EXHIBIT S

HEALTH CARE PROXY

To my family, friends, physicians, health care providers, and community care facilities, and any other person who may have an interest in my medical care:

I, Sophie June Torres, being of sound mind, voluntarily create this Health Care Proxy.

Appointment of Health Care Agent

I, Sophie June Torres, appoint my My Son, Jesse Enos Torres III, as my agent.

My agent will serve unless any of the following conditions occur:

- I revoke his or her authority
- he or she becomes unavailable or unwilling to act as my agent, or
- he or she is my spouse or registered domestic partner and we commence proceedings for dissolution, annulment, or termination of the marriage or registered domestic partnership.

Contact information:

Jesse Enos Torres III
1 Carriage Shop Road
Waquoit, Massachusetts 02536
(617) 291-0862 (main)

Agent's Authority

Unless I have specified otherwise in this document, I grant my agent full authority on all matters relating to my health care, including full power to give or refuse consent to all medical, surgical, hospital, and related health care.

X SJT By initialing this paragraph, I expressly authorize my agent to make decisions to withhold or withdraw life-prolonging procedures, which would allow me to die, and I acknowledge such decisions could or would allow my death.

X SJT By initialing this paragraph, I expressly authorize my agent to make decisions to withhold or withdraw artificially administered food and water, which would allow me to die, and I acknowledge such decisions could or would allow my death.

My agent's power includes, but is not limited to, the authority to:

EXHIBIT 5

- hire and fire medical personnel
- visit me in any hospital, hospice, nursing home, adult home, or other medical care facility
- in accordance with the Health Insurance Portability and Accountability Act, and as my personal representative, request, receive, and review any information, verbal or written, regarding my physical or mental health, including medical and hospital records and other protected health information, and to execute any releases or other documents that may be required in order to obtain such information
- in accordance with any other instructions I give in this document, sign any documents required to request, withdraw, or refuse medical treatment or to be released or transferred to or from a hospital, hospice, nursing home, adult home, or other medical care facility
- authorize my admission to or discharge from (including transfer to another facility) any hospital, hospice, nursing home, adult home, or other medical care facility, and to execute any releases or other documents that may be required to do so
- choose where I live and receive care and support when those choices relate to my health care needs
- sign any waiver or release from liability required by a hospital or physician, and
- contract on my behalf for any health care related service or facility, without incurring personal financial liability for such contracts.

When Effective

The authority of my agent is effective when my primary physician determines I am incapable of making informed decisions regarding my health care. However, when this document is signed, each individual identified as my agent is, in accordance with the Health Insurance Portability and Accountability Act, my personal representative for all purposes related to any assessment of my capacity to make informed decisions regarding my health care.

Agent's Obligation

My agent shall make decisions for me in accordance with this document and any other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values

EXHIBIT S

to the extent known to my agent.

Agent's Postdeath Authority

The authority of my agent shall continue after my death for a period of time sufficient for my agent to carry out any wishes described in this section:

I authorize my agent to decide whether to donate my organs, tissues, or other body parts after I die.

I authorize my agent to decide whether or not to direct or consent to an autopsy after I die.

I authorize my agent to direct the disposition of my remains after I die.

Guardian Nomination

If a court must appoint a guardian of my person, I nominate the agent designated in this form to serve without bond or security.

Primary Physician

I designate Dr. Arthur E. Crago as my primary physician.

Contact information:

Dr. Arthur E. Crago
315 Palmer Avenue
Falmouth, Massachusetts 02540
(508) 548-4303

Effect of Copy

A copy of this document has the same effect as the original.

Governing Law

I intend this document to be my Health Care Proxy under Massachusetts law.

Definitions

For purposes of this document:

Health care means any treatment, service, or procedure to diagnose or treat the physical or mental condition of a patient.

Terminal condition means an incurable or irreversible medical condition which, without the administration of life-prolonging procedures, will, in the opinion of the

EXHIBITS

patient's attending physician, result in death within a relatively short time.

Permanently unconscious means an irreversible coma or persistent vegetative state where the patient is unaware of himself or herself and is unable to show any behavioral response to the environment.

Life-prolonging procedure means any medical procedure that would be administered solely to sustain the patient's life.

Artificially administered food and water—also called nutrition and hydration—means a mix of nutrients and fluids given through tubes inserted into veins or various body parts, depending on the patient's condition.

Severability

If a court finds any of the specific provisions in this document to be invalid, that shall not affect other provisions that can be given effect without the invalid provision.

Signature

Signed this 24 day of April, 2009

Signature: Sophie J Torres

Place: Barnstable County, MA.
(City or County and State)

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EXHIBITS

Declaration of Witnesses

We are each at least 18 years old. We, the undersigned, each witnessed the signing of this health care proxy by Sophie June Torres or at the direction of Sophie June Torres and state that she appears to be:

- at least 18 years of age
- of sound mind, and
- under no constraint or undue influence.

Neither of us is named as an agent in this document.

Witness: Gail L. Framson

Print Name: Gail L. Framson

Address: 5 Carriage Shop Rd. Waquoit, MA 02536

Witness: Drew M Framson

Print Name: DREW M. FRAMSON

Address: 5 Carriage Shop Rd, Waquoit MA 02536

The Commonwealth of Massachusetts

On this 24 day of April 2009,

before me, the undersigned notary public, personally appeared

Sophie Torres, Drew and Gail Framson

proved to me through satisfactory evidence of identification, which were Drivers Licenses

to be the person whose name is signed on the preceding or attached document and acknowledged to me that he/she signed it voluntarily for its stated purpose.

SARAH K. MAYO, Notary Public

My Commission Expires September 29, 2011

 S.T.S. - 4-24-09