IN THE

Supreme Court of New Jersey

No. 63,768

LLANFAIR HOUSE NURSING HOME, A CORPORATION OF THE STATE OF NEW JERSEY,

Plaintiff-Respondent,

v.

ESTATE OF ETHEL LITCHULT BY ITS EXECUTRIX, JANIS CAMPAGNA, AND JANIS CAMPAGNA INDIVIDUALLY,

Defendants-Petitioners.

ON CERTIFICATION FROM A FINAL JUDGMENT OF THE SUPERIOR COURT OF NEW JERSEY, APPELLATE DIVISION (NO. A-932-07T1)
(CARCHMAN, P.J.A.D., COLEMAN, J.A.D., AND SIMONELLI, J.A.D.)

BRIEF OF AMICUS CURIAE PUBLIC ADVOCATE OF NEW JERSEY IN SUPPORT OF DEFENDANTS-PETITIONERS

RONALD K. CHEN
PUBLIC ADVOCATE OF NEW JERSEY

CATHERINE WEISS
Director, Division of Public Interest Advocacy

GWEN ORLOWSKI
Director, Division of Elder Advocacy

BRIAN WEEKS
Deputy Public Advocate

REBECCA ESTELLE
Assistant Deputy Public Advocate

On the Brief

DEPARTMENT OF THE PUBLIC ADVOCATE
240 West State Street, 16th Floor
Post Office Box 851
Trenton, New Jersey 08625-0851
(609) 826-5090

Attorneys for Amicus Curiae Public Advocate

June 8, 2009

TABLE OF CONTENTS

BRIEF

TABLE OF CONTENTS

APPENDIX, VOLUME I: Unpublished Decisions

APPENDIX, VOLUME II: Sample Nursing Home Admission Agreements

TABLE OF AUTHORITIES

CASES

STATUTES

State

Federal

REGULATIONS

State

Federal

LEGISLATIVE MATERIALS

RULES OF COURT

OTHER AUTHORITIES

INTRODUCTION

At the invitation of the Court, Amicus Curiae, the Department of the Public Advocate, respectfully submits this brief in support of Defendant-Petitioner Janis Campagna.

This matter involves an issue of first impression in New Jersey: whether a third party can be held personally liable for the debts incurred by a resident of a nursing home, where the third party signed an admission agreement purportedly guaranteeing the debt. For the reasons discussed below, the Llanfair House Private Admission Agreement ("Admission Agreement") executed by Janice Campagna as the "resident's representative" for her mother, Ethel Litchult, is an unlawful guarantee of payment under the Federal Nursing Home Reform Act and the New Jersey Nursing Home Responsibilities and Rights of Residents Act. This Court should therefore find that the guarantor provisions of the Admission Agreement at issue are void as a matter of law and public policy. And because judicial enforcement of such provisions would be inimical to the public interest, the Court should vacate the default judgment entered in this case and dismiss the complaint against Janice Campagna.

INTEREST OF AMICUS CURIAE

The Legislature reconstituted the Department of the Public Advocate in recognition that "[t]here is a great need for

consumer protection and advocacy on behalf of the indigent, the elderly, children, and other persons unable to protect themselves as individuals or a class." N.J. Stat. Ann. § 52:27EE-2(a). In accordance with the Legislature's finding that "[t]he elderly represent an ever-increasing portion of the population that requires special attention," a new Division of Elder Advocacy was created within the Department, and the Office of the Ombudsman for the Institutionalized Elderly, a preexisting office, was placed within the Division. N.J. Stat. Ann. §§ 52:27EE-2(h), 52:27EE-61 to -65. The Public Advocate is authorized by statute to "represent the public interest in such administrative and court proceedings . . . as the Public Advocate deems shall best serve the public interest" in general, and "the interests of elderly adults" in particular. N.J. Stat. Ann. §§ 52:27EE-57, 52:27EE-62.

Through the Division of Elder Advocacy, the Public Advocate has developed special expertise in the needs and interests of elderly residents of long-term care facilities and their families. On April 16, 2009, the Department released a report chronicling its investigation into how certain assisted living facilities in New Jersey respond when residents spend down their private resources and need to convert to Medicaid coverage. See N.J. Dep't Pub. Advocate, Aging in Place – Promises to Keep: An Investigation into Assisted Living Concepts, Inc. and Lessons

for Protecting Seniors in Assisted Living Facilities (2009), available at http://www.state.nj.us/publicadvocate/seniors/pdf/alc_report.pdf. While the legal and regulatory contexts are different for nursing homes and assisted living facilities, this investigation involved in-depth study into the complexities and difficulties that older people and their families face at the pivotal moment when private resources run out and the resident requires public assistance to stay in the facility that has become her home. This is the same circumstance that gave rise to this case.

BACKGROUND

The questions presented in this case are increasingly relevant as New Jersey's population continues to age. Currently, 1,150,941 of our 8,682,661 residents are over the age of sixty-five, and 175,310 are over the age of eighty-five. Population Division, U.S. Census Bureau, Estimates of the Resident Population by Selected Age Groups for the United States, States, and Puerto Rico (2008), http://www.census.gov/popest/states/asrh/tables/SC-EST2008-02-34.csv. Seniors rely heavily on long-term care, with 44,459 older New Jerseyans currently residing in nursing homes. Kaiser Found., Total Number of Residents in Certified Nursing Facilities (2007), http://www.statehealthfacts.org/comparemaptable.jsp?cat=

8&ind=408. The private cost of nursing home care averages $87,384 per year. Dep't Human Servs., Medicaid Communication (Jan. 12, 2009), http://www.state.nj.us/humanservices/dmahs/Medcomms/09_01_Increase_in_the_Penalty_Divisor_Effective_November_1_2008.pdf. As the average senior household net worth is less than $330,000, many will run out of money if they remain in a nursing home for more than a few years. Patrick Purcell, Cong. Research Serv., Retirement Savings and Household Wealth in 2007 (Apr. 8, 2009), available at http://assets.opencrs.com/rpts/RL30922_20090408.pdf. As a result, 63% of New Jersey's nursing home residents currently rely on Medicaid. Kaiser Found., Distribution of Certified Nursing Facility Residents by Primary Payer Source (2007), available at http://www.statehealthfacts.org/comparebar.jsp?ind=410&cat=8.

Nursing Home Admission Contracts Commonly Purport To Impose Liability on Third Parties.

Congress enacted the Nursing Home Reform Act in 1987 to address serious and widespread problems in the nursing home industry. Katherine C. Pearson, The Responsible Thing To Do About "Responsible Party" Provisions in Nursing Home Agreements: A Proposal for Change on Three Fronts, 37 U. Mich. J.L. Reform 757, 760 (2004). Of particular concern to Congress was a problem identified by the Institute of Medicine in a 1986 study of the industry: the nursing home industry consisted of two

tiers, "'a preferential one for those who can pay their way and a second, more restricted one, for those whose stays are paid by Medicaid.'" Id. at 760-761, 779 (quoting Comm. on Nursing Home Regulation, Inst. of Med., Improving the Quality of Care in Nursing Homes (1986)). Not only did this disparate treatment raise questions about differences in quality of care, but it also raised questions about possibly unfair admission practices with regard to potential Medicaid residents. Id. at 761, 761 n.22.

Advocates for residents noted common nursing home practices such as asking residents or their families to "promise" private payment for a period of time before making application for Medicaid or to "waive" the resident's rights to apply for Medicaid at all. Id. at 780, 780 n.139 (citing Thomas D. Begley, Jr. & Jo-Anne Herina Jeffreys, Representing the Elderly Client: Law and Practice 4.04 (1999)). Nursing facilities also regularly refused "to admit a resident unless another person (usually a child of the incoming resident) would agree to be jointly and severally liable for any and all nursing facility charges." Eric Carlson, Long-Term Care Advocacy 3.06, n.7 (2008). This potential liability threatened to discourage family members from rendering often indispensible assistance to their older relatives in interacting with a nursing facility. Pearson, supra, 37 U. Mich. J.L. Reform at 759-60.

The Nursing Home Reform Act sought to provide protection against these kinds of anti-consumer practices, which are most burdensome to low-income nursing home residents and applicants. The prohibition against third-party guarantees of payment as a condition of admission or continued residence, coupled with a bar on personal financial liability for legal representatives who contract to use the resident's funds to pay for care, are central to the Nursing Home Reform Act's protective mission. 42 U.S.C. §§ 1395i-3(c)(5)(A)(ii)(regarding residents' rights under Medicare), 1396r(c)(5)(A)(ii)(regarding residents' rights under Medicaid); 42 C.F.R. § 483.12(d)(2). These provisions, among others,[1] are meant in part to level the field, so that applicants who lack significant family resources have the same access to nursing home care as those with greater resources. See Pearson, supra, 37 U. Mich. J.L. Reform at 779-80.

[1] The federal law also prohibits facilities from requiring applicants or residents to waive their right to Medicare or Medicaid benefits; requiring oral or written promises that the resident or applicant is not or will not be eligible for Medicare or Medicaid in the future; or soliciting any money, gift or other contribution as a condition of admission or continued residency where the applicant or resident has been deemed eligible for Medicaid. 42 C.F.R. § 483.12(d). In addition, the federal law requires nursing homes to display and provide information to an applicant or resident about how to apply for benefits under Medicare and Medicaid. 42 U.S.C. §§ 1395i-3(c)(5)(A)(i)(III), 1396r(c)(5)(A)(i)(III).

In addition, it appears that Congress intended to prevent a system that asked families – often those still raising children while also assisting aging parents – to deplete their resources to support older relatives in nursing care. As the federal Department of Health and Human Services noted in promulgating final rules for long-term care facilities participating in Medicare and Medicaid:

> The legislative history reveals that Congress was concerned with prohibiting [skilled nursing facilities] and [nursing facilities] from requiring a person, such as a relative, to accept responsibility for the charges incurred by a resident, unless that person is authorized by law to disburse the income or assets of the resident. In such allowable cases, the person providing the guarantee assumes no personal liability. He or she only promises to make payment out of the resident's financial holdings.

56 Fed. Reg. 48,826 (Sept. 26, 1991); see also Eric Carlson, Illegal Guarantees in Nursing Homes: A Nursing Facility Cannot Force a Resident's Family Members and Friends to Become Financially Responsible for Nursing Facility Expenses, 30 Clearinghouse Rev. 33, 44 (1996) ("Due to the enormous expense of nursing facility care, Congress decided that only the resident should bear financial responsibility.").

In the years after the enactment of the Nursing Home Reform Act in 1987, many states around the country adopted analogs to

the federal law.[2] Some closely paralleled the brief federal law while other states enacted more comprehensive schemes governing nursing home admission agreements.

Despite the law prohibiting nursing homes from requiring third-party guarantees of payment as a condition of admission or continued stay, commentators and elder advocates have noted that admission agreements nonetheless commonly purport to create third-party liability for a resident's nonpayment. Pearson, supra, 37 U. Mich. J.L. Reform at 762-64; see also Prospect Park Nursing Home v. Goutier, No. 103442/04, 2006 N.Y. Misc. LEXIS 2130, at *2 (N.Y. Civ. Ct. Aug. 7, 2006) ("In 2001 and 2003, the New York State Attorney General's Office took action against a total of 15 nursing homes that required third-party guarantees as a condition of admission in violation of state and federal law.").[3]

---

[2] "[T]he federal statutes at issue do not include a preemption clause and do not appear to occupy the field of nursing home regulations." Podolsky v. First Healthcare Corp., 58 Cal. Rptr. 2d 89, 97 n.8 (Cal. Ct. App. 1996). States may apply stricter admission standards under state or local laws than are specified in federal law to prohibit discrimination against individuals entitled to Medicaid. 42 U.S.C. §§ 1395i-3(c)(5)(B)(i), 1396r(c)(5)(B)(i); Pearson, supra, 37 U. Mich. J.L. Reform at 761 n.21.

[3] Cf. Thomas D. Begley, Jr. & Jo-Anne Herina Jeffreys, Representing the Elderly Client § 3.08 (1999)(finding that even after the passage of the Nursing Home Reform Act "[m]any nursing homes certified for Medicaid insist that the resident pay on a

(footnote continued . . .)

Sometimes, these third parties are legal agents, authorized to act on behalf of the resident through a power of attorney, guardianship order, or other formal mechanism. Often, however, they are family members without formal legal authority, seeking to facilitate admission by assisting an often overwhelmed resident with extensive paperwork. Pearson, supra, 37 U. Mich. J.L. Reform at 763. Denominating these helpers as "responsible parties," the agreements create "financial traps for people who believe they are acting merely as facilitators in the admission process." Id. at 759.

The Department of the Public Advocate recently collected and reviewed an admittedly small and nonrandom sample of six contracts that reveal the ongoing use of problematic contract terms in New Jersey. Amicus identified at least three interrelated mechanisms that purport to impose personal liability on third parties. Despite the statutory prohibitions on guarantor agreements in this context, two of the contracts include express guarantor language, requiring third parties to accept personal liability for the nursing home resident's bill. (Oceana Agreement (Aa91-92); Wedgewood Agreement (Aa101).) One contract states, "the resident or responsible party will remain

---

private-pay basis for a period of time before becoming eligible for Medicaid.").

financially responsible for all costs and bills incurred [by the resident]." (Wedgewood Agreement (Aa101).) Another contract requires the responsible party to "agree to pay for such charges upon presentation of a bill with a statement to the effect that Medicare, Medicaid, or the third party payor has refused to pay for services rendered." (Oceana Agreement (Aa91-92).)

Other contracts employ more subtle mechanisms to impose personal liability on third parties either instead of or in conjunction with express guarantor language. Four of the six contracts purport to impose a duty on responsible parties – whether legal agents or not – to participate in, cooperate in, initiate, or even successfully complete a Medicaid application. (HCR Manor Agreement (Aa41); Lutheran Agreement (Aa71, Aa75); Oceana Agreement (Aa91); Wedgewood Agreement (Aa101).) In addition, two contracts impose a duty on the "responsible party" to use his or her authority as a legal agent to ensure that the nursing home's bill is paid. (HCR Manor (Aa41), Lutheran Agreement (Aa70).) In both of these scenarios, the contracts provide that the remedy for a breach is for the third party to pay the resident's bill. (HCR Manor Agreement (Aa41); Lutheran Agreement (Aa70); Oceana Agreement (Aa90); Wedgewood Agreement (Aa101, Aa105).) Thus, even aside from express guarantor clauses, these contracts impose personal liability on third

parties in the event that the nursing home does not receive payment from the resident or from Medicaid.

The Medicaid Application Process Is Rife with Pitfalls.

In New Jersey, the Medicaid application process generally starts with the submission of an application to the County Board of Social Services in the county where the resident resides or is institutionalized. N.J. Admin. Code § 10:71-2.5(a). If a resident cannot complete the application for him- or herself, the regulations allow both formal legal agents and certain "agent[s] for the purpose of initiating an application" to file for him or her. N.J. Admin. Code § 10:71-2.5(c). These individuals include (1) a relative by blood or marriage, (2) a staff member of a public or private welfare agency of which the person is a client, (3) a physician or attorney, or (4) a staff member of an institution or facility in which the person is receiving care. N.J. Admin. Code § 10:71-2.5(c). Applicants must show that the resident meets medical or clinical eligibility, e.g., N.J. Admin. Code § 10:71-3.12 (definitions of eligible disabilities); N.J. Admin. Code § 10:71-3.9 (eligibility based on age), and that he or she satisfies certain financial criteria, N.J. Admin. Code §§ 10:71-4.1 to -5.9.

While nursing homes often facilitate the clinical eligibility part of the determination, residents are generally

left to handle the financial aspects of eligibility on their own. Residents must show that they have resources worth less than $2,000 and a monthly income below an annually adjusted amount — for 2009, less than $2,022. 42 U.S.C. § 1382a, N.J. Admin. Code § 10:71-5.1. Providing the County Board of Social Services with enough information to make these determinations under the Medicaid rules can be trying. "As many have described, the regulatory framework and paperwork associated with application for Medicaid assistance with long-term care is often burdensome, chaotic and difficult." Pearson, supra, 37 Mich. J.L. Reform at 781. What appears to be a relatively simple calculation is complicated by numerous rules concerning what counts as income and what counts as resources under the Medicaid regulations. N.J. Admin. Code §§ 10:71-4.1 to 4.11 (resources), 10:71-5.1 to -5.9 (income).

Ultimately, applications are routinely denied "for highly technical reasons, such as failure to 'verify' resources, even if the possibility of certain resources would have no effect on eligibility." Pearson, supra, 37 U. Mich. J.L. Reform at 781. While potentially burdensome to all applicants, this "verification" process can be especially difficult when the person making the application is not the resident or a formally authorized agent, but simply a family member or other person acting as an "agent for the purpose of initiating an

application" under N.J. Admin. Code § 10:71-2.5(c). When such a requestor lacks formal legal authority, banks and other institutions are hesitant to turn over documents critical to proving resource qualification, and the current law assists only formal agents in obtaining such documentation. See, e.g., N.J. Stat. Ann. § 46:2B-13 (requiring that banks turn over documents where a valid power of attorney exists).

In addition to being burdensome, the process can also take a long time to complete. Under federal regulation, applications must be acted upon within forty-five days of submission when the basis for eligibility is age, and within ninety days when the basis for eligibility is disability. 42 C.F.R. § 435.911. Yet significantly longer delays are often reported. Sunrise Healthcare Corp. v. Azarigian, 821 A.2d 835, 837 (Conn. App. Ct. 2003)(24-month delay); see N.J. Dep't Pub. Advocate, Aging in Place at 22-24 (chronicling mistakes made by county board of social services that led to a five-month delay).

These delays, when combined with the system's tendency toward denial, can yield long periods when no one is paying the facility. Under New Jersey regulations, Medicaid will pay retroactively for nursing home service for only up to three months before the date an application is filed. N.J. Admin. Code § 10:71-2.16. When an application is officially denied as deficient – as Mrs. Litchult's appears to have been, see infra

Statement of Facts - the applicant must submit a new application with a new three-month retroactive payment window. N.J. Admin. Code § 10:71-2.16. For those applicants who experience significant delays on their first application, the new three-month retroactive window may not cover all of the time spent unsuccessfully pursuing the first application. Thus, applicants may end up with bills that Medicaid will not pay, regardless of whether they were in fact eligible during the entire process.

These complexities and challenges in the Medicaid application process make third-party financial liability for nursing home care especially troubling. Families will often find themselves in the position of Ms. Campagna in this case – threatened in the end with significant personal liability after assisting aging relatives to find appropriate care and trying in good faith, but not always successfully, to obtain the necessary coverage when the resident's resources run out.

STATEMENT OF FACTS AND PROCEDURAL HISTORY

Facts

On June 16, 2003, Ethel and Theodore Litchult entered Llanfair House Nursing Home as residents. (Campagna Certif. ¶ 3

(Da5).[4]) In connection with their admission, Mr. and Mrs. Litchult entered into an Admission Agreement with Llanfair House, and their daughter, Janis Campagna, signed the Agreement as the "Resident's Representative." (Id.; Admission Agreement (Pa13).) Despite having developed Alzheimer's disease, Mr. Litchult handled the couple's finances until he died on April 10, 2004. (Campagna Certif. ¶¶ 8, 9 (Da6).) Within a year of Mr. Litchult's death, Ms. Campagna informed Llanfair House that her mother, Mrs. Litchult, had exhausted her resources. (Campagna Certif. ¶ 11 (Da6-7).) The Litchults paid Llanfair House more than $225,000 before they ran out of money. (Id. ¶ 14 (Da7).)

In mid-2005, Ms. Campagna and her attorney assisted Mrs. Litchult in applying for Medicaid through the Passaic County Board of Social Services. (Campagna Certif. ¶¶ 11, 13 (Da6-7); Corres. between Joseph Hallock, Esq., and Passaic County Bd. Soc. Servs. (May-Oct. 2005) (Da27, Da29-34).) Because Mr. Litchult had kept disorganized financial records during his lifetime, however, Ms. Campagna was unable to find some of the documents requested by the County Board. (Campagna Certif. ¶ 9

[4] Citations to the appendix of the Defendants-Appellants are Da__, to the appendix of Plaintiff-Respondent are Pa__, to the reply appendix of Defendants-Appellants are Dra__, and to the appendix of Amicus Public Advocate are Aa__.

(Da6).) The County Board reported to her attorney in October 2005 that it had denied Mrs. Litchult's Medicaid application on August 1 for failing to include all requested documents. (Memorandum from Passaic County Bd. Soc. Servs. to Joseph Hallock, Esq. (Oct. 7, 2005) (Da27).[5]) This memorandum recites that, although Ms. Campagna had provided some of the requested documentation to the County Board in the interim, Mrs. Litchult's Medicaid application remained deficient and could no longer be reactivated. (Id.) On October 24, 2005, Ethel Litchult died. (Campagna Certif. ¶ 12 (Da7).) The $48,882.77 bill for nursing home care rendered to her between April and October 2005 remains unpaid. (Kowalchuk Aff. ¶ 4 (Pa17); Llanfair House Billing Statement (Pa18).)

Procedural History

On May 22, 2006, Plaintiff Llanfair House filed an action in the Law Division against Defendants Estate of Ethel Litchult by its executrix, Janis Campagna, and Janis Campagna individually, to recover the unpaid cost of Mrs. Litchult's nursing home care. (Compl. (Pa22-27).) Llanfair House claimed breach of obligations in a private Admission Agreement and of

[5] The record does not contain a copy of a denial notice dated August 1, 2005.

alleged verbal representations by Ms. Campagna, on unspecified dates, that she would help her mother apply for Medicaid. (Id.)

The Summons and Complaint were served on Defendants on June 12, 2006. (Sheriff's Return of Process (Pa7).) On July 10, 2006, Defendants' attorney requested and was granted a thirty-day extension of time to file an answer. (Pl.'s Ltr. Br. (Aug. 29, 2007) at 2 (Da53).) Defendants' attorney did not file an answer within that time but, on August 17, 2006, requested and was granted another thirty-day extension. (Id.) Again, Defendants' attorney did not file an answer within thirty days. (Id.) On September 15, Defendants' attorney requested and was granted a third extension of time, to file an answer by October 2, 2006. (Id.) Defendants' attorney did not file an answer within that time. (Id.)

On October 23, 2006, Llanfair House requested the entry of a default and final judgment by default against Defendants. (Pl.'s Ltr. to Clerk (Dra1-3).) The Clerk received that request on October 26, 2006, and entered it on the docket the same day. (Id.)

On October 31, 2006, Defendants' attorney requested another extension of time to file an answer, said that he would submit a copy of Mrs. Litchult's Medicaid application documentation to Plaintiff for its review, and requested that during its review Plaintiff take no further action in the litigation. (Pl.'s Ltr.

Br. (Aug. 29, 2007) at 2 (Da53).) During that call, Plaintiff informed Defendants' attorney that it had filed a request to enter a default and final default judgment. (Id.; see Db7; Pl.'s Ltr. Br. (Sept. 4, 2007) (Da63-64).)

On November 6, 2006, Defendants' attorney submitted a copy of Mrs. Litchult's Medicaid application documentation to Plaintiff. (Letter from Kenneth Rosellini, Esq., to Madelyn Iulo, Esq. (Nov. 6, 2006) (Da20-22); Rosellini Certif. ¶ 12 (Da17); Corres. between Joseph Hallock, Esq. and Passaic County Bd. Soc. Servs. (May-Oct. 2005) (Da27-37).) The record does not indicate any affirmative action by Plaintiff to withdraw its request for entry of default and final default judgment. The clerk entered the final judgment by default against Defendants on November 13, 2006. (Final J. by Default (Da57).)

On December 15, 2006, Defendants' attorney forwarded a consent order to Plaintiff to vacate the default and default judgment and to allow Defendants to file an answer within fourteen days. (Letter from Kenneth Rosellini, Esq., to Madelyn Iulo, Esq. (Dec. 15, 2006) (Da24-25).) Although the Appellate Division found that "Plaintiff returned the executed consent order to defendants' attorney on December 21," Llanfair House Nursing Home v. Estate of Litchult, No. A-932-07T1, slip op. at 4 (Dec. 22, 2008), the parties dispute whether Plaintiff in fact returned the consent order. In July 2007, Defendants' attorney

requested that Plaintiff provide an executed copy of the consent order. (Rosellini Certif. ¶ 19 (Da17-18).) Plaintiff at this point refused its consent to vacate the default judgment. (Id.; Pl.'s Ltr. Br. (Aug. 29, 2007) at 2 (Da53).)

In August 2007, Defendants' attorney moved to vacate the default judgment (Defs.' Notice Mot. To Vacate Default J. (Da2-4)), seeking relief under Rules 4:43-3 and 4:50-1 (Rosellini Certif. ¶ 20 (Da18).) On September 7, 2007, the trial court entered an order denying Defendants' motion, holding that Defendants had not demonstrated that their neglect in failing to answer the Complaint was excusable. (Order (Da70-71).)

On October 22, 2007, Defendants filed a notice of appeal and challenged the trial court order as inconsistent with Rule 4:50-1(a), (c), and (f). (See Letter from Kenneth Rosellini, Esq., to Super. Ct. App. Div. (Oct. 22, 2007) (Da72); Db16-32).) In a per curiam opinion on December 22, 2008, the Appellate Division affirmed. Llanfair House, No. A-932-07T1. Appellant moved for reconsideration on January 2, 2009, and the Appellate Division denied that motion on January 16, 2009. Defendants filed a petition for certification on February 9, 2009, which this Court granted on March 20, 2009.

ARGUMENT

I. THE TRIAL COURT ABUSED ITS DISCRETION IN DECLINING TO VACATE THE DEFAULT JUDGMENT UNDER RULE 4:50-1(f) TO AVOID THE MANIFEST INJUSTICE THAT WOULD RESULT FROM ITS ENFORCEMENT.

In challenging the default judgment entered against her, Ms. Campagna faces a lower hurdle than if she were contesting a final judgment on the merits. "A court should view 'the opening of default judgments . . . with great liberality,' and should tolerate 'every reasonable ground for indulgence . . . to the end that a just result is reached.' . . . All doubts . . . should be resolved in favor of the parties seeking relief." Mancini v. EDS ex rel. N.J. Auto. Full Ins. Underwriting Ass'n, 132 N.J. 330, 334 (1993) (quoting Marder v. Realty Constr. Co., 84 N.J. Super. 313, 319 (App. Div.), aff'd, 43 N.J. 508 (1964)). Default judgments are especially vulnerable because they are "based on only one side's presentation of the evidence without due consideration to any countervailing evidence or point of view, and, thus, may not be a fair resolution of the dispute." Nowosleska v. Steele, 400 N.J. Super. 297, 303 (App. Div. 2008); see also F.B. v. A.L.G., 176 N.J. 201, 209-10 (2003) (distinguishing default judgment, which deprives a defendant of "his opportunity to be heard," from more robust judgment based on the defendant's affirmative admission of paternity).

Ms. Campagna asks the Court to vacate the default judgment on three grounds: excusable neglect under Rule 4:50-1(a), misrepresentation under Rule 4:50-1(c), and exceptional circumstances under Rule 4:50-1(f). Amicus leaves to the parties the arguments based on excusable neglect and misrepresentation, but notes that indulgence is called for under these, as under all subsections of Rule 4:50-1, when a party challenges a default judgment.

Guided by this rule of lenity, the trial court exercises discretion concerning whether to reopen a default judgment, and a reviewing court will disturb its decision only for abuse of discretion. F.B., 176 N.J. at 207; Court Inv. Co. v. Perillo, 48 N.J. 334, 341 (1966). The trial court abused its discretion in this case by denying Ms. Campagna's motion to vacate the judgment, and the Appellate Division erred in affirming that decision.

Basing its decision primarily on the "excusable neglect" prong of Rule 4:50-1(a), and finding none, the Appellate Division gave short shrift to Ms. Campagna's alternative argument that extraordinary circumstances warrant the reopening and ultimate reversal of the default judgment in the interests of justice. Finding neither "exceptional circumstances" nor "overarching equities" under subsection (f), Llanfair House, No. A-932-07T1, slip op. at 9, the Appellate Division characterized

the dispute as "simply a case where, for reasons not fully explained, an answer was not filed when plaintiff's counsel willingly indulged opportunities to respond," id. The Appellate Division thus reduced its inquiry into "exceptional circumstances" to a brief reference back to its earlier rejection of any grounds for excusable neglect.[6]

This was an error of law. The two relevant subsections of Rule 4:50-1, (a) and (f), are distinct and independent. The Appellate Division's conclusion that there was no excusable neglect under subsection (a) cannot dispose of Ms. Campagna's challenge to the default judgment as fundamentally inequitable under subsection (f). See Mancini, 132 N.J. at 335-38 (finding no excusable neglect under subsection (a) but nevertheless vacating judgment under subsection (f)); Siwiec v. Fin. Res., Inc., 375 N.J. Super. 212, 218-19 (App. Div. 2005) (same). In conflating subsections (a) and (f), the Appellate Division misapplied the law, and its "interpretation of the law . . .

[6] Insofar as the handwritten notes on the trial court's order of September 7, 2007, reveal, that court did not even consider whether to vacate the judgment under Rule 4:50-1(f) but relied solely on a finding of lack of excusable neglect under subsection (a). (Order (Da70-71).)

[is] not entitled to any special deference." Manalapan Realty v. Manalapan Twp. Comm., 140 N.J. 366, 378 (1995).[7]

The independent analysis called for under Rule 4:50-1(f), but missing in the trial court and Appellate Division decisions, leads to the conclusion that the default judgment should be vacated, because its execution would result in the kind of injustice that subsection (f) is meant to avoid.

> We have repeatedly noted the broad parameters of a court's discretion under subsection (f), and that a court should have authority under it to reopen a judgment where such relief is necessary to achieve a fair and just result. . . . "[T]he very essence of (f) is its capacity for relief in exceptional situations. And in such exceptional cases its boundaries are as expansive as the need to achieve equity and justice."

Manning Eng'g, Inc. v. Hudson County Park Comm'n, 74 N.J. 113, 122 (1977) (quoting Court Inv. Co., 48 N.J. at 341).

In the interest of reaching "a fair and just result," id., this Court has repeatedly relied on subsection (f) to avoid the enforcement of judgments that would contravene the law or undermine the public policy of the State. In Manning Engineering, 74 N.J. 113, for example, the Court vacated a final judgment on the merits – which enjoys a stronger presumption of

[7] See also State v. Drury, 190 N.J. 197, 209 (2007) ("[The matter before the Court] is a question of law. We therefore owe no deference to the interpretation of the trial court or the appellate panel and apply instead a de novo standard of review.") (citation omitted).

finality than a default judgment – based on evidence that the plaintiff engineering firm had obtained a public contract in part by serving as a conduit for kickbacks to corrupt local officials. The Court reopened the judgment under subsection (f) "because of the public policy to prevent recovery of damages for breach of an illegal public contract executed by plaintiff as part of a fraudulent scheme." Id. at 125.[8] Even in the absence of so extreme a ground as the prevention of public fraud, this Court has vacated a judgment based on an otherwise inexcusable default because the injured plaintiff in an automobile accident case had failed to follow the legally required arbitration procedures, resulting in a potentially excessive award against an insurer funded in part by the public. Mancini, 132 N.J. at 336-38.[9]

[8] See also Good Luck Nursing Home, Inc. v. Harris, 636 F.2d 572 (D.C. Cir. 1980) (affirming vacatur of judgment under Fed. R. Civ. P. 60(b)(6) based on evidence that nursing home that had earlier won claim for Medicare reimbursement was in fact defrauding the government to recover litigation costs incurred in unsuccessfully defending against fraud charges arising out of its participation in the program); Hous. Auth. v. Little, 135 N.J. 274, 285 (1994) (noting that federal cases can provide guidance for interpretation of Rule 4:50-1, which is modeled on Fed. R. Civ. P. 60(b)).

[9] See also Cho Hung Bank v. Kim, 361 N.J. Super. 331 (App. Div. 2003) (vacating default judgment of foreclosure because of conflict with bankruptcy stay and Fair Foreclosure Act, among other reasons).

In this case, too, enforcement of the judgment would conflict with the law. As explained in Part II.A. infra, the Federal Nursing Home Reform Act and its state analog forbid guarantor agreements through which third parties assume personal liability for the debts of residents as a condition of their admission to or continued stay in the facility. 42 U.S.C. §§ 1395i-3(c)(5)(A)(ii), 1396r(c)(5)(A)(ii); 42 C.F.R. 483.12(d)(2); N.J. Stat. Ann. § 30:13-3.1(a). These laws preclude the enforcement of a money judgment against Ms. Campagna individually for her mother's debts to Llanfair House under the Admission Agreement. Likewise, these laws prevent the nursing home from seeking to recover from Ms. Campagna personally for her alleged failure to complete her mother's Medicaid application. Infra Point II.B.

Moreover, the Admission Agreement itself contains clauses shielding Ms. Campagna from personal financial liability, and these clauses should be construed strictly against Llanfair House as the author of the contract. Infra Point II.C. No less than the enforcement of the contract obtained by fraud in Manning or the judgment based on an unlawful arbitration process in Mancini, the enforcement of the money judgment against Ms. Campagna as an individual would subvert the overriding goal of resolving this dispute in a manner that comports with the law. See, e.g., Goldfarb v. Roeger, 54 N.J. Super. 85, 92 (App. Div.

1959) (reversing trial court and reopening default judgment under subsection (f) on the ground that the defendant's "asserted defense to the effect that he as a mere employee was not liable for the firm's debts is not technical or frivolous").

A default judgment of doubtful legality is subject to reopening under Rule 4:50-1(f) on that ground alone, but it is all the more vulnerable when it threatens significant hardship to the defendant. In Housing Authority v. Little, 135 N.J. 274 (1994), this Court set aside a default judgment of possession to allow a low-income tenant and her five minor children to remain in their home. Observing that alternative "suitable housing was not readily available at the same monthly rental" and that the public housing project where the family lived was "subject to public-policy responsibilities not generally imposed on private landlords," id. at 291, the Court concluded that "the State's homelessness-prevention policies would be disserved by the eviction of a tenant in public housing who had demonstrated satisfactorily her ability to fulfill her rental obligations," id. at 293.[10]

[10] See also Nowosleska, 400 N.J. Super. 297 (App. Div. 2008) (reversing trial court's refusal to set aside default judgment of possession under subsection (f) and remanding for trial on question whether defendant could be ejected from her home because of her defaults on a series of loans subject to challenge as fraudulent, unconscionable, and barred by federal

(footnote continued . . .)

In a similar vein, the Appellate Division has acted to protect a family from a potentially ruinous default judgment for a medical bill they did not properly owe. The judgment was entered against a mother who failed to answer a hospital's suit to collect a bill for emergency heart surgery performed on her Medicaid-eligible newborn son. New York Hosp. v. Robinson, No. A-5219-97T3, 1999 WL 34876247 (N.J. App. Div. May 28, 1999). Medicaid had refused coverage because of a technical error. Ms. Robinson moved to vacate the default judgment, and the trial court denied her motion. The Appellate Division reversed, noting that "the trial court did not take into account the prevailing equities, i.e., that defendant presented a meritorious defense to plaintiff's claim." Id. at *9. The basis of that defense was a provision in the Medicaid regulations forbidding providers who participate in the program from billing eligible patients directly for services. Id. at *5 (citing 42 C.F.R. § 447.15). The Appellate Division emphasized that, under this regulation, the hospital "was legally barred from ever having brought suit against defendant," id., and

---

and state statutes); City of East Orange v. Kynor, 383 N.J. Super. 639 (App. Div. 2006) (reversing trial court's refusal to vacate judgment of foreclosure because of potential due process violation in denying defendant's right of redemption based on a possibly misleading complaint and public notice about the amount necessary to redeem her house).

allowing the judgment to stand would "circumvent the purpose behind the [Medicaid] program," id. at *6.

Likewise here, Ms. Campagna faces potentially overwhelming personal liability of more than $48,000 for nursing home care for her mother which Medicaid has declined to cover. Yet the applicable law shields Ms. Campagna from such liability. The purpose of that law is to ensure that families can assist their aging relatives in finding appropriate care without the risk of being saddled with bills they cannot afford. Enforcement of the default judgment against Ms. Campagna would undermine this public purpose just as surely as the improper eviction of Ms. Little would have frustrated the goal of homelessness-prevention and the collection of the hospital bill from Ms. Robinson would have thwarted the intent of the Medicaid program.

Amicus respectfully asks the Court to set aside the default judgment in this case because its enforcement would violate the law and undermine the important public policy of protecting third parties from individual liability for the costs of nursing home care for their aging relatives.

II. THE LLANFAIR HOUSE PRIVATE ADMISSION AGREEMENT CANNOT BE READ TO IMPOSE PERSONAL LIABILITY ON MS. CAMPAGNA FOR HER MOTHER'S DEBTS TO THE NURSING FACILITY.

A. The Admission Agreement and Its Enforcement by Llanfair House Against Janice Campagna Individually Create a Third-Party Guarantee of Payment That Is Void as a Matter of Federal and State Law.

Amicus Public Advocate bases its argument regarding the validity of the Llanfair House Private Admission Agreement on four premises:

(1) a contract term that violates legislatively established public policy is void and unenforceable;

(2) federal and state statutes establish a public policy that forbids a third-party guarantee of payment as a condition of admission or continued residency;

(3) Plaintiff asserts and is attempting to enforce the Admission Agreement as a third-party guarantee of payment; and

(4) the third-party guarantee of payment by Ms. Campagna was a condition of admission and continued residency of her mother, Ethel Litchult.

The syllogisms formed by these premises lead to the conclusion that any judgment of personal liability upon Janice Campagna is void as a matter of law and must be struck down.

First, basic principles of contract law forbid the enforcement of provisions that violate law or public policy. See Vasquez v. Glassboro Serv. Ass'n, 83 N.J. 86, 98-99 (1980) ("[C]ourts in New Jersey have refused to enforce contracts that violate the public policy of the State. No contract can be sustained if it is inconsistent with the public interest or detrimental to the common good. Contracts have been declared invalid because they violate statutes . . . .") (citations omitted). Thus, "no court, be it equity or law, will enforce or entertain construction of a contract in a manner incompatible with the laws or public policies of the state." Sheridan v. Sheridan, 247 N.J. Super. 552, 559 (Ch. Div. 1990) (citing In re Baby M., 109 N.J. 396, 434-41 (1988); Sewerage Auth. v. Util. Auth., 117 N.J. 239, 246 (1989)).

Here, the relevant public policy is derived directly from federal and state statutes.[11] The Federal Nursing Home Reform Act provides, in pertinent part:

[11] See Restatement (Second) of Contracts § 178(1) (1981) ("A promise or other term of an agreement is unenforceable on grounds of public policy if legislation provides that it is unenforceable or the interest in its enforcement is clearly outweighed in the circumstances by a public policy against the enforcement of such terms"); id. § 179(a) ("A public policy against the enforcement of promises or other terms may be derived by the court from (a) legislation relevant to such a policy").

> (A) Admissions. With respect to admissions practices, a nursing facility must—
>
> . . .
>
> (ii) not require a third party guarantee of payment to the facility as a condition of admission (or expedited admission) to, or continued stay in, the facility
>
> . . .
>
> (B) Construction.
>
> (i) Contracts with legal representatives.
>
> Subparagraph (A)(ii) shall not be construed as preventing a facility from requiring an individual, who has legal access to a resident's income or resources available to pay for care in the facility, to sign a contract (without incurring personal financial liability) to provide payment from the resident's income or resources for such care.[12]

42 U.S.C. §§ 1396r(c)(5)(A)(ii), (B)(ii)(Medicaid); 42 U.S.C. §§ 1395i-3(c)(5)(A)(ii), (B)(ii)(Medicare).

Moreover, in 1997, New Jersey amended the Nursing Home Responsibilities and Rights of Residents Act ("Nursing Home Bill of Rights") in light of the federal law. N.J. Stat. Ann. §§ 30:13-1 to -17. With respect to third-party guarantees of payment, the New Jersey law provides:

---

[12] The federal law applies to all nursing facilities that participate in Medicare or Medicaid, 42 C.F.R. § 483.5 ("For Medicare and Medicaid purposes . . . the 'facility' is always the entity that participates in the program . . . ."), as well as all applicants and residents of these nursing facilities regardless of payment source, 56 Fed. Reg. 48,826 (Sept. 26, 1991) ("[T]he prohibition against third party guarantees applies to all residents and prospective residents regardless of the payment source . . . ."). It is undisputed that Llanfair House is a certified Medicaid provider.

> A nursing home shall not, with respect to an application for admission or resident of the facility . . . (2) require a third party guarantee of payment to the facility as a condition of admission or expedited admission to, or continued residence in, that facility; except that when an individual has legal access to a resident's income or resources available to pay for facility care pursuant to a durable power of attorney, order of guardianship or other valid document, the facility may require the individual to sign a contract to provide payment to the facility from the resident's income or resources without incurring personal financial liability.

N.J. Stat. Ann. § 30:13-3.1(a)(2). While this provision prohibiting third-party guarantees of payment mirrors federal law, New Jersey has gone further under other provisions of the Nursing Home Bill of Rights to provide additional protections for residents and their families from unfair admissions practices.[13]

Next, Llanfair alleges and seeks to enforce a personal obligation against Ms. Campagna as a third-party guarantor of her mother's debts. Ms. Campagna signed the Llanfair House

[13] For example, residents and alleged third-party guarantors of payment who prevail against nursing facilities to enforce the provisions of N.J. Stat. Ann. § 30:13-3.1 may be awarded treble damages, attorney's fees and costs pursuant to N.J. Stat. Ann. § 30:13-8(b). In addition, nursing homes must disclose to prospective residents and their families the protections contained in N.J. Stat. Ann. § 30:13-3.1, including the prohibition against third-party guarantees of payment. N.J. Stat. Ann. § 30:13-10.1.

Admission Agreement as the "Resident's Representative."[14] (Admission Agreement (Pa13); Campagna Certif. ¶ 3 (Da5).) The Admission Agreement states that the "Resident's Representative" signs agreeing "to be jointly and severally responsible for the charges due the Home." (Admission Agreement (Pa14).) This status makes Ms. Campagna the functional equivalent of a third-party guarantor. See Podolsky v. First Healthcare Corp., 58 Cal. Rptr. 2d 89, 97 (Ct. App. 1996) ("[W]e hold that a 'responsible party' under California law is no different than a third party guarantor under federal Medicare and Medicaid law.").

Other provisions throughout the Admission Agreement (albeit contradicted by other provisions in the Agreement, see infra Point II.C.) also purport to hold the resident's representative personally liable for the cost of the resident's nursing facility care: the "resident and resident's representative agree jointly and severally . . . [to] [p]ay timely all charges of the Home as set forth herein" (Admission Agreement (Pa10)); "[R]esident's representative and resident agree to pay all charges incurred at the time of discharge as well as any other

[14] The Complaint does not allege, nor is there anything else in the record to suggest, that Ms. Campagna was her mother's legal agent pursuant to an instrument such as a durable power of attorney.

charges due that are not available at the time of discharge" (Admission Agreement (Pa11)); and the "[r]esident and/or resident's representative accept full financial responsibility for and agree to pay the full amount claimed by the Home in the event that any third party payor shall deny coverage of or responsibility for resident's claim, or any part thereof" (Admission Agreement (Pa12)).

Moreover, the first count of the Complaint makes clear that Llanfair House is seeking to enforce a breach of contract claim against Ms. Campagna, personally, based on these provisions. (Compl. ¶¶ 1-13 (Pa22-24).) The remedy Llanfair House seeks for the alleged breach is the full measure of unpaid charges, $48,882.77, which the facility claims is due for the care it provided to Mrs. Litchult up to the point she died. (Id.) The Complaint alleges that Llanfair House "relied on the Admission Agreement entered into by the Defendants and the rights and responsibilities thereunder in rendering the aforementioned goods and services." (Compl. ¶ 11 (Pa24).)

Regardless of the precise terminology used, Congress's intent was to prevent a nursing facility "from requiring a person, such as a relative, to accept responsibility for the charges incurred by a resident, unless that person is authorized by law to disburse the income or assets of the resident." 56 Fed. Reg. 48,826 (Sept. 26, 1991). This prohibited result is

what has occurred here. Thus, the provisions of the Admission Agreement that purport to hold Ms. Campagna personally liable for the nursing home debt of her mother constitute a "third party guarantee of payment" under federal and state law. See 42 U.S.C. § 1396r(c)(5)(A)(ii); 42 U.S.C. § 1395i-3(c)(5)(A)(ii); N.J. Stat. Ann. § 30:13-3.1(a)(2).

The next premise to be proved is that Ms. Campagna signed the Agreement, including the third-party guarantor provisions, as a condition of her mother's admission to, and continued stay at, Llanfair House. This principle is established by the common definition of the word "condition" and by basic principles of contract law.

A "condition," generally understood, is "a premise on which the fulfillment of an agreement depends." Merriam-Webster's Collegiate Dictionary 259 (11th ed. 2005). Here, Llanfair House made an "agreement" to "fulfill[]" its obligation to care for Mrs. Litchult that "depend[ed]" on Ms. Campagna's guarantee. Because of this inter-dependence, Ms. Campagna's guarantee was a "condition" of her mother's admission. Such a guarantor agreement flatly contradicts both the federal and state statutes forbidding a nursing home from requiring a resident's family member to execute a guarantee "as a condition of" the resident's

admission to or continued stay in a facility. It is therefore unenforceable against Ms. Campagna.[15]

The conclusion that the parties intended mutuality of obligation is reinforced by the black-letter law that a promise of performance by one party is a condition of performance by the other. See Restatement (Second) of Contracts § 232 (1981) ("Where the consideration given by each party to a contract consists in whole or in part of promises, all the performances to be rendered by each party taken collectively are treated as performances to be exchanged"); Id. § 237 ("[I]t is a condition of each party's remaining duties to render performances to be exchanged under an exchange of promises that there be no uncured material failure by the other party to render any such performance due at an earlier time.").[16]

---

[15] See Carroll v. Butterfield Health Care, Inc., No. 02-C-4903, 2003 U.S. Dist. LEXIS 19287 (N.D. Ill. Oct. 28, 2003)(holding that federal law prohibits a nursing facility from requiring a personal guarantee of payment by a third party as a condition of admission); Amsterdam Nursing Home Corp. v. Lang, No. 601821-05, 2007 N.Y. Misc. LEXIS 6255 (N.Y. Sup. Ct. Sept. 13, 2007) (denying nursing facility's motion for entry of default judgment, finding that grandson had not signed third-party guarantee requiring him to be personally liable for grandmother's unpaid nursing facility bill, and stating that facility could not legally require such a guarantee as condition of grandmother's admission).

[16] For New Jersey cases applying this doctrine, see Nolan v. Lee Ho, 120 N.J. 465, 472 (1990)("When there is a breach of a material term of an agreement, the non-breaching party is relieved of its obligations under the agreement."); Magnet Res.,

(footnote continued . . .)

Indeed, as most first year law students are taught, the ancient and arcane proposition[17] that promises exchanged in the context of a bargain are merely independent covenants, and not mutual conditions of each other, was decisively rejected more than 250 years ago by Lord Mansfield in Kingston v. Preston, 2 Doug. 689, 99 Eng. Rep. 437 (K.B. 1773). The ensuing doctrine of "constructive conditions of exchange," in which (absent unequivocal contrary evidence) the promises exchanged by contracting parties are presumed to be mutual conditions of each other, has been hornbook law ever since. See E. Allan Farnsworth, Contracts 539 (4th ed. 2004) ("[O]nly by the clearest language can the parties make a promise to which the concept of constructive conditions does not apply."). Thus, "the judicial preference for constructive conditions of exchange . . . is overwhelming." Id. (emphasis added).[18]

Inc. v. Summit MRI, Inc., 318 N.J. Super. 275, 285 (App. Div. 1998) ("It is black letter contract law that material breach by either party to a bilateral contract excuses the other party from rendering any further contractual performance.").

[17] For a well known example of this now obsolete doctrine, see Nichols v. Raynbred, 80 Eng. Rep. 238 (K.B. 1615) (in bilateral contract for sale of cow, plaintiff seller need not plead delivery of cow to sue buyer for purchase price, since promises were independent of each other).

[18] It is of no moment that the Admission Agreement does not expressly use the word "condition." "The law has outgrown its primitive stage of formalism when the precise word was the sovereign talisman, and every slip was fatal." Palisades

(footnote continued . . .)

The principle that contractual promises are mutually dependent conditions is so entrenched that courts reviewing nursing home contracts that purport to include "voluntary" third-party guarantees demand extensive indicia that such guarantees are not made in exchange for the facility's admission or continued care of the resident. In Podolsky, 58 Cal. Rptr. 2d 89, for example, the California Court of Appeals concluded that the "execution of the guarantee [was] not required" in the admission agreement under review. Id. at 97. In reaching this conclusion, the court relied on conspicuous language in the agreement – twice and in capital letters – disclosing the federal and state prohibitions against third-party guarantees as a condition of admission or continued residence, and giving the guarantor a right to terminate the agreement unilaterally at any time. Id. at 94-95.[19] The contract also purported to provide

---

Props., Inc. v. Brunetti, 44 N.J. 117, 130 (1965). In place of this formalism, courts instead can infer such terms as the "parties must have intended" or that are required in light of "fairness and justice." Id. Indeed, even in an earlier time when formalism held sway, New Jersey courts observed, "According to the settled rules for the construction of covenants, their nature and precedency depend on the meaning and intention of the parties, rather than upon particular phrases or forms of words." Ackley v. Richman, 10 N.J.L. 304, 307-308 (Sup. Ct. 1829) (citation omitted) (finding that "[t]he dependence or independence of covenants was to be collected from the evident sense of meaning of the parties.").

[19] Compare Extendicare Health Servs. v. Henderson, No. A06-734, 2007 Minn. App. Unpub. LEXIS 285 at *12 (Minn. Ct. App. Apr. 3,

(footnote continued . . .)

alternative consideration for the guarantee, independent of the nursing home's promise to admit and care for the resident. Podolsky, 58 Cal. Rptr. 2d at 94-95. During the pendency of the action, the nursing facility even removed the third-party guarantee agreement from the admission contract and placed it in a separate document. Id. at 94. The court found these many steps sufficient to negate the otherwise obvious assumption that the nursing home had extracted the guarantee as a condition of its services in violation of federal and state law. Id. at 97.[20]

The Llanfair House Admission Agreement contains no such indications that the guarantee has been severed from the nursing home's promise to offer and provide care. The Agreement does not disclose the federal and state prohibition against third-party guarantees of payment as conditions of admission or

---

2007) (holding that, where nursing home contract fails to disclose that "it could not require [her son] to assume any financial responsibility for his mother's care," it may "violat[e] the [Minnesota] statute governing nursing-home contracts").

[20] Nevertheless, the court declined to enforce the third-party guarantee. Reviewing the rushed and emotional nature of the nursing home admission process, the court remanded for consideration of whether the guarantee was procured in violation of state law banning deceptive business practices. Id. at 101-104. Indeed, the court went so far as to suggest that coercive admissions procedures (as distinct from the language of the contract itself) could "in effect require the signature of a third party guarantor as a condition of admission," potentially reviving the claim under "the federal Reform Act." Id. at 102.

continued stay. Nor does it even pretend to offer consideration beyond the mutual promises exchanged: Llanfair's promise to admit and continue to care for Mrs. Litchult, and Ms. Campagna's purported promise to pay for that care. Any suggestion that the admission and continued residence of her mother was not part of the "bargained for consideration" for Ms. Campagna's guarantee of payment flies in the face of common sense. It implies that a resident's representative is motivated by feelings of altruism toward the nursing facility in making such a promise and wishes to make the facility a gift, rather than being prompted by the normal motivations of quid pro quo that animate arm's length contract transactions. This Court should reject such a counter-intuitive interpretation of the parties' intent.

Indeed, Llanfair House apparently knows that this is an unlawful third-party guarantor agreement. In its Appellate Division brief, it states that it is not attempting to hold Ms. Campagna liable as a guarantor, but rather pursuant to her alleged promise to "access her mother's resources to pay her bills." (Pb17).

This argument is not persuasive. Llanfair House does not allege in its complaint that Ms. Campagna signed a contract agreeing to provide payment to the facility from her mother's funds. (See Compl. (Pa22-27).) Nothing in the record indicates that Ms. Campagna had legal access to her mother's income and

resources to pay Llanfair House pursuant to a durable power of attorney, order of guardianship, or other valid instrument. Absent such legal authority, Ms. Campagna cannot enter into a contract with Llanfair House to pay for care from her mother's funds, nor could Ms. Campagna be held personally liable for breach of such a promise even assuming she had made one. N.J. Stat. Ann. § 30:13-3.1(a)(2); see also 42 U.S.C. §§ 1396r(c)(5)(B)(ii), 1395i-3(c)(5)(B)(ii). And nothing in the Complaint alleges that Ms. Campagna ever misapplied her mother's funds. (See Compl. (Pa22-27).)

B. Public Policy Prevents Llanfair House from Enforcing the Admission Agreement by Holding Ms. Campagna Personally Liable for any Alleged Failure To Complete Her Mother's Medicaid Application.

The Court should also reject the argument that Ms. Campagna, even if not personally liable under the guarantor provisions discussed above, may be held liable under the alternative theory that she breached her promise to apply for Medicaid on her mother's behalf. This argument conflicts with persuasive precedents in other states, constitutes an impermissible end-run around the prohibition on guarantor agreements, and would violate public policy by discouraging family members from assisting their aging relatives in the daunting process of applying for Medicaid.

The Admission Agreement imposes on Ms. Campagna some obligation to apply for Medicaid on behalf of her mother. (Admission Agreement (Pa9).) In its complaint, Llanfair House relies on these provisions to support both its contractual and equitable causes of action, and seeks damages equal to the full measure of private-pay liability. (Compl. ¶¶ 7-11 (Pa24).)

As an initial matter, the record in this case suggests that Ms. Campagna complied with the Medicaid provisions in the Agreement by filing a Medicaid application on her mother's behalf in May 2005 and following up during subsequent months in an effort to complete the application. (Campagna Certif. ¶¶ 12, 13 (Da7); Rosellini Certif. ¶ 5 & Ex. C (Da16, Da27-Da37).) The Agreement requires her to "make timely application" and to cooperate with Llanfair House "to start the . . . application process" (Admission Agreement (Pa9)); it does not require her to complete the application successfully.

Even if Ms. Campagna had breached these promises, however, the remedy could not be personal financial liability. Other state cases addressing third parties' alleged failures to apply for Medicaid conclude, for a variety of reasons, that they are not personally liable for any balance allegedly due to a nursing home as a result. In Walton v. Mariner Health of Maryland, 894 A.2d 584, 586-87 (Md. 2006), for example, Maryland's high court held that a daughter who signed an admission agreement as her

mother's agent was not "personally liable for the outstanding nursing home bill even though the agent failed to seek Medicare or Medical Assistance for the resident." The court relied in part on basic principles of agency law: "As an agent, [the daughter] entered into the contract only for the benefit of [her mother] and is personally insulated from liability by virtue of her station as an agent." Id. at 591. A Minnesota appellate court reasoned instead that the nursing home had failed to show that a son, who had signed his mother's admission agreement as a "responsible party," actually had access to his mother's income and assets, although such access was a component of the definition of "responsible party" under Minnesota law. Extendicare Health Servs. v. Henderson, No. A06-734, 2007 Minn. App. Unpub. LEXIS 285, at *5-*6, *10 (Minn. Ct. App. Apr. 3, 2007).[21]

Similar arguments counsel against personal liability in this case. Llanfair House has made no allegation that Ms. Campagna is her mother's formal agent. Yet New Jersey law permits a person "to sign a contract to provide payment to the

[21] See also Alzheimer's Res. Ctr. of Conn. v. Carlstrom, No. CV 44002045S, 2005 Conn. Super. LEXIS 2752 (Conn. Super. Ct. Sept. 30, 2005) (relying on technical discrepancy between language in complaint and in admission agreement to absolve son of personal liability for failure to file a proper Medicaid application as "responsible party" for his mother).

facility from the resident's income or resources" only if that person "has legal access to a resident's income or resources" through "a durable power of attorney, order of guardianship or other valid document." N.J. Stat. Ann. § 30:13-3.1(a)(2). Having failed even to allege such a formal agency relationship between mother and daughter, Llanfair House cannot hold Ms. Campagna responsible for accessing her mother's funds to pay the bills. See Extendicare, 2007 Minn. App. Unpub. LEXIS 285, at *10.

Even if Ms. Campagna were her mother's formal agent, however, both the New Jersey statute and general principles of agency law would forbid Llanfair House to resort to the alternative of collecting from her personally. N.J. Stat. Ann. § 30:13-3.1(a)(2) (a person who is otherwise qualified to agree to pay nursing home costs out of a resident's income or assets does so "without incurring personal financial liability"); see also Walton, 894 A.2d at 586-87.

The courts' reluctance to assign personal liability for a family member's failure to pursue Medicaid coverage reflects an underlying tension with the governing law: such liability would defeat the federal and state prohibitions on third-party guarantor agreements. It is the purpose of those prohibitions to protect a family member from "accept[ing] responsibility for the charges incurred by a resident, unless that person is

authorized by law to disburse the income or assets of the resident." 56 Fed. Reg. 48,826 (Sept. 26, 1991). Whether the resident's debts to the nursing home result from lapses in a private-pay arrangement or a denial of Medicaid coverage, the result is the same – a family member cannot be held personally liable to pay those debts as a condition of the home's acceptance of or continuing care for the resident. See supra Point II.A.

Public policy also cautions against holding family members liable when Medicaid does not pay. In Methodist Manor Health Center v. Py, 746 N.W.2d 824 (Wis. Ct. App. 2008), the court affirmed summary judgment in favor of a granddaughter who, while holding a power of attorney for her institutionalized grandmother, disbursed her funds in accordance with her instructions. The court rejected the nursing home's claims in part because they "would impose huge potential personal liability on unknowing and, in many cases, unsophisticated agents who were doing nothing more than attempting to assist an elderly parent or grandparent with their finances." Id. at 832. In a similar context, a New York court remarked that public policy should not discourage "the relatives and friends of the elderly and infirm . . . from participating in their care by fear of potentially crippling personal financial

responsibility." Prospect Park Nursing Home, 2006 N.Y. Misc. LEXIS 2130, at *5.

While law and public policy thus foreclose a nursing home from imposing personal liability on a family member for failing to obtain Medicaid coverage for a resident, the facility retains alternative remedies. Nursing homes can act in the moment to avoid periods of non-payment like the one that unfolded here. Where the resident has capacity, the nursing home can designate a staff member to initiate the application and assist the resident in completing it. N.J. Admin. Code § 10:71-2.5(c)(iv). If the resident lacks capacity, the nursing home can petition the court to appoint a guardian who can initiate and pursue the application. N.J. Stat. Ann. §§ 3B:12-24.1(c), 3B:12-25; N.J. Ct. R. 4:86-1; In re Bennett, 180 N.J. Super. 406, 413 (Law Div. 1981) ("any person may petition this court for the appointment of a guardian in the declaration of incompetency"). Importantly, a guardian will have the documented formal authority necessary to succeed in completing a Medicaid application. N.J. Stat. Ann. § 3B:12-56 (powers of guardians). Under certain circumstances, the nursing home also has the option of transferring or discharging the resident for his or her failure to pay for services. See 42 C.F.R. §

483.12(a)(2)(v); N.J. Admin. Code §§ 8:39-4.1(a)(31)(iv), 8:85-1.10(e)(3).[22]

Thus, Llanfair House had remedies available to secure payment from Medicaid or to cease providing unpaid services. Having not pursued these legally authorized alternatives, it cannot now seek to recover from Ms. Campagna personally in violation of both law and public policy.

C. The Language of the Admission Agreement Relieves Ms. Campagna of Individual Liability.

Where a contract, especially a contract of adhesion, contains ambiguous or contradictory terms, as a matter of law those terms are construed against the drafter. On the one hand, the Admission Agreement contains provisions that purport to hold Ms. Campagna liable as a "resident representative" for all of

[22] The majority of nursing homes in New Jersey contact the Office of the Ombudsman for the Institutionalized Elderly when there is a potential involuntary discharge because of nonpayment. Pursuant to N.J. Stat. Ann. § 52:27G-7(g), the Ombudsman assists nursing homes and families in the Medicaid application process in an effort to prevent an involuntary discharge or transfer that might adversely affect the resident. The Ombudsman intervenes with the county welfare agency to help obtain the resident's financial information, and may instruct a facility to defer involuntary discharge until the conclusion of the investigation. Families are advised that during the Medicaid application process, the resident's income should be paid over to the nursing home. When needed, the Ombudsman's Office uses its subpoena power to obtain the necessary documents to complete the Medicaid application. As a result, a resident's application for Medicaid is often approved and the facility begins to receive payments for the care provided.

her mother's charges. On the other hand, a directly contradictory clause shields her from personal financial exposure. In light of this ambiguity, the Agreement should be read to absolve Ms. Campagna of personal liability.

"Generally, the terms of an agreement are to be given their plain and ordinary meaning." M.J. Paquet, Inc. v. N.J. Dep't of Transp., 171 N.J. 378, 396 (2002). But "if the terms of the contract are susceptible to at least two reasonable alternative interpretations," the language is ambiguous. Id. (internal quotation and citation omitted). This Court has recognized that "[w]here an ambiguity appears in a written agreement, the writing is to be strictly construed against the draftsman." In re Estate of Miller, 90 N.J. 210, 221 (1982) (citing Terminal Constr. Corp. v. Bergen County Hackensack River Sanitary Sewer Dist. Auth., 18 N.J. 294, 302 (1955)); see also Restatement (Second) of Contracts § 206 (1981) ("In choosing among the reasonable meanings of a promise or agreement or term thereof, that meaning is generally preferred which operates against the party who supplies the words or from whom a writing otherwise proceeds.").

That principle has special force where the parties to the contract do not have the same bargaining power. This Court has therefore been careful to vindicate the rights of the less powerful party when interpreting contracts of adhesion. "[T]he

essential nature of a contract of adhesion is that it is presented on a take-it-or-leave-it basis, commonly in a standardized printed form, without opportunity for the 'adhering' party to negotiate except perhaps on a few particulars." Rudbart v. N. Jersey Dist. Water Supply Comm'n, 127 N.J. 344, 353 (1992). When such a contract is ambiguous, the Court reads it "to effectuate the reasonable expectations of the [adhering party]." Bd. of Educ. v. Utica Mut. Ins. Co., 172 N.J. 300, 307 (2002) (holding that insurance contract, as a contract of adhesion, must be read in favor of the insured).

The Admission Agreement at issue here creates profound ambiguity. Scattered throughout its five pages are provisions that purport to subject the "resident's representative" to personal liability. See supra Point II.A. At the same time, the Agreement contains a clause that purports to absolve the resident's representative from any and all personal financial obligation under the contract. Section I(b) begins: "Whenever this agreement refers to resident and/or residents' [sic] representative with regards to monies this solely relates to the residents' [sic] funds." Id. (Pa9).[23]

[23] The Appellate Division mentioned this clause in a footnote and remarked that "[t]he applicability of this provision to the resident's representative responsibility for the outstanding

(footnote continued . . .)

In the face of such contradictory provisions, axioms of contract interpretation dictate that the Agreement be read to favor Ms. Campagna and her parents.[24] Families seeking appropriate care for elderly relatives are not often in a position to negotiate or shop around. The decision to enter a nursing home, or to assist one's elderly parent in entering a nursing home, is emotionally fraught and, depending on geography and financial capacity, the alternatives may be few. See Podolsky, 58 Cal. Rptr. 2d at 101 ("We again note that admission of a close family member to a nursing home – usually by the child of a parent in declining mental or physical health – is often an emotionally-charged, stress-laden event." (citing D. M. Ambrogi, Legal Issues in Nursing Home Admissions, 18 Law Med. & Health Care 254, 255, 258 (1990))); Pearson, supra, 37 U. Mich. J.L. Reform at 770 ("Most admissions agreements are signed by family members in practical - if not legally recognized - duress."). As appears to have been the case here, families typically sign the agreement that the facility presents without

---

obligations is not clear." Llanfair House, No. A-932-07T1, slip op. at 2 n.1.

[24] Cf. Five Star Quality Care—MO, L.L.C. v. Lawson, No. WD69712, 2009 Mo. App. LEXIS 418, at *10-*11 (Mo. Ct. App. Apr. 7, 2009) (holding that clause in admission agreement limiting guardian's liability for "any and all unpaid charges" to amounts payable from "the Resident's assets" overrode any contradictory provisions of the agreement) (emphasis omitted).

negotiation or alteration. These circumstances reinforce the rule that the contract is read in the manner that favors the "adhering party" and disfavors the draftsman. In line with these principles, this contract should be construed to give effect to the provision that absolves Ms. Campagna of all personal liability.

To the extent that Llanfair House seeks to hold Ms. Campagna personally liable for her purported agreement to apply for Medicaid on behalf of her mother, the contract itself limits the remedy Plaintiff may seek. After imposing on the resident's representative a duty to apply for Medicaid (Admission Agreement (Pa9)), the Agreement states: "[F]ailure to [cooperate in initiating the Medicaid application process] will lead to the facility sending a 30 day discharge notice" (id.). This remedy of involuntary discharge comports with the provision in the same section of the Agreement absolving Ms. Campagna of all personal financial liability, id., and supports a construction of the contract that a breach of the Medicaid application provisions, if there were such a breach, is not punishable by charging the resident's representative personally for the cost of continuing care.

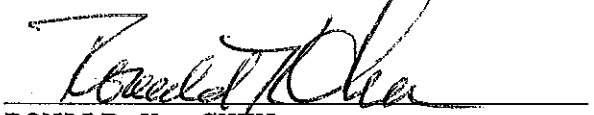
Plaintiff cannot have it both ways – it cannot write a contract that purports both to hold Ms. Campagna personally liable for the cost of her mother's nursing home services and

also to absolve her of that responsibility. Because the terms of the Admission Agreement limit reference to "monies" to the resident's funds and provide the remedy of discharge for failure to cooperate in the Medicaid application process, the Agreement does not impose on Ms. Campagna any personal liability for any debt of her mother to Plaintiff.

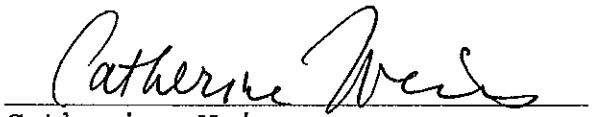
CONCLUSION

For these reasons, Amicus Public Advocate of New Jersey respectfully asks the Court to vacate the default judgment under Rule 4:50-1(f); hold that Ms. Campagna cannot be held individually liable under any theory presented in the case; and remand for further proceedings to determine any potential liability of Mrs. Litchult's estate.

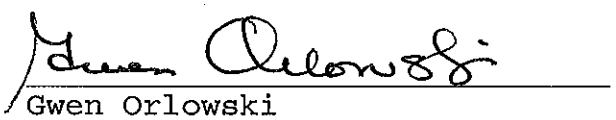
Respectfully submitted,



RONALD K. CHEN
PUBLIC ADVOCATE OF NEW JERSEY



Catherine Weiss
Director, Division of Public Interest Advocacy



Gwen Orlowski
Director, Division of Elder Advocacy

Brian Weeks
Deputy Public Advocate

Rebecca Estelle
Assistant Deputy Public Advocate

Dated: June 8, 2009

APPENDIX

VOLUME I

TABLE OF CONTENTS

APPENDIX, VOLUME I: Unpublished Decisions

APPENDIX, VOLUME II: Sample Nursing Home Admission Agreements

LexisNexis

2 of 3 DOCUMENTS

Alzheimer's Resource Center of Connecticut, Inc. v. Ronald Carlstrom

CV044002045S

SUPERIOR COURT OF CONNECTICUT, JUDICIAL DISTRICT OF NEW BRITAIN AT NEW BRITAIN

2005 Conn. Super. LEXIS 2752

September 30, 2005, Decided

NOTICE: [*1] THIS DECISION IS UNREPORTED AND MAY BE SUBJECT TO FURTHER APPELLATE REVIEW. COUNSEL IS CAUTIONED TO MAKE AN INDEPENDENT DETERMINATION OF THE STATUS OF THIS CASE.

PRIOR HISTORY: *Alzheimer's Res. Ctr. of Conn. v. Carlstrom, 2005 Conn. Super. LEXIS 1490 (Conn. Super. Ct., May 23, 2005)*

JUDGES: ROBERT B. SHAPIRO, JUDGE OF THE SUPERIOR COURT.

OPINION BY: ROBERT B. SHAPIRO

OPINION

MEMORANDUM OF DECISION ON MOTION TO STRIKE (# 115)

The court heard oral argument on this matter at the short calendar on September 6, 2005. After considering the parties' arguments, the court issues this memorandum of decision. For the reasons set forth below, the defendant's motion to strike is granted.

I.

BACKGROUND

In its one-count amended complaint (# 114), the plaintiff, The Alzheimer's Resource Center of Connecticut, Inc. (The Alzheimer's), a skilled nursing care facility, seeks to recover monies allegedly due from defendant Ronald Carlstrom (Carlstrom), based on a claimed breach of contract. Alzheimer's alleges that in April 2002, Jennie Carlstrom, Carlstrom's mother, through Carlstrom, as responsible party, entered into a written agreement with The Alzheimer's, wherein The Alzheimer's would provide medical care and residential services to Jennie Carlstrom (Agreement). A copy thereof is annexed to the amended complaint.

The Alzheimer's [*2] claims that Jennie Carlstrom has failed to pay for the services for the period December 1, 2003 to June 30, 2004, and seeks to recover $ 66,030.00. It alleges that Carlstrom signed the Agreement as responsible party.

Further, it alleges that "the Agreement provides that it is enforceable against [Carlstrom], as responsible party, individually and personally, only if the resident or the person acting on his or [her] behalf, fails to return a properly completed application for Title XIX (Medicaid) to the Department of Income Maintenance in accordance with the department's regulations." See amended complaint, P7.

The Alzheimer's claims that Carlstrom filed two applications for Title XIX, in June 2003, and in November 2003, both of which were denied because Jennie Carlstrom was "over asset." See amended complaint, P8. The Alzheimer's also alleges that a third application was granted in December 2004, retroactive to July 1, 2004. See amended complaint, P9.

The Alzheimer's further alleges that Carlstrom "has breached the Agreement by failing to timely qualify Jennie Carlstrom for Title XIX (Medicaid) benefits." See amended complaint, P12.

In his motion, Carlstrom contends that the [*3] Agreement does not impose a duty upon him to "timely qualify" his mother for Medicaid benefits. Alternatively, he argues that, if the Agreement does impose such an obligation upon him, that would render the Agreement a personal guarantee, making him personally liable for his

mother's debts, in violation of *42 U.S.C. § 1396r(c)(5)(A)(ii)* and *42 U.S.C. § 1396r(c)(5)(B)(ii)*, and the Connecticut Patients' Bill of Rights, *General Statute § 19a-550(b)(26)*.

In response, The Alzheimer's contends that Carlstrom's motion is a "speaking motion" which improperly asks the court to interpret facts which are outside the complaint. It also argues that the Agreement does not violate the cited statutes since it does not cause Carlstrom to personally guarantee payment in any manner. See The Alzheimer's memorandum of law (# 117), p. 6.

II

STANDARD OF REVIEW

The standard of review on a motion to strike is well-established. "A motion to strike challenges the legal sufficiency of a pleading, and, consequently, requires no factual findings by the trial court." *Broadnax v. New Haven, 270 Conn. 133, 173, 851 A.2d 1113 (2004).* **[*4]** "We take the facts to be those alleged in the complaint . . . and we construe the complaint in the manner most favorable to sustaining its legal sufficiency . . . Thus, if facts provable in the complaint would support a cause of action, the motion to strike must be denied Moreover, we note that what is necessarily implied [in an allegation] need not be expressly alleged . . . It is fundamental that in determining the sufficiency of a complaint challenged by a defendant's motion to strike, all well-pleaded facts and those facts necessarily implied from the allegations are taken as admitted . . . Indeed, pleadings must be construed broadly and realistically, rather than narrowly and technically . . ." (Citations omitted and internal quotation marks omitted.) *Commissioner of Labor v. C.J.M. Services, Inc., 268 Conn. 283, 292-93, 842 A.2d 1124 (2004).*

III

DISCUSSION

The Alzheimer's contends that "the defendant attempts to argue that [his] failure to 'timely file' does not necessarily mean the defendant 'failed to return a properly completed application,' pursuant to the terms of the contract." See The Alzheimer's memorandum of law, p. 6. The reference to "timely **[*5]** file" is not attributed either to Carlstrom's motion or to his memorandum of law by page reference. Rather than reference a duty to "timely file," Carlstrom's motion refers to The Alzheimer's amended complaint's allegation, quoted above, that he failed to "timely qualify" his mother for Medicaid benefits. See amended complaint, P12. Also, as stated above, in its amended complaint, The Alzheimer's refers to the contractual requirement to "return a properly completed application," see amended complaint, P7. However, the allegation of breach in paragraph 12 does not state that the alleged breach involved a failure to properly complete an application. Paragraph 12 alleges that Carlstrom "has breached the Agreement by failing to timely qualify Jennie Carlstrom for Title XIX. (Medicaid) benefits." See amended complaint, P12.

"In deciding upon a motion to strike or a demurrer, a trial court must take the facts to be those alleged in the complaint; . . . and cannot be aided by the assumption of any facts not therein alleged . . . Where the legal grounds for such a motion are dependent upon underlying facts not alleged in the plaintiff's pleadings, the defendant must await the evidence which **[*6]** may be adduced at trial, and the motion should be denied." (Citations omitted; internal quotation marks omitted.) *Liljedahl Bros., Inc. v. Grigsby, 215 Conn. 345, 348, 576 A.2d 149 (1990).*

Contrary to The Alzheimer's contention, Carlstrom's motion to strike is not a speaking motion. It does not raise facts which are outside the complaint. Rather, its arguments are based on the language of the amended complaint and that of the Agreement, which is part of the amended complaint, having been incorporated by reference therein and attached thereto. See *Practice Book § 10-29(a); H. Pearce Real Estate Co. v. Kaiser, 176 Conn. 442, 444, 408 A.2d 230 (1976)* ("Exhibit A is therefore crucial to evaluation of the plaintiff's complaint, and its terms control the propriety of the defendant's demurrer"); *Redmond v. Matthies, 149 Conn. 423, 426, 180 A.2d 639 (1962).*

"What duty the defendant had, if any, is a question of law. *Nolan v. New York, N.H & H.R. Co., 53 Conn. 461, 471, 4 A. 106 (1885).* The issue of whether the defendant owed the plaintiff a duty . . . is an appropriate one for a motion to strike because the question embodies **[*7]** a matter of law to be decided by the court." *Bennett v. Connecticut Hospice, Inc., 56 Conn.App. 134, 137, 741 A.2d 349 (1999)*, cert. denied, *252 Conn. 938, 747 A.2d 2 (2000).*

"Although ordinarily the question of contract interpretation, being a question of the parties' intent, is a question of fact . . . where there is definitive contract language, the determination of what the parties intended by their contractual commitments is a question of law." (Internal quotation marks omitted.) *Goldberg v. Hartford Fire Insurance Co., 269 Conn. 550, 559-60, 849 A.2d 368 (2004).*

"As with the interpretation of all contracts, we must construe the instrument to effectuate the intent of the parties, which is determined from the language used interpreted in the light of the situation of the parties and the circumstances connected with the transaction. The intent of the parties is to be ascertained by a fair and reasonable

construction of the written words and . . . the language used must be accorded its common, natural, and ordinary meaning and usage where it can be sensibly applied to the subject matter of the contract . . . Where the language of the [*8] contract is clear and unambiguous, the contract is to be given effect according to its terms." (Citations omitted; internal quotation marks omitted.) *Id., 559.*

In pertinent part, under "Payment," the Agreement provides, "With respect to payment of the total per diem rate and all ancillary charges [for] care rendered by the Facility to the Resident, this agreement is enforceable against the Responsible Party, individually and personally, only: . . . b) If the Resident, or the person acting on his/her behalf, fails to return a properly completed application for Title XIX (Medicaid) to the Department of Income Maintenance in accordance with the department's regulations." See Exhibit A to amended complaint, p. 3 of 7.

The Alzheimer's contends that "it is not a leap of faith to imply that the Defendant 'improperly completed' the application when he filed the application three times to accomplish the purpose of qualifying for Medicaid, yet failed, which the Plaintiff clearly alleges in the Complaint. Moreover it is not inconsistent with the terms of the contract that an 'improperly completed' application is one not 'timely filed' or twice 'over assets.' " See The Alzheimer's [*9] memorandum of law, pp. 7-8 (footnote omitted).

Again, the reference to an allegation of "not timely filed" does not appear in the amended complaint. It does not arise by necessary implication. Also, the amended complaint does not allege that breach occurred due to an application having been denied for being "over asset."

The Alzheimer's cites our Appellate Court's recent decision in *Sunrise Healthcare Corp. v. Azarigian, 76 Conn.App. 800, 821 A.2d 835 (2003)*, where the court determined that the language employed in the agreement at issue there did not violate the prohibition against third-party guarantees of payment set forth in *42 U.S.C. § 1396r(c)(5)(A)(ii)*. That agreement concerned different contract terms than are at issue here. See *id., 806, 808-09, 811*. In *Sunrise Healthcare Corp. v. Azarigian, supra*, the court quoted the language of the agreement: "Subparagraph 8(8) provides that 'if the responsible party has control of or access to the resident's income and/or assets, the responsible party agrees that these funds shall be used for the resident's *welfare, including but not limited to making prompt* [*10] *payment . . . [in] accordance with the terms of this agreement.*' . . . Accordingly, the defendant was obligated to make 'prompt payments' to the plaintiff." (Emphasis in original.) *Id., 811*. In contrast, as noted above, the Agreement at issue here provides, in pertinent part, for Carlstrom to be personally liable only in the event of a failure to return a properly completed application.

All that is alleged in paragraph 12 of the amended complaint is a breach of the Agreement "by failing to timely qualify Jennie Carlstrom for Title XIX (Medicaid) benefits." The complaint does not allege breach by failure to "return a properly completed application." See Agreement, amended complaint, Exhibit A, p. 3 of 7.

"A motion to strike is properly granted if the complaint alleges mere conclusions of law that are unsupported by the facts alleged." (Internal quotation marks omitted.) *Fort Trumbull Conservancy, LLC v. Alves, 262 Conn. 480, 498, 815 A.2d 1188 (2003)*. In concluding that The Alzheimer's has alleged a breach of a claimed duty to "timely qualify" Carlstrom's mother for Title XIX, which is not set forth in the Agreement as a basis on which to hold [*11] Carlstrom individually and personally liable, the court is not making a determination based on factual allegations which are outside the complaint. Rather, it is simply measuring the complaint's allegations against the terms of the contractual agreement which The Alzeimer's incorporated within its complaint. In the absence of such a contractual duty, the complaint is legally insufficient. [1]

1 In its memorandum of law, pp. 4, 6, The Alzheimer's notes that, in connection with its application for a prejudgment remedy, the court (Robinson, J.) found that there was probable cause to believe that a judgment would enter in its favor. See # 112. Our Appellate Court has stated that "the PJR probable cause review is extremely limited . . . This limited evidentiary standard contrasts sharply with the detailed and substantive arguments and conclusions necessary in a motion to strike." (Citation omitted; internal quotation marks omitted.) *William Beazley Co. v. Business Park Associates, Inc., 34 Conn.App. 801, 805, 643 A.2d 1298 (1994)*. The court's determination on the JRP application is irrelevant to the issues raised by the motion to strike. See *id., 806.*

[*12] Under these circumstances, the court need not consider Carlstrom's alternative argument, concerning a personal guarantee in violation of applicable statutes.

CONCLUSION

For the foregoing reasons, the defendant's motion to strike is granted. It is so ordered.

BY THE COURT

ROBERT B. SHAPIRO

JUDGE OF THE SUPERIOR COURT

1 of 1 DOCUMENT

[*1] Amsterdam Nursing Home Corp., Plaintiff, against Ronald Lang, Defendant.

601821/05

SUPREME COURT OF NEW YORK, NEW YORK COUNTY

2007 NY Slip Op 51727U; 16 Misc. 3d 1138A; 851 N.Y.S.2d 56; 2007 N.Y. Misc. LEXIS 6255; 238 N.Y.L.J. 72

September 13, 2007, Decided

NOTICE: THIS OPINION IS UNCORRECTED AND WILL NOT BE PUBLISHED IN THE PRINTED OFFICIAL REPORTS.

HEADNOTES

[1138A]** **[***56]** Process--Service of Process--Timeliness. Health--Nursing Homes--Liability of Third Party for Cost of Care.

COUNSEL: Plaintiff: Abrams, Fensterman, Fensterman, Eisman, Greenberg, Formato & Einiger, LLP, Lake Success, NY.

Defendant: No appearance.

JUDGES: Doris Ling-Cohan, J.

OPINION BY: Doris Ling-Cohan

OPINION

Doris Ling-Cohan, J.

The issue before the Court is whether defendant Ronald Lang can be held liable for the cost of care his grandmother received at a nursing home, based on his signature on the admission agreement.

Background

Plaintiff Amsterdam Nursing Home (plaintiff or Amsterdam) commenced this case against defendant Ronald Lang (defendant or Lang) to recover the sum of $ 18,574.53, allegedly due for the services provided to Clarissa Merritt, a resident of the facility (Affirmation of Susan Mauro, Esq. in Support of Motion [Mauro Aff.], at P 3). Lang is the grandson of Ms. Merritt (*id.*). Lang signed the Admission Agreement, as the "Legally Authorized Representative", of Ms. Merritt Mauro Aff., Ex. I [Admission Agreement] at 14). According to the submitted affidavit of service, plaintiff was able to effectuate service of process on Lang on or about February 5, 2006, after several unsuccessful attempts. Lang has failed to appear, or otherwise respond to the complaint; nor has he requested an extension of time to do so.

Plaintiff moves: (1) for an order, pursuant to *CPLR 306-b*, for an extension of time for service of process; and (2) for an order, pursuant to *CPLR 3215*, authorizing the entry of a default judgment against Lang. For the reasons set forth below, both branches of plaintiff's motion are denied.

Discussion

1. Extension of Time for Service of Process

Plaintiff commenced this action by filing the summons and complaint, on or about May 19, 2005 (Mauro Aff., Ex. A). Amsterdam made several unsuccessful attempts to serve Lang at his last known address of 131 St. Nicholas Avenue, Apt. 13A, New York, New York 10026. A process server employed by plaintiff unsuccessfully attempted to personally serve Lang with the summons and complaint at the above

address on or about May 31, 2005, and was advised by the new tenant in Lang's apartment that Lang had moved and had left no forwarding address (Mauro Aff., Ex. C). In response to plaintiff's inquiry, on or about June 20, 2005, the United States Postal Service indicated that Lang had not filed a change of address form (Mauro Aff., Ex. D).

On or about September 16, 2005, nearly three months after being advised by the U. S. Postal Service that Lang had left no forwarding address, Amsterdam's attorneys employed a private investigative agency, Windsearch, to **[*2]** make additional efforts to locate Lang (Mauro Aff., at P 9 and Ex. E). In or about November 2005, Windsearch advised Amsterdam's attorneys that, after searching many nationwide databases, it could not locate an address for Lang, other than his last known address of 131 St. Nicholas Avenue (*id.*). Amsterdam was finally able to effectuate service on Lang by the nail, mail and file method at his last known address, pursuant to *CPLR 308 (4)*. After several unsuccessful attempts to personally serve Lang at the 131 St. Nicholas Avenue address, a process server retained by plaintiff affixed a copy of the summons and complaint to his last known residence, on or about January 18, 2006, and then mailed a copy of the summons and complaint to Lang at his last known address on January 24, 2006 (Mauro Aff., Ex. F). The affidavit of service was filed with the office of the New York County Clerk on January 26, 2006. In accordance with *CPLR 308 (4)*, service on Lang was complete ten days after the filing, on or about February 5, 2006.

CPLR 306-b provides that service of the summons and complaint must be made within 120 days after filing, or in the instant case on or about September 20, 2005. In this case, however, Amsterdam did not effectuate service on Lang until over four months after the prescribed time. *CPLR 306-b* further provides, however, that the court may extend the time for service of process "upon good cause shown or in the interest of justice". In order to show "good cause", Amsterdam must establish that it made reasonably diligent efforts to serve Lang within the prescribed 120 day period (*see Leader v Maroney, Ponzini & Spencer, 97 N.Y.2d 95, 105, 761 N.E.2d 1018, 736 N.Y.S.2d 291 [2001]*). Amsterdam has failed to demonstrate that it made reasonably diligent efforts to effectuate service on Lang within 120 days after filing the summons and complaint. There is no justification for the delay of more than three months in retaining the private investigative agency, after being advised by the U.S. Postal Service that there was no forwarding address for Lang. Nor did Amsterdam provide any explanation for the further delay of approximately two months in serving Lang by the nail, mail and file method, after receiving the report from the investigative agency. If Amsterdam cannot establish "good cause' for failing to effectuate timely service on Lang, it certainly cannot demonstrate a basis for extending the time for service "in the interests of justice', which requires the balancing of a number of factors, including the reasonable diligence of efforts to serve Lang (*id., at 105-106*).

2. Default Judgment; Merits of Lang's Liability for Services Rendered to his Grandmother

Even assuming, for the sake of argument, that Amsterdam had established a basis to extend its time to effectuate service on Lang, it has failed to demonstrate entitlement to the entry of a default judgment against him for services rendered to his grandmother. This case deals with the relatively novel issue of third-party liability for the costs of nursing home services. As discussed in detail below, Amsterdam has shown no basis for holding Lang liable for the services it rendered to his grandmother, under the facts and circumstances herein.

The requirements for nursing home reimbursement pursuant to the Medicaid program, as was the case at bar, are set forth in certain provisions of the Federal Social Security Act, *42 U.S.C. § 1396r*. That statute contains the following provision:

> "(5) Admissions policy
>
> (A) Admission
>
> With respect to admissions practices, a nursing facility must --
>
> (ii) not require a third party guarantee of payment to the facility as a condition of admission (or expedited admission) to, or continued stay in, the facility; and . . .
>
> (B) Construction . . .
>
> (ii) Contracts with legal representatives
>
> Subparagraph (A) (ii) shall not be construed as preventing a facility from

> requiring an individual, who has legal access to a resident's income or resources available to pay for care in the facility, to sign a contract (without incurring personal financial liability) to provide payment from the resident's income or resources for such care."

(*42 U.S.C. § 1396r [c] [5] [A] [ii]* and *[B] [ii]*). There are similar provisions in the section of the Social Security Act dealing with Medicare benefits (*42 U.S.C. § 1396r [c] [5] [A] [ii]* and *[B] [ii]*).

The federal regulations for the Centers for Medicare and Medicaid Services (CMS) contain the following provision, reflecting the above statutory requirements:

> "(2) The facility must not require a third party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay in the facility. However, the facility may require an individual who has legal access to a resident's income or resources available to pay for facility care to sign a contract, without incurring personal financial liability, to provide facility payment from the resident's income or resources."

(*42 C.F.R. § 483.12 [d] [2]*).

[*3] The regulations of the New York State Department of Health contain a provision reflecting the federal statutory and regulatory requirements, discussed above:

> "(b) *Admission rights*. The nursing home shall protect and promote the rights of residents and potential residents by establishing and implementing policies which ensure that the facility:
>
> > (1) shall not require a third-party guarantee of payment to the facility as a condition of admission, or expedited admission, or continued stay in the facility; . . .
> >
> > (6) may require an individual who has legal access to a resident's income or resources available to pay for facility care, to sign a contract, without incurring personal financial liability, to provide the facility payment from the resident's income or resources; . . . ."

(*10 NYCRR § 415.3 [b] [1]* and *[6]*).

Amsterdam argues that Lang, based upon his signature on the Admission Agreement as his grandmother's "Legally Authorized Representative", assumed responsibility for payment of her Net Available Monthly Income (NAMI), an amount determined by Medicaid that a nursing home resident is responsible for paying a health care facility, after evaluating her assets and income (Mauro Aff., at P 22, and Ex. J). In this case, the New York City Medicaid agency determined that Ms. Merritt's NAMI, based upon the net pension and Social Security income available to her, was $ 1043.65 (Mauro Aff., Ex. J). The $ 18,574.53 sought by Amsterdam is the total of Ms. Merritt's unpaid NAMI for her stay at the facility.

Lang did not sign a third-party guarantee requiring him to be personally liable for his grandmother's unpaid NAMI and other fees owed to Amsterdam; nor could Amsterdam legally require such a guarantee as a condition of Ms. Merritt's admission (*see 42 U.S.C § 1396r [c] [5] [A] [ii]* and *[B] [ii]*; *10 NYCRR § 415.3 [b] [1]* and *[6]*). The Admission Agreement does not define the term, "Legally Authorized Representative[1]" (Admission Agreement, at 13-14[K]). Further, the Admission Agreement only requires the resident, in this case Ms. Merritt, rather than the Legally Authorized Representative, to pay the basic daily rate and all other charges for services not covered by Medicare, Medicaid or other third-party insurance, and to pay the NAMI, as determined by the Department of Health (*see* Admission Agreement, at 3 [C] [1] and 4 [d]).

1 The regulations promulgated by the New York State Department of Health define the term

"Designated Representative" to "mean the individual or individuals designated in accordance with this subdivision to receive information and to assist and/or act in behalf or a particular resident to the extent permitted by State law" (*10 NYCRR § 415.2 [ff]*).

The following provision of the Admission Agreement describes the responsibilities of the Legally Authorized Representative:

> "*K. LEGALLY AUTHORIZED REPRESENTATION DOCUMENTATION*
>
> Resident's Legally Authorized Representative agrees to obtain and provide Amsterdam with formal documentation confirming authorization to act on behalf of Resident with respect to financial and/or personal matters. Resident's Legally Authorized Representative will obtain formal court appointment as a guardian, or power-of-attorney to act on Resident's behalf, or any such formal designation that is determined to be necessary by Amsterdam. Upon receipt and verification of such documentation, Amsterdam will give to the Legally Authorized Representative all notification of information which is required to be given to Resident by applicable laws or regulations subject to applicable limitations based upon confidentiality."

(Admission Agreement, at 13-14 [K]). Amsterdam has presented no evidence that Lang has obtained formal documentation confirming his authorization to act on behalf of his grandmother. Nor has Amsterdam stated that it has directed Lang to obtain a formal designation to act on behalf of Ms. Merritt, including appointment by a court as her legal guardian or power-of-attorney to act on her behalf with respect to financial matters.

In addition, it is significant that Lang did not sign the last page of the Admission Agreement, containing the following language: "The undersigned agrees, without incurring personal financial liability, to provide Amsterdam with payment from Resident's income or resources for any amounts due from Resident under the terms of this Agreement" (Admission Agreement, at 15). This language reflects the provisions of the Social Security Act and the applicable federal and state regulations discussed above (*see 42 U.S.C. § 1396r [c] [5] [A] [ii]* and *[B] [ii]*; *42 C.F.R. §* [*4] *483.12 [d] [2]*; and *10 NYCRR § 415.3 [b] [1]* and *[6]*). Even if Lang had signed the above provision of the Admission Agreement, Amsterdam could only legally require him to provide the facility with payment for his grandmother's NAMI, using his access to *her* available income or resources, without incurring any personal financial liability (*see 42 U.S.C § 1396r [c] [5] [A] [ii]* and *[B] [ii]*; *10 NYCRR § 415.3 [b] [1]* and *[6]*). As has been emphasized, however, Amsterdam has presented no evidence that Lang has any legal control over or access to his grandmother's financial resources (*see* Mauro Aff., at P 19; Admission Agreement, at 13-14[K]). Therefore, based upon the record before this Court, Amsterdam has failed to establish that Lang is liable to pay for the services rendered to his grandmother.

The limited case law on this issue from New York supports the above conclusion. In the recent decision of *Prospect Park Nursing Home, Inc. v Goutier (12 Misc. 3d 1192(A), 824 N.Y.S.2d 770, 2006 NY Slip Op 51536(U) [Civ Ct, Kings County 2006] [Battaglia, J])*, the court concluded that a third party who had signed a resident's nursing home admission agreement as the "Designated Representative" was not liable to pay for services rendered to the resident by the facility, in excess of the funds received from third party sources. The court found no evidence that the third party, who had obtained a durable power of attorney over the resident's financial assets two years after the resident had left the nursing home, had any access to the resident's assets or had received any of those assets . As noted above, in the instant case, Amsterdam presented no evidence that Lang had a power of attorney or other legal control over his grandmother's assets and income (*see also Wedgewood Care Ctr., Inc. v McGloin, 2002 NY Slip Op 40545(U), 2002 N.Y. Misc. LEXIS 1689 [App Term 2002]* [summary judgment denied to nursing home operator seeking reimbursement from widow for unpaid balance for husband's services; widow was not guarantor for her husband, but question of fact existed as to whether widow acted as a trustee to receive benefits on behalf of her husband]).

The New York decisions cited by Amsterdam are distinguishable from the instant matter. For example, in

Putnam Nursing and Rehabilitation Ctr. v Bowles (239 A.D.2d 479, 658 N.Y.S.2d 57 [2d Dept 1997]), the Appellate Division held that a nursing home could assert claims against the defendants, who were third parties to whom a deceased resident had transferred ownership of her residence. In addition, one of the defendants had executed a "Responsible Party" agreement with the facility, agreeing to guarantee continuity of payment from the resident's funds or from third-party sources (*id., at 480*). Defendants obtained a loan of $ 20,000 after mortgaging the residence, but did not transfer this money to the nursing home (*id.*). The Appellate Division held that the defendants could be held liable to the nursing facility for both breach of contract and for a fraudulent conveyance voidable pursuant to the Debtor and Creditor Law (*id., at 481*). In *Putnam Nursing and Rehabilitation Ctr. v Bowles*, the "responsible party" actually had control over the resident's property and had obtained monetary resources based upon that property. By contrast, in the instant case, Amsterdam has presented no evidence that Lang obtained any control over or access to his grandmother's assets or income (*see also Daughters of Sarah Nursing Home Co. v Lipkin, 145 A.D.2d 808, 535 N.Y.S.2d 790 [3d Dept 1988]* [holding defendant liable for resident's charges as third-party guarantor where charges were incurred prior to effective date of provisions of Social Security Act prohibiting nursing homes from requiring third-party guarantees as a condition of admission]).

Decisions from other states support the imposition of liability on third parties for the cost of a nursing home resident's care only where the third party has legal control over or access to the resident's assets and/or income. For example in *Sunrise Healthcare Corp. v Azarigian (76 Conn App 800, 821 A.2d 835 [2003])*, a Connecticut appellate court concluded that a nursing home could hold a daughter liable for breach of contract, where the daughter had signed her mother's contract as the "legal representative" and had power of attorney over her mother's financial assets. In *Sunrise Healthcare*, the daughter had improperly transferred money from her mother's accounts, instead of using her mother's assets to pay for her care (*see also Methodist Manor of Waukesha, Inc. v Martin, 2002 WI App 130, 255 Wis2d 707, 647 N.W.2d 409 [2002]* [nursing facility stated cause of action against son for conversion, where son was mother's attorney-in-fact and joint bank account holder, and had failed to turn over to the facility his mother's Social Security benefits which were under his control]; *compare Slovik v Prime Healthcare Corp., 838 So. 2d 1054 [Ala 2002]* [court finds insufficient evidence to hold stepson liable for failing to pay his stepfather's Social Security benefits to a nursing facility]).

Thus, Amsterdam's complaint must be dismissed on the merits, as it is not entitled to hold Lang liable for any portion of his grandmother's outstanding charges, based upon the language of the Admission Agreement he signed, the applicable provisions of the Social Security Act, the federal and state regulations, or the relevant case law.

Accordingly, it is

ORDERED that plaintiff's motion for an extension of time to effectuate service of process on defendant or, in the alternative, to enter a default judgment against defendant is denied, and the complaint is dismissed and the Clerk of the Court shall enter judgment in accordance herewith.

This constitutes the Decision and Order of the Court.

Dated: ENTER:

[*5] Doris Ling-Cohan, JSC

LEXSEE 2003 US DIST LEXIS 19287

DAVID P. CARROLL, Plaintiff, v. BUTTERFIELD HEALTH CARE, INC., d/b/a MEADOWBROOK MANOR BOLINGBROOK; KIANOOSH JAFARI; and FRIEDMAN, ANSELMO, LINDBERG & RAPPE, Defendants.

02 C 4903

UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF ILLINOIS, EASTERN DIVISION

2003 U.S. Dist. LEXIS 19287

October 28, 2003, Decided
October 29, 2003, Docketed

DISPOSITION: [*1] Defendant Freedman's motion to dismiss granted in part and denied in part.

COUNSEL: For David P Carroll, PLAINTIFF: Cathleen M Combs, Edelman, Combs & Latturner, Chicago, IL USA. Daniel A Edelman, Edelman, Combs & Latturner, Chicago, IL USA. James O Latturner, Edelman, Combs & Latturner, Chicago, IL USA. Michelle R Teggelaar, Edelman, Combs & Latturner, Chicago, IL USA.

JUDGES: George M. Marovich, United States District Judge.

OPINION BY: George M. Marovich

OPINION

MEMORANDUM OPINION AND ORDER

Plaintiff, David P. Carroll ("Carroll") filed a lawsuit against Butterfield Health Care, Inc. doing business as Meadowbrook Manor Bolingbrook ("Meadowbrook"), Kianoosh Jafari ("Jafari"); and Freedman, Anselmo, Lindberg & Rappe ("Freedman"). Carroll filed a four-count complaint alleging, inter alia, violations of the *Fair Debt Collection Practices Act* ("FDCPA") against Freedman and violations of the *Illinois Consumer Fraud Act* against Meadowbrook and Jafari. Freedman now moves to dismiss Count I and IV of Meadowbrook's complaint. Jafari and Meadowbrook now move to dismiss Count II of Meadowbrook's complaint pursuant to *Fed R. Civ. P. 12(b)(6)* [*2] . For the reasons set forth below, the motions are granted in part and denied in part.

BACKGROUND

The Complaint alleges the following relevant facts which, for purposes of deciding this motion, are taken as true. *Hishon v. Kemp & Spalding, 467 U.S. 69, 73, 81 L. Ed. 2d 59, 104 S. Ct. 2229 (1984)*. On December 9, 2000, James R. McDonald ("McDonald") was admitted to Meadowbrook's nursing home in Bolingbrook, Illinois. At the time McDonald was admitted, Carroll, his son-in-law, was accompanying him and was told by Meadowbrook that McDonald could not be admitted unless Carroll signed a personal guarantee of payment. The guarantee held Carroll liable in the event McDonald did not pay Meadowbrook their pre-arranged fees.

On August 2, 2001, Freedman filed a suit on behalf of Meadowbrook against Carroll to fulfill the terms of the guarantee. Freedman has filed over 50 lawsuits on behalf of Meadowbrook collecting fees owed to Meadowbrook when parties have defaulted on personal guarantees. In several of these lawsuits, defendants have succeeded by claiming the personal guarantee violates the Medicaid Act, *42 U.S.C. 1396r(c)(5)(A)(ii)* ("Medicaid Act").

[*3] On September 6, 2001, Freedman obtained a judgment in favor of Meadowbrook to enforce the agreement. Subsequently, Meadowbrook and Freedman garnished Carroll's wages. However, on May 17, 2002, the judgment was vacated. Freedman continued to garnish Carroll's wages and in response Carroll has filed this lawsuit.

DISCUSSION

I. *Standard for a Motion to Dismiss*

When considering a motion to dismiss, a court must view the complaint's allegations in the light most favorable to the plaintiff, and all well-pleaded facts in the complaint must be accepted as true. *Wilson v. Formigoni, 42 F.3d 1060, 1062 (7th Cir. 1994). Rule 8(a) of the Federal Rules of Civil Procedure* states that a complaint must identify the basis of jurisdiction and contain "a short and plain statement of the claim showing that the pleader is entitled to relief". *Bartholet v. Reishauer A.G., 953 F.2d 1073, 1078 (7th Cir. 1992).* Dismissal is proper only if it appears beyond a doubt that plaintiff can prove no set of facts in support of a claim which would entitle him to relief. *Conley v. Gibson, 355 U.S. 41, 45-46, 2 L. Ed. 2d 80, 78 S. Ct. 99 (1957).* [*4] Plaintiff is not, however, entitled to allege mere legal conclusions. *Kunik v. Racine County, 946 F.2d 1574, 1579 (7th Cir. 1991).* To withstand a motion to dismiss, a complaint must allege facts which sufficiently set forth the essential elements of the cause of action. *Gray v. County of Dane, 854 F.2d 179, 182 (7th Cir. 1988).* However, the complaint does not need to contain all of the facts that will be necessary to prevail. *Hoskins v. Poelstra, 320 F.3d 761, 764 (7th Cir. 2003).* With these principles in mind, we turn to the motion presently before the court.

I. *Violation of the Fair Debt Collection Practices Act*

In Count I, Carroll alleges that the personal guarantee Meadowbrook required Carroll to sign was in violation of the Medicaid Act. Carroll further alleges that Freedman violated the Fair Debt Collection Practices Act, *15 U.S.C. 1692*, ("FDCPA") by trying to collect on the personal guarantees on behalf of Meadowbrook, which were in violation of the Medicaid Act.

A. *The Medicaid Act*

This Court must address a threshold issue of whether requiring a personal guarantee as a condition for admission [*5] to the nursing facility violates Congress's intent for the Medicaid Act. The statute states, in pertinent part, "with respect to admissions practices, a nursing facility must . . . (ii) not require a third party guarantee of payment to the facility as a condition of admission (or expedited admission) to, or continued stay in, the facility." *42 U.S.C. 1396r(c)(5)(A)(ii).*

The statute plainly states that conditioning such an admission to a nursing facility is a violation of the statute. *Id.* See also *Manor of Lake City, Inc. v. Hinners, 548 N.W.2d 573, 575-76 (Iowa 1996); Podolsky v. First Healthcare Corp, 50 Cal.App.4th 632, 644-46, 58 Cal. Rptr. 2d 89 (Cal. App. 2nd. Dist. 1996).* Jafari and Meadowbrook clearly violated the statute by requiring Carroll to sign a personal guarantee that Carroll would fulfill all the covenants and agreements for the maintenance of McDonald at Meadowbrook's facility.

B. *Fair Debt Collection Practices Act*

The next issue the Court must resolve is whether the Medicaid Act violation can form the basis of an FDCPA claim against Freedman. A lawyer collecting a debt on behalf of a client is considered a debt collector. [*6] *Heintz v. Jenkins, 514 U.S. 291, 294, 131 L. Ed. 2d 395, 115 S. Ct. 1489 (1995).* The FDCPA does not hold attorney's collecting debts to a different standard than other debt collectors. *Jenkins v. Heintz, 124 F.3d 824, 833 (7th Cir. 1997).* Nor does the FDCPA say that a "collector's status as an attorney should add a requirement of independent legal analysis for each aspect of the creditor's claim." *Id.* "To require an attorney debt collector to conduct an independent investigation into the legal intricacies of the client's contract with the consumer would create a double standard . . . based upon the identity of the collector." *Id. at 834.* Treating lawyers and debt collectors equally under the FDCPA is in line with both Congress's and the Supreme Court's interpretation of that Act. *Id.*

Based upon the both the Supreme Court and Seventh Circuit's rulings, Freedman did not have a duty to investigate the validity of the collection claim placed against Carroll. However, Carroll states in his complaint that Freedman had knowledge that the personal guarantee required by Meadowbrook was in violation of the Medicaid Act. In previous [*7] lawsuits filed by Freedman, on behalf of Meadowbrook, several defendants have raised the defense that the personal guarantee violates the Medicaid Act and had their

lawsuits dismissed. Based upon these prior lawsuits, Freedman had knowledge that conditioning admission to Meadowbrook's facility was in violation of the Medicaid Act. Therefore, Freedman violated the FDCPA by attempting to collect on an illegal guarantee. The Court must deny the motion to dismiss Count I.

II. *Illinois Consumer Fraud Act Claim*

Carroll alleges in Count II of his complaint that Jafari and Meadowbrook violated Section 2 of the Illinois Consumer Fraud Act ("CFA") *815 Ill. Comp. Stat. 505/2.* Carroll alleges that by requiring a personal guarantee from relatives of nursing home residents and enforcing the guarantees, Jafari and Meadowbrook violated the public policy of *Section 2 of the CFA*, inflicted substantial injury on the guarantor in the course of trade or commerce and were deceptive.

Section 2 of the CFA describes, in pertinent part, unfair or deceptive acts as:

> "including but not limited to the use or employment of any deception, fraud, false pretense, false **[*8]** promise, misrepresentation or the concealment, suppression or omission of any material fact, with intent that others rely upon the concealment, suppression or omission of such material fact in the conduct of any trade or commerce."

Robinson v. Toyota Motor Credit Corporation, 201 Ill. 2d 403, 775 N.E.2d 951, 960, 266 Ill. Dec. 879 (Ill. 2002) (quoting *815 Ill. Comp. Stat. 505/2*). The elements of a claim under the Act are: (1) a deceptive act or practice by the defendant; (2) the defendant's intent that the plaintiff rely on the deception; and (3) the occurrence of the deception during a course of conduct involving trade or commerce. *Id.*

Moreover, the CFA requires this Court give consideration to the factors set forth by the Federal Trade Commission to determine whether Jafari and Meadowbrook's alleged violation of the Medicaid Act states a cause of action under the CFA. *Id. at 961.* Those factors are: (1) whether the practice offends public policy; (2) whether it is immoral, unethical, oppressive or unscrupulous; and (3) whether it causes substantial injury to consumers. *Federal Trade Comm'n v. Sperry & Hutchinson Co., 405 U.S. 233, 244 n.5, 31 L. Ed. 2d 170, 92 S. Ct. 898 (1972).* **[*9]** Specifically, the Illinois Supreme Court has also stated that "defendant's conduct must violate public policy, be so oppressive as to leave the consumer with little alternative except to submit to it and injure the consumer." *Robinson, at 961.*

First, the Medicaid Act does not provide for a private right of action. *Brogdon v. National Healthcare Corp., 103 F. Supp. 2d 1322, 1330-31 (N.D. Ga. 2000).* Both the legislative history of the Medicaid Act and the Medicaid Act itself do not support the conclusion that a private cause of action exists. However, the Medicaid Act does provide that a *State* may enforce a violation of the Medicaid Act. *42 U.S.C. 1396r(h).* Therefore, since the Medicaid Act does not provide a private right of action and because Congress did not create a standard of conduct, which if breached gave rise to any private claim, the Court finds that Jafari and Meadowbrook's conduct does not offend public policy. Further, Count II of Carroll's Amended Complaint is devoid of any allegation that defendant Jafari and Meadowbrook's actions were immoral, unethical, oppressive or unscrupulous.

Finally, the injury to the plaintiff **[*10]** was not substantial. Carroll has not alleged in his Complaint that he was coerced into admitting his father-in-law into Meadowbrook's facility. Nor does he allege that he had no alternate choices in what facility to enroll his father-in-law into. Absent this showing, there can be no substantial injury to Carroll. See *Robinson, at 962.*

Since Jafari and Meadowbrook's conduct has not satisfied any of the requirements under the *Sperry* test, Count II of Carroll's Complaint is dismissed.

III. *Equitable Relief Claim*

Count IV of Plaintiff's amended complaint requests cancellation of the personal guarantees Jafari and Meadowbrook have against Carroll. Jafari and Meadowbrook claim Count IV is moot because they have cancelled the personal guarantee and have restructured their admission policy to not condition admission upon a third party guarantee.

The Supreme Court has stated that "voluntary cessation of allegedly illegal conduct does not deprive the tribunal of power to hear and determine the case, i.e., does not make the case moot." *United States v. W.T. Grant Co., 345 U.S. 629, 632, 97 L. Ed. 1303, 73 S. Ct. 894 (1953).* It is the duty of the courts to **[*11]** be

cautious when a defendant has claimed they have reformed the alleged wrong.*Id.* However, the case may be moot if the defendant can show that there is no probability of resuming the illegal activity. *Id. at 633.* This is a heavy burden for defendant to prove and a mere profession that defendant has discontinued his practice and has no intention to revive it does not suffice. *Id.*

Jafari and Meadowbrook have met this heavy burden. They have stipulated that they will not continue to seek payment in conjunction with the personal guarantee signed by Carroll. Jafari and Meadowbrook have also guaranteed in a judicial filing that they will not seek enforcement of the personal guarantee. (Defs'. Memo. Supp. Mot. Dismiss at 7). Thus, the claim in Count IV has been rendered moot. See *Stokes v. Village of Wurtsboro, 818 F.2d 4, 5 (2nd Cir. 1987).* Accordingly, Count IV is dismissed.

Conclusion

For the reasons set forth above, Freedman's motion to dismiss Count I is denied and Count II and Count IV of Jafari, Meadowbrook and Freedman's motions to dismiss are granted.

George M. Marovich

United States District Judge

DATED: Oct. 28, 2003

LexisNexis

1 of 1 DOCUMENT

Extendicare Health Services, Inc., Appellant, vs. Craig T. Henderson, Respondent, Brett F. Henderson, Respondent.

A06-734

COURT OF APPEALS OF MINNESOTA

2007 Minn. App. Unpub. LEXIS 285

April 3, 2007, Filed

NOTICE: [*1] THIS OPINION WILL BE UNPUBLISHED AND MAY NOT BE CITED EXCEPT AS PROVIDED BY MINNESOTA STATUTES.

PRIOR HISTORY: Anoka County District Court File No. C3-05-3915. Hon. Sean C. Gibbs.

DISPOSITION: Affirmed.

COUNSEL: For Appellant: Mark Pitzele, Zenaida Chico, Mark Pitzele, P.A., St. Louis Park, MN.

For Craig T. Henderson, Respondent: Terri A. Melcher, Larson & Melcher, Fridley, MN; and Norris J. Skogerboe, Skoberboe Law Offices, PLLC, Blaine, MN.

For Brett F. Henderson, Respondent: Mark V. Steffenson, Erin R. Schulte, Henningson & Snoxell, Ltd., Maple Grove, MN.

JUDGES: Considered and decided by Klaphake, Presiding Judge; Willis, Judge; and Shumaker, Judge.

OPINION BY: WILLIS

OPINION

UNPUBLISHED OPINION

WILLIS, Judge

Appellant nursing home challenges the district court's grant of summary judgment to respondents, arguing that there is a genuine issue of material fact regarding whether one or both respondents is personally liable under *Minn. Stat. § 144.6501* (2004) for the unpaid costs of respondents' mother's nursing-home care. Because we conclude that there is no genuine issue of material fact that precludes summary judgment, we affirm.

FACTS

In May 2000, respondent [*2] Brett Henderson admitted his mother, Helen Henderson, to a nursing home owned by appellant Extendicare Health Services, Inc. (EHS). As part of the admission process, Brett Henderson signed a form "admissions agreement" on a line that designated him to be the "responsible party." The admissions agreement included the following provision:

> By signing this Agreement, the Resident's Responsible Party agrees to the following:
>
> 1. That he/she has access to the Resident's income, assets, and resources and agrees to apply the Resident's income, assets, and resources to pay for the Resident's care.
>
> 2. To take responsibility to work directly with the Resident to assist him/her, or if that is not practicable the Responsible Party will perform the following:
>
> > a. To make and complete [an] application for Medical Assistance within thirty (30) day[s] of the date on which the Resident appears to be eligible for Medical Assistance.
> >
> > . . . .

> c. To assist the Resident, [the nursing home], Medical Assistance, and any other designated parties in properly utilizing and applying all designated assets and funds to pay for all charges assessed by [the nursing home] for the care of the [*3] Resident.

Notably, Brett Henderson did not sign the admissions agreement on the line designating him to be a "guarantor," who, according to the signature page of the admissions agreement, "agrees to be individually as well as jointly liable for, and hereby assumes financial responsibility for, the Resident's care and for payments of all sums due under this Agreement." Neither Helen Henderson nor her other son, respondent Craig Henderson, signed the admissions agreement.

Initially, insurance paid for Helen Henderson's nursing-home care. When her insurance provider discontinued coverage, her family applied for medical assistance on her behalf, but the request was denied on the ground that she had too many assets to be eligible. When Helen Henderson died in April 2001, her account at the nursing home had an unpaid balance. Helen Henderson's will designated Craig Henderson as her personal representative and as the sole beneficiary of her residuary estate. Evidence in the record indicates that Helen Henderson's estate contained assets at her death sufficient to pay the balance of her account. But EHS did not make a claim against Helen Henderson's estate, and the statutory time [*4] period for doing so expired.

EHS sued respondents, alleging that each violated *Minn. Stat. § 144.6501* (2006). The district court granted respondents' motions for summary judgment. This appeal follows.

DECISION

On an appeal from summary judgment, this court asks two questions: (1) whether genuine issues of material fact exist and (2) whether the district court erred in its application of the law. *State by Cooper v. French, 460 N.W.2d 2, 4 (Minn. 1990)*. We view the evidence in the light most favorable to the party against whom summary judgment was granted. *Fabio v. Bellomo, 504 N.W.2d 758, 761 (Minn. 1993)*. "[T]here is no genuine issue of material fact for trial when the nonmoving party presents evidence which merely creates a metaphysical doubt as to a factual issue and which is not sufficiently probative with respect to an essential element of the nonmoving party's case to permit reasonable persons to draw different conclusions." *DLH, Inc. v. Russ, 566 N.W.2d 60, 71 (Minn. 1997)*.

Minn. Stat. § 144.6501 (2006) governs nursing-home admission contracts. *Minn. Stat. § 144.6501 , subd. 4(d)* [*5] , provides:

> A person who desires to assume financial responsibility for the resident's care may contract with the facility to do so. A person other than the resident or a financially responsible spouse who signs an admission contract must not be required by the facility to assume personal financial liability for the resident's care. However, if the responsible party has signed the admission contract and fails to make timely payment of the facility obligation, or knowingly fails to spend down the resident's assets appropriately for the purpose of obtaining medical assistance, then the responsible party shall be liable to the facility for the resident's costs of care which are not paid for by medical assistance. A responsible party shall be personally liable only to the extent the resident's income or assets were misapplied.

To be a "responsible party" under *section 144.6501*, and thus financially liable for a nursing-home resident's care, an individual must both (1) have access to the resident's income and assets, and (2) either agree to apply the resident's income and assets to pay for the resident's care or agree to apply for medical assistance on behalf [*6] of the resident. *Minn. Stat. § 144.6501, subd. 1(d)* (2006).

I.

The district court granted summary judgment to Craig Henderson because it concluded that, although he satisfies the first element of the definition of a "responsible party" by admitting that he had access to his mother's income and assets as her personal representative, he did not satisfy the second element of the definition. EHS offered no evidence to the district court that Craig Henderson agreed "to apply the resident's income and assets to pay for the resident's care" or "to make and complete an application for medical assistance on behalf of the resident." *See Minn. Stat. § 144.6501, subd. 1(d)*.

EHS argues that even though Craig Henderson did not sign the admissions agreement as a responsible party, he should be personally liable under *Minn. Stat. § 144.6501, subd. 4*, because he had control of Helen

Henderson's assets and because the intent of *section 144.6501, subdivision 4*, is to ensure that nursing homes are paid for the care that they provide to patients. EHS asserts that respondents ought not be allowed to avoid the **[*7]** law by dividing responsibility so that neither is liable under the statute.

But there is no ambiguity in the provision of the statute that defines a "responsible party," and when statutory language is unambiguous, this court applies its plain meaning, which presumably manifests legislative intent. *See Ruter v. State, 695 N.W.2d 389, 393 (Minn. App. 2005), review denied* (Minn. July 19, 2005). Therefore, we decline to read into the statute a definition of "responsible party" that is different from the one that the legislature provided. There is simply no evidence, and EHS points to none, that Craig Henderson agreed to take on the responsibilities of a "responsible party" under *Minn. Stat. § 144.6501*. Thus, EHS fails to raise a genuine issue of material fact sufficient to warrant reversal of the district court's grant of summary judgment to Craig Henderson.

Craig Henderson also argues that this court "perhaps" should review the district court's conclusion that statutes imposing time limits on claims against the personal representative and the distributees of an estate do not apply here. But he failed to file a notice of review with this **[*8]** court, so we decline to consider his argument. *See City of Ramsey v. Holmberg, 548 N.W.2d 302, 305 (Minn. App. 1996)* (noting that a party that receives a favorable judgment must file a notice of review to challenge a district court's ruling on a particular issue), *review denied* (Minn. Aug. 6, 1996).

II.

The district court granted summary judgment to Brett Henderson because, although Brett Henderson agreed to apply his mother's assets to pay for her nursing-home care when he signed the admissions agreement, thereby satisfying the second element of the definition of a "responsible party," EHS "has not provided any evidence to indicate that Brett Henderson actually had access to his mother's income or assets during his mother's life or after her death."

EHS argues that there is a genuine issue of material fact regarding whether Brett Henderson had access to Helen Henderson's assets. First, EHS notes, Brett Henderson represented that he had access to those assets when he signed the admissions agreement as a responsible party. EHS points next to an affidavit submitted by Brett Henderson in the district-court proceedings in which he states that he "agreed to **[*9]** make [his] best effort[] to ensure that [Helen Henderson's] account would be paid out of her own assets" when he signed the admissions agreement. Finally, EHS points to the fact that Brett Henderson is listed in EHS's records as the person to whom bills should be sent. These facts, EHS argues, create a genuine issue of material fact regarding whether Brett Henderson had access to Helen Henderson's assets.

Brett Henderson argues that the evidence to which EHS points is "[m]ere speculation." We agree. The statement in Brett Henderson's affidavit to which EHS refers gives no indication that he had access to his mother's assets, nor does the fact that EHS sent bills to Brett Henderson's home. And Brett Henderson's representation in the admissions agreement that he had access to his mother's assets does not, without more, create a genuine issue of material fact. As the district court noted, *Minn. Stat. § 144.6501* requires that a responsible party actually *have* access to the resident's income and assets, not that he merely hold himself out as having access.

The evidence to which EHS points to establish that Brett Henderson had access to his mother's **[*10]** assets is not sufficiently probative to create a genuine issue of material fact. We conclude that Brett Henderson does not meet the statutory definition of a "responsible party," notwithstanding the fact that he signed EHS's form admissions agreement on a line designating him as such. Therefore, he cannot be held personally liable under *Minn. Stat. § 144.6501*. We need not consider whether EHS has offered sufficient evidence that Brett Henderson violated the statute by failing to "make timely payment" to EHS or spend down his mother's assets to secure medical assistance, or that he misapplied his mother's assets. *See Northfield Care Center, Inc. v. Anderson, 707 N.W.2d 731, 735 (Minn. App. 2006)* (noting that *Minn. Stat. § 144.6501, subd. 4(d)*, imposes personal liability "only to the extent the resident's income or assets were misapplied"). Summary judgment was appropriately granted to Brett Henderson.

EHS also argues that the doctrines of equitable estoppel and apparent authority demand reversal of the district court's grant of summary judgment to Brett Henderson. Brett Henderson argues that because EHS did not **[*11]** raise these arguments to the district court, it cannot raise them on appeal. EHS asserts that it had "no reason" to raise its equitable-estoppel and apparent-authority arguments below because it "was unaware that the district court would improperly weigh evidence and decide that [Brett Henderson's] denial of his assertion in the signed admissions contract carried more weight than the contract itself." EHS claims that it raises these arguments on appeal not as "separate cause[s] of action" but in response to the district court's "improper weighing of facts."

We disagree that anything in the district court's order gave EHS new reason to raise arguments based on equitable estoppel or apparent authority. Brett Henderson denied in his motion for summary judgment to the district court that he had access to his mother's assets. And it was this denial to which EHS's equitable-estoppel and apparent-authority arguments respond. EHS had a reason and an opportunity to raise these arguments to the district court and to present evidence sufficient to create a genuine issue of material fact regarding the elements of each doctrine. Because they were not raised below, EHS's equitable-estoppel **[*12]** and apparent-authority arguments are waived. *Thiele v. Stich, 425 N.W.2d 580, 582-83 (Minn. 1988).*

We note with some concern that although *Minn. Stat. § 144.6501, subd. 4(d)*, prohibits nursing homes from requiring any person "other than the resident or a financially responsible spouse who signs an admission contract" to assume personal financial liability for the resident's care, nothing in the record suggests that EHS offers any alternative to the form admissions agreement that Brett Henderson signed here. And the record does not show that EHS told Brett Henderson that it could not require him to assume any financial responsibility for his mother's care. Instead, the EHS admissions agreement appears to require a "responsible party" signature, at least when, as here, the resident does not sign the agreement, in an apparent attempt to impose statutory personal financial liability under specified circumstances. A nursing home that offers no alternative to the type of form admissions agreement that Brett Henderson signed here is in danger of violating the statute governing nursing-home admission contracts.

Affirmed.

LexisNexis

7 of 7 DOCUMENTS

FIVE STAR QUALITY CARE - MO, L.L.C., d/b/a ARBOR VIEW HEALTHCARE & REHABILITATION CENTER, Respondent, vs. BONNIE SUE LAWSON, PUBLIC ADMINISTRATOR, Appellant.

DOCKET NUMBER WD69712

COURT OF APPEALS OF MISSOURI, WESTERN DISTRICT

2009 Mo. App. LEXIS 418

April 7, 2009, Decided
April 7, 2009, Opinion Filed

NOTICE:

NOT FINAL UNTIL EXPIRATION OF THE REHEARING PERIOD.

PRIOR HISTORY: [*1]

APPEAL FROM THE CIRCUIT COURT OF BUCHANAN COUNTY, MISSOURI. The Honorable Keith B. Marquart, Judge.

COUNSEL: William E. Erdrich, St. Joseph, Missouri, for Respondent.

Jere L. Loyd, St. Joseph, Missouri, for Appellant.

JUDGES: Before Lisa White Hardwick, P.J., Victor C. Howard, Judge and Zel M. Fischer, Special Judge. All concur.

OPINION BY: VICTOR C. HOWARD

OPINION

Bonnie Sue Lawson appeals the judgment of the trial court awarding Five Star Quality Care $ 16,779.65 on its breach of contract claim. In her sole point on appeal, Ms. Lawson claims that the trial court erred in holding her personally liable on the contract. Ms. Lawson's point is granted, and the judgment of the trial court is reversed.

Factual and Procedural Background

Five Star Quality Care, doing business as Arbor View Healthcare and Rehabilitation Center ("Arbor View"), filed suit against Bonnie Sue Lawson, who was the guardian of Eloise Selby, a resident of Arbor View. In its petition, Arbor View claimed that Ms. Lawson had breached her agreement with Arbor View to use due care by not promptly following the proper procedures to ensure that Medicaid would cover Ms. Selby's fees. The trial court found that Ms. Lawson had breached her agreement with Arbor View by [*2] not using due care in carrying out her duties as Ms. Selby's guardian and that, in the absence of Medicaid coverage, Arbor View expended funds for the care of Ms. Selby. The trial court awarded $ 16,779.65 in damages to Arbor View and an additional $ 6,597.00 for costs and attorney fees.

Ms. Lawson, who was the public administrator of Buchanan County at the time, became the guardian of Ms. Selby in July 2004. Prior to Ms. Lawson's appointment as guardian, Ms. Selby had been a resident of Arbor View. In order to continue Ms. Selby's residence in Arbor View, Ms. Lawson executed an admission agreement which designated her as the "Fiduciary Party" and designated Ms. Selby as the "Resident." Paragraph I.B. of the agreement states that "[e]xcept as otherwise expressly provided to the contrary herein, if Fiduciary Party uses due care, Fiduciary Party will not become personally liable for the payment of the Resident's fees and charges by signing this agreement." An addendum to the agreement further provides in a paragraph titled "Benefit Disallowance" that "[i]f the Resident's third-party eligibility coverage is denied or terminated for any reason, the Resident and/or the Fiduciary Party shall [*3] pay, *from the Resident's assets*, any and all unpaid charges for care previously rendered to the extent permitted by law."

Prior to Ms. Lawson's appointment as guardian, Ms. Selby submitted an application for Medicaid benefits on July 6, 2004. Kathy Jordan, an employee of the Family

Support Division ("the Division"), testified that Kim Adams, Ms. Lawson's deputy, called the Division in July 2004 and stated that the proper paperwork would be sent to the Division so that the cash value of Ms. Selby's two life insurance policies could be verified. According to Ms. Jordan's testimony, a rejection of the application was sent to Ms. Lawson on August 19, 2004. The notice of rejection stated that the application was denied due to a failure to provide guardianship forms and to sign another form so that the cash value of the policies could be verified in order to determine Ms. Selby's eligibility to receive Medicaid benefits.

Ms. Lawson sent a second application for Medicaid benefits on September 16, 2004. Once the Division received the proper paperwork and was able to determine the cash value of the life insurance policies, it sent a rejection of the application to Ms. Lawson on November 5, 2004. **[*4]** The second application was denied because the cash value of the policies exceeded $ 999.99, making Ms. Selby ineligible to receive Medicaid benefits. Ms. Lawson submitted a third application on December 16, 2004, which was rejected on February 18, 2005, because the cash value of the policies remained in excess of $ 999.99.

Ms. Adams testified that while she had been employed in Ms. Lawson's office, an insurance policy could only be cashed in if Ms. Lawson had been appointed as a conservator, rather than solely as a guardian. Ms. Adams stated that, therefore, the notice of rejection of the second Medicaid application, which disclosed the cash value of the policies, should have triggered the filing of an application for a conservatorship. On July 8, 2005, Ms. Lawson filed a petition for conservatorship, and the order appointing her as conservator was signed the same day. Thereafter, the insurance policies were redeemed and Ms. Lawson forwarded the proceeds to Arbor View on June 30, 2005. Ms. Lawson's final application for Medicaid benefits, which was filed on June 30, 2005, was approved.

During the months prior to Ms. Lawson's appointment as conservator, Arbor View had continued to provide **[*5]** care for Ms. Selby, incurring expenses of $ 16,779.65. Arbor View filed suit against Ms. Lawson, seeking to recover $ 16,779.65 and attorney fees. Arbor View alleged that by waiting until June 8, 2005, to apply for a conservatorship, Ms. Lawson "failed to use due care as agreed" and failed to "exercise due and diligent care in the exercise of her duties as set out in *RSMo 475.120*." The trial court found that, by entering into the contract with Arbor View, Ms. Lawson had waived any immunities, and that by the terms of the contract, she had agreed to "use due care in the performance of her responsibilities to her ward including the payment of fees and charges for room, board, medical and other necessities required for the care of her ward []." The court further found that Ms. Lawson failed to use due care by not acting on Ms. Selby's disqualification for Medicaid benefits for nearly nine months, and during that time, Arbor View continued to provide care for Ms. Selby. Therefore, the trial court granted judgment in favor of Arbor View, awarding $ 16,779.65 in damages and $ 6,597.00 in costs and attorney fees. This appeal by Ms. Lawson followed.

Standard of Review

In a court-tried case, **[*6]** the appellate court will affirm the judgment of the trial court unless there is no substantial evidence to support it, it is against the weight of the evidence, it erroneously declares the law, or it erroneously applies the law. *Murphy v. Carron, 536 S.W.2d 30, 32 (Mo. banc 1976)*. However, the "[i]nterpretation of a contract is a question of law and is subject to *de novo* review." *Crestwood Shops, L.L.C. v. Hilkene, 197 S.W.3d 641, 648 (Mo. App. W.D. 2006)*.

Discussion

In her sole point on appeal, Ms. Lawson contends that the trial court erred in granting judgment in favor of Arbor View and against her personally, rather than in her capacity as guardian or conservator. Ms. Lawson argues that under the express terms of the admission agreement, if Ms. Selby's application for Medicaid benefits was denied, Arbor View was required to seek payment for any unpaid charges from Ms. Selby's assets. In its petition and at trial, Arbor View argued that Ms. Lawson should be held personally liable for the unpaid charges due to her failure to exercise due care as required by the contract and in violation of the duties imposed upon her as a guardian under *section 475.120*.

In describing the general powers **[*7]** and duties of a guardian, *section 475.120* states that the guardian "shall act in the best interest of the ward" and shall "provide for the ward's care, treatment, habilitation, education, support and maintenance." *§§ 475.120.2-.3*. According to *section 475.120.4*, a guardian "is not obligated by virtue of such guardian's appointment to use the guardian's own financial resources for the support of the ward." Another statute referred to at trial and in Ms. Lawson's brief is *section 475.132*, which governs the individual liability of a conservator. *Section 475.132.2* provides that a "conservator is individually liable for obligations arising from ownership or control of property of the estate or for torts committed in the course of administration of the estate only if he is personally at fault."

While Arbor View argues that Ms. Lawson failed to use due care in the exercise of her duties as set out in *section 475.120*, Missouri cases characterize the duties of the guardian to the ward as creating a fiduciary relation-

ship between the guardian and ward. *See, e.g., In re Mansour's Estate, 238 Mo. App. 623, 185 S.W.2d 360, 369 (Mo. App. 1945)*; *see also Scott v. Flynn, 946 S.W.2d 248, 253 (Mo. App. E.D. 1997)*. Although **[*8]** *Scott* involved the fiduciary duties of a conservator, rather than a guardian, the same analysis applies to Arbor View's claim. In *Scott*, the wife and daughter of a deceased ward brought an action asserting a breach of fiduciary duty claim against the ward's conservator. *Id.* The trial court noted that the wife and daughter failed to cite any authority supporting the contention that the conservator owed statutory or fiduciary duties to them. *Id.* Because the claim asserted a breach of the fiduciary duties owed to the ward, the court found that the wife and daughter lacked standing to bring the claim against the conservator. *Id.* Similarly, as the duties outlined in *section 475.120* are owed to Ms. Selby, rather than to Arbor View, Ms. Lawson's alleged breach of those duties does not provide a basis for Arbor View to recover the costs associated with Ms. Selby's care.

As to *section 475.132.2*, which addresses the individual liability of a conservator, Arbor View asserted in a response to Ms. Lawson's motion to dismiss that its claim was based, in part, on torts committed during Ms. Lawson's conservatorship. However, Arbor View's action is based on Ms. Lawson's failure to promptly apply for **[*9]** a conservatorship and redeem Ms. Selby's life insurance policies. Therefore, the basis of Arbor View's claim shows that Ms. Lawson's alleged failure to use due care occurred while she was only the guardian of Ms. Selby, and prior to her appointment as conservator. Consequently, in the absence of facts showing that Ms. Lawson committed a tort during her conservatorship, Arbor View has no basis upon which to proceed against Ms. Lawson under *section 475.132.2*.

Without the aid of *sections 475.120* and *475.132*, Arbor View can recover from Ms. Lawson only if the terms of the admission agreement establish that she can be held personally liable for unpaid charges. "The guiding principle of contract interpretation under Missouri law is that a court will seek to ascertain the intent of the parties and to give effect to that intent." *Triarch Indus., Inc. v. Crabtree, 158 S.W.3d 772, 776 (Mo. banc 2005)*. It is presumed that the intent of the parties is "expressed by the ordinary meaning of the contract's terms." *Id.* When a provision of a contract deals with a specific situation, it will prevail over a more general provision if there is ambiguity or inconsistency between them. *H.B. Oppenheimer & Co. v. Prudential Ins. Co. of Am., 876 S.W.2d 629, 632 (Mo. App. W.D. 1994)*.

Arbor **[*10]** View claims that the terms of the admission agreement required Ms. Lawson to use due care and that if she did so, she would not become personally liable by signing the agreement. The term of the contract referred to by Arbor View is located under the heading "General Provisions" and provides that "[e]xcept as otherwise expressly provided to the contrary herein, if Fiduciary Party uses due care, Fiduciary Party will not become personally liable for the payment of the Resident's fees and charges by signing this agreement." However, Ms. Lawson points to a paragraph in the addendum to the admission agreement which states that "[i]f the Resident's third-party eligibility coverage is denied or terminated *for any reason*, the Resident and/or the Fiduciary Party shall pay, *from the Resident's assets*, any and all unpaid charges for care previously rendered to the extent permitted by law." (Emphasis added.) Ms. Lawson contends that pursuant to this term of the agreement, in the event that Ms. Selby's Medicaid applications were denied, Arbor View could only recover from Ms. Selby's assets. Additionally, Ms. Lawson argues that this provision is more specific than the general provision obligating **[*11]** her to use due care in order to avoid personal liability, and therefore, it should be construed as a limitation on the general provision. We agree with both assertions.

The agreement designates the section which states that Ms. Lawson would become personally liable if she failed to use due care as a general provision. The same section also provides that the language therein will be superseded by any contrary provisions. The "benefit disallowance" paragraph cited by Ms. Lawson is both more specific than and contrary to the general provision in that it provides that, in the event that Ms. Selby's third-party eligibility coverage was denied for any reason, unpaid charges were to be recovered "from the Resident's assets." The benefit disallowance clause refers to a specific situation in which payment must come from the resident's assets. In requiring payment to be made from the resident's assets if third-party eligibility coverage is denied for any reason, the provision makes no exception for circumstances in which eligibility is denied due to the guardian's negligence. Arbor View's allegation is that Ms. Lawson failed to use due care by waiting nine months to apply for a conservatorship **[*12]** and cash in Ms. Selby's life insurance policies. Both Arbor View's petition and the trial court's judgment connected her failure to use due care with the denial of Ms. Selby's Medicaid applications. [1] However, even if it was Ms. Lawson's failure to use due care that caused Ms. Selby to be ineligible for Medicaid benefits, in the absence of an exception in the benefit disallowance paragraph, Ms. Lawson's negligence falls within the condition that benefits be denied "for any reason."

1 In its petition, Arbor View alleged that "[a]s a result of the failure of [Ms. Lawson] to secure a conservatorship . . . and redeem the cash value of the insurance policies, thereby qualifying the

> ward for medical assistance [through] the Division, and thus securing funds necessary for the care of the ward, [Arbor View] has incurred unpaid costs." In its judgment, the trial court stated that Ms. Lawson "failed to use due care in securing the possession of two insurance policies that were the basis for the denial of Medicaid benefits of her Ward, Eloise Selby."

By the terms of the admission agreement, Arbor View's recovery was limited to the assets of Ms. Selby in the event that her Medicaid applications were **[*13]** denied for any reason, including the presence of two life insurance policies that had not been redeemed due to Ms. Lawson's failure to promptly obtain a conservatorship. In addition, the admission agreement states that "in disputes arising from this Agreement, the prevailing party shall be entitled to attorney's fees." Therefore, the trial court's award of $ 16,779.65 in unpaid charges and $ 6,597.00 in costs and attorney fees against Ms. Lawson individually is reversed.

The judgment of the trial court is reversed.

VICTOR C. HOWARD, JUDGE

All concur.

Only the Westlaw citation is currently available.

UNPUBLISHED OPINION. CHECK COURT RULES BEFORE CITING.

Superior Court of New Jersey,
Appellate Division.
NEW YORK HOSPITAL, Plaintiff-Respondent,
v.
Beverly ROBINSON, Defendant-Appellant.
Submitted [FN1] April 28, 1999.

FN1. Originally scheduled for oral argument on this date, both counsel agreed to waive oral argument.

Decided May 28, 1999.

SYNOPSIS

On appeal from the Superior Court of New Jersey, Law Division, Special Civil Part, Passaic County.
Madeline L. Houston, attorney for appellant.

Hayt, Hayt & Landau, attorneys for respondent (Carey A. Aquilina, on the brief).

Before Judges KING and FALL.

PER CURIAM.

*1 Defendant, Beverly Robinson, appeals from denial of her motion to vacate a default judgment entered against her on November 4, 1987 on a hospital bill relating to medical treatment due to complications in the birth of her son on April 22, 1982. At the time of the treatment, defendant was a recipient of public assistance and covered for medical expenses under Medicaid. We reverse.

I

Defendant gave birth to her son Frank Robinson April 22, 1982, in St. Joseph's Hospital in Paterson. At the time defendant was a Medicaid recipient. A few days after his birth, it was determined defendant's son had a hole in his heart and would need to have an operative procedure performed to correct it. St. Joseph's transported Frank to New York Hospital where the procedure was performed in May 1982.

Plaintiff, New York Hospital, submitted a claim for the cost of treatment to New Jersey Medicaid which was denied. While the basis of that denial is not contained in the record before us, Frank's date of birth was mistakenly recorded by the Passaic County Board of Social Services as May 11, 1982, instead of April 22, 1982. This discrepancy apparently resulted in denial of the claim. Plaintiff issued a bill to defendant in 1985 in the amount of $2,584.00 for the services rendered in 1982. According to defendant, this is the only medical bill incurred by her son which was denied by Medicaid, including a stay at New York Hospital in 1984 for heart surgery.

Upon receipt of the bill from-plaintiff, defendant certifies she called the billing department at New York Hospital and was told the bill had been submitted to Medicaid and not paid, but that it would be resubmitted. Upon receiving a subsequent bill from plaintiff, defendant called plaintiff's billing department again and was told Medicaid was not paying and the hospital would hold her responsible for the charges. Defendant certifies she then contacted Medicaid and also attempted to explain the error to plaintiff's counsel, from whom she started to receive collection letters.

On or about August 4, 1987, plaintiff filed a complaint against defendant seeking $2,584.00 plus an additional $1,260.42 in interest. Plaintiff's proof of service indicates defendant was served September 17, 1987. Upon receiving the complaint, defendant claims she contacted Medicaid and was told the

claim was denied by mistake and that it would be taken care of. Based on this exchange, defendant believed she did not need to answer the complaint. Default judgment was entered against defendant November 4, 1987, in the amount of $3,844.42.

Plaintiff sent defendant a letter dated May 18, 1988, advising her of the judgment and requesting payment. Upon receipt of the letter, defendant telephoned plaintiff's law firm May 23, 1988, and advised them she was not responsible for the hospital bill as she was covered by Medicaid. According to plaintiff, defendant was again contacted November 27, 1990, regarding the judgment by an employee of plaintiff's law firm. Thereafter, plaintiff's counsel was unable to locate defendant's address or place of employment until 1996.

*2 In October 1996, nine years after entry of the default judgment, defendant's wages were garnished. Defendant filed a pro se motion to vacate the default judgment November 18, 1996, maintaining Medicaid was responsible for the hospital bill. Defendant's motion was heard and denied on January 24, 1997. The judge found defendant's motion was filed out of time, and that proper service was made upon defendant. However, the judge indicated defendant should seek the assistance of an attorney. Defendant sought the assistance of the Passaic County Legal Aid Society which brought a motion to vacate the default judgment on October 23, 1997.

In her certification in support of the motion to vacate judgment, defendant asserts she and her son lived in the same apartment since 1990 and had qualified for Section 8 housing. Defendant has been off Medicaid and Aid For Dependent Children (AFDC) since approximately 1985, and has held the same job with the North Jersey Developmental Center since June 1992. Prior to the wage garnishment, defendant's take home pay was approximately $560 every two weeks. Subsequent to the wage garnishment, her take home pay is approximately $480 every two weeks. According to defendant, since Section 8 counts the tenant's share of the rent based on the tenant's income prior to any deductions for items such as wage garnishments, she could no longer afford the rent for her apartment. She and her son now live in one room that plaintiff rents in a private house. Defendant also asserts she sought a night job with a bank doing encoding in order to make ends meet, but was denied employment, as the bank would not hire someone with a wage garnishment in effect.

A different judge heard oral argument on defendant's motion March 13, 1998, and placed his decision on the record April 3, 1998. The judge outlined the history of the case, and concluded defendant did not bring the motion within a reasonable amount of time. The judge also found defendant had not presented "truly exceptional circumstances" warranting relief, noting,

> Rather, I find that defendant was aware of the bills in 1985, had conversations with the hospital regarding Medicaid and its declamation prior to the initiation of the lawsuit, had discussions with plaintiff's counsel prior to the initiation of a lawsuit, chose not to answer the complaint in 1987, was notified of the judgment against her in May 1988, spoke with the plaintiff counsel's law firm shortly after notification in May, 1988 and did nothing until her wages were garnished in November of 1996.
>
> To take her first step in the judicial process nine years after entry of judgment was too late and unreasonable under the circumstances. Given the notice she admittedly received prior to a lawsuit in which plaintiff proved by credible evidence that she received within one year after judgment. If she had consulted with counsel or at least taken some action in 1988 when she became aware of the judgment, this would most likely be a different result.

*3 As of March 13, 1998, $2,319.00 had been collected through the wage garnishment. On appeal, plaintiff contends the judge erred in denying her motion to vacate the default judgment pursuant to *R.* 4:50-1(f) on the basis she has a meritorious de-

fense, and the public policy behind the Medicaid law requires vacating the judgment.

II

A court should view "the opening of default judgments ... with great liberality," and should tolerate "every reasonable ground for indulgence ... to the end that a just result is reached." *Mancini v. EDS,* 132 *N.J.* 330, 334 (1993), *citing, Marder v. Realty Constr. Co.,* 84 *N.J.Super.* 313, 319 (App.Div.), *aff'd,* 43 *N.J.* 508 (1964). The decision whether to grant the motion is left to the sound discretion of the trial court, and will not be disturbed absent an abuse of discretion. *Mancini,* 132 *N.J.* at 334,*citing, Court Inv. Co. v. Perillo,* 48 *N.J.* 334, 341 (1966). All doubts, however, should be resolved in favor of the parties seeking relief. *Mancini,* 132 *N.J.* at 334,*citing, Arrow Mfg. Co. v. Levinson,* 231 *N.J.Super.* 527, 534 (App.Div.1989).

Plaintiff asserts the judge correctly denied defendant relief, as she was unable to establish the elements necessary for vacating a default judgment-excusable neglect and a meritorious defense. *Marder,* 84 *N.J.Super.* at 318."Carelessness may be excusable when attributable to an honest mistake that is compatible with due diligence or reasonable prudence." *Mancini,* 132 *N.J.* at 330. While defendant did not act through proper legal channels to resolve the dispute over the hospital bill, she did act in other ways. Upon receipt of the bill, she immediately called the hospital to point out the mistake. Upon receipt of a subsequent bill, defendant again called the hospital and was advised she would be held responsible for the amount, as Medicaid denied the claim. Defendant then contacted both Medicaid and plaintiff's counsel in an attempt to resolve the matter. Upon receipt of the complaint in 1987, defendant again contacted Medicaid, and was informed that the denial was a mistake and it would be taken care of. When defendant received a collection letter from plaintiff informing her of the default judgment and seeking payment, defendant called plaintiff's law firm and informed them she was not responsible for the bill as it had been incorrectly denied by Medicaid. Nine years later when plaintiff acted on the default judgment by garnishing defendant's wages, defendant immediately responded by moving *pro se* to have the default judgment vacated. Upon denial of her request, she sought legal assistance. In light of these factors, we find defendant's neglect in responding to the complaint is excusable, as she exercised due diligence in attempting to resolve the dispute over the bill through direct contact with plaintiff and Medicaid.

Even if defendant were unable to demonstrate excusable neglect, she is not precluded from relief under *R.* 4:50-1(f). That subsection authorizes relief from judgments in "exceptional situations." *Baumann v. Marinaro,* 95 *N.J.* 380, 395 (1984)."No categorization can be made of the situations which would warrant redress under subsection (f)." *Court Inv. Co.,* 48 *N.J* . at 341,*quoted in Baumann,* 95 *N.J.* at 395, and *Palko v. Palko,* 73 *N.J.* 395, 398 (1977)."[T]he very essence of (f) is its capacity for relief in exceptional situations. And in such exceptional causes its boundaries are as expansive as the need to achieve equity and justice."*Ibid.* For relief under subsection (f), "strict bounds should never confine its scope." *Hodgson v. Applegate,* 31 *N.J.* 29, 41 (1959).

*4 Here, the motion judge did not find defendant demonstrated "exceptional circumstances," instead finding the nine-year delay between entry of the default judgment and defendant's motion to vacate unreasonable under the circumstances. The judge noted, "[i]f she had consulted with counsel, or at least taken some action on her own in 1988 when she became aware of the judgment, this would most likely be a different result."However, contrary to these observations, as outlined above, defendant did take action on her own in 1988; she continued to call plaintiff's counsel in an attempt to resolve the dispute over payment of the bill. In addition, defendant's response to plaintiff's actions on the default judgment was timely; once plaintiff began collecting on the default judgment through wage gar-

nishment, defendant immediately moved to vacate the judgment.

Plaintiff argues this case is most like *Garza v. Paone,* 44 *N.J.Super.* 553 (App.Div.1957), where we found defendant's four-year delay in applying for relief from a void judgment was not "within a reasonable time," noting defendant did not move for relief until he felt "the pinch of the need for a driving license." *Id.* at 559.Similarly here, plaintiff argues, defendant did not move to vacate the judgment until she felt the pinch of the wage garnishment and her delay of nine years should not be considered reasonable. However, *Garza* is distinguishable from these facts. First, unlike the defendant here, the defendant in *Garza* consulted with an attorney prior to entry of the default judgment, who explained to defendant his rights and inquired of plaintiff's counsel concerning an extension of time to file an answer. *Id.* at 556.The defendant's attorney was never authorized to proceed further. *Ibid.* Second, the co-defendant in *Garza* had die d, and we determined this fact, coupled with the amount of time that had elapsed since the accident, might preclude a fair retrial of issues of liability. *Id.* at 558-559.Here, plaintiff brought the action to collect on the unpaid bill. It follows that any proofs to establish defendant's obligation on this claim would be in plaintiff's exclusive possession, and any lapse in time between the entry of judgment and a retrial should not prejudice plaintiff. Finally, in contrast to the defendant in the present case, the defendant in Garza, upon learning of his rights and obligations on the claim, took no action to resolve the matter until four years later. Here, contrary to plaintiff's assertion that defendant "took no action for almost ten years," defendant took a proactive stance and attempted to resolve the claim through direct contact with both plaintiff and Medicaid. *See Almodovar v. Beese,* No. A-007721-95 (App.Div. Feb. 6, 1998) (relief should have been granted under subsection (f) where defendant had a meritorious defense to the matter, had consulted with an attorney within one year of the default judgment and retained counsel when financially able; court found defendant was not "dilatory" in her actions).

***5** In *Mancini,* the Court granted relief from a default judgment under subsection (f), finding the circumstances "sufficiently exceptional to entitle EDS to relief."*Mancini,* 132 *N.J.* at 336. There, the Court found defendant's neglect in responding to plaintiff's complaint and requests for arbitration, while inexcusable, was neither willful nor calculated. *Ibid.* The Court based its grant of relief on the failure of plaintiff to conduct the arbitration proceeding consistent with the provisions of the arbitration act, *N.J.S.A.* 2A:24-1 to -11. *Ibid.*

Similarly here, even if defendant's neglect was inexcusable, the circumstances surrounding this case are such that relief should be granted under subsection (f). Not only did defendant act within a reasonable time in light of plaintiff's delay of nine years in enforcing the default judgment, defendant presented a meritorious defense to plaintiff's claim. Since defendant's son was a Medicaid recipient at the time the hospital services were rendered, plaintiff was legally barred from ever having brought suit against defendant. The judge did not address this issue, and the failure to grant relief on this claim under subsection (f) was error.

III

Medicaid providers are prohibited from billing Medicaid beneficiaries except in limited circumstances. *N.J.A.C.* 10:49-7.3(d) outlines the circumstances under which a provider may seek payment from a recipient:

> Medicaid and NJ KidCare participating providers are prohibited from billing Medicaid or NJ KidCare beneficiaries for any amount, except:
>
> 1. For services, goods, or supplies not covered or authorized by the New Jersey Medical Assistance and Health Services Act (*N.J.S.A* . 30:4D-1 et seq.), as amended and supplemented, if the beneficiary elected to receive the services, goods, or supplies with the knowledge that they were not

covered or authorized;

2. For payments made to the beneficiary by a third party on claims submitted to the third party by the provider; or

3. For NJ KidCare-Plan C enrollee's contribution to care responsibility.

[*N.J.A.C.* 10:49-7.3(d).]

Providers who participate in the Medicaid program must accept the amount paid by the agency, including any deductible, coinsurance, or copayment required by the individual, as payment in full. 42 *C.F.R.* § 447.15. A child born to a woman receiving Medicaid is deemed automatically eligible for such assistance on the date of birth and remains eligible for a period of one year, so long as the woman remains eligible for such services. 42 *U.S.C.A.* § 1396a(e)(4). Here, it is undisputed defendant was receiving Medicaid and AFDC. Thus, her son was automatically covered under Medicaid. The record does not reflect the basis for Medicaid's denial of defendant's claim, however the services provided to the infant were services which clearly appear covered under Medicaid. *See N.J.S.A.* 30:4D-6(a)(1) (inpatient hospital services is a classification under which the department "shall provide medical assistance to qualified applicants"); *see also N.J.A.C.* 10:52-1.5 (covered inpatient and outpatient services); *N.J.A.C.* 10:52-1.3 (inpatient services excluded from coverage).

***6** Plaintiff asserts the "not covered or authorized" language of *N.J.A.C.* 10:49-3(d)(1) includes all denied claims, thus permitting plaintiff to bill defendant directly for the services. This interpretation is not supported by the plain language of the regulation. In addition, *N.J.S.A.* 30:4D-6(c) contradicts plaintiff's interpretation of *N.J.A.C.* 10:49-3(d)(1).*N.J.S.A* . 30:4D-6(c) prohibits a provider from seeking payment from the recipient *even where the reimbursement was denied* because the services were medically unnecessary, unless the recipient elected to receive the services with the knowledge that they were not authorized. *N.J.S.A.* 30:4D-6(c) (emphasis supplied). Here, defendant's infant son was born with a hole in his heart. There is nothing in the record to suggest the services rendered by the hospital were medically unnecessary, or that defendant sought out the services with the knowledge that they were not authorized.

Even assuming plaintiff could establish the "not covered or authorized" language of *N.J.A.C.* 10:49-7.3(d)(1) included denied claims, so that the first prong of the regulation was met, plaintiff cannot establish the second prong of the regulation-that defendant "elected to receive the services, goods, or supplies with the knowledge that they were not covered or authorized."Therefore, plaintiff was barred from billing defendant for these services, and defendant has offered a meritorious defense to plaintiff's claim. *See also*42 *U.S.C.A.* § 1396a(a)(18); 42 *U.S.C.A.* § 1396p(a)(1), ("No lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan, except ... pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual,...."); *N.J.S.A.* 30:4D-7.2 (permitting a lien to be filed against an estate of a recipient in certain limited circumstances).

Allowing a Medicaid provider to recover directly from a recipient would circumvent the purpose behind the program. "Medicaid is a program whose principal aim is that of 'enabling each State, as far as practicable under the conditions in such State, to furnish ... medical assistance [to] individuals whose income and resources are insufficient to meet the costs of necessary medical services....' " *Monmouth Medical Center v. State,* 80 *N.J.* 299, 302,*cert. denied,* 444 *U.S.* 942, 100 *S.Ct.* 297, 62 *L.Ed.*2d 308 (1979), *citing,*42 *U.S.C.A.* § 1396. The stated purpose behind the New Jersey Medicaid statute, *N .J.S.A.* 30:4D1 to -35, is "to provide medical assistance, insofar as practicable, on behalf of persons whose resources are determined to be inadequate to enable them to secure quality medical care at their

own expense...." *N.J.S.A.* 30:4D-2. Permitting a provider, such as plaintiff, to recover from a recipient circumvents this statutory scheme and thwarts the purpose behind Medicaid, as persons needing medical assistance who are economically disadvantaged will be reluctant to seek treatment for fear of being held responsible for the charges incurred.

*7 In an analogous case, *Hospital Center at Orange v. Cook,* 177 *N.J. Super,* 289, 303 (App.Div.1981), we found a hospital's failure to comply with the notice requirements of the Hill-Burton Act, 42 *U.S.C.A.* §§ 291 to -291o and 42 *U.S.C.A.* §§ 300s to -300s-6, precluded it from collecting on its bill.[FN2] The defendant in *Hospital Center* was a mother whose sole income for the year proceeding her son's hospital treatment was Social Security survivor's benefits. *Hospital Center,* 177 *N.J.Super.* at 292. Defendant subsequently received a bill in the amount of $2,060.50 which she was unable to pay. *Ibid.* The hospital brought suit against her, and defendant attempted to amend her answer to include, by way of an affirmative defense that she was an intended beneficiary of the Hill-Burton Act and the hospital failed to perform its contractual obligations to her by failing to give her appropriate notice of the availability to her of free or reduced-cost hospital service. *Id.* at 293.[FN3]

> FN2. The underlying purpose of the Hill-Burton Act is to make federal funds available for construction and modernization of hospitals and other state facilities. The provision of a reasonable amount of uncompensated services to those medically indigent is the Hospital's *quid pro quo* for its receipt of capital funds under the act. *Hospital Center,* 177 *N.J.Super.* at 294-295.
>
> FN3.42 *C.F.R.* § 53.111(f) requires a written determination of eligibility [under the Hill-Burton Act] to be made by the hospital prior to rendering services except where emergency services are rendered. In the case of emergency services, the bill rendered is required to contain the eligibility information prescribed by the notice provisions of section (i).*See*8 *N.J.R.* 182(b)(1976); *Hospital Center,* 177 *N.J.Super.* at 297.

In determining the hospital's failure to comply with notice requirements of the Hill-Burton Act constituted an absolute bar to recovery, we noted,

> We regard the notice requirements imposed upon hospitals by state and federal imperatives to be the fundamental technique for assuring fulfillment both of the federal legislative purpose and of the hospital's compliance with assurances which they have given the state as a condition of capital funding. Because failure of a hospital to comply with its notice obligations so clearly constitutes a mechanism by which the legislative intent may be defeated, the dictates of public policy demand that they be subject to the strictest possible enforcement. Our courts have heretofore steadfastly refused to enforce private contractual rights if enforcement would do violence to overriding concerns of public policy; consequently, violation of public policy is a traditionally cognizable and viable affirmative defense to a contract action.
>
> [*Id.* at 303 (citations omitted).]

Similarly here, while no notice provisions were violated, allowing plaintiff to pursue a claim against defendant for services which should have been covered by Medicaid, allows the legislative intent of providing services to persons unable to afford medical treatment to be circumvented. In addition, allowing plaintiff's claim to stand is contrary to the plain language of *N.J.A.C.* 10:49-7.3(d). As such, defendant has presented a viable defense to plaintiff's action and the failure to address the merit s of this defense under *R.* 4:50-1(f) was error.

Guidance can be found in New York cases dealing with similar issues. In *Amsterdam Memorial Hospital v. Cintron,* 384 *N.Y.S.*2d 225, 227 (App.Div.1976), the court held recipients of Medi-

caid or Social Services "cannot be held responsible for payment in any form compatible with the appropriate provisions of the Social Services Law when the patient is eligible for such service."*Amsterdam* involved an action by the plaintiff, Amsterdam Memorial Hospital, to recover for services rendered to defendant's wife. Defendant set forth as an affirmative defense plaintiff's failure to make a timely claim for services from the local agency. *Id.* at 225.At the time of admission, defendant signed a form agreeing to pay for services rendered, and the wife was eligible for Medicaid benefits. *Ibid.* The hospital did not request payment from the Social Services agency, and while the Social Services Law in New York does not specifically address the rights of a Medicaid vendor to recover from the recipient, *compare N.J.A.C.* 10:49-7.3(d), the court found the legislative intent behind the Social Services Law of "making available to everyone regardless of ... economic standing, high-quality medical care," precluded a "shifting of payment from [the Social Service agency] to the recipient."*Id.* at 227 (citing Social Services Law § 363).*See Shaw v. Tait,* 431 *N.Y.S.*2d 247, 248 (Sup.Ct.1980) (defendants demonstrated meritorious defense where part of debt to hospital should have been paid by Medicaid; while defendants did not apply for Medicaid, at time of services defendants were eligible for Medicaid and hospital had an obligation to ascertain whether they were eligible or take steps to see that they applied for Medicaid when defendants were unable to pay their bill).

***8** In *Mount Sinai Hospital v. Kornegay,* 347 *N.Y.S.*2d 807 (Civ.Ct.1973), the court held where the defendant applied for Medicaid, but the application was incomplete, the hospital, upon receipt of the unexecuted application forms had a clear duty to ascertain what had happened. The forms were returned to the hospital, which took no action with regard to them, instead billing the defendant for the services some years later. *Id.* at 809.In evaluating the hospital's obligations under Social Service Law § 363, the court noted,

> Although the responsibilities of the hospital are not defined with adequate clarity in the statute or accompanying regulations, I am satisfied that the situation set up by the statutory pattern imposes on the hospital the duty to ascertain the possible eligibility of the patient or family, give adequate directions and information, and maintain a sufficient continuing interest to insure that eligible patients or family file the required applications and that appropriate actions is taken. *These responsibilities follow inexorably from the obvious reality that specialized hospital personnel are almost certain to be far more knowledgeable about the legal requirements than the average patient and also to have an ongoing relationship with the Department that permits ready correction of misunderstandings or points of confusion.*
>
> ....
>
> Surely, the hospitals have a very direct interest in being compensated through medical assistance rather than pursuing poor people for money they do not have.
>
> ....
>
> I am satisfied that if the hospital had made such inquires the problem, *whatever it was,* would have been straightened out ... and this lawsuit would never have come to pass. The failure to make such inquires, or even inform the Defendant or her mother promptly that an application had to be executed, seems to me to require the dismissal of this action. *It would completely frustrate the intended purpose of the Medicaid statute to permit a hospital to default so completely on its obligation in a way that forestalled the Medicaid payment and then sue the needy patient or family for the cost of the medical services.*

[*Id.* at 809-810 (emphasis supplied).]

While the court did not consider the consequences of a failure by the Department to authorize payment because of an error in evaluating the facts correctly,

id. at 810, as is present in the instant case, the underlying rationale is the same. Plaintiff, because of its unique and on-going relationship with Medicaid, was in a position to inquire into the reasons behind Medicaid's denial of defendant's claim. This inquiry would likely have revealed the administrative error and allowed the mistake to have been corrected, without the necessity of legal action some five years after the services were rendered.

While plaintiff maintains it did not have a duty to appeal Medicaid's denial of defendant's claim, as noted by the court in *Mount Sinai,* plaintiff was in a superior position to ascertain the reasons behind the denial and to straighten out any administrative errors forming the basis of Medicaid's denial of defendant's claim. In addition, while plaintiff may not have had an obligation to appeal the denial of defendant's claim, in the instant case, the right to appeal the decision of the agency rested squarely with plaintiff.*N.J.A.C.* 10:49-10.3(a) and (b) impose twenty-day time limits for appealing claim denials upon both providers and claimants. Here, the record does not reflect the date plaintiff received notice of the denial of defendant's claim, or if defendant ever received notice from Medicaid of the denial, however, considering the three years which passed between the rendering of services and plaintiff's subsequent billing, it is reasonable to assume the twenty-day window had elapsed. *See N.J.A.C.* 10:49-10.3(a)(3) (twenty-day notice period for providers starts from date on the Remittance Advice Claims Status); (b)(3) (claimants shall have twenty days from the date of notice of Medicaid Agent (agency/department)). As plaintiff had control over the notice provided to defendant, by way of its decision to bill defendant three years after the service was performed, it is reasonable to impose on plaintiff, if not an obligation to appeal the decision, at least an obligation to inform defendant of her right to appeal the denial of her claim.

IV

***9** Plaintiff asserts equity and justice require the default judgment entered in this action remain intact, as public policy requires that there be some finality of judgment. Defendant maintains here, the interests of justice weigh heavily in favor of vacating the judgment.

The principle of finality of judgments dictates that "litigation must eventually be ended and that at some point the prevailing party be allowed to rely confidently on the inviolability of his judgment. But it is not an absolute rule, and must be weighed in the balance with the equally salutary principle that justice should be done in every case." *Hodgson v. Applegate,* 31 *N.J.* at 43. The power to set aside judgments "should doubtless be freely exercised when the enforcement of a judgment would be unjust, oppressive or inequitable as to the party moving to vacate it." *Wilford v. Sigmund Eisner Co.,* 13 *N.J.Super.* 27, 33 (App.Div.1951).

"A court typically vacates a judgment because ... the relief granted did not adequately take into account the prevailing equities ." *Housing Authority of Town of Morristown v. Little,* 135 *N.J.* 274, 289 (1994)."[T]he rule is designed to provide relief from judgments in situations in which, were it not applied, a grave injustice would occur."*Ibid.* Here, the trial court did not take into account the prevailing equities, i.e., that defendant presented a meritorious defense to plaintiff's claim. While plaintiff maintains even if defendant was able to present a meritorious defense to the action, her failure to move within a "reasonable time" to vacate judgment precludes her from seeking relief, the issue raised by defendant is of public importance, and should not be dismissed on a technical procedural ground. *See Bauer v. Griffin,* 104 *N.J.Super.* 530, 541 (Law Div.1969), *aff'd,* 108 *N.J.Super.* 414 (App.Div.), *certif. denied,* 56 *N.J.* 245 (1970) (where infant moved to set aside judgment on novel grounds, under *R.R.* 4:62-2(a) and (f) (current *R.* 4:50-1 and -2), court refused to avoid reaching merits of plaintiff's claim based on procedural grounds though five years had passed between entry of judgment and plaintiff's motion).

Plaintiff further argues the judge did not abuse his discretion in refusing to vacate the judgment, as defendant was well aware of the action and chose not to defend against it. Plaintiff relies on our decision in *Woodrick v. Jack J. Burke Real Estate, Inc.*, 306 *N.J.Super.* 61 (App.Div.1997), in support of its claim. In *Woodrick,* the defendant chose not to defend against an action, arguing that it "reasonably believed that [corporate successor liability] was not a valid theory against it."*Id.* at 77.The defendant in *Woodrick* made a decision not to defend itself because it felt confident it was insulated from liability. *Ibid.* We found no abuse of discretion in the trial court's refusal to vacate to default judgment against defendant, noting that defendant presented no "exceptional circumstances" warranting relief; the legal theory relied on by defendant had been called into question as early as 1976; and even if defendant was able to present a meritorious defense, no excusable neglect was demonstrated. *Id.* at 77-78.Here, in contrast, defendant has demonstrated both a meritorious defense and "exceptional circumstances" sufficient to warrant relief. In addition, this is not a case where defendant chose to ignore the claim against her based upon reliance on a legal theory insulating her from liability. Here, defendant reached out to the entity she knew was responsible for the bill and relied on their representation that they would "take care of it."

***10** Allowing this judgment to stand would be unjust, as plaintiff was precluded from seeking reimbursement from defendant in the first instance; defendant was not dilatory, as she made efforts to resolve the dispute over the bill with both plaintiff and Medicaid; plaintiff was in a superior position to resolve the dispute with Medicaid which would have likely brought the clerical error to light/ eliminating the need for a lawsuit; and allowing plaintiff to collect from defendant circumvents the legislative purpose behind the Medicaid statute.

Reversed and remanded.

N.J.Super.A.D.,1999.
New York Hosp. v. Robinson

Not Reported in A.2d, 1999 WL 34876247 (N.J.Super.A.D.)

END OF DOCUMENT

LEXSEE 12 MISC 3D 1192A

[*1] Prospect Park Nursing Home, Inc., Plaintiff, against Monroa B. Goutier and Saul Bethay, Defendants.

103442/04

CIVIL COURT OF THE CITY OF NEW YORK, KINGS COUNTY

2006 NY Slip Op 51536U; 12 Misc. 3d 1192A; 824 N.Y.S.2d 770; 2006 N.Y. Misc. LEXIS 2130

August 7, 2006, Decided

NOTICE: THIS OPINION IS UNCORRECTED AND WILL NOT BE PUBLISHED IN THE PRINTED OFFICIAL REPORTS.

HEADNOTES

[1192A]** Powers--Power of Attorney--Power of attorney alone insufficient to establish third-party liability for nursing home care.

COUNSEL: Plaintiff appeared by David A. Mersky, Esq. of Abrams, Fensterman, Fensterman, Flowers, Greenberg and Eisman, LLP.

Defendant Monroa B. Goutier did not appear.

Defendant Saul Bethay appeared Pro se.

JUDGES: Jack M. Battaglia, Judge, Civil Court.

OPINION BY: Jack M. Battaglia

OPINION

[*770]** Jack M. Battaglia, J.

From June 2 until November 17, 2003, defendant Monroa B. Goutier was a resident at Prospect Park Care Center, a nursing home operated by Prospect Park Nursing Home, Inc. This action was commenced by Prospect Park against Mr. Goutier and Saul Bethay, a friend who signed the Admission Agreement as Mr. Goutier's "Designated Representative", to collect charges in excess of $ 15,000.00 allegedly due for the skilled nursing care rendered to Mr. Goutier. A judgment on default was entered against both defendants, but was vacated as to Mr. Bethay only. Also subsequent to entry of the judgment, Medicaid made payment to Prospect Park for all but $ 6,488.70 of the charges for Mr. Goutier's care, and the action proceeded to trial only against Mr. Bethay for recovery of that amount.

The Admission Agreement signed by Mr. Bethay does not define "Designated Representative", but the term is defined in regulations of the New York State Department of Health as "the individual...designated...to receive information and to assist and/or act in behalf of a particular resident to the extent permitted by State law." (*See 10 NYCRR § 415.2 [f]*. A

"Designated Representative" is to be contrasted with a "Sponsor", defined in the regulations as "the agency or the person or persons, other than the resident, responsible in whole or in part for the financial support of the resident, including the costs of care in the facility." (*See 10 NYCRR § 415.2[s]*.) Prospect Park does not contend that Mr. Bethay was or is Mr. Goutier's "Sponsor".

Nursing homes that accept residents whose charges will be paid in whole or in part by the Medicaid program are governed by the federal Nursing Home Reform Act (*see 42 USC § 1396r*), and federal and state regulations (*see* 42 CFR Part 483; 10 NYCRR Part 415 .) As pertinent here, the federal statute provides that "a nursing facility must...not require a third party guarantee of payment to the facility as a condition of admission (or expedited admission) to, or continued stay in, the facility" (*42 USC § 1396r[c][5][A][ii]*), but provides in another subparagraph that the **[*2]** restriction "shall not be construed as preventing a facility from requiring an individual, who has legal access to a resident's income or resources available to pay for care in the facility, to sign a contract (without incurring personal financial liability) to provide payment from a resident's income or resources for such care" (*42 USC § 1396r[c][5][B][ii]*.) Virtually the same language appears in applicable federal regulations (*see 42 CFR § 483.12[d][2]*) and state regulations (*see 10 NYCRR § 415.3[b][1], [b][6]*).

Although the restriction on third-party guarantee and the authorization for requiring payment from the resident's assets and income are often posited as the obverse of each other, theoretically at least "[n]either federal nor state law prohibit nursing homes from voluntarily obtaining the signature of a willing responsible party or third party guarantor when admitting nursing home residents" (see *Podolsky v First Healthcare Corp., 50 Cal. App. 4th 632, 58 Cal.Rptr.2d 89, 97 [2d Dist 1996]*; *see also Manor of Lake City, Inc. v Hinners, 548 N.W.2d 573, 576 [Sup Ct Iowa 1996]*.) But legal commentators have called attention to the potential for abuse and other difficulties that arise when third parties are asked to sign nursing home admission agreements. (*See* Katherine C. Pearson, The Responsible Thing to Do About "Responsible Party" Provisions in Nursing Home Agreements: A Proposal for Change on Three Fronts, *37 U Mich. JL Reform 757 [2004]*; Lawrence M. McGaughey, Reviewing a Nursing Home Admissions Contract, 68-Aug NY St B J 34 [1996].)

In 2001 and 2003, the New York State Attorney General's Office took action against a total of 15 nursing homes that required thirty-party guarantees as a condition of admission in violation of state and federal law. (*See* "NY State Attorney General's Office Get [*sic*] Nursing Homes to Revise Policies", The Daily Record of Rochester [Rochester NY], March 18, 2003.) As will appear, however, Prospect Park's Admission Agreement does not contain a third-party guarantee.

In a section titled "Financial Arrangements", the Admission Agreement signed by Mr. Bethay as Designated Representative contains the following statement in bold print:

> "Although the Designated Representative is not personally responsible for the cost of care from the Designated Representative's personal assets, the Designated Representative may be held personally responsible to the Facility for non-payment to the extent that he or she has control over the Resident's assets, such as by Power of Attorney, access to joint accounts and the like..."
>
> "The Resident...and Designated Representative understand that if the anticipated payor does not pay the cost of care, then the Resident...and Designated Agent will

> be responsible for the cost of care through funds legally available to the Resident and/or by securing coverage through another third party payor."

And again, although not in bold print: **[*3]**

> "The Designated Representative is responsible to provide payment from Resident's income and resources to the extent he/she has access to said income and resources without the Designated Representative incurring personal financial liability."

In a paragraph headed "Medicaid" and an Attachment "B" on "Special Rules Regarding Selected Payors", the Admission Agreement describes how the Resident's and Designated Representative's payment obligation may be affected by Medicaid. Specifically:

> "If the Resident's care is covered by Medicaid, the Resident...and Designated Representative agree to remit to the Facility the Resident's Net Available Monthly Income (NAMI') on a timely basis, pursuant to the Resident's Medicaid budget...The Resident's Medicaid budget and the NAMI amount will be determined by Medicaid."

Mr. Goutier's first 100 days at Prospect Park were covered by Medicare and his private insurance with Blue Cross/Blue Shield. Mr. Goutier applied for Medicaid coverage, and was approved by Medicaid, but not until almost two years after he left the nursing home. In a Notice of Acceptance of Your Medical Assistance Application dated October 20, 2005, Mr. Goutier was advised that Medicaid would pay his nursing home charges in excess of NAMI, which was determined to be $ 2,162.90. Mr. Goutier's Medicaid budget was determined to include Social Security benefits and private pension income totaling $ 2,886.23. After application of Medicare, Blue Cross/Blue Shield, and Medicaid, Mr. Goutier owed $ 6,488.70 for his stay at Prospect Park, and separate invoices for that amount were sent to Mr. Goutier and to Mr. Bethay.

By that time, Prospect Park had commenced this action, filed October 18, 2004, alleging "[u]pon information and belief" that Mr. Bethay "had access to [Mr. Goutier's] assets and income, and they were sufficient to satisfy the indebtedness" to Prospect Park. (Verified Complaint, P15.)

On April 28, 2005, shortly after the April 6 return date for Mr. Bethay's motion to vacate the default judgment taken against him, Mr. Goutier executed in Mr. Bethay's favor a Durable General Power of Attorney/New York Statutory Short Form. Mr. Bethay explained at trial that the Power of Attorney was obtained at the suggestion of the judge who granted his motion, for reasons that are not explained in the record and apparently not understood by Mr. Bethay. In any event, the Power of Attorney includes authority for banking transactions, insurance transactions, claims and litigation, personal relationships and affairs, and retirement benefit transactions, among others.

Prospect Park's claim against Mr. Bethay rests upon the Power of Attorney. As stated in its post-trial submission: "In the case at bar, Defendant was required to ensure payment to the facility by ensuring payment from Mr. Goutier's bank account to which he had access as Power of Attorney"; "The Defendant breached the Agreement with the Plaintiff and remains **[*4]** responsible for the outstanding balance at this time."

The Court notes that neither at the time he signed the Admission Agreement, nor at any time during Mr. Goutier's stay at Prospect Park, did Mr. Bethay possess power of attorney from Mr. Goutier. Indeed, the Power of Attorney was not executed until after the commencement of this action. The Admission Agreement provision, however, that would make the Designated Representative "personally responsible to the Facility for non-payment to the extent that he or she has control over the Resident's assets" is not limited by its terms to the time of admission or the duration of the Resident's stay, and must be understood to obligate the Designated Representative for so long as the Resident may be obligated to the Facility. And although commencement of the action might be deemed "premature" to the extent the allegations of breach against Mr. Bethay would assume the Power of Attorney, the Verified Complaint contains other allegations of breach as well. (*See* PP14, 16; *State of New York v Ehasz, 80 A.D.2d 671, 671-72, 436 N.Y.S.2d 387 [3d Dept.1981]*.)

A power of attorney of the type held by Mr. Bethay would, at least *prima facie*, constitute "legal access to a resident's income or resources" within the meaning of the governing statute (*see 42 USC § 1396r[c][5][B][ii]*) and "control over the Resident's assets" within the meaning of the Admission Agreement. "An attorney in fact is essentially an alter ego of the principal...*Sections 5-1502 A through 5-1502 L of the General Obligations Law* describe and explain the extraordinary scope of the authority of an attorney in fact with respect to the principal's various matters." (*Zaubler v Picone, 100 A.D.2d 620, 621, 473 N.Y.S.2d 580 [2d Dept 1984]*.) It is the "public policy of this State that there be liberal use and judicial recognition of the efficacy of powers of attorney. " (*Arens v Shainswit, 37 A.D.2d 274, 279, 324 N.Y.S.2d 321 [1st Dept], aff'd 29 N.Y.2d 663, 274 N.E.2d 444, 324 N.Y.S.2d 954 [1971]*.)

Certainly, Mr. Bethay's use of the power of attorney to transfer assets to himself that could have been used for Mr. Goutier's nursing home care would constitute a breach of the Admission Agreement (*see Leonard Nursing Home, Inc. v Kay, 2003 N.Y. Misc. LEXIS 201, 2003 NY Slip Op 50623[U]*[Sup Ct, Saratoga County]), as would presumably any failure to turn over funds actually received by him with authority for their use (*see Putnam Nursing & Rehabilitation Center v Bowles, 239 A.D.2d 479, 481, 658 N.Y.S.2d 57 [2d Dept 1997];Wedgewood Care Center Inc. v McFloin, 2002 N.Y. Misc. LEXIS 1689, 2002 NY Slip Op 40545[U]*[App Term, 2d Dept].)

But there is no allegation of self-dealing in this case, and no evidence that Mr. Bethay has received any of Mr. Goutier's funds since the Power of Attorney was executed in April 2005. Mr. Bethay denies that he has ever used the Power of Attorney for any purpose, and there is no evidence to contradict him. He testified that Mr. Goutier is alive and competent, capable of handling his financial affairs, and that he does so without Mr. Bethay's involvement. "As a general rule an attorney-in-fact's authority may be revoked by the principal expressly or impliedly through words or conduct which are inconsistent with the continuation of authority." (*Zaubler v Picone, 100 A.D.2d at 621*.)

It is not enough, moreover, that there be "legal access" or "control" for the contract to be **[*5]** breached. There must also be a "resident's income or resources available to pay for care in the facility." (*See 42 USC § 1396r[C][5][B][ii]*.) "The defendant is liable only for her handling of the [resident's] assets and only to the extent that [the resident's] assets would cover outstanding payments owed to the Plaintiff." (*Sunrise Healthcare Corp. v Azarigian, 76 Conn App 800, 808, 821 A.2d 835, 840 [2003]*.)

Without such proof there can be no breach and no damages. Prospect Park appears to recognize this with its allegations of assets and

income of Mr. Goutier "sufficient to satisfy the indebtedness" (Verified Complaint, P15), and its reference to Mr. Bethay's access to "Mr. Goutier's bank account." But Prospect Park introduced no evidence of the existence of any bank account in Mr. Goutier's name at any time since Mr. Bethay has had Mr. Goutier's power of attorney, and no evidence of the amount of any assets of Mr. Goutier. The Medicaid budget does identify sources of income to Mr. Goutier, presumably as of the time of his stay at the nursing home in 2003, but Prospect Park has made no showing that the statements are admissible as evidence against Mr. Bethay, or that the income was "available to pay for care in the facility" since Mr. Bethay has held the Power of Attorney.

The balance of interests in a case like this is complex. Prospect Park should be paid for the care it gave Mr. Goutier, and not be discouraged from accepting Medicaid patients by long delays and difficulty in collecting the resident's share. But neither should the relatives and friends of the elderly and infirm be discouraged from participating in their care by fear of potentially crippling personal financial responsibility. The evidence in this case, particularly the terms of the Admission Agreement, shows that Prospect Park is aware of the restrictions under which it must operate, but it does not show that this defendant has breached the Agreement.

Judgment for defendant Saul Bethay, dismissing the Verified Complaint.

August 7, 2006