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IN THE UNITED STATES BANKRUPTCY COURT

CENTRAL DISTRICT OF CALIFORNIA – LOS ANGELES DIVISION

In re: **VERITY HEALTH SYSTEM OF CALIFORNIA, INC., et al.,** Debtor and Debtors In Possession.	CASE NO. 2:18-bk-20151-ER **CREDITOR CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES'S SUPPLEMENTAL OBJECTION TO (1) DEBTORS' MOTION FOR THE ENTRY OF AN ORDER AUTHORIZING THE SALE OF PROPERTY FREE AND CLEAR OF ALL CLAIMS, LIENS, AND ENCUMBRANCES; (2) APPROVING FORM OF ASSET PURCHASE AGREEMENT** Hearing: September 25, 2019 Time: 10:00 a.m. Courtroom: 1568 Judge Ernest M. Robles
/x/ Affects All Debtors. Affects Verity Health System of California, Inc. Affects O'Connor Hospital Affects Saint Louise Regional Hospital Affects St. Francis Medical Center Affects St. Vincent Medical Center Affects Seton Medical Center Affects O'Connor Hospital Foundation Affects Saint Louise Regional Hospital	

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Foundation
Affects St. Francis Medical Center of Lynwood Foundation
Affects St. Vincent Foundation
Affects St. Vincent Dialysis Center, Inc.
Affects Seton Medical Center Foundation
Affects Verity Business Services
Affects Verity Medical Foundation
Affects Verity Holdings, LLC
Affects De Paul Ventures, LLC
Affects De Paul Ventures – San Jose Dialysis, LLC,

Debtors and Debtors in Possession.

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INTRODUCTION

California Department of Health Care Services (Department) hereby objects to the Motion for the Entry of an Order authorizing the sale of property free and clear of all claims, liens, and encumbrances (ECF No. 1279) and approving of the proposed Asset Purchase Agreement (Motion) (ECF No. 1279) between (i) Verity, Verity Holdings, LLC, a California limited liability company (Verity Holdings), St. Francis Medical Center, a California nonprofit public benefit corporation (St. Francis Medical Center), St. Vincent Medical Center, a California nonprofit public benefit corporation (St. Vincent Medical Center), St. Vincent Dialysis Center, Inc., a California nonprofit public benefit corporation (St. Vincent Dialysis Center) and Seton Medical Center, a California nonprofit public benefit corporation (Seton Medical Center)(collectively Debtors) and (ii) Strategic Global Management. If this sale goes through as intended by Debtors, the Department will be precluded from meeting its statutory obligations to collect Hospital Quality Assurance Fees (HQA Fees) and overpayments.

The proposed Asset Purchase Agreement (APA) between Debtors and the Buyer misrepresents that the Agreements will be transferred as licenses. (APA 66, ECF No. 1279). Debtors' Medi-Cal Provider Agreements (hereafter, Agreements) are executory contracts that must be assumed and assigned to the Buyer. For the intended assumption and assignment to occur, either Debtors must pay all of the outstanding HQA Fees incurred before the closing of the sale or any outstanding HQA Fees on Debtors' account must be paid by the Buyer through joint and severally liability. In addition to the HQA Fee debt, Debtors and/or the Buyer must also reimburse the Department for any Medi-Cal overpayment and pay other debts owed to the Department.

Accordingly, Debtors must assume and assign the Agreements and pay the HQA Fee debt and other debts to the Department. Otherwise, the Buyer must be

ordered to be held jointly and severally liable for those debts under assumption and assignment of the Agreements. The proposed APA, to transfer the Agreements as licenses, without cure of the debts to the Department and without joint and several liability, cannot be approved by this Court.

If Debtors propose to pay the debt through the proceeds of the sale, the Department will agree to accept payment of the entire HQA Fee debt incurred by Debtors within five days of the closing of the Sale. Moreover, Debtors must establish and maintain a trust account in the amount of $70 million for 36 months for potential reimbursement to the Department of any Medi-Cal overpayment, with any excess overpayment over $70 million to be paid by the Buyer.[1]

PROCEDURAL BACKGROUND

On August 31, 2018 (Petition Date), Debtors filed their voluntary petitions for relief under Chapter 11 of Title 11 of the United States Code. Debtors' cases are jointly administered with their affiliates and, pursuant to 11 U.S.C. §§ 1107(a) and 1108, Debtors continue to operate their businesses and manage their affairs as debtors-in-possession.

On January 17, 2019, Debtors filed the Motion for an order (a) approving form of the APA for the Buyer and for prospective orders, (b) approving procedures related to the assumption of certain executory contracts and unexpired leases, and (c) to sell their property free and clear of any claims, liens, and encumbrances. Motion, ECF No. 1279.

STATUTORY BACKGROUND

I. ADMINISTRATION OF THE MEDI-CAL PROGRAM

The federal Medicaid Act, enacted in 1965 as title XIX of the Social Security Act, is a federal-state administered Spending Clause program designed to provide

[1] Information related to the $70 million projection can be provided by the Department upon request.

medical assistance to eligible low-income individuals. 42 U.S.C. § 1396a & b (2019). The financing and administration of the Medicaid program are a cooperative effort between the federal government and participating states, as authorized under a federally approved State Medicaid Plan. Title 42 U.S.C. § 1396a, et seq., authorizes federal financial support to states for medical assistance provided to certain low-income persons. In California, this program is the California Medical Assistance Program, which is commonly known as Medi-Cal. Cal. Welf. & Inst. Code § 14063 (West 2019). The Department is the single state agency authorized to administer the Medi-Cal program. Cal. Welf. & Inst. Code § 10740 (West 2019); Cal. Code Regs. tit. 22, § 50004(b)(1) (2019).

II. MEDI-CAL FINANCING

The costs of the Medicaid program are generally shared between states and the federal government based on a set formula. 42 U.S.C. §§ 1396b(a) and 1396d(b) (2019). Except for certain covered populations or discrete service expenditures specified in 42 U.S.C. §§ 1396b or 1396d, the federal government reimburses medical assistance expenditures under California's State Medicaid Plan at a rate of 50%. When the Department makes expenditures for medical assistance covered under Medi-Cal, the Department claims the appropriate federal share of those costs at the appropriate federal medical assistance percentage. *Id.*

Federal Medicaid law permits states to finance the non-federal share of Medicaid costs through several sources, including but not limited to:

> State General Funds. State general funds are revenues collected primarily through personal income, sales, and corporate income taxes.

42 C.F.R. § 433.51 (2019).

> Charges on Health Care Providers. Federal Medicaid law permits states to (1) levy various types of charges – including taxes, fees, or assessments – on health care providers and (2) use the proceeds to draw down FFP (federal financial participation) to support the non-federal share of state Medicaid expenditures. These charges must meet certain requirements and be approved by CMS (Centers for Medicare &

> Medicaid Services of the United States Department of Health and Human Services) for revenues from these charges to be eligible to draw down FFP. A number of different types of providers can be subject to these charges, including hospitals.

42 U.S.C. § 1396b(w) (2019); 42 C.F.R. §§ 433.50 – 433.74 (2019).

The HQA Fee is a charge imposed by the Department on non-exempt hospitals to finance the non-federal share of specified Medi-Cal costs. Cal. Welf. & Inst. Code § 14169.51(*l*) (West 2019). The quarterly HQA Fee imposed upon non-exempt hospitals has been collected by the Department in similar form since 2009. The collected HQA Fees are used to support Medi-Cal expenditures and maximize available federal participation for Medi-Cal costs. *See* http://www.lao.ca.gov/BallotAnalysis/Proposition?number=52&year=2016.

III. DELIVERY OF MEDI-CAL SERVICES

The vast majority of Medi-Cal benefits are delivered through one of two systems: (i) the fee-for-service system and (ii) the managed care plan system. Cal. Welf. & Inst. Code § 14016.5(b) (West 2019). In the fee-for-service system, Medi-Cal contracts with and pays health care providers (such as physicians, hospitals, and clinics) directly for covered services provided to Medi-Cal beneficiaries. *Id.*, § 14132 et seq. (West 2019).

The Department also administers Medi-Cal through various managed care plans operated by public and private entities under contract pursuant to various statutory authorities. *See generally* Cal. Welf. & Inst. Code §§ 14087.3-14089.8; 14200, et. seq. (West 2019). In the managed care system, the Department contracts with managed care plans to provide the vast majority of covered services for enrolled Medi-Cal beneficiaries within a fixed geographic location. *See generally id.* at § 14087.3 et seq. (setting forth standards governing contracts between the Department and managed care providers) and § 14169.51(ab) (West 2019) (defining "managed health care plan" for purposes of the HQA Fee program).

Medi-Cal managed care enrollees may obtain non-emergency services from contracted providers – including hospitals – that accept payments from their health plans. The Department develops and pays an actuarially sound (capitation) rate per Medi-Cal beneficiary enrollee per month to contracted managed care plans. Cal. Welf. & Inst. Code § 14301.1 (West 2019).

IV. PAYMENTS TO HOSPITALS FOR MEDI-CAL SERVICES

The Department provides payments to approximately 400 licensed general acute care hospitals. *https://lao.ca.gov/ballot/2013/130602.aspx.* These hospitals are divided into three general categories (private hospitals, designated public hospitals (county and University of California), and non-designated public hospitals (district hospitals) based on whether the hospital is privately or publicly owned, and who operates the hospital. *Id.* Debtors are private hospitals.

Hospitals may receive several types of payments based on their participation in Medi-Cal, including direct payments from the Department, managed care payments from managed care plans, and supplemental payments from both the Department and managed care plans. https://lao.ca.gov/ballot/2013/130602.aspx.

Direct payments are payments to providers such as Debtor for providing covered services to Medi-Cal beneficiaries through the fee-for-service system. Managed care payments are payments from managed care plans to providers (including hospitals such as Debtor) for services delivered to Medi-Cal beneficiaries enrolled in these plans. The plans receive funds from the Department to pay the providers. https://lao.ca.gov/ballot/2013/130602.aspx.

Quality assurance payments are supplemental payments, supported by the HQA Fee revenue and federal matching funds, providing additional payments to Medi-Cal hospitals to supplement the Department's direct fee-for service payments and the managed care plans' payments to hospitals, including Debtor. Cal. Welf. & Inst. Code § 14169.53(b) (West 2019).

V. HOSPITAL QUALITY ASSURANCE FEE

California Assembly Bill 1383 established a program that imposed a quarterly HQA Fee to be paid by non-exempt hospitals, which would be used to increase federal financial participation in order to make supplemental payments to hospitals including private hospitals (such as Debtors), and to help pay for health care coverage for low-income children, for the period of April 1, 2009 through December 31, 2010. The California Legislature extended the HQA Fee program through December 31, 2016. Then, on November 8, 2016, California voters passed Proposition 52 continuing the HQA Fee program indefinitely from January 1, 2017, onward. *See* Cal. Const., art 16, § 3.5; HTTP://WWW.DHCS.CA.GOV/PROVGOVPART/PAGES/HOSPITALQUALITYASSURANCEFEEPROGRAM.ASPX.

More specifically, the Medi-Cal Hospital Reimbursement Improvement Act of 2013 (the Act) extended the imposition of the HQA Fee from January 1, 2014, through December 31, 2016. The Act was signed into law in October 2013 and is codified at California Welfare and Institutions Code sections 14169.50 through 14169.76. It was later made permanent pursuant to Proposition 52. Cal. Const., art 16, § 3.5. The Act requires non-exempt hospitals to pay a quarterly HQA Fee, which is assessed regardless of a hospital's participation in the Medi-Cal program. Cal. Welf. & Inst. Code § 14169.52(a) (West 2019).

VI. STATUTORY BASIS FOR COLLECTION OF HQA FEES

California Welfare and Institutions Code section 14169.50 sets forth the legislative purpose and intent for the HQA Fee program. "It is the intent of the Legislature that funding provided to hospitals through a hospital quality assurance fee be continued with the goal of increasing access to care and to improving hospital reimbursement through supplemental Medi-Cal payments to hospitals." Cal. Welf. & Inst. Code § 14169.50(b) (West 2019). "It is [also] the intent of the

Legislature to impose a quality assurance fee to be paid by hospitals, which would be used to increase federal financial participation in order to make supplemental Medi-Cal payments to hospitals, and to help pay for health care coverage for low-income children." Cal. Welf. & Inst. Code § 14169.50(d) (West 2019) (emphasis added). California Welfare and Institutions Code section 14169.52(h) provides the Department with the statutory remedy to recover the unpaid HQA Fee debt from Medi-Cal payments until the entire debt is recovered (recoupment).

VII. REIMBURSEMENT OF MEDI-CAL OVERPAYMENTS

Medi-Cal makes interim payments to an authorized Medi-Cal provider after it renders services and submits claims to Medi-Cal for payment. The Department later audits the claims for Medi-Cal payment submitted by Medi-Cal providers. Cal. Welf. & Inst. Code §§ 14133 and 14170 (West 2019). In that regard, the Department is statutorily authorized to audit and review a provider's cost report[2] within three years after the close of the period covered by the report, or after the date of submission of the original or amended report by the provider, whichever is later. Cal. Welf. & Inst. Code § 14170(a)(1) (West 2019).

If the audit indicates any overpayment, the provider must reimburse Medi-Cal for the overpayment. The Department may begin liquidation of any overpayment to a Medi-Cal provider 60 days after issuance of the first Statement of Accountability or demand for repayment. Cal. Code Regs. title 22, § 51047 (2019).

A provider can appeal the Department's audit findings. Cal. Code Regs. tit. 22, §§ 51016-51048 (2019). A Medi-Cal provider is entitled to a formal administrative hearing on any disputed overpayment. Cal. Welf. & Inst. Code § 14171 (West 2019).

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[2] Cost reports and other data submitted by Medi-Cal providers are submitted to the Department for the purpose of determining reasonable costs for Medi-Cal services or establishing rates of Medi-Cal payment. Cal. Welf. & Inst. Code § 14170(a)(1) (West 2019).

VIII. THE DEPARTMENT'S RECOUPMENT RIGHT

The Agreements state that "[a]s a condition for participation . . . in the Medi-Cal program, Provider agrees to comply with all of the following terms and conditions . . . ." Hanh Vo Declaration (Vo Decl.), Exs. 1 & 2, at 1. Those terms and conditions include the requirement that Debtors comply with applicable law:

> 2. Compliance with Laws and Regulations. Provider agrees to comply with all applicable provisions of Chapters 7 and 8 of the Welfare and Institutions Code (commencing with Sections 14000 and 14200), and any applicable rules or regulations promulgated by DHCS pursuant to these Chapters. Provider further agrees that if it violates any of the provisions of Chapters 7 and 8 of the Welfare and Institutions Code, or any other regulations promulgated by DHCS pursuant to these Chapters, it may be subject to all sanctions or other remedies available to DHCS. Provider further agrees to comply with all federal laws and regulations governing and regulating Medicaid providers.

Id.

California Welfare and Institutions Code section 14169.52(h) provides that "[w]hen a hospital fails to pay all or part of the quality assurance fee on or before the date that payment is due, the [Department] may immediately begin to deduct the unpaid assessment and interest from any Medi-Cal payments owed to the hospital . . . ." Cal. Welf. & Inst. Code § 14169.52(h) (West 2019).

Both this Court and the Bankruptcy Appellate Panel of the Ninth Circuit held that the imposition of the HQA Fees and the Department's recovery of the unpaid HQA Fees from payments intended for a provider/debtor satisfy the "same transaction" requirement for recoupment. *In re Gardens Regional Hospital and Medical Center, Inc.*, 569 B.R. 788, 797 (Bankr. C.D. Cal. 2017); *In re Gardens Regional Hospital and Medical Center, Inc.*, 2018 WL 1354334 *5 (BAP 9th Cir. 2018).

Based upon the case law and California statute, the Department can recover the unpaid HQA Fees from Medi-Cal payments intended for Debtors. *In re Gardens Regional Hospital and Medical Center, Inc.*, 569 B.R. at 796-797.

Accordingly, the Department may choose to recoup, offsetting any HQA Fee liabilities incurred by Debtors against any Medi-Cal payments intended for them or to the Buyer through successor liability. However, the Department is not required to do so, nor can it be compelled to exercise this equitable remedy.

FACTUAL BACKGROUND

I. ST. VINCENT MEDICAL CENTER'S HQA FEE DEBT TO MEDI-CAL

St. Vincent Medical Center, as of September 6, 2019, has HQA Fee liabilities for Phase V in the amount of **$6,565,679.74**.

ST. VINCENT MEDICAL CENTER (NPI# 1124004304) (OSHPD# 106190762)					
PHASE V		AMOUNT DUE	AMOUNT PAID	WITHHELD	OUTSTANDING BALANCE
FISCAL YEAR	CYCLE (PERIOD)				
2017/18	MANAGED CARE 2 (Directed B) (01/01/2018 - 06/30/2018)	$908,143.74	$0.00	$0.00	$908,143.74
2018/19	MANAGED CARE 3 (Passthrough) (07/01/2018 - 08/31/2018)	$2,828,768.00	$0.00	$0.00	$2,828,768.00
	MANAGED CARE 3 (Directed) (07/01/2018 - 08/31/2019)	$3,433,071.00	$0.00	$0.00	$2,828,768.00
Total Outstanding Balance					**$6,565,679.74**

Vo Decl., ¶ 11 - 14.

II. SETON MEDICAL CENTER'S HQA FEE DEBT TO MEDI-CAL

Seton Medical Center, as of September 6, 2019, has outstanding HQA Fee liabilities for Phase V in the amount of **$16,927,759.87**, as shown below:

SETON MEDICAL CENTER (NPI# 1154428688) (OSHPD# 106410817)					
PHASE V		AMOUNT DUE	AMOUNT PAID	WITHHELD	OUTSTANDING BALANCE
FISCAL YEAR	CYCLE (PERIOD)				
2017/18	CYCLE 3 (07/01/2017 - 09/30/2017)	$2,223,369.00	$0.00	$1,348,558.98	$874,810.02

	CYCLE 4 (10/01/2017 - 12/31/2017)	$2,223,368.94	$0.00	$0.00	$2,223,368.94
	CYCLE 5 (01/01/2018 - 03/31/2018)	$2,223,369.00	$0.00	$0.00	$2,223,369.00
	CYCLE 6 (04/01/2018 – 06/30/2018)	$2,223,369.00	$0.00	$0.00	$2,223,369.00
	MANAGED CARE 2 (Directed B) (07/01/2017 –	$671,377.91	$0.00	$0.00	$671,377.91
2018/19	**CYCLE 7** (07/01/2018 - 09/30/2018)	$2,293,835.00	$0.00	$0.00	$2,293,835.00
	CYCLE 8 (10/01/2018 - 12/31/2018)	$2,293,835.00	$0.00	$0.00	$2,293,835.00
	MANAGED CARE 3 (Passthrough) (07/01/2018- 08/31/2019)	$2,061,897.50	$0.00	$0.00	$2,061,897.50
	MANAGED CARE 3 (Passthrough) (07/01/2018- 08/31/2019)	$2,061,897.50	$0.00	$0.00	$2,061,897.50
Total Outstanding Balance					**$16,927,759.87**

Vo Decl., ¶ 11 - 14.

III. ST. FRANCIS MEDICAL CENTER'S HQA FEE DEBT TO MEDI-CAL

St. Francis Medical Center, as of August 23, 2019, has HQA Fee liabilities for Phase V in the amount of **$3,835,489.67**.

ST. FRANCIS MEDICAL CENTER (NPI# 1487697215) (OSHPD# 106190754)					
PHASE V		**AMOUNT DUE**	**AMOUNT PAID**	**WITHHELD**	**OUTSTANDING BALANCE**
FISCAL YEAR	**CYCLE (PERIOD)**				
2018/19	**Managed Care 2 (Directed B)** (01/01/2018 - 06/30/2018)	$1,888,160.53	$0.00	$0.00	$1,888,160.53
	Managed Care 3 (Passthrough) (07/01/2018 – 08/31/2018)	$973,664.57	$0.00	$0.00	$973,664.57

	MANAGED CARE 3 (07/01/2018-06/30/2019)	$973,664.57	$0.00	$0.00	$973,664.57
Total Outstanding Balance					**$3,835,489.67**

Vo Decl., ¶ 11 - 14.

IV. MEDI-CAL OVERPAYMENTS TO DEBTORS

For July 1, 2016, through June 30, 2017, the Department has determined, based on retroactive claim adjustments, that St. Francis was overpaid **$24,254,503.36** by Medi-Cal for hospital operations. Vo Decl., ¶ 15. For St. Francis, there are cost reports for fiscal years 2017/18, 2018/19, and 2019/20, that still need to be reviewed and/or audited by the Department.

Further, for July 1, 2016, through June 30, 2017, the Department has determined, based on retroactive claim adjustments, that Seton Medical Center was overpaid **$4,205.25** by Medi-Cal for hospital operations. Vo Decl., ¶ 16.

Also, St. Francis was overpaid by Medi-Cal in the amount of **$662,327.67** in supplemental reimbursements under the Supplemental Reimbursement for Construction Renovation Reimbursement Program. *See* Declaration of Shiela Mendiola.

V. DEBTORS CONTINUE AS MEDI-CAL PROVIDERS POST PETITION

Since the Petition Date, Debtors have continued to provide Medi-Cal services, have continued to submit claims to Medi-Cal for payment, and have continued to receive Medi-Cal payments. In other words, despite their bankruptcy filings, Debtors have remained in the Medi-Cal system, enjoying Medi-Cal provider benefits, such as direct payments from the Department, managed care payments from managed care plans, and supplemental payments from both the Department and managed care plans.

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ARGUMENT

I. MEDI-CAL AGREEMENTS ARE EXECUTORY CONTRACTS

Contrary to the representations in the proposed APA, the Agreements cannot be transferred as licenses. They must be assumed and assigned as executory contracts.

The Bankruptcy Code does not define the term "executory contract"; however, the legislative history of 11 U.S.C. § 365 leaves no doubt that an executory contract is one "in which neither side has fully performed at the commencement of bankruptcy." *In re Monsour Medical Center*, 8 B.R. 606, 612 (Bankr. W.D. Pa. 1981), aff'd 11 B.R. 1014 (W.D. Pa. 1981) (citing Fogel, *Executory Contracts and Unexpired Leases in the Bankruptcy Code*, 64 Minnesota Law Review 341, 344 (1980). The legislative history provides:

> Though there is no precise definition of what contracts are executory, it generally includes contracts on which performance remains due to some extent on both sides. A note is not usually an executory contract if the only performance that remains is repayment. Performance on one side of the contract would have been completed and the contract is no longer executory.

Id.

This interpretation of the term "executory contract" is in accord with the view adopted by commentary and case law discussing Section 70(b) of the former Bankruptcy Act, the provision from which 11 U.S.C. § 365 is derived, that an executory contract is one "under which the obligation of both the bankrupt and the other party to the contract are so far unperformed that the failure of either to complete performance would constitute a material breach excusing the performance of the other." *In re Monsour Medical Center*, 8 B.R. at 612-613 (citing Countryman, *Executory Contracts in Bankruptcy: Part 1*, 57 Minn. L. Rev. 439, 460 (1973); *Chattanooga Mem. Park v. Still*, 574 F.2d 349, 352 (6th Cir.), cert. denied, 439 U.S. 929, 99 S. Ct. 316, 58 L. Ed. 2d 322 (1978).) In other words, executory contracts include contracts where, to some extent, performance remains

due from both parties. *In re Holland Enterprises, Inc.* (*In re Holland*), 25 B.R. 301 (Bankr. E.D. N.C. 1982) (citing *In re Rovine Corp.*, 5 B.R. 402, 404 (W.D. Tenn. 1980).

To become entitled to receive Medi-Cal payments as Medi-Cal providers, Debtors were required to enter into Agreements with the Department. *In re Gardens Regional Hospital and Medical Center, Inc.* (*In re Gardens*), 569 B.R. 788, 792 (Bankr. C.D. Cal. 2017). Debtors' eligibility to participate in the Medi-Cal program is conditioned upon its consent to the terms of the Agreements. *In re Gardens*, 569 B.R. at 796-97. In that regard, the Agreements specifically emphasize:

> **AS A CONDITION FOR PARTICIPATION OR CONTINUED PARTICIPATION AS A PROVIDER IN THE MEDI-CAL PROGRAM, PROVIDER AGREES TO COMPLY WITH ALL OF THE FOLLOWING TERMS AND CONDITIONS, AND WITH ALL OF THE TERMS AND CONDITIONS INCLUDED ON ANY ATTACHMENT(S) HERETO, WHICH IS/ARE INCORPORATED HEREIN BY REFERENCE.**

Declaration of Hanh Vo (Vo Decl.), Exs. 1 – 4, at 1 (original emphasis).

Debtors have alleged that Medicare and Medicaid provider agreements are not contracts because there was no consideration by the parties to the agreements. In that regard, Debtors erroneously allege that the provider agreements: (1) merely informs the provider to applicable rules and statutes, which it has a preexisting legal duty to do so, (2) provides no benefits to Medicare or Medi-Cal, and (3) imposes no duties on Medicare or Medi-Cal other than to follow existing statutes and regulations.

When Debtors contracted with the Department to participate in Medi-Cal, they agreed to not only comply with applicable law governing Medi-Cal providers, but also agreed to explicit payment and reimbursement terms that are expressly set forth in the Agreements. Debtors' voluntary consent to those contractual provisions is consideration for the Department to contract with Debtors, allowing Debtors to participate in the Medi-Cal system and receive payments in the millions to tens of

millions of dollars. As a governmental entity, the Department and Medi-Cal are guided by public policy considerations when contracting with providers to provide medical treatment and services to Medi-Cal beneficiaries. *In re Gardens Regional Hospital and Medical Center, Inc.*, 2018 WL 1354334 *6. As affirmed by the California Court of Appeal, the relationship between a Medi-Cal provider and the Department is contractual in nature. *Mednik v. State Department of Health Care Services* 175 Cal. App. 4th 631, 642 (Ct. App. 2009).

The parties' consideration for the Agreements is indisputably exemplified by the following terms and conditions specified in the Agreements:

(1) Debtors must comply with all applicable state law and be subject to all sanctions available to the Department, if they fail to do so. Vo Decl., Ex. 5, ¶ 2, at 1.

(2) Debtors cannot submit any treatment authorization requests or claims to the Department using a National Provider Identifier (NPI) unless that NPI is appropriately registered to Debtors and is in compliance with all NPI requirements. *Id.*, ¶ 3, at 2.

(3) Debtors cannot engage in any conduct inimical to the public health, morals, welfare, and safety of any Medi-Cal beneficiary, or to the fiscal integrity of the Medi-Cal system." *Id.*, ¶ 4, at 2.

(4) Debtors cannot "exclude or deny aid, care, service, or other benefits available under Medi-Cal or in any other way discriminate against any Medi-Cal patients because of that person's race, color, ancestry, marital status, national origin, gender, age, economic status, physical or mental disability . . . ." *Id.*, ¶ 5, at 2.

(5) Health care services provided by Debtors must be by qualified personnel for conditions that cause "suffering, endanger life, result in illness or infirmity, interfere with capacity for normal activity, including employment, or for conditions which may develop into some significant handicap or disability." *Id.*, ¶ 6, at 2.

(6) Any overpayment must be repaid by Debtors in accordance with applicable federal and California statutes, regulations, and rules and policies of the Department, and the Department may recoup any overpayment from monies otherwise payable to Provider under the Agreement. *Id.*, ¶ 23, at 4.

(7) Debtors are subject to certain automatic and permissive suspensions and mandatory and permissive exclusions. *Id.*, ¶ 25, at 4.

Given the continuing nature of the duties imposed upon Debtors and the Department by both the Agreement and applicable law, Debtors' Agreements are executory contracts. Under the Agreements, Debtors must continue to comply with the express terms of the Agreement with regard to providing care to Medi-Cal beneficiaries and for conducting themselves as Medi-Cal providers, in order to avoid breaching the Agreement and remain in the Medi-Cal system as an authorized provider. Moreover, as the First Circuit found for Medicare provider agreements, Debtors' respective Agreement constitutes a single, ongoing, and integrated transaction. *In re Holyoke Nursing Home, Inc.*, 372 F.3d 1, 5 (1st Cir. 2004).

II. CASE LAW AFFIRMS THAT THE AGREEMENTS ARE EXECUTORY CONTRACTS

The Agreements are similar in many respects to the Medicare Provider Agreement. *In re Gardens*, 569 B.R. at 799 n.12. "A majority of bankruptcy courts considering the Medicare-provider relationship conclude that the Medicare provider agreement, with its attendant benefits and burdens, is an executory contract.") *In re Vitalsigns Homecare, Inc.*, 396 B.R. 232, 239 (Bankr. D. Mass. 2008) (citing *In re University Medical Center*, 973 F.2d 1065, 1075 and n.13 (3rd Cir. 199). "The [Medicare] Provider Agreement is a unique type of contract." *In re University Medical Center*, 973 F.2d at 1081 (quoting *University Medical Center*, 122 B.R. 919, 930 (E.D. Pa. 1990)). "The Medicare Provider Agreement is a contract providing for advance payments based on estimates and expressly permitting the withholding of overpayments from future advances." *In re Hefferman Memorial Hospital District*, 192 B.R. 228, 231 n. 4 (S.D. Cal. 1996). "Medicare provider agreements are executory in nature, calling for future performance by both parties until either party requests termination, and thus are subject to § 365." *University Medical Center*, 122 B.R. at 919.

Case law consistently holds that a Medicare provider agreement easily fits within this definition of executory contract. *In re Slater Health Center, Inc.*, 294

B.R. 423, 432 (Bankr. D. RI. 2003) (citing *In re University Medical Center*, 973 F.2d at 1075.) A Medicare provider agreement is an executory contract. *In re Hefferman Memorial Hospital District*, 192 B.R. at 231 n.4. Most courts have concluded that a provider agreement is an executory contract subject to assumption or rejection by a debtor-in-possession. [Internal citations omitted.]" *In re St. Johns Home Health Agency Co.*, 173 B.R. 238, 242 n.1 (S.D. Fl. 1994).

> As we conclude that Congress contemplated that the Medicare provider agreements would constitute a single, ongoing, and integrated transaction, the equitable powers of the bankruptcy court do not entitle it to second-guess Congress's implicit policy choices. *Both by statute and by contract* [emphasis added], the HCFA [Health Care Financing Administration] has the unqualified right to recoup those overpayments *in full* [original emphasis], and to return the funds to the public fisc, where they can be used to fund other facilities providing care to Medicare beneficiaries.

In re Holyoke Nursing Home, Inc., 372 F.3d at 5.

In re Monsour Medical Center involved the determination of the Medicare contractual relationship between a medical center and the government. The bankruptcy court found that the medical center and the government were parties to two executory contracts as of the date of the filing of the petition and approved the medical center's assumption of the executory contracts. *In re Memorial Hosp. of Iowa County, Inc.*, 82 B.R. 478, 482-483 (W. D. Wis. 1988) (explaining *In re Monsour Medical Center*).

In *In re Hefferman*, the bankruptcy court of the Southern District of California stressed:

> The Medicare Provider Agreement is a contract, providing for advance payments based on estimates and expressly permitting the withholding of overpayments from future advances. Most recoupment cases involve the *type of contract involved in this case* . . . .

In re Hefferman Memorial Hospital District, 192 B.R. at 231 n.4 (emphasis added).

Accordingly, given that courts have consistently held that Medicare Provider Agreements are executory contracts, Medi-Cal Provider Agreements are also executory contracts as the two agreements are similar in many respects. *In re*

Gardens Regional Hospital and Medical Center, Inc., 569 B.R. at 800, n.12.

III. THE AGREEMENTS CANNOT BE SOLD FREE AND CLEAR OF DEBT OWED TO MEDI-CAL UNDER 11 U.S.C. § 363

Debtors have erroneously argued that Medicare/Medi-Cal Provider Agreements provide them with a "statutory entitlement" to bill Medicare and Medi-Cal, which effectively makes the provider agreements akin to licenses to continue to participate in the Medicare and Medi-Cal programs. Because they are licenses, according to Debtors' erroneous analysis, the provider agreements can be sold as property of their estate, free and clear of any debt under 11 U.S.C. § 363(f).

Debtors have erroneously cited *Hollander* for the proposition that their relationship with Medicare or Medi-Cal is merely a "statutory relationship," rather than a contractual one. *Hollander v. Berezenoff*, 787 F.2d 834, 839 (2nd Cir. 1986). In *Hollander*, the Medicaid provider, a former licensed operator of several nursing homes that provided Medicaid services in New York State, claimed that it was undercompensated by the New York City Department of Social Services in violation of the Social Security Act and New York Medicaid statutes. On appeal, the provider asserted that its "provider agreements controll[ed] its relationship" with the New York City Department of Social Services. *Id.*, at 838. In response, the Second Circuit noted that "a provider must agree to the terms of these agreement in order to become a recognized health care facility under the Medicaid statutes, and while the Medicaid statute regulates the contents of these agreements, 42 U.S.C. § 1396a(a)(27), and gives providers a right to reimbursement, whatever rights a provider has arise exclusively from the executed Medicaid provider agreement." *Id.*, at 838 (citing *Green v. Cashman*, 605 F.2d 945, 946 (6th Cir. 1979).) As further noted by the Second Circuit, a "provider agreement may achieve a status of their own as contracts." *Hollander*, 787 F.2d at 838.

Nonetheless, the Medicaid provider agreement in *Hollander* did not contain any provision or language related to reimbursement rights. *Hollander*, 787 F.2d at

838. Without any specific reimbursement provision in the provider agreements from which the court could determine proper compensation, the Second Circuit defaulted to the statute to make that determination. In so doing, the Second Circuit merely explained that a provider's right may be "statutorily determined" if those rights are not explicitly provided for in the agreement." *Id.*, at 839. Accordingly, *Hollander* neither supports Debtors' position, nor does it undermine the well-established law that a Medicare or Medi-Cal Agreement is an executory contract.

In further support of their argument that Debtors have a statutory entitlement to bill Medicare and Medi-Cal because provider agreements are not contracts, Debtors cite *U.S. ex rel. Academy Health Center, Inc. v. Hyperion Foundation, Inc.*, 2014 WL 3385189 (S.D. Miss. 2014), *Maximum Care Home Health Agency v. HCFA, No. 3-97-CV-1451-R*, 1998 WL 901642 *5 (N.D. Tex. April 14, 1998), and *U.S. ex rel. Roberts v. Aging Care Home Health, Inc.*, 474 F. Supp. 2d 810 (W.D. La 2007). Debtors have also cited a bankruptcy court's order in *In re BDK Health Management, Inc.* as legal authority that they have statutory entitlements, not contractual rights, to bill Medicare and Medi-Cal. *In re BDK Health Management, Inc.*, 1998 WL 34188241 *6 (not reported in B.R.) (citing *Hollander v. Brezenoff*, 787 F.2d 838-839). Debtors' reliance upon these legal authorities is misplaced. The cited cases contravene the Ninth Circuit's holding that Medi-Cal providers have no statutory rights or entitlements to continue to participate in Medi-Cal, as further explained below. Also, those cases contradict the holdings by the Sixth Circuit (*Green v. Cashman*, 605 F.2d at 946) that provider agreements are contracts and whatever rights a Medicaid provider has arise "exclusively from a contract called a 'Provider' agreement," which was observed by the Second Circuit in *Hollander*.

The Ninth Circuit and other circuits have firmly held that providers are not entitled to continued participation in Medicare and Medicaid program (including

Medi-Cal). Accordingly, the providers have no statutory entitlement to continue to bill Medi-Cal. They lack a protectable property interest to do so.

If a benefit is a "matter of statutory entitlement for persons qualified to receive them," a property interest in that benefit is created. *Goldberg v. Kelly*, 397 U.S. 254, 262, 90 S. Ct. 1011, 25 L. Ed. 2d 287 (1970). Property interest arises from a statutory entitlement. *Southeast Kansas Community Action Program v. Secretary of Agriculture of the United States*, 967 F.2d 1452, 1457 (10th Cir. 1992). Food-stamp benefits are a matter of statutory entitlement for persons qualified to receive them, and thus are appropriately treated as a form of "property." *Atkin v. Parker*, 472 U.S. 115, 128, 105 S. Ct. 2520, 86 L. Ed. 2d 81 (1985). Statutory entitlement of eligible veterans to receipt of educational assistance constitute a property interest. *Devine v. Cleland*, 616 F. 2d 1080, 1086 (9th Cir. 1980). A state issued license for the continued pursuit of the licensee's livelihood creates a property interest. *Bell v. Burson*, 402 U.S. 535, 539, 91 S. Ct. 1586, 29 L. Ed. 2d 90 (1971).

The Tenth Circuit held that a Medicare provider such as a physician had no property interest in his eligibility for Medicare reimbursement. A provider is not the intended beneficiary of the Medicare program; thus, the provider has no protectable property interest in the Medicare program. *Koerpel v. Heckler*, 797 F.2d 858, 863-65 (10th Cir. 1986). Similarly, the First Circuit concluded that a provider has no protectable property interest in his participation in Medicare. *Cervoni v. Secretary of Health, Education and Welfare*, 581 F.2d 1010 (1st Cir. 1978).

In *Erickson v. United States Department of Health and Human Services*, the district court granted an injunction to plaintiffs, a Medicare provider, to prohibit the Secretary of Health and Human Services from excluding them from federally-funded health care programs. On appeal, the Ninth Circuit followed the reasoning of the First and Tenth Circuits in *Koerpel* and *Cervoni* and held that plaintiffs were

not entitled to the continued participation in Medicare/Medicaid programs. Plaintiffs failed to show entitlement, including statutory entitlement, for continued participation in those programs; therefore, they have no property interest in continued participation in those programs. *Erickson v. United States Department of Health and Human Services*, 67 F. 3d 858, 862 (9th Cir. 1995). Similarly, the California Court of Appeal in *Lin v. State of California*, 78 Cal. App. 4th 931 (Ct. App. 2012) held that providers of Medicare and Medicaid services have no protected interests in continued participation in those programs. *Id.*, at 935. Accordingly, Debtors' do not have any statutory entitlement to bill Medi-Cal. Instead, their ability to retain their Medi-Cal provider status and to provide Medi-Cal services and bill for those services, depends upon their ongoing fulfilment of duties and obligations required by the Agreements.

Consistent with the Ninth Circuit holding that providers have no property interests in their continued participation in Medicare or Medicaid, a bankruptcy court specifically declared that a Medicare Provider Agreement, and similarly, the Medi-Cal Provder Agreement, cannot be sold as an asset under 11 U.S.C. § 363, free and clear of any debt.

> Notwithstanding . . . anything in the Motion or Purchase Agreement to the contrary, *the Medicare Provider Agreement shall not be considered an "asset" that may be sold pursuant to section 363 of the Bankruptcy Code and shall be treated as an executory contract subject to the Assumption and Assignment Procedures*. Assumption and assignment of the Medicare Provider Agreement shall require, as a cure, successor liability on the part of the Buyer for liabilities under the Medicare Provider Agreement.

In re Berks Behavioral Health, LLC, 2010 WL 4922173, 7 (Bankr. E.D. Pa. 2010) (emphasis added).

Consistent with the First, Ninth, and the Tenth Circuits as well as the California Court of Appeal, Debtors' Agreements explicitly assert that no property interests exist in or to the providers' status (such that they can be sold as an asset under 11 U.S.C. § 363). Instead, the Agreements expressly state that any rights or

obligations associated with the Agreements, as executory contracts, may only be assigned and assumed with successor liability.

> Provider agrees that it has no property right in or to its status as a Provider in the Medi-Cal program or in or to the provider number(s) assigned to it, and that Provider may not assign its provider number for use as a Medi-Cal provider, or any rights or obligations it has under [the] Agreement, *except to the extent purchasing owner is joining this provider agreement with successor joint and several liability.*"

Vo Decl., Ex 5, ¶ 37, at 8, (emphasis added).

Aside from the fact that Debtors have no property interests to continue to participate in the Medi-Cal system, 11 U.S.C. § 363(f) does not allow Debtors to sell their Agreements free and clear of any debt or successor liability. Under 11 U.S.C. § 363(f), property can be sold free and clear of any interest in that property of an entity other than the estate, only if:

> (1) applicable nonbankruptcy law permits sale of such property free and clear of such interest;
> (2) such entity consents;
> (3) such interest is a lien and the price at which property is to be sold is greater than the aggregate value of all liens on such property;
> (4) such interest is in bona fide dispute; or
> (5) such entity can be compelled, in a legal or equitable proceeding, to accept a money satisfaction of such interest.

11 U.S.C. § 363(f).

Here, none of the above requisite elements of 11 U.S.C. § 363(f) apply. For the first criteria, as shown above, non-bankruptcy law does not permit sale of Debtors' Agreements as assets, free and clear of any debt. The Ninth Circuit specifically held that providers have no property interest in their continued participation in Medi-Cal. Accordingly, the Agreements make clear that Debtors have no property rights in or to their status as Medi-Cal Providers. Rather than being assets that can be sold, the Agreements and any rights and obligations therein can only be assigned with successor liability. Vo Decl., Exs. 4, ¶ 36, at 8.

With regard to second and third criteria, they are inapplicable because the Department has not consented to the sale of the Agreements as Debtor's assets or property and no lien interests are involved here.

For the fourth criteria, there is no bona dispute regarding the assumption and assignment of the Agreements with successor liability. "A bona fide dispute exists when there is an objective basis for either factual or legal dispute as to the validity of an interest in property." *In re Octagon Roofing*, 123 B.R. 583, 590 (Bankr. N.D. Ill. 1991). As shown above, both the Debtors and the Buyer know and acknowledge in the APA that the Agreements can only be assumed and assigned with the Department's agreement. APA, § 8.8, ECF No. 365-1, Ex. A.

For the fifth criteria, the Department cannot be compelled to accept a money satisfaction in exchange for its rights to prevent a sale of Debtors' Medi-Cal provider status or Debtors' benefits, duties and obligations under the Agreements.

Accordingly, Debtors cannot sell their Medi-Cal Provider Agreements, free and clear of any debt under 11 U.S.C. § 363(f). The Agreements can only be assumed and assigned with successor liability.

IV. THE AGREEMENTS, AS EXECUTORY CONTRACTS, REQUIRE CURE OF DEFAULTS AND DEBTS

It is well settled that the curing of all defaults is an essential pre-condition to assumption of a contract under 11 U.S.C. § 365(b). "Cure is a critical component of assumption." *In re: Thane International, Inc. v. 9472541 Canada Inc.*, 586 B.R. 540, 549 (Bankr. D. Del. 2018). When an executory contract is assumed, valid claims for default must be cured by the debtor. *In re Memorial Hospital of Iowa County, Inc.*, 82 B.R. 478, 481 (Bankr. W.D. Wis. 1988).

Accordingly, all HQA Fee debt and other debts to the Department must be paid by Debtors or be assumed jointly and severally by the Buyer.

V. DEBTORS' AGREEMENTS REQUIRE SUCCESSOR LIABILITY BY THE BUYER

A party must accept the contract as a whole, meaning that a party cannot choose to accept the benefits of the contract and reject its burdens to the detriment of the other party to the agreement. *Richmond Leasing Co. v. Capital Bank, N.A.*, 762 F.2d 1303, 1311 (5th Cir. 1985) (citing *In re Holland*, 25 B.R. 301). It is axiomatic that an assumed contract under 11 U.S.C. § 365 is accompanied by its provisions and conditions. *In re Holland*, 25 B.R. at 303 (citing *Atchison, Topeka & Santa Fe Ry Co. v. Hurley*, 153 F. 403 (8th Cir. 1907), aff'd 213 U.S. 126, 29 S. Ct. 466, 53 L. Ed. 729 (1909)). "Assumption or rejection of an executory contract requires an all-or-nothing commitment going forward, and then a debtor cannot assume part of an executory contract in the future while rejecting another part." *In re St. Mary Hospital*, 89 B.R. 503, 509 (E.D. Pa. 1988).

An executory contract must be assumed or rejected *in toto*. *In re Holland*, 25 B.R. at 303. "To hold otherwise, would construe the bankruptcy law as providing a debtor in bankruptcy with greater rights and powers under a contract than the debtor had outside the bankruptcy." *Id.* (citing *In re Nashville White Trucks, Inc.*, 5 B.R. 112, 117 (Bankr. M.D. Tenn.)).

> The Court remains cognizant of the legislative purpose behind section 365. This provision vests the bankruptcy court with a unique power designed to facilitate the rehabilitation of debtors. Nevertheless, a debtor may not retreat to this provision, derived from the inherent equitable powers of the bankruptcy courts, to avoid an obligation while it enjoys a benefit which arises in conjunction with that obligation.

In re Holland, 25 B.R. at 303.

Accordingly, if the Buyer assumes the Agreements, then the Buyer will be held jointly and severally liable for any debt owed by Debtors to the Department, including unpaid HQA Fees and any Medi-Cal overpayments to Debtors, as Debtors' Agreements specifically mandate. In addition, under the Agreements, the Buyer will be subject to Department's recoupment for any unpaid HQA Fees and

Medi-Cal overpayments owed by Debtors. 11 U.S.C. § 365. "It is hornbook law that a debtor cannot assume the benefits of an executory contract while rejecting the burdens." *In re Tidewater Memorial Hospital, Inc.*, 106 B.R. 876, 884 n.9 (Bankr. E.D. Va. 1989).

If Debtors are allowed to sell, transfer, and assign the Agreements, as licenses, without paying their HQA Fee liabilities or requiring the Buyer to assume those liabilities jointly and severally, then Debtors and the Buyer would be allowed to divorce the benefits from the burdens of the Agreements and undermine the HQA Fee system. They would receive the benefits of Debtors' Agreements including Medi-Cal service payments and quality assurance payments, while disregarding the obligations of the same Agreements, including successor liability for any HQA Fee debt and other debts incurred by Debtors to the Department. The Court should not permit such a result.

VI. THE DEPARTMENT OPPOSES WAIVER OF THE 14-DAY STAY OF ANY SALE ORDER

Bankruptcy Rule 6004(h) provides that an "order authorizing the use, sale or lease of property . . . is stayed until the expiration of 14 days after the entry of the order, unless the court orders otherwise." The Department objects to the requested waiver of the 14-day stay of the order on the Motion. The purpose of the Rule 6004(h) stay is to provide sufficient time for an objecting party to appeal before an order can be implemented. See Advisory Committee Notes to Fed. R. Bankr. P. 6004(h) and 6006(d). Because the payment of the QA Fee and Medi-Cal overpayment is a significant public concern involving millions of dollars, the Department will need the full 14-day period to appeal the order, if necessary.

CONCLUSION

For the foregoing reasons, the proposed APA, to transfer the Agreements as licenses, without cure of the debts to the Department and without joint and several liability, cannot be approved by this Court. Debtors must assume and assign the

Agreements and pay the HQA Fee debt and other debts to the Department. Otherwise, the Buyer must be ordered to be held jointly and severally liable for those debts under assumption and assignment of the Agreements.

Dated: September 11, 2019

Respectfully submitted,

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IN THE UNITED STATES BANKRUPTCY COURT

CENTRAL DISTRICT OF CALIFORNIA – LOS ANGELES DIVISION

In re: **VERITY HEALTH SYSTEM OF CALIFORNIA, INC., et al.,** Debtor and Debtors In Possession.	CASE NO. 2:18-bk-20151-ER **DECLARATION OF HANH VO IN SUPPORT OF CREDITOR CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES'S SUPPLEMENTAL OBJECTION TO (1) DEBTORS' MOTION FOR THE ENTRY OF AN ORDER AUTHORIZING THE SALE OF PROPERTY FREE AND CLEAR OF ALL CLAIMS, LIENS, AND ENCUMBRANCES; (2) APPROVING FORM OF ASSET PURCHASE AGREEMENT** Hearing: TBD Time: TBD Courtroom: 1568 Judge Ernest M. Robles
/x/ Affects All Debtors. Affects Verity Health System of California, Inc. Affects O'Connor Hospital Affects Saint Louise Regional Hospital Affects St. Francis Medical Center Affects St. Vincent Medical Center Affects Seton Medical Center Affects O'Connor Hospital Foundation	

Affects Saint Louise Regional Hospital Foundation
Affects St. Francis Medical Center of Lynwood Foundation
Affects St. Vincent Foundation
Affects St. Vincent Dialysis Center, Inc.
Affects Seton Medical Center Foundation
Affects Verity Business Services
Affects Verity Medical Foundation
Affects Verity Holdings, LLC
Affects De Paul Ventures, LLC
Affects De Paul Ventures – San Jose Dialysis, LLC,

Debtors and Debtors in Possession.

I, Hanh Vo, declare:

1. I am currently a Staff Services Manager III, serving as Chief of the General Collections Branch of the Third Party Liability and Recovery Division of the California Department of Health Care Services (Department). I have been employed by the Department since September 2007. In that capacity, I have personal knowledge of the matters stated herein.

2. My responsibilities as Staff Services Manager III, Chief of the General Collections Branch, include management oversight of all activities performed by three collection units of the Department, the Quality Assurance Fee (QAF) Units A & B, and the Overpayments Unit.

3. Attached as Exhibit 1 to this declaration is a true and correct copy of the Medi-Cal Provider Agreement for St. Vincent Medical Center, Inc., which was executed on or about October 15, 2009.

4. Attached as Exhibit 2 to this declaration is a true and correct copy of the Medi-Cal Provider Agreement for St. Francis Medical Center, which was executed on or about August 16, 2010.

5. Attached as Exhibit 3 to this declaration is a true and correct copy of the Medi-Cal Provider Agreement for Seton Medical Center, which was executed

on or about October 2010.

6. Attached as Exhibit 4 to this declaration is a true and correct copy of the Medi-Cal Provider Agreement for Saint Vincent Dialysis Center, Inc., which was executed on or about March 7, 2011.

7. Attached as Exhibit 5 is a true and correct copy of the sample Medi-Cal Provider Agreement that was in effect in or about 2009 through 2011.

8. Based upon my personal knowledge and having reviewed Exhibits 1 through 5, I know that the substantive terms and provisions contained in these Medi-Cal Provider Agreements are similar.

9. I have reviewed the attached Hospital Quality Assurance Fee (HQA Fee) debt summaries for St. Vincent Medical Center, Inc., for St. Francis Medical Center, and for Seton Medical Center, which were prepared at my direction.

10. The calculation of the HQA Fee debt for these three hospitals is based upon the HQA Fee model.

11. The HQA Fee debt summaries are divided into six columns, which are described below:

(A) FISCAL YEAR – This term refers to the fiscal year period. The HQA Fee fiscal year is from July 1 through June 30.

(B) CYCLE (PERIOD) – This term refers to the period included under each HQA Fee payment cycle. HQA Fee cycles for Medi-Cal fee-for-service system are quarterly, and HQA Fee cycles for Medi-Cal Managed Care system cover all or the portion of the fiscal year included in the program phase.

(C) AMOUNT DUE – This term refers to the amount owed by the Debtor as determined by the HQA Fee model.

(D) AMOUNT PAID – This term refers to the amount from the Debtor applied to the AMOUNT DUE of a particular HQA Fee PERIOD.

(E) WITHHELD – This term refers to the amount collected through Medi-

Cal claims offset from the Debtor's Medi-Cal check writes and applied to the AMOUNT DUE of a PERIOD.

(F) OUTSTANDING BALANCE – This term refers to the amount of the HQA Fee debt that remains owed by the Debtor.

12. With regard to the noted amounts due for the Managed Care cycles, the amounts stated are estimates and are subject to change based upon Medi-Cal Managed Care utilization at the time of payment and fee liability from Medi-Cal fee-for-service reconciliation activities of the prior program period.

13. Based upon my review of the attached HQA Fee debt summaries, I certify that total amount of HQA Fee debt for St. Vincent Medical Center (NPI No. 1124004304 and OSHPD No. 106190762) for Phase V (January 1, 2017 through June 30, 2019) is $6,565,679.74, for Seton Medical Center (NPI No. 1154428688, OSHPD No. 106410817) for Phase V is $16,927,759.87, and for St. Francis Medical Center (NPI No. 148769215, OSPHD No. 106190754) for Phase V is $3,835,489.67.

14. A true and correct copy of the debt summaries for St. Vincent Medical, Seton Medical Center and St. Francis Medical Center is attached to this declaration as Exhibit 6.

15. For July 1, 2016, through June 30, 2017, the Department has determined, based on retroactive claim adjustments, that St. Francis was overpaid **$24,254,503.36** by Medi-Cal for hospital operations.

16. Further, for July 1, 2016, through June 30, 2017, the Department has determined, based on retroactive claim adjustments, that Seton Medical Center was overpaid **$4,205.25** by Medi-Cal for hospital operations.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on this 10th day of September 2019, at Sacramento, California.

Hanh Vo

EXHIBIT 1

BOX NO.. 5048 Number of Pages: 8

SCAN ONLY COVER SHEET

Submitted By: Gerred B Smith Date: 6/23/10

PLEASE SCAN THE FOLLOWING DOCUMENTS TO:

Group/Provider Name: St. Vincent Medical Center

Main Provider Number: (Or NPI number) 1124004304

Other Provider Number(s):

PED Document Number: 399285

✓ **CHECK the appropriate Doc Type/Alias title below to indicate where document should be scanned. Attach this form to the document and place in the SCAN ONLY BOX.**

	DOC TYPE	ALIAS		DOC TYPE	ALIAS
☐	Address Change	ADDRCHNG	☐	Provider Master File Screen Shot	PMFSCRN
☐	Application	APP	☐	Procedure Code	PROCODE
☐	Archive File	ARCHIVE FILE	☐	Rates	RATES
☐	CCS/GHPP & CHDP	CCS/GHPP& CHDP	☐	Re-Enrollment	RECORR
☐	CD173 (returned warrant)	CD173	☐	Returned Mail	RTNMAIL
☐	Change of Ownership	CHOW	☐	Scanned Document	SCANNED
☐	CMC Agreements	CMC	☐	Settlement Agreement	STLMNT
☐	Correspondence	CORR	☐	State Controller's Office Letter	SCOLETTER
☐	Deactivation	DEACTREQUEST	☐	Special Claims Review/Provider Prior Authorization	SCRPPA
☐	Deficiency Letter	DEFLTR			
☐	Denial/Denied/Appeal	DENIED	☐	Status Change	STATCNG
☐	E-Mail	EMAIL	☐	Supplemental Application	SUPAPP
☐	Family Pact	FPACT	☐	Surety Bonds	SURETY
☐	Gatekeeper Request	GATEKPRRQUEST	☐	Suspended & Ineligible/Appeal	SUSPINE
☐	Letter	LETTER	☐	Temp Suspension Request	TEMPSUSPREQUT
☐	Local Education	LEA	☐	Vehicle	VEHICLE
☐	Memo	MEMO	☐	Withdrawal Request	WITHDRAWL
☐	Miscellaneous	MISC	☐	Withhold	WITHHOLD
☐	Moratorium	MORTRM	☐	Watermark Converted	WMCONVERT
☐	Non Provider	NONPROVIDER	☐	X-Reference	XREF
☐	Old PEEPS Converted	OLDPEERS	☒	Other	OTHER

ALL DOCUMENTS NOT COMPLETELY FILLED OUT WILL BE RETURNED

PROVIDER MASTER INQUIRY LOCATION DETAIL PSS070

PROVIDER: [illegible] OWNER NO: 01 LOCATION: 001

LEGAL NAME: ST VINCENT MEDICAL CTR

BUSINESS NAME: ST VINCENT MEDICAL CTR TELEPHONE NO: 213-484-7111

	PAY TO ADDRESS	SERVICE ADDRESS	MAIL TO ADDRESS
ATT:			
LN1:	FILE #52675	2131 W 3RD ST	2131 W 3RD ST
LN2:			
CTY:	LOS ANGELES	LOS ANGELES	LOS ANGELES
ST:	CA ZIP: 90074 - 2675	CA ZIP: 90057 - 1901	CA ZIP: 90057 - 1901

DATA FROM ADDRESS DATABASE

LN1:			
LN2:			
CTY:			
ST:	ZIP: -	ZIP: -	ZIP: -

COUNTY CODE: 19
MAIL ADDRESS IND: Q
CON AREA IND: C
FAC ADMINSTRATOR: BRIAN CONNOLLY

DATABASE COUNTY:
OUT OF STATE: 0
EFF DATE: 04/01/1983

PSRO REGION CODE: 24
END DATE: 12/31/2069

PF3=RETURN PF4=PROVIDER DETAIL CLEAR=MENU

Mailing & Pay to

399285

MEDI-CAL PROVIDER AGREEMENT
(Institutional Provider)
(To Accompany Applications for Enrollment)*

FOR STATE USE ONLY

GACH
05-0502

Do not use staples on this form or on any attachments.
Type or print clearly in ink. If you must make corrections, please line through, date, and initial in ink.
Do not leave any questions, lines, etc. blank. Enter N/A if not applicable to you.

Date: 10-15-09

Legal name of applicant or provider (as listed with the IRS)	Business name (if different than legal name)		
St. Vincent Medical Center, Inc.	St. Vincent Medical Center		
Provider number (NPI number)		Business Telephone Number	
1124004304 SV		(213) 484 - 7111	
Business address (number, street)	City	State	Nine-digit ZIP code
2131 West Third Street	Los Angeles	CA	90057-0992
Mailing address (number, street, P.O. Box number)	City	State	Nine-digit ZIP code
P.O. Box 57992	Los Angeles	CA	90057-0992
Pay-to address (number, street, P.O. Box number)	City	State	Nine-digit ZIP code
2131 West Third Street	Los Angeles	CA	90057-0992
Previous business address (number, street, P.O. Box number)	City	State	Nine-digit ZIP code
N/A			
Taxpayer Identification Number**			
91-2154438			

EXECUTION OF THIS PROVIDER AGREEMENT BETWEEN AN APPLICANT OR PROVIDER (HEREINAFTER JOINTLY REFERRED TO AS "PROVIDER") AND THE DEPARTMENT OF HEALTH CARE SERVICES (HEREINAFTER "DHCS"), IS MANDATORY FOR PARTICIPATION OR CONTINUED PARTICIPATION AS A PROVIDER IN THE MEDI-CAL PROGRAM PURSUANT TO 42 UNITED STATES CODE, SECTION 1396a(a)(27), TITLE 42, CODE OF FEDERAL REGULATIONS, SECTION 431.107, WELFARE AND INSTITUTIONS CODE, SECTION 14043.2, AND TITLE 22, CALIFORNIA CODE OF REGULATIONS, SECTION 51000.30(a)(2).

AS A CONDITION FOR PARTICIPATION OR CONTINUED PARTICIPATION AS A PROVIDER IN THE MEDI-CAL PROGRAM, PROVIDER AGREES TO COMPLY WITH ALL OF THE FOLLOWING TERMS AND CONDITIONS, AND WITH ALL OF THE TERMS AND CONDITIONS INCLUDED ON ANY ATTACHMENT(S) HERETO, WHICH IS/ARE INCORPORATED HEREIN BY REFERENCE:

1. **Term and Termination.** This Agreement will be effective from the date applicant is enrolled as a provider by the Department of Health Care Services (DHCS), or, from the date provider is approved for continued enrollment. This agreement may be terminated for cause if the Provider is suspended/excluded from further participation in the Medi-Cal program unless and until such time as Provider is re-enrolled by DHCS in the Medi-Cal program. This agreement may be terminated for cause if Provider is suspended/excluded for any of the reasons set forth in Paragraph 27(a) below, which termination will result in Provider's immediate disenrollment and exclusion (without formal hearing under the Administrative Procedures Act) from further participation in the Medi-Cal program. During any period in which the provider is on provisional provider status or preferred provisional provider status, DHCS may terminate this agreement for any of the grounds stated in Welfare and Institutions Code Section 14043.27(c).

2. **Compliance With Laws and Regulations.** Provider agrees to comply with all applicable provisions of Chapters 7 and 8 of the Welfare and Institutions Code (commencing with Sections 14000 and 14200), and any applicable rules or regulations promulgated by DHCS pursuant to these Chapters. Provider further agrees that if it violates any of the provisions of Chapters 7 and 8 of the Welfare and Institutions Code, or any other regulations promulgated by DHCS pursuant to these Chapters, it may be subject to all sanctions or other remedies available to DHCS. Provider further agrees to comply with all federal laws and regulations governing and regulating Medicaid providers.

RECEIVED
OCT 21 2009

* Every applicant and provider must execute this Provider Agreement.
** The taxpayer identification number may be a Taxpayer Identification Number (TIN) or a social security number for sole proprietors.

11. **Confidentiality of Beneficiary Information.** Provider agrees that all medical records of beneficiaries made or acquired by Provider shall be confidential and shall not be released without the written consent of the beneficiary or his/her personal representative, or as otherwise authorized by law.

12. **Disclosure of Information to DHCS.** Provider agrees to disclose all information as required in Federal Medicaid laws and regulations and any other information required by DHCS, and to respond to all requests from DHCS for information. Provider further agrees that the failure of Provider to disclose the required information, or the disclosure of false information shall, prior to any hearing, result in the denial of the application for enrollment or shall be grounds for termination of enrollment status or suspension from the Medi-Cal program, which shall include deactivation of all provider numbers used by Provider to obtain reimbursement from the Medi-Cal program. Provider further agrees that all bills or claims for payment to DHCS by Provider shall not be due and owing to Provider for any period(s) for which information was not reported or was reported falsely to DHCS. Provider further agrees to reimburse those Medi-Cal funds received during any period for which information was not reported, or reported falsely, to DHCS.

13. **Background Check.** Provider agrees that DHCS may conduct a background check on Provider for the purpose of verifying the accuracy of the information provided in the application and in order to prevent fraud or abuse. The background check may include, but not be limited to, the following: (1) on-site inspection prior to enrollment; (2) review of medical and business records; and, (3) data searches.

14. **Unannounced Visits By DHCS, CDPH, AG and Secretary.** Provider agrees that DHCS, CDPH, AG and/or Secretary may make unannounced visits to Provider, at any of Provider's business locations, before, during or after enrollment, for the purpose of determining whether enrollment, continued enrollment, or certification is warranted, to investigate and prosecute fraud against the Medi-Cal program, to investigate complaints of abuse and neglect of patients in health care facilities receiving payment under the Medi-Cal program, and/or as necessary for the administration of the Medi-Cal program and/or the fulfillment of the AG's powers and duties under Government Code Section 12528. Premises subject to inspection include billing agents, as defined in Welfare and Institutions Code Section 14040.1. Failure to permit inspection by DHCS, CDPH, AG or Secretary or any agent, investigator or auditor thereof, shall be grounds for immediate suspension of provider from participation in the Medi-Cal program.

15. **Provider Fraud and Abuse.** Provider agrees that it shall not engage in or commit fraud or abuse. "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or herself or some other person. It includes any act that constitutes fraud under applicable federal or state law. "Abuse" means either: (1) practices that are inconsistent with sound fiscal or business practices and result in unnecessary cost to the Medicare program, the Medi-Cal program, another state's Medicaid program, or other health care programs operated, or financed in whole or in part, by the Federal Government or any state or local agency in this state or any other state; (2) practices that are inconsistent with sound medical practices and result in reimbursement by the Medi-Cal program or other health care programs operated, or financed in whole or in part, by the Federal Government or any state or local agency in this state or any other state, for services that are unnecessary or for substandard items or services that fail to meet professionally recognized standards for health care.

16. **Investigations of Provider for Fraud or Abuse.** Provider certifies that, at the time this Agreement was signed, it was not under investigation for fraud or abuse pursuant to Subpart A (commencing with Section 455.12) of Part 455 of Title 42 of the Code of Federal Regulations or under investigation for fraud or abuse by any other government entity. Provider further agrees to notify DHCS within ten business days of learning that it is under investigation for fraud or abuse. Provider further agrees that it shall be subject to temporary suspension pursuant to Welfare and Institutions Code, Section 14043.36(a), which shall include temporary deactivation of all provider numbers used by Provider to obtain reimbursement from the Medi-Cal program, if it is discovered that Provider is under investigation for fraud or abuse. Provider further agrees to cooperate with and assist DHCS and any state or federal agency charged with the duty of identifying, investigating, sanctioning, or prosecuting suspected fraud and abuse.

17. **Provider Fraud or Abuse Convictions and/or Civil Fraud or Abuse Liability.** Provider certifies that it and its owners, officers, directors, employees, and agents, has not: (1) been convicted of any felony or misdemeanor involving fraud or abuse in any government program, within the last ten years; or (2) been convicted of any felony or misdemeanor involving the abuse of any patient; or (3) been convicted of any felony or misdemeanor substantially related to the qualifications, functions, or duties of a provider; or (4) entered into a settlement in lieu of conviction for fraud or abuse, within the last ten years; or, (5) been found liable for fraud or abuse in any civil proceeding, within the last ten years. Provider further agrees that DHCS shall not enroll Provider if within the last ten years, Provider has been convicted of any felony or any misdemeanor involving fraud or abuse in any government program, has entered into a settlement in lieu of conviction for fraud or abuse, or has been found liable for fraud or abuse in any civil proceeding.

or managing employees of the provider have been convicted of any felony or misdemeanor involving fraud or abuse in any government program related to neglect of health care in connection with the delivery of a health care item or service, or in connection with the interference with, or obstruction of, any investigation into health care related fraud or abuse, or have been found liable for fraud or abuse in any civil proceeding, or have entered into a settlement in lieu of conviction for fraud or abuse in any government program within 10 years of the date of the application package.

b. There is a material discrepancy in the information provided to the department, or with the requirements to be enrolled, that is discovered after provisional provider status or preferred provisional provider status has been granted and that cannot be corrected because the discrepancy occurred in the past.

c. The provider has provided material information that was false or misleading at the time it was provided.

d. The provider failed to have an established place of business at the business address for which the application package was submitted at the time of any onsite inspection, announced or unannounced visit, or any additional inspection or review conducted pursuant to this article or a statute or regulation governing the Medi-Cal program, unless the practice of the provider's profession or delivery of services, goods, supplies, or merchandise is such that services, goods supplies, or merchandise are rendered or delivered at locations other than the business address and this practice of delivery of services, goods, supplies, or merchandise has been disclosed in the application package approved by the department when the provisional provider status of preferred provisional provider status was granted.

e. The provider meets the definition of a clinic under Section 1200 of the Health and Safety Code, but is not licensed as a clinic pursuant to Chapter 1 (commencing with Section 1200) of Division 2 of the Health and Safety Code and fails to meet the requirements to qualify for at least one exemption pursuant to Section 1206 or 1206.1 of the Health and Safety Code.

f. The provider performs clinical laboratory tests or examinations, but it or its personnel do not meet CLIA, and the regulations adopted thereunder, and the state clinical laboratory law, do not possess valid CLIA certificates and clinical laboratory registrations or licenses pursuant to Chapter 3 (commencing with Section 1200) of Division 2 of the Business and Professions Code, or are not exempt from licensure as a clinical laboratory under Section 1241 of the Business and Professions Code.

g. The provider fails to possess either of the following:

(1) The appropriate licenses, permits, certificates, or other approvals needed to practice the profession or occupation, or provide the services, goods, supplies, or merchandise the provider identified in the application package approved by the department when the provisional provider status or preferred provisional provider status was granted and for the location for which the application was submitted.

(2) The business or zoning permits or other approval necessary to operate a business at the location identified in its application package approved by the department when the provisional provider status or preferred provisional provider status was granted.

h. The provider, or if the provider is a clinic, group, partnership, corporation, or other association, any officer, director, or shareholder with a 10 percent or greater interest in that organization, commits two or more violations of the federal or state statutes or regulation governing the Medi-Cal program, and the violations demonstrate a pattern or practice of fraud, abuse, or provision of unnecessary or substandard medical services.

i. The provider commits any violation of a federal or state statute or regulation governing the Medi-Cal program or of a statute or regulation governing the provider's profession or occupation and the violation represents a threat of immediate jeopardy or significant harm to any Medi-Cal beneficiary or to the public welfare.

j. The provider submits claims for payment that subject a provider to suspension under Section 14043.61.

k. The provider submits claims for payment for services, goods, supplies, or merchandise rendered at a location other than the location for which the provider number was issued, unless the practice of the provider's profession or delivery of services, goods, supplies, or merchandise is such that services, goods, supplies, or merchandise are rendered or delivered at locations other than the business address and this practice or delivery of services, goods, supplies, or merchandise has been disclosed in the application package approved by the department when the provisional provider status was granted.

(4) When necessary to protect the public welfare or the interests of the Medi-Cal program. Administrative appeal pursuant to Health and Safety Code, Section 1007 1, Welfare and Institutions Code Section 14123(c)).

(5). Provider submits claims for payment under any provider number from an individual or entity that is suspended, excluded or otherwise ineligible. This includes a provider on the Suspended and Ineligible Provider List or any list published by the Office of the Inspector General or the Department of Health and Human Services. Appeal pursuant to Welfare and Institutions Code, Section 14043.65. (Welfare and Institutions Code, Section 14043.61).

28. **Provider Termination, Imposition of Federal Sanctions, and Appeal Rights for Long Term Care Facilities.** Provider agrees that it is subject to any federal sanctions authorized under the state plan including termination of this provider agreement in accordance with federal law. Provider further agrees that the termination of this provider agreement or imposition of other federal sanctions authorized under the state plan shall include deactivation of all of Provider's provider numbers and shall preclude Provider from submitting claims for payment either personally or through claims submitted by any individual, clinic, group, corporation, or other association to the Medi-Cal program for any services, supplies, goods, or merchandise that provider has provided directly or indirectly to a Medi-Cal beneficiary, except for services, supplies, goods, or merchandise provided prior to the termination or imposition of sanctions.

    a. **Skilled Nursing Facility and Intermediate Care Facility Appeal Procedures.** SNF and ICF Medi-Cal Providers shall have the appeal rights set forth in Article 1.6 of Chapter 3 of Division 3 of Title 22.

    b. **Intermediate Care Facilities-Mental Retardation Appeal Procedures.** Intermediate Care Facilities-Developmentally Disabled; Intermediate Care Facilities-Developmentally Disabled-Habilitative; Intermediate Care Facilities-Developmentally Disabled-Nursing shall have the appeal rights set forth in 42 CFR 431.153 and 431.154.

29. **Liability of Group Providers.** Provider agrees that, if it is a provider goup, the group, and each member of the group, are jointly and severally liable for any breach of this Agreement, and that action against any of the providers in the provider group may result in action against all of the members of the provider group.

30. **Legislative and Congressional Changes.** Provider agrees that this Agreement is subject to any future additional requirements, restrictions, limitations, or conditions enacted by the California Legislature or the United States Congress which may affect the provisions, terms, conditions, or funding of this Agreement in any manner.

31. **Provider Capacity.** Provider agrees that Provider, and the officers, directors, employees, and agents of Provider, in the performance of this Agreement, shall act in an independent capacity and not as officers or employees or agents of the State of California.

A provider agrees that compliance with the provisions of this agreement is a condition of participation to provider

The parties agree that this agreement is a legal and binding document and is fully enforceable in a court of competent jurisdiction. The provider signing this agreement warrants that he/she has read this agreement and understands it.

I declare under penalty of perjury under the laws of the State of California that the foregoing information is true, accurate, and complete to the best of my knowledge and belief.

I declare I am the provider or I have the authority to legally bind the provider, which is an entity and not an individual person.

St. Vincent Medical Center, Inc.

1. Printed legal name of provider

Cathy Ficken

2. Printed name of person signing this declaration on behalf of provider (if an entity or business name is listed in item 1 above)

3. Original signature of provider or representative if this provider is an entity other than an individual person as sole proprietor

President/CEO

4. Title of person signing this declaration

5. Notary Public (Affix notary seal or stamp in the space below)

See Attached California ~~Acknowelegement~~ Acknowlegement

Executed at: _____ (City), _____ (State) on _____ (Date)

Applicants and providers licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act, or the Chiropractic Initiative Act ARE NOT REQUIRED to have this form notarized. If notarization is required, the Certificate of Acknowledgement signed by the Notary Public must be in the form specified in Section 1189 of the Civil Code.

6. Contact Person's Information

☐ Check here if you are the same person identified in Item 2. If you checked the box, provide only the email address and phone number below.

Contact Person's Name (last) (first) (middle) (gender)

☐ Male ☐ Female

Title/Position | CathyFicken@dochs.org Email address | 213-484-7111 Telephone Number

Privacy Statement
(Civil Code Section 1798 et seq.)

All information requested on the application, the disclosure statement, and the provider agreement is mandatory with the exception of the social security number for any person other than the person or entity for whom an IRS Form 1099 must be provided by the Department pursuant to 26 USC 6041. This information is required by the Department of Health Care Services, Provider Enrollment Division, by the authority of Welfare and Institutions Code Section 14043.2(a) The consequences of not supplying the mandatory information requested are denial of enrollment as a Medi-Cal provider or denial of continued enrollment as a provider and deactivation of all provider numbers used by the provider to obtain reimbursement from the Medi-Cal program. The consequence of not supplying the voluntary social security number information requested is delay in the application process while other documentation is used to verify the information supplied. Any information provided will be used to verify eligibility to participate as a provider in the Medi-Cal program. Any information may also be provided to the State Controller's Office, the California Department of Justice, the Department of Consumer Affairs, the Department of Corporations, or other state or local agencies as appropriate, fiscal intermediaries, managed care plans, the Federal Bureau of Investigation, the Internal Revenue Service, Medicare Fiscal Intermediaries, Centers for Medicare and Medicaid Services, Office of the Inspector General, Medicaid, and licensing programs in other states.

CALIFORNIA ALL-PURPOSE ACKNOWLEDGMENT

State of California
County of Los Angeles }

On 15 Oct 2009 (Date) before me, Robert S. Yesko, Notary Public (Here Insert Name and Title of the Officer)

personally appeared Cathy Fickes (Name(s) of Signer(s))

who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

ROBERT S. YESKO
Commission # 1742089
Notary Public - California
Los Angeles County
My Comm. Expires May 16, 2011

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature Robert S. Yesko Notary Public
(Signature of Notary Public)

Place Notary Seal Above

OPTIONAL

Though the information below is not required by law, it may prove valuable to persons relying on the document and could prevent fraudulent removal and reattachment of this form to another document.

Description of Attached Document

Title or Type of Document: Medi-Cal Provider Agreement

Document Date: 15 Oct 2009 Number of Pages: 2+9 Information -Typed/Signature 9 pages

Signer(s) Other Than Named Above: NONE

Capacity(ies) Claimed by Signer(s)

Signer's Name: Cathy Fickes
☐ Individual
☒ Corporate Officer — Title(s): President/CEO
☐ Partner — ☐ Limited ☐ General
☐ Attorney in Fact
☐ Trustee
☐ Guardian or Conservator
☐ Other:
Signer is Representing: St Vincent Medical Center, Los Angeles

RIGHT THUMBPRINT OF SIGNER
Top of thumb here

Signer's Name:
☐ Individual
☐ Corporate Officer — Title(s):
☐ Partner — ☐ Limited ☐ General
☐ Attorney in Fact
☐ Trustee
☐ Guardian or Conservator
☐ Other:
Signer is Representing:

RIGHT THUMBPRINT OF SIGNER
Top of thumb here

EXHIBIT 2

MEDI-CAL PROVIDER AGREEMENT
(Institutional Provider)
(To Accompany Applications for Enrollment)*

FOR STATE USE ONLY

55-5238

Date

Do not use staples on this form or on any attachments.
Type or print clearly in ink. If you must make corrections, please line through, date, and initial in ink.
Do not leave any questions, lines, etc. blank. Enter N/A if not applicable to you.

Legal name of applicant or provider (as listed with the IRS)	Business name (if different than legal name)
St. Francis Medical Center	ST. FRANCIS MEDICAL CENTER D/P SNF

Provider number (NPI number)	Business Telephone Number
1487697215(Acute); 1245227180(SNF)	(310) 900-8900

Business address (number, street)	City	State	Nine-digit ZIP code
3630 E. Imperial Highway	Lynwood	CA	90262
Mailing address (number, street, P.O. Box number)	**City**	**State**	**Nine-digit ZIP code**
3630 E. Imperial Highway	Lynwood	CA	90262
Pay-to address (number, street, P.O. Box number)	**City**	**State**	**Nine-digit ZIP code**
File #56850	Los Angeles	CA	90074
Previous business address (number, street, P.O. Box number)	**City**	**State**	**Nine-digit ZIP code**
N/A	N/A	N/A	N/A

Taxpayer Identification Number**
91-2154439

EXECUTION OF THIS PROVIDER AGREEMENT BETWEEN AN APPLICANT OR PROVIDER (HEREINAFTER JOINTLY REFERRED TO AS "PROVIDER") AND THE DEPARTMENT OF HEALTH CARE SERVICES (HEREINAFTER "DHCS"), IS MANDATORY FOR PARTICIPATION OR CONTINUED PARTICIPATION AS A PROVIDER IN THE MEDI-CAL PROGRAM PURSUANT TO 42 UNITED STATES CODE, SECTION 1396a(a)(27), TITLE 42, CODE OF FEDERAL REGULATIONS, SECTION 431.107, WELFARE AND INSTITUTIONS CODE, SECTION 14043.2, AND TITLE 22, CALIFORNIA CODE OF REGULATIONS, SECTION 51000.30(a)(2).

AS A CONDITION FOR PARTICIPATION OR CONTINUED PARTICIPATION AS A PROVIDER IN THE MEDI-CAL PROGRAM, PROVIDER AGREES TO COMPLY WITH ALL OF THE FOLLOWING TERMS AND CONDITIONS, AND WITH ALL OF THE TERMS AND CONDITIONS INCLUDED ON ANY ATTACHMENT(S) HERETO, WHICH IS/ARE INCORPORATED HEREIN BY REFERENCE:

1. **Term and Termination.** This Agreement will be effective from the date applicant is enrolled as a provider by DHCS, or, from the date provider is approved for continued enrollment. Provider may terminate this Agreement by providing DHCS with written notice of intent to terminate, which termination shall result in Provider's immediate disenrollment and exclusion (without formal hearing under the Administrative Procedure Act) from further participation in the Medi-Cal program, including deactivation of any provider agreement, unless and until such time as Provider is re-enrolled by DHCS in the Medi-Cal Program. DHCS may immediately terminate this Agreement for cause if Provider is suspended/excluded for any of the reasons set forth in Paragraph 25(a) below, which termination will result in Provider's immediate disenrollment and exclusion (without formal hearing under the Administrative Procedures Act) from further participation in the Medi-Cal program.

2. **Compliance With Laws and Regulations.** Provider agrees to comply with all applicable provisions of Chapters 7 and 8 of the Welfare and Institutions Code (commencing with Sections 14000 and 14200), and any applicable rules or regulations promulgated by DHCS pursuant to these Chapters. Provider further agrees that if it violates any of the provisions of Chapters 7 and 8 of the Welfare and Institutions Code, or any other regulations promulgated by DHCS pursuant to these Chapters, it may be subject to all sanctions or other remedies available to DHCS. Provider further agrees to comply with all federal laws and regulations governing and regulating Medicaid providers.

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* Every applicant and provider must execute this Provider Agreement.
** The taxpayer identification number may be a Taxpayer Identification Number (TIN) or a social security number for sole proprietors

10. **Confidentiality of Beneficiary Information.** Provider agrees that all documents, whether paper, electronic or in any media, that contain protected health information as defined under the Health Information Portability and Accountability Act or personal, confidential information of beneficiaries made or acquired by Provider, shall be confidential and shall not be released without the written consent of the beneficiary or his/her personal representative, or as otherwise authorized by law. Provider agrees to enter into a business associate agreement with any billing agents to assure that they comply with these requirements.

11. **Disclosure of Information to DHCS.** Provider agrees to disclose all information as required in Federal Medicaid laws and regulations and any other information required by DHCS, and to respond to all requests from DHCS for information. Provider further agrees that the failure of Provider to disclose the required information, or the disclosure of false information shall, prior to any hearing, result in the denial of the application for enrollment or shall be grounds for termination of enrollment status or suspension from the Medi-Cal program, which shall include deactivation of all provider numbers used by Provider to obtain reimbursement from the Medi-Cal program. Provider further agrees that all bills or claims for payment to DHCS by Provider shall not be due and owing to Provider for any period(s) for which information was not reported or was reported falsely to DHCS. Provider further agrees to reimburse those Medi-Cal funds received during any period for which information was not reported, or reported falsely, to DHCS.

12. **Background Check.** Provider agrees that DHCS may conduct a background check on Provider for the purpose of verifying the accuracy of the information provided in the application and in order to prevent fraud or abuse. The background check may include, but not be limited to, the following: (1) on-site inspection prior to enrollment; (2) review of medical and business records; and, (3) data searches.

13. **Unannounced Visits By DHCS, AG and Secretary.** Provider agrees that DHCS, AG and/or Secretary may make unannounced visits to Provider, at any of Provider's business locations, before, during or after enrollment, for the purpose of determining whether enrollment, continued enrollment, or certification is warranted, to investigate and prosecute fraud against the Medi-Cal program, to investigate complaints of abuse and neglect of patients in health care facilities receiving payment under the Medi-Cal program, and/or as necessary for the administration of the Medi-Cal program and/or the fulfillment of the AG's powers and duties under Government Code Section 12528. Premises subject to inspection include billing agents, as defined in Welfare and Institutions Code Section 14040.1. Pursuant to Welfare and Institutions Code Section 14043.7(b), such unannounced visits are authorized should the department have reason to believe that the provider will defraud or abuse the Medi-Cal program or lacks the organizational or administrative capacity to provide services under the program. Failure to permit inspection by DHCS, AG or Secretary or any agent, investigator or auditor thereof, shall be grounds for immediate suspension of provider from participation in the Medi-Cal program.

14. **Provider Fraud and Abuse.** Provider agrees that it shall not engage in or commit fraud or abuse. "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or herself or some other person. It includes any act that constitutes fraud under applicable federal or state law. "Abuse" means either: (1) practices that are inconsistent with sound fiscal or business practices and result in unnecessary cost to the Medicare program, the Medi-Cal program, another state's Medicaid program, or other health care programs operated, or financed in whole or in part, by the Federal Government or any state or local agency in this state or any other state; (2) practices that are inconsistent with sound medical practices and result in reimbursement by the Medi-Cal program or other health care programs operated, or financed in whole or in part, by the Federal Government or any state or local agency in this state or any other state, for services that are unnecessary or for substandard items or services that fail to meet professionally recognized standards for health care.

15. **Investigations of Provider for Fraud or Abuse.** Provider certifies that, at the time this Agreement was signed, it was not under investigation for fraud or abuse pursuant to Subpart A (commencing with Section 455.12) of Part 455 of Title 42 of the Code of Federal Regulations or under investigation for fraud or abuse by any Federal, state or local law enforcement agency, including the Medicaid investigation units of DHCS and the Office of the Inspector General for the Federal Department of Health and Human Services. Provider further agrees to notify DHCS within ten business days of learning that it is under investigation for fraud or abuse by any such entity. Provider further agrees that it may be subject to temporary suspension pursuant to Welfare and Institutions Code, Section 14043.36(a), which may include temporary deactivation of all provider numbers used by Provider to obtain reimbursement from the Medi-Cal program, if it is discovered that Provider is under investigation as described in that section. Provider further agrees to cooperate with and assist DHCS and any state or federal agency charged with the duty of identifying, investigating, sanctioning, or prosecuting suspected fraud and abuse, although Provider does not waive any timely and properly asserted rights it may have under the 5th Amendment privilege against self-incrimination.

23. **Compliance With Requirements.** Provider and any billing agent agree that it shall comply with all of the requirements set forth in the Welfare and Institutions Code and its implementing regulations, and the Medi-Cal Provider Manuals, including applicable changes to the Medi-Cal Provider Manuals published by DHCS subsequent to the effective date of this Agreement. Providers and their billing agents agree to comply with Welfare and Institutions Code Section 14115 and California Code of Regulations, Title 22, Section 51008 and 51008.5. Providers agree to submit all claims within 60 days of the dates of service but no later than six months to receive full payment. Provider and its billing agent also agree to exhaust all administrative remedies with the fiscal intermediary prior to filing a writ of mandate pursuant to Welfare and Institutions Code Section 14104.5. In the event DHCS determines a reimbursement overpayment has been made to Provider or monies are otherwise owed pursuant to this Agreement, Provider agrees to promptly repay the amounts owed in accordance with applicable federal and California statutes and regulations, and rules and policies of DHCS. DHCS may recoup any overpayment from monies otherwise payable to Provider under this Agreement under any provider number of Provider.

24. **Deficit Reduction Act of 2005, Section 6032 Implementation.** To the extent applicable, as a condition of payment for services, goods, supplies and merchandise provided to beneficiaries in the Medical Assistance Program ("Medi-Cal"), providers must comply with the False Claims Act employee training and policy requirements in 1902(a) of the Social Security Act (42 USC 1396a(a)(68)), set forth in that subsection and as the federal Secretary of Health and Human Services may specify.

25. **Provider Suspension; Appeal Rights; Reinstatement.** Provider agrees that it is to be subject to the following suspension actions. Provider further agrees that the suspension of Provider shall include deactivation of all of Provider's provider numbers and shall preclude Provider from submitting claims for payment, either personally or through claims submitted by any individual, clinic, group, corporation, or other association to the Medi-Cal program for any services, supplies, goods, or merchandise that provider has provided directly or indirectly to a Medi-Cal beneficiary, except for services, supplies, goods, or merchandise provided prior to the suspension.

    a. **Automatic Suspensions/Mandatory Exclusions.** The provider shall be automatically suspended under the following circumstances:

        (1) Upon notice from the Secretary of the United States Department of Health and Human Services that Provider has been excluded from participation in the Medicare or Medicaid programs. No administrative appeal of a suspension on this ground shall be available to Provider. (Welfare and Institutions Code, Section 14123(b),(c)).

        (2) If Provider has license(s), certificate(s), or other approval(s) to provide health care services, revoked or suspended by a federal, California, or another state's licensing, certification, or approval authority, has otherwise lost that/those license(s), certificate(s), or approval(s), or has surrendered that/those license(s), certificate(s), or approval(s) while a disciplinary hearing on that license, certificate, or approval was pending. (Welfare and Institutions Code, Section 14043.6).

        (3) If Provider is convicted of any felony or any misdemeanor involving fraud, abuse of the Medi-Cal program or any patient, or otherwise substantially related to the qualifications, functions, or duties of a provider of service. Suspension following conviction is not subject to the proceedings under Welfare and Institutions Code Section 14123(c). However, the director may grant an informal hearing at the request of the provider to determine in the director's sole discretion if the circumstances surrounding the conviction justify rescinding or otherwise modifying the suspension.

    b. **Permissive Suspensions/Permissive Exclusions.** The provider may be suspended under the following circumstances:

        (1) Provider violates any of the provisions of Chapter 7 of the Welfare and Institutions Code (commencing with Section 14000 except for Sections 14043-14044), or Chapter 8 (commencing with Section 14200) or any rule or regulations promulgated by DHCS pursuant to those provisions. Administrative appeal pursuant to Health and Safety Code, Section 100171. (Welfare and Institutions Code, Section 14123(a),(c)).

        (2) Provider fails to comply with DHCS's request to examine or receive copies of the books and records pertaining to services rendered to Medi-Cal beneficiaries. Administrative appeal pursuant to Health and Safety Code, Section 100171. (Welfare and Institutions Code, Section 14124.2).

        (3) Provider participating in the Medi-Cal dental program provides services, goods, supplies, or merchandise that are below or less than the standard of acceptable quality, as established by the California Dental Association Guidelines for the Assessment of Clinical Quality and Professional Performance, Copyright 1995, Third Edition, as periodically amended. (Welfare and Institutions Code, Section 14123(f)).

The parties agree that this agreement is a legal and binding document and is fully enforceable in a court of competent jurisdiction. The provider signing this agreement warrants that he/she has read this agreement and understands it.

I declare under penalty of perjury under the laws of the State of California that the foregoing information is true, accurate, and complete to the best of my knowledge and belief.

I declare I am the provider or I have the authority to legally bind the provider, which is an entity and not an individual person.

1. Printed legal name of provider
   St. Francis Medical Center
2. Printed name of person signing this declaration on behalf of provider (if an entity or business name is listed in Item 1 above)
   Gerald T. Kozai, Pharm D.
3. Original signature of provider or representative if this provider is an entity other than an individual person as sole proprietor
4. Title of person signing this declaration
   President and C.E.O.
5. Notary Public (Affix notary seal or stamp in the space below)

State of California, County of Los Angeles
Subscribed and sworn to (or affirmed) before me on this 16th day of Aug, 2010, by Gerald T Kozai proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.
Signature of Notary

LARCENIA L. FREEMAN
Commission # 1801587
Notary Public - California
Los Angeles County
My Comm. Expires Jul 10, 2012

Executed at: Lynwood (City), California (State) on August 16, 2010 (Date)

Applicants and providers licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act, or the Chiropractic Initiative Act ARE NOT REQUIRED to have this form notarized. If notarization is required, the Certificate of Acknowledgement signed by the Notary Public must be in the form specified in Section 1189 of the Civil Code.

6. Contact Person's Information
   ☐ Check here if you are the same person identified in Item 2. If you checked the box, provide only the email address and phone number below.

Contact Person's Name (last)	(first)	(middle)	(gender)
Thomas, Ta-Tanisha			☐ Male ☒ Female

Title/Position	Email address	Telephone Number
Director of ManagedCare and Provider Relations	tankshathomas@dochs.org	(310) 900-7323

Privacy Statement
(Civil Code Section 1798 et seq.)

All information requested on the application, the disclosure statement, and the provider agreement is mandatory with the exception of the social security number for any person other than the person or entity for whom an IRS Form 1099 must be provided by the Department pursuant to 26 USC 6041. This information is required by the Department of Health Care Services, Provider Enrollment Division, by the authority of Welfare and Institutions Code Section 14043.2(a). The consequences of not supplying the mandatory information requested are denial of enrollment as a Medi-Cal provider or denial of continued enrollment as a provider and deactivation of all provider numbers used by the provider to obtain reimbursement from the Medi-Cal program. The consequence of not supplying the voluntary social security number information requested is delay in the application process while other documentation is used to verify the information supplied. Any information provided will be used to verify eligibility to participate as a provider in the Medi-Cal program. Any information may also be provided to the State Controller's Office, the California Department of Justice, the Department of Consumer Affairs, the Department of Corporations, or other state or local agencies as appropriate, fiscal intermediaries, managed care plans, the Federal Bureau of Investigation, the Internal Revenue Service, Medicare Fiscal Intermediaries, Centers for Medicare and Medicaid Services, Office of the Inspector General, Medicaid, and licensing programs in other states.

EXHIBIT 3

PED PROVIDER MASTER FILE INPUT DOCUMENT

PROV NAME FOR SCAN:SETON MEDICAL CENTER **NO. OF PGS:** 12

DOC# 431776 **REVIEW DUE DATE:** 04/20/2011

RISK: Low **PAGE#** 1 of 1

Document Review and Approve Signatures								
Analyst: Gerard Smith	Date: 11/10/10	Reviewer	Date	Return	Supervisor: K		Date: 11/15/10	Return
Comments:								

PMF Transaction Signatures						
Technician:	Date: 11-16-2010	Return	Status change update and review signature		Date	Return
Reviewer: AS 11/17/10	Date	Return	Supervisor (optional)		Date	Return
Comments:						

ACTION REQUESTED: UPDATE A PROV **DOC TYPE:** OTHER

PROV NUM: 1154428688 **OWNR NUM:** **LOC NUM:** **PROV TYPE:** 015

PSS059 OWNER SCREEN

LEGAL NAME: SOCIAL SECURITY NO:

EFF. BEGIN DATE: EFF. END DATE: LAST FISCAL MONTH: WARRANT:

FED EMP ID NO/ TIN:

TIN DATE: IRS UPDATE TYPE:

FACILITY /CLINIC BASED:

MEDICARE NO:

SANCTIONS:

PROVIDER CROSS REFERENCE
N/A

PSS070 LOCATION SCREEN

BUSINESS NAME: TELEPHONE NO: 650-991-6400

	PAY-TO ADDRESS	SERVICE ADDRESS	MAIL TO ADDRESS
ATN:			
LN 1:	1900 SULLIVAN AVE		1900 SULLIVAN AVE
LN 2:			
CTY:	DALY CITY		DALY CITY
STATE:	CA		CA
ZIP:	940154132		940154132

OUT OF STATE:

PSS055 PROVIDER DETAIL SCREEN

APP DATE: PROV TYPE: PRACTICE: STAT. CODE:

STAT. EFF DATE: REJT RSN:

CATEGORIES OF SERVICE (CATEGORY, BEGIN DATE, ENDDATE):

LIC. NO: LIC. EFF DT: CLIA NO:

CHDP PROV NO:

SPEC PROC TYP: PROV ENR: NA PROV ENR DT: RE ENR IND:

PSS054

LAB STAT: LAB EFF DT:

PF3 PSS124 TAXONOMY CODES

State of California—Health and Human Services Agency

Department of Health Care Services

MEDI-CAL PROVIDER AGREEMENT
(Institutional Provider)
(To Accompany Applications for Enrollment)*

FOR STATE USE ONLY

05-0289

Do not use staples on this form or on any attachments.
Type or print clearly in ink. If you must make corrections, please line through, date, and initial in ink.
Do not leave any questions, lines, etc. blank. Enter N/A if not applicable to you.

Date

Legal name of applicant or provider (as listed with the IRS)	Business name (if different than legal name)		
SETON MEDICAL CENTER	SAME		
Provider number (NPI number)		Business Telephone Number	
1154428688		(650) 991-6400	
Business address (number, street)	City	State	Nine-digit ZIP code
1900 SULLIVAN AVE.	DALY CITY	CA	94015-4132
Mailing address (number, street, P.O. Box number)	City	State	Nine-digit ZIP code
1900 SULLIVAN AVE.	DALY CITY	CA	94015-4132
Pay-to address (number, street, P.O. Box number)	City	State	Nine-digit ZIP code
1900 SULLIVAN AVE.	DALY CITY	CA	94015-4132
Previous business address (number, street, P.O. Box number)	City	State	Nine-digit ZIP code

Taxpayer Identification Number**
91215444 1

EXECUTION OF THIS PROVIDER AGREEMENT BETWEEN AN APPLICANT OR PROVIDER (HEREINAFTER JOINTLY REFERRED TO AS "PROVIDER") AND THE DEPARTMENT OF HEALTH CARE SERVICES (HEREINAFTER "DHCS"), IS MANDATORY FOR PARTICIPATION OR CONTINUED PARTICIPATION AS A PROVIDER IN THE MEDI-CAL PROGRAM PURSUANT TO 42 UNITED STATES CODE, SECTION 1396a(a)(27), TITLE 42, CODE OF FEDERAL REGULATIONS, SECTION 431.107, WELFARE AND INSTITUTIONS CODE, SECTION 14043.2, AND TITLE 22, CALIFORNIA CODE OF REGULATIONS, SECTION 51000.30(a)(2).

AS A CONDITION FOR PARTICIPATION OR CONTINUED PARTICIPATION AS A PROVIDER IN THE MEDI-CAL PROGRAM, PROVIDER AGREES TO COMPLY WITH ALL OF THE FOLLOWING TERMS AND CONDITIONS, AND WITH ALL OF THE TERMS AND CONDITIONS INCLUDED ON ANY ATTACHMENT(S) HERETO, WHICH IS/ARE INCORPORATED HEREIN BY REFERENCE:

1. **Term and Termination.** This Agreement will be effective from the date applicant is enrolled as a provider by DHCS, or, from the date provider is approved for continued enrollment. Provider may terminate this Agreement by providing DHCS with written notice of intent to terminate, which termination shall result in Provider's immediate disenrollment and exclusion (without formal hearing under the Administrative Procedure Act) from further participation in the Medi-Cal program, including deactivation of any provider agreement, unless and until such time as Provider is re-enrolled by DHCS in the Medi-Cal Program. DHCS may immediately terminate this Agreement for cause if Provider is suspended/excluded for any of the reasons set forth in Paragraph 25(a) below, which termination will result in Provider's immediate disenrollment and exclusion (without formal hearing under the Administrative Procedures Act) from further participation in the Medi-Cal program.

2. **Compliance With Laws and Regulations.** Provider agrees to comply with all applicable provisions of Chapters 7 and 8 of the Welfare and Institutions Code (commencing with Sections 14000 and 14200), and any applicable rules or regulations promulgated by DHCS pursuant to these Chapters. Provider further agrees that if it violates any of the provisions of Chapters 7 and 8 of the Welfare and Institutions Code, or any other regulations promulgated by DHCS pursuant to these Chapters, it may be subject to all sanctions or other remedies available to DHCS. Provider further agrees to comply with all federal laws and regulations governing and regulating Medicaid providers.

RECEIVED

OCT 12 2010

* Every applicant and provider must execute this Provider Agreement.
** The taxpayer identification number may be a Taxpayer Identification Number (TIN) or a social security number for sole proprietors.

10. **Confidentiality of Beneficiary Information.** Provider agrees that all documents, whether paper, electronic or in any media, that contain protected health information as defined under the Health Information Portability and Accountability Act or personal, confidential information of beneficiaries made or acquired by Provider, shall be confidential and shall not be released without the written consent of the beneficiary or his/her personal representative, or as otherwise authorized by law. Provider agrees to enter into a business associate agreement with any billing agents to assure that they comply with these requirements.

11. **Disclosure of Information to DHCS.** Provider agrees to disclose all information as required in Federal Medicaid laws and regulations and any other information required by DHCS, and to respond to all requests from DHCS for information. Provider further agrees that the failure of Provider to disclose the required information, or the disclosure of false information shall, prior to any hearing, result in the denial of the application for enrollment or shall be grounds for termination of enrollment status or suspension from the Medi-Cal program, which shall include deactivation of all provider numbers used by Provider to obtain reimbursement from the Medi-Cal program. Provider further agrees that all bills or claims for payment to DHCS by Provider shall not be due and owing to Provider for any period(s) for which information was not reported or was reported falsely to DHCS. Provider further agrees to reimburse those Medi-Cal funds received during any period for which information was not reported, or reported falsely, to DHCS.

12. **Background Check.** Provider agrees that DHCS may conduct a background check on Provider for the purpose of verifying the accuracy of the information provided in the application and in order to prevent fraud or abuse. The background check may include, but not be limited to, the following: (1) on-site inspection prior to enrollment; (2) review of medical and business records; and, (3) data searches.

13. **Unannounced Visits By DHCS, AG and Secretary.** Provider agrees that DHCS, AG and/or Secretary may make unannounced visits to Provider, at any of Provider's business locations, before, during or after enrollment, for the purpose of determining whether enrollment, continued enrollment, or certification is warranted, to investigate and prosecute fraud against the Medi-Cal program, to investigate complaints of abuse and neglect of patients in health care facilities receiving payment under the Medi-Cal program, and/or as necessary for the administration of the Medi-Cal program and/or the fulfillment of the AG's powers and duties under Government Code Section 12528. Premises subject to inspection include billing agents, as defined in Welfare and Institutions Code Section 14040.1. Pursuant to Welfare and Institutions Code Section 14043.7(b), such unannounced visits are authorized should the department have reason to believe that the provider will defraud or abuse the Medi-Cal program or lacks the organizational or administrative capacity to provide services under the program. Failure to permit inspection by DHCS, AG or Secretary or any agent, investigator or auditor thereof, shall be grounds for immediate suspension of provider from participation in the Medi-Cal program.

14. **Provider Fraud and Abuse.** Provider agrees that it shall not engage in or commit fraud or abuse. "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or herself or some other person. It includes any act that constitutes fraud under applicable federal or state law. "Abuse" means either: (1) practices that are inconsistent with sound fiscal or business practices and result in unnecessary cost to the Medicare program, the Medi-Cal program, another state's Medicaid program, or other health care programs operated, or financed in whole or in part, by the Federal Government or any state or local agency in this state or any other state; (2) practices that are inconsistent with sound medical practices and result in reimbursement by the Medi-Cal program or other health care programs operated, or financed in whole or in part, by the Federal Government or any state or local agency in this state or any other state, for services that are unnecessary or for substandard items or services that fail to meet professionally recognized standards for health care.

15. **Investigations of Provider for Fraud or Abuse.** Provider certifies that, at the time this Agreement was signed, it was not under investigation for fraud or abuse pursuant to Subpart A (commencing with Section 455.12) of Part 455 of Title 42 of the Code of Federal Regulations or under investigation for fraud or abuse by any Federal, state or local law enforcement agency, including the Medicaid investigation units of DHCS and the Office of the Inspector General for the Federal Department of Health and Human Services. Provider further agrees to notify DHCS within ten business days of learning that it is under investigation for fraud or abuse by any such entity. Provider further agrees that it may be subject to temporary suspension pursuant to Welfare and Institutions Code, Section 14043.36(a), which may include temporary deactivation of all provider numbers used by Provider to obtain reimbursement from the Medi-Cal program, if it is discovered that Provider is under investigation as described in that section. Provider further agrees to cooperate with and assist DHCS and any state or federal agency charged with the duty of identifying, investigating, sanctioning, or prosecuting suspected fraud and abuse, although Provider does not waive any timely and properly asserted rights it may have under the 5th Amendment privilege against self-incrimination.

23. **Compliance With Requirements.** Provider and any billing agent agree that it shall comply with all of the requirements set forth in the Welfare and Institutions Code and its implementing regulations, and the Medi-Cal Provider Manuals, including applicable changes to the Medi-Cal Provider Manuals published by DHCS subsequent to the effective date of this Agreement. Providers and their billing agents agree to comply with Welfare and Institutions Code Section 14115 and California Code of Regulations, Title 22, Section 51008 and 51008.5. Providers agree to submit all claims within 60 days of the dates of service but no later than six months to receive full payment. Provider and its billing agent also agree to exhaust all administrative remedies with the fiscal intermediary prior to filing a writ of mandate pursuant to Welfare and Institutions Code Section 14104.5. In the event DHCS determines a reimbursement overpayment has been made to Provider or monies are otherwise owed pursuant to this Agreement, Provider agrees to promptly repay the amounts owed in accordance with applicable federal and California statutes and regulations, and rules and policies of DHCS. DHCS may recoup any overpayment from monies otherwise payable to Provider under this Agreement under any provider number of Provider.

24. **Deficit Reduction Act of 2005, Section 6032 Implementation.** To the extent applicable, as a condition of payment for services, goods, supplies and merchandise provided to beneficiaries in the Medical Assistance Program ("Medi-Cal"), providers must comply with the False Claims Act employee training and policy requirements in 1902(a) of the Social Security Act (42 USC 1396a(a)(68)), set forth in that subsection and as the federal Secretary of Health and Human Services may specify.

25. **Provider Suspension; Appeal Rights; Reinstatement.** Provider agrees that it is to be subject to the following suspension actions. Provider further agrees that the suspension of Provider shall include deactivation of all of Provider's provider numbers and shall preclude Provider from submitting claims for payment, either personally or through claims submitted by any individual, clinic, group, corporation, or other association to the Medi-Cal program for any services, supplies, goods, or merchandise that provider has provided directly or indirectly to a Medi-Cal beneficiary, except for services, supplies, goods, or merchandise provided prior to the suspension.

a. **Automatic Suspensions/Mandatory Exclusions.** The provider shall be automatically suspended under the following circumstances:

(1) Upon notice from the Secretary of the United States Department of Health and Human Services that Provider has been excluded from participation in the Medicare or Medicaid programs. No administrative appeal of a suspension on this ground shall be available to Provider. (Welfare and Institutions Code, Section 14123(b),(c)).

(2) If Provider has license(s), certificate(s), or other approval(s) to provide health care services, revoked or suspended by a federal, California, or another state's licensing, certification, or approval authority, has otherwise lost that/those license(s), certificate(s), or approval(s), or has surrendered that/those license(s), certificate(s), or approval(s) while a disciplinary hearing on that license, certificate, or approval was pending. (Welfare and Institutions Code, Section 14043.6).

(3) If Provider is convicted of any felony or any misdemeanor involving fraud, abuse of the Medi-Cal program or any patient, or otherwise substantially related to the qualifications, functions, or duties of a provider of service. Suspension following conviction is not subject to the proceedings under Welfare and Institutions Code Section 14123(c). However, the director may grant an informal hearing at the request of the provider to determine in the director's sole discretion if the circumstances surrounding the conviction justify rescinding or otherwise modifying the suspension.

b. **Permissive Suspensions/Permissive Exclusions.** The provider may be suspended under the following circumstances:

(1) Provider violates any of the provisions of Chapter 7 of the Welfare and Institutions Code (commencing with Section 14000 except for Sections 14043-14044), or Chapter 8 (commencing with Section 14200) or any rule or regulations promulgated by DHCS pursuant to those provisions. Administrative appeal pursuant to Health and Safety Code, Section 100171. (Welfare and Institutions Code, Section 14123(a),(c)).

(2) Provider fails to comply with DHCS's request to examine or receive copies of the books and records pertaining to services rendered to Medi-Cal beneficiaries. Administrative appeal pursuant to Health and Safety Code, Section 100171. (Welfare and Institutions Code, Section 14124.2).

(3) Provider participating in the Medi-Cal dental program provides services, goods, supplies, or merchandise that are below or less than the standard of acceptable quality, as established by the California Dental Association Guidelines for the Assessment of Clinical Quality and Professional Performance, Copyright 1995, Third Edition, as periodically amended. (Welfare and Institutions Code, Section 14123(f)).

30. **Provider Capacity.** Provider agrees that Provider, and the officers, directors, employees, and agents of Provider, in the performance of this Agreement, shall act in an independent capacity and not as officers or employees or agents of the State of California.

31. **Indemnification.** Provider agrees to indemnify, defend, and save harmless the State of California, its officers, agents, and employees, from any and all claims and losses accruing or resulting to any and all persons, firms, or corporations furnishing or supplying services, materials, or supplies in connection with Provider's performance of this Agreement, and from any and all claims and losses accruing or resulting to any Medi-Cal beneficiary, or to any other person, firm, or corporation who may be injured or damaged by Provider in the performance of this Agreement.

32. **Governing Law.** This Agreement shall be governed by and interpreted in accordance with the laws of the State of California.

33. **Venue.** Venue for all actions, including federal actions, concerning this Agreement, lies in Sacramento County, California, or in any other county in which the California Department of Justice maintains an office.

34. **Titles.** The titles of the provisions of this Agreement are for convenience and reference only and are not to be considered in interpreting this Agreement.

35. **Severability.** If one or more of the provisions of this Agreement shall be invalid, illegal, void, or unenforceable, the validity, legality, and enforceability of the remaining provisions shall not in any way be affected or impaired. Either party having knowledge of such a provision shall promptly inform the other of the presumed non-applicability of such provision. Should the non-applicable provision go to the heart of this Agreement, the Agreement shall be terminated in a manner commensurate with the interests of both parties.

36. **Assignability.** Provider agrees that it has no property right in or to its status as a Provider in the Medi-Cal program or in or to the provider number(s) assigned to it, and that Provider may not assign its provider number for use as a Medi-Cal provider, or any rights and obligations it has under this Agreement except to the extent purchasing owner is joining this provider agreement with successor joint and several liability.

37. **Waiver.** Any action or inaction by DHCS or any failure of DHCS on any occasion, to enforce any right or provision of this Agreement, shall not be interpreted to be a waiver by DHCS of its rights hereunder and shall not prevent DHCS from enforcing such provision or right on any future occasion. The rights and remedies of DHCS herein are cumulative and are in addition to any other rights or remedies that DHCS may have at law or in equity.

38. **Complete Integration.** This Agreement, including any attachments or documents incorporated herein by express reference, is intended to be a complete integration and there are no prior or contemporaneous different or additional agreements pertaining to the subject matter of this Agreement, unless such additional agreement(s) is between DHCS and the Provider, expressly references or incorporates all or part of this Agreement, and is signed by the Provider.

39. **Amendment.** Any alteration or modification by the applicant or Provider of this Medi-Cal Provider Agreement (DHCS Form 9098) or to any of the terms in its exhibits or attachments, shall automatically and immediately void this agreement upon submission of the signed agreement to the State, unless such agreement is also signed by the State.

40. **Provider Attestation.** Provider agrees that all information it submits on the application form for enrollment, this Agreement, and all attachments or changes to either, is true, accurate, and complete to the best of Provider's knowledge and belief. Provider further agrees to sign the application form for enrollment, this Agreement, and all attachments or changes to either, under penalty of perjury under the laws of the State of California.

EXHIBIT 4

RED PROVIDER MASTER FILE INPUT DOCUMENT

PROV NAME FOR SCAN:SAINT VINCENT DIALYSIS CENTER **NO. OF PGS:** 8

DOC# 458698 **REVIEW DUE DATE:**

RISK:Low **PAGE#** 1 of 1

Document Review and Approve Signatures								
Analyst	Date	Reviewer	Date	Return	Supervisor	Date	Return
Comments:							

PMF Transaction Signatures						
Technician	Date	Return	Status change update and review signature		Date	Return
Reviewer	Date	Return	Supervisor (optional)		Date	Return
Comments:						

ACTION REQUESTED:UPDATE A PROV. **DOC TYPE:** OTHER

PROV NUM:1992700314 **OWNR NUM:1** **LOC NUM:1** **PROV TYPE:042**

----------PSS059 OWNER SCREEN----------

LEGAL NAME:**SAINT VINCENT DIALYSIS** SOCIAL SECURITY NO: - -

EFF. BEGIN DATE: EFF. END DATE: LAST FISCAL MONTH: WARRANT:

FED EMP ID NO/ TIN:

TIN DATE: IRS UPDATE TYPE:I

FACILITY /CLINIC BASED:

MEDICARE NO:

SANCTIONS:

PROVIDER CROSS REFERENCE
N/A

----------PSS070 LOCATION SCREEN----------

BUSINESS NAME: TELEPHONE NO:

	PAY-TO ADDRESS	SERVICE ADDRESS	MAIL TO ADDRESS
ATN:	**CENTER INC**	**CENTER INC**	**CENTER INC**
LN 1:			
LN 2:		**STE 220**	
CTY:			
STATE:	ZIP:	STATE: ZIP:**900572388**	STATE: ZIP:

OUT OF STATE:

----------PSS055 PROVIDER DETAIL SCREEN----------

APP DATE: PROV TYPE: PRACTICE: STAT. CODE:

STAT. EFF DATE: REJT RSN:

CATEGORIES OF SERVICE (CATEGORY, BEGIN DATE, ENDDATE):

LIC. NO: LIC. EFF DT: CLIA NO:

CHDP PROV NO:

SPEC PROC TYP: PROV ENR: 5 PROV ENR DT: RE ENR IND:

----------PSS054----------

LAB STAT: LAB EFF DT:

----------PF3 PSS124 TAXONOMY CODES----------

State of California—Health and Human Services Agency Department of Health Care Services

MEDI-CAL PROVIDER AGREEMENT
(Institutional Provider)
(To Accompany Applications for Enrollment)*

FOR STATE USE ONLY
052582

Do not use staples on this form or on any attachments.
Type or print clearly in ink. If you must make corrections, please line through, date, and initial in ink.
Do not leave any questions, lines, etc. blank. Enter N/A if not applicable to you.

Date: 3/7/2011

Legal name of applicant or provider (as listed with the IRS)	Business name (if different than legal name)		
SAINT VINCENT DIALYSIS CENTER, INC			
Provider number (NPI number) 1992700314 CDC 700305		Business Telephone Number (213) 484-7425	
Business address (number, street) 201 SOUTH ALVARADO STREET, SUITE 220	City LOS ANGELES	State CA	Nine-digit ZIP code 90057-3413
Mailing address (number, street, P.O. Box number) S.A.A.	City	State	Nine-digit ZIP code
Pay-to address (number, street, P.O. Box number) S.A.A.	City	State	Nine-digit ZIP code
Previous business address (number, street, P.O. Box number) N/A	City	State	Nine-digit ZIP code
Taxpayer Identification Number** 95-3749293			

EXECUTION OF THIS PROVIDER AGREEMENT BETWEEN AN APPLICANT OR PROVIDER (HEREINAFTER JOINTLY REFERRED TO AS "PROVIDER") AND THE DEPARTMENT OF HEALTH CARE SERVICES (HEREINAFTER "DHCS"), IS MANDATORY FOR PARTICIPATION OR CONTINUED PARTICIPATION AS A PROVIDER IN THE MEDI-CAL PROGRAM PURSUANT TO 42 UNITED STATES CODE, SECTION 1396a(a)(27), TITLE 42, CODE OF FEDERAL REGULATIONS, SECTION 431.107, WELFARE AND INSTITUTIONS CODE, SECTION 14043.2, AND TITLE 22, CALIFORNIA CODE OF REGULATIONS, SECTION 51000.30(a)(2).

AS A CONDITION FOR PARTICIPATION OR CONTINUED PARTICIPATION AS A PROVIDER IN THE MEDI-CAL PROGRAM, PROVIDER AGREES TO COMPLY WITH ALL OF THE FOLLOWING TERMS AND CONDITIONS, AND WITH ALL OF THE TERMS AND CONDITIONS INCLUDED ON ANY ATTACHMENT(S) HERETO, WHICH IS/ARE INCORPORATED HEREIN BY REFERENCE:

1. **Term and Termination.** This Agreement will be effective from the date applicant is enrolled as a provider by DHCS, or, from the date provider is approved for continued enrollment. Provider may terminate this Agreement by providing DHCS with written notice of intent to terminate, which termination shall result in Provider's immediate disenrollment and exclusion (without formal hearing under the Administrative Procedure Act) from further participation in the Medi-Cal program, including deactivation of any provider agreement, unless and until such time as Provider is re-enrolled by DHCS in the Medi-Cal Program. DHCS may immediately terminate this Agreement for cause if Provider is suspended/excluded for any of the reasons set forth in Paragraph 25(a) below, which termination will result in Provider's immediate disenrollment and exclusion (without formal hearing under the Administrative Procedures Act) from further participation in the Medi-Cal program.

2. **Compliance With Laws and Regulations.** Provider agrees to comply with all applicable provisions of Chapters 7 and 8 of the Welfare and Institutions Code (commencing with Sections 14000 and 14200), and any applicable rules or regulations promulgated by DHCS pursuant to these Chapters. Provider further agrees that if it violates any of the provisions of Chapters 7 and 8 of the Welfare and Institutions Code, or any other regulations promulgated by DHCS pursuant to these Chapters, it may be subject to all sanctions or other remedies available to DHCS. Provider further agrees to comply with all federal laws and regulations governing and regulating Medicaid providers.

RECEIVED
MAR 28 2011

* Every applicant and provider must execute this Provider Agreement.
** The taxpayer identification number may be a Taxpayer Identification Number (TIN) or a social security number for sole proprietors.

458698

The parties agree that this agreement is a legal and binding document and is fully enforceable in a court of competent jurisdiction. The provider signing this agreement warrants that he/she has read this agreement and understands it.

I declare under penalty of perjury under the laws of the State of California that the foregoing information is true, accurate, and complete to the best of my knowledge and belief.

I declare I am the provider or I have the authority to legally bind the provider, which is an entity and not an individual person.

1. Printed legal name of provider

SAINT VINCENT DIALYSIS CENTER, INC.

2. Printed name of person signing this declaration on behalf of provider (if an entity or business name is listed in item 1 above)

JAMES T. ROE, M.D.

3. Original signature of provider or representative if this provider is an entity other than an individual person as sole proprietor

X James T. Roe MD

4. Title of person signing this declaration

MEDICAL DIRECTOR

5. Notary Public (Affix notary seal or stamp in the space below)

See attached acknowledgment 3/15/11 tdr

Executed at: LOS ANGELES (City), CA (State) on / / (Date)

Applicants and providers licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act, or the Chiropractic Initiative Act ARE NOT REQUIRED to have this form notarized. If notarization is required, the Certificate of Acknowledgement signed by the Notary Public must be in the form specified in Section 1189 of the Civil Code.

6. **Contact Person's Information**

☑ Check here if you are the same person identified in Item 2. If you checked the box, provide only the email address and phone number below.

Contact Person's Name (last) (first) (middle) (gender)

☐ Male ☐ Female

Title/Position	Email address	Telephone Number
	gracieperez@dochs.org	213 484-7295

Privacy Statement
(Civil Code Section 1798 et seq.)

All information requested on the application, the disclosure statement, and the provider agreement is mandatory with the exception of the social security number for any person other than the person or entity for whom an IRS Form 1099 must be provided by the Department pursuant to 26 USC 6041. This information is required by the Department of Health Care Services, Provider Enrollment Division, by the authority of Welfare and Institutions Code Section 14043.2(a). The consequences of not supplying the mandatory information requested are denial of enrollment as a Medi-Cal provider or denial of continued enrollment as a provider and deactivation of all provider numbers used by the provider to obtain reimbursement from the Medi-Cal program. The consequence of not supplying the voluntary social security number information requested is delay in the application process while other documentation is used to verify the information supplied. Any information provided will be used to verify eligibility to participate as a provider in the Medi-Cal program. Any information may also be provided to the State Controller's Office, the California Department of Justice, the Department of Consumer Affairs, the Department of Corporations, or other state or local agencies as appropriate, fiscal intermediaries, managed care plans, the Federal Bureau of Investigation, the Internal Revenue Service, Medicare Fiscal Intermediaries, Centers for Medicare and Medicaid Services, Office of the Inspector General, Medicaid, and licensing programs in other states.

CALIFORNIA ALL-PURPOSE ACKNOWLEDGMENT

State of California
County of LOS ANGELES }

On MAR 15, 2011 (Date) before me, VENUS NEVERSON, NOTARY PUBLIC (Here Insert Name and Title of the Officer)

personally appeared JAMES T. ROE, M.D (Name(s) of Signer(s))

who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/~~are~~ subscribed to the within instrument and acknowledged to me that he/~~she~~/~~they~~ executed the same in his/~~her~~/~~their~~ authorized capacity(~~ies~~), and that by his/~~her~~/~~their~~ signature(~~s~~) on the instrument the person(~~s~~), or the entity upon behalf of which the person(~~s~~) acted, executed the instrument.

VENUS NEVERSON
Commission # 1742270
Notary Public - California
Los Angeles County
My Comm. Expires May 21, 2011

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature Venus Neverson (Signature of Notary Public)

Place Notary Seal Above

OPTIONAL

Though the information below is not required by law, it may prove valuable to persons relying on the document and could prevent fraudulent removal and reattachment of this form to another document.

Description of Attached Document

Title or Type of Document: Medi-Cal Provider Agreement

Document Date: 3/7/11 Number of Pages: 2

Signer(s) Other Than Named Above: N/A

Capacity(ies) Claimed by Signer(s)

Signer's Name: JAMES T. ROE, M.D
☒ Individual
☐ Corporate Officer — Title(s):
☐ Partner — ☐ Limited ☐ General
☐ Attorney-in-Fact
☐ Trustee
☐ Guardian or Conservator
☐ Other:
Signer is Representing:

RIGHT THUMBPRINT OF SIGNER
Top of thumb here

Signer's Name:
☐ Individual
☐ Corporate Officer — Title(s):
☐ Partner — ☐ Limited ☐ General
☐ Attorney-in-Fact
☐ Trustee
☒ Guardian or Conservator
☐ Other:
Signer is Representing:

RIGHT THUMBPRINT OF SIGNER
Top of thumb here

VN 3/15/10

VKN 3/15/10 mcPA

STATE OF CALIFORNIA – HEALTH AND WELFARE AG — DEPARTMENT OF HEALTH SERVICES

MEDI-CAL PROVIDER DATA FORM

1. FACILITY NAME 202	4. FEDERAL EMPLOYER'S ID NUMBER 212	5. FISCAL YEAR END MONTH 218
St. Vincent Dialysis Center, Inc.	95-3749293	June 30, 1983

2. FACILITY ADDRESS 203

NUMBER	STREET	ROOM/SUITE
201	South Alvarado Street	Suite 220

CITY	COUNTY	STATE	ZIP CODE
Los Angeles,	California		90057

3. PAY TO ADDRESS (IF DIFFERENT) 204

NUMBER	STREET	ROOM/SUITE
Same		

CITY	COUNTY	STATE	ZIP CODE

6A. TYPE OF ORGANIZATION (CHECK ONE) 210

- ☐ State Government
- ☐ County Government
- ☐ City Government
- ☒ Nongovernmental Nonprofit
- ☐ Nongovernmental for Profit
- ☐ Other (specify)

6B. TYPE OF OWNERSHIP (CHECK ONE) 210

- ☐ Individual
- ☒ Corporation
- ☐ Partnership
- ☐ Other (specify)

7. List facility owner(s). List owner(s) professional license numbers, if applicable. (For corporations, list corporate name only.) *(Attach a separate sheet of paper if more space is needed).* 266/250

NAME	PROFESSIONAL STATE LICENSE NUMBER	NAME	PROFESSIONAL STATE LICENSE NUMBER
St. Vincent Dialysis Center, Inc.			

8. In addition to this facility, please indicate other facilities or practices that the owner(s) may have. 270
(Attach a separate sheet of paper if more space is needed).

ADDRESS (Actual Facility or Practice Location)	NAME USED FOR BILLING FROM THIS LOCATION	PROVIDER NUMBER ASSIGNED TO THIS LOCATION
NONE		

9. List previous Medi-Cal provider numbers that the owner(s) have been issued. 271

NONE

10. Is this a teaching facility for residents and/or interns who are salaried by a hospital? ☐ Yes ☒ No 247

I certify that the above information is true, accurate and complete to the best of my knowledge.

11. APPLICANT'S TYPED OR PRINTED NAME	12. APPLICANT'S TYPED OR PRINTED TITLE
Sina M. Pierret	Executive Director
13. APPLICANT'S SIGNATURE	**14. DATE**
▶ Sina M. Pierret	September 29, 1982

MC 003 (11/79)

EXHIBIT 5

MEDI-CAL PROVIDER AGREEMENT
(Institutional Provider)
(To Accompany Applications for Enrollment)*

FOR STATE USE ONLY

Do not use staples on this form or on any attachments.
Type or print clearly in ink. If you must make corrections, please line through, date, and initial in ink.
Do not leave any questions, lines, etc. blank. Enter N/A if not applicable to you.

Date

Legal name of applicant or provider (as listed with the IRS)	Business name (If different than legal name)		
Provider number (NPI number)		Business Telephone Number ( )	
Business address (number, street)	City	State	Nine-digit ZIP code
Mailing address (number, street, P.O. Box number)	City	State	Nine-digit ZIP code
Pay-to address (number, street, P.O. Box number)	City	State	Nine-digit ZIP code
Previous business address (number, street, P.O. Box number)	City	State	Nine-digit ZIP code

Taxpayer Identification Number**

EXECUTION OF THIS PROVIDER AGREEMENT BETWEEN AN APPLICANT OR PROVIDER (HEREINAFTER JOINTLY REFERRED TO AS "PROVIDER") AND THE DEPARTMENT OF HEALTH CARE SERVICES (HEREINAFTER "DHCS"), IS MANDATORY FOR PARTICIPATION OR CONTINUED PARTICIPATION AS A PROVIDER IN THE MEDI-CAL PROGRAM PURSUANT TO 42 UNITED STATES CODE, SECTION 1396a(a)(27), TITLE 42, CODE OF FEDERAL REGULATIONS, SECTION 431.107, WELFARE AND INSTITUTIONS CODE, SECTION 14043.2, AND TITLE 22, CALIFORNIA CODE OF REGULATIONS, SECTION 51000.30(a)(2).

AS A CONDITION FOR PARTICIPATION OR CONTINUED PARTICIPATION AS A PROVIDER IN THE MEDI-CAL PROGRAM, PROVIDER AGREES TO COMPLY WITH ALL OF THE FOLLOWING TERMS AND CONDITIONS, AND WITH ALL OF THE TERMS AND CONDITIONS INCLUDED ON ANY ATTACHMENT(S) HERETO, WHICH IS/ARE INCORPORATED HEREIN BY REFERENCE:

1. **Term and Termination.** This Agreement will be effective from the date applicant is enrolled as a provider by the Department of Health Care Services (DHCS), or, from the date provider is approved for continued enrollment. This agreement may be terminated for cause if the Provider is suspended/excluded from further participation in the Medi-Cal program unless and until such time as Provider is re-enrolled by DHCS in the Medi-Cal program. This agreement may be terminated for cause if Provider is suspended/excluded for any of the reasons set forth in Paragraph 27(a) below, which termination will result in Provider's immediate disenrollment and exclusion (without formal hearing under the Administrative Procedures Act) from further participation in the Medi-Cal program. During any period in which the provider is on provisional provider status or preferred provisional provider status, DHCS may terminate this agreement for any of the grounds stated in Welfare and Institutions Code Section 14043.27(c).

2. **Compliance With Laws and Regulations.** Provider agrees to comply with all applicable provisions of Chapters 7 and 8 of the Welfare and Institutions Code (commencing with Sections 14000 and 14200), and any applicable rules or regulations promulgated by DHCS pursuant to these Chapters. Provider further agrees that if it violates any of the provisions of Chapters 7 and 8 of the Welfare and Institutions Code, or any other regulations promulgated by DHCS pursuant to these Chapters, it may be subject to all sanctions or other remedies available to DHCS. Provider further agrees to comply with all federal laws and regulations governing and regulating Medicaid providers.

* Every applicant and provider must execute this Provider Agreement.
** The taxpayer identification number may be a Taxpayer Identification Number (TIN) or a social security number for sole proprietors.

3. **National Provider Identifier (NPI).** Provider agrees to submit any claims to DHCS using an NPI that is appropriately registered within the Centers for Medicare and Medicaid Services (CMS) and is in compliance with all NPI requirements established by CMS as of the date the claim is submitted. Provider agrees that submission of an NPI to DHCS as part of an application to use that NPI to obtain payment constitutes an implied representation that the NPI submitted is appropriately registered and in compliance with all CMS requirements at the time of submission. Provider also agrees that any subsequent defect in registration or compliance of the NPI constitutes an "addition or change in the information previously submitted" which must be reported to DHCS under the requirements of California Code of Regulations, Title 22, Section 51000.40.

4. **Forbidden Conduct.** Provider agrees that it shall not engage in conduct inimical to the public health, morals, welfare and safety of any Medi-Cal beneficiary, or the fiscal integrity of the Medi-Cal program.

5. **Nondiscrimination.** Provider agrees that it shall not exclude or deny aid, care, service or other benefits available under Medi-Cal or in any other way discriminate against a person because of that person's race, color, ancestry, marital status, national origin, gender, age, economic status, physical or mental disability, political or religious affiliation or beliefs in accordance with California and federal laws. Provider further agrees that it shall provide aid, care, service, or other benefits available under Medi-Cal to Medi-Cal beneficiaries in the same manner, by the same methods, and at the same scope, level, and quality as provided to the general public.

6. **Scope of Health and Medical Care.** Provider agrees that the health care services it provides may include diagnostic, preventive, corrective, and curative services, goods, supplies, and merchandise essential thereto, provided by qualified personnel for conditions that cause suffering, endanger life, result in illness or infirmity, interfere with capacity for normal activity, including employment, or for conditions which may develop into some significant handicap or disability. Provider further agrees such health care services may be subject to prior authorization to determine medical necessity.

7. **Licensing.** Provider agrees to possess at the time this Agreement becomes effective, and to maintain in good standing throughout the term of this Agreement, valid and unexpired license(s), certificate(s), or other approval(s) to provide health care services, which is appropriate to the services, goods, supplies, and merchandise being provided, if required by the state or locality in which Provider is located, or by the Federal Government. Provider further agrees it shall be automatically suspended as a provider in the Medi-Cal program pursuant to Welfare and Institutions Code, Section 14043.6, if Provider has license(s), certificate(s), or other approval(s) to provide health care services, which are revoked or suspended by a federal, California, or another state's licensing, certification, or approval authority, has otherwise lost that/those license(s), certificate(s), or approval(s), or has surrendered that/those license(s), certificate(s), or approval(s) while a disciplinary hearing on that/those license(s), certificate(s), or approval(s) was pending. Such suspension shall be effective on the date that Provider's license, certificate, or approval was revoked, suspended, lost, or surrendered. Provider further agrees to notify DHCS within ten business days of learning that any restriction has been placed on, or of a suspension of Provider's license, certificate, or other approval to provide health care. Provider further agrees to provide DHCS complete information related to any restriction to, or revocation or loss of, Provider's license, certificate, or other approval to provide health care services.

8. **Insurance.** Provider agrees to possess at the time this Agreement becomes effective, and to maintain in good standing throughout the term of this Agreement, liability insurance for the business address and, if a licensed practitioner, professional liability (malpractice) insurance coverage from an authorized insurer pursuant to Section 700 of the Insurance Code.

9. **Record Keeping and Retention.** Provider agrees to make, keep and maintain in a systematic and orderly manner, and have readily retrievable, such records as are necessary to fully disclose the type and extent of all services, goods, supplies, and merchandise provided to Medi-Cal beneficiaries, including, but not limited to, the records described in Section 51476 of Title 22, California Code of Regulations, and the records described in Section 431.107 of Title 42 of the Code of Federal Regulations. Provider further agrees that such records shall be made at or near the time at which the services, goods, supplies, and merchandise are delivered or rendered, and that such records shall be retained by Provider in the form in which they are regularly kept for a period of three years from the date the goods, supplies, or merchandise were delivered or the services rendered.

10. **DHCS, CDPH, AG and Secretary Access to Records; Copies of Records.** Provider agrees to make available, during regular business hours, all pertinent financial records, all records of the requisite insurance coverage, and all records concerning the provision of health care services to Medi-Cal beneficiaries to any duly authorized representative of DHCS, CDPH, the California Attorney General's Medi-Cal Fraud Unit ("AG"), and the Secretary of the United States Centers for Medicare and Medicaid Services (Secretary). Provider further agrees to provide, if requested by any of the above, copies of the records and documentation, and that failure to comply with any request to examine or receive copies of such records shall be grounds for immediate suspension of Provider from participation in the Medi-Cal program. Provider will be reimbursed for reasonable copy costs as determined by DHCS, CDPH, AG or Secretary.

11. **Confidentiality of Beneficiary Information.** Provider agrees that all medical records of beneficiaries made or acquired by Provider shall be confidential and shall not be released without the written consent of the beneficiary or his/her personal representative, or as otherwise authorized by law.

12. **Disclosure of Information to DHCS.** Provider agrees to disclose all information as required in Federal Medicaid laws and regulations and any other information required by DHCS, and to respond to all requests from DHCS for information. Provider further agrees that the failure of Provider to disclose the required information, or the disclosure of false information shall, prior to any hearing, result in the denial of the application for enrollment or shall be grounds for termination of enrollment status or suspension from the Medi-Cal program, which shall include deactivation of all provider numbers used by Provider to obtain reimbursement from the Medi-Cal program. Provider further agrees that all bills or claims for payment to DHCS by Provider shall not be due and owing to Provider for any period(s) for which information was not reported or was reported falsely to DHCS. Provider further agrees to reimburse those Medi-Cal funds received during any period for which information was not reported, or reported falsely, to DHCS.

13. **Background Check.** Provider agrees that DHCS may conduct a background check on Provider for the purpose of verifying the accuracy of the information provided in the application and in order to prevent fraud or abuse. The background check may include, but not be limited to, the following: (1) on-site inspection prior to enrollment; (2) review of medical and business records; and, (3) data searches.

14. **Unannounced Visits By DHCS, CDPH, AG and Secretary.** Provider agrees that DHCS, CDPH, AG and/or Secretary may make unannounced visits to Provider, at any of Provider's business locations, before, during or after enrollment, for the purpose of determining whether enrollment, continued enrollment, or certification is warranted, to investigate and prosecute fraud against the Medi-Cal program, to investigate complaints of abuse and neglect of patients in health care facilities receiving payment under the Medi-Cal program, and/or as necessary for the administration of the Medi-Cal program and/or the fulfillment of the AG's powers and duties under Government Code Section 12528. Premises subject to inspection include billing agents, as defined in Welfare and Institutions Code Section 14040.1. Failure to permit inspection by DHCS, CDPH, AG or Secretary or any agent, investigator or auditor thereof, shall be grounds for immediate suspension of provider from participation in the Medi-Cal program.

15. **Provider Fraud and Abuse.** Provider agrees that it shall not engage in or commit fraud or abuse. "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or herself or some other person. It includes any act that constitutes fraud under applicable federal or state law. "Abuse" means either: (1) practices that are inconsistent with sound fiscal or business practices and result in unnecessary cost to the Medicare program, the Medi-Cal program, another state's Medicaid program, or other health care programs operated, or financed in whole or in part, by the Federal Government or any state or local agency in this state or any other state; (2) practices that are inconsistent with sound medical practices and result in reimbursement by the Medi-Cal program or other health care programs operated, or financed in whole or in part, by the Federal Government or any state or local agency in this state or any other state, for services that are unnecessary or for substandard items or services that fail to meet professionally recognized standards for health care.

16. **Investigations of Provider for Fraud or Abuse.** Provider certifies that, at the time this Agreement was signed, it was not under investigation for fraud or abuse pursuant to Subpart A (commencing with Section 455.12) of Part 455 of Title 42 of the Code of Federal Regulations or under investigation for fraud or abuse by any other government entity. Provider further agrees to notify DHCS within ten business days of learning that it is under investigation for fraud or abuse. Provider further agrees that it shall be subject to temporary suspension pursuant to Welfare and Institutions Code, Section 14043.36(a), which shall include temporary deactivation of all provider numbers used by Provider to obtain reimbursement from the Medi-Cal program, if it is discovered that Provider is under investigation for fraud or abuse. Provider further agrees to cooperate with and assist DHCS and any state or federal agency charged with the duty of identifying, investigating, sanctioning, or prosecuting suspected fraud and abuse.

17. **Provider Fraud or Abuse Convictions and/or Civil Fraud or Abuse Liability.** Provider certifies that it and its owners, officers, directors, employees, and agents, has not: (1) been convicted of any felony or misdemeanor involving fraud or abuse in any government program, within the last ten years; or (2) been convicted of any felony or misdemeanor involving the abuse of any patient; or (3) been convicted of any felony or misdemeanor substantially related to the qualifications, functions, or duties of a provider; or (4) entered into a settlement in lieu of conviction for fraud or abuse, within the last ten years; or, (5) been found liable for fraud or abuse in any civil proceeding, within the last ten years. Provider further agrees that DHCS shall not enroll Provider if within the last ten years, Provider has been convicted of any felony or any misdemeanor involving fraud or abuse in any government program, has entered into a settlement in lieu of conviction for fraud or abuse, or has been found liable for fraud or abuse in any civil proceeding.

18. **Changes to Provider Information.** Provider agrees to keep its application for enrollment in the Medi-Cal program current by informing the California Department of Public Health (CDPH), District Office, in writing on a form or forms to be specified by DHCS, within 35 days of any changes to the information contained in its application for enrollment, its disclosure statement, this Agreement, and/or any attachments to these documents.

19. **Prohibition of Rebate, Refund, or Discount.** Provider agrees that it shall not offer, give, furnish, or deliver any rebate, refund, commission preference, patronage dividend, discount, or any other gratuitous consideration, in connection with the rendering of health care services to any Medi-Cal beneficiary. Provider further agrees that it shall not solicit, request, accept, or receive, any rebate, refund, commission preference, patronage dividend, discount, or any other gratuitous consideration, in connection with the rendering of health care services to any Medi-Cal beneficiary. Provider further agrees that it will not take any other action or receive any other benefit prohibited by state or federal law.

20. **Payment From Other Health Coverage Prerequisite to Claim Submission.** Provider agrees that it shall first seek to obtain payment for services provided to Medi-Cal beneficiaries from any private or public health insurance coverage to which the beneficiary is entitled, where Provider is aware of this coverage and to the extent the coverage extends to these services, prior to submitting a claim to DHCS for the payment of any unpaid balance for these services. In the event that a claim submitted to a private or public health insurer has not been paid within 90 days of billing by Provider, Provider may submit a claim to DHCS.

21. **Beneficiary Billing.** Provider agrees that it shall not submit claims to or demand or otherwise collect reimbursement from a Medi-Cal beneficiary, or from other persons on behalf of the beneficiary, for any service included in the Medi-Cal program's scope of benefits in addition to a claim submitted to the Medi-Cal program for that service, except to: (1) collect payments due under a contractual or legal entitlement pursuant to Welfare and Institutions Code, Section 14000(b); (2) bill a long-term care patient for the amount of his/her liability; and, (3) collect a co-payment pursuant to Welfare and Institutions Code, Sections 14134 and 14134.1. Provider further agrees that, in the event that a beneficiary willfully refuses to provide current other health care coverage billing information as described in Section 50763(a)(5) of Title 22, California Code of Regulations, Provider may, upon giving the beneficiary written notice of intent, bill the beneficiary as a private pay patient.

22. **Payment From Medi-Cal Program Shall Constitute Full Payment.** Provider agrees that payment received from DHCS in accordance with Medi-Cal fee structures shall constitute payment in full, except that Provider, after making a full refund to DHCS of any Medi-Cal payments received for services, goods, supplies, or merchandise, may recover all of Provider's fees to the extent that any other contractual entitlement, including, but not limited to, a private group or indemnification insurance program, is obligated to pay the charges for the services, goods, supplies, or merchandise provided to the beneficiary.

23. **Return of Payment for Services Otherwise Covered by the Medi-Cal Program.** Provider agrees that any beneficiary who has paid Provider for health care services, goods, supplies, or merchandise otherwise covered by the Medi-Cal program received by the beneficiary shall be entitled to a prompt return from Provider of any part of the payment which meets any of the following: (1) was rendered during any period prior to the receipt of the beneficiary's Medi-Cal card, for which the card authorizes payment under Welfare and Institutions Code, Sections 14018 or 14019; (2) was reimbursed to Provider by the Medi-Cal program, following audits and appeals to which Provider is entitled; (3) is not payable by a third party under contractual or other legal entitlement; (4) was not used by the beneficiary to satisfy his/her paid or obligated liability for health care services, goods, supplies, or merchandise, or to establish eligibility.

24. **Compliance With Billing and Claims Requirements.** Provider agrees that it shall comply with all of the billing and claims requirements set forth in the Welfare and Institutions Code and its implementing regulations, and the provider manual.

25. **Deficit Reduction Act of 2005, Section 6032 Implementation.** As a condition of payment for services, goods, supplies and merchandise provided to beneficiaries in the Medical Assistance Program ("Medi-Cal"), providers must comply with the False Claims Act employee training and policy requirements in 1902(a) of the Social Security Act (42 USC 1396a(a)(68)), set forth in that subsection and as the federal Secretary of Health and Human Services may specify.

26. **Termination of Provisional Provider or Preferred Provisional Provider Status.** Provider agrees that, while it is on provisional provider status or preferred provisional provider status, the provider will be subject to immediate termination of its provisional provider status or preferred provisional provider status and disenrollment from the Medi-Cal program in the following circumstances:

a. The provider, persons with an ownership or control interest in the provider, or persons who are directors, officers, or managing employees of the provider have been convicted of any felony, or convicted of any misdemeanor involving fraud or abuse in any government program, related to neglect or abuse of a patient in connection with the delivery of a health care item or service, or in connection with the interference with, or obstruction of, any investigation into health care related fraud or abuse, or have been found liable for fraud or abuse in any civil proceeding, or have entered into a settlement in lieu of conviction for fraud or abuse in any government program within 10 years of the date of the application package.

b. There is a material discrepancy in the information provided to the department, or with the requirements to be enrolled, that is discovered after provisional provider status or preferred provisional provider status has been granted and that cannot be corrected because the discrepancy occurred in the past.

c. The provider has provided material information that was false or misleading at the time it was provided.

d. The provider failed to have an established place of business at the business address for which the application package was submitted at the time of any onsite inspection, announced or unannounced visit, or any additional inspection or review conducted pursuant to this article or a statute or regulation governing the Medi-Cal program, unless the practice of the provider's profession or delivery of services, goods, supplies, or merchandise is such that services, goods supplies, or merchandise are rendered or delivered at locations other than the business address and this practice of delivery of services, goods, supplies, or merchandise has been disclosed in the application package approved by the department when the provisional provider status of preferred provisional provider status was granted.

e. The provider meets the definition of a clinic under Section 1200 of the Health and Safety Code, but is not licensed as a clinic pursuant to Chapter 1 (commencing with Section 1200) of Division 2 of the Health and Safety Code and fails to meet the requirements to qualify for at least one exemption pursuant to Section 1206 or 1206.1 of the Health and Safety Code.

f. The provider performs clinical laboratory tests or examinations, but it or its personnel do not meet CLIA, and the regulations adopted thereunder, and the state clinical laboratory law, do not possess valid CLIA certificates and clinical laboratory registrations or licenses pursuant to Chapter 3 (commencing with Section 1200) of Division 2 of the Business and Professions Code, or are not exempt from licensure as a clinical laboratory under Section 1241 of the Business and Professions Code.

g. The provider fails to possess either of the following:

   (1) The appropriate licenses, permits, certificates, or other approvals needed to practice the profession or occupation, or provide the services, goods, supplies, or merchandise the provider identified in the application package approved by the department when the provisional provider status or preferred provisional provider status was granted and for the location for which the application was submitted.

   (2) The business or zoning permits or other approval necessary to operate a business at the location identified in its application package approved by the department when the provisional provider status or preferred provisional provider status was granted.

h. The provider, or if the provider is a clinic, group, partnership, corporation, or other association, any officer, director, or shareholder with a 10 percent or greater interest in that organization, commits two or more violations of the federal or state statues or regulation governing the Medi-Cal program, and the violations demonstrate a pattern or practice of fraud, abuse, or provision of unnecessary or substandard medical services.

i. The provider commits any violation of a federal or state statute or regulation governing the Medi-Cal program or of a statute or regulation governing the provider's profession or occupation and the violation represents a threat of immediate jeopardy or significant harm to any Medi-Cal beneficiary or to the public welfare.

j. The provider submits claims for payment that subject a provider to suspension under Section 14043.61.

k. The provider submits claims for payment for services, goods, supplies, or merchandise rendered at a location other than the location for which the provider number was issued, unless the practice of the provider's profession or delivery of services, goods, supplies, or merchandise is such that services, goods, supplies, or merchandise are rendered or delivered at locations other than the business address and this practice or delivery of services, goods, supplies, or merchandise has been disclosed in the application package approved by the department when the provisional provider status was granted.

f. The provider has not paid its fine, or has a debt due and owing, including overpayments and penalty assessments, to any federal, state, or local government entity that relates to Medicare, Medicaid, Medi-Cal, or any other federal or state health care program, and has not made satisfactory arrangements to fulfill the obligation or otherwise been excused by legal process from fulfilling the obligation.

27. **Provider Suspension; Appeal Rights; Reinstatement.** Provider agrees that it is to be subject to the following suspension actions. Provider further agrees that the suspension of Provider shall include deactivation of all of Provider's provider numbers and shall preclude Provider from submitting claims for payment, either personally or through claims submitted by any individual, clinic, group, corporation, or other association to the Medi-Cal program for any services, supplies, goods, or merchandise that provider has provided directly or indirectly to a Medi-Cal beneficiary, except for services, supplies, goods, or merchandise provided prior to the suspension.

a. **Automatic Suspensions/Mandatory Exclusions.** The provider shall be automatically suspended under the following circumstances:

(1) Upon notice from the Secretary of the United States Department of Health and Human Services that Provider has been excluded from participation in the Medicare or Medicaid programs. No administrative appeal of a suspension on this ground shall be available to Provider. (Welfare and Institutions Code, Section 14123(b),(c)).

(2) If Provider has license(s), certificate(s), or other approval(s) to provide health care services, revoked or suspended by a federal, California, or another state's licensing, certification, or approval authority, has otherwise lost that/those license(s), certificate(s), or approval(s), or has surrendered that/those license(s), certificate(s), or approval(s) while a disciplinary hearing on that license, certificate, or approval was pending. (Welfare and Institutions Code, Section 14043.6).

(3) If Provider is convicted of any felony or any misdemeanor involving fraud, abuse of the Medi-Cal program or any patient, or otherwise substantially related to the qualifications, functions, or duties of a provider of service. Suspension following conviction is not subject to the proceedings under Welfare and Institutions Code, Section 14123(c). However, the director may grant an informal hearing at the request of the provider to determine in the director's sole discretion if the circumstances surrounding the conviction justify rescinding or otherwise modifying the suspension.

b. **Permissive Suspensions/Permissive Exclusions.** The provider may be suspended under the following circumstances:

(1) Provider violates any of the provisions of Chapter 7 of the Welfare and Institutions Code (commencing with Section 14000 except for Sections 14043–14044), or Chapter 8 (commencing with Section 14200) or any rule or regulations promulgated by DHCS pursuant to those provisions. Administrative appeal pursuant to Health and Safety Code, Section 100171. (Welfare and Institutions Code, Section 14123(a),(c)).

(2) Provider fails to comply with DHCS' request to examine or receive copies of the books and records pertaining to services rendered to Medi-Cal beneficiaries. Administrative appeal pursuant to Health and Safety Code, Section 100171. (Welfare and Institutions Code, Section 14124.2).

(3) Provider participating in the Medi-Cal dental program provides services, goods, supplies, or merchandise that are below or less than the standard of acceptable quality, as established by the California Dental Association Guidelines for the Assessment of Clinical Quality and Professional Performance, Copyright 1995, Third Edition, as periodically amended. (Welfare and Institutions Code, Section 14123(f)).

c. **Temporary Suspension.** The provider may be temporarily suspended under the following circumstances:

(1) Provider fails to disclose all information as required in federal Medicaid regulations or any other information required by DHCS, or discloses false information. Administrative appeal pursuant to Welfare and Institutions Code, Section 14043.65. (Welfare and Institutions Code, Section 14043.2(a)).

(2) If it is discovered that Provider is under investigation for fraud or abuse. Administrative appeal pursuant to Welfare and Institutions Code, Section 14043.65. (Welfare and Institutions Code, Section 14043.36(a)).

(3) Provider fails to remediate discrepancies discovered as a result of an unannounced visit to Provider. Administrative appeal pursuant to Welfare and Institutions Code, Section 14043.65. (Welfare and Institutions Code, Section 14043.7(c)).

(4) When necessary to protect the public welfare or the interests of the Medi-Cal program. Administrative appeal pursuant to Health and Safety Code, Section 100171. (Welfare and Institutions Code, Section 14123(c)).

(5) Provider submits claims for payment under any provider number from an individual or entity that is suspended, excluded or otherwise ineligible. This includes a provider on the Suspended and Ineligible Provider List or any list published by the Office of the Inspector General or the Department of Health and Human Services. Appeal pursuant to Welfare and Institutions Code, Section 14043.65. (Welfare and Institutions Code, Section 14043.61).

28. **Provider Termination, Imposition of Federal Sanctions, and Appeal Rights for Long Term Care Facilities.** Provider agrees that it is subject to any federal sanctions authorized under the state plan including termination of this provider agreement in accordance with federal law. Provider further agrees that the termination of this provider agreement or imposition of other federal sanctions authorized under the state plan shall include deactivation of all of Provider's provider numbers and shall preclude Provider from submitting claims for payment either personally or through claims submitted by any individual, clinic, group, corporation, or other association to the Medi-Cal program for any services, supplies, goods, or merchandise that provider has provided directly or indirectly to a Medi-Cal beneficiary, except for services, supplies, goods, or merchandise provided prior to the termination or imposition of sanctions.

    a. **Skilled Nursing Facility and Intermediate Care Facility Appeal Procedures.** SNF and ICF Medi-Cal Providers shall have the appeal rights set forth in Article 1.6 of Chapter 3 of Division 3 of Title 22.

    b. **Intermediate Care Facilities-Mental Retardation Appeal Procedures.** Intermediate Care Facilities-Developmentally Disabled; Intermediate Care Facilities-Developmentally Disabled-Habilitative; Intermediate Care Facilities-Developmentally Disabled-Nursing shall have the appeal rights set forth in 42 CFR 431.153 and 431.154.

29. **Liability of Group Providers.** Provider agrees that, if it is a provider goup, the group, and each member of the group, are jointly and severally liable for any breach of this Agreement, and that action against any of the providers in the provider group may result in action against all of the members of the provider group.

30. **Legislative and Congressional Changes.** Provider agrees that this Agreement is subject to any future additional requirements, restrictions, limitations, or conditions enacted by the California Legislature or the United States Congress which may affect the provisions, terms, conditions, or funding of this Agreement in any manner.

31. **Provider Capacity.** Provider agrees that Provider, and the officers, directors, employees, and agents of Provider, in the performance of this Agreement, shall act in an independent capacity and not as officers or employees or agents of the State of California.

32. **Indemnification.** Provider agrees to indemnify, defend, and save harmless the State of California, its officers, agents, and employees, from any and all claims and losses accruing or resulting to any and all persons, firms, or corporations furnishing or supplying services, materials, or supplies in connection with Provider's performance of this Agreement, and from any and all claims and losses accruing or resulting to any Medi-Cal beneficiary, or to any other person, firm, or corporation who may be injured or damaged by Provider in the performance of this Agreement.

33. **Governing Law.** This Agreement shall be governed by and interpreted in accordance with the laws of the State of California.

34. **Venue.** Venue for all actions, including federal actions, concerning this Agreement, lies in Sacramento County, California, or in any other county in which the California Department of Justice maintains an office.

35. **Titles.** The titles of the provisions of this Agreement are for convenience and reference only and are not to be considered in interpreting this Agreement.

36. **Severability.** If one or more of the provisions of this Agreement shall be invalid, illegal, void, or unenforceable, the validity, legality, and enforceability of the remaining provisions shall not in any way be affected or impaired. Either party having knowledge of such a provision shall promptly inform the other of the presumed nonapplicability of such provision. Should the nonapplicable provision go to the heart of this Agreement, the Agreement shall be terminated in a manner commensurate with the interests of both parties.

37. **Assignability.** Provider agrees that it has no property right in or to its status as a Provider in the Medi-Cal program or in or to the provider number(s) assigned to it, and that Provider may not assign its provider number for use as a Medi-Cal provider, or any rights and obligations it has under this Agreement except to the extent purchasing owner is joining this provider agreement with successor liability with joint and several liability.

38. **Waiver.** Any action or inaction by DHCS or any failure of DHCS on any occasion, to enforce any right or provision of this Agreement, shall not be interpreted to be a waiver by DHCS of its rights hereunder and shall not prevent DHCS from enforcing such provision or right on any future occasion. The rights and remedies of DHCS herein are cumulative and are in addition to any other rights or remedies that DHCS may have at law or in equity.

39. **Complete Integration.** This Agreement, including any attachments or documents incorporated herein by express reference, is intended to be a complete integration and there are no prior or contemporaneous different or additional agreements pertaining to the subject matter of this Agreement.

40. **Amendment.** No alteration or variation of the terms or provisions of this Agreement shall be valid unless made in writing and signed by the parties to this Agreement, and no oral understanding or agreement not set forth in this Agreement, shall be binding on the parties to this Agreement.

41. **Provider Attestation.** Provider agrees that all information it submits on the application form for enrollment, this Agreement, and all attachments or changes to either, is true, accurate, and complete to the best of Provider's knowledge and belief. Provider further agrees to sign the application form for enrollment, this Agreement, and all attachments or changes to either, under penalty of perjury under the laws of the State of California.

Provider agrees that compliance with the provisions of this agreement is a condition precedent to payment to provider.

The parties agree that this agreement is a legal and binding document and is fully enforceable in a court of competent jurisdiction. The provider signing this agreement warrants that he/she has read this agreement and understands it.

I declare under penalty of perjury under the laws of the State of California that the foregoing information is true, accurate, and complete to the best of my knowledge and belief.

I declare I am the provider or I have the authority to legally bind the provider, which is an entity and not an individual person.

1. Printed legal name of provider

2. Printed name of person signing this declaration on behalf of provider (if an entity or business name is listed in Item 1 above)

3. Original signature of provider or representative if this provider is an entity other than an individual person as sole proprietor

4. Title of person signing this declaration

5. Notary Public (Affix notary seal or stamp in the space below)

Executed at: _____ (City), _____ (State) on _____ (Date)

Applicants and providers licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act, or the Chiropractic Initiative Act ARE NOT REQUIRED to have this form notarized. If notarization is required, the Certificate of Acknowledgement signed by the Notary Public must be in the form specified in Section 1189 of the Civil Code.

6. **Contact Person's Information**

☐ Check here if you are the same person identified in Item 2. If you checked the box, provide only the email address and phone number below.

Contact Person's Name (last) (first) (middle) (gender)

☐ Male ☐ Female

Title/Position Email address Telephone Number

Privacy Statement
(Civil Code Section 1798 et seq.)

All information requested on the application, the disclosure statement, and the provider agreement is mandatory with the exception of the social security number for any person other than the person or entity for whom an IRS Form 1099 must be provided by the Department pursuant to 26 USC 6041. This information is required by the Department of Health Care Services, Provider Enrollment Division, by the authority of Welfare and Institutions Code Section 14043.2(a). The consequences of not supplying the mandatory information requested are denial of enrollment as a Medi-Cal provider or denial of continued enrollment as a provider and deactivation of all provider numbers used by the provider to obtain reimbursement from the Medi-Cal program. The consequence of not supplying the voluntary social security number information requested is delay in the application process while other documentation is used to verify the information supplied. Any information provided will be used to verify eligibility to participate as a provider in the Medi-Cal program. Any information may also be provided to the State Controller's Office, the California Department of Justice, the Department of Consumer Affairs, the Department of Corporations, or other state or local agencies as appropriate, fiscal intermediaries, managed care plans, the Federal Bureau of Investigation, the Internal Revenue Service, Medicare Fiscal Intermediaries, Centers for Medicare and Medicaid Services, Office of the Inspector General, Medicaid, and licensing programs in other states.

EXHIBIT 6

Hospital Quality Assurance Fee (HQAF) Debt Summary (updated 09/06/2019)

ST. VINCENT MEDICAL CENTER (NPI# 1124004304) (OSHPD# 106190762)

PHASE V		DUE DATE	AMOUNT DUE		AMOUNT PAID		WITHHELD		OUTSTANDING BALANCE
FISCAL YEAR	CYCLE (PERIOD)								
2016/17	CYCLE 1 (01/01/2017-03/31/2017)	2/5/2018	$2,967,293.00	-	$0.00	-	$2,967,293.00	=	$0.00
	CYCLE 2 (04/01/2017-06/30/2017)	2/28/2018	$2,967,293.00	-	$0.00	-	$2,967,293.00	=	$0.00
	Managed Care 1 (Passthrough) (01/01/2017-06/30/2017)	3/13/2019	$2,482,372.56	-	$2,482,372.56	-	$0.00	=	$0.00
2017/18	CYCLE 3 (07/01/2017-09/30/2017)	3/21/2018	$3,295,382.00	-	$0.00	-	$3,295,382.00	=	$0.00
	CYCLE 4 (10/01/2017-12/31/2017)	4/11/2018	$3,295,382.47	-	$0.00	-	$3,295,382.47	=	$0.00
	CYCLE 5 (01/01/2018-03/31/2018)	5/2/2018	$3,295,382.00	-	$0.00	-	$3,295,382.00	=	$0.00
	CYCLE 6 (04/01/2018-06/30/2018)	7/11/2018	$3,295,382.00	-	$0.00	-	$3,295,382.00	=	$0.00
	Managed Care 2 (Passthrough) (07/01/2017-06/30/2018)	3/13/2019	$2,560,919.99	-	$2,560,919.99	-	$0.00	=	$0.00
	Managed Care 2 (Directed A) (07/01/2017-12/31/2017)	8/22/2019	$1,667,296.00	-	$1,667,296.00	-	$0.00	=	$0.00
	Managed Care 2* (Directed B) (01/01/2018-06/30/2018)	TBD	$908,143.74	-	$0.00	-	$0.00	=	$908,143.74
2018/19	CYCLE 7 (07/01/2018-09/30/2018)	10/3/2018	$3,433,071.00	-	$0.00	-	$3,433,071.00	=	$0.00
	CYCLE 8 (10/01/2018-12/31/2018)	1/2/2019	$3,433,071.00	-	$0.00	-	$3,433,071.00	=	$0.00
	CYCLE 9 (01/01/2019-03/31/2019)	4/3/2019	$3,433,071.00	-	$3,433,071.00	-	$0.00	=	$0.00
	CYCLE 10 (04/01/2019-06/30/2019)	7/3/2019	$3,342,337.51	-	$3,342,337.51	-	$0.00	=	$0.00
	Managed Care 3* (Passthrough) (07/01/2018-08/31/2019)	TBD	$2,828,768.00	-	$0.00	-	$0.00	=	$2,828,768.00
	Managed Care 3* (Directed) (07/01/2018-08/31/2019)	TBD	$2,828,768.00	-	$0.00	-	$0.00	=	$2,828,768.00
Total Outstanding Balance									$6,565,679.74

*Amount due is an estimate and is subject to change based upon Medi-Cal Managed Care utilization at the time of payment and fee liability from Medi-Cal fee-for-service reconciliation activities of the prior program period.

Hospital Quality Assurance Fee (HQAF) Debt Summary (updated 09/06/2019)

SETON MEDICAL CENTER (NPI# 1154428688) (OSHPD# 106410817)

PHASE V										
FISCAL YEAR	CYCLE (PERIOD)	DUE DATE	AMOUNT DUE		AMOUNT PAID		WITHHELD		OUTSTANDING BALANCE
2016/17	CYCLE 1 (01/01/2017-03/31/2017)	2/5/2018	$2,040,467.00	-	$0.00	-	$2,040,467.00	=	$0.00
	CYCLE 2 (04/01/2017-06/30/2017)	2/28/2018	$2,040,467.00	-	$0.00	-	$2,040,467.00	=	$0.00
	Managed Care 1 (Passthrough) (01/01/2017-06/30/2017)	3/13/2019	$1,870,925.10	-	$1,870,925.10	-	$0.00	=	$0.00
2017/18	CYCLE 3 (07/01/2017-09/30/2017)	3/21/2018	$2,223,369.00	-	$0.00	-	$1,348,558.98	=	$874,810.02
	CYCLE 4 (10/01/2017-12/31/2017)	4/11/2018	$2,223,368.94	-	$0.00	-	$0.00	=	$2,223,368.94
	CYCLE 5 (01/01/2018-03/31/2018)	5/2/2018	$2,223,369.00	-	$0.00	-	$0.00	=	$2,223,369.00
	CYCLE 6 (04/01/2018-06/30/2018)	7/11/2018	$2,223,369.00	-	$0.00	-	$0.00	=	$2,223,369.00
	Managed Care 2 (Passthrough) (07/01/2017-06/30/2018)	3/13/2019	$1,893,251.67	-	$1,893,251.67	-	$0.00	=	$0.00
	Managed Care 2 (Directed A) (07/01/2017-12/31/2017)	8/22/2019	$1,232,608.00	-	$1,232,608.00	-	$0.00	=	$0.00
	Managed Care 2* (Directed B) (01/01/2018-06/30/2018)	TBD	$671,377.91	-	$0.00	-	$0.00	=	$671,377.91
2018/19	CYCLE 7 (07/01/2018-09/30/2018)	10/3/2018	$2,293,835.00	-	$0.00	-	$0.00	=	$2,293,835.00
	CYCLE 8 (10/01/2018-12/31/2018)	1/2/2019	$2,293,835.00	-	$0.00	-	$0.00	=	$2,293,835.00
	CYCLE 9 (01/01/2019-03/31/2019)	4/3/2019	$2,293,835.00	-	$2,293,835.00	-	$0.00	=	$0.00
	CYCLE 10 (04/01/2019-06/30/2019)	7/3/2019	$2,231,441.90	-	$2,231,441.90	-	$0.00	=	$0.00
	Managed Care 3* (Passthrough) (07/01/2018-08/31/2019)	TBD	$2,061,897.50	-	$0.00	-	$0.00	=	$2,061,897.50
	Managed Care 3* (Directed) (07/01/2018-08/31/2019)	TBD	$2,061,897.50	-	$0.00	-	$0.00	=	$2,061,897.50
Total Outstanding Balance									$16,927,759.87

*Amount due is an estimate and is subject to change based upon Medi-Cal Managed Care utilization at the time of payment and fee liability from Medi-Cal fee-for-service reconciliation activities of the prior program period.

Hospital Quality Assurance Fee (HQAF) Debt Summary (updated 08/23/2019)

ST. FRANCIS MEDICAL CENTER (NPI# 1487697215) (OSHPD# 106190754)

PHASE V		DUE DATE	AMOUNT DUE		AMOUNT PAID		WITHHELD		OUTSTANDING BALANCE UP TO 8/31/18
FISCAL YEAR	CYCLE (PERIOD)								
2016/17	Managed Care 1 (Passthrough) (01/01/2017-06/30/2017)	3/13/2019	$5,256,386.70	-	$5,256,386.70	-	$0.00	=	$0.00
2017/18	Managed Care 2 (Passthrough) (07/01/2017-06/30/2018)	3/13/2019	$5,324,520.88	-	$5,324,520.88	-	$0.00	=	$0.00
	Managed Care 2 (Directed A) (07/01/2017-12/31/2017)	8/22/2019	$3,466,549.00	-	$3,466,549.00	-	$0.00	=	$0.00
	Managed Care 2* (Directed B) (01/01/2018-06/30/2018)	TBD	$1,888,160.53	-	$0.00	-	$0.00	=	$1,888,160.53
2018/19	CYCLE 8 (10/01/2018-12/31/2018)	1/2/2019	$6,703,466.00	-	$0.00	-	$6,703,466.00	=	
	CYCLE 9 (01/01/2019-03/31/2019)	4/3/2019	$6,703,466.00	-	$6,703,466.00	-	$0.00	=	
	CYCLE 10 (04/01/2019-06/30/2019)	7/3/2019	$6,520,041.59	-	$6,520,041.59	-	$0.00	=	
	Managed Care 3* (Passthrough) (07/01/2018-08/31/2018)	TBD	$973,664.57	-	$0.00	-	$0.00	=	$973,664.57
	Managed Care 3* (Directed B) (07/01/2018-08/31/2018)	TBD	$973,664.57	-	$0.00	-	$0.00	=	$973,664.57
Total Outstanding Balance									**$3,835,489.67**

*Amount due is an estimate and is subject to change based upon Medi-Cal Managed Care utilization at the time of payment and fee liability from Medi-Cal fee-for-service reconciliation activities of the prior program period.

DECLARATION OF SHIELA MENDIOLA

I, Shiela Mendiola, declare as follows:

1. The following matters stated in this declaration are true to my personal knowledge.

2. I am employed as the Section Chief of Medi-Cal Supplemental Payment Section, Staff Services Manager II, for the Safety Net Financing Division (SNFD) of the California Department of Health Care Services (DHCS). In that position, I oversee supplemental payment programs for the SNFD, and am a custodian of records for the Supplemental Reimbursement for Construction-Renovation Reimbursement Program. I have been in my current position since January 2015.

3. Senate Bill (SB) 1732 established California Welfare and Institutions Code Section 14085.5, Statutes of 1989. This is an ancillary program to the Medi-Cal Selective Provider Contracting Program. The Construction Renovation Reimbursement Program is commonly referred to as the SB 1732 program. This statute requires the State, through the Department of Health Care Services to provide supplemental reimbursement for the debt service incurred on revenue bonds used to finance eligible projects for qualifying hospitals, for either construction, renovation, replacement or retrofitting of hospitals and/or their ancillary or fixed equipment used to provide patient care. Subsequent Senate and Assembly bills amended this statute, adding provisions to narrowly define the time periods and criteria for hospital eligibility under the Construction Renovation Reimbursement Supplemental Payment Program.

4. Supplemental reimbursements under the Supplemental Reimbursement for Construction-Renovation Reimbursement Program to an eligible hospital allows two types of funding, State General Funds and matched Federal Funding. State general funds are used to draw down Federal Financial Participation Title XIX funding. State general fund is used to draw down Federal Match funding (Title XIX). This follows the supplemental reimbursement and reconciliation methodologies described in Attachment 4.19-A, pages 1 of California's State Medicaid Plan.

5. The interim reconciliation for St. Francis Medical Center beginning in State Fiscal Year (SFY) 2013-14 resulted in an overpayment of $662,327.67 and is pending repayment from this provider. The Department of Health Care Services (DHCS) sent a demand letter to St. Francis Hospital on May 14, 2018 for SFY 2013-14 interim reconciliation overpayment for $662,327.67. Since then, St. Francis and DHCS have been in both written and verbal communication regarding the backup documentation and the repayment.

In March 2019, DHCS followed up on the overpayment and provided St. Francis with additional backup calculation documentation. On July 31, 2019, St. Francis notified DHCS management through a verbal conversation that St. Francis is undergoing bankruptcy proceedings.

I declare under the laws of perjury of the State of California that the statements in this declaration are true and correct.

Executed at Sacramento, California, August 14, 2019

Shiela Mendiola

PROOF OF SERVICE OF DOCUMENT

I am over the age of 18 and not a party to this bankruptcy case or adversary proceeding. My business address is: California Office of the Attorney General, 300 South Spring Street, Suite 1702, Los Angeles, CA 90013.

A true and correct copy of the foregoing document entitled:

CREDITOR CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES'S SUPPLEMENTAL OBJECTION TO (1) DEBTORS' MOTION FOR THE ENTRY OF AN ORDER AUTHORIZING THE SALE OF PROPERTY FREE AND CLEAR OF ALL CLAIMS, LIENS, AND ENCUMBRANCES; (2) APPROVING FORM OF ASSET PURCHASE AGREEMENT

DECLARATION OF HANH VO IN SUPPORT OF CREDITOR CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES'S SUPPLEMENTAL OBJECTION TO (1) DEBTORS' MOTION FOR THE ENTRY OF AN ORDER AUTHORIZING THE SALE OF PROPERTY FREE AND CLEAR OF ALL CLAIMS, LIENS, AND ENCUMBRANCES; (2) APPROVING FORM OF ASSET PURCHASE AGREEMENT

DECLARATION OF SHIELA MENDIOLA

will be served or was served **(a)** on the judge in chambers in the form and manner required by LBR 5005-2(d); and **(b)** in the manner stated below:

1. **TO BE SERVED BY THE COURT VIA NOTICE OF ELECTRONIC FILING (NEF)**:

Pursuant to controlling General Orders and LBR, the foregoing document will be served by the court via NEF and hyperlink to the document. On **September 11, 2019**, I checked the CM/ECF docket for this bankruptcy case or adversary proceeding and determined that the following persons are on the Electronic Mail Notice List to receive NEF transmission at the email addresses stated below:

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Bryan L Ngo bngo@fortislaw.com
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Lior Katz katzlawapc@gmail.com

2. SERVED BY UNITED STATES MAIL:

Pursuant to F.R.Civ.P. 5 and/or controlling LBR, on **September 11, 2019**, I served the following persons and/or entities at the last known addresses in this bankruptcy case or adversary proceeding by placing a true and correct copy thereof in a sealed envelope in the United States mail, first class, postage prepaid, and addressed as follows.

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3. **SERVED BY OVERNIGHT MAIL AND ELECTRONIC MAIL**: Pursuant to F.R.Civ.P. 5 and/or controlling LBR, on **September 11, 2019**, I served the following persons and/or entities by overnight mail and electronic mail as follows.

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4. **SERVED BY PERSONAL DELIVERY**: Pursuant to F.R.Civ.P. 5 and/or controlling LBR, on **September 11, 2019**, I served the following persons and/or entities by personal delivery as follows. Listing the judge here constitutes a declaration that personal delivery on, or overnight mail to, the judge will be completed no later than 24 hours after the document is filed.

Hon. Ernest M. Robles
United States Bankruptcy Court
255 East Temple Street
Courtroom 1568
Los Angeles, CA 90012

I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct.

September 11, 2019	Stacy McKellar	
Date	*Printed Name*	*Signature*