

Our File No.: 3309

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Attorney for Plaintiff

Plaintiff(s)
HAMPTON RIDGE HEALTHCARE &
REHABILITATION CENTER

SUPERIOR COURT OF NEW JERSEY
LAW DIVISION: OCEAN COUNTY

-vs-

DOCKET NO.: OCN-L-002335-16

Defendant(s)
ESTATE OF IDELLA WRIGHT and
CHARLES DOUGLAS

Civil Action

ACKNOWLEDGEMENT OF SERVICE

Service of the Summons and Amended Complaint for is hereby acknowledged this

_____ day of _____ 2016.

BY: Jon-Henry Barr,
Attorney for Defendant, Charles Douglas

SUMMONS

Attorney(s) Richard J. Kozel, Esq. #027991977
Office Address 1200 Route 46 West, Suite 130
Town, State, Zip Code Clifton, New Jersey 07013
Telephone Number (973) 778-9800
Attorney(s) for Plaintiff
Hampton Ridge Healthcare & Rehabilitation Center

Superior Court of New Jersey

Ocean COUNTY
LAW DIVISION

Docket No: OCN-L-002335-16

Plaintiff(s)

Vs.

Estate of Idella Wright and Charles Douglas

Defendant(s)

CIVIL ACTION SUMMONS

From The State of New Jersey To The Defendant(s) Named Above:

The plaintiff, named above, has filed a lawsuit against you in the Superior Court of New Jersey. The complaint attached to this summons states the basis for this lawsuit. If you dispute this complaint, you or your attorney must file a written answer or motion and proof of service with the deputy clerk of the Superior Court in the county listed above within 35 days from the date you received this summons, not counting the date you received it. (A directory of the addresses of each deputy clerk of the Superior Court is available in the Civil Division Management Office in the county listed above and online at http://www.judiciary.state.nj.us/pro se/10153_deptyclerklawref.pdf.) If the complaint is one in foreclosure, then you must file your written answer or motion and proof of service with the Clerk of the Superior Court, Hughes Justice Complex, P.O. Box 971, Trenton, NJ 08625-0971. A filing fee payable to the Treasurer, State of New Jersey and a completed Case Information Statement (available from the deputy clerk of the Superior Court) must accompany your answer or motion when it is filed. You must also send a copy of your answer or motion to plaintiff's attorney whose name and address appear above, or to plaintiff, if no attorney is named above. A telephone call will not protect your rights; you must file and serve a written answer or motion (with fee of \$175.00 and completed Case Information Statement) if you want the court to hear your defense.

If you do not file and serve a written answer or motion within 35 days, the court may enter a judgment against you for the relief plaintiff demands, plus interest and costs of suit. If judgment is entered against you, the Sheriff may seize your money, wages or property to pay all or part of the judgment.

If you cannot afford an attorney, you may call the Legal Services office in the county where you live or the Legal Services of New Jersey Statewide Hotline at 1-888-LSNJ-LAW (1-888-576-5529). If you do not have an attorney and are not eligible for free legal assistance, you may obtain a referral to an attorney by calling one of the Lawyer Referral Services. A directory with contact information for local Legal Services Offices and Lawyer Referral Services is available in the Civil Division Management Office in the county listed above and online at http://www.judiciary.state.nj.us/prose/10153_deptyclerklawref.pdf.

S/Michelle M. Smith
Clerk of the Superior Court

DATED: 10/18/2016

Name of Defendant to Be Served: Charles Douglas c/o Jon-Henry Bar, Esq.

Address of Defendant to Be Served: 21 Brant Avenue, Clark, New Jersey 07066

Our File No.: 3309

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Tel. (973) 778-9800
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Attorney for Plaintiff

Plaintiff(s)
HAMPTON RIDGE HEALTHCARE &
REHABILITATION CENTER

SUPERIOR COURT OF NEW JERSEY
LAW DIVISION: OCEAN COUNTY

-vs-

DOCKET NO.: OCN-L-002335-16

Defendant(s)
ESTATE OF IDELLA WRIGHT and
CHARLES DOUGLAS

Civil Action

AMENDED COMPLAINT, CERTIFICATIONS and
CASE INFORMATION STATEMENT

Plaintiff, Hampton Ridge Healthcare & Rehabilitation Center being located at 94 Stevens Road, Toms River, New Jersey 08755 by way of Complaint states:

1. At all times hereinafter mentioned plaintiff is a duly licensed healthcare facility of the State of New Jersey and is located at 94 Stevens Road, Toms River, New Jersey 08755.

2. At all times hereinafter mentioned defendant, Idella Wright, executed and delivered a Power of Attorney to her nephew, defendant, Charles Douglas, dated July 23, 2014 giving him access to and control over, her income, assets and property. A copy of the Power of Attorney is attached hereto as Exhibit "A".

3. Defendant, Charles Douglas, executed plaintiff's Admission Agreement on July 28, 2014 thereby becoming the sponsor and responsible party for his aunt. A copy of the Admission Agreement is attached hereto as Exhibit "B".

4. At the time of admission Defendants were duly advised that Defendant, the late Idella Wright would remain a private pay patient until such time as she qualified for Medicaid benefits through

the Ocean County Board of Social Services, that a proper spend down had to occur pursuant to Federal and New Jersey Law, that her income, assets, and property had to be used solely for her care, that a timely and complete Medicaid application needed to be filed, and that the Defendants needed to fully cooperate and produce copies of all required documents.

5. Defendant acknowledged this responsibility and promised and represented that she would timely apply for and obtain Medicaid benefits and pay plaintiff's recurring bills.

6. Plaintiff relied upon these promises and representations to accept defendant as a patient.

7. At the specific instance and request of the defendant, plaintiff duly rendered all necessary and required medical care and treatment which was accepted without protest.

8. To the best of plaintiff's knowledge information and belief, Idella Wright passed away in September of 2016.

9. Defendants breached the terms of the Admission Agreement and their promises and representations by failing to properly and timely apply for Medicaid benefits, failing to cooperate with the Ocean County Board of Social Services, failing to properly spend down, and failing to pay plaintiff's final bill in the sum of \$18,322.00. A copy of the final billing is attached hereto as Exhibit "C".

10. Pursuant to Paragraph 4 of the Additional Conditions for private pay patients of the Admission Agreement for any bill unpaid for thirty (30) days, plaintiff is entitled to collect interest at the rate of twelve percent (12%) per annum adding the additional sum of \$3,858.82 through September 1, 2016.

11. Pursuant to the terms of the Admission Agreement, for any account placed for collection, plaintiff is entitled to collect its reasonable counsel fees of twenty five percent (25%) of the unpaid principal balance adding the sum of \$4,580.50.

12. Plaintiff is owed a total of \$26,761.32. Defendant is not entitled to any further credits or set offs as against the amount due plaintiff.

13. Plaintiff has demanded that defendant pay to it the sum of \$26,761.32 but, to date, defendants have failed and refused to do so.

14. WHEREFORE, plaintiff demands judgment against the defendants, both individually and jointly, for:

- A. \$26,761.32 together with 12% interest from and after September 1, 2016.
- B. Counsel fees as per the terms of the Admission Agreement.
- C. Costs of suit and filing fees.
- D. Such other and further relief as may be just.

Dated: October 12, 2016

Richard J. Kozel,
Attorney for Plaintiff

1. This matter is not the subject of any other lawsuit or arbitration proceeding, nor is one contemplated.

2. There are no other parties to be joined in this action unless same are disclosed through subsequent discovery.

Dated: October 12, 2016

Richard J. Kozel,
Attorney for Plaintiff

CERTIFICATION PURSUANT TO RULE 1:38-7(B)

I certify that confidential personal identifiers have been redacted from documents now submitted to the Court, and will be redacted from all documents submitted in the future in accordance with Rule 1:38-7(B).

Dated: October 12, 2016

Richard J. Kozel,
Attorney for Plaintiff

EXHIBIT "A"

POWER OF ATTORNEY

KNOW ALL MEN BY THESE PRESENTS that I, Idella Wright, have made, constituted and appointed and by these presents do make, constitute and appoint Charles Douglas, my true and lawful attorney (hereinafter my "Attorney-in-Fact"), to act in, manage and conduct all my estate and affairs for me and to concur with persons jointly interested with myself therein in the doing or executing of all or any of the following acts, deeds, and things, in my place and stead:

1. To conduct banking transactions as set forth in section 2 of P.L. 1991, c. 95 (N.J.S. 46:2B-8 et seq.), or any analogous successor to that statute or any similar legislation in any other jurisdiction;

2. To ask, demand, sue for, recover, collect and receive all sums of money, specialties, claims, debts, dues, coupons, dividends, annuities and demands whatsoever, that now are, or which hereafter shall become due, owing, payable or belonging to me, and to have, use and employ all lawful ways and means in my name or otherwise, for the recovery thereof; to compromise and agree with respect to the same and accept receipts, a quittance, discharges, satisfactions, assignments and releases for me and in my name; to make, seal and deliver or endorse or cash checks, drafts, notes and other negotiable instruments for collection or for transfer; to make bank deposits by check, draft or other means;

3. To purchase, receive, accept or otherwise acquire U.S. Treasury bonds redeemable in payment of federal estate taxes upon such terms, as my Attorney-in-Fact shall deem advisable, and to borrow money for the purpose of purchasing such bonds, upon such terms as my Attorney-in-Fact shall deem advisable;

4. To bring and defend claims, actions and proceedings in law and in equity for and against me, or in any manner arbitrate, compromise or otherwise deal with and settle all such claims and actions;

5. To pay my bills and make disbursements from my assets;

6. To enter any safe deposit box in any bank or trust company standing in my name and withdraw therefrom my property of every description;

7. To buy, receive, lease, accept or otherwise acquire, to sell, convey, mortgage, hypothecate, pledge, quit-claim or otherwise encumber or dispose of, or to contract or agree for the acquisition, disposal or encumbrance of, any property whatsoever, whether real, personal or mixed, including, but not by way of limitation, stocks, bonds and other securities of every kind and nature, or any custody, possession, interest, or right therein, upon such terms as my Attorney-in-Fact shall deem advisable;

8. To take, hold, possess, invest, lease or let, or otherwise manage any or all of my property or any interest therein, to eject, remove, or relieve tenants or other persons from, and recover possession of, such property by all lawful means and to maintain, protect, preserve, insure, remove, store, transport, repair, rebuild, modify or improve the same or any part thereof;

9. To act as my agent or proxy with respect to any stocks, shares, bonds or other investments, rights or interests I may now or hereafter hold and with respect to any reorganization, consolidation, merger or other capital readjustment of any corporation the stocks or securities of which may at any time be held by me;

10. To engage and dismiss agents, counsel and employees, and to appoint and remove at pleasure any substitute for, or agent of my Attorney-in-Fact, with respect to all or any of the matters or things herein mentioned and upon such terms as my Attorney-in-Fact shall deem advisable;

11. To make, execute and verify any and all tax returns, forms or applications, or papers necessary or desirable for obtaining certificates or papers issued by any government agency;

12. To execute, amend and revoke trust agreements on my behalf, and to contribute property to and withdraw property from any trust, to the extent not prohibited by the terms of such trust agreements;

13. To execute change of beneficiary and change of ownership forms with respect to any life insurance policy owned by me, and to change the beneficiary of any benefits payable under any qualified or non-qualified retirement plan or deferred compensation plan in which I am a participant, to the extent not prohibited by the terms of such plan;

14. To make gifts on one or more occasions to one or more charitable organizations and individuals who are determined by my Attorney-in-Fact to be the natural objects of my bounty (and I hereby specifically declare that my Attorney-in-Fact himself or herself is one of the natural objects of my bounty, and I specifically authorize my Attorney-in-Fact to make gifts to himself or herself), provided, however, that in no event shall the total gifts to any one individual in any one calendar year exceed the federal gift tax annual exclusion in effect at the time of such gift;

15. To resign from or renounce any fiduciary position to which I have been or may be appointed or elected, including the positions of executor, administrator, personal representative, trustee, guardian, attorney-in-fact, or officer or director of any corporate or other entity, or any governmental or political office or position to which I have been or may be elected or appointed;

16. To renounce and disclaim any property or interest in property or any powers over property to which for any reason and by any means I may become entitled, whether by gift, will, intestate succession or otherwise; to release or abandon any property or interest in property or powers over property which I may now or hereafter own, including any interests in or rights over trusts (including the right to alter, amend, revoke or terminate); to exercise any right to claim an elective share in any estate or under any will; and

17. To make, execute, seal and deliver any and all papers and instruments essential, necessary, proper or incidental to the carrying out of any and all of the above-mentioned accts, powers and purposes.

Giving and Granting unto my Attorney-in-Fact full power and authority to do and perform all and every act and thing whatsoever requisite and necessary to be done in and about my estate, property, and affairs as fully as I might or could do if personally present, the special powers enumerated above being an explanation of and not a limitation of such general power, and I hereby ratify and confirm all that my Attorney-in-Fact or any substitute for my Attorney-in-Fact shall lawfully do or cause to be done by virtue hereof.

I expressly exonerate my Attorney-in-Fact for any loss incurred in the execution of this Power, except when occasioned by fraud or gross negligence.

And I do for myself, my heirs, executors and administrators, expressly covenant and agree with each and every person and corporation dealing with my Attorney-in-Fact in reliance upon these premises, that this Power shall continue, and all acts performed by my Attorney-in-Fact or any substitute for my Attorney-in-Fact pursuant to the authority of my Attorney-in-Fact hereunder shall be valid and effectual to bind me and those succeeding me in interest, until express notice of revocation of this Power by me, or express notice of my death, is received by such person or corporation.

The powers and authority granted to my Attorney-in-Fact by this Power shall not apply with respect to any policy of insurance I may own on the life of my Attorney-in-Fact.

If at any time I sign a health care power of attorney authorizing someone to make health care treatment decisions on my behalf, I intend that all health care treatment decisions on my behalf shall be made exclusively by me or the person or persons named therein, and not by my

Attorney-in-Fact acting under this instrument.

This Power of Attorney shall not be affected by my disability or mental or physical incapacity. This Power of Attorney shall not be diminished or revoked by the mere passage of time.

IN WITNESS WHEREOF, I have hereunto set my hand and seal the 3rd day of May, 2014.


IDELLA WRIGHT

STATE OF NEW JERSEY)
)SS
COUNTY OF OCEAN)

BE IT REMEMBERED that on this 22nd day of July , 2014 before me, the subscriber, IDELLA WRIGHT personally appeared, who I am satisfied is the principal in the within Power of Attorney named, and I having first made known to him the contents thereof, he acknowledged that he signed, sealed and delivered the same as his voluntary act and deed for the uses and purposes therein expressed.



A Notary Public of New Jersey
LORI-ANN POLEWCZAK
A Notary Public of New Jersey
My Commission Expires January 24, 2007 2017

EXHIBIT "B"

**HEALTH CARE ADVANCE DIRECTIVE AND
DESIGNATION OF HEALTH CARE REPRESENTATIVE
of IDELLA WRIGHT**

NOTICE TO PERSON EXECUTING THIS DOCUMENT

This is an important legal document. Before you sign it, you should know these important facts:

This document gives the person you designate as your Health Care Representative the power to make health care decisions for you. Your Health Care Representative must act consistently with your desires as stated in this document, or as you make known by other means.

Unless you specify otherwise in this document, this document gives your Health Care Representative the power to consent that your doctor withhold treatment or stop treatment necessary to keep you alive.

Notwithstanding this document, you retain the right to make medical and other health care decisions for yourself so long as you can give informed consent with respect to each particular decision. In addition, no treatment may be given to you over your objection, and health care necessary to keep you alive may not be stopped or withheld if you object at the time.

This document gives your Health Care Representative authority to consent, to refuse to consent, or to withdraw consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition. That authority is subject to any statement of your desires and any limitations you include in this document. You may state in this document any types of treatment that you do not desire. In addition, a Court can take away your Health Care Representative's power to make health care decisions for you if your Health Care Representative (1) authorizes anything that is illegal, (2) acts contrary to your known desires, or (3) if your desires are not known, does anything that is clearly contrary to your best interests.

You have the right to revoke your Health Care Representative's power by notifying your treating doctor, hospital or other health care provider of the revocation orally or in writing.

Your Health Care Representative has the right to examine your medical records and to consent to their disclosure unless you limit that right in this document.

Unless you specify otherwise in this document, this document gives your Health Care Representative the power after you die to (1) authorize an autopsy, (2) donate your body or parts thereof transplant or therapeutic or educational or scientific purposes, and (3) direct the disposition of your remains. None of the following persons should be designated as your Health Care Representative: (1) your treating health care provider, (2) a non-relative employee of your treating health care provider, (3) a non-relative operator of a care facility, or (4) a non-relative employee of an operator of a care facility. ["Non-relative" means not related to you by blood, adoption or marriage.]

1. CREATION OF HEALTH ADVANCE DIRECTIVE AND DESIGNATION OF HEALTH CARE REPRESENTATIVE

By this document I, Idella Wright, a competent adult and a resident of 52 Ronald Avenue South, Bayville, NJ 08721 intends to create a Health Care Advance Directive and to designate a Health Care Representative as authorized by the Statutes of the State of New Jersey.

2. DESIGNATION OF HEALTH CARE REPRESENTATIVE

I hereby make known to my family, my physician, and others my instructions and wishes for my future health care. In the event I become incapable of making health care decisions or of providing or denying informed consent for any medical procedures, then in that case I designate and appoint my son Charles Douglas, whose mailing address is 1458-1464 Brentwood Terrace, Plainfield, NJ 07060, as my Health Care Representative ("Representative") to make health care decisions for me as authorized in this document.

3. GENERAL STATEMENT OF AUTHORITY GRANTED

If I become incapable of giving informed consent to health care decisions, I give my Representative full power and authority to make health care decisions for me including the right to consent, refuse consent, or withdraw consent to any care, treatment, service or procedure to maintain, diagnose or treat a physical or mental condition, and to receive and to consent to the release of medical information, subject to the statement of desires, special provisions and limitations set out in this document. This authority shall include, to the extent noted in this document, the right to withhold or withdraw life sustaining treatment.

4. INSTRUCTIONS - STATEMENT OF DESIRES, SPECIAL PROVISIONS, AND LIMITATIONS

_____ I do not want my life to be prolonged and I do not want life-sustaining treatment to be provided or continued if I am in a persistent vegetative condition or, if in the opinion of my designated health care decision maker, the burdens of my condition, including the likelihood of recovery, the manner and length of suffering I would endure, and my future life expectancy, would outweigh the anticipated benefits of my survival. Once my doctors OR my designated decision maker have concluded that I am in such a condition, I direct that life-sustaining treatment NOT be provided or continued and specifically authorize my representative to withdraw or withhold life sustaining treatment in such a situations.

Other or additional statement, special provisions, or limitation: I specifically advise that I do not wish to be placed on a respirator.

5. SPECIFIC INSTRUCTIONS: Artificially Provided Fluids and Nutrition and Cardiopulmonary Resuscitation (CPR).

_____ In the circumstances, which I have indicated in item number 4, I also direct that artificially provided fluids and nutrition, such as by feeding tube or intravenous infusion, be withheld and or withdrawn and I be allowed to die.

6. CONTRIBUTION OF ANATOMICAL GIFT

Pursuant to the Uniform Anatomical Gift Act, effective upon my death:

_____ I DO NOT wish to make an anatomical gift upon my death of any organs.

7. AUTOPSY AND DISPOSITION OF MY REMAINS

I understand that my Representative will be able to authorize an examination of my body after my death to determine the cause of my death, and to direct the disposition of my remains unless I limit that authority in this document. I direct my Representative not to authorize an autopsy unless needed for a criminal investigation and I further direct the person who directs the disposition of my remains to follow any instructions I have given in a written contract for funeral services or by some other method.

8. DESIGNATION OF ALTERNATE HEALTH CARE REPRESENTATIVES

If the person designated in Paragraph 2 as my Representative is not available and willing to make a health care decision for me, then I designate the following person to serve as my alternate health care representatives to make health care decisions for me as stated in this document:

<u>Name</u>	<u>Address</u>	<u>Telephone Number</u>
Lawrence Douglas	52 Ronald Avenue So, Bayville, NJ	

9. DURATION

I understand that this designation of Health Care Representative and the authority I have given my Representative (including alternates) will continue unless I revoke this document.

10. PREVIOUS DESIGNATIONS REVOKED

I revoke any prior Health Care Advance Directive, Designation of Health Care Representative or Durable Power of Attorney for Health Care signed before this date.

By writing this advance directive, I inform those who may become entrusted with my health care

of my wishes and intend to ease the burdens of decision making which this responsibility may impose. I have discussed the terms of this designation with my healthcare representative and he or she has willingly agreed to accept the responsibility for acting on my behalf in accordance with this directive. I understand the purpose and effect of this document and sign it knowingly, voluntarily and after careful deliberation.

Signed this 23rd day of July, 2014

Signature: Idella Wright
Idella Wright

Address: 52 Ronald Avenue S., Bayville, NJ 08721

SELF-PROVING AFFIDAVIT

State of New Jersey)
 SS
County of Ocean)

I, Idella Wright, sign my name to this instrument this 23rd day of July, 2014 and being first duly sworn, do hereby declare to the undersigned authority that I sign and execute this instrument as my Health Care Advance Directive and that I sign it willingly, and that I execute it as my free and voluntary act for the purposes therein expressed, and that I am 18 years of age or older, of sound mind and under no constraint or undue influence.

Idella Wright
Idella Wright

STATEMENT OF WITNESSES

Elizabeth Dalton and Jennifer Lorwey, the witnesses, being duly sworn declare under penalty of perjury that the person who signed and acknowledged this document is personally known to us to be the Declarant; that the Declarant signed and acknowledged this Health Care Advance Directive and Designation of Health Care Representative in our presence; that the Declarant appeared to be of sound mind and under no duress, fraud or undue influence; that neither of us is the person appointed as Health Care Representative by this document; that neither of us is a health care provider, an employee of a health care provider, the operator of a care facility, or an employee of an operator of a care facility; that we are not related to the Declarant by blood, marriage, or adoption; and that, to the best of our knowledge, neither of us is entitled to any part of the Declarant's estate upon the Declarant's death under a Will now existing or by operation of law. We state that in the presence and hearing of the Declarant, we hereby signs this Health Care Advance Directive as witness to the Declarant's signing, and that to the best of our knowledge the Declarant is 18 years or older.

Signature: 1. Elizabeth Dalton
Name: Elizabeth Dalton
Address: 28 Deer Path Dr.
Flanders, NJ 07836

2. Jennifer Lantry
311 Wimbeldon Ct
North Brunswick, NJ 08902

State of New Jersey)

County of Ocean)

Subscribed, sworn to and acknowledged before me by Idella Wright, the Declarant, and subscribed and sworn to before me by Elizabeth Dalton and Jennifer Lantry, witnesses, this 23rd day of July, 2014.

Lori Ann Polewczak
Notary Public of the State of New Jersey
LORI-ANN POLEWCZAK
A Notary Public of New Jersey
My Commission Expires January 24, 2017

**HAMPTON RIDGE HEALTHCARE & REHABILITATION CENTER
ADMISSION AGREEMENT**

This is an agreement made on the 28th day of July, 2014 between
Hampton Ridge Healthcare and Rehabilitation Center (Facility) at 94 Stevens Rd. Toms River, N.J.
08755 and Wanda Wright, who is the Resident /Responsible Party.

AUTHORITY / OBLIGATION OF RESPONSIBLE PARTY

11 Authority of the Responsible Party

If a Responsible Party and not the Resident signs this agreement, and the Responsible Party is the Resident's Power of Attorney and/or Legal Guardian, legal proof of such should be furnished to the Facility. Residents may appoint a person other than a Power of Attorney or Legal Guardian to act as their Responsible Party. In the case of a Resident who is 'admitted in a confused state and is unable to appoint a Responsible Party, the Facility will 'reach out to 'the Resident's next of kin, and if there is no family, the Resident's closest contact, to act as Responsible Party.

1.2 Primary Obligation of the Responsible Party

The obligation of the Responsible Party is a primary obligation, and not one of guaranty of payment or other performance. However, if the Responsible Party manages the Resident's finances, he/she is responsible for making payments owed to the facility out of the Resident's funds on time, and in the case of Resident's covered by Medicaid, turning over their monthly benefits in the beginning of each the month. If this provision or any other provision of this agreement is breached by the responsible party, the obligation becomes one of guarantee of payment.

FACILITY SERVICES

The Facility agrees to render care to the Resident, which includes food, shelter and general nursing care, so long as the Resident and I or Responsible Party fulfills their obligations under this agreement,

PHYSICIANS AND DENTISTS

31 Care by Attending Physician

The Resident shall be under the care of an attending physician, or if they choose, a physician from outside the facility, who is duly licensed by the State of New Jersey and who has submitted proof of his/her credentials for approval to the Facility and has agreed to abide by its policies and procedures. The Facility will inform the Resident / Responsible Party of the physicians who currently attend to the Residents at this Facility and the Resident / Responsible Party may choose which Physician will be assigned to the Resident's care, or if so requested, a representative of this Facility will choose the physician on the Resident's behalf.

Should the Resident require medical attention, the Facility will strive to obtain the services of the designated physician, but if the designated physician is unavailable, unless the Resident has designated an alternate physician, the Facility shall have the right to secure the services of another physician. The Medical Director of the Facility May also be contacted at this time.

3.2 Dentists

The Resident will be given the opportunity to be seen by the facility dentist within the first six (6) months of admission. If the Resident has a community dentist whom he wishes to continue to see, this is allowable.

33. Financial Arrangements with the Physician/Dentist

All financial arrangements for compensating the physician and dentist shall be between the Resident and the physician / dentist. A third party payer, such as Medicare, may cover physician services. Medicaid pays for physician and dental services for Residents that are covered by Medicaid only.

PERSONAL NEEDS ALLOWANCE ACCOUNT

4.1 The Account

Upon admission of a resident, a Personal Needs Allowance (PNA) account may be established on behalf of the Resident with monies to be made available to the Resident at the receptionist desk, Monday through Friday, 9:00 A.M. to 3:00 P.M. and Saturday and Sunday from 9:00 A.M. to 3:00 P.M. The Resident must sign for each withdrawal.

Each Medicaid recipient receiving Social Security income will have thirty-five dollars (\$35), of this monthly check deposited into their account each month.

if the PNA is over fifty dollars (\$50), the PNA will earn interest at the prevailing rate for savings bank accounts.

4.2 Statements

A quarterly statement will be generated to the Resident and/or Responsible Party, showing all deposits, withdrawals, credit for interest, and the balance.

V. RESIDENTS MANAGEMENT OF OWN FINANCIAL AFFAIRS AND SAFEGUARDING OF FUNDS

The Resident has the right to manage his/her own financial affairs. If the Resident gives the Facility a written request, the Facility shall hold, safeguard and account for any personal funds that the Resident wishes to deposit with the Facility under a system established and maintained under applicable law.

VI. PROVISIONS RELATING TO MEDICAID 6.1

Special Charges for Medicaid Recipients

If the Resident is receiving Medicaid benefits, certain items and services are included as part of the Medical program, Other Items not covered by Medicaid shall be the responsibility of the Resident and/or Responsible Party. Such non-covered services include, but are not limited to:

Beautician-Barber/Dry Cleaning Personal Clothing

6.2 Supplemental Income Checks

As required under the Medicaid Program, when the Resident converts to Medicaid, all supplemental income checks (Social Security, Veteran's Benefits, Pension Plan Payments, etc.) may not be cashed, but rather turned over to the Facility promptly after receipt

VII. TRANSFER TO HOSPITALS AND OTHER FACILITIES I TERMINATION OF AGREEMENT AND DISCHARGE

7.1 Transfer to Hospitals (Transportation)

In the event of a change in the Resident's physical and/or mental condition which necessitates a change in care which the Facility is not prepared to provide, the Facility will attempt to have the Resident transferred to a hospital, hospice or other appropriate facility, as specified by the designated physician or other attending physician and agreed to by the Resident or Responsible Party.

The Facility maintains transfer agreements with various hospitals. In the event of a need for emergency hospitalization, the Resident will be transferred to Atlantic Coast.

Payment for transportation to the hospital arranged by the Facility is the responsibility of the Resident and/or Responsible Party and/or the third party payer. In cases of Medicaid recipients, Medicaid pays this fee.

7.2 Release of Information

In case of transfer, the Facility is hereby authorized to release needed medical information to the hospital.

7.3 Holding a Bed for Return of the Resident

For the Medicaid recipient, New Jersey Medicaid will pay to hold the bed at this Facility for the first ten (10) days after discharge.

VIII. RIGHTS OF THE PARTIES TO TERMINATE THIS AGREEMENT / VOLUNTARY DISCHARGE

8.1 By the Facility

The Facility shall have the right, with cause, to terminate this agreement and the services hereunder, with thirty (30) days prior written notice to the Resident and/or Responsible Party.

8.2 By the Resident or Responsible Party

The Resident or Responsible Party shall have the right, without cause, to terminate this agreement and the services hereunder.

8.3 Certain Other Conditions for Voluntary Discharge

If the Resident wishes to discharge himself or herself from the Facility, he/she must first present a release signed by him/herself, or if the Resident is incompetent, by his or her Responsible Party.

IX. DEATH OF THE RESIDENT / BURIAL

The Resident and/or the Responsible Party acknowledge that the Facility assumes no financial responsibility for transfer to funeral homes or other expenses involved with respect to the death of a Resident. If the Resident has not made arrangements for burial or cremation prior to his/her passing, in the event of the Resident's death, the Responsible Party shall make such arrangements. In the absence of a Responsible Party, the Facility maintains the right to choose a facility to handle the necessary arrangements.

X. PERSONAL BELONGINGS OF RESIDENTS

10.1 General Rule

The Facility shall take every reasonable precaution to prevent the loss or damage of the personal belongings of the Resident

10.2 After Discharge or Death

The Facility is not responsible in any way for any of the Residents personal belongings remaining in the Facility thirty (30) days from the Residents death or discharge.

XI. RESIDENT RIGHTS ADVANCE DIRECTIVES

The Resident or Responsible Party acknowledges; by signing this Agreement, that the Resident or Responsible Party has read and understands all the written information provided by the Facility, including the statement of "Residents Rights" set forth in New Jersey Administrative Code B:39-4.1 (a copy of these Rights has been furnished to the Resident and/or the Responsible Party and will be reviewed yearly hereafter). The Resident or Responsible Party understands these Rights include the right of the Resident to make decisions concerning their medical care and the right to execute an Advance Directive. Information on Advance Directives will be given by the Social Worker as part of the Admission's process.

XII. INSURANCE AUTHORIZATION FOR PAYMENT

The Resident or Responsible Party requests and authorizes, by signing this Agreement, that this facility submit for all reimbursement from the Resident's insurance company (Medicare or Private) for benefits that may be due, as well as for the full cost of services rendered, and that the insurance company make payment for benefits that may be due, as well as for the full cost of services rendered.

XIII. ADDITIONAL FACTS AND ADVISEMENTS

12.1 No Discrimination

The Facility agrees to comply with the Provisions of the Federal Civil Rights Act of 1964, as the same may be amended from time to time, and to accept Residents without regard to race, color, national origin, ancestry, age, or religious creed, marital status or physical handicap.

This policy of non-discrimination also applies to the Residents physician and all employees.

12.2 Tips and Gratuities

Staff is not permitted to accept tips and gratuities.

12.3 Money and Valuables / Clothing

It is advisable that jewelry and other valuables should be retained by the Responsible Party and should not be kept on the Resident's person or in the Resident's room. It is advisable further that sums of money over \$10.00 should be retained by the Responsible Party or in the P.N.A. We strongly recommend that all clothing be brought to the receptionist so they may be inventoried and marked with the Resident's name.

12.4 Smoking

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This is a smoke free facility, however, Residents are permitted to smoke outdoors, provided they adhere to the rules and regulations set forth in the facility's smoking policy.

12.5 Temporary Leave of this Facility

The Resident may, upon written order of the designated physician, temporarily leave the Facility, but the Resident or his/her Responsible Party must first sign out with the Nurse of the unit on which the Resident resides. Any Resident leaving the Facility with or without a physician's order relieves the Facility of any responsibility.

12.6 Visiting Days and Hours

Visiting is permitted at any time, seven (7) days a week. For security, the main doors are open 8:00 a.m. to 8:00 p.m. Monday through Friday, and 9:00 a.m. to 6:00 p.m. Saturday and Sunday. All visitors must sign in at the main reception desk in the lobby. The facility has the right to impose reasonable restrictions to certain visitors to protect the security of our residents and staff.

12.7 Private Duty Services

Private duty care can be provided by the Facility at the request of a Resident or his/her Responsible Party. More information on this service can be obtained from the Administrator.

XIV. MISCELLANEOUS

This agreement comprises the entire agreement of the parties. It may not be modified except by a written statement signed by the Facility and the Resident and/or the Responsible Party.

13.1 Binding Effect

This agreement shall be to the benefit of and binding upon the party's respective heirs, administrators, executors, personal representatives, successors and assigns.

ADDITIONAL CONDITIONS FOR PRIVATE PAY RESIDENTS

f. Per Diem Rate Charge

The Resident/Responsible Party agrees to pay from the Resident's funds the amount of the Facility's daily charge for room/board and general nursing care (the Per Diem). The Per Diem rate is currently \$300.00 private/\$295.00 semi private per day. The Facility agrees to give the Resident/Responsible Party thirty (30) days advance notice in writing, of any increase in the Per Diem rate.

The Per Diem rate shall be paid monthly and in advance. Discharge from the Facility is at 11:00 A.M. If the Resident remains at the Facility after 11:00 A.M., the Facility shall be paid for the full Per Diem rate for that day. In the event that the Resident has a third party payer, and the full amount of the Facility's Per Diem rate is not paid, the Resident / Responsible Party will be required to pay the balance.

2. Security Deposit

A deposit of -----, equal to thirty (30) days at the Per Diem rate of \$300.00 private room/\$295.00 semi private room payable upon admission (the Security Deposit). No later than thirty (30) days after the end of the Resident's stay at the Facility, the unearned portion of the Security Deposit shall be refunded to the Resident and/or the Responsible Party.'

3. Special Charges Where There is No Third Party Payer

The Resident or Responsible Party agrees to pay the Facility within ten (10) days of billing for all charges for services/supplies rendered/ordered by the Resident's physician, or provided by the Facility, that are not covered by a third party payer. Such services may include, but are not limited to, the following:

Physician and Consultation Services / Surgical Supplies and Special Medical Equipment / Rental Equipment / Any Form of Transportation, Including Ambulance / Prescription Drugs / Dental Care / Oxygen / Podiatry Care / Ophthalmology Care / Any Form of Therapy / Lab Services / Radiology / Hand Feeding / Hairdresser and/or Barber Service.

4. Interest on Overdue Charges

Bills for the Per Diem rate shall be rendered monthly and shall be paid within ten (10) days of receipt. All bills for any account overdue more than thirty (30) days will bear interest at the rate of one percent (1%) per month, (i.e.) twelve percent (12%) per annum, compounded monthly, Should this matter be referred to an attorney for collection, the Resident 1 Responsible Party are liable to the facility for all attorney fees and costs incurred,

5 Applications for Third Party Payment

Should applications for payment be made for Medicaid, Medicare, Public Assistance, Veteran's Benefits or any insurance coverage, the Resident or Responsible Party agrees, nevertheless, that their obligations to the Facility for payments due pursuant to this agreement are not relieved unless and until the, third party actually ,ma_kes_ payment._

6 Right of Facility to Discharge Resident in Case of Non.Payment

For private pay Residents, in case of non-payment of amounts due to the Facility, the Facility, in its sole discretion, shall, after reasonable attempts to try to resolve the situation, have the right to discharge the Resident from the Facility. In case of such discharge, the Resident or Responsible Party must ensure that the Resident leave the Facility on the date of specified for discharge.

7 Application for Medicaid

The New Jersey Medicaid Program/Board of Social Services determines Medicaid eligibility. It is the responsibility of the Resident and/or Responsible Party to Inform the facility at least six (6) months prior to the anticipated end of the private pay period. It is further the responsibility of the Resident and/or Responsible Party to contact the Board of Social Services and apply for Medicaid, also at least six (6) months prior to the anticipated end of the private pay period, and to provide all documents requested by the Board of Social Services. If the Medicaid application is in process as of the date hereof or the date of admission, the Resident or Responsible Party must provide this information to the Facility.

8. Holding a Bed for Return of the Resident

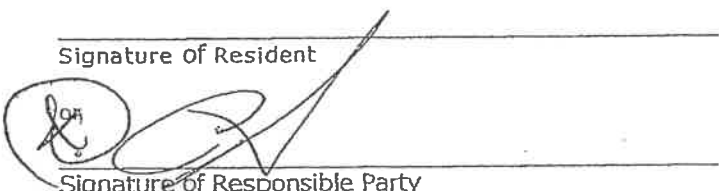
In the event of transfer of the Resident to a hospital and the Resident is a private pay Resident, the Resident will be given the opportunity to hold the bed by paying the Per Diem rate while the Resident is in the hospital. Payment must be made for seven (7) day periods, in advance.

9. Residents Admitted Under Medicare

Individuals covered by the Medicare program will only incur cost after utilization of their benefits and for supplies/services not covered by the Medicare program. Medicare allows for up to 20 days full coverage and a maximum of 80 days partial coverage. Private funds or co-insurance will be charged for the difference during the partial coverage period.

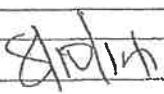
By signing below I acknowledge that I have reviewed the Admissions Agreement of Hampton Ridge Healthcare and Rehabilitation center and understand the contents within, as well as my responsibilities.
HAMPTON RIDGE HEALTHCARE AND REHABILITATION CENTER

Signature of Resident



Signature of Responsible Party

Address (of Responsible Party):

_____  _____

Date

EXHIBIT "C"



HamptonRidge

HEALTHCARE & REHABILITATION

94 Stevens Road ♦ Toms River, NJ 08755 ♦ 732-286-5005

Charles Douglas
1458 Brentwood Terrace
Plainfield, NJ 07060

Statement Date: 10/22/2015
Resident Name: Idella Wright
Resident ID: 1628

Date	Description	Period Covered	Days	Rate	Charge	Credit	Balance
9/01/2014	Room and Board	Sep 20 - 30 2014	11	305.00	3,355.00		\$3,355.00
10/01/2014	Room and Board	Oct 01 - 31 2014	31	305.00	9,455.00		\$12,810.00
11/01/2014	Room and Board	Nov 01 - 21 2014	21	305.00	6,405.00		\$19,215.00
11/01/2014	Bedhold	Nov 22 - 26 2014	5	305.00	1,525.00		\$20,740.00
9/30/2015	Payment	Oct 01 - 31 2014				1,209.00	\$19,531.00
9/30/2015	Payment	Nov 01 - 22 2014				1,209.00	\$18,322.00

Total Amount Due: \$18,322.00

If you'd like to discuss this statement please contact Chana at 732-994-4360
or email Chana@HamptonRidgeHealth.com.

Please detach and return with your payment.

Statement Date: 10/22/2015

Charles Douglas
1458 Brentwood Terrace
Plainfield, NJ 07060

Resident Name: Idella Wright
Resident ID: 1628

**Hampton Ridge Healthcare and
Rehab LLC**
94 Stevens Road
Toms River, NJ 08755

Total Amount Due:	\$18,322.00
Amount Enclosed:	_____