of its work, the Commission has concluded that there is a clear need to help all participants better understand how ADR works, what forms ADR takes, and what problems to avoid.

In submitting these ADR Models, the Commission does not wish to suggest that these methods are exclusive or that in some instances other procedures may not be appropriate. Rather, in its study the Commission has concluded that these are the primary ADR methods or procedures which would be most responsive to the types of managed health care disputes as outlined in Section XI of this Final Report (Areas in the Private Managed Health Care Environment Where ADR Can Be Helpful). The ADR processes summarized below also assume the presence and need for a neutral third party. To be sure, the Commission recognizes and affirms that direct negotiation among the parties and internal appeal mechanisms are often appropriate first steps in any dispute resolution scheme. The work of the Commission, however, was to explore processes which involve the use of a neutral third party dispute resolver, either to facilitate a negotiated resolution among the parties (e.g., mediation) or to render a decision (e.g., arbitration).

The Commission submits that perhaps of greatest importance are the fundamental guiding principles of efficiency, of both time and money, and fairness. Characteristics of the ADR procedures presented here, and in detail in Exhibit III of the Appendix to this Final Report (Alternative Dispute Resolution Models, are to be supplemented by the due process protocols set forth in Section XII (Due Process Standards).

B. ADR Models

The Commission submits the following proposed neutral models for ADR as prototypes for use in those matters or disputes involving managed health care. A consistent theme throughout is an effort to maintain a "level playing field" for all participants. Fully-developed models and explanations are set forth in Exhibit III of the Appendix.

Ombuds: A neutral third party (either from within or outside the program) is designated to receive information regarding managed health care disputes, and to confidentially investigate and propose settlement of complaints. The ombudsperson may also provide information on how the dispute resolution process works.

Fact-finding: The investigation of a complaint by an impartial third person (or team) who examines the complaint, considers the facts ascertained, and issues a non-binding report.

Consensus-building: A process which involves the use of a neutral third party, often referred to as a convener, who assists numerous persons or groups in arriving at a consensus through a structured negotiation among chosen representatives of all stakeholders.

Mediation: The process in which the parties discuss their disputes with an impartial person who assists them in reaching a settlement. The mediator may suggest ways of resolving the dispute but may not impose a settlement on the parties. Mediation offers the advantage of informality, with reduced time and expense needed to resolve disputes.

Arbitration: The submission of disputes to one or more impartial persons pursuant to established procedures, generally for final and binding determination. Variants include non-binding arbitration. There are four major types of arbitration agreements:

- pre-dispute, final and binding arbitration
- pre-dispute, nonbinding arbitration
- post-dispute, final and binding arbitration, and
- post-dispute, nonbinding arbitration.

The concept of the timing of the agreement to arbitrate is discussed in Section XII of this Final Report (Due Process Standards) and in Exhibit III of the Appendix (Alternative Dispute Resolution Models). *It is worth noting here, however, that the Commission's unanimous view is that in disputes involving patients and/or plan subscribers, binding arbitration should be used only where the parties agree to same after a dispute arises.*

ADR Hybrids: The combination of one or more ADR formats, frequently in sequence. For example: "Med/Arb" is mediation followed by arbitration in the event mediation is not successful. The number of potential ADR hybrids is virtually unlimited.

C. The "ERISA Problem"

As stated above, the Commissions focus was on the use of ADR in the private managed health care environment. It is worth noting that the overwhelming majority of individuals covered by private health plans obtained this coverage through an employer-provided health plan. According to the President's Advisory Commission, 123 million American receive health insurance through their employer, while only 10 to 16 million Americans purchase directly their own coverage (*Final Report,* p. 164). The Employee Retirement Income Security Act of 1974 (ERISA) governs, among other things, all health benefit plans that are employer-provided, establishing standards for the enforcement of "consumer" rights under employer-provided health plans.

By its terms, ERISA preempts the states from providing different remedies for denials of health benefits. Thus, an individual covered by an employer-provided health plan, under ERISA, may not invoke tort or

contract law remedies in state courts, and is thus limited to seeking judicial intervention for only the following remedies:

- providing the covered service, or reimbursing the cost of the service;
- directing the plan to act;
- clarifying future benefits.

A question arose concerning whether the use of ADR as a form of external review of health plan determinations might be precluded by the ERISA preemption. It was the conclusion of the Commission, however, that ERISA does not preclude the parties from voluntarily adopting the use of ADR-- even binding forms of ADR -- to resolve disputes among them. It may well be that legislative clarification would be helpful to avoid confusion or concern over the appropriate use of ADR in the managed health care area, but specific recommendations in this regard would be beyond the scope of the Commission's charge from the convening institutions.

XI. AREAS IN THE PRIVATE MANAGED HEALTH CARE ENVIRONMENT WHERE ADR CAN BE HELPFUL

A. Introduction

The Commission's major focus was on one type of dispute in the private managed health care context -- "consumer v. plan." Nevertheless, the Commission recognizes that managed care involves a range of disputes (and alliances) among a number of participants, including buyers, plans, providers in the plans, providers not in the plans, as well as consumers. The disputes that exist in this area are those that exist in the traditional insurance context as well, i.e., the long-standing insurance coverage issues, which now more frequently arise because the insurer/managed plan may simply be saying "no" more frequently.

In addition, in managed care, the "consumer v. plan" dispute is often a "consumer + provider v. plan" dispute, in which the issue is whether the provider can perform services with the expectation of payment from the plan, and the consumer is convinced by the provider that the services will be beneficial. There are also "provider v. plan" disputes that can involve a provider not in the plan. For example, the provider may want to participate in, or dispute, some out-of-plan payment policy.

Finally, there are also a series of "purchaser/plan/provider" disputes arising. In some markets, the larger employers are beginning to determine and select provider networks without regard to a plan's decisions. Thus, it can be anticipated that "provider v. purchaser v. plan" disputes will arise, especially as data collection and reporting begin to dominate, and plans and providers dispute the data/reports.

B. Matching ADR Process to Dispute Type

The Commission considered developing a matrix that matched specific types of managed health care disputes to specific ADR methods. In the final analysis, however, it seemed more efficient and useful to identify both broad categories of potential disputes and subcategories of areas of conflict that would be well served by an ADR procedure. This is presented schematically in Exhibit IV of the Appendix (Matrix of Areas of Disputes Amenable to ADR). It was the consensus of the Commission that a form of ADR would be appropriate for resolving the identified categories and subcategories of disputes, but that identifying a particular form of ADR as the single most appropriate means of resolving a particular dispute type was an inappropriate limitation on the parties' discretion.

C. Detailed Analysis of Potential Disputes

Managed health care disputes for which alternate dispute resolution is particularly appropriate include: medical necessity; length of stay; medical appropriateness of place or provider; situations requiring early coordination of treatment by various disciplines such as mental health or substance abuse planning or planning for outcomes among medical, social, psychological, legal and ethical experts; reduction or termination of services; over or under-utilization of resources or facilities; physician or patient concerns about utilization incentives or disincentives; bioethical conflicts; staff disagreements; interpersonal disputes; access to appropriate procedures and equipment and access between providers and outside networks; and, in general, disputes involving non-monetary outcomes.

Health care ADR is best and most effective where the parties have legitimate and serious issues in dispute, and external review of a decision made by a managed health care organization is called for. Generally, limitations on such use of ADR processes for external review should be by exception only. At the same time, appropriate thresholds should be established so as not to overburden available health care ADR resources with either frivolous claims involving mere misunderstandings or miscommunications, or disputes of such high complexity as to defy resolution (e.g. whether the plan should be essentially re-written to cover new cutting edge, experimental technology or treatment). Unequivocal contract provisions, such as health care insurance eligibility requirements and coverage limitations and exclusions, are generally not appropriate for health care ADR because it is usually not the province of ADR to rewrite unambiguous contract provisions. Intra-family disputes over treatment plans or modalities are probably best dealt with by other means.

ADR processes are, however, well suited to managed health care situations where the need for specialized, confidential, non-precedential disposition is critical. ADR is particularly valuable when rules are unclear or are ambiguous or where the stakes for the interested parties are very high, or where strong emotions such as distrust or the need for retribution are present. In a typical indemnity health plan, grievances by consumers usually involve denial of payment to providers after services have been rendered. In a managed health care arrangement, services are pre-authorized and disputes usually involve denial of access to health care services. The majority of disputes between the consumer and the private managed health care organization thus involve benefit coverage issues and coverage for out of plan services. These potential areas of conflict are set forth below.

1. Health Plan Coverage Issues (within health plan or with affiliated providers)
    a. Surgical procedures (denial for surgery, usually elective surgery)
    b. Cosmetic surgery (denial of request for service)
    c. Dental/oral surgery (denial of request for service)
    d. Durable medical equipment (denial of requests for equipment)
    e. Procedures and tests (denial of specific lab tests, x-rays, other diagnostic procedures)
    f. Physical therapy/occupational therapy (denial of request for services)
    g. Denial of referral from primary care provider to specialists or other providers requiring Referrals
    h. Mental health services (denial of request for specific therapy or treatment program length)
    i. Second opinions
    j. Restricted formulary (denial of specific medications and treatment regimens not included in health plan formulary)
    k. Excessive wait time for access to needed service
    l. Home health care benefits
    m. Length of stay (discharge from hospital or other health care facility before consumer feels he/she is able)

n. Hospice

2. Out of Health Plan Coverage Issues (not part of plan or nonaffiliated providers)
    a. Out of area (out-of-state) coverage for needed medical services
    b. Emergency services (nonaffiliated hospital /ER)
    c. Access to nonaffiliated primary care providers
    d. Access to nonaffiliated specialty care providers
    e. Access to nonaffiliated mental health services
    f. Admission to nonaffiliated hospitals
    g. Second opinions with nonaffiliated providers (primary care or specialty care)
    h. Access to nonaffiliated dental/oral surgery
3. Access to nontraditional/"alternative" Medical Care
4. Experimental Care/"Last Chance" Therapy (as stated above, the issue amenable to ADR is not whether the contract should be re-written to include experimental care or "Last Chance" Therapies -- since managed health care plans may specifically exclude such coverage -- but, in instances in which experimental care is a covered benefit, whether such treatment is medically necessary or appropriate)
5. Continuity of Care Issues (continued treatment of preexisting conditions by current provider not affiliated with the health plan when health plan coverage is switched: pregnancy, oncology, primary care/continuation of treatment plan including prescriptions)
6. Time-Sensitive Situations (any dispute between a consumer and a health plan where the timing of access to the disputed service has a permanent adverse effect on treatment outcome: emergency care, out-of-state care, transplants, oncology, surgery, potentially terminal conditions)
7. Customer Service Issues (complaints regarding health care providers, health care workers, processes, wait times)

XII. DUE PROCESS STANDARDS

A. Background

The members of the Commission believe that mediation and arbitration of health care disputes -- conducted with proper due process safeguards -- should be encouraged in order to provide expeditious, accessible, inexpensive, and fair resolution of disputes. As ADR systems are developed for resolving private managed health care disputes, it is essential that such systems provide adequate levels of procedural due process protections for all involved.

The nature of the relationship between plans and patients or providers is such that little, if any, negotiation over terms -- including external review or ADR systems -- takes place. Since these ADR systems or external review procedures will invariably not be the product of a negotiated agreement, the Commission believes it would be especially useful to set forth key aspects of procedural due process, to ensure a "level playing field" for resolving health care disputes by ADR. Similarly, these due process protocols can serve as guidance for legislators or regulators as they focus on establishing fair and appropriate methods for resolving health care disputes.

Due process protocols for the use of ADR have also been developed in two other areas -- employment and consumer-- where, as in health care, the establishment and terms of the ADR system are matters not generally subject to negotiation. Those protocols, which the Commissioners drew upon in developing the

Due Process Protocol for the Resolution of Health Care Disputes , appear respectively as Exhibits V and VI of the Appendix of this Report.

B. Covered Relationships

The Due Process Protocol for the Resolution of Health Care Disputes contained in this section was developed for a wide range of transactions arising out of the private managed health care relationship. As described in Section XI of this Report (Areas in the Private Managed Health

Care Environment Where ADR Can Be Helpful), these can include: "consumer v. plan" disputes, "provider v. plan" disputes, and "purchaser v. plan v. provider" disputes.

The purpose of the Protocol is not to define each and every type of health care dispute in which due process standards for the use of ADR are needed. The Commission believes that as a matter of general principle, any ADR system developed in the health care environment would be well-served by adhering to the due process concepts articulated below.

C. A Due Process Protocol for Resolution of Health Care Disputes

PRINCIPLE 1: FUNDAMENTALLY FAIR PROCESS

All parties are entitled to a fundamentally fair ADR process. As embodiments of fundamental fairness, these Principles should be observed in structuring ADR Programs.

PRINCIPLE 2: ACCESS TO INFORMATION REGARDING ADR PROGRAM

Full and accurate information regarding the program, in writing, should be provided by the plan to patients and providers in plain, easily understood language. If a substantial number of users speak languages other than English, the material describing the program should be available in other languages. The information regarding the program should include a description of the process, the role of the parties, the means of selecting neutrals, the rules of conduct of the parties and the neutrals, and an accurate description of fees and expenses.

After a dispute arises, participants should have access to all information necessary for effective participation in ADR. Disputes over exchanges of information should be resolved by the neutral.

PRINCIPLE 3: KNOWING AND VOLUNTARY AGREEMENT TO USE ADR

The agreement to use ADR should be knowing and voluntary. Consent to use an ADR process should not be a requirement for receiving emergency care or treatment. In disputes involving patients, binding forms of dispute resolution should be used only where the parties agree to do so after a dispute arises.

PRINCIPLE 4: NEUTRALITY AND INDEPENDENCE

1. *Independent and Impartial Neutral: All parties are entitled to a neutral who is independent and impartial.*
2. *Independent Administration: Administration of the ADR program should be neutral, and independent of the parties. In no event should the ADR program be administered by the health plan. Administrative services should include the maintenance of a panel of*

prospective neutrals, facilitation of neutral selection, collection and disbursement of neutral fees and expenses, oversight and implementation of ADR rules and procedures, and monitoring neutral qualifications, performance, and adherence to pertinent rules, procedures, and ethical standards.

3. *Standards for Neutrals: The rules of administration should guarantee impartiality in selecting neutrals and require conformity with ethical standards of conduct.*
4. *Selection of Neutrals: All parties should have an equal voice in the selection of neutrals in connection with a specific dispute.*
5. *Disclosure and Disqualification: Neutrals should be required to disclose to the administering agency any circumstance likely to affect impartiality, including any bias or financial or personal interest which might affect the result of the ADR proceeding, or any past or present relationship or experience with the parties or their representatives, including past ADR experiences. The administrator should communicate any such information to the parties and other neutrals, if any. Upon objection of a party to the continued service of a neutral, the administrator should determine whether the neutral should be disqualified and should inform the parties of its decision. The disclosure obligation of the neutral and procedure for disqualification should continue throughout the period of appointment.*

PRINCIPLE 5: QUALITY AND COMPETENCE OF NEUTRALS

All parties are entitled to competent, qualified neutrals. ADR administrators are responsible for establishing and maintaining standards for neutrals in ADR programs they administer. Neutrals serving in health care disputes should have knowledge and experience in health care matters. Disputes concerning the provision of medical care based on medical necessity standards should be resolved by neutrals who are qualified to render medical decisions in the particular medical branch and related specialty involved in the dispute.

The creation of a roster containing the foregoing qualifications dictates the development of a training program to educate existing and potential mediators and arbitrators as to the relevant law, and the substantive, procedural and remedial issues likely to be encountered in the conduct and control of arbitration hearings and mediation sessions.

PRINCIPLE 6: RIGHT TO REPRESENTATION

It is recommended that plans provide, at their expense, the services of an ombudsperson whose function would be to explain the dispute resolution process to patients, and to provide an initial screening of the case.

All parties participating in the ADR process have the right, at their own expense, to be represented by an attorney or other spokesperson of their own choosing. The ADR procedures should direct the parties to referral services for representation of bar associations, legal service associations, unions, consumer organizations, and the like.

PRINCIPLE 7: ADR HEARINGS

1. *Fair Hearing: The pre-hearing and hearing should be conducted with adequate notice and with a fair opportunity to be heard and to present relevant evidence and witnesses. There should be a right to examine and cross-examine witnesses, and to argue orally and/or in writing. The right to present relevant evidence should include access to*

relevant books and records. The hearing and determination through mediation or arbitration should be private and confidential, unless the parties agree otherwise.

2. *Place of Arbitration or Mediation: The place of the proceedings should be reasonably accessible to the parties and to the production of relevant evidence and witnesses. In cases involving a patient, the place should be in close proximity to the patient's place of residence. If the parties are unable to agree on the place of arbitration or mediation, the administering agency or the neutral should determine that issue. In a case of acute emergency, it may be appropriate to conduct the arbitration or mediation by telephone or other electronic means.*
3. *Confidentiality: Consistent with general expectations of privacy in ADR, the neutral should make reasonable efforts to maintain the privacy of ADR hearings to the extent permitted by applicable law. In arbitration, the arbitrator should carefully consider claims of privilege and confidentiality in addressing evidentiary issues.*

PRINCIPLE 8: REASONABLE TIME LIMITS

ADR proceedings should occur within a reasonable time, and without undue delay. The rules governing ADR should establish specific reasonable time periods for each step in the ADR process and, where necessary, set forth default procedures in the event a party fails to participate in the process after reasonable notice. The Commission recommends the following general timeframes for resolving disputes: acute emergencies -- 24 hours; emergencies -- 72 hours; non-emergencies -- 60 days.

PRINCIPLE 9: SETTLEMENT IN MEDIATION OR AWARD IN ARBITRATION

1. *Mediation Settlement: Any settlement in mediation or other non-binding form of ADR should be in writing.*
2. *Arbitration Award: The arbitration award should be in writing, and should be accompanied by an opinion, where requested by any party. In the case of an acute emergency, the arbitrator may make a preliminary award orally. The arbitrator should be empowered to grant whatever relief would be available in court under law or in equity. There should be limited judicial review. Courts should defer to the arbitrator's award absent manifest disregard of clearly defined governing law.*

PRINCIPLE 10: COSTS IN MANDATED, NONBINDING ADR PROCESSES

If mediation is mandated, the cost thereof should be at the expense of the health plan.

As provided in Principle 3, binding ADR arbitration should not be mandated in cases involving patients. Nonbinding arbitration may be required, as can binding arbitration in cases not involving patients, in which case the plan should pay the costs of at least one day of hearing before a single arbitrator, including the arbitrator's fees and expenses. If there are additional days of arbitration, or more than one arbitrator, the costs should be shared equally, subject to the arbitrator's authority to determine the allocation of costs.

XIII. CONCLUSION

The Commission concludes that alternative dispute resolution has a valuable role to play in the resolution of disputes arising out of the private managed health care relationship. ADR complements internal review programs, serving as the next efficient and effective step for resolving unsettled claims. ADR can function effectively as a means of external review or appeal of determinations made by managed health

care organizations. It is essential, however, that ADR programs be developed with due process safeguards for the rights of all participants in the process.

The Commission urges that its recommendations be used as guidance by legislative bodies, regulators, and policy leaders, as well as private managed health care organizations establishing ADR programs.

XIV. PLANNED COURSE OF FUTURE ACTION

The Commission met both its short-term major goal of the promulgation of an Interim Progress Report by late January 1998, and the longer-term goal of publication of this Final Report by the Summer of 1998. Each of the Commissioners has signed off on the Final Report as individuals representing, but not necessarily binding, their respective organizations. The Final Report will be presented for timely review by the three sponsoring organizations, and will then be widely disseminated to diverse groups (i.e., provider organizations, patient advocacy groups, employer groups, employee groups, labor, consumer groups, academia, government, regulatory agencies, managed health care organizations and health plans).

Following review by the three sponsoring organizations, a Final Report will be released.

The members of the Commission appreciate the opportunity to play a role in helping to shape the public debate over the use of ADR as a means of resolving disputes in the private managed health care arena.

Submitted this 27th day of July 1998

George H. Friedman
Commission Rapporteur and Secretary,

To the Co-Chairs: Jerome J. Shestack, Esq.; William K. Slate II, Esq.; Percy Wootton, M.D.

APPENDIX

I. COMMISSION ROSTER

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Mary Ellen	Bliss	Federal Affairs Team	American Association of Retired Persons

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Edward K.	Wissing	CEO	American Home Patient, Inc.

III. ALTERNATIVE DISPUTE RESOLUTION MODELS

The models set forth below are by no means exhaustive; they represent sensible approaches to the major forms of alternative dispute resolution. In designing any ADR system, care should be taken to tailor the system to the specific needs of the parties. Guidance on the process of developing dispute resolution systems, as well as model language for various provisions and features of ADR clauses, can be found in *Drafting Dispute Resolution Clauses* , published by the American Arbitration Association (1997).

A. Ombuds

The ombuds process involves a neutral third party who is often employed or appointed by an institution, whose primary role is the investigation of complaints, as well as their prevention and resolution. An ombudsperson may also make recommendations with respect to the resolution of the matter, but cannot make a binding decision.

The most even-handed, fair, and appropriate ADR system will not work effectively if parties are not aware of the existence of the program, or are not educated as to how the system works. Therefore, another key role of the ombudsperson is to provide information on the dispute resolution process, both internal and external. In effect, the ombudsperson serves as a system guide to users, providing useful information about how the managed health care organization resolves disputes.

With regard to those matters involving the provision of health care, it is suggested that those plans which desire to put in place an ombuds system of dispute resolution observe the following guidelines. The ombuds should be a person with a medical education and experience. While the ombuds will likely be an employee of the managed health care organization, it is suggested that the ombuds process, if opted for, should also involve the participation of the patient's family and/or significant other, where desired and appropriate. While much should be left to the discretion of the ombudsperson, it is recommended that the health care provider, as well as the plan decision maker, also be included in the preliminary discussions and fact gathering.

In some models, the ombudsperson's function is strictly neutral. In others, the ombudsperson acts as a patient advocate. The Commission takes no position on which model is most desirable.

B. Mediation

In mediation, a neutral third party, the mediator, facilitates the voluntary and mutually acceptable resolution of a dispute. A non-adversarial approach to dispute resolution, mediation emphasizes direct communication among the parties and creativity in problem solving. The mediator's role is to help the disputants explore issues, needs and settlement options. The mediator may point out issues that the disputants may have overlooked and in some instances offer suggestions, but resolution of the dispute rests with the disputants themselves.

- The benefits of successfully mediating a dispute to settlement vary, depending on the needs and interests of the parties. The most common advantages are that:
- parties are directly engaged in the negotiation of the settlement;
- the mediator, as a neutral third party, can view the dispute objectively and can assist the parties in exploring alternatives which they might not have considered on their own;
- as mediation can be scheduled at an early stage in the dispute, a settlement can be reached more quickly than in litigation;
- parties generally save money through reduced legal costs and less staff time;
- parties enhance the likelihood of continuing their business relationship;
- creative solutions or accommodations to special needs of the parties can become a part of the settlement;
- a high probability of settlement. A frequently-cited mediation settlement rate is 85% (statistical data provided by the American Arbitration Association, Client Services Group, June 1998).

1. Providing for Mediation

The parties can provide for the resolution of future disputes by including a mediation clause in their contract. A typical mediation clause reads as follows:

> *If a dispute arises out of or relates to this policy/contract or the breach thereof and if the dispute cannot be settled through negotiation, the parties agree first to try in good faith to settle the dispute by mediation administered by [named ADR provider], prior to resorting to arbitration, litigation, or some other dispute resolution procedure.*

The clause may also provide for the qualifications of the mediator, the method of payment, the locale of meetings, and any other item of concern to the parties.

2. Requesting and Scheduling the Mediation

Although mediations can originate at various times, including as an adjunct procedure to pending litigation (including appeals), it is anticipated that mediation will occur when a dispute between the patient and the managed health care organization initially arises and before other, more formal means of dispute resolution such as arbitration or a lawsuit is initiated.

In the case of health care, timing is of the essence and the mediation agreement (or mediation clause) should specifically spell out the time within which a mediation must be conducted, after such has been requested or demanded. In fact, one of the primary advantages to the mediation process is that a mediation conference can be scheduled very quickly and requires a relatively small amount of preparation time. In cases of emergency, the mediation should be scheduled in accordance with the time frames in Principle 8 of the *Due Process Protocol for the Mediation and Arbitration of Health Care Disputes* (Section XII of this Final Report).

When a party files a Request for Mediation, the requesting party should forward a copy of the mediation clause contained in the contract under which the dispute arose.

The mediation should be conducted at a location which is convenient for both the patient and family as well as the provider and the plan decision maker. Priority consideration should also be

given to the health and well being of the patient in terms of the ability to travel, when determining the location of the mediation session. The duration of the mediation session itself may also need to be abridged if the patient's health imposes such limitations. Consideration should also be given to the managed health care organization decision-maker, particularly in non-emergency matters, such as the ability to participate in several mediations at a given time.

In those situations where the health of a party makes it difficult for their personal appearance at the mediation, latitude should be given to the mediator for the use of telephones, video conferencing, and the Internet as alternative methods for communication and participation (*Protocol,* Principle 7(2)).

3. Qualifications and Selection of the Mediator(s)

Upon receipt of a Request for Mediation or the Submission to Dispute Resolution, the administrator will appoint a qualified mediator to serve on the case. All participants (which include family members or significant others of the patient seeking treatment, who are not considered actual parties) will be provided biographical information about the mediator. The parties are instructed to review the sketch closely and advise the administrator of any objections they may have to the appointment. Since it is essential that all parties have complete confidence in the mediator's ability to be fair and impartial, any mediator not acceptable to the parties will generally not serve. In the situation where there has not been a designation of an administrator, the party seeking the mediation should notify the other by the means specified in the mediation agreement, and the mediator will be selected as provided in the agreement of the parties.

Mediators serving in health care disputes should have knowledge and experience in health care matters. Disputes concerning the provision of medical care based on medical necessity standards should be heard by mediators who are qualified to render medical decisions in the particular medical branch and related specialty involved in the dispute (*Protocol,* Principle 5), although this is ultimately a matter for determination by the parties given the consensual, nonbinding nature of mediation. General dispute resolution qualities in mediators for these cases include, but are not limited to the following: commitment to impartiality and objectivity; dispute management skills, including excellent communication abilities; judicious temperament: impartiality; patience; courtesy; respect of bar or business community for integrity; strong academic background and professional or business credentials. The mediator must also be committed to compliance with the nationally-recognized *Model Standards of Conduct for Mediators,* promulgated by the American Arbitration Association, the American Bar Association, and the Society of Professionals in Dispute Resolution.

In some instances, the use of co-mediation may be appropriate. Co-mediation involves two mediators who simultaneously and equally mediate the matter. For example, in situations that are quite complex in terms of technology or science, where expertise from two or more disciplines is needed, it is advocated that the parties consider using a co-mediation model. And, in some cases where the number of parties affected, and hence participants in the process is large, or, where the issues presented for resolution are very diverse, co-mediation is also recommended.

4. Participant Preparation for Mediation

To prepare for mediation, each of the participants may wish to define and analyze the primary issues in dispute, and recognize the parameters of the given situation. This would include what can realistically be expected, time constraints, available resources, legal ramifications, generally

accepted practices, options for alternative treatment, costs, and the like. Each person or organization should also attempt to identify and prioritize the needs and interests in settling the dispute. Determination of alternative courses of action, positions, tradeoffs, and exploration of a variety of possible solutions in advance of the session can be helpful. To reach a mutually acceptable agreement through mediation, it is usually necessary that each party be willing to make reasonable and legitimate proposals, which accommodate needs of the other party. Since disputes are often the result of misunderstandings or a lack of understanding about the matter, parties should be prepared with facts, documents, and sound reasoning to support claims and desired outcome. In doing so, it is also helpful to the process if some consideration is given to the other party's needs, demands, strengths and weaknesses, positions, and version of facts and perceptions.

5. Presence and Participation in the Mediation

All participants in the mediation should come to the session prepared with all of the information, including documentation that they feel will be necessary to discuss their respective cases. Parties are, of course, entitled to representation by counsel. At the beginning of the session, mediators describe the procedures and ground rules covering each party's opportunity to talk, order of presentation, decorum, discussion of unresolved issues, use of caucuses, and confidentiality of proceedings.

After the introductory matters, each party will be provided the opportunity to describe respective views of the dispute. The initiating party discusses his/her understanding of the issues, the facts surrounding the dispute, what he/she wants, and why. The other parties then have the same opportunity to make presentations. In this initial session, the mediator gathers as much information as possible and appropriate under the circumstances as well as attempts to clarify discrepancies. The mediator tries to understand the perceptions of each party, their interests, and their positions on the issues. It is imperative, however, that the mediator remain neutral on the issues, and refrain from providing an opinion on the ultimate outcome of the matter.

When joint discussions have reached a stage where no further progress is being made, the mediator may decide to meet with each party privately, or in caucuses. While holding separate sessions with each party, the mediator may shuttle back and forth. By discussing all options, parties can assess the consequences of continuing or resolving the dispute.

- Gaining certain knowledge or facts from these meetings, a mediator can selectively use the information derived from each side to:
- reduce the hostility between the parties and help them to engage in a meaningful dialogue on the issues at hand;
- open discussions into areas not previously considered or inadequately developed;
- communicate positions or proposals in understandable or more palatable terms;
- probe and uncover additional facts and the real interests of the parties;
- help each party to better understand the other parties' views and evaluations of a particular issue, without violating confidences;
- narrow the issues and each party's positions and deflate extreme demands;
- gauge the receptiveness for a proposal or suggestion;
- explore alternatives and search for solutions;
- identify what is important and what is expendable;
- prevent regression or raising of surprise issues; and
- structure a settlement to resolve current problems and future parties' needs.

6. The Role of the Mediator

The mediator acts as a facilitator to keep discussions focused and avoid new outbreaks of disagreement. The mediator also assists the parties in communicating with, and ultimately understanding, the other parties. In particular, the mediator should work with the parties to: narrow the issues and each party's positions, and deflate extreme demands; gauge the receptiveness for a proposal or suggestion; explore alternatives and search for solutions; structure a resolution which will not only resolve current problems, but moreover is likely to meet and satisfy the parties' needs in the future. The mediator serves not as an advocate for any party or position, but rather as an "agent of reality." The mediator is likely to urge each party to think through demands, priorities, and views, and deal with the other party's contentions.

During the mediation, whether in private or joint sessions, the mediator works with the parties to narrow differences and attempts to acquire agreement on both major and minor issues. At appropriate times, the mediator may offer suggestions about a final settlement, stress the consequences of failure to reach agreement, emphasize the progress which has been made, and formalize offers to achieve an agreement.

The mediator will often have the parties negotiate the final terms of a settlement while together in a joint session. The mediator will then verify the specifics of the agreement and make sure that the terms are comprehensive, specific, and clear in the final session.

7. The Mediated Settlement

It is anticipated that in the majority of cases, the mediation session will result in an agreement among the parties. In these cases, when the parties reach an agreement, the terms should be reduced to writing, usually by the mediator, or in the event of legal representation, the parties' lawyers, signed by all present, and copies distributed. In those matters where pending litigation exists, the parties or their counsel may also request that the agreement be put in the form of an agreed judgment or consent award. In the event that the issue is critical, from a medical standpoint, and time is of the essence, a party may elect to telephonically or electronically convey the agreement to the appropriate and necessary person or organization.

If the mediation fails to reach a settlement of any or all of the issues, the parties may agree to submit to binding arbitration. Such arbitration would be administered under the appropriate arbitration rules as agreed by the parties. In accordance with most available mediation rules, court rules of evidence, or the parties' submission to mediation, the information offered in mediation may not be used in arbitration (or in subsequent litigation).

8. Costs

As provided in Principle 10 of the *Due Process Protocol for the Resolution of Health Care Disputes,* if mediation is mandated by the managed health care organization, the costs of the process (mediation filing fee, and mediator compensation and expenses) should be borne by the plan. If the parties mutually agree to utilize mediation, these costs should be borne equally or as otherwise agreed to by the parties.

In no instance should the mediator's compensation be contingent upon a specific outcome. Should any dispute arise about the costs of the mediation, it is recommended that such be submitted first

to mediation, and in the event of no agreement, to arbitration. The neutral mediator or arbitrator should have no interest in the outcome of the fee dispute.

C. Arbitration

Arbitration is referral of a dispute to one or more impartial persons for a decision on the matter. Arbitrations may result in either final and binding determinations, or alternatively, be merely advisory in nature. An adversarial process, arbitration results in a determination being made by a neutral third party, based upon the presentation of evidence and argument by the parties or their counsel. Private and confidential, it is designed for quick, practical, and economical settlements.

1. Providing for Arbitration

Arbitration clauses are common in a number of contracts. The clause will govern the procedure, and can be simple or quite detailed in the elements included. As provided in Principle 3 of the *Protocol,* in disputes involving patients, binding forms of ADR, such as arbitration, should be used only where the parties agree to same after a dispute arises. A binding arbitration clause, however, may be perfectly appropriate for other relationships in the private managed health care area, such as disputes between health care providers and managed health care organizations. A sample of a simple contractual arbitration clause for use in such instances is as follows:

> *Any controversy or claim arising out of or relating to this contract, or the breach thereof, shall be settled by arbitration administered by [named ADR provider] in accordance with its [applicable] rules and judgment upon the award rendered by the arbitrator may be entered in any court having jurisdiction thereof.*

Parties can exercise additional control over the arbitration process by adding specific provisions to arbitration clauses or, when a dispute arises, through the modification of certain of the arbitration rules to suit a particular dispute. For example, stipulations may be made regarding confidentiality of proprietary information used, evidence, locale, the number of arbitrators, and the issues subject to arbitration. The parties may also provide for expedited arbitration procedures, including the time limit for rendering an award, if they anticipate a need for hearings to be scheduled on short notice. It is anticipated that this will likely be the case in a number of situations addressed in the health care area. All such mutual agreements will be binding on the administrator of the process, as well as the arbitrator.

For disputes involving patients, there are two ways to provide for post-dispute submission to binding arbitration. The first is to include a provision in the managed health care policy providing consideration of submission to binding arbitration, after a dispute arises. The following clause can be utilized:

> *Any controversy or claim arising out of or relating to this policy/contract that is not resolved by the parties, shall, upon the written agreement of the parties after the dispute arises, be settled by arbitration administered by [named ADR provider] under its [applicable] rules, and judgment upon the award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof.*

If the managed health care policy does not provide for optional, post-dispute binding arbitration, the parties are free to submit an existing dispute to arbitration by using the following clause:

> *We, the undersigned parties, hereby agree to submit to arbitration administered by the [named ADR provider] under its [applicable] rules the following controversy: (cite briefly). We further agree that the above controversy be submitted to (one) (three) arbitrator(s). We further agree that we will faithfully observe this agreement and the rules, that we will abide and perform any award rendered by the arbitrator(s), and that judgment of the court having jurisdiction may be entered on the award.*

2. Timing of Agreement to Arbitrate

As stated in Section X(B) of this Final Report (ADR Models) there are four major types of agreements to arbitrate:

- pre-dispute, final and binding arbitration
- pre-dispute, nonbinding arbitration
- post-dispute, final and binding arbitration, and
- post-dispute, nonbinding arbitration.

It is worth elaborating on what these concepts mean:

Pre-dispute, final and binding arbitration: The parties agree in advance to use arbitration to resolve disputes and they are bound by the outcome.

Pre-dispute, nonbinding arbitration: The parties agree in advance to use arbitration to resolve disputes, but they are not bound by the outcome.

Post-dispute, final and binding arbitration: The parties have the option, after a dispute arises, of deciding to arbitrate unresolved issues, and they are bound by the outcome.

Post-dispute, nonbinding arbitration: The parties have the option, after a dispute arises, of deciding to arbitrate unresolved issues, but they are not bound by the outcome.

The first form of arbitration (pre-dispute, final and binding arbitration) engendered considerable discussion among the Commission members. As provided in Principle 3 of the *Due Process Protocol for the Resolution of Health Care Disputes,* the agreement to use arbitration (or any form of ADR) should be knowing and voluntary. This of course assumes that full and accurate information regarding the ADR program is provided by the plan to participants (*Protocol,* Principle 2). In the Commission's view, participation in ADR should not be a requirement for receiving emergency medical care or treatment, (*Protocol,* Principle 3), and good practice dictates that a patient in an emergency situation not be approached at that time to consent to ADR.

As regards binding arbitration, it may be technically correct that a provision in a managed health care plan requiring binding arbitration is "voluntary" in the sense that a patient or subscriber who has received clear notice of this fact has, by accepting the health coverage, agreed to this term of the policy. Nonetheless, it was the Commissioners view that in disputes involving patients,

binding arbitration should be used only where the parties agree to arbitrate after a dispute arises (*Protocol,* Principle 3).

3. Benefits of Arbitration

Arbitration has several claimed or perceived benefits. To a certain extent, the benefits may be inferred either from experience or from knowledge of the arbitration process. There has been some research which sets forth the perceptions of participants in the ADR process (see, for example, Deloitte & Touche Litigation Services *1993 Survey of General and Outside Counsels: Alternative Dispute Resolution* (1993)). Major benefits of arbitration are as follows:

- Expert Neutrals: The arbitrators have expertise in the subject matter in dispute, as well as training in the arbitration process;
- Speed: There is no docket or backlog in arbitration. Hearings are scheduled as soon as the parties and the arbitrator have dates available;
- Cost Savings: Because of the limited discovery and the informal hearing procedures, as well as the expedited nature of the process, the parties save on legal fees and transactional costs;
- Confidentiality: Arbitration is a private process. There is generally no public record of the proceedings; and
- Limited Discovery: Extensive, litigation-like discovery is generally not associated with arbitration. Necessary document exchanges will take place as directed by the arbitrator.

4. Administration; Requesting and Scheduling Arbitration

It was the Commission's view that administration of ADR arising out of health plans be neutral and independent of the parties, and that in no event should an ADR program be administered by a health plan (*Protocol,* Principle 4(1)). This will ensure to a reasonable extent that administration of disputes will be handled with dispatch and without inherent conflicts of interest. This element of the Protocol is in accord with the leading court case dealing with the issue of independence of ADR case administration, *Engalla v. Kaiser Permanente Medical Group Inc.,* 938 P.2d 903 (Cal. 1998).

In an administered system, the administrator will be responsible for the management of most details and arrangements. In each matter, the designated administrator would consult all parties and arbitrators to determine a mutually convenient day and time for the hearing. If the parties cannot agree, the arbitrator is empowered to set dates.

All parties should endeavor to conduct the arbitration hearing at a location that is convenient for both the patient and family as well as the provider and the plan decision-maker. In some instances, this will require travel costs for the arbitrator, and such should be allocated in the agreement to arbitrate, if not in a prior arbitration clause. As provided in Principle 8 of the *Due Process Protocol,* consideration should also be given to the health and well-being of the patient in terms of the ability to travel, when determining the location of the hearing.

At the request of any party, or at the discretion of the administrator, an administrative conference with the administrator and the parties and/or their representatives will be scheduled in appropriate cases to expedite the proceedings. This is particularly pertinent in cases where time is critical and life threatening matters are at issue.

5. Qualifications and Selection of Arbitrators

Selected qualities in arbitrators include the following: commitment to impartiality and objectivity; dispute management skills; judicious temperament: impartiality, patience, courtesy; respect of bar or business community for integrity; and strong academic background and professional credentials. Arbitrators serving in health care disputes should have knowledge and experience in health care matters. Disputes concerning the provision of medical care based on medical necessity standards should be resolved by arbitrators who are qualified to render medical decisions in the particular medical branch and related specialty involved in the dispute (*Protocol,* Principle 5).

The conduct of arbitrators should be guided by the *Code of Ethics for Arbitrators in Commercial Disputes* of the AAA and ABA (*Protocol,* Principle 4(3)).

6. Preparation for the Arbitration Hearing

The administrator will usually be in contact with the parties and/or their representatives in advance of the hearing. Because arbitration is an adversarial procedure, direct communication between the parties should be generally prohibited so to avoid the danger that one side will offer arguments or evidence that the other has no opportunity to rebut.

In complex cases, at the request of any party or at the discretion of the arbitrator or the administrator, a preliminary hearing with the parties and/or their representatives may be conducted. In addition, in order to expedite the process, documents should be exchanged and provided to the arbitrator(s) at least three days in advance, except for those cases scheduled within less than seven days. In those instances, the document exchange shall be no less than 24 hours, unless so waived by agreement.

The right to representation in arbitration by counsel or another authorized person is guaranteed by the *Due Process Protocol* set forth herein (Principle 6), as well all modern arbitration statutes. A party who desires to be represented should notify the other side and file a copy of the notice with the case administrator at least three days before the hearing. When arbitration is initiated by a representative or when the respondent replies through a representative, however, such notice is deemed to have been given.

If a transcript of the hearing is needed, the parties are responsible for making the arrangements and notifying the other parties of such arrangements in advance of the hearing. In those instances where a party is unable, due to health difficulties, to be present at the arbitration, the arbitrator should be immediately notified and measures undertaken to provide an alternative method of testimony, such as telephone, videotape, video-conferencing and the use of the Internet.

7. Presentation of the Case

Arbitration hearings are conducted somewhat like court trials, except that arbitration is usually less formal. Arbitrators are generally not required to follow strict rules of evidence, unless otherwise agreed by the parties. They must hear all of the evidence material to an issue but they may determine for themselves what is relevant. Arbitrators will therefore be inclined to accept evidence that might not be allowed by judges. However, this does not mean that all evidence will be considered of equal weight. Direct testimony of witnesses is usually more persuasive than hearsay evidence, and facts will be better established by documents and exhibits than by argument only.

In these situations where the health of one party makes it difficult for personal appearance at the arbitration hearing, wide latitude should be given by the arbitrator(s) for the use of video-conferencing, the Internet, and other modes of communication that can obviate the need for an in-person hearing, if deemed necessary by the arbitrator. Furthermore, in cases of acute emergency, the arbitrator may determine to conduct the hearing by telephone (*Protocol,* Principle 7(2)), and other creative means, such as the Internet.

It is customary for the claimant to proceed first with its case, followed by the respondent. This order may be varied, however, when the arbitrator thinks it necessary. In any event, the "burden of proof" is not on one side more than the other; each party must try to convince the arbitrator of the correctness of its position and no hearing is closed until both have had a full opportunity to do so. That is why it is equally the responsibility of the claimant and the respondent to present their cases to the arbitrator in an orderly and logical manner. This may include:

- An opening statement that clearly but briefly describes the controversy and indicates what is to be proved. Such a statement lays the groundwork and helps the arbitrator understand the relevance of testimony to be presented.
- A discussion of the remedy sought. This is important because the arbitrator's power is conferred by the agreement of the parties. Each party should try to show that the relief it requests is within the arbitrator's authority to grant.
- Introduction of witnesses in a systematic order to clarify the nature of the controversy and to identify documents and exhibits. Cross examination of witnesses is important, but each party should plan to establish its case by its own witnesses.
- A closing statement that should include a summary of the evidence and arguments and a refutation of points made by the opposition.

Above all, a cooperative attitude is essential for effective arbitration. Overemphasis or exaggeration, concealment of facts, introduction of legal technicalities with the objective of delaying proceedings is discouraged.

8. The Role of the Arbitrators

The arbitrator's role is akin to that of a judge hearing a case without a jury: to listen to the presentations, review the evidence presented, and upon evaluation, make a decision on the matter. The arbitrator is not bound by the strict rules of evidence or trial procedure, unless same is desired by the parties.

9. The Award

The award is the decision of the arbitrator on the matters submitted to him or her under the arbitration agreement. If the arbitration panel consists of more than one arbitrator, the majority decision is binding. The purpose of the award is to dispose of the controversy finally and conclusively, and to rule on each claim submitted. While the arbitrator is generally viewed as a "creature of the parties' contract," and must make his or her award within the limits of the arbitration agreement, the *Protocol* (Principle 9(2)) provides that "the arbitrator should be empowered to grant whatever relief would have been available in court under law or in equity."

The award as a matter of law must be in writing. The *Protocol* (Principle 9(2)) relaxes that requirement somewhat, in that in cases of acute emergency, the arbitrator is permitted to make a

preliminary award orally. In such instances, however, a written award would still follow as required by law.

In general business disputes, arbitrators are not as a rule required to write opinions explaining the reasons for their decisions. In view of the issues involved in health care disputes, however, the Commission recommends that the award be accompanied by an opinion where requested by any party (*Protocol,* Principle 9(2)). An opinion would serve the dual purposes of helping a patient or provider better understand the outcome, and also serving as guidance to health plans in terms of future actions and behavior.

The power of the arbitrator ends with the making of the award. An award may not be changed by the arbitrator, once it is made, unless the parties agree to restore the power of the arbitrator or unless the law provides otherwise.

10. Costs

As provided in the *Protocol* (Principle 10) binding arbitration should not be mandated in disputes involving patients. It may be mandated in disputes not involving patients, as can nonbinding arbitration in any dispute. Where arbitration is mandated, the plan should pay the costs of at least one day of hearing before a single arbitrator (including the arbitrator's fee and expenses). If there are additional days of arbitration, the costs should be shared equally, subject to the power of the arbitrator to allocate costs. In some jurisdictions, the dominant party may be required to pay all arbitrator compensation where the use of arbitration is mandated by that party (see, e.g., *Cole v. Burns International Security Services,* 105 F.3d 1465 (D.C. Cir. 1997) (employment arbitration).

Where arbitration is consensual, the administrative fees and the costs of compensating the arbitrator will generally be borne as provided in the parties' arbitration agreement. Failing that, administrative fees are generally advanced by the filing party, and arbitrator's compensation is advanced equally by the parties. Both of these costs may be allocated by the arbitrator in the award.

Arbitrators generally charge a rate consistent with his or her stated rate of compensation, beginning with the first day of service. Should any dispute arise about the costs of the proceeding, it is recommended that such be submitted first to mediation, and, in the event of no agreement, to arbitration.

D. Hybrid Processes of ADR

In some instances, two or more ADR processes may be combined or used succeeding one another; this is often referred to as hybrid procedures. The advantage of such an arrangement is that if one process fails to achieve resolution, additional procedural options exist, and, where the final step is binding arbitration, comes with the assurance of finality. In situations where time is of the essence, it is important that the parties have the capability of achieving a final resolution rapidly.

One example of a hybrid ADR form is Mediation/Arbitration (Med/Arb). A clause can be inserted into a contract that provides first for mediation under an agreed upon set of mediation rules. In the event the mediation does not reach resolution of the matter, then the dispute would then go to arbitration under the agreed upon arbitration rules. Set forth below is a sample med/arb clause:

If a dispute arises out of or relates to this policy/contract, or the breach thereof, and if said dispute cannot besettled through direct discussions, the parties agree to first endeavor to settle the dispute in an amicable manner by mediation administered [named ADR provider] under its Mediation Rules. Thereafter, any unresolved controversy or claim arising out of or relating to this contract, or breach thereof, shall upon the written agreement of the parties after the dispute arises, be settled by arbitration administered by [named ADR provider] in accordance with its [applicable] Rules, and judgment upon the Award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof.

IV. MATRIX OF AREAS OF DISPUTES AMENABLE TO ADR

In Plan

Disputed Service	*Timeframe for resolution*	*Example*	*Comments*
Surgical Services	Depends on procedure Maximum 30 days	Hysterectomy	2nd opinion useful; clinical guidelines
Cosmetic Surgery	6 months +	Breast reduction or augmentation	Psychological effects of not doing need consideration
Dental/Oral Surgery	90 days	TMJ dysfunction	Separate dental insurance may cover
Durable Medical Equipment	30 days	Glucose monitor for diabetics, wheel chairs, nebulizers	Clinical standards/ guidelines useful
Procedures & Tests	30 days	CT Scan for headaches, repreat cholesterol tests, abdominal ultrasound	Clinical standards/ guidelines useful
Physical Therapy & Occupational Therapy	30 to 60 days	Excess services per plan speech therapy for children	For children:overlap Coverage with school system; work disability an issue
Denial of Referral	30 days	Dermatology, OB/GYN, Ortho	Limited referral may be acceptable; open access to OB/GYN recommended
Mental Health	30 to 60 days	Length of treatment, length of stay	opinion useful
Second Opinion	30 days	In Network vs out of Network 2nd opinion	Can be used in mediation
Hospice	30 days	Terminal cancer care	Quality of "end of life"
Restricted Formulary	60 days	Paxil instead of Prozac; generic vs nongeneric; switch of medication	2nd opinion; clinical guidelines
Excessive Wait Times	30 days	Waits of 60 days for	Service standards shoud

		diagnostic services	be in place
Home Health Care	30 days	Number of visits for specific care 24hr neonatal discharge follow-up; early discharge from hospital	With decreasing LOS in hospitals, more need for home health care nursing
Length of Stay	24 hours	Any discharge felt to be early	Goal of hospitalization should be communicated to patient on admission
Out of area coverage for medical services	30 days -- sooner if care is emergent	Dispute would normally be regarding payment after services rendered	Health plans should have provisions for out of area coverage
Emergency services	30-60 days if service has been rendered	Dispute would normally be regarding payment after services rendered	Health plans should have "prudent layperson" language for ER services
Access to non affiliated primary care providers	60 days	Desire to keep personal doctor	Continuity of care issues
Access to non affiliated specialty care providers	30 days	Desire to see previously seen specialist or specific program	Limited referral a possibility
Access to nonaffiliated mental health providers	30-60 days	Desire to keep current specialist; desire for specific program	Limited referral a possibility
Admission to nonaffiliated hospital	Depends on nature of admission	Desire for admission to University Hospital/Mayo Clinic	Limited referral a possibility
Second opinion with nonaffiliated providers	30 days	Desire for consultation at a University Hospital/Mayo Clinic	Limited referral a possibility
Access to nonaffiliated dental/oral surgery	30-60 days		Limited referral a Possibility
Access to nontraditional "alternative" medical care	60 days	Chiropractic/podiatry if not covered; herbal treatments, acupuncture	
Experimental care	30 days (or less depending on condition)	In the past, bone marrow treatments	Should be part of study conducted by reputable health science program
Continuity of care issues	30 days	Switch of insurance during pregnancy, cancer treatment	
Time sensitive situations	Depends on medical condition	Dialysis, cancer treatments, withdrawal	
Customer service	Varies	Failure to respond to inquiry	

V. DUE PROCESS PROTOCOL FOR EMPLOYMENT DISPUTES

A Due Process Protocol for Mediation and Arbitration
Of Statutory Disputes arising
Out of the Employment Relationship
May 9, 1995

The following protocol is offered by the undersigned individuals, members of the Task Force on Alternative Dispute Resolution in Employment, as a means of providing due process in the resolution by mediation and binding arbitration of employment disputes involving statutory rights. The signatories were designated by their respective organizations, but the protocol reflects their personal views and should not be construed as representing the policy of the designating organizations.

GENESIS

This Task Force was created by individuals from diverse organizations involved in labor and employment law to examine questions of due process arising out of the use of mediation and arbitration for resolving employment disputes. In this protocol we confine ourselves to statutory disputes.

The members of the Task Force felt that mediation and arbitration of statutory disputes conducted under proper due process safeguards should be encouraged in order to provide expeditious, accessible, inexpensive and fair private enforcement of statutory employment disputes for the 100,000,000 members of the workforce who might not otherwise have ready, effective access to administrative or judicial relief. They also hope that such a system will serve to reduce the delays which now arise out of the huge backlog of cases pending before administrative agencies and courts and that it will help forestall an even greater number of such cases.

A. Pre or Post Dispute Arbitration

The Task Force recognizes the dilemma inherent in the timing of an agreement to mediate and/or arbitrate statutory disputes. It did not achieve consensus on this difficult issue. The views in this spectrum are set forth randomly, as follows:

- Employers should be able to create mediation and/or arbitration systems to resolve statutory claims, but any agreement to mediate and/or arbitrate disputes should be informed, voluntary, and not a condition of initial or continued employment.
- Employers should have the right to insist on an agreement to mediate and/or arbitrate statutory disputes as a condition of initial or continued employment. Postponing such an agreement until a dispute actually arises, when there will likely exist a stronger predisposition to litigate, will result in very few agreements to mediate and/or arbitrate, thus negating the likelihood of effectively utilizing alternative dispute resolution and overcoming the problems of administrative and judicial delays which now plague the system.
- Employees should not be permitted to waive their right to judicial relief of statutory claims arising out of the employment relationship for any reason.
- Employers should be able to create mediation and/or arbitration systems to resolve statutory claims, but the decision to mediate and/or arbitrate individual cases should not be made until after the dispute arises.

The Task Force takes no position on the timing of agreements to mediate and/or arbitrate statutory employment disputes, though it agrees that such agreements be knowingly made. The focus of this protocol is on standards of exemplary due process.

B. Right of Representation

1. Choice of Representative

Employees considering the use of or, in fact, utilizing mediation and/or arbitration procedures should have the right to be represented by a spokesperson of their own choosing. The mediation and arbitration procedure should so specify and should include reference to institutions which might offer assistance, such as bar associations, legal service associations, civil right organizations, trade unions, etc.

2. Fees for Representation

The amount and method of payment for representation should be determined between the claimant and the representative. We recommend, however, a number of existing systems which provide employer reimbursement of at least a portion of the employee's attorney fees, especially for lower paid employees. The arbitrator should have the authority to provide for fee reimbursement, in whole or in part, as part of the remedy in accordance with applicable law or in the interests of justice.

3. Access to Information

One of the advantages of arbitration is that there is usually less time and money spent in pre-trial discovery. Adequate but limited pre-trial discovery is to be encouraged and employees should have access to all information reasonably relevant to mediation and/or arbitration of their claims. The employees' representative should also have reasonable pre-hearing and hearing access to all such information and documentation.

Necessary pre-hearing depositions consistent with the expedited nature of arbitration should be available. We also recommend that prior to selection of an arbitrator, each side should be provided with the names, addresses and phone numbers of the representatives of the parties in that arbitrator's six most recent cases to aid them in selection.

C. Mediator and Arbitrator Qualification

1. Roster Membership

Mediators and arbitrators selected for such cases should have skill in the conduct of hearings, knowledge of the statutory issues at stake in the dispute, and familiarity with the workplace and employment environment. The roster of available mediators and arbitrators should be established on a non-discriminatory basis, diverse by gender, ethnicity, background, experience, etc. to satisfy the parties that their interests and objectives will be respected and fully considered.

Our recommendation is for selection of impartial arbitrators and mediators. We recognize the right of employers and employees to jointly select as mediator and/or arbitrator one in whom both parties have requisite trust, even though not possessing the qualifications here recommended, as most promising to bring finality and to withstand judicial scrutiny. The existing cadre of labor and employment mediators and arbitrators, some lawyers, some not, although skilled in conducting hearings and familiar with the employment milieu is unlikely, without special training, to consistently possess knowledge of the statutory environment in which these disputes arise and of the characteristics of the non-union workplace.

There is a manifest need for mediators and arbitrators with expertise in statutory requirements in the employment field who may, without special training, lack experience in the employment area and in the conduct of arbitration hearings and mediation sessions. Reexamination of rostering eligibility by designating agencies, such as the American Arbitration Association, may permit the expedited inclusion in the pool of this most valuable source of expertise.

The roster of arbitrators and mediators should contain representatives with all such skills in order to meet the diverse needs of this caseload.

Regardless of their prior experience, mediators and arbitrators on the roster must be independent of bias toward either party. They should reject cases if they believe the procedure lacks requisite due process.

2. Training

The creation of a roster containing the foregoing qualifications dictates the development of a training program to educate existing and potential labor and employment mediators and arbitrators as to the statutes, including substantive, procedural and remedial issues to be confronted and to train experts in the statutes as to employer procedures governing the employment relationship as well as due process and fairness in the conduct and control of arbitration hearings and mediation sessions.

Training in the statutory issues should be provided by the government agencies, bar associations, academic institutions, etc., administered perhaps by the designating agency, such as the AAA, at various locations throughout the country. Such training should be updated periodically and be required of all mediators and arbitrators. Training in the conduct of mediation and arbitration could be provided by a mentoring program with experienced panelists.

Successful completion of such training would be reflected in the resume or panel cards of the arbitrators supplied to the parties for their selection process.

3. Panel Selection

Upon request of the parties, the designating agency should utilize a list procedure such as that of the AAA or select a panel composed of an odd number of mediators and arbitrators from its roster or pool. The panel cards for such individuals should be submitted to the parties for their perusal prior to alternate striking of the names on the list, resulting in the designation of the remaining mediator and/or arbitrator.

The selection process could empower the designating agency to appoint a mediator and/or arbitrator if the striking procedure is unacceptable or unsuccessful. As noted above, subject to the consent of the parties, the designating agency should provide the names of the parties and their representatives in recent cases decided by the listed arbitrators.

4. Conflicts of Interest

The mediator and arbitrator for a case has a duty to disclose any relationship which might reasonably constitute or be perceived as a conflict of interest. The designated mediator and/or arbitrator should be required to sign an oath provided by the designating agency, if any, affirming the absence of such present or preexisting ties.

5. Authority of the Arbitrator

The arbitrator should be bound by applicable agreements, statutes, regulations and rules of procedure of the designating agency, including the authority to determine the time and place of the hearing, permit reasonable discovery, issue subpoenas, decide arbitrability issues, preserve order and privacy in the hearings, rule on evidentiary matters, determine the close of the hearing and procedures for post-hearing submissions, and issue an award resolving the submitted dispute.

The arbitrator should be empowered to award whatever relief would be available in court under the law. The arbitrator should issue an opinion and award setting forth a summary of the issues, including the type(s) of dispute(s), the damages and/or other relief requested and awarded, a statement of any other issues resolved, and a statement regarding the disposition of any statutory claim(s).

6. Compensation of the Mediator and Arbitrator

Impartiality is best assured by the parties sharing the fees and expenses of the mediator and arbitrator. In cases where the economic condition of a party does not permit equal sharing, the parties should make mutually acceptable arrangements to achieve that goal if at all possible. In the absence of such agreement, the arbitrator should determine allocation of fees. The designating agency, by negotiating the parties' share of costs and collecting such fees, might be able to reduce the bias potential of disparate contributions by forwarding payment to the mediator and/or arbitrator without disclosing the parties' share therein.

D. Scope of Review

The arbitrator's award should be final and binding and the scope of review should be limited.

Dated: May 9, 1995

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VI. DUE PROCESS PROTOCOL FOR CONSUMER DISPUTES

A Due Process Protocol for the Mediation and Arbitration of Consumer Disputes
April 17, 1998

PRINCIPLE 1. FUNDAMENTALLY-FAIR PROCESS

All parties are entitled to a fundamentally-fair ADR process. As embodiments of fundamental fairness, these Principles should be observed in structuring ADR Programs.

PRINCIPLE 2. ACCESS TO INFORMATION REGARDING ADR PROGRAM

Providers of goods or services should undertake reasonable measures to provide consumers with full and accurate information regarding Consumer ADR Programs. At the time the Consumer contracts for goods or services, such measures should include (1) clear and adequate notice regarding the ADR provisions, including a statement indicating whether participation in the ADR Program is mandatory or optional, and (2) reasonable means by which Consumers may obtain additional information regarding the ADR Program. After a dispute arises, Consumers should have access to all information necessary for effective participation in ADR.

PRINCIPLE 3. INDEPENDENT AND IMPARTIAL NEUTRAL; INDEPENDENT ADMINISTRATION

1. Independent and Impartial Neutral. All parties are entitled to a Neutral who is independent and impartial.

2. Independent Administration. If participation in mediation or arbitration is mandatory, the procedure should be administered by an Independent ADR Institution. Administrative services should include the maintenance of a panel of prospective Neutrals, facilitation of Neutral selection, collection and distribution of Neutral's fees and expenses, oversight and implementation of ADR rules and procedures, and monitoring of Neutral qualifications, performance, and adherence to pertinent rules, procedures and ethical standards.
3. Standards for Neutrals. The Independent ADR Institution should make reasonable efforts to ensure that Neutrals understand and conform to pertinent ADR rules, procedures and ethical standards.
4. Selection of Neutrals. The Consumer and Provider should have an equal voice in the selection of Neutrals in connection with a specific dispute.
5. Disclosure and Disqualification. Beginning at the time of appointment, Neutrals should be required to disclose to the Independent ADR Institution any circumstance likely to affect impartiality, including any bias or financial or personal interest which might affect the result of the ADR proceeding, or any past or present relationship or experience with the parties or their representatives, including past ADR experiences. The Independent ADR Institution should communicate any such information to the parties and other Neutrals, if any. Upon objection of a party to continued service of the Neutral, the Independent ADR Institution should determine whether the Neutral should be disqualified and should inform the parties of its decision. The disclosure obligation of the Neutral and procedure for disqualification should continue throughout the period of appointment.

PRINCIPLE 4. QUALITY AND COMPETENCE OF NEUTRALS

All parties are entitled to competent, qualified Neutrals. Independent ADR Institutions are responsible for establishing and maintaining standards for Neutrals in ADR Programs they administer.

PRINCIPLE 5. SMALL CLAIMS

Consumer ADR Agreements should make it clear that all parties retain the right to seek relief in a small claims court for disputes or claims within the scope of its jurisdiction.

PRINCIPLE 6. REASONABLE COST

1. Reasonable Cost. Providers of goods and services should develop ADR programs which entail reasonable cost to Consumers based on the circumstances of the dispute, including, among other things, the size and nature of the claim, the nature of goods or services provided, and the ability of the Consumer to pay. In some cases, this may require the Provider to subsidize the process.
2. Handling of Payment. In the interest of ensuring fair and independent Neutrals, the making of fee arrangements and the payment of fees should be administered on a rational, equitable and consistent basis by the Independent ADR Institution.

PRINCIPLE 7. REASONABLY CONVENIENT LOCATION

In the case of face-to-face proceedings, the proceedings should be conducted at a location which is reasonably convenient to both parties with due consideration of their ability to travel and other pertinent

circumstances. If the parties are unable to agree on a location, the determination should be made by the Independent ADR Institution or by the Neutral.

PRINCIPLE 8. REASONABLE TIME LIMITS

ADR proceedings should occur within a reasonable time, without undue delay. The rules governing ADR should establish specific reasonable time periods for each step in the ADR process and, where necessary, set forth default procedures in the event a party fails to participate in the process after reasonable notice.

PRINCIPLE 9. RIGHT TO REPRESENTATION

All parties participating in processes in ADR Programs have the right, at their own expense, to be represented by a spokesperson of their own choosing. The ADR rules and procedures should so specify.

PRINCIPLE 10. MEDIATION

The use of mediation is strongly encouraged as an informal means of assisting parties in resolving their own disputes.

PRINCIPLE 11. AGREEMENTS TO ARBITRATE

Consumers should be given:

a. clear and adequate notice of the arbitration provision and its consequences, including a statement of its mandatory or optional character;
b. reasonable access to information regarding the arbitration process, including basic distinctions between arbitration and court proceedings, related costs, and advice as to where they may obtain more complete information regarding arbitration procedures and arbitrator rosters;
c. notice of the option to make use of applicable small claims court procedures as an alternative to binding arbitration in appropriate cases; and,
d. a clear statement of the means by which the Consumer may exercise the option (if any) to submit disputes to arbitration or to court process.

PRINCIPLE 12. ARBITRATION HEARINGS

1. Fundamentally-Fair Hearing. All parties are entitled to a fundamentally-fair arbitration hearing. This requires adequate notice of hearings and an opportunity to be heard and to present relevant evidence to impartial decision-makers. In some cases, such as some small claims, the requirement of fundamental fairness may be met by hearings conducted by electronic or telephonic means or by a submission of documents. However, the Neutral should have discretionary authority to require a face-to-face hearing upon the request of a party.
2. Confidentiality in Arbitration. Consistent with general expectations of privacy in arbitration hearings, the arbitrator should make reasonable efforts to maintain the privacy of the hearing to the extent permitted by applicable law. The arbitrator should also carefully consider claims of privilege and confidentiality when addressing evidentiary issues.

PRINCIPLE 13. ACCESS TO INFORMATION

No party should ever be denied the right to a fundamentally-fair process due to an inability to obtain information material to a dispute. Consumer ADR agreements which provide for binding arbitration should establish procedures for arbitrator-supervised exchange of information prior to arbitration, bearing in mind the expedited nature of arbitration.

PRINCIPLE 14. ARBITRAL REMEDIES

The arbitrator should be empowered to grant whatever relief would be available in court under law or in equity.

PRINCIPLE 15. ARBITRATION AWARDS

1. Final and Binding Award; Limited Scope of Review. If provided in the agreement to arbitrate, the arbitrator's award should be final and binding, but subject to review in accordance with applicable statutes governing arbitration awards.
2. Standards to Guide Arbitrator Decision-Making. In making the award, the arbitrator should apply any identified, pertinent contract terms, statutes and legal precedents.
3. Explanation of Award. At the timely request of either party, the arbitrator should provide a brief written explanation of the basis for the award. To facilitate such requests, the arbitrator should discuss the matter with the parties prior to the arbitration hearing.

Dated: April 17, 1998

Some of the signatories to this Protocol were designated by their respective organizations, but the Protocol reflects their personal views and should not be construed as representing the policy of the designating organizations

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