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Case No. 2:19−cv−10352−DSF[1]

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

In re: VERITY HEALTH SYSTEM OF CALIFORNIA, INC., *et al.*,[2] Debtors and Debtors in	On Appeal from the United States Bankruptcy Court for the Central District of California (Bankr. Lead Case No.: 2:18-bk-20151-ER)

[1] This appeal (2:19-cv-10352-DSF) has been consolidated with the following related appeals: 2:19-cv-10354-DSF and 2:19-cv-10356-DSF.

[2] The other Debtors in the chapter 11 cases, being jointly administered under Lead Case No. 2:18-bk-20151-ER, are O'Connor Hospital 2:18-bk-20168-ER, Saint Louise Regional Hospital 2:18-bk-20162-ER, St. Francis Medical Center 2:18-cv-20165-ER, St. Vincent Medical Center 2:18-bk-20164-ER, Seton Medical Center 2:18-cv-20167-ER, O'Connor Hospital Foundation 2:18-bk-20179-ER, Saint Louise Regional Hospital Foundation 2:18-cv-20172-ER, St. Francis Medical Center of Lynwood Foundation 2:18-cv-20178-ER, St. Vincent Foundation 2:18-cv- 20180-ER, St. Vincent Dialysis Center, Inc. 2:18-cv-20171- ER Seton Medical Center Foundation 12:8-cv-20175-ER, Verity Business Services 2:18-cv-20173-ER, Verity Medical Foundation 2:18-cv-20169-ER, Verity Holdings, LLC 2:18-cv-20163-ER, DePaul Ventures, LLC 2:18-cv-20176-ER, and DePaul Ventures – San Jose Dialysis, LLC 2:18-cv-20181-ER.

Possession.	**STRATEGIC GLOBAL MANAGEMENT, INC.'S NOTICE OF MOTION AND MOTION TO: (1) AUGMENT RECORD ON APPEAL AND REQUEST FOR JUDICIAL NOTICE; AND (2) ACCEPT THE SALE CORRESPONDENCE FILED UNDER SEAL WITH THE BANKRUPTCY COURT FOR PURPOSES OF THE APPEALS; DECLARATION OF GARY E. KLAUSNER IN SUPPORT THEREOF**
STRATEGIC GLOBAL MANAGEMENT, INC., Appellant, v. STATE OF CALIFORNIA; VERITY HEALTH SYSTEM OF CALIFORNIA, INC., *et al*. Appellees.	[NO HEARING REQUIRED]

PLEASE TAKE NOTICE that Appellant, Strategic Global Management, Inc. ("SGM") hereby submits the attached motion (the "Motion") requesting that the Court enter an order: (1) augmenting the Record on Appeal and taking judicial notice of the Additional Medi-Cal Documents, pursuant to Federal Rule of Appellate Procedure 10(e) and Federal Rule of Evidence 201; and (2) accepting the Sale Correspondence filed by the Debtors under seal with the Bankruptcy Court for the purposes of the Appeals, pursuant to Federal Rule of Bankruptcy Procedure 8009(f).

PLEASE TAKE FURTHER NOTICE that the Motion is based on this Notice of Motion and Motion, the Declaration of Gary E. Klausner in support of the Motion (the "Klausner Declaration"), the arguments of counsel at any hearing on the Motion, and any other admissible evidence brought before the Court.

PLEASE TAKE FURTHER NOTICE that SGM will serve this Notice of Motion and Motion, and the Klausner Declaration on the parties set forth in the Proof of Service attached hereto. Pursuant to Federal Rule of Bankruptcy Procedure 8013(a)(3): (1) a response to the Motion must be filed within 7 days after service of the Motion; and (2) a reply to a response to the Motion must be filed within 7 days after service of the response.

PLEASE TAKE FURTHER NOTICE that, in the event that the Court sets a hearing on the Motion, SGM shall provide notice of entry of the order setting the hearing as directed by the Court.

Dated: February 13, 2020

LEVENE, NEALE, BENDER, YOO & BRILL L.L.P.

By: */s/ Gary E. Klausner*
Gary E. Klausner
Jeffrey S. Kwong

MEMORANDUM OF POINTS AND AUTHORITIES

Appellant, Strategic Global Management, Inc. ("SGM") hereby moves this Court for an order (1) augmenting the Record on Appeal and taking judicial notice of the Additional Medi-Cal Documents (defined below), pursuant to Federal Rule of Appellate Procedure 10(e) and Federal Rule of Evidence 201; and (2) accepting the Sale Correspondence (defined below) filed by the Debtors under seal with the Bankruptcy Court for the purposes of the Appeals, pursuant to Federal Rule of Bankruptcy Procedure 8009(f).

A. The Court Should Enter An Order Augmenting The Record On Appeal To Include The Additional Medi-Cal Documents.

SGM requests that the Court augment the Record on Appeal and take judicial notice of the following pleadings and documents (the "Additional Medi-Cal Documents"):

Filing Date	Bankr. Docket No. (Opening Brief Reference[3])	Docket Text
3/22/2019	1879 (Augment Mot. Ex. 1)	Creditor California Department of Health Care Services's Objection to Notice of Counterparties to Executory Contracts and Unexpired Leases of the Debtors That May be Assumed and Assigned (ECF No. 1704) (Filed by Creditor California Department of Health Care Services)

[3] For purposes of SGM's Opening Brief, the Additional Medi-Cal Documents will be cited to in the manner described below.

Filing Date	Bankr. Docket No. (Opening Brief Reference[3])	Docket Text
04/10/2019	2115 (Augment Mot. Ex. 2)	Debtors' Memorandum in Support of Entry of an Order: (A) Authorizing the Sale of Property Free and Clear of All Claims, Liens and Encumbrances; (B) Authorizing the Assumption and Assignment of Designated Executory Contracts and Unexpired Leases; and (C) Granting Related Relief (Filed by Debtor Verity Health System of California, Inc.)
9/11/2019	3043 (Augment Mot. Ex. 3)	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 (Filed by Creditor California Department of Health Care Services)
09/18/2019	3095 (Augment Mot. Ex. 4)	Debtors' Reply to California Department of Health Care Services Objection to Debtors' Sale of Assets to Strategic Global Management (Filed by Debtor Verity Health System of California, Inc.)
9/26/2019	3146 (Augment Mot. Ex. 5)	Memorandum of Decision Authorizing Debtors to Sell Medi-Cal Provider Agreements, Free and Clear of Interests Asserted by the California Department of Health Care Services, Pursuant to § 363(f)(5)
10/8/2019	3322 (Augment Mot. Ex. 6)	Notice of Lodgment of Order in Bankruptcy Case re: Debtors' Bid Procedures Motion [Docket No. 1279] (Filed by Debtor Verity Health System of California, Inc.)

Filing Date	Bankr. Docket No. (Opening Brief Reference[3])	Docket Text
10/09/2019	3327 (Augment Mot. Ex. 7)	Notice of Appeal and Statement of Election (Filed by Creditor California Department of Health Care Services)
10/09/2019	3330 (Augment Mot. Ex. 8)	Creditor California Department of Health Care Services's Opposition to the Proposed Order [ECF No. 3322] (Filed by Creditor California Department of Health Care Services)

Attached as **Exhibits "1" to "8"** to the Declaration of Gary E. Klausner in support of the Motion (the "Klausner Declaration") are the Additional Medi-Cal Documents, in the order that they were filed with the Bankruptcy Court.

On February 4, 2020, SGM requested that all parties to the Appeals stipulate to supplement the record with the Additional Medi-Cal Documents; SGM's request (attaching a copy of a proposed stipulation to supplement the record) was ignored. Since SGM's Opening Brief is due on February 14, 2020, SGM is requesting that it be allowed to augment the record so that the Additional Medi-Cal Documents can be properly cited in its Opening Brief. Unless and until the Court rules on this Motion, SGM will refer to the Additional Medi-Cal Documents in the following form: "(Augment Mot. Ex. __)."

Federal Rule of Appellate Procedure 10(e)(2), applicable to bankruptcy proceedings and appeals,[4] states in part that:

[4] *In re Food Fair, Inc.*, 15 B.R. 569, 571 (Bankr. S.D.N.Y. 1981) ("Appellate Rule 10(e) sets forth such a procedure, and, as Colliers commentary states, Appellate Rule 10(e) would probably apply to correction or modification of the record in a bankruptcy proceeding. 13 Collier on Bankruptcy, 14th ed., P 806.03. This Court *views Appellate Rule 10(e) as applicable to bankruptcy proceedings* to correct or modify a record on appeal.") (emphasis added).

> If anything material to either party is *omitted* from or misstated in the record by error or accident, the omission or misstatement *may be corrected and a supplemental record may be certified and forwarded*:
>
> > (A) on stipulation of the parties; (B) by the district court before or after the record has been forwarded; or (C) by the court of appeals.

F.R.A.P. 10(e)(2) (emphasis added). In turn, Bankruptcy Rule 8006 provides that the record on appeal shall include "the items so designated by the parties, the notice of appeal, the judgment, order, or decree appealed form, and any opinion, findings of fact, and conclusions of law of the [bankruptcy] court." Fed. R. Bankr. P. 8006. Acting as an appellate court, the district court is authorized, exercising its discretion, to "supplement the record in a bankruptcy appeal, and to take judicial notice of appropriate evidence." *In re Musilli*, 398 B.R. 447, 453 (E.D. Mich. 2008), *aff'd on other grounds*, 379 F. App'x 494 (6th Cir. 2010). *See also Rivera-Siaca v. DCC Operating, Inc.*, 416 B.R. 9, 17 (D.P.R. 2009) ("Rule 10(e) gives the appellate court *discretion* to supplement the record on appeal.") (emphasis added); *In re Prudential Lines, Inc.*, 1994 WL 142017, *1 (S.D.N.Y. April 20, 1994) ("This Court, in its posture as appellate court, has discretion to augment the record pursuant to the second sentence of the Rule 10(e), relating to misstatements or omissions due to errors or accidents."). In determining whether to exercise discretion, courts have considered the following factors that favor allowing a party to supplement the record on appeal:

- (1) where the documents at issue consist of "proceedings before other federal courts and state courts of record";[5]

[5] *See Musilli*, 398 B.R. at 453 ("All but Attachment 6 are copies of proceedings before the Bankruptcy Court, Oakland County Circuit Court Judges Mester and Potts, the Michigan Court of Appeals, and the Federal District Court for the Eastern District of Michigan").

- (2) where the documents at issue were considered or "filed with the court below";[6]
- (3) where the documents at issue establishes a fact that both parties concede to be true;[7] and
- (4) where the documents will assist the appellate court in the appellate case.[8]

There is a large body of law both within and outside of the Ninth Circuit which permits appellate courts to take judicial notice, pursuant to Federal Rule of Evidence 201 or otherwise, "of proceedings in other courts, both within and without the federal judicial system, if those proceedings have a direct relation to matters at issue." *United States v. Borneo, Inc.*, 971 F.2d 244, 248 (9th Cir. 1992) (*citing St. Louis Baptist Temple, Inc. v. FDIC*, 605 F.2d 1169, 1172 (10th Cir.1979)).

Here, although SGM's designations of record filed in the Appeals [Doc.

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[6] *In re W. T. Grant Co.*, 432 F. Supp. 105, 107 (S.D.N.Y. 1977) ("Here, it would be pointless to submit this dispute over the record on appeal to the bankruptcy court since all parties are in agreement that the three letters objected to by U.S. Trust came before the bankruptcy court and were relied upon in rendering its decision[.]").

[7] *See Brody By and Through Sugzdinis v. Spang*, 957 F.2d 1108, 1114 (3d Cir. 1992) ("Although this fact is not part of the record below, the parties to this appeal have submitted a stipulation pursuant to Fed. R. App. P. 10(e), stating that these two parents do have such younger children in the Downingtown school system. Rule 10(e) permits us, in our discretion, to supplement the record on appeal in this manner[.]"); FEDERAL PRACTICE AND PROCEDURE (WRIGHT & MILLER), § 3956.4 Correction or Modification of the Record, 16A Fed. Prac. & Proc. Juris. § 3956.4 (5th ed., Aug. 2019 Update) ("Supplementation may be particularly likely to occur if the item added to the record establishes a fact that both parties concede to be true").

[8] *In re Geriatrics Nursing Home, Inc.*, 187 B.R. 128, 131 (D.N.J. 1995) (denying motion to supplement because "Court [was] not convinced that supplementing the record will assist it in deciding this appeal. Therefore, the Court shall deny the appellee's motion to supplement the record on appeal.").

Nos. 3810, 3811 & 3812] (the "SGM Designations") include the Bankruptcy Court's Medi-Cal Order, the Additional Medi-Cal Documents (including the Bankruptcy Court's memorandum decision supporting the Medi-Cal Order) were inadvertently excluded.

The Court should exercise its discretion to allow SGM to include in the record the Additional Medi-Cal Documents, because they are not only documents that were "considered," filed," or entered by the Bankruptcy Court, but also constitute "proceedings" that took place in the Bankruptcy Court prior to the entry of the appealed November 27 Order. *See Musilli*, 398 B.R. at 453; *W. T. Grant Co.*, 432 F. Supp. at 107. Specifically, the Additional Medi-Cal Documents were either: (1) filed by the Debtors or the California Department of Health Care Services ("DHCS") prior to the Bankruptcy Court's entry of the Med-Cal Order, such that they were read and considered by the Bankruptcy Court prior to its decision on the Medi-Cal issue[9]; or (2) entered by the Bankruptcy Court prior to entry of the Medi-Cal Order. *See e.g.*, (Doc. No. 3146) (Medi-Cal Memorandum Decision, "The Court considered the following papers in adjudicating this matter . . . . "). Importantly, none of the appellees will be prejudiced by the augmentation of the record requested herein because the Debtors themselves litigated the Medi-Cal issues, and are fully familiar with the Additional Medi-Cal Documents.

Further, the Additional Medi-Cal Documents will assist this Court in analyzing the Opening Brief, and the issues presented in the Appeals, because they complement, explain, and/or are the foundation for the Bankruptcy Court's "*Order Authorizing Debtors to Sell Medi-Cal Provider Agreements, Free and Clear of Interests Asserted by the California Department of Health Care Services, Pursuant*

[9] *See* (Doc. No. 3372, 3) (Medi-Cal Order, "The Court, having considered the Sale Motion and the Sale Brief, the DHCS Objections, the Debtors' Reply, the Committee's Reply, and the DHCS' objection to the Debtors' proposed form of order memorializing the relief granted in the Memorandum Decision [Docket No. 3330] . . . . ").

to §§ 363(b) and (f)(5)" [Doc. No. 3372] entered on October 11, 2019 (the "Medi-Cal Order") which, in turn, the Bankruptcy Court cited to, and relied on in its appealed November 27 Order and accompanying Memorandum Decision to find that the Debtors have satisfied all of its conditions to closing the Sale (including, and namely, Section 8.7 of the APA). *See* (Doc. No. 3723, n.7) (November 27 Memorandum Decision, "The Debtors materially complied with Article 8.7 by obtaining an order authorizing the transfer of the Medi-Cal Provider Agreements free and clear of any interest asserted by the DHCS. See *Order Authorizing Debtors to Sell Medi-Cal Provider Agreements, Free and Clear of Interest Asserted by the California Department of Health Care Services, Pursuant to §§ 363(b) and (f)(5) [Doc. No. 3372].*") (emphasis added). *See also Geriatrics Nursing Home, Inc.*, 187 B.R. at 131.

The Additional Medi-Cal Documents will provide this Court with a more complete record regarding the Bankruptcy Court's finding that the Debtors have satisfied all of their conditions for closing to obligate SGM to close on December 5, 2019 – which is disputed by SGM, and the subject of the Appeals.

In light of the foregoing, this Court may augment the record on appeal and take judicial notice of the documents attached hereto.

B. The Court Should Accept The Sale Correspondence Filed Under Seal With The Bankruptcy Court.

The Bankruptcy Court considered, relied on, and cited to the "*Correspondence Regarding the SGM Sale Related to Debtors' Status Report*" that was filed under seal by the Debtors on November 26, 2019 (the "Sale Correspondence") in its November 27 Memorandum Decision.[10] *See* (Doc. No. 3723, n.7) (November 27 Memorandum Decision, "SGM has made representations to the Debtors that provide reasonable grounds for the Debtors to doubt that SGM

[10] For purposes of SGM's Opening Brief, the Sale Correspondence will be referred to as "(Augment Mot. Ex. 9)."

will fulfill its obligations under the APA. (*The contents of those representations are not discussed herein because they have been presented to the Court under seal*.) In response to the Debtors' demand for written assurance that SGM would fulfill its obligations, SGM sent the Debtors two letters [dated November 22 and November 25] casting further doubt upon whether it would perform under the APA (the "Nov. 22 Letters") . . . . *The Nov. 22 Letters contain 19 single-spaced pages of legal argument and 38 pages of supporting exhibits*. SGM's arguments regarding its obligations under the APA have been fully presented to the Court.") (emphasis added).

The Sale Correspondence was included in the SGM Designations, and there is no dispute that certain of the letters sent by SGM to the Debtors (constituting a portion of the Sale Correspondence) were considered, and served as a basis for the Bankruptcy Court's November 27 Order and Memorandum Decision. However, because the Sale Correspondence (and the letters therein) were filed under seal with the Bankruptcy Court, it is necessary for this Court to formally accept the documents from the Bankruptcy Court as part of the record on appeal of the Orders.

This Court has authority to obtain the sealed document from the clerk of the Bankruptcy Court under Federal Rule of Bankruptcy Procedure 8009(f) which provides, in relevant part, that "a document placed under seal by the bankruptcy court may be designated as part of the record on appeal." Fed. R. Bankr. P. 8009(f). The party designating it "must identify it without revealing confidential or secret information, but the bankruptcy clerk must not transmit it to the clerk of the court where the appeal is pending as part of the record." *Id*. "Instead, a party must file a motion with the court *where the appeal is pending* to accept the document under seal. If the motion is granted, the movant must notify the bankruptcy court of the ruling, and the bankruptcy clerk must promptly transmit

the sealed document to the clerk of the court where the appeal is pending." *Id.* (emphasis added.)

SGM emphasizes that it is *not* seeking to "unseal" the Sale Correspondence so that its contents would be revealed to the public – only that the Court accept it for purposes of the Appeals. Unlike "Plan B" which was not made available to SGM, the Sale Correspondence includes, among other correspondence: (1) a letter sent by the Debtors to SGM on November 20; and (2) letters sent by SGM to the Debtors on November 22 and 25, SGM has access to, and can (if necessary and ordered to do so) promptly file or submit these documents with this Court (under seal or otherwise) for its consideration in the Appeals.

Like the Additional Medi-Cal Documents, SGM intends to reference, and cite to the Sale Correspondence in its Opening Brief. Inclusion of the Sale Correspondence in the record on appeal will provide this Court with a more complete record regarding the Bankruptcy Court's finding that the Debtors have satisfied all of their conditions for closing to obligate SGM to close on December 5, 2019, which is disputed by SGM and the subject of the Appeals. Further, because both the Debtors and SGM have access to the Sale Correspondence, and the Sale Correspondence was considered by the Bankruptcy Court prior to the its entry of the November 26 Order and accompanying Memorandum Decision, there is no prejudice to any party for this Court to "accept," and consider these documents.

CONCLUSION

For the foregoing reasons, SGM respectfully requests the Court enter an order: (1) granting the Motion; (2) augmenting the Record on Appeal and taking judicial notice of the Additional Medi-Cal Documents; (3) accepting the Sale Correspondence filed by the Debtors under seal with the Bankruptcy Court for the purposes of the Appeals; and (4) affording such other relief as if appropriate under the circumstances.

Dated: February 13, 2020

LEVENE, NEALE, BENDER, YOO & BRILL L.L.P.

By: /s/ Gary E. Klausner
GARY E. KLAUSNER
JEFFREY S. KWONG
Attorneys for Strategic Global Management, Inc.

DECLARATION OF GARY E. KLAUSNER, ESQ.

I, Gary E. Klausner, declare as follows:

1. I am over 18 years of age. I have personal knowledge of the facts set forth below and, if called to testify, would and could competently testify thereto.

2. I am a partner of Levene, Neale, Bender, Yoo & Brill L.L.P. ("LNBYB"), bankruptcy counsel for Strategic Global Management, Inc. ("SGM"). I am licensed to practice law in the State of California and before this court.

3. I submit this Declaration in support of the foregoing Motion. Unless otherwise indicated, all capitalized but undefined terms herein shall have the same meanings ascribed to them in the Motion.

4. The Additional Medi-Cal Documents were inadvertently excluded from SGM's designations of record filed in the Appeals (the "SGM Designations"). Attached as **Exhibits "1" to "8"** hereto are the Additional Medi-Cal Documents, in the order that they were filed with the Bankruptcy Court.

5. Most, if not all, of the Additional Medi-Cal Documents were considered by the Bankruptcy Court before it entered the Medi-Cal Order.

6. The Sale Correspondence was included in the SGM Designations, and was considered by the Bankruptcy Court prior to the entry of its November 27 Order and accompanying Memorandum Decision.

7. SGM intends to reference, and cite to the Additional Medi-Cal Documents and Sale Correspondence in its Opening Brief that will be filed with this Court.

8. On February 4, 2020, SGM requested that all parties to the Appeals stipulate to supplement the record with the Additional Medi-Cal Documents; SGM's request (attaching a copy of a proposed stipulation to supplement the record) was ignored. Since SGM's Opening Brief is due on February 14, 2020, SGM is requesting that it be allowed to augment the record so that the Additional Medi-Cal Documents can be properly cited in its Opening Brief.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct. Executed February 13, 2020, at Los Angeles, California.

/s/ Gary E. Klausner
GARY E. KLAUSNER

EXHIBIT "1"

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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 OBJECTION TO NOTICE OF COUNTERPARTIES TO EXECUTORY CONTRACTS AND UNEXPIRED LEASES OF THE DEBTORS THAT MAY BE ASSUMED AND ASSIGNED (ECF NO. 1704)** Hearing: April 17, 2019 Time: 10:00 a.m. Courtroom: 1568 Judge Ernest M. Robles

Affects All Debtors.
Affects Verity Health System of California, Inc.
Affects O'Connor Hospital
Affects Saint Louise Regional Hospital
/x/ Affects St. Francis Medical Center
/x/ Affects St. Vincent Medical Center
/x/ 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
/x/ 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

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Affects De Paul Ventures – San Jose Dialysis, LLC,

Debtors and Debtors in Possession.

TABLE OF CONTENTS

	Page
INTRODUCTION	1
PROCEDURAL BACKGROUND	2
FACTUAL BACKGROUND	2
STATUTORY BACKGROUND	2
I. Administration of the Medi-Cal Program	2
II. Medi-Cal Financing	3
III. Delivery of Medi-Cal Services	4
IV. Payments to Hospitals for Medi-Cal Services	5
V. Hospital Quality Assurance Fee	6
VI. Statutory Basis for Collection of HQA Fees	6
FACTUAL BACKGROUND	7
I. St. Vincent Medical Center's HQA Fee Debt to Medi-Cal	7
II. Seton Medical Center's HQA Fee Debt to Medi-Cal	8
III. St. Francis Medical Center's HQA Fee Debt to Medi-Cal	9
IV. St. Vincent Dialysis Center	10
IV. Debtors Continue as Medi-Cal Providers Post Petition	10
ARGUMENT	10
I. Medi-Cal Agreements Are Executory Contracts	10
II. Case Law Affirms that the Agreements Are Executory Contracts	13
III. The Agreements Cannot Be Sold Free and Clear of Debt Owed to Medi-Cal under 11 U.S.C. § 363	15
IV. The Agreements, as Executory Contracts, Require Cure of Defaults and Debts	19
V. Debtors' Agreements Require Successor Liability by the Buyer	20
CONCLUSION	21

TABLE OF AUTHORITIES

Page

CASES

Atkin v. Parker
472 U.S. 115 (1985) 16

Bell v. Burson
402 U.S. 535 (1971) 16

Cervoni v. Secretary of Health, Education and Welfare
581 F.2d 1010 (1st Cir. 1978) 16

Devine v. Cleland
616 F. 2d 1080 (9th Cir. 1980) 16

Erickson v. United States Department of Health and Human Services
67 F. 3d 858 (9th Cir. 1995) 16, 17

Goldberg v. Kelly
397 U.S. 254, 262, 90 S. Ct. 1011, 25 L. Ed. 2d 287 (1970) 15

In re Berks Behavioral Health, LLC
2010 WL 4922173 (Bankr. E.D. Pa. 2010) 17

In re Gardens Regional Hospital and Medical Center, Inc.
2018 WL 1354334 12

In re Gardens Regional Hospital and Medical Center, Inc. (*In re Gardens*)
569 B.R. 788 (Bankr. C.D. Cal. 2017) 11, 13, 15

In re Hefferman Memorial Hospital District
192 B.R. 228 (S.D. Cal. 1996) 14, 15

In re Holland Enterprises, Inc. (*In re Holland*)
25 B.R. 301 (Bankr. E.D. N.C. 1982) 11, 19, 20

In re Holyoke Nursing Home, Inc.
372 F.3d 1 (1st Cir. 2004) 13, 14

In re Memorial Hosp. of Iowa County, Inc.
82 B.R. 478 (W. D. Wis. 1988) 15, 19

TABLE OF AUTHORITIES
(continued)

Page

In re Monsour Medical Center
8 B.R. 606 (Bankr. W.D. Pa. 1981) 10, 11, 14, 15

In re Octagon Roofing
123 B.R. 583 (Bankr. N.D. Ill. 1991) 18

In re Slater Health Center, Inc.
294 B.R. 423 (Bankr. D. RI. 2003) 14

In re St. Johns Home Health Agency Co.
173 B.R. 238, 242 n.1 (S.D. Fl. 1994) 14

In re St. Mary Hospital
89 B.R. 503 (E.D. Pa. 1988) 20

In re: Thane International, Inc. v. 9472541 Canada Inc.
586 B.R. 540 (Bankr. D. Del. 2018) 19

In re Tidewater Memorial Hospital, Inc.
106 B.R. 876 (Bankr. E.D. Va. 1989) 20

In re University Medical Center
973 F.2d 1065 (3rd Cir. 199) 14

In re Vitalsigns Homecare, Inc.
396 B.R. 232 (Bankr. D. Mass. 2008) 14

Koerpel v. Heckler
797 F.2d 858 (10th Cir. 1986) 16

Lin v. State of California
78 Cal. App. 4th 931 (Ct. App. 2012) 16

Mednik v. State Department of Health Care Services
175 Cal. App. 4th 631 (Ct. App. 2009) 12

Richmond Leasing Co. v. Capital Bank, N.A.
762 F.2d 1303 (5th Cir. 1985) 19

TABLE OF AUTHORITIES
(continued)

Page

Southeast Kansas Community Action Program v. Secretary of Agriculture of the United States
967 F.2d 1452 (10th Cir. 1992) 15

STATUTES

11 U.S.C.
§ 363 ..... 15, 17
§ 363(f) 18, 19
§ 365 ..... *passim*
§ 365(b) 19
§§ 1107(a) and 1108 2

42 U.S.C.
§ 1396a 3
§ 1396a, et seq. 3
§ 1396b 3
§§ 1396b(a) and 1396d(b) (2016) 3
§ 1396b(w) (2017) 4

Cal. Code Regs. Title 22, § 50004(b)(1) (2017) 3

Cal. Welf. & Inst. Code
§ 10740 (West 2017) 3
§ 14016.5(b) (West 2014) 4
§ 14063 (West 2017) 3
§§ 14087.3-14089.8 4
§ 14132 et seq. (West 2014) 4
§ 14169.50 6
§ 14169.50(b) (West 2018) 7
§ 14169.50(d) (West 2014) 7
§§ 14169.50 through 14169.76 6
§ 14169.51(ab) (West 2014) 5
§ 14169.51(*l*) (West 2018) 4
§ 14169.52(a) (West 2014) 6
§ 14169.52(h) 7
§ 14169.53(b) (West 2014) 6
§ 14301.1 (West 2017) 5

TABLE OF AUTHORITIES
(continued)

Page

Federal Medicaid Act 3

Medi-Cal Hospital Reimbursement Improvement Act of 2013 6

Social Security Act Title XIX 3

CONSTITUTIONAL PROVISIONS

Cal. Const., Article 16, § 3.5 6

OTHER AUTHORITIES

42 C.F.R.
§§ 433.50 – 433.74 (2016) 4
§ 433.51 (2010) 3

HTTP://WWW.DHCS.CA.GOV/ 6

http://www.lao.ca.gov/BallotAnalysis/Proposition?number=52&year=2016 4

https://lao.ca.gov/ballot/2013/130602.aspx 5

Minnesota Law Review 341, 344 (1980) 10

INTRODUCTION

California Department of Health Care Services (Department) hereby objects to Notice to Counterparties to Executory Contracts and Unexpired Leases of the Debtors that May Be Assumed and Assigned (Notice). ECF No. 1704. The Notice and its accompanying exhibits do not list Debtors' Medi-Cal Provider Agreements (Agreements) as executory contracts for St. Francis Medical Center (St. Francis), St. Vincent Medical Center (St. Vincent), Seton Medical Center (Seton), and St. Vincent Dialysis Center (St. Vincent Dialysis) (collectively, Debtors or Hospitals), and the cure amounts for those Medi-Provider Agreements as executory contracts. The Notice's failure to list the Medi-Cal Provider Agreements as executory contracts contradicts the specific terms of the Agreement and the law. 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 Stalking Horse Bidder (Buyer) misrepresents that the Agreements will be transferred as licenses. APA 66, ECF No. 1279. Debtors' Agreements are executory contracts that must be assumed and assigned to the buyer.

For the intended assumption and assignment to occur and given the agreed payment arrangements between the Buyer and Debtors, Debtors must pay all of HQA Fees liabilities for Phase V (to cure by paying all of the HQA Fees in default before the closing of the sale, which is consistent with Debtors' representation in the APA that it would pay all of HQA Fee liabilities for Phases IV and V before the sale closing) in the amount of $79,969,946.80 before the closing of the sale. In addition to the HQA Fee debt, Debtors and/or the Buyer (through joint and several liability) must also reimburse the Department for any Medi-Cal overpayments and pay other debts owed to the Department.

Accordingly, the Notice and its accompanying exhibits must be corrected because they are erroneous. The Agreements should have been included in the Notice and the accompanying exhibits along with the cure amounts for the assumption and assignments of those Agreements.

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 stalking horse bidder 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.

On March 5, 2019, Debtors filed the Notice and the accompanying exhibits. ECF No. 1704.

FACTUAL BACKGROUND

Debtors filed a copy of the APA on January 17, 2019. ECF No. 1279. Pursuant to Sections 1.7 and 1.7(u) of the APA, the Buyer intends to acquire all of the Hospitals' rights, title, and interests in the Agreements. Along with the intended acquisition of those rights and interests is the Buyer's assumption of any and all obligations, claims, and liabilities under the Agreements. APA 66 and 69, ECF No. 1279.

Further, as set forth in Sections 1.1 and 1.1(d) of the APA, Debtors will pay any HQA Fees owing under Phases IV and V of the HQA Fee Program. APA 61-62, 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 medical assistance to eligible low-income individuals. 42 U.S.C. § 1396a & b (2016). 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 2017). The Department is the single state agency authorized to administer the Medi-Cal program. Cal. Welf. & Inst. Code § 10740 (West 2017); Cal. Code Regs. tit. 22, § 50004(b)(1) (2017).

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) (2016). 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 (2010).

> 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) (2017); 42 C.F.R. §§ 433.50 – 433.74 (2016).

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 2018). 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.

II. 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 2014). 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 2014).

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 2014). 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 2014) (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 2017).

III. 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 2014).

IV. 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 2014).

V. 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 2018). "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 2014) (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).

FACTUAL BACKGROUND

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

St. Vincent Medical Center, as of March 15, 2019, has HQA Fee liabilities for Phase V in the amount of **$21,427,707.82.**

ST. VINCENT MEDICAL CENTER (NPI# 1124004304) (OSHPD# 106190762)					
PHASE V		AMOUNT DUE	DUE DATE	WITHHELD	OUTSTANDING BALANCE
FISCAL YEAR	CYCLE (PERIOD)				
2017/18	MANAGED CARE 2 (Directed) (07/01/2017-06/30/2018)	$2,575,439.74	TBD	$0.00	$2,575,439.74
2018/19	CYCLE 7 (07/01/2018 - 09/30/2018)	$3,433,071.00	10/3/2018	$537,551.92	$2,895,519.08
	CYCLE 8 (10/01/2018-12/31/2018)	$3,433,071.00	1/2/2019	$0.00	$3,433,071.00
	CYCLE 9 (01/01/2019-03/31/2019)	$3,433,071.00	4/3/2019	$0.00	$3,433,071.00
	CYCLE 10 (04/01/2019-06/30/2019)	$3,433,071.00	7/3/2019	$0.00	$3,433,071.00
	MANAGED CARE 3 (Passthrough) (07/01/2018-06/30/2019)	$2,828,768.00	TBD	$0.00	$2,828,768.00
	MANAGED CARE 3 (Directed) (07/01/2018-06/30/2019)	$2,828,768.00	TBD	$0.00	$2,828,768.00

Total Outstanding Balance	$21,427,707.82

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

Seton Medical Center, as of March 15, 2019, has outstanding HQA Fee liabilities for Phase V in the amount of **$28,160,469.45**, as shown below:

SETON MEDICAL CENTER (NPI# 1154428688) (OSHPD# 106410817)					
PHASE V		AMOUNT DUE	DUE DATE	WITHHELD	OUTSTANDING BALANCE
FISCAL YEAR	CYCLE (PERIOD)				
2016/17	CYCLE 1 (01/01/2017 – 03/31/2017)	$2,040,467.00	2/5/2018	$0.00	$2,023,405.60
	CYCLE 2 (04/01/2017 – 06/30/2017)	$2,040,467.00	2/28/2018	$0.00	$2,040,467.00
2016/17	MANAGED CARE 1 (Passthrough) (01/01/2017-06/30/2017)	$1,870,925.10	3/13/2019	$1,870,925.10	$1,758,838.00
2017/18	CYCLE 3 (07/01/2017 - 09/30/2017)	$2,223,369.00	3/21/2019	$0.00	$2,223,369.00
	CYCLE 4 (10/01/2017 - 12/31/2017)	$2,223,368.94	4/11/2018	$0.00	$2,223,368.94
	CYCLE 5 (01/01/2018 - 03/31/2018)	$2,223,369.00	5/2/2018	$0.00	$2,223,369.00
	CYCLE 6 (04/01/2018 – 06/30/2018)	$2,223,369.00	7/11/2018	$0.00	$2,223,369.00
	MANAGED CARE 2 (Passthrough) (07/01/2017 – 06/30/2018	$1,893,251.67	3/13/2019	$1,893,251.67	$0.00
	MANAGED CARE 2 (Directed) (07/01/2017 – 06/30/2018	$1,903,985.91	TBD	$0.00	$1,903,985.91
2018/19	CYCLE 7 (07/01/2018 - 09/30/2018)	$2,293,835.00	10/3/2018	$0.00	$2,293,835.00

	CYCLE 8 (10/01/2018 - 12/31/2018)	$2,293,835.00	1/2/2019	$0.00	$2,293,835.00
	CYCLE 9 (01/01/2019- 03/31/2019)	$2,293,835.00	4/3/2019	$0.00	$2,293,835.00
	CYCLE 10 (04/01/2019- 06/30/2019)	$2,293,835.00	7/3/2019	$0.00	$2,293,835.00
	MANAGED CARE 3 (Passthrough) (07/01/2018- 06/30/2019)	$2,061,897.50	TBD	$0.00	$2,061,897.50
	MANAGED CARE 3 (Directed) (07/01/2018- 06/30/2019)	$2,061,897.50	TBD	$0.00	$2,061,897.50
Total Outstanding Balance					**$28,160,469.45**

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

St. Francis Medical Center, as of March 15, 2019, has HQA Fee liabilities for Phase V in the amount of **$30,381,769.53**.

ST. FRANCIS MEDICAL CENTER (NPI# 1487697215) (OSHPD# 106190754)					
PHASE V		**AMOUNT DUE**	**DUE DATE**	**WITHHELD**	**OUTSTANDING BALANCE**
FISCAL YEAR	**CYCLE (PERIOD)**				
2017/18	**MANAGED CARE 2** (Directed) (07/01/2017- 06/30/2018)	$5,354,709.53	TBD	$0.00	$5,354,709.53
2018/19	**CYCLE 9** (01/01/2019 - 03/31/2019)	$6,703,466.00	4/3/2019	$0.00	$6,703,466.00
	CYCLE 10 (04/01/2019- 06/30/2019)	$6,703,466.00	7/3/2019	$0.00	$6,703,466.00
	MANAGED CARE 3 (Passthrough) (07/01/2018- 06/30/2019)	$5,810,064.00	TBD	$0.00	$5,810,064.00
	MANAGED CARE 3 (Directed) (07/01/2018- 06/30/2019)	$5,810,064.00	TBD	$0.00	$5,810,064.00
Total Outstanding Balance					**$30,381,769.53**

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IV. ST. VINCENT DIALYSIS CENTER

St. Vincent Dialysis has an existing overpayment debt of $372.52, which must be reimbursed to the Department.

OVERPAYMENTS DEBT SUMMARY (UPDATED 01/23/2019)

Provider	NPI	Outstanding Balance
St. Vincent Dialysis Center	1992700314	$375.52

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.

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 I*, 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 these 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

The Agreements cannot be sold by Debtors as assets free and clear of any liabilities, obligations, and claims.

The Ninth Circuit and other circuits have firmly held that providers are not entitled to continued participation in the Medicare and Medicaid programs (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, Medicare providers, 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 Provider 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 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, Ex. A, § 8.8, ECF No. 365-1.

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. As such, Debtors must cure by paying the HQA Fees in default.

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

It is well settled that curing 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 existing HQA Fees debt – HQA Fees in default – must be paid by Debtors before closing of the sale.

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 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, 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.

CONCLUSION

For the foregoing reasons, the Notice and its accompanying exhibits are erroneous. The Agreements are executory contracts that can only be assumed and assigned. To satisfy this pre-condition to assumption and assignment, Debtors must cure by paying the HQA Fees in default and the Buyer assume any and all obligations and liabilities under the Agreements with joint and several liability. The Agreements cannot be sold by Debtors to the Buyer free and clear of all liabilities, claims, and obligations.

Dated: March 22, 2019

Respectfully submitted,

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JENNIFER M. KIM
Supervising Deputy Attorney General

/s/ Kenneth K. Wang
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Attorneys for Creditor
Department of Health Care Services

LA2018602105
Verity - DHCS's Objection (FINAL 3-22-19).docx

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 OBJECTION TO NOTICE OF COUNTERPARTIES TO EXECUTORY CONTRACTS AND UNEXPIRED LEASES OF THE DEBTORS THAT MAY BE ASSUMED AND ASSIGNED (ECF NO. 1704)

DECLARATION OF HANH VO IN SUPPORT OF CREDITOR CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES'S OBJECTION TO NOTICE OF COUNTERPARTIES TO EXECUTORY CONTRACTS AND UNEXPIRED LEASES OF THE DEBTORS THAT MAY BE ASSUMED AND ASSIGNED (ECF NO. 1704)

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 **March 22, 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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2. SERVED BY UNITED STATES MAIL:

Pursuant to F.R.Civ.P. 5 and/or controlling LBR, on **March 22, 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 **March 22, 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 **March 22, 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.

March 22, 2019	Stacy McKellar	
Date	*Printed Name*	*Signature*

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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 OBJECTION TO NOTICE OF COUNTERPARTIES TO EXECUTORY CONTRACTS AND UNEXPIRED LEASES OF THE DEBTORS THAT MAY BE ASSUMED AND ASSIGNED (ECF NO. 1704)** Hearing: April 17, 2019 Time: 10:00 a.m. Courtroom: 1568 Judge Ernest M. Robles

Affects All Debtors.
Affects Verity Health System of California, Inc.
Affects O'Connor Hospital
Affects Saint Louise Regional Hospital
/x/ Affects St. Francis Medical Center
/x/ Affects St. Vincent Medical Center
/x/ 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 /x/ 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 II, serving as Chief of the General Collections Section 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 II, Chief of the General Collections Section, 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) DUE DATE – This term refers to the date upon which a particular HQA Fee payment to the Department is due.

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

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

(F) 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.

(G) 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 $21,427,707.82, for Seton Medical Center (NPI No. 1154428688, OSHPD No. 106410817) for Phases V is $28,160,469.45, and for St. Francis Medical Center (NPI No. 148769215, OSPHD No. 106190754) for Phase V is $30,381,769.53.

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.

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

Executed on this 22nd day of March 2019, at Sacramento, California.

Hanh Vo

EXHIBIT 1

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
CACH
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): St. Vincent Medical Center, Inc.	Business name (if different than legal name): St. Vincent Medical Center		
Provider number (NPI number): 1124004304 SV		Business Telephone Number: (213) 484 - 7111	
Business address (number, street): 2131 West Third Street	City: Los Angeles	State: CA	Nine-digit ZIP code: 90057-0992
Mailing address (number, street, P.O. Box number): P.O. Box 57992	City: Los Angeles	State: CA	Nine-digit ZIP code: 90057-0992
Pay-to address (number, street, P.O. Box number): 2131 West Third Street	City: Los Angeles	State: CA	Nine-digit ZIP code: 90057-0992
Previous business address (number, street, P.O. Box number): N/A	City:	State:	Nine-digit ZIP code:
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.

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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 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.

(4). Provider agrees to keep records as required by the Department pursuant to Health and Safety Code, Section 100171. (Welfare and Institutions Code, Section14123(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.

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: St. Vincent Medical 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): Cathy Fickes
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/CEO
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	CathyFickes@docha.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.

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)

ROBERT S. YESKO
Commission # 1742483
Notary Public - California
Los Angeles County
My Comm. Expires May 16, 2011

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

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EXHIBIT 2

P.2

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

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) 1487697215(Acute); 1245227180(SNF)		Business Telephone Number (310) 900-8900	
Business address (number, street) 3630 E. Imperial Highway	City Lynwood	State CA	Nine-digit ZIP code 90262
Mailing address (number, street, P.O. Box number) 3630 E. Imperial Highway	City Lynwood	State CA	Nine-digit ZIP code 90262
Pay-to address (number, street, P.O. Box number) File #56850	City Los Angeles	State CA	Nine-digit ZIP code 90074
Previous business address (number, street, P.O. Box number) N/A	City N/A	State N/A	Nine-digit ZIP code 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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AUG 26 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)).

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.
Larcenia L Freeman
(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	tanishathomas@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

8-5

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)		
SEQUOIA 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**
912154441

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

4/3/1716

* 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

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): SAINT VINCENT DIALYSIS CENTER, INC	Business name (if different than legal name):		
Provider number (NPI number): 1992700314 CDC700302		Business Telephone Number: (213) 484-7426	
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 acknowledgement 3/15/11 hh

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: gracieperez@dochs.org

Telephone Number: 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
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UN 3/15/10

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VKN 3/15/11 MCPA

STATE OF CALIFORNIA – HEALTH AND WELFARE AG

DEPARTMENT OF HEALTH SERVICES

MEDI-CAL PROVIDER DATA FORM

DEPARTMENT OF HEALTH SERVICES SACRAMENTO OCT 0 1 1982 Provider Certification Program

1. FACILITY NAME 202
St. Vincent Dialysis Center, Inc.

2. FACILITY ADDRESS
NUMBER STREET 203
201 South Alvarado Street
ROOM/SUITE
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

4. FEDERAL EMPLOYER'S ID NUMBER 212
95-3749293

5. FISCAL YEAR END MONTH 216
June 30, 1983

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 803 (11/79)

EXHIBIT 5

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

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 not to submit any claims to DHCS using an NPI unless that NPI is appropriately registered with 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:

The provider, or if the provider is a clinical owner, supplier, 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.

l. 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, Section14123(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 03/15/2019)

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) (07/01/2017-06/30/2018)	TBD	$2,575,439.74	-	$0.00	-	$0.00	=	$2,575,439.74
2018/19	CYCLE 7 (07/01/2018-09/30/2018)	10/3/2018	$3,433,071.00	-	$0.00	-	$537,551.92	=	$2,895,519.08
	CYCLE 8 (10/01/2018-12/31/2018)	1/2/2019	$3,433,071.00	-	$0.00	-	$0.00	=	$3,433,071.00
	CYCLE 9 (01/01/2019-03/31/2019)	4/3/2019	$3,433,071.00	-	$0.00	-	$0.00	=	$3,433,071.00
	CYCLE 10 (04/01/2019-06/30/2019)	7/3/2019	$3,433,071.00	-	$0.00	-	$0.00	=	$3,433,071.00
	Managed Care 3* (Passthrough) (07/01/2018-06/30/2019)	TBD	$2,828,768.00	-	$0.00	-	$0.00	=	$2,828,768.00
	Managed Care 3* (Directed) (07/01/2018-06/30/2019)	TBD	$2,828,768.00	-	$0.00	-	$0.00	=	$2,828,768.00
Total Outstanding Balance									**$21,427,707.82**

*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 03/15/2019)

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

PHASE V		DUE DATE	AMOUNT DUE		AMOUNT PAID		WITHHELD		OUTSTANDING BALANCE
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) (07/01/2017-06/30/2018)	TBD	$5,354,709.53	-	$0.00	-	$0.00	=	$5,354,709.53
2018/19	**CYCLE 8** (10/01/2018-12/31/2018)	1/2/2019	$6,703,466.00	-	$0.00	-	$6,703,466.00	=	$0.00
	CYCLE 9 (01/01/2019-03/31/2019)	4/3/2019	$6,703,466.00	-	$0.00	-	$0.00	=	$6,703,466.00
	CYCLE 10 (04/01/2019-06/30/2019)	7/3/2019	$6,703,466.00	-	$0.00	-	$0.00	=	$6,703,466.00
	Managed Care 3* (Passthrough) (07/01/2018-06/30/2019)	TBD	$5,810,064.00	-	$0.00	-	$0.00	=	$5,810,064.00
	Managed Care 3* (Directed) (07/01/2018-06/30/2019)	TBD	$5,810,064.00	-	$0.00	-	$0.00	=	$5,810,064.00
Total Outstanding Balance									**$30,381,769.53**

*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.

SETON MEDICAL CENTER (NPI# 1154428688) (OSHPD# 106410817)									
PHASE V		DUE DATE	AMOUNT DUE		AMOUNT PAID		WITHHELD		OUSTANDING BALANCE
FISCAL YEAR	CYCLE (PERIOD)								
2016/17	CYCLE 1 (01/01/2017-03/31/2017)	2/5/2018	$2,040,467.00	-	$0.00	-	$17,061.40	=	$2,023,405.60
	CYCLE 2 (04/01/2017-06/30/2017)	2/28/2018	$2,040,467.00	-	$0.00	-	$0.00	=	$2,040,467.00
	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	-	$0.00	=	$2,223,369.00
	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) (07/01/2017-06/30/2018)	TBD	$1,903,985.91	-	$0.00	-	$0.00	=	$1,903,985.91
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	-	$0.00	-	$0.00	=	$2,293,835.00
	CYCLE 10 (04/01/2019-06/30/2019)	7/3/2019	$2,293,835.00	-	$0.00	-	$0.00	=	$2,293,835.00
	Managed Care 3* (Passthrough) (07/01/2018-06/30/2019)	TBD	$2,061,897.50	-	$0.00	-	$0.00	=	$2,061,897.50
	Managed Care 3* (Directed) (07/01/2018-06/30/2019)	TBD	$2,061,897.50	-	$0.00	-	$0.00	=	$2,061,897.50
Total Outstanding Balance									**$28,160,469.45**

*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.

EXHIBIT "2"

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UNITED STATES BANKRUPTCY COURT
CENTRAL DISTRICT OF CALIFORNIA - LOS ANGELES DIVISION

In re VERITY HEALTH SYSTEM OF CALIFORNIA, INC., *et al.*, Debtors and Debtors In Possession.	Lead Case No. 2:18-bk-20151-ER Jointly Administered With: Case No. 2:18-bk-20162-ER Case No. 2:18-bk-20163-ER Case No. 2:18-bk-20164-ER Case No. 2:18-bk-20165-ER Case No. 2:18-bk-20167-ER Case No. 2:18-bk-20168-ER Case No. 2:18-bk-20169-ER Case No. 2:18-bk-20171-ER Case No. 2:18-bk-20172-ER Case No. 2:18-bk-20173-ER Case No. 2:18-bk-20175-ER Case No. 2:18-bk-20176-ER Case No. 2:18-bk-20178-ER Case No. 2:18-bk-20179-ER Case No. 2:18-bk-20180-ER Case No. 2:18-bk-20181-ER Hon. Judge Ernest M. Robles
☒ 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 ASC, LLC Debtors and Debtors In Possession.	**DEBTORS' MEMORANDUM IN SUPPORT OF ENTRY OF AN ORDER: (A) AUTHORIZING THE SALE OF PROPERTY FREE AND CLEAR OF ALL CLAIMS, LIENS AND ENCUMBRANCES; (B) AUTHORIZING THE ASSUMPTION AND ASSIGNMENT OF DESIGNATED EXECUTORY CONTRACTS AND UNEXPIRED LEASES; AND (C) GRANTING RELATED RELIEF** Hearing: Date: April 17, 2019 Time: 10:00 am Location: Courtroom 1568 255 E. Temple St., Los Angeles, CA

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TABLE OF CONTENTS

		Page
I.	STATEMENT OF FACTS	1
	A. The Bid Procedures Order	1
	B. Marketing Efforts	2
	C. The Principal Terms of the SGM APA	4
II.	ARGUMENT	10
	A. The Court Should Authorize The Debtors To Sell The Purchased Assets To SGM In Accordance With The Terms Of The APA.	10
	1. Sound Business Purpose.	11
	2. Accurate and Reasonable Notice	12
	3. Fair and Reasonable Price.	13
	4. Good Faith.	14
	B. Section 363(f) Permits the Debtors' Sale of the Purchased Assets to SGM to Be Free and Clear of Any and All Interests and Liens.	15
	1. The Debtors' Proposed Sale is Permissible Pursuant to 11 U.S.C. § 363(f)(2).	16
	2. The Debtors' Proposed Sale is Permissible Pursuant to 11 U.S.C. § 363(f)(3).	18
	3. The Debtors' Proposed Sale is Permissible Pursuant to 11 U.S.C. § 363(f)(5).	18
	C. The Court Should Authorize the Debtors to Assume and Assign to SGM All of the Assumed Contracts that SGM Designates.	20
	D. Potential Disputes Regarding Assignment of Certain Agreements to SGM	22
	E. The Court Should Waive the Fourteen-Day Waiting Periods Set Forth in Bankruptcy Rules 6004(h) and 6006(d).	22
III.	CONCLUSION	22

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TABLE OF AUTHORITIES

Page(s)

Cases

In re Abbotts Dairies of Pa., Inc.,
788 F.2d 143 (3d Cir. 1986).....9, 13, 14

In re AEG Acquisition Corp.,
127 B.R. 34 (Bankr. C.D. Cal. 1991), *aff'd* 161 B.R. 50 (B.A.P. 9th Cir. 1993) 19

In re Alpha Indus., Inc.,
84 B.R. 703 (Bankr. D. Mont. 1988) 14

In re Apex Oil Co.,
92 B.R. 847 (Bankr. E.D. Mo. 1988).....14

In re Atlanta Packaging Prods., *Inc.*,
99 B.R. 124 (Bankr. N.D. Ga. 1988) 13

In re Bowman,
194 B.R. 227 (Bankr. D. Ariz. 1995*)* 19

In re Central Fla. Metal Fabrication, Inc.,
190 B.R. 119 (Bankr. N.D. Fla. 1995) 18

Coastal Indus., Inc. v. U.S. Internal Revenue Serv. (In re Coastal Indus., Inc.),
63 B.R. 361 (Bankr. N.D. Ohio 1986) 12

Comm. of Equity SEC Holders v. Lionel Corp. (In re Lionel Corp.),
722 F.2d 1063 (2d Cir. 1983).....9, 10

In re Continental Airlines, Inc.,
780 F.2d 1223 (5th Cir. 1986).....10

In re Continental Country Club, Inc.,
114 B.R. 763 (Bankr. M.D. Fla. 1990) 18

In re Delaware and Hudson Ry. Co.,
124 B.R. 169 (D. Del. 1991) 9, 12

In re Embers 86th Street. Inc.,
184 B.R. 892 (Bankr. S.D.N.Y. 1995) 19

In re Exennium, Inc.,
715 F.2d 1401 (9th Cir. 1983).....14

In re Filtercorp, Inc.,
163 F.3d 570 (9th Cir. 1998).....14

DENTONS US LLP
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Folger Adam Sec., Inc. v. DeMatteis/MacGregor JV,
209 F.3d 252 (3d Cir. 2000).....15

In re Gardens Regional Hospital and Medical Center, Inc.,
567 B.R. 802 (Bankr. C.D. Cal 2017).....9, 10, 15

In re Grand Slam U.S.A., Inc.,
178 B.R. 460 (E.D. Mich. 1995).....17

In re Grumman Indus., Inc.,
467 B.R. 694 (S.D.N.Y. 2012).....14

In re Gucci,
193 B.R. 411 (S.D.N.Y. 1996).....18

In re Gulf States Steel, Inc. of Alabama,
285 B.R. 497 (Bankr. N.D. Ala. 2002).....17

In re Healthco Int'l Inc.,
174 B.R. 174 (Bankr. D. Mass. 1994).....17

In re Hunt Energy Co., Inc.,
48 B.R. 472 (Bankr. N.D. Ohio 1985).....17

In re Huntington, Ltd.,
654 F.2d 578 (9th Cir. 1981).....9

In *re Integrated Resources, Inc.*,
135 B.R. 746 (Bankr. S.D.N.Y. 1992), *aff'd*, 147 B.R. 650 (S.D.N.Y. 1992).....13

In re Indus. Valley Refrig. and Air Cond. Supplies, Inc.,
77 B.R. 15 (Bankr. E.D. Pa. 1987).....13

In re Karpe,
84 B.R. 926 (Bankr. M.D. Pa. 1988).....12

In re Klein Sleep Prods, Inc.,
78 F.3d 18 (2d. Cir. 1996).....18

Lubrizol Enterprises v. Richmond Metal Finishers,
756 F.2d 1043 (4th Cir. 1985), *cert. denied*, 475 U.S. 1057 (1986).....19

In re M Capital Corp.,
290 B.R. 743 (B.A.P. 9th Cir. 2003).....14

In re Martin (Myers v. Martin),
91 F.3d 389 (3d Cir. 1996).....9

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In re La Paloma Generating, Co.,
2017 WL 5197116 (Bankr. D. Del. Nov. 9, 2017) 15

Mass. Dep't of Unemployment Assistance v. OPK Biotech, LLC (In re PBBPC, Inc.),
484 B.R. 860 (1st Cir. BAP 2013) 15

P.K.R. Convalescent Ctrs., Inc. v. Commonwealth of Va., Dep't of Med. Assistance Serv. (In re P.K.R. Convalescent Ctrs., Inc.),
189 B.R. 90 (Bankr. E.D. Va. 1995) 16

In re Perroncello,
170 B.R. 189 (Bankr. D. Mass. 1994) 17

In re Prime Motors Inns,
124 B.R. 378 (Bankr. S.D. Fla. 1991) 18

In re PW, LLC,
391 B.R. 25 (B.A.P. 9th Cir. 2008) 17

In re Rock Indus. Mach. Corp.,
572 F.2d 1195 (7th Cir. 1978) 14

In re Sandy Ridge Dev. Corp.,
881 F.2d 1346 (5th Cir. 1989) 17

Scherer v. Fed. Nat'l Mortgage Ass'n (In re Terrace Chalet Apartments, Ltd.),
159 B.R. 821 (Bankr. N.D. Ill. 1993) 17

In re Schipper (Fulton State Bank v. Schipper),
933 F.2d 513 (7th Cir. 1991) 9

In re Shary,
152 B.R. 724 (Bankr. N.D. Ohio 1993) 15

In re Trans World Airlines, Inc.,
322 F.3d 283, 285, 288 (3d Cir. 2001) 15

Titusville Country Club v. Pennbank (In re Titusville Country Club),
128 B.R. 396 (Bankr. W.D. Pa. 1991) 9

United Mine Workers of Am. Combined Benefit Fund v. Leckie Smokeless Coal Co. (In re Leckie Smokeless Coal Co.),
99 F.3d 573 (2012) 15

In re Walter,
83 B.R. 14 (9th Cir. B.A.P. 1988) 9, 10

In re Wilde Horse Enterprises,
136 B.R. 830 (Bankr. C.D. Cal. 1991) 13, 14

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Statutes

11 U.S.C.
§ 101 et. seq. 9
§ 363 ....2, 11
§ 363(b) 9, 10, 11, 12
§ 363(b)(1) 13
§ 363(f) 14, 15, 16
§ 363(f)(1)-(5) 15
§ 363(f)(2) 15
§ 363(f)(3) 16, 17
§ 363(f)(5) 16, 17, 18
§ 363(m) 8, 14
§ 365 8
§ 365(a) 18
§ 365(b)(1) 19
§ 365(b)(1)(A) 20
§ 365(f)(1) 19
§ 365(f)(2) 19
§ 503(b) 8
§ 506(a) 18
§ 1107 1
§ 1107(a) 18
§ 1108 1
§ 1113 20
§ 1129 13
§ 1129(a)(3)-(b)(1) 17
§ 1129(b)(1) 17
§ 1129(b)(1) 17
§ 1129(b)(2) 17
§ 1129(b)(2)(A) 17, 18
§ 1129(b)(2)(A)(i)(II) 17
§ 1129(b)(2)(A)(iii) 17

Rules and Regulations

Federal Rules of Bankruptcy Procedure
Rule 2002 12
Rule 6004(a) 12
Rule 6004(a)(c) 12
Rule 6004(c) 12
Rule 6004(h) 21
Rule 6004(h) 21
Rule 6006(d) 21
Rule 6006(d) 21

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MEMORANDUM

Verity Health System of California, Inc. ("VHS") and the above-referenced affiliated debtors, the debtors and debtors in possession in the above-captioned chapter 11 bankruptcy case (collectively, the "Debtors"), hereby file this Memorandum in support of the entry of an order of the Court (the "Sale Order") approving the sale of four of the Debtors' hospitals (collectively, the "Hospitals") and related assets (the "Assets"), including, 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"), to Strategic Global Management, Inc., a California corporation ("SGM" or the "Stalking Horse Purchaser"), in accordance with the terms of the Asset Purchase Agreement ("APA"), attached as Exhibit "A" to the Sale and Bidding Procedures Motion (as defined below). In connection therewith, the Debtors also seek the Court's approval of the Debtors' assumption and assignment to SGM of those unexpired leases and executory contracts that SGM wishes to assume and have assigned to it (defined in the APA as the "Assumed Contracts"). For all of the reasons set forth herein and those in the Sale and Bidding Procedures Motion, the Debtors respectfully request that the Court enter the Sale Order.

I. STATEMENT OF FACTS

A. General Background And The Bid Procedures Order.

1. On August 31, 2018, the Debtors each filed a voluntary petition for relief under chapter 11 of title 11 of the Bankruptcy Code (the "Petition Date").[1] Since the commencement of their cases, the Debtors have been operating their businesses as debtors in possession pursuant to §§ 1107 and 1108.

2. On January 17, 2019, the Debtors filed the *Notice Of Motion And Motion For The Entry Of (I) An Order (1) Approving Form Of Asset Purchase Agreement For Stalking Horse*

[1] All references to § herein are to sections of the Bankruptcy Code, 11 U.S.C. §§ 101-1532; all references to "Bankruptcy Rules" are to provisions of the Federal Rules of Bankruptcy Procedure.

Bidder And For Prospective Overbidders To Use, (2) Approving Auction Sale Format, Bidding Procedures And Stalking Horse Bid Protections, (3) Approving Form Of Notice To Be Provided To Interested Parties, (4) Scheduling A Court Hearing To Consider Approval Of The Sale To The Highest Bidder And (5) Approving Procedures Related To The Assumption Of Certain Executory Contracts And Unexpired Leases; And (II) An Order (A) Authorizing The Sale Of Property Free And Clear Of All Claims, Liens And Encumbrances (the "Sale and Bidding Procedures Motion") [Docket No. 1279].

3. On February 19, 2019, the Court held a hearing on the Sale and Bidding Procedures Motion and thereafter entered an order approving the Sale and Bidding Procedures Motion (the "Bidding Procedures Order")[2] [Docket No. 1572]. SGM served as the Stalking Horse Purchaser, and the Bidding Procedures Order approved the APA, as modified therein.

4. The Bidding Procedures Order established a deadline of March 28, 2019, at 4:00 p.m. (PST), for bidders to submit partial bids for the Assets, and a deadline of April 3, 2019, at 4:00 p.m. (PST), to submit full bids for the Assets (each a "Bid Deadline"). The Partial Bid Auction was scheduled to take place on April 8, 2018, and the Full Bid Auction was scheduled to take place on April 9, 2019.

B. Marketing Efforts & Results Thereof

5. In June 2018, the Debtors engaged Cain Brothers, a division of KeyBanc Capital Markets ("Cain"), to identify potential buyers of some or all of the Verity hospitals and related assets and commenced discussions with those potential buyers. Cain prepared a Confidential Investment Memorandum and organized an online data site to share information with potential buyers and contacted over 181 strategic and financial buyers beginning in July 2018 to solicit their interest in exploring a transaction regarding the Debtors hospitals. As a result of its broad marketing process, Cain received sixteen indications of interest or other proposals, and continued to develop potential sales.

[2] Unless otherwise defined, all capitalized terms used herein shall have the meaning ascribed to them in the Bidding Procedures Order.

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6. The Debtors, in consultation with Cain and its other advisors, selected SGM's offer to serve as the stalking-horse bid to acquire the Assets through a sale under § 363. The APA was the result of extensive negotiations between the Debtors and SGM. As set forth below, under the APA, SGM submitted a stalking-horse bid to purchase the Assets for $610 million ($420 million allocated to St. Francis Medical Center, $120 million allocated to St. Vincent Medical Center and $70 million allocated to Seton Medical Center and Seton Coastside combined), plus payments of cure costs, as set forth therein.

7. Thereafter, in accordance with the bidding procedures, Cain continued to actively market the Assets. As a part of this process, Cain vigilantly monitored interest and continued to communicate with parties that had expressed interest and that Cain had identified as potential bidders, either as partial or aggregate bidders. Cain's marketing process was meant to identify and shepherd any bidders who could contribute to a competitive auction. Cain notified 90 parties that had previously sent a Non-Disclosure Agreements ("NDA") of the sale process, directly sent these parties the approved Bidding Procedures and represented Cain's availability to assist in the bidding process. Thereafter, sixteen parties who executed NDAs requested continued access to the data room containing information about the Assets. Cain continued to populate the data room it had opened with new and relevant information as it became available.

8. On the applicable Bid Deadlines, the Debtors received two partial bids and one full system bid. Thereafter, the Debtors consulted with the Consultation Parties regarding the bids received and deemed the two partial bids Qualified Full Bids (one for St. Vincent Medical Center and one for St. Francis Medical Center). There was not a full system Qualified Bid.[3] After consultation with the Consultation Parties, the Debtors determined not to conduct either a Partial Bid Auction or Full Bid Auction, as set forth in the *Notice That No Auction Shall Be Held Re Debtors' Motion and Motion for the Entry of (I) An Order (1) Approving Form of Asset Purchase*

[3] The Debtors received a letter from Prime Healthcare describing a potential partial bid for St. Francis and another letter from Prime Healthcare describing a potential full bid. In both instances, Prime expressly stated that it "recognize[d] that this bid will not be formally considered at auction" and did not include the mandatory good faith deposit, but was submitted solely "for reference, when needed when there is no credible back up bidder or all other bidders are unable to close."

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Agreement for Stalking Horse Bidder and for Prospective Overbidders; (2) Approving Auction Sale Format, Bidding Procedures and Stalking Horse Bid Protections; (3) Approving Form of Notice to Be Provided to Interested Parties; (4) Scheduling a Court Hearing to Consider Approval of the Sale to the Highest Bidder; and (5) Approving Procedures Related to the Assumption of Certain Executory Contracts and Unexpired Leases; and (II) an Order (A) Authorizing the Sale of Property Free and Clear of All Claims, Liens and Encumbrances [Docket No. 2053] (the "No-Auction Notice").

9. Accordingly, SGM was named the Successful Bidder for the Assets under the Bidding Procedures Order. *See* Bidding Procedures Order, Exhibit "1," at 6; *see also* No-Auction Notice, at 2.

C. The Principal Terms of the SGM APA[4]

10. The primary terms of the APA are set forth below:[5]

Stalking Horse APA Provision	Summary Description
APA Parties	Verity Health System of California, Verity Holdings, LLC, St. Francis Medical Center, St. Vincent Medical Center, St. Vincent Dialysis Center and Seton Medical Center ("Sellers"). Strategic Global Management, Inc. ("Purchaser").
Consideration **APA § 1.1**	Six Hundred Ten Million Dollars ($610,000,000), which shall be allocated as follows: Four Hundred Twenty Million Dollars ($420,000,000) to St. Francis Medical Center, One Hundred Twenty Million Dollars ($120,000,000) to St. Vincent Medical Center and Seventy Million Dollars ($70,000,000) to Seton Medical Center for Seton Medical Center and Seton Coastside, plus assumption of the Assumed Liabilities, provided, that if the California Attorney General's approval does not include a requirement that Seton Hospital remain open as an acute care hospital or that Seton Coastside Hospital remain open as a skilled nursing facility, then an amount to be determined by Purchaser, in its sole discretion, of such Cash Consideration

[4] The following is a summary of the terms of the APA. In the event of any inconsistencies between the provisions of the APA and the summary set forth herein, the terms of the APA shall govern.

[5] The summary of the terms contained in this Memorandum highlights some of the material terms of the APA. This summary is qualified in its entirety by reference to the provisions of the APA. In the event of any inconsistencies between the provisions of the APA and the summary set forth herein, the terms of the APA shall govern. Unless otherwise defined in the summary set forth in the accompanying text, capitalized terms shall have the meanings ascribed to them in the APA.

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Stalking Horse APA Provision	Summary Description
	shall be re-allocated from St. Francis to Seton; plus payment of Cure Costs associated with any Assumed Leases and/or Assumed Contracts.
QAF Adjustment **APA § 1.1(c), 1.1(d)**	At Closing, Sellers shall credit against the cash consideration, the amount by which payments received by Sellers under QAF IV and QAF V between the Signing Date and Closing exceed the sum of (i) fees paid under QAF IV and QAF V during such period plus (ii) the amount of fees which are unpaid and owing as of the Closing in respect of invoices received by Sellers prior to Closing under QAF IV and QAF V (the "Net QAF Reduction Amount"), or Purchaser shall pay Sellers (as an increase to the cash consideration) the amount by which the sum of (i) fees paid under QAF IV and QAF V between the Signing Date and Closing plus (ii) the amount of fees which are unpaid and owing as of Closing in respect of invoices received by Sellers prior to Closing under QAF IV and QAF V exceeds payments received under QAF IV and QAF V during such period (the "Net QAF Increase Amount").
Assets; Avoidance Actions **APA § 1.7**	In each case, solely to the extent used primarily in the conduct of the Business, "Assets" shall mean (a) all of the tangible personal property owned by such Seller and used by such Seller in the operation of the Hospital of such Seller, or in the case of St. Vincent Dialysis Center, the operation of its dialysis business, including equipment, furniture, fixtures, machinery, vehicles, office furnishings and leasehold improvements; (b) all of such Seller's rights, to the extent assignable or transferable, in and to all Licenses; (c) all of such Seller's right, title and interest in and to the Owned Real Property and all of such Seller's interest, to the extent assignable or transferable, in and to the Assumed Leases; (d) all of such Seller's right, title and interest in and to any and all Assumed Contracts; (e) all claims, rights, interests and proceeds with respect to amounts overpaid by such Seller to any third party health plans with respect to periods prior to the Effective Time, except with respect to any causes of action or proceeds thereof arising under Chapter 5 of the Bankruptcy Code other than with respect to Assumed Contracts and Assumed Leases; (f) all Inventory; (g) all Prepaids; (h) all operating manuals, files and computer software, including all patient records, medical records, employee records, financial records, equipment records, construction plans and specifications and medical and administrative libraries; (i) all systems, servers, computers, hardware, firmware, middleware, telecom equipment, networks, data communications lines, routers, hubs, switches and all other information technology equipment, and all associated documentation; (j) all Measure B trauma funding received after the Signing Date; (k) all Accounts Receivable; (l) all rights, claims and causes of action of such Seller arising out of the Accounts Receivable acquired by Purchase; (m) all regulatory settlements, rebates, adjustments, refunds or group appeals; (n) all casualty insurance proceeds arising in respect of casualty losses occurring after the Signing Date in connection with the ownership or operation of the Assets; (o) all surpluses arising out of any risk pools, shared savings program or accountable care organization arrangement; (p) all transferable unclaimed property of any Person in Sellers' possession as of the Closing Date; (q) all warranties in favor of the Hospitals or Sellers; (r) certain intellectual property rights, as further described in the Transition Services Agreement; (s) all goodwill; (t) all rights and interest in the telephone and facsimile numbers and uniform resource locaters; (u) all Medicare and Medi-Cal provider agreements and lockbox accounts identified

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Stalking Horse APA Provision	Summary Description
	on Schedule 1.7(u) to the Stalking Horse APA; (v) all documents, records, correspondence, work papers and other documents, other than patient records, relating to the Accounts Receivable; (w) the Purchased Verity Holdings Assets; (x) except for the Excluded Assets, any other asset owned by the Seller; (y) all of Seton's interest in and to the PACE Obligations; and (z) all QAF V and subsequent QAF program payments received after the Closing (e.g., QAF VI and QAF VII).
Excluded Assets **APA § 1.8**	"Excluded Assets" include cash, cash equivalents and investments; all Seller Plans and the assets of all Seller Plans; all contracts and leases that are not Assumed Contracts or Assumed Leases; inventory and assets disposed of by any Seller in the ordinary course of business after the Signing Date but prior to the Effective Time; all claims, counterclaims, and causes of action of each Seller or each Seller's bankruptcy estate; (except as otherwise provided) all insurance policies and contracts and coverages obtained by any Seller or listing a Seller as insured party, a beneficiary or loss payee; all Utility Deposits; all bank accounts of each Seller (except as otherwise provided); all tax refunds of each Seller; all QAF IV and QAF V payments actually received prior to the Signing Date.
Assumed Obligations **APA § 1.9**	"Assumed Obligations" include all Assumed Contracts and Assumed Leases and all liabilities and obligations arising thereunder on and after the Effective Time, including any related Cure Costs; all liabilities and obligations arising out of or relating to any act, omission, event, or occurrence connected with the use, ownership, or operation by Purchaser of the Hospital or any of the Assets on or after the Effective Time; all unpaid real and personal property taxes that are attributable to the Assets after the Effective Time, subject to prorations; and all liabilities and obligations arising on or following the Effective Time relating to utilities being furnished to the Assets, subject to prorations and all accrued vacation and other paid time off, to the extent assumed under Section 1.1(a)(ii).
Excluded Liabilities **APA § 1.10**	Purchaser shall not assume or become responsible for any duties, obligations, or liabilities of any Seller other than the Assumed Obligations.
Assumption of Transferred Contracts and Assignment **APA § 1.11**	Not later than seven (7) days prior to the date of the Auction (i) Purchaser shall notify each Seller in writing of which Evaluated Contracts are to be assumed by such Seller and assigned to Purchaser, and (ii) Purchaser shall notify each Seller in writing signed and dated by Purchaser of which Evaluated Contracts are to be rejected by such Seller (collectively, the "Rejected Contracts"). Each Seller shall file such motions in the Bankruptcy Court and take such other actions as are reasonably necessary to ensure that final and non-appealable orders (x) assuming and assigning the respective Assumed Contracts or Assumed Leases applicable to such Seller to Purchaser are entered, and (y) rejecting the Rejected Contracts are entered. With respect to each Assumed Lease, the applicable Seller shall execute and deliver to Purchaser an Assignment and Assumption of Lease. Notwithstanding anything to the contrary set forth in this Agreement, the Rejected Contracts

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Stalking Horse APA Provision	Summary Description
	shall constitute part of the Excluded Assets pursuant to, and as defined in, this Agreement. At Closing and pursuant to an order of the Bankruptcy Court, each Seller will assume and immediately assign to Purchaser the leases of such Seller for Leased Real Property and the Tenant Leases.
Good Faith Deposit **APA § 1.2**	Purchaser has made a good faith deposit in the amount of Thirty Million Dollars ($30,000,000.00) (the "Deposit") by wire transfers to an account designated by Sellers. The Deposit shall be non-refundable in all events, except in the event Purchaser is not the winning bidder at the Auction, in the event Purchaser terminates the Stalking Horse APA if a stay of the sale order has not been vacated on or before 180 days following issuance of such stay, or in the event Purchaser has terminated the Stalking Horse APA pursuant to Section 9.1 (other than Section 9.1(b)). Upon Closing, the Deposit will be credited against the Purchase Price.
Closing Date **APA § 1.3**	The Closing Date shall occur within ten (10) business days following the satisfaction or waiver of the conditions precedent to Closing set forth in Articles 7 and 8 of the Stalking Horse APA.
Employment Provisions **APA § 5.3**	Purchaser agrees to make offers of employment, effective as of the Effective Time, to substantially all employees (the "Hospital Employees") who, immediately prior to the Effective Time are: (i) employees of either Seller; (ii) employees of any affiliate of either Seller which employs individuals at the Hospital and are listed on Schedule 5.3; or (iii) employed by an affiliate of either Seller and are listed on Schedule 5.3. Any of the Hospital Employees who accept an offer of employment with Purchaser as of or after the Effective Time shall be referred to in this Agreement as the "Hired Employees." All employees who are Hired Employees shall cease to be employees of the applicable Seller or its affiliates as of the Effective Time.
Payment of Cure Costs **APA § 5.8**	Purchaser, upon assumption, shall pay the Cure Costs for each Assumed Contract and Assumed Lease so that each such Assumed Contract and Assumed Lease may be assumed by the applicable Seller and assigned to Purchaser in accordance with the provisions of section 365 of the Bankruptcy Code.
Break-Up Fee and Minimum Bid **APA § 6.1**	Any full overbids must be in a minimum amount of Six Hundred Ten Million Dollars ($610,000,000.00), plus Cure Costs and the Break-Up Fee, and accompanied by a deposit in the form of cash or a cashier's check in the amount of Thirty Million Dollars ($30,000,000.00). The "Break-Up Fee" shall mean a breakup fee in the amount totaling three and a half percent (3.5%) of the Cash Consideration (or $21,350,000.00) plus reimbursement of reasonably documented reasonable costs and expenses incurred by Purchaser related to its due diligence, and pursuing, negotiating, and documenting the transactions contemplated by this Agreement in an amount not to exceed $2,000,000.00; provided, however, that in the event that the Purchaser is successful in acquiring some but not all of the Assets,

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Stalking Horse APA Provision	Summary Description
	the Break-Up Fee shall be reduced pro rata to the percentage of Assets actually purchased by the Purchaser, based on the allocation of the Purchase Price as described in Section 1.1(a)(i) of the Stalking Horse APA. The Break-Up Fee will be subject to Bankruptcy Court approval and shall be deemed to be an allowed expense of the kind specified in § 503(b) of the Bankruptcy Code to be paid solely from the proceeds of an alternate transaction, pursuant to the Sale Order. Purchaser shall be allowed to credit bid the Break-Up Fee in any overbids that Purchaser may elect to make with respect to the Assets.
Requested Findings as to Good Faith, **APA § 6.1**	Each Seller agrees to proceed in good faith to obtain Bankruptcy Court approval of the sale contemplated herein with a determination that Purchaser is a good faith purchaser pursuant to § 363(m) and to file such declarations and other evidence as may be required to support a finding of good faith.
Buyer's Termination Rights **APA § 9.1**	The Stalking Horse APA may be terminated by Purchaser if it is not satisfied with either (i) the results of its due diligence examination of the Hospitals, or (ii) the contents of any schedule or exhibit that was not completed and attached to the Stalking Horse APA, but which has been provided to Purchaser after the Signing Date, and Purchaser has notified Seller of its election to terminate the Agreement under Section 9.1(c) on or prior to January 8, 2019 [which period has expired], by Purchaser if a material breach of the Agreement has been committed by Sellers and such breach has not been (i) waived in writing by Purchaser or (ii) cured by Sellers to the reasonable satisfaction of Purchaser within fifteen (15) business days after service by Purchaser and by Purchaser or Sellers or if the Closing has not occurred on or before December 31, 2019. The Stalking Horse APA may also be terminated by Purchaser if satisfaction of any condition in Article 8 has not occurred by December 31, 2019 or becomes impossible and Purchaser has not waived such condition in writing. The Stalking Horse APA may also be terminated by Purchaser if the Bankruptcy Court enters an order dismissing the Bankruptcy Case or fails to approve the sale of the Assets to Purchaser.

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Stalking Horse APA Provision	Summary Description
Record Retention **APA § 10.2**	From the Closing Date until seven (7) years after the Closing Date or such longer period as required by law (the "Document Retention Period"), Purchaser shall keep and preserve all medical records, patient records, medical staff records and other books and records which are among the Assets as of the Effective Time, but excluding any records which are among the Excluded Assets. After the expiration of the Document Retention Period, if Purchaser intends to destroy or otherwise dispose of any of the documents, Purchaser shall provide written notice to Sellers of Purchaser's intention no later than forty-five (45) calendar days prior to the date of such intended destruction or disposal.
Limitation on Liability **APA § 11.1**	If Purchaser commits any material default under the APA, Sellers shall have the right to sue for damages; provided, however that the amount of such damages shall never exceed $60,000,000.00. For the avoidance of doubt, Sellers shall have no right to sue for specific performance under the APA.

D. Notices & Objections Related to Cure Amounts

11. On March 5, 2019, the Debtors filed the *Notice To Counterparties To Executory Contracts And Unexpired Leases Of The Debtors That May Be Assumed And Assigned* listing all of the known executory contracts and unexpired leases and related cure amounts (the "Cure Notice") [Docket No. 1704]. A supplement to the Cure Notice (adding and removing some agreements and revising Cure Amounts) was later filed on March 18, 2019 [Docket No. 1836].

12. On March 18, 2019, the Debtors filed their *Supplemental Re Notice To Counterparties To Executory Contracts and Unexpired Leases of The Debtors That May Be Assumed and Assigned* [Docket No. 1836]. On April 5, 2019, the Debtors filed their *Second Supplemental Notice Re Notice to Counterparties to Executory Contracts and Unexpired Leases of the Debtors That May Be Assumed and Assigned* [Docket No. 2065].

13. Since the Cure Notice, counterparties to executory contracts and unexpired leases have filed objections regarding the cure amounts and other issues [Docket Nos. 1788; 1804; 1819; 1830; 1849; 1850; 1853; 1853; 1856-1858; 1863; 1866; 1869; 1870; 1873-1877; 1881; 1882; 1890; 1891;1892; 1904; 1926; 1930; 1933; 1946; 1948; 1949; 1953; 1954; 1965; 2058; 2066; 2108].

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14. The Debtors have entered into the multiple stipulations to provide the Debtors and counterparties time to resolve the cure issues informally. *See*, e.g., Docket Nos. 1871; 1950.

II. ARGUMENT

A. The Court Should Authorize The Debtors To Sell The Assets To SGM In Accordance With The Terms Of The APA.

Section 363(b) provides that a debtor "after notice and a hearing, may use, sell or lease, other than in the ordinary course of business, property of the state." 11 U.S.C. § 363(b). To approve a use, sale or lease of property other than in the ordinary course of business, the Court must find "some articulated business justification." *See, e.g., In re Gardens Regional Hospital and Medical Center, Inc.* ("*In re Gardens*"), 567 B.R. 802, 825 (Bankr. C.D. Cal. 2017); *In re Martin (Myers v. Martin)*, 91 F.3d 389, 395 (3d Cir. 1996) (*citing In re Schipper (Fulton State Bank v. Schipper)*, 933 F.2d 513, 515 (7th Cir. 1991)); *Comm. of Equity SEC Holders v. Lionel Corp. (In re Lionel Corp.)*, 722 F.2d 1063, 1070 (2d Cir. 1983); *In re Abbotts Dairies of Pa., Inc*., 788 F.2d 143 (3d Cir. 1986) (implicitly adopting the "sound business judgment" test of *Lionel Corp.* and requiring good faith); *In re Delaware and Hudson Ry. Co*., 124 B.R. 169 (D. Del. 1991) (concluding that the Third Circuit adopted the "sound business judgment" test in the *Abbotts Dairies* decision). Similarly, in the Ninth Circuit, "cause" exists for authorizing a sale of estate assets if it is in the best interest of the estate, and a business justification exists for authorizing the sale. *In re Huntington, Ltd*., 654 F.2d 578 (9th Cir. 1981); *In re Walter*, 83 B.R. 14, 19-20 (9th Cir. B.A.P. 1988).

In determining whether a sale satisfies the business judgment standard, courts have held that: (1) there be a sound business reason for the sale; (2) accurate and reasonable notice of the sale be given to interested persons; (3) the sale yield an adequate price (*i.e*., one that is fair and reasonable); and (4) the parties to the sale have acted in good faith. *Titusville Country Club v. Pennbank (In re Titusville Country Club)*, 128 B.R. 396, 399 (Bankr. W.D. Pa. 1991); *see also In re Walter*, 83 B.R. at 19-20.

The Debtors submit that their proposed sale of the Assets to SGM clearly satisfied each of these four criteria, is consistent with the terms of the APA, and demonstrates that the Debtors'

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business judgment to proceed with the proposed sale of the Assets to SGM in accordance with the terms of the APA is sound.

1. Sound Business Purpose.

There must be some articulated business justification, other than appeasement of major creditors, for using, selling or leasing property out of the ordinary course of business before the bankruptcy court may order such disposition under § 363(b). *In re Gardens*, 567 B.R. at 825; *In re Lionel Corp*., 722 F.2d at 1070. The court in *In re Walter*, established a flexible case-by-case test to determine whether the business purpose for a proposed sale justifies disposition of property of the estate under § 363(b). 83 B.R. at 19. In *Walter*, the court, adopting the reasoning of the Fifth Circuit in *In re Continental Airlines, Inc*., 780 F.2d 1223 (5th Cir. 1986) and the Second Circuit *in In re Lionel Corp., supra*, articulated the standard to be applied under § 363(b) as follows:

> Whether the proffered business justification is sufficient depends on the case. As the Second Circuit held in *Lionel*, the bankruptcy judge should consider all salient factors pertaining to the proceeding and, accordingly, act to further the diverse interests of the Debtor, creditors and equity holders, alike. He might, for example, look to such relevant facts as the proportionate value of the asset to the estate as a whole, the amount of elapsed time since the filing, the likelihood that a plan of reorganization will be proposed and confirmed in the near future, the effect of the proposed disposition on future plans of reorganization, the proceeds to be obtained from the disposition vis-a-vis any appraisals of the property, which of the alternatives of use, sale or lease the proposal envisions and, most importantly perhaps, whether the asset is increasing or decreasing in value. This list is not intended to be exclusive, but merely to provide guidance to the bankruptcy judge.

In re Walter, 83 B.R. at 19-20 (*citing In re Continental Air Lines, Inc*., 780 F.2d at 1226).

The facts pertaining to the Debtors' proposed sale of the Assets to SGM substantiate the Debtors' business decision that such contemplated sale serves the best interests of the Debtors' estates, their creditors and shareholders and merits the approval of the Court. The Debtors incur significant operational losses at their Hospitals, and continued operations are simply not financially viable. *See Declaration of Richard Adcock in Support of Emergency First-Day Motions*, at ¶ 95 [Docket No. 8]. Thus, the Debtors' Board of Directors concluded that the best course of action to preserve the Debtors' Hospitals as going concerns, serve the charitable mission of the Debtors and

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the original legacy of the Daughters of Charity, preserve jobs and maximize the recovery for creditors, was to sell the Debtors' Hospitals, as going concerns, in a bankruptcy court supervised sale and have pursued this objective throughout these cases. *Id.* ¶ 96.

As discussed *supra*, the Debtors engaged in a comprehensive marketing process to sell the Assets prior to and during the bankruptcy case for a period of more than ten months. The Debtors are confident that their proposed asset sale to SGM is the best option available to the Debtors to, among other things, maximize the value of the Assets and recovery for their creditors. Despite Cain's vigorous attempts to market the Assets, SGM's stalking-horse bid was the highest, best and only Qualified Full Bid the Debtors received for all four Hospitals. The Debtors believe that SGM's offer represents a fair market value for the assets. Also, SGM is a buyer who will maintain the healthcare characteristics of all four Hospitals, continuing patient care for the communities served by the Hospitals and continuing to provide employment for the Debtors' employees. Therefore, the Debtors submit that their proposed asset sale is justified by sound business purposes, satisfying the first requirement for a sale under § 363(b).

2. Accurate and Reasonable Notice

In connection with a proposed sale under § 363, "four pieces of information must be presented to the creditors. The notice should: place all parties on notice that the debtor is selling its business; disclose accurately the full terms of the sale; explain the effect of the sale as terminating the debtor's ability to continue in business; and explain why the proposed price is reasonable and why the sale is in the best interest of the estate." *In re Delaware*, 124 B.R. at 180. A notice is sufficient if it includes the terms and conditions of the sale and if it states the time for filing objections. *In re Karpe*, 84 B.R. 926, 930 (Bankr. M.D. Pa. 1988). The purpose of the notice is to provide an opportunity for objections and hearing before the court if there are objections. *Id*.

On February 20, 2019, the Debtors served a *Notice of Sale Procedures, Auction Date and Sale Hearing* [Docket. No. 729] on the following parties: (i) the Office of the United States Trustee; (ii) counsel to the Committee of Unsecured Creditors; (iii) any parties requesting notices in this case pursuant to Bankruptcy Rule 2002; (iv) all Potential Bidders; (i) all parties known by the Debtors to assert a lien on any of the Assets; (vi) all persons known or reasonably believed to have

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asserted an interest in any of the Assets; (vii) all non-Debtor parties to any contracts and leases to be assumed; (viii) the Office of the United States Attorney for the Central District of California; (ix) the Office of the California Attorney General; (x) the Office of the California Secretary of State; (xi) all taxing authorities having jurisdiction over any of the Assets, including the IRS; and (xii) all environmental authorities having jurisdiction over any of the Assets. (*See* Certificate of Service [Docket No. 1997]). Also, as explained above, the Bidding Procedures Order was entered by the Court and has been provided to all known prospective bidders by Cain. The Debtors will also serve this Memorandum on the same parties in advance of the Sale Hearing.

The Debtors submit that the foregoing satisfies the requirements of Bankruptcy Rules 6004(a) and (c), which provide as follows:

> (a) ... Notice of a proposed ... sale ... of property ... not in the ordinary course of business shall be given pursuant to Rule 2002(a)(2),(c)(1),(i) and (k) ... (c) ... A motion for authority to sell property free and clear of liens or other interests shall be made in accordance with Rule 9014 and shall be served on the parties who have liens or other interests in the property to be sold. The notice required by subdivision (a) of this rule shall include the date of the hearing on the motion and the time within which objections may be filed and served on the debtor in possession..."

Fed. R. Bankr. P. 6004(a)(c).

3. Fair and Reasonable Price.

In order to be approved under § 363(b), the purchase price must be fair and reasonable. *Coastal Indus., Inc. v. U.S. Internal Revenue Serv. (In re Coastal Indus., Inc.)*, 63 B.R. 361, 368 (Bankr. N.D. Ohio 1986). However, the Debtors also realize that "[their] main responsibility, and the primary concern of the bankruptcy court, is the maximization of the value of the asset sold." In *re Integrated Resources, Inc*., 135 B.R. 746, 750 (Bankr. S.D.N.Y. 1992), *aff'd*, 147 B.R. 650 (S.D.N.Y. 1992). "It is a well-established principle of bankruptcy law that the objective of bankruptcy rules and the [debtor's] duty with respect to such sales is to obtain the highest price or greatest overall benefit possible for the estate." *In re Atlanta Packaging Prods.*, *Inc*., 99 B.R. 124, 131 (Bankr. N.D. Ga. 1988); *see also In re Wilde Horse Enterprises*, 136 B.R. 830, 841 (Bankr.

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C.D. Cal. 1991) ("In any sale of estate assets, the ultimate purpose is to obtain the highest price for the property sold").

The marketing and sale process undertaken by Cain and the Debtors was designed to insure that the highest price and greatest benefit possible was obtained for the Assets. Cain robustly marketed the assets since July 2018, and these same assets had been fully marketed in 2014-2015 while under control of the Daughters of Charity. SGM's offer to purchase the Assets for $610 million (plus cure costs) represents the fair market value for the Assets and will provide a substantial benefit to the Debtors' estates. Accordingly, the Court should find that the sale price to SGM is fair and reasonable.

4. Good Faith.

When a bankruptcy court authorizes a sale of assets pursuant to § 363(b)(1), it is required to make a finding with respect to the "good faith" of the purchaser. *In re Abbotts Dairies*, 788 F.2d at 149. Such a procedure ensures that § 363(b)(1) will not be employed to circumvent the creditor protections of chapter 11, and as such, it mirrors the requirement of § 1129, that the Court independently scrutinizes the debtor's reorganization plan and makes a finding that it has been proposed in good faith. *Id*. at 150.

"Good faith" encompasses fair value, and further speaks to the integrity of the transaction. *In re Wilde Horse Enters.*, 136 B.R. at 842. With respect to the Debtors' conduct in conjunction with the sale, the good faith requirement "focuses principally on the element of special treatment of the Debtors' insiders in the sale transaction." *See In re Indus. Valley Refrig. and Air Cond. Supplies, Inc*., 77 B.R. 15, 17 (Bankr. E.D. Pa. 1987). With respect to the buyer's conduct, this Court should consider whether there is any evidence of "fraud, collusion between the purchaser and other bidders or the [debtor], or an attempt to take grossly unfair advantage of other bidders." *In re Abbotts Dairies*, 788 F.2d at 147; *In re Rock Indus. Mach. Corp*., 572 F.2d 1195, 1198 (7th Cir. 1978); *In re Wilde Horse Enters., Inc*., 136 B.R. at 842; *In re Alpha Indus., Inc*., 84 B.R. 703, 706 (Bankr. D. Mont. 1988). In short, "[l]ack of good faith is generally determined by fraudulent conduct during the sale proceedings." *In re Apex Oil Co*., 92 B.R. 847, 869 (Bankr. E.D. Mo. 1988)

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(*citing In re Exennium, Inc.*, 715 F.2d 1401, 1404-05 (9th Cir. 1983)); *see also In re M Capital Corp.*, 290 B.R. 743 (B.A.P. 9th Cir. 2003).

In *In re Filtercorp, Inc.*, 163 F.3d 570 (9th Cir. 1998), the Ninth Circuit set forth the following test for determining whether a buyer is a good faith purchaser:

> A good faith buyer "is one who buys 'in good faith' and 'for value.'" [citations omitted.] [L]ack of good faith is [typically] shown by 'fraud, collusion between the purchaser and other bidders or the trustee, or an attempt to take grossly unfair advantage of other bidders.'" [citations omitted.]

Filtercorp, 163 F.3d at 577.

The Ninth Circuit made clear in *Filtercorp* that this standard for determining good faith is applicable even when the buyer is an insider. However, neither SGM nor any of SGM's representatives or affiliates are an "insider" of the Debtors. The Debtors and Cain are not aware of any fraud, collusion or attempt to take unfair advantage of other potential bidders. Additionally, the APA was intensively negotiated at arm's length with all parties involved acting in good faith. Based on the foregoing, the Debtors submit that the Court should find that SGM constitutes a good faith purchaser entitled to all of the protections afforded by § 363(m).

B. Section 363(f) Permits the Debtors' Sale of the Purchased Assets to SGM to Be Free and Clear of Any and All Interests and Liens.

The Debtors have requested that, under § 363(f), the proposed sale be effected "free and clear" of encumbrances, interests or liens in the Assets. 11 U.S.C. § 363(f); *see also In re Grumman Indus., Inc.*, 467 B.R. 694, 702 (S.D.N.Y. 2012) (discussing generally "free and clear" provision in § 363(f)). Section 363(f) "empowers the trustee to sell the debtor's assets 'free and clear of any interest in such property of an entity other than the estate.'" While "[t]he Bankruptcy Code does not define the phrase "interest in ... property" for purposes of § 363(f) … [the] trend in caselaw '[favors] a broader definition [of the phrase] that encompasses other obligations that may flow from ownership of the property.'" *In re Gardens*, 567 B.R. at 825–26 (citing 3 Alan N. Resnick & Henry J. Sommer, Collier on Bankruptcy ¶ 363.06[1] (16th ed. 2017)). Therefore, courts interpret the term "any interest" expansively to effectuate liquidations and reorgazinations "to include not only in rem interests in property, but also other obligations that are "connected to or arise from the

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property being sold" or that could "potentially travel with the property being sold." *See, e.g., In re La Paloma Generating, Co.*, 2017 WL 5197116, *4 (Bankr. D. Del. Nov. 9, 2017) (quoting *In re Trans World Airlines, Inc.*, 322 F.3d 283, 285, 288 (3d Cir. 2001)); *see also Mass. Dep't of Unemployment Assistance v. OPK Biotech, LLC (In re PBBPC, Inc.)*, 484 B.R. 860 (1st Cir. BAP 2013) (interests in property include monetary obligations arising from the ownership of property, even when those obligations are imposed by statute).

The alternative five conditions spelled out in § 363(f) under which a sale free and clear may be authorized are the following:

> (1) applicable nonbankruptcy law permits sale of such property free and clear of such interest;
> (2) such entity [the holder of the interest] consents;
> (3) such interest is a lien and the price at which such 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 could be compelled, in a legal or equitable proceeding, to accept a money satisfaction of such interest.

11 U.S.C. § 363(f)(1)-(5) (2012); *see In re Shary*, 152 B.R. 724, 725 (Bankr. N.D. Ohio 1993) (stating the five conditions in § 363(f) are disjunctive and sale is proper where trustee can prove existence of any of the five conditions). The Debtors submit that one or more of the tests of § 363(f) are satisfied here.

1. The Debtors' Proposed Sale is Permissible Pursuant to § 363(f)(1).

Any conditions previously imposed by the Attorney General in the 2015 transaction are an "interest in property" which is subject to § 363(f)(1). *See Memorandum of Decision Overruling Objections of the California Attorney General to the Debtors' Sale Motion* [Docket No. 1146] ("The [AG] Conditions are an 'interest in property' within the meaning of §363(f)."); *In re Gardens Reg'l Hosp. & Med. Ctr., Inc.*, 567 B.R. at 826 ("The Attorney General's claim to regulatory authority … constitutes an 'interest in ... property' for purposes of § 363(f)."). A decision on point is *In re La Paloma Generating, Co*., 2017 WL 5197116, *4 (Bankr. D. Del. Nov. 9, 2017). In this case, the California Attorney General argued that the debtors could not transfer substantially all of their assets—including their electricity generating facility—to a purchaser free and clear of any obligation to surrender compliance instruments under the California

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cap and trade program for emissions generated by such facility during the pre-transfer period. The Delaware Bankruptcy Court stated:

> Whether property "may" be sold free and clear of an interest pursuant to section 363(f)(1) of the Bankruptcy Code turns on whether "applicable nonbankruptcy law permits sale of such property free and clear of such interest." Applicable nonbankruptcy law here is California law, and, in particular, the Regulation. Under California law, the general rule of successor liability is that the corporate purchaser of another corporation assets presumptively does not assume the seller's liabilities unless: (1) there is an express or implied assumption of liability; (2) the transaction amounts to a consolidation or merger of the two corporations; (3) the purchasing corporation is a mere continuation of the sellers; or (4) the transfer of assets to the purchaser is for the fraudulent purpose of escaping liability for the seller's debts. […] The Regulation does not provide for successor liability nor does it in anyway make a Purchaser of a Facility liable for the emissions of the former-Covered Entity. Nor does it explicitly express the need for a purchasing entity to provide for the former-Covered Entity's emissions. […] Under section 363(f), "[t]he trustee may sell property ... free and clear of any interest in such 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 ...." As noted above, the Court finds that the Regulation does not provide for successor liability related to the Debtor Emission Surrender Obligations. Nor is environmental liability excepted by Section 363(f). […] In the case *sub judice*, Debtor Emission Surrender Obligations are an interest under section 363(f) and the Regulation does not impose successor liability nor does section 363(f).

In re La Paloma Generating, Co., 2017 WL 5197116, *4-8.

Here, the applicable statutes and regulations do not expressly impose successor liability and the obligations sought to be imposed by California Attorney General are an "interest in property" under § 363(f). The Debtors recognize that they must sell the assets "in accordance with applicable non-bankruptcy law," and will submit the necessary application. But conditions imposed on these assets in 2015 by the California Attorney General are an interest in the property, which does not transfer with property because of the sale being free and clear of interests. However, the Debtors will submit the applications required for the transfer of nonprofit healthcare assets to the California Attorney General in accordance with applicable law. The Debtors reserve the right to challenge any conditions imposed by the California Attorney General after that review, but unless and until

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the Attorney General seeks to impose conditions, it is impossible to know whether those conditions violate the Bankruptcy Code.

2. The Debtors' Proposed Sale is Permissible Pursuant to § 363(f)(2).

Section 363(f)(2 authorizes a sale to be free and clear of an interest if the interest holder consents to the sale. Here, all secured claimants that hold liens secured by the Assets have consented to the proposed sale to SGM. Thus, the sale is authorized pursuant to § 363(f)(2).

3. The Debtors' Proposed Sale is Permissible Pursuant to § 363(f)(3).

Section 363(f)(3) permits a sale free and clear of an interest in property specifically where the interest is a lien, and where the sale price exceeds the aggregate value of all liens. Here, the Assets are encumbered by approximately $521 million of prepetition secured debt, while the Purchase Price, to be paid at closing, is $610 million. Thus, the purchase price exceeds the aggregate amount of all claims held by creditors who hold a lien or security interest in the property being sold, and the sale is also authorized pursuant to § 363(f)(3).

4. The Debtors' Proposed Sale is Permissible Pursuant to 11 U.S.C. § 363(f)(5).

Section 363(f)(5) permits a sale of property free and clear of liens and interests if "such entity could be compelled, in a legal or equitable proceeding, to accept a money satisfaction of such interest." 11 U.S.C. § 363(f)(5); *P.K.R. Convalescent Ctrs., Inc. v. Commonwealth of Va., Dep't of Med. Assistance Serv. (In re P.K.R. Convalescent Ctrs., Inc.)*, 189 B.R. 90 (Bankr. E.D. Va. 1995) (allowing sale of nursing home assets under § 363(f)(5) over objection of the Department of Medical Assistance Service where its interest was reducible to a claim and subject to a hypothetical money satisfaction).

Section 363(f)(5) has generally been interpreted to mean that if, under applicable law, the holder of the lien or interest could be compelled to accept payment in exchange for its interest, the trustee (or debtor in possession) may take advantage of that right by replacing the holder's lien or interest with a payment or other adequate protection. Collier on Bankruptcy, ¶ 363.06 [6] (15th ed. rev. 2003) ("Collier"). Applicable nonbankruptcy law may recognize a monetary satisfaction when the lienholder is to be paid in full out of the proceeds of the sale or otherwise. *Id.* Thus, for example, a sale free of a first mortgage might be approved when the proceeds are sufficient to pay

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in full the first mortgage and the second mortgagee has consented to the sale. However, § 363(f)(5) does not require full payment to the lien or interest holder if the trustee can demonstrate the existence of another legal or equitable proceeding by which the holder may be compelled to accept less than full satisfaction of the secured debt. *In re Grand Slam U.S.A., Inc*., 178 B.R. 460, 461-62 (E.D. Mich. 1995) (holding that the "money satisfaction" language in § 363(f)(5) does not require full payment to the lien holder); *In re Healthco Int'l Inc*., 174 B.R. 174, 176-78 (Bankr. D. Mass. 1994) (construing "money satisfaction of such interest" to mean a payment constituting less than full payment of the underlying debt because any lien can always be discharged by full payment of the underlying debt pursuant to §363(f)(3)); *Scherer v. Fed. Nat'l Mortgage Ass'n (In re Terrace Chalet Apartments, Ltd.)*, 159 B.R. 821, 829 (Bankr. N.D. Ill. 1993).

Courts have held that a chapter 11 cramdown is a typical "legal proceeding" by which an entity may be compelled to accept less than full money satisfaction and which will permit the sale of creditor's collateral free and clear of interest under § 363(f)(5). *In re Gulf States Steel, Inc. of Alabama*, 285 B.R. 497, 508 (Bankr. N.D. Ala. 2002) (holding that the liens or interests identified in the sale motion could be compelled to accept a money satisfaction in a cramdown plan of reorganization in a chapter 11 case); *In re Terrace Chalet Apartments, LTD.*, 159 B.R. at 829 (finding that § 1129(b)(2) cramdown is such a provision); *In re Perroncello*, 170 B.R. 189 (Bankr. D. Mass. 1994); Collier, ¶ 363.06[6][a]; *but see In re PW, LLC*, 391 B.R. 25, 46 (B.A.P. 9th Cir. 2008). Thus, the trustee can sell property free and clear of a creditor's lien it if demonstrates it can cramdown the creditor's interest pursuant to § 1129(b)(2).

In addition to the legal arguments set forth above, the ability of a debtor to "cramdown" a secured creditor under § 1129(b)(1) and (2) also constitutes a "legal proceeding," pursuant to which a secured creditor could be compelled to accept a money satisfaction. *See In re Grand Slam, U.S.A. Inc.,* 178 B.R. 460, 462 (E.D. Mich. 1995). Section 1129(b)(2)(A) allows cramdown of a secured creditor, provided that it receives "the indubitable equivalent" of its claim. A debtor can cramdown a secured creditor if it demonstrates (1) the debtor is not unfairly discriminating against the secured creditor, § 1129(b)(1); (2) it is acting in good faith, § 1129(a)(3)-(b)(1); and (3) the secured creditor is receiving the actual value of its claim, § 1129(b)(2)(A)(i)(II), § 1129(b)(2)(A)(iii). *See also In*

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re Sandy Ridge Dev. Corp., 881 F.2d 1346, 1350 (5th Cir. 1989) (holding that "indubitable equivalent" of a secured creditor's interest is the actual value of the claim). In *In re Hunt Energy Co., Inc*., 48 B.R. 472, 485 (Bankr. N.D. Ohio 1985), the court found that a lien which attaches to the proceeds of a sale would necessarily be reduced by subsequent valuation at a hearing under § 506(a) to meet the "indubitable equivalence" requirements of section 1129(b)(2)(A). Once § 1129(b)(2)(A) is satisfied, the lienholder would be compelled through the cramdown process to accept such money satisfaction as dictated by the cramdown provisions. *Id*.

All of the above requirements for cramdown are met in this proposed transaction. The sale of the Assets to SGM was negotiated and is being conducted in good faith. The secured creditors with valid liens against the Assets are being treated fairly and in accordance with their respective lien priorities, so there is no unfair discrimination present in the proposed sale. Finally, any such secured creditors will receive the actual value of their secured claim as measured by § 506(a).

Based upon all of the foregoing, all creditors of the Debtors, including all secured creditors of the Debtors, could be compelled, in a legal or equitable proceeding, to accept a money satisfaction of their interest. The Debtors' proposed sale of the Assets to SGM should therefore be free and clear of all interests and liens pursuant to § 363(f)(5).

C. The Court Should Authorize the Debtors to Assume and Assign to SGM All of the Assumed Contracts that SGM Designates.

Barring exceptions not herein relevant, §§ 365(a) and 1107(a) authorize a debtor in possession, "subject to the Court's approval, ... [to] assume or reject any executory contract or unexpired lease of the debtor." A debtor in possession may assume or reject executory contracts for the benefit of the estate. *In re Klein Sleep Prods, Inc*., 78 F.3d 18, 25 (2d. Cir. 1996); *In re Central Fla. Metal Fabrication, Inc*., 190 B.R. 119, 124 (Bankr. N.D. Fla. 1995); *In re Gucci*, 193 B.R. 411, 415 (S.D.N.Y. 1996). In reviewing a debtor in possession's decision to assume or reject an executory contract, a bankruptcy court should apply the "business judgment test" to determine whether it would be beneficial to the estate to assume it. *In re Continental Country Club, Inc*., 114 B.R. 763, 767 (Bankr. M.D. Fla. 1990); *see also In re Gucci*, 193 B.R. at 415. The business judgment standard requires that the court follow the business judgment of the debtor unless that judgment is the product of bad faith, whim, or caprice. *In re Prime Motors Inns*, 124 B.R. 378, 381

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(Bankr. S.D. Fla. 1991) (*citing Lubrizol Enterprises v. Richmond Metal Finishers*, 756 F.2d 1043, 1047 (4th Cir. 1985), *cert. denied*, 475 U.S. 1057 (1986)).

Pursuant to § 365(f)(2), a debtor may assign its executory contracts and unexpired leases, provided the debtor first assumes such executory contracts and unexpired leases in accordance with §365(b)(1), and provides adequate assurance of future performance by the assignee. Pursuant to § 365(b)(1), assumption of executory contracts and unexpired leases requires a debtor to: (a) cure any existing defaults under such agreements; (b) compensate all non-debtor parties to such agreements for any actual pecuniary loss resulting from the defaults; and (c) provide adequate assurance of future performance under the contract or lease. 11 U.S.C. § 365(b)(1); *see also In re Bowman*, 194 B.R. 227, 230 (Bankr. D. Ariz. 1995*); In re AEG Acquisition Corp*., 127 B.R. 34, 44 (Bankr. C.D. Cal. 1991), *aff'd* 161 B.R. 50 (B.A.P. 9th Cir. 1993). Pursuant to § 365(f)(1), a debtor may assign an executory contract or unexpired lease pursuant to § 365(f)(2) notwithstanding any provision in such executory contract or unexpired lease that prohibits, restricts or conditions the assignment of such executory contract or unexpired lease.

The assumption and assignment of executory contracts furthers the goals of chapter 11 of promoting reorganization by balancing the debtor's interest in maximizing the value of its estate against the contracting party's interest in receiving the benefit of its bargain and being protected against default by the debtor after assumption has occurred. *In re Embers 86th Street. Inc*., 184 B.R. 892, 896 (Bankr. S.D.N.Y. 1995).

Here, the Debtors are seeking to assume and assign to SGM all of the Debtors' executory contracts and unexpired leases that SGM designates as executory contracts and unexpired leases subject to assumption and assignment. As set forth above, the Debtors have filed several notices and supplements listing all of the known executory contracts and unexpired leases and related cure amounts and are working with counterparties to resolve any issues regarding outstanding cure amounts. As a result of the foregoing, and in connection with the sale, the Debtors are seeking the Court's authority to assume and assign to SGM the Assumed Contracts and to fix the required Cure Amounts that would need to be paid to the other parties to the executory contracts and unexpired leases to enable compliance with the provisions of § 365(b)(1)(A) at the Cure Amounts set forth in

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the Cure Notice unless the other parties to the executory contracts and unexpired leases file a timely objection to the Cure Notice and the Court determines that the required Cure Amount is different than the amount set forth in the Cure Notice.

D. Potential Disputes Regarding Assignment of Certain Agreements to SGM.

The Bidding Procedures Order set a deadline of April 15, 2019, at 4:00 p.m., for the Debtors to reply to any objection or response. The Debtors will either (i) respond or object as appropriate to pending objections or responses or (ii) submit a stipulation or notice, as applicable, for resolution of any objection or response.[6]

E. The Court Should Waive the Fourteen-Day Waiting Periods Set Forth in Bankruptcy Rules 6004(h) and 6006(d).

Bankruptcy Rule 6004(h) provides, among other things, that an order authorizing the use, sale or lease of property […] is stayed until the expiration of fourteen days after entry of the Court order, unless the Court orders otherwise. Bankruptcy Rule 6006(d) has a similar provision with respect to an order approving of a debtor's assumption and assignment of unexpired leases and executory contracts.

For all of the reasons set forth above, the Debtors believe that selling the Assets to SGM in accordance with the timeline provided in the APA and the Bidding Procedures Order is in the best interests of the Debtors' estates, their creditors and shareholders. In order to facilitate the most expeditious Closing possible, the Debtors request that the Sale Order be effective immediately upon entry by providing that the fourteen-day waiting periods of Bankruptcy Rule 6004(h) and 6006(d) are waived.

III. CONCLUSION

For all these reasons, the Court should enter the Sale Order and grant all of the other relief requested in this Memorandum.

[6] Under the APA, SGM and the Debtors agreed to meet and confer with the various unions whose Collective Bargaining Agreements ("CBAs") are implicated by the proposed sale to attempt "to renegotiate each [CBA] currently in effect with each applicable union." Stalking Horse APA at § 5.11. SGM and the Debtors will proceed with this process, and SGM has not yet made a decision yet regarding the treatment of the CBAs.

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Dated: April 10, 2019

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EXHIBIT "3"

Docket #3043 Date Filed: 9/11/2019

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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.

TABLE OF CONTENTS

	Page
INTRODUCTION	1
PROCEDURAL BACKGROUND	2
STATUTORY BACKGROUND	2
I. Administration of the Medi-Cal Program	2
II. Medi-Cal Financing	3
III. Delivery of Medi-Cal Services	4
IV. Payments to Hospitals for Medi-Cal Services	5
V. Hospital Quality Assurance Fee	6
VI. Statutory Basis for Collection of HQA Fees	6
VII. Reimbursement of Medi-Cal Overpayments	7
VIII. The Department's Recoupment Right	8
FACTUAL BACKGROUND	9
I. St. Vincent Medical Center's HQA Fee Debt to Medi-Cal	9
II. Seton Medical Center's HQA Fee Debt to Medi-Cal	9
III. St. Francis Medical Center's HQA Fee Debt to Medi-Cal	10
IV. Medi-Cal Overpayments to Debtors	11
V. Debtors Continue as Medi-Cal Providers Post Petition	11
ARGUMENT	12
I. Medi-Cal Agreements Are Executory Contracts	12
II. Case Law Affirms that the Agreements Are Executory Contracts	15
III. The Agreements Cannot Be Sold Free and Clear of Debt Owed to Medi-Cal under 11 U.S.C. § 363	17
IV. The Agreements, as Executory Contracts, Require Cure of Defaults and Debts	22
V. Debtors' Agreements Require Successor Liability by the Buyer	23
VI. The Department Opposes Waiver of the 14-Day Stay of any Sale Order	24
CONCLUSION	24

TABLE OF AUTHORITIES

Page

CASES

Atkin v. Parker
472 U.S. 115 (1985) 19

Bell v. Burson
402 U.S. 535 (1971) 19

Cervoni v. Secretary of Health, Education and Welfare
581 F.2d 1010 (1st Cir. 1978) 19

Devine v. Cleland
616 F. 2d 1080 (9th Cir. 1980) 19

Erickson v. United States Department of Health and Human Services
67 F. 3d 858 (9th Cir. 1995) 19, 20

Green v. Cashman
605 F.2d 945 (6th Cir. 1979) 17, 18

Hollander v. Berezenoff
787 F.2d 834 (2nd Cir. 1986) 17, 18

In re BDK Health Management, Inc.
1998 WL 34188241 18

In re Berks Behavioral Health, LLC
2010 WL 4922173 (Bankr. E.D. Pa. 2010) 20

In re Gardens Regional Hospital and Medical Center, Inc.
2018 WL 1354334 ..... 8, 14

In re Gardens Regional Hospital and Medical Center, Inc.
569 B.R. 788 (Bankr. C.D. Cal. 2017) 8, 13, 15, 17

In re Hefferman Memorial Hospital District
192 B.R. 228 (S.D. Cal. 1996) 15, 16

In re Holland Enterprises, Inc. (*In re Holland*)
25 B.R. 301 (Bankr. E.D. N.C. 1982) 13, 23

TABLE OF AUTHORITIES
(continued)

Page

In re Holyoke Nursing Home, Inc.
372 F.3d 1 (1st Cir. 2004) 15, 16

In re Memorial Hosp. of Iowa County, Inc.
82 B.R. 478 (W. D. Wis. 1988) 16, 22

In re Monsour Medical Center
8 B.R. 606 (Bankr. W.D. Pa. 1981) 12, 16

In re Octagon Roofing
123 B.R. 583 (Bankr. N.D. Ill. 1991) 22

In re Slater Health Center, Inc.
294 B.R. 423 (Bankr. D. RI. 2003) 15

In re St. Mary Hospital
89 B.R. 503 (E.D. Pa. 1988) 23

In re: Thane International, Inc. v. 9472541 Canada Inc.
586 B.R. 540 (Bankr. D. Del. 2018) 22

In re Tidewater Memorial Hospital, Inc.
106 B.R. 876 (Bankr. E.D. Va. 1989) 24

In re University Medical Center
973 F.2d 1065 (3rd Cir. 1992) 15

In re Vitalsigns Homecare, Inc.
396 B.R. 232 (Bankr. D. Mass. 2008) 15

Koerpel v. Heckler
797 F.2d 858 (10th Cir. 1986) 19

Lin v. State of California
78 Cal. App. 4th 931 (Ct. App. 2012) 20

Maximum Care Home Health Agency v. HCFA, No. 3-97-CV-1451-R
1998 WL 901642 (N.D. Tex. April 14, 1998) 18

Mednik v. State Department of Health Care Services
175 Cal. App. 4th 631 (Ct. App. 2009) 14

TABLE OF AUTHORITIES
(continued)

Page

Richmond Leasing Co. v. Capital Bank, N.A.
762 F.2d 1303 (5th Cir. 1985) 23

Southeast Kansas Community Action Program v. Secretary of Agriculture of the United States
967 F.2d 1452 (10th Cir. 1992) 19

U.S. ex rel. Academy Health Center, Inc. v. Hyperion Foundation, Inc.
2014 WL 3385189 (S.D. Miss. 2014) 18

U.S. ex rel. Roberts v. Aging Care Home Health, Inc.
474 F. Supp. 2d 810 (W.D. La 2007) 18

STATUTES

11 U.S.C.
§ 363(f) 17, 21, 22
§ 365 24
§ 365(b) 22
§§ 1107(a) and 1108 2

42 U.S.C.
§ 1396a(a)(27) 17
§ 1396a 3
§ 1396b 3
§§ 1396b(a) and 1396d(b) 3
§ 1396b(w) 4

Cal. Code Regs. Title 22
§ 50004(b)(1) 3
§§ 51016-51048 7
§ 51047 7

TABLE OF AUTHORITIES
(continued)

Page

Cal. Welf. & Inst. Code
§ 10740 3
§ 14016.5(b) 4
§ 14063 3
§§ 14087.3-14089.8 4
§§ 14133 and 14170 7
§ 14169.50 6
§ 14169.50(b) 6
§ 14169.50(d) 7
§ 14169.51(*l*) 4
§ 14169.52(a) 6
§ 14169.52(h) 7, 8
§ 14169.53(b) 5
§ 14170(a)(1) 7
§ 14171 7
§ 14301.1 5

CONSTITUTIONAL PROVISIONS

Cal. Const., Article 16, § 3.5 6

COURT RULES

Bankruptcy Rule 6004(h) 24

Bankruptcy Rule 6006(d) 24

OTHER AUTHORITIES

42 C.F.R. §§ 433.50 – 433.74 4

42 C.F.R. § 433.51 3

HTTP://WWW.DHCS.CA.GOV/ 6

http://www.lao.ca.gov/BallotAnalysis/Proposition?number=52&year=2016 4

https://lao.ca.gov/ballot/2013/130602.aspx 5

TABLE OF AUTHORITIES
(continued)

Page

Fogel, *Executory Contracts and Unexpired Leases in the Bankruptcy Code*, 64 Minnesota Law Review 341, 344 (1980)..... 12

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 10 th 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: 394285

✓ **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

PSS070

PROVIDER: 399285 SERVICE CODE: 02 PROVIDER DETAIL 01/01/19 13:42:06
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 DATABASE COUNTY: PSRO REGION CODE: 24
MAIL ADDRESS IND: Q OUT OF STATE: 0
CON AREA IND: C EFF DATE: 04/01/1983 END DATE: 12/31/2069
FAC ADMINSTRATOR: BRIAN CONNOLLY

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.

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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.

11. **Confidentiality of Beneficiary Information.** Provider agrees that all medical records and beneficiaries' records of 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.

a. The provider, persons with an ownership or control interest in the provider, or persons who are employed by or contracting with the provider have been convicted of a felony or misdemeanor involving fraud or abuse in any government program related to negligent practice 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 1280.2 and Welfare and Institutions Code, Section 14124.2.

(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.

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: St. Vincent Medical 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): Cathy Ficken

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/CEO

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

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EXHIBIT 2

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

FOR STATE USE ONLY

55-5238

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) St. Francis Medical Center	Business name (if different than legal name) ST. FRANCIS MEDICAL CENTER D/P SNF		
Provider number (NPI number) 1487697215(Acute); 1245227180(SNF)		Business Telephone Number (310) 900-8900	
Business address (number, street) 3630 E. Imperial Highway	City Lynwood	State CA	Nine-digit ZIP code 90262
Mailing address (number, street, P.O. Box number) 3630 E. Imperial Highway	City Lynwood	State CA	Nine-digit ZIP code 90262
Pay-to address (number, street, P.O. Box number) File #56850	City Los Angeles	State CA	Nine-digit ZIP code 90074
Previous business address (number, street, P.O. Box number) N/A	City N/A	State N/A	Nine-digit ZIP code 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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AUG 26 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)).

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

LAROENIA 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	Date	Reviewer	Date	Return	Supervisor	Date	Return
Gerard Smith	11/10/10				K	11/15/10	

Comments:

PMF Transaction Signatures

Technician	Date	Return	Status change update and review signature	Date	Return
QS	11-16-2010				
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** ZIP:**940154132**	STATE: ZIP:	**CA** ZIP:**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

4/3/17

* 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:

DOC# 458698 REVIEW DUE DATE:

RISK:Low PAGE# 1 of 1

Document Review and Approve Signatures

Analyst	Date	Reviewer	Date	Return	Supervisor	Date	Return
	7/7/11	Farra Cazem	7/12/11				

Comments:

PMF Transaction Signatures

Technician	Date	Return	Status change update and review signature	Date	Return
Reviewer	Date	Return	Supervisor (optional)	Date	Return

Comments: 8 | 7/20/11

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 CDC700301		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 thr

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
- [X] 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
- [X] Guardian or Conservator
- [ ] Other:

Signer Is Representing:

RIGHT THUMBPRINT OF SIGNER — Top of thumb here

VN 3/15/10

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VKN 3/15/10 mcPA

STATE OF CALIFORNIA — HEALTH AND WELFARE AG

DEPARTMENT OF HEALTH SERVICES

MEDI-CAL PROVIDER DATA FORM

DEPARTMENT OF HEALTH SERVICES SACRAMENTO OCT 0 1 1982 Provider Certification Program

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. *(Attach a separate sheet of paper if more space is needed).* 270

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? 247 ☐ Yes ☒ No

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 that it shall obtain any applicable 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.

Case 2:19-bk-21515-ER Doc 30421 Filed 09/13/19 Page 181 of 296 Page ID #:3947

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		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	$2,040,467.00	-	$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	=	[redacted]
	CYCLE 9 (01/01/2019-03/31/2019)	4/3/2019	$6,703,466.00	-	$6,703,466.00	-	$0.00	=	[redacted]
	CYCLE 10 (04/01/2019-06/30/2019)	7/3/2019	$6,520,041.59	-	$6,520,041.59	-	$0.00	=	[redacted]
	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:

Lance N Jurich ljurich@loeb.com
David E Lemke david.lemke@wallerlaw.com
Bryan L Ngo bngo@fortislaw.com
Mary H Haas maryhaas@dwt.com
Mark A Neubauer mneubauer@carltonfields.com
Latonia Williams lwilliams@goodwin.com
Latonia Williams lwilliams@goodwin.com
Alicia K Berry Alicia.Berry@doj.ca.gov
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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
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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*

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Attorneys for the Chapter 11 Debtors and Debtors In Possession

UNITED STATES BANKRUPTCY COURT

CENTRAL DISTRICT OF CALIFORNIA - LOS ANGELES DIVISION

In re

VERITY HEALTH SYSTEM OF CALIFORNIA, INC., *et al.*,

Debtor and Debtor In Possession.

☒ 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.

Lead Case No. 2:18-bk-20151-ER

Jointly Administered With:
Case No. 2:18-bk-20162-ER
Case No. 2:18-bk-20163-ER
Case No. 2:18-bk-20164-ER
Case No. 2:18-bk-20165-ER
Case No. 2:18-bk-20167-ER
Case No. 2:18-bk-20168-ER
Case No. 2:18-bk-20169-ER
Case No. 2:18-bk-20171-ER
Case No. 2:18-bk-20172-ER
Case No. 2:18-bk-20173-ER
Case No. 2:18-bk-20175-ER
Case No. 2:18-bk-20176-ER
Case No. 2:18-bk-20178-ER
Case No. 2:18-bk-20179-ER
Case No. 2:18-bk-20180-ER
Case No. 2:18-bk-20181-ER

Chapter 11 Cases

Hon. Judge Ernest M. Robles

DEBTORS' REPLY TO CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES OBJECTION TO DEBTORS' SALE OF ASSETS TO STRATEGIC GLOBAL MANAGEMENT

Hearing:
Date: September 25, 2019
Time: 10:00 a.m. (Pacific Time)
Location: Courtroom 1568
255 E. Temple Street
Los Angeles, CA

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TABLE OF CONTENTS

I. INTRODUCTION 1

II. STATEMENT OF FACTS 3

A. General Background 3

B. The SGM Sale and DHCS Objection 3

C. The DHCS Supplemental Objection 5

D. The Debtors' Response to the DHCS Supplemental Objection 6

E. Improper Setoffs 7

III. ARGUMENT 7

A. The Provider Agreement Is Not A Contract. 7

1. The Provider Agreements Are Not Contracts Because They Impose No Duties On The DHCS. 8

2. The DHCS Objections Ignore Controlling Ninth Circuit Precedent That Provider Agreements Are Not Contracts. 9

3. If The Provider Agreements Are Not Contracts Outside Of Bankruptcy They Do Not Become Contracts In A Bankruptcy Case. 10

B. The Medi-Cal Provider Agreements Are Property Of The Debtors' Estates Which Can Be Sold Through § 363. 13

C. The Medi-Cal Provider Agreement Can Be Sold Free And Clear Of Successor Liability. 15

D. Even If The Medi-Cal Provider Agreement Is A Contract, The Debtors Do Not Have To Pay The HQAF Fees As A Cure. 17

IV. CONCLUSION 18

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TABLE OF AUTHORITIES

Page(s)

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2014 U.S. Dist. LEXIS 93185 (S.D. Miss., July 9, 2014) 10

Armstrong v. Exceptional Child Ctr., Inc.,
135 S. Ct. 1387-88 (2015) 8

In re BDK Health Mgmt., Inc.,
No. 98-609-B1, 1998 Bankr. LEXIS 2031 (Bankr. M.D. Fla., Nov. 16, 1998) 13

Butner v. United States,
440 U.S. 48 (1979) 11

Folger Adam Sec., Inc. v DeMatteis/Macgregor, JV,
209 F.3d 252 (3d Cir. 2000) 17

In re Frontier Properties, Inc.,
979 F.2d 1358 (9th Cir. 1992) 10

In re Fugazy Express, Inc.,
124 B.R. 426 (S.D.N.Y. 1991) 14, 15

In re Gardens Regional Hospital and Medical Center, Inc.,
569 B.R. 788 (Bankr. C.D. Cal. 2017) 9

Greater Dallas Homecare Alliance v. United States,
10 F. Supp.2d. 638 (N.D. Tex 1998) 10

In re Grumman Olson Industries. Inc.,
467 B.R. 694 (S.D.N.Y 2012) 16

Guzman v. Shewry,
552 F.3d 941 (9th Cir. 2008) 1, 10

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53 B.R. 874 (Bankr. D.R.I. 1985) 15

Hollander v. Brezenoff,
787 F.2d 834 (2d Cir. 1986) 10

Homecare Ass''n of America Inc. v. United States,
1998 U.S. Dist. Lexis 20515 (W.D. Okla. Aug., 1998) 10

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In re Kings Terrace Nursing Home and Health Related Facility,
1995 WL 65531 (Bankr. S.D.N.Y. Jan. 27, 1995), *aff'd*, 184 B.R. 200
(S.D.N.Y. 1995) 13

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No. 3-97-CV-1451-R, 1998 WL 901642 (N.D. Tex. Apr. 14, 1998) 10

Maynard v. Bonta,
No. CV 02-06539, 2003 U.S. Dist. LEXIS 16201 (C.D. Cal. Aug. 29, 2003) 15

Mission Prods. Holdings, Inc. v. Tempnology, LLC,
139 S. Ct. 1652 (May 20, 2019) 11

Mlq Investors, L.P., v. Pac. Quadracasting, Inc.,
146 F.3d 746 (9th Cir. 1998) 15

Myers v. United States,
297 B.R. 774 (S.D. Cal. 2003) 16

Nieves v. Hess Oil Virgin Islands Corp.,
819 F.2d 1237 (3d Cir. 1987) 13

Orthopaedic Hospital v. Belshe,
103 F.3d 1491 (9th Cir. 1997) 8

PAMC, Ltd. v. Sebelius,
747 F.3d 1214 (9th Cir. 2014) 9, 12, 14

PBBPC, Inc. v. OPK Biotech, LLC (In re PBBPC, Inc.),
484 B.R. 860 (1st Cir. B.A.P. 2013) 16

Pennhurst State Sch. & Hosp. v. Halderman,
451 U.S. 1, 101 S. Ct. 1531, 67 L. Ed. 2d 694 (1981) 13

In re Re Tak Communications,
985 F.2d 916 (7th Cir. 1993) 15

U.S. ex rel. Roberts v. Aging Care Home Health, Inc.,
474 F. Supp. 2d 810 (W.D. La. 2007) 10

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292 B.R. 815 (Bankr. E.D. Pa. 2003) 18

In re Sigel & Co., Ltd.,
923 F.2d 142 (9th Cir. 1991) 18

In re Smith,
94 B.R. 220 (Bankr. M.D. Ga. 1988) 14, 15

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Matter of Superior Toy & Manufacturing Company, Inc.,
78 F.3d 1169 (7th Cir. 1996) 18

Tatum v. RJR Pension Inv. Comm.,
761 F.3d 346 (4th Cir. 2014) 13

Taylor v. Freeland & Kronz,
503 U.S. 638 (1992) 15

In re Tougher Industries,
2013 WL 1276501 (Bankr. N.D.N.Y. Mar. 27, 2013) 16

In re UAL Corp.,
635 F.3d 312 (7th Cir. 2011) 18

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99 F.3d 573 (4th Cir. 1996) 16

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No. 12-1234, 2013 WL 3948074 (D.D.C. June 13, 2013) 12

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No. CV-03-206, 2005 WL 3784642 (C.D. Cal. Dec. 22, 2005) 11

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802 F.2d 1164 (9th Cir. 1986) 9

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462 U.S. 198 (1983) 15

In re Vitalsigns Homecare, Inc.,
396 B.R. 232 (Bankr. D. Mass. 2008) 17

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189 B.R. 97 (Bankr. E.D. Va. 1995) 16

Statutes

11 United States Code
§§ 101-1532 ..... 1, 14, 15
§ 363 ..... *passim*
§ 365 ..... *passim*

42 United States Code
§ 1396a(a)(30)(A) 8
§ 1396a(a)(37)(B) 15

California Health and Safety Code § 1250(a) 18

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California Welfare and Institutions Code
§ 14169.51(q) 18
§ 14169.52 18
§ 14169.52(a) et. seq. 4, 5

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I.

INTRODUCTION

The Debtors are trying to close the sale of their remaining significant assets to the only buyer who made an offer to keep four important community hospitals open and providing essential care to underserved communities, continued employment to thousands of hard-working and dedicated employees, and a meaningful return to creditors. Despite all those powerful reasons for the Department of Health Care Services of the State of California (the "DHCS") to support the proposed sale, instead it objects to the proposed sale of the Debtors' remaining Hospitals (St. Francis Medical Center ("SFMC"), St. Vincent Medical Center ("SVMC") including the St. Vincent Dialysis Center ("SVDC"), and Seton Medical Center ("SMC"), including Seton Medical Center Coastside Campus ("SMCC"), collectively the "Hospitals") to Strategic Global Management, Inc. and/or one or more of its affiliated entities (collectively, "SGM") only with regard to the proposed transfer of the Medi-Cal[1] Provider Agreements between DHCS and the Hospitals. In its two long (although virtually identical) objections (collectively, the "DHCS Objections"), the DHCS argues that the Medi-Cal Provider Agreements (the "Provider Agreement" or "Provider Agreements") are executory contracts which must be transferred pursuant to section § 365 of the Bankruptcy Code,[2] which, according to the DHCS, means that the Debtors must, among other things, pay more than $24 million based on an audit which is subject to significant disputes, as well as any unpaid Hospital Quality Assurance Fees ("HQAF Fees") which are due to be paid in the future, and that SGM must assume successor liability for any amounts subsequently discovered to be owed by the Debtors to the DHCS related to the Provider Agreements. In effect, the government agency responsible for overseeing medical assistance to those whose too poor to afford it, is intent on elevating its financial goals over the medical needs of the communities it is supposed

[1] "Medicaid is a cooperative federal-state program that authorizes the United States Government to provide funds to participating states to administer medical assistance to individuals whose income and resources are insufficient to meet the costs of necessary medical services. The program operates by authorizing the Federal Government to pay a percentage of the costs a state incurs for patient care, and, in return, the state complies with certain federal requirements. California participates in Medicaid through the California Medical Assistance Program ('Medi-Cal'), and has designated [the DHCS] as the agency responsible for its administration." *Guzman v. Shewry*, 552 F.3d 941, 946 (9th Cir. 2008) (internal citations and quotations omitted).

[2] Unless specified otherwise, all chapter and section references are to the Bankruptcy Code, 11 U.S.C. §§ 101-1532.

to serve.

The DHCS Objections are without merit. DHCS conflates statutory obligations with contractual rights and is wrong on all points. For example, it argues that the Provider Agreement is analogous to the Medicare Provider Agreement, and therefore is a contract, ignoring that (a) the United States argues regularly that the Medicare Provider Agreement is not a contract, (b) the Ninth Circuit Court of Appeals (the "Ninth Circuit") has held that the Medicare Provider Agreement is not a contract, and (c) the Ninth Circuit has stated that the Medi-Cal Provider Agreement is merely "contractual in nature," as opposed to being a contract. Although the DHCS points to obligations imposed on the Debtors by the Medi-Cal Provider Agreement, it cannot point to any obligations imposed on it by the agreement, because DHCS's obligations all arise from statute rather than contract. Absent mutual obligations the Provider Agreements are not a contract.

The DHCS also argues that the Debtors must pay all unpaid HQAF Fees to "cure" existing defaults under the Medi-Cal Provider Agreement, ignoring that hospitals must pay the HQAF Fees as an obligation under statutory law without regard to whether they have a Medi-Cal Provider Agreement. Further, relying on recent audit findings related to fiscal year 2016-17, Medi-Cal now asserts for the first time that the Debtors must pay more than $24 million as a cure, and escrow $70 million for three years, without any explanation of how it arrived at that amount, against any other potential obligations it may subsequently discover. The Debtors dispute these audit results, and is confident that, given an opportunity, they can show that they are not liable for the amounts alleged.

For all the reasons argued below, the Court should overrule the Objection and allow the sale of the Medi-Cal Provider Agreement under § 363 without successor liability and without requiring the payment of the outstanding HQAF Fees or the alleged audit obligations. If the Court determines that Provider Agreements are contracts, however, the Court should set a briefing schedule and subsequent hearing to determine the cure amounts.

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II.

STATEMENT OF FACTS

A. General Background

1. The Hospitals have Medi-Cal provider agreements ("Medi-Cal Provider Agreements") with the DHCS, which enable them to receive Medi-Cal payments for services provided to Medic-Cal beneficiaries. The SFMC Provider Agreement is assigned No. 148769215; the SVMC Provider Agreement is assigned No. 1124004304; the SMC Provider Agreement is assigned No. 1154428688; and the SVDC Provider Agreement is assigned No. CDC70030F.

2. As described in the *Declaration of Richard Adcock in Support of Emergency First-Day Motions* (the "Adcock Declaration") [Docket No. 8], filed on August 31, 2018, the Debtors have struggled financially to survive for decades, and currently sustain operational cash flow losses of approximately $175 million annually. The Debtors estimate that (a) secured claims in these Bankruptcy Cases total more than $567 million (including claims of various prepetition secured creditors), and (b) the total of scheduled and filed unsecured claims, including pension claims, may exceed $1.5 billion.

B. The SGM Sale and DHCS Objection

3. The Debtors are selling the Hospitals at a price of approximately $610 million, plus payment of "cure" costs associated with certain assumed leases and/or assumed contracts, pursuant to § 363 ("the SGM Sale") to SGM. The closing of the SGM Sale (the "Closing") is contingent on, among other things, the Attorney General's approval, with conditions that are substantially consistent with the conditions approved by SGM, as set forth on Schedule 8.6 to the SGM asset purchase agreement. *See* Docket No. 2305-1. The Debtors and SGM expect the SGM Sale of the Hospitals to close in mid-to-late October 2019.

4. On February 19, 2019, the Bankruptcy Court entered its *Order (1) Approving Form Of Asset Purchase Agreement For* Stalking *Horse Bidder And For Prospective Overbidders, (2) Approving Auction Sale Format, Bidding Procedures And Stalking Horse Bid Protections, (3) Approving Form Of Notice To Be Provided To Interested Parties, (4) Scheduling A Court Hearing To Consider Approval Of The Sale To The Highest Bidder, And (5) Approving Procedures Related*

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To The Assumption Of Certain Executory Contracts And Unexpired Leases; And (II) An Order (A) Authorizing The Sale Of Property Free And Clear Of All Claims, Liens And Encumbrances [Docket No. 1572] the ("Bidding Procedures Order").

5. On March 5, 2019, the Debtors filed a *Notice of Counterparties to Executory Contracts and Unexpired Leases of the* Debtors *That May Be Assumed and Assigned* [Docket No. 1704].

6. On March 22, 2019, the DHCS filed its *Creditor California Department of Health Care Services's Objection To Notice of Counterparties to Executory Contracts and Unexpired Leases of the Debtors That May Be Assumed and Assigned* [Docket No. 1879], which asserted that the Debtor had to transfer the Medi-Cal Provider Agreements as executory contracts pursuant to § 365 (the "DHCS Objection"). In the DHCS Objection, the DHCS asserted it was owed the following amounts in connection with the Hospitals, as of March 15, 2019: (a) SFMC - liability arising from the Hospital Quality Assurance Fees Program ("HQAF), California Welfare & Institutions Code, § 14169.52(a) et. seq., in the amount of $30,381,769.53; (b) SVMC (including SVDC) - HQAF liability in the amount of $21,427,707.82; and SMC (including its SMCC campus) - HQAF liabilities in the amount of $28,160,469.45. In the DHCS Objection, the DHCS did not reflect any obligations owed to it related to the Medi-Cal fee-for-service payments in connection with the Hospitals.

7. On March 29, 2019, the DHCS filed the following proofs of claim in the Bankruptcy Cases: (a) against SVMC, assigned Claim No. 62-1, asserting that it is owed $5,287,280.73, based solely on the unpaid HQAF Fees; (b) against SFMC, assigned Claim No. 134-1, asserting that it is owed $7,302,038.67, based solely on the unpaid HQAF Fees; and (c) against SMC, assigned Claim No. 66-1, asserting that it is owed $ 17,090,035.65, based solely on the unpaid HQAF Fees. The DHCS asserts in its proofs of claims, that, in the aggregate, it is owed approximately $29,679,354 by the Debtors, all solely related to unpaid HQAF Fees. However, all HQAF Fees have been paid in the ordinary course of business during the Bankruptcy Cases and no amounts are presently due and owing to the DHCS.

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8. On May 2, 2019, the Bankruptcy Court entered the *Order (A) Authorizing The Sale Of Certain Of The Debtors' Assets To Strategic Global Management, Inc. Free And Clear Of Liens, Claims, Encumbrances, And Other Interests; (B) Approving The Assumption And Assignment Of An Unexpired Lease Related* Thereto*; And (C) Granting Related Relief* [Docket No. 2306], approving a sale of the Debtors' Hospitals to SGM. Certain counterparties to executory contracts and leases objected to the cure amounts and some of those objections are still being resolved.

C. The DHCS Supplemental Objection

9. On September 11, 2019, the DHCS filed its *Creditor California Department of Health Care Services's Supplemental Objection To (1) Debtors' Motion For 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* [Docket No. 3043] (the "DHCS Supplemental Objection"), which asserted that (i) the Debtor had to transfer the Medi-Cal Provider Agreements as executory contracts pursuant to § 365; (ii) the Debtors had to pay all outstanding HQAF Fees; (iii) the Debtors or the Buyers would have to reimburse the DHCS for any outstanding obligations between the Debtors and the DHCS; and (iv) the Debtors would have to escrow $70 million for 36 months for any potential claims which the DHCS might subsequently discover, and if $70 million proved to be insufficient, the Buyer would have to assume liability for the excess amount.

10. In the DHCS Supplemental Objection, the DHCS asserted it was owed the following amounts in connection with the Hospitals, as of September 6, 2019: (a) SFMC - liability arising from the Hospital Quality Assurance Fees Program ("HQAF), California Welfare & Institutions Code, § 14169.52(a) et. seq., in the amount of $3,835,489.67; (b) SVMC (including SVDC) - HQAF liability in the amount of $6,565,679.74; and SMC (including its SMCC campus) - HQAF liabilities in the amount of $16,927,759.87.

11. Further, in the DHCS Supplemental Objection, the DHCS asserted, for the first time, the following obligations owed to it related to the Medi-Cal fee-for-service payments in connection with the Hospitals: (a) SFMC - (i) liability arising from alleged claims adjustments for fiscal year 2016-2017, in the amount of $24,254,503.36, and (ii) an overpayment in the amount of $662,327.67 related to an alleged overpayment for Supplemental Reimbursement for the Construction

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Renovation Reimbursement Program; and (b) SMC - liability in the amount of $4,205.25 based on retroactive claims adjustments for the period July 1, 2016 through June 30, 2017.

D. The Debtors' Response to the DHCS Supplemental Objection

12. With regard to the 2017 audit, the Debtors received audit findings alleging overpayments of $25,176,471 for SFMC for the fiscal period ending June 30, 2017, but these amounts are grossly overinflated and an unlawful overreach by the DHCS's auditors. As background, for claims with dates of service from July 1, 2016, through and including June 30, 2017, DHCS calculated outlier payments based on the cost-to-charge ratio in the cost report filed by SFMC for the fiscal year ending June 30, 2014. DHCS did so despite having more recent and audited data on hand. The data in the cost report filed by SFMC for the fiscal year ending June 30, 2014, established a cost-to-charge ratio of 56.8%. The audited cost-to-charge ratio for fiscal year ending 2014 was approximately 28%. On May 15, 2019, the Debtors received DHCS's audit findings on its cost report for the fiscal year ending June 30, 2017. That report included a number of adjustments that substantially impacted the hospital's cost-to-charge ratio for the fiscal year ending June 30, 2017. Chief among these were: (1) the reduction of days and charges associated with behavioral health patients in adjustments 7, 8, and 9; and (2) the movement of nearly 3,000 bed days from the neonatal intensive care unit to the nursery in adjustment 7, without the movement of any of the corresponding costs or charges. These two adjustments alone accounted for almost the entirety of the reduction of the hospital's cost to charge ratio from 29.3% (as filed) to 23.8% (as audited). The significant reduction of the cost-to-charge ratio applied to calculate outlier payments from 56.8% to 23.8% resulted in the calculation of an approximately $25 million overpayment. The auditor did not present these outlier calculations in the exit conference, depriving the Debtors of their right to review and respond to the calculations.

13. The Debtors dispute the validity of DHCS's audit. As a preliminary matter, the introduction of a reconciliation process in the context of the APR-DRG payment methodology is in direct conflict with the mandate imposed by the Legislature on the DHCS when it granted DHCS the authority to develop and implement the APR-DRG payment methodology. Accordingly, this reconciliation process violates the Legislature's intent for an APR-DRG payment methodology that

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results in a simple, single transaction. Further, the DHCS audit findings are improper because: (1) the DHCS lacks the authority to adjust outlier payments paid based on a cost to charge ratio from the Provider's as filed fiscal year end 2014 cost report with a cost-to-charge ratio from the Provider's as audited fiscal year end 2017 cost report; (2) the DHCS improperly removed psychiatric services from the Provider's cost report because those psychiatric services were rendered to Medi-Cal beneficiaries, but were not paid by a "HMO;" (3) the DHCS's movement of NICU days and costs to nursery is unjustified because the use of Revenue Code 173 does not indicate that these patients did not receive NICU care, and because the movement of cost without moving the related charges artificially decreases the Provider's cost-to-charge ratio; and (4) the DHCS's audit was procedurally improper because it failed to raise the outlier adjustments (15, 16 and 17) at the audit exit conference, depriving the Provider of due process.

E. Improper Setoffs

14. Medi-Cal has been offsetting, without Court permission, one-hundred percent (100%) of SFMC's fee-for-service payments to pay itself on the alleged overpayments; it has already offset more than $2 million otherwise owed to SFMC.

15. SGM is willing to provide needed services to Medi-Cal beneficiaries and to accept a transfer of the Medi-Cal Provider Agreements, provided that SGM does not incur any exposure for liability under the Medi-Cal Provider Agreements, or otherwise for any Medi-Cal Claims, or HQAF Claims, for goods and services provided, and otherwise for events related to periods, prior to SGM taking possession and control of the Hospitals, or to otherwise assume any obligations or liabilities of the Debtors other than those expressly provided for in the Purchase Agreement related to the SGM Sale.

III.

ARGUMENT

A. The Provider Agreement Is Not A Contract.

The DHCS argues that the Provider Agreements are executory contracts, first arguing that the Provider Agreements impose obligations on both parties to the Provider Agreements, and second, arguing by analogy that a Provider Agreement is like a Medicare Provider Agreement, and

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therefore is also a contract. It strikingly fails to address binding, contrary precedent on the latter issue, and provides no evidence as to any obligations imposed on the DHCS from its purported contract that are independent of other, pre-existing legal obligations. As this Court has previously noted, pre-existing legal obligations cannot provide consideration for a contract, which dooms the DHCS argument with regard to the Provider Agreement. *See In re Gardens Regional Hospital and Medical Center, Inc*., 569 B.R. 788, 797 (Bankr. C.D. Cal. 2017).

1. The Provider Agreements Are Not Contracts Because They Impose No Duties On The DHCS.

The DHCS argues that the Provider Agreements are contracts because they impose duties on both the Debtors and the DHCS. Supplemental Objection, at 12, line 26-at 13, line 2. However, the Provider Agreements, despite 40 numbered paragraphs, do not impose any obligations on the DHCS, and certainly do not contain language stating that the DHCS has any obligation to pay for medical services. *See, e.g*., Supplemental Objection, at 14, lines 8-28 (listing obligations imposed on the Provider without listing a single obligation imposed on the DHCS). This is not surprising, as the DHCS's obligation to pay a Medi-Cal provider such as the Hospitals arises not from the Provider Agreements, but rather from federal and state law. 42 U. S. C. §1396a(a)(30)(A); *see generally Armstrong v. Exceptional Child Ctr., Inc*., 135 S. Ct. 1387-88 (2015); *Orthopaedic Hospital v. Belshe*, 103 F.3d 1491 (9th Cir. 1997).

The DHCS argues that the Provider Agreements are contracts, at least in part, because of duties imposed on the parties by "applicable law." Supplemental Objection, at 15, line 2. However, a document that requires parties to comply with pre-existing legal obligations does not provide consideration sufficient to create a contract: "[A]n agreement to comply with applicable law is a gratuitous promise which does not provide the consideration necessary to make a contract enforceable." *In re Gardens Regional Hospital and Medical Center, Inc*., 569 B.R. 788, 797 (Bankr. C.D. Cal. 2017) (citing and quoting *Auerbach v. Great W. Bank*, 74 Cal. App. 4th 1172, 1185, 88 Cal. Rptr. 2d 718, 727 (Cal. Ct. App. 1999) ("In contractual parlance, for example, doing or promising to do something one is already legally bound to do cannot constitute the consideration needed to support a binding contract.")); *see, e.g*., *United States v. Travelers Indem. Co.,* 802 F.2d

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1164, 1167 (9th Cir. 1986) ("Although the rule has been subject to criticism . . . performance of a preexisting legal duty is not sufficient consideration."). The plain text of the Provider Agreements reveal no obligations imposed on the DHCS by the terms of the Provider Agreement, and therefore, the Provider Agreement is not a contract. Thus, DHCS's argument should be rejected.

2. The DHCS Objections Ignore Controlling Ninth Circuit Precedent That Provider Agreements Are Not Contracts.

The DHCS correctly notes the similarities between Medicare Provider Agreements and the Provider Agreements. However, the DHCS's argument by analogy is conclusory, and merely recites non-binding precedent that has found that Medicare Provider Agreements are contracts. However, in the vast majority of those cases the issue was not disputed by the debtor and the findings are either *dicta* or not well analyzed because of this lack of opposition.

Substantive analysis of precedent vindicates the Debtors' position. In fact, the Ninth Circuit (in a decision the DHCS ignored) expressly held that Medicare Provider Agreements, and by extension, the Medi-Cal Provider Agreements, do not create a contractual relationship:

> We have, on occasion, stated that providers and others have contracts with the government in this area, **but our decisions have turned on the regulatory regime rather than on contract principles**. […] As the Eleventh Circuit Court of Appeals held when hospitals complained of legislative impairment of their contract rights in this area because they had agreements with the Secretary: 'Upon joining the Medicare program, however, **the hospitals received a statutory entitlement, not a contract right**."

PAMC, Ltd. v. Sebelius, 747 F.3d 1214, 1221 (9th Cir. 2014) (emphasis added) (quoting *Memorial Hosp. v. Heckler*, 706 F.2d 1130, 1136 (11th Cir. 1983)).

Previously, but consistently with its decision in *PAMC*, the Ninth Circuit held that the Medi-Cal Provider Agreements create a statutory entitlement, rather than a contractual relationship when it found that Medi-Cal was statutory and did not implicate "government contracts" or "contracting with the state:"

> Participation in the Medi-Cal program entitles [a provider] to reimbursement for treating patients who receive MediCal benefits; **it does not involve bidding on government contracts**. . . . Accordingly, we must conclude that DHCS's action **does not deprive Guzman of his interest in contracting with the state**.

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Guzman v. Shewry, 552 F.3d 941, 946 (9th Cir. 2008) (emphasis added).

These decisions of the Ninth Circuit are consistent with the vast majority of cases to have addressed the issue outside of bankruptcy cases. *See, e.g., Hollander v. Brezenoff*, 787 F.2d 834 (2d Cir. 1986) (characterizing the Medicare relationship with providers as a "statutory business relationship"); *U.S. ex rel. Acad. Health Ctr., Inc. v. Hyperion Foundation, Inc.*, 2014 U.S. Dist. LEXIS 93185 (S.D. Miss., July 9, 2014) (holding that Provider Agreements are not contracts); *U.S. ex rel. Roberts v. Aging Care Home Health, Inc.,* 474 F. Supp. 2d 810 (W.D. La. 2007) ("Medicare Provider Agreements create statutory, not contractual, rights."); *Maximum Care Home Health Agency v. HCFA*, No. 3-97-CV-1451-R, 1998 WL 901642, at *5 (N.D. Tex. Apr. 14, 1998) ("[A] Medicare service provider agreement is not a contact in the traditional sense. It is a statutory entitlement created by the Medicare Act."); *Greater Dallas Homecare Alliance v. United States*, 10 F. Supp.2d. 638, 647 (N.D. Tex 1998) ("Plaintiffs argue that the Medicare participation agreements between [HCFA] and the [health care providers] are essentially contracts. The court disagrees and finds that the participation agreements are not contracts, for the right to receive payments under the Medicare Act is a manifestation of government policy and, as such, is a statutory rather than a contractual right."); *Homecare Ass'n of America Inc. v. United States*, 1998 U.S. Dist. Lexis 20515 (W.D. Okla. Aug., 1998) (holding that no contractual obligation existed between government and provider of Medicare services).

3. If The Provider Agreements Are Not Contracts Outside Of Bankruptcy They Do Not Become Contracts In A Bankruptcy Case.

That Provider Agreements are not contracts outside of bankruptcy resolves the issue of whether they are executory contracts inside of bankruptcy. The Bankruptcy Code does not define what is a contract for its purposes, *In re Frontier Properties, Inc.,* 979 F.2d 1358 (9th Cir. 1992) ("The [bankruptcy] code does not define 'executory contract.'"), and, therefore, the Court should look to applicable non-bankruptcy law to determine what is a contract in bankruptcy. *See, e.g., Butner v. United States*, 440 U.S. 48 (1979) (noting that Congress has "generally left the determination of property rights in the assets of a bankrupt's estate" to applicable non-bankruptcy law). Moreover, to the extent the argument that an agreement could be a contract in bankruptcy

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even though it is only "contractual in nature" outside of bankruptcy ever had any validity, a recent Supreme Court decision makes it clear that the assertion that the Provider Agreement could be a contract inside of bankruptcy but not outside of bankruptcy cannot survive even cursory scrutiny. The Supreme Court has recently held that "[b]ecause 'contract' is 'neither a defined nor a specialized bankruptcy term … [i]t means in the [Bankruptcy] Code what it means in contract law outside bankruptcy." *Mission Prods. Holdings, Inc. v. Tempnology, LLC*, 139 S. Ct. 1652 (May 20, 2019). The Supreme Court recognizes that a document which is not a contract outside of bankruptcy cannot become a contract for bankruptcy case purposes.

Importantly, in federal litigation in this district, even the United States has successfully argued that the Medicare Provider Agreement is not a contract. For example, in 2005 in litigation in this district the United States argued:

> Provider Agreements referenced by defendants are one page documents that do no more than notify providers of the statutory and regulatory provisions of the Medicare program and do not in themselves convert the government's statutory and common law remedies into contractual ones. Under those Agreements, providers "agree[] to conform to the provisions of … the Social Security Act and applicable provisions in [the Code of Federal Regulations]." . . . The Agreements impose no duties upon the United States or the Department of Health and Human Services. … Importantly, a Provider Agreement imposes no additional duties upon a provider that are not also embodied in the Social Security Act and regulations. Any "breach" of the Agreement by a provider would necessarily be a violation of the Social Security Act and/or the regulations because to determine what duties the provider had breached, one would have to turn to the statute and the regulations.

United States' Sur-Reply to Tenant's Reply to its Motion for Summary Adjudication (Statute of Limitations), at 2, *United States v. Tenant Healthcare Corp.*, No. CV-03-206, 2005 WL 3784642 (C.D. Cal. Dec. 22, 2005) (internal citations omitted).

The United States regularly argues that the Medicare Provider Agreement is not a contract nationally as well. *Southeast Arkansas Hospice, Inc. v. Sebelius*, 1 Fed. Supp. 3d 915 (E.D. Ark. 2014) ("[T]he Secretary [of the United States Department of Health and Human Services] argues first that the provider agreement is a statutory entitlement and not a contract. … The Secretary cites several cases in this area as to Medicare provider agreements, all of which support the Secretary's position that the agreement with SEARK is not a contract. …. The weight of authority supports a

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finding that the provider agreement is not a contract."); Government Parties' Reply in Further Support of their Motion for Partial Summary Judgment at 2, 4, *United States v. Malik*, No. 12-1234, 2013 WL 3948074 (D.D.C. June 13, 2013) ("The overwhelming weight of authority rejects any notion that providers participating in Government Health Care Programs have contractual relationships with them. Although provider enrollment applications and materials are often referred to as "agreements," these materials do not establish a contractual relationship -- instead providers' rights to reimbursement are statutory in nature. … In the context of the Medicare program, the Medicare statute requires providers to enter into an agreement, commonly referred to as a provider agreement, with the Secretary of HHS in order to receive Medicare reimbursement. While the provider "agreement" is a condition for reimbursement, it does not establish a contractual relationship between providers and the United States.").

In addition to the Ninth Circuit law that plainly defeats DHCS's argument, the Ninth Circuit's reasoning—differentiating between a true contract right and a statutory right implicating an election by a private party to take on statutory burdens and benefits from the government—exposes the flaw in the DHCS's stance that because the "relationship between a Medi-Cal provider and the DHCS is contractual in nature," that there must be an actual § 365 contract. Supplemental Objection, at 14, lines 4-7. Much like the concession in *PAMC* by the Ninth Circuit that courts frequently describe the Medicare (and by analogy, Medi-Cal) Program as "contractual," although it is not a true contract, it is similarly true that courts refer to the Medi-Cal relationship as "contractual in nature," when, in fact, the Medi-Cal Provider Agreements are not substantively contractual, but are statutory. Just because "legislation [particularly that which is] enacted pursuant to the spending power is much in the nature of a contract" between a person and his government and/or a beneficiary of the law, does not mean the legislation is a "contract" under § 365. *See generally Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 2, 101 S. Ct. 1531, 1532, 67 L. Ed. 2d 694 (1981). Therefore, courts (like the Ninth Circuit) acknowledge that though "rights and liabilities [that] have been called 'contractual in nature' [because they derive from] 'a definite statutory status or relationship which is in essence contractual' are not truly contractual." *Nieves v. Hess Oil Virgin Islands Corp.*, 819 F.2d 1237, 1254–55 (3d Cir. 1987) (emphasis added) (citing

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McAllister v. Bd. of Education, 79 N.J. Super. 249, 191 A.2d 212 (1963), aff'd, 42 N.J. 56, 198 A.2d 765 (1964)); *cf. Tatum v. RJR Pension Inv. Comm.*, 761 F.3d 346, 363 n. 11 (4th Cir. 2014) (analyzing dispute between employer and employee regarding retirement plan and holding that "ERISA—not a contract—governs the parties' relationship, and expressly imposes fiduciary—not contractual—duties."). The Debtors' and the DHCS's relationship is underpinned by statute - not a contract - and § 365 does not apply.

B. The Medi-Cal Provider Agreements Are Property Of The Debtors' Estates Which Can Be Sold Through § 363.

Although courts have treated provider agreements as executory contracts, the issue was not disputed in the vast majority of cases. Bankruptcy courts which have actually addressed this issue in a meaningful way have concluded that Provider Agreements are not contracts, and therefore can be sold under § 363. For example, the decision in *In re BDK Health Mgmt., Inc*., Case Nos. 98-609-B1, *Order Authorizing Sale of Assets Out Of The Ordinary Course of Business*, 1998 Bankr. LEXIS 2031 (Bankr. M.D. Fla., Nov. 16, 1998), is directly on point, well-reasoned and persuasive, and concludes that provider agreements generally are not executory contracts. *See also In re Kings Terrace Nursing Home and Health Related Facility*, 1995 WL 65531, *7-8 (Bankr. S.D.N.Y. Jan. 27, 1995) (Medicaid relationship is statutory relationship, not contractual relationship, despite existence of provider agreement.), *aff'd*, 184 B.R. 200 (S.D.N.Y. 1995).

The court's reasoning in *BDK* dealt with Medicare Provider Agreements, but (as the DHCS Objections admit) its reasoning is equally applicable to the Medi-Cal Provider Agreements. The court noted that the Provider Agreements imposed no obligations and conferred no benefits on the debtor or the government other than establishing that the debtor was entitled to operate and be reimbursed in accordance with the applicable Medicare statutes and regulations. Like the Ninth Circuit in *PAMC*, the court found that Provider Agreements created "statutory entitlement" relationships rather than contractual relationships. There is very little to distinguish the Medicare Provider Agreement from the Medi-Cal Provider Agreement in these aspects, and should the Debtors seek to sell the Provider Agreements as licenses, the result should be that the Provider Agreements are treated as licenses rather than as contracts.

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Although the DHCS argues at length about the Debtors' estates having no "property rights" in the Provider Agreements (without focusing on bankruptcy law, Supplemental Objection, at 19), this misses the point given the broad definition of "property of the estate" under the under § 541(a). Section 541(a) broadly defines "property" of the estate to include "all legal or equitable interests of the debtor in property as of the commencement of the case" - a far more expansive definition than the one urged by the DHCS and applied by the non-bankruptcy cases it cites.[3]

In a *bankruptcy* context, courts have held that interests such as the Medi-Cal Provider Agreements are "property" under § 541(a). For instance, in dealing with licenses issued by the Federal Communications Commission, courts have held that debtors can sell licenses even if they were not an "owned asset" or a "vested property interest." *Stephens Industries, Inc. vs. McClung*, 789 F. 2d. 386 (6th Cir. 1986) (court held that the broadcast license was not an owned asset or a vested property interest that could be subject to a mortgage, lien, pledge, attachment, seizure or similar right but authorized the § 363 sale of all assets of the debtor, including whatever rights attached to the license); *In re Fugazy Express, Inc*., 124 B.R. 426 (S.D.N.Y. 1991) (analyzing the property of the estate question and concluding that § 541 includes any conceivable tangible or intangible property, including licenses issued by governmental authority); *In re Smith*, 94 B.R. 220 (Bankr. M.D. Ga. 1988) (holding that license was property of the estate). This is consistent with Ninth Circuit precedent holding that "[g]overnment licenses, as a general rule, are considered to be 'general intangibles' under the Uniform Commercial Code, 'i.e., personal property interests in which security interests may be perfected.'" *Mlq Investors, L.P., v. Pac. Quadracasting, Inc.,* 146 F.3d 746, 749 (9th Cir. 1998) (quoting *In re Ridgely Communications, Inc.*, 139 B.R. 374, 379 (Bankr. D. Md. 1992)).

Here, the Court should find that the Provider Agreements are licenses, and are therefore property of the bankruptcy estate which can be sold pursuant to § 363. *See, e.g., In re Re Tak*

[3] The DHCS argues that the Debtors have no property interest in the Medi-Cal Provider Agreement, which is inconsistent with its argument that the Provider Agreement is a contract. There is no dispute that an executory contract is property of a debtor's estate, and DHCS argues strongly that the Provider Agreement is such a contract and is subject to assumption. DHCS does not explain how the Debtors could have contract rights but not be any property rights in that alleged contract.

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Communications, 985 F.2d 916 (7th Cir. 1993); *In re Fugazy Express, Inc*., 124 B.R. 426 (S.D.N.Y. 1991); *In re Smith*, 94 B.R. 220 (Bankr. M.D. Ga. 1988); *In re Hoffman*, 53 B.R. 874, 876 (Bankr. D.R.I. 1985) (transfer of liquor license free and clear of any interest permissible even though the estate had unpaid taxes). This is consistent with the general rule that all of a debtor's property, including all legal and equitable interests, becomes property of the bankruptcy estate. *See, e.g*., 11 U.S.C. § 541; *Taylor v. Freeland & Kronz*, 503 U.S. 638, 642 (1992); *United States v. Whiting Pools, Inc*., 462 U.S. 198, 203-05 (1983).

Courts have recognized that providers have a property interest in the statutory entitlement to bill and be paid by the Medi-Cal Program. Controlling Ninth Circuit precedent holds that "a person has a property interest in a benefit if they have 'a legitimate claim of entitlement to it' which interest may be "created by 'rules or understandings' from independent sources, such as statutes, regulations, and ordinances, or express or implied contracts.'" *Maynard v. Bonta*, No. CV 02-06539, 2003 U.S. Dist. LEXIS 16201 at **36-37 (C.D. Cal. Aug. 29, 2003) (citing *Board of Regents v. Roth*, 408 U.S. 564, 577; *Erickson,* 67 F.3d at 862; *Orloff v. Cleland*, 708 F.2d 372, 377 (9th Cir. 1983)). Although the DHCS argues that providers like the Debtors are not the intended beneficiaries of the Provider Agreement, that is a red-herring. Parties can enter into agreements for the benefits of third parties and that does not extinguish the property rights of the parties to the agreement. In any event, federal law requires that state Medicaid plans "provide for procedures of prepayment and postpayment claims review, including review of appropriate data with respect to the . . . provider of service," 42 U.S.C. § 1396a(a)(37)(B). The Debtors have a property interest in the Provider Agreements because they create a legitimate claim of entitlement to payment that derives from statute and regulation (although not from a contract). These rulings are totally consistent with the position that the Provider Agreement is merely a license creating a statutory entitlement for medical providers to bill the Medi-Cal Program.

C. The Medi-Cal Provider Agreement Can Be Sold Free And Clear Of Successor Liability.

Section 363(f) allows the Debtors to sell the Medi-Cal Provider Agreements "free and clear of ***any interest*** in such property," including the "interest" of successor liability. Many circuit courts

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of appeals and lower courts have applied an expansive interpretation to include not only *in rem* interests in property, but also other obligations that may "arise from the property being sold." *See, e.g., In re Grumman Olson Industries. Inc*., 467 B.R. 694, 702-3 (S.D.N.Y 2012); *see also United Mine Workers of America 1992 Benefit Plan v. Leckie Smokeless Coal Co. (In re Leckie Smokeless Coal Co.)*, 99 F.3d 573 (4th Cir. 1996) (coal mine operators could sell their assets free and clear of their obligations to a benefits plan and fund under the Coal Act); *PBBPC, Inc. v. OPK Biotech, LLC (In re PBBPC, Inc.)*, 484 B.R. 860 (1st Cir. B.A.P. 2013) (the right of the Commonwealth of Massachusetts to treat a purchaser of substantially all of the assets of chapter 11 debtor as "successor employer" to which debtor's experience rating could be imputed to determine purchaser's unemployment insurance contribution fell within "any interest," of which debtor's assets could be sold free and clear); *In re Tougher Industries*, 2013 WL 1276501 (Bankr. N.D.N.Y. Mar. 27, 2013) (the right of the New York State Department of Labor to use the debtor's experience rating to access the buyer's tax liability as successor to the Debtor was "interest" in property, of which debtor's assets could be sold free and clear); *WBO P'ship v. Virginia Dept. of Medical Assistance Servs. (In re WBO P'ship)*, 189 B.R. 97, 104-05 (Bankr. E.D. Va. 1995) (Commonwealth of Virginia's right to recapture depreciation is an "interest" as used in §363(f)).[4]

The DHCS argues that the Provider Agreement cannot be sold because the Debtors cannot satisfy any of the provisions under § 363(f). However, the DHCS confuses what is the "property" and what is the "interest" in its argument. The DHCS argues that it "cannot be compelled to accept a money satisfaction in exchange for its rights to prevent a sale of the Debtors' Medi-Cal provider status or Debtors' benefits, duties and obligations under the Agreements." Supplemental Objection, at 22, lines 11-14. However, the issue the Court must resolve is whether the financial obligations which the DHCS argues must be conveyed along with the Provider Agreement to the Buyer are "interests" in the property (the Medi-Cal Provider Agreement) which can be satisfied by the payment of money. Here, where the DHCS argues that it must be paid money to cure the "defaults," it is hard to fathom how this provision of § 363 is not satisfied.

[4] In addition, the Bankruptcy Code preempts state law on successor liability. *Myers v. United States*, 297 B.R. 774 (S.D. Cal. 2003). Though as the decisions herein demonstrate, courts allow assets to be sold free and clear of successor liability under state or federal law.

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If the Debtors sell the Provider Agreements to SGM, the sale will cut off any rights of the DHCS to setoff obligations. *Folger Adam Sec., Inc. v DeMatteis/Macgregor, JV,* 209 F.3d 252, 263 (3d Cir. 2000) (holding that setoff rights under § 553 are subject to § 363 and are therefore extinguished by "free and clear" sale). The Debtors are mindful that some courts (but not this Court) have held that recoupment, as a defense rather than a claim, is not extinguished by a sale under § 363. *Id*. at 261. However, even if the Court were to find that recoupment survives the sale, the Court's order should state that the DHCS's recoupment rights against SGM, if any, could be exercised only after the DHCS recouped from any payments due to the Debtors from Medi-Cal, next against funds held by the Debtors if the funds were generated by past interim Medi-Cal payments, and then against any sale proceeds generated by the sale of the Provider Agreement. *In re Vitalsigns Homecare, Inc*., 396 B.R. 232 (Bankr. D. Mass. 2008).

D. Even If The Medi-Cal Provider Agreement Is A Contract, The Debtors Do Not Have To Pay The HQAF Fees As A Cure.

Section 365(b)(1)(A) only requires a debtor to cure a "default *in* an executory contract," not all claims of a creditor that has a contract. The statutory requirement that a chapter 11 debtor cure any existing defaults as a condition to assuming an executory contract is intended to "insure that a contracting party is made whole before a court can force the party to continue performing with a bankrupt debtor," and, it is well-established that a nondebtor "party to an executory contract must be paid all amounts due him **under the contract** before the contract may be assumed." *Matter of Superior Toy & Manufacturing Company, Inc*., 78 F.3d 1169, 1174 (7th Cir. 1996) (emphasis added). However, the "flip side" of that statement is that a debtor does not have to pay amounts owed to a creditor which are not due under a contract to assume that contract in bankruptcy. *In re UAL Corp.*, 635 F.3d 312, 316 (7th Cir. 2011), as amended on denial of reh'g (Apr. 13, 2010) (agreeing that "the right to cure does not arise out of a claim. It arises out of a contract."); *In re Sigel & Co., Ltd.*, 923 F.2d 142, 145 (9th Cir. 1991) ("[u]nder section 365(b), the trustee may assume executory contracts and unexpired leases only if he cures the defaults—**but the cure need address only the individual event of default**, thereby repealing [only] the [specific] contractual consequences.") (quoting *In re Taddeo*, 685 F.2d 24, 27 (2d Cir.1982); *In re Rowland*, 292 B.R.

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815, 818 (Bankr. E.D. Pa. 2003) ("The weight of authority . . .holds that § 365(b)(1) . . . does not provide an independent right of recovery. . .to any other component of a cure amount. . . Rather, claims relative to amounts necessary to cure a [contract] default must be traced to and flow from the relevant . . . agreement.").

Here, the Debtors would owe the HQAF Fees under California law without regard to having a Medi-Cal Provider Agreement. The DHCS's argument ignores that a hospital that does not have a Medi-Cal provider agreement, but is a private hospital licensed under California Health and Safety Code § 1250(a) (that is, is a general acute care hospital), and is not exempt from paying the HQAF fees (such as a rural hospital) is obligated to pay the fees due under the HQAF even though such a hospital receives no payments under the HQAF. The obligation to pay the fees is based on licensure and not on Medi-Cal participation. The relevant statute is California Welfare and Institutions Code § 14169.52. This statute imposes the fee "on each general acute care hospital that is not an exempt facility." "General acute care hospital" is defined in California Welfare and Institutions Code § 14169.51(q) to be "any hospital licensed pursuant to subdivision (a) of Section 1250 of the Health and Safety Code." This would include any licensed acute care hospital regardless of whether it participated in Medi-Cal. Thus, the HQAF Fees allegedly owed by the Debtor to the DHCS are not due under the Medi-Cal Provider Agreement (because hospitals with licenses but without a provider agreement must still pay the fees). Allowing the DHCS to claim statutory fees as an administrative cure claim subverts the priority of the Code, and, thus, DHCS's arguments should be overruled.

IV.

CONCLUSION

For all the reasons stated above, the Court should overrule the DHCS's Objections, and enter an order enforcing the sale order and permitting the sale of the Debtors' interest in the Medi-Cal Provider Agreements "free and clear" of any interests of the DHCS, including but not limited to the HQAF obligations.

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EXHIBIT "5"

Docket #3146 Date Filed: 9/26/2019

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UNITED STATES BANKRUPTCY COURT

CENTRAL DISTRICT OF CALIFORNIA

LOS ANGELES DIVISION

In re: Verity Health System of California, Inc., *et al.*,

Debtors and Debtors in Possession.

☒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 Medical 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.,

Lead Case No.: 2:18-bk-20151-ER
Chapter: 11

MEMORANDUM OF DECISION AUTHORIZING DEBTORS TO SELL MEDI-CAL PROVIDER AGREEMENTS, FREE AND CLEAR OF INTERESTS ASSERTED BY THE CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES, PURSUANT TO § 363(F)(5)

Jointly Administered With:
Case No. 2:18-bk-20162-ER;
Case No. 2:18-bk-20163-ER;
Case No. 2:18-bk-20164-ER;
Case No. 2:18-bk-20165-ER;
Case No. 2:18-bk-20167-ER;
Case No. 2:18-bk-20168-ER;
Case No. 2:18-bk-20169-ER;
Case No. 2:18-bk-20171-ER;
Case No. 2:18-bk-20172-ER;
Case No. 2:18-bk-20173-ER;
Case No. 2:18-bk-20175-ER;
Case No. 2:18-bk-20176-ER;
Case No. 2:18-bk-20178-ER;
Case No. 2:18-bk-20179-ER;
Case No. 2:18-bk-20180-ER;
Case No. 2:18-bk-20181-ER;

Chapter 11 Cases.

Date: September 25, 2019

Time: 10:00 a.m.

Location: Ctrm. 1568
Roybal Federal Building
255 East Temple Street
Los Angeles, CA 90012

1820151190926000000000002

At issue is whether Medi-Cal Provider Agreements (the "Provider Agreements") entered into between four hospitals (the "Hospitals") and the California Department of Health Care Services (the "DHCS") are executory contracts which must be transferred pursuant to § 365 of the Bankruptcy Code, or statutory entitlements that may be transferred free and clear of successor liability under § 363 of the Bankruptcy Code.[1] If the Provider Agreements are executory contracts, the DHCS may be entitled to receive payments potentially in excess of $50 million in connection with the transfer of the Provider Agreements to the purchaser of the Hospitals. By contrast, if the Provider Agreements are statutory entitlements, they can be transferred to the purchaser free and clear of claims and interests under § 363, meaning that the DHCS would receive no payments in connection with the transfer. For the reasons set forth below, the Court finds that the Provider Agreements are statutory entitlements.[2]

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[1] Unless otherwise indicated, all "Civil Rule" references are to the Federal Rules of Civil Procedure, Rules 1–86; all "Bankruptcy Rule" references are to the Federal Rules of Bankruptcy Procedure, Rules 1001–9037; all "Evidence Rule" references are to the Federal Rules of Evidence, Rules 101–1103; all "LBR" references are to the Local Bankruptcy Rules of the United States Bankruptcy Court for the Central District of California, Rules 1001-1–9075-1; and all statutory references are to the Bankruptcy Code, 11 U.S.C. §§101–1532.

[2] The Court considered the following papers in adjudicating this matter:

1) Debtors' Memorandum in Support of Entry of an Order: (A) Authorizing the Sale of Property Free and Clear of all Claims, Liens and Encumbrances; (B) Authorizing the Assumption and Assignment of Designated Executory Contracts and Unexpired Leases; and (C) Granting Related Relief [Doc. No. 2115] (the "Sale Motion");
2) Creditor California Department of Health Care Services's Objection to Notice to Counterparties to Executory Contracts and Unexpired Leases of the Debtors that May be Assumed and Assigned [Doc. No. 1879];
3) 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 [Doc. No. 3043];
4) Official Committee of Unsecured Creditors' Reply to Creditor California Department of Health Care Services's Supplemental Objection to Sale [Doc. No. 3093];
5) Debtors' Reply to California Department of Health Care Services Objection to Debtors' Sale of Assets to Strategic Global Management [Doc. No. 3095];
    a) Objection to 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 [Doc. No. 3115];
    b) Declaration of Anita Chou in Support of Debtors' Reply to the California Department of Health Care Services' Objection to Debtors' Sale of Assets to Strategic Global Management [Doc. No. 3112]; and
    c) Notice of Debtors' Request to Bifurcate Hearing Regarding California Department of Health Care Services' Objection to Debtors' Sale of Assets to Strategic Global Management [Doc. No. 3113].

I. Facts

On August 31, 2018 (the "Petition Date"), Verity Health Systems of California ("VHS") and certain of its subsidiaries (collectively, the "Debtors") filed voluntary petitions for relief under Chapter 11 of the Bankruptcy Code. On August 31, 2018, the Court entered an order granting the Debtors' motion for joint administration of the Debtors' Chapter 11 cases.[3]

On May 2, 2019, the Court entered an order approving the sale of substantially all of the assets of four of the Debtors' hospitals—St. Francis Medical Center, St. Vincent Medical Center, St. Vincent Dialysis Center, and Seton Medical Center (collectively, the "Hospitals")—to Strategic Global Management, Inc. ("SGM").[4]

Each of the Hospitals has executed a Provider Agreement with DHCS. The Asset Purchase Agreement (the "APA") [Doc. No. 2305-1] which governs the sale of the Hospitals to SGM provides that the sale cannot close unless issues regarding alleged financial defaults existing under each Provider Agreement have been resolved.[5]

Pursuant to Cal. Welf. & Inst. Code § 14169.52(a), each of the Hospitals is required to pay a quarterly Hospital Quality Assurance Fee (an "HQA Fee") to the DHCS, which is assessed regardless of whether the hospital participates in the Medi-Cal Program. *See* Cal. Welf. & Inst. Code § 14169.52(a) (imposing the HQA Fee upon "each general acute care hospital that is not an exempt facility"). As this Court has previously explained, the "HQA Fee allows California to obtain more healthcare funds from the federal government, which generally matches state Medi–Cal contributions dollar-for-dollar." *In re Gardens Reg'l Hosp. & Med. Ctr., Inc.*, 569 B.R. 788, 791 (Bankr. C.D. Cal. 2017), *aff'd,* No. 2:16-BK-17463-ER, 2018 WL 1354334 (B.A.P. 9th Cir. Mar. 12, 2018) ("*Gardens II*").

According to the DHCS, the Debtors are liable for approximately $30 million in HQA Fees attributable to the Hospitals. DHCS asserts that the Provider Agreements associated with each Hospital cannot be transferred to SGM unless the Debtors first assume the Provider Agreements under § 365 of the Bankruptcy Code. In the process of assuming the Provider Agreements, the Debtors would be required to cure the unpaid HQA Fees, or provide adequate assurance that the unpaid HQA Fees would be promptly cured.

The Debtors receive Medi-Cal fee-for-service payments on account of medical services provided to Medi-Cal beneficiaries by the Hospitals. DHCS asserts that the Debtors are liable for approximately $25 million in Medi-Cal fee-for-service overpayments, and that such overpayments must also be cured in connection with the assumption of the Provider Agreements. The Debtors dispute the validity of the audit that resulted in the calculation of the overpayments.

The Debtors contend that the Provider Agreements are not contracts and that it is therefore unnecessary for the Debtors to assume the Provider Agreements under § 365 in order to transfer the agreements to SGM. According to the Debtors, the Provider Agreements are a statutory entitlement to participate in the Medi-Cal program and should be treated as licenses that can be sold, free and clear of claims, interests, and encumbrances, pursuant to § 363(f). In support of the contention that the Provider Agreements are not contracts, Debtors argue that the Provider Agreements do not impose any obligations upon the DHCS. Debtors maintain that the only obligations existing under the Provider Agreements are those that are already imposed under applicable law, and that an agreement to comply with applicable law "is a gratuitous promise

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[3] Doc. No. 17.
[4] Doc. No. 2306 (the "SGM Sale Order").
[5] APA at ¶ 8.7.

which does not provide the consideration necessary to make a contract enforceable." *Gardens II*, 569 B.R. at 797.

The Official Committee of Unsecured Creditors (the "Committee") agrees with the Debtors that the Provider Agreements are not contracts. Like the Debtors, the Committee takes the position that the Provider Agreements are assets of the Debtors' respective estates that can be sold free and clear of all interests pursuant to § 363(f).

II. Discussion

If the Provider Agreements are executory contracts, they can be transferred to SGM only if they are first assumed by the Debtors. To assume an executory contract, the Debtors must either cure all defaults under the contract, or provide adequate assurance that the defaults will be cured promptly. § 365(b).

An executory contract is "a contract that neither party has finished performing." *Mission Prod. Holdings, Inc. v. Tempnology, LLC*, 139 S. Ct. 1652, 1657, 203 L. Ed. 2d 876 (2019). Of course, an agreement that is not a contract can never qualify as an executory contract.

Terms not defined in the Bankruptcy Code have the meaning accorded to such terms under nonbankruptcy law. *See Mission Prod. Holdings,* 139 S.Ct. at 1661 ("And 'breach' is neither a defined nor a specialized bankruptcy term. It means in the Code what it means in contract law outside bankruptcy."). The Bankruptcy Code does not define the term "contract," so the term has the same meaning under § 365 of the Bankruptcy Code as it does under non-bankruptcy law. As the Supreme Court has explained, "[p]roperty interests are created and defined by state law. Unless some federal interest requires a different result, there is no reason why such interests should be analyzed differently simply because an interested party is involved in a bankruptcy proceeding." *Butner v. United States*, 440 U.S. 48, 55, 99 S. Ct. 914, 918, 59 L. Ed. 2d 136 (1979).

A. The Provider Agreements Are Not Contracts

The first issue the Court must confront, then, is whether the Provider Agreements are contracts. The Court finds that they are not.[6]

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[6] In *Gardens II*, the Court found that under the principle of equitable recoupment, DHCS could withhold Medi-Cal and supplemental quality assurance payments owed to a debtor, for the purpose of recovering unpaid hospital quality assurance fees owed by the debtor. *Gardens II* did not decide whether a Medi-Cal Provider Agreement was a contract or a statutory entitlement akin to a license, as the issue did not affect the outcome of the decision:

> The Court finds that, regardless of whether the Provider Agreement is considered a license or contract, the Debtor's HQA Fee liability and entitlement to Medi-Cal Payments would still arise from the same transaction or occurrence…. As discussed previously, the Debtor's acknowledgment in the Provider Agreement that unpaid HQA Fees could be withheld from its Medi-Cal Payments establishes the necessary logical relationship between the Debtor's fee liabilities and its payment entitlements. That logical relationship exists whether the Provider Agreement is classified as a license or a contract.

Gardens II, 569 B.R. at 799.

The Court's determination of whether the Provider Agreements are contracts is informed by decisions involving Medicare Provider Agreements. For purposes of this issue, there are no meaningful differences between the Provider Agreements and a Medicare Provider Agreement. Both types of agreements allow hospitals to obtain reimbursement from the government for providing healthcare services. In both cases, the hospitals' reimbursement entitlement is dictated by the Medicare statute and the regulations promulgated thereunder.[7]

In *PAMC, Ltd. v. Sebelius*, 747 F.3d 1214, 1221 (9th Cir. 2014), the Ninth Circuit declined to apply the contract doctrine of "substantial compliance" to a Medicare Provider Agreement. In that case, PAMC, a hospital, appealed the decision of the Secretary of the Department of Health and Human Services to reduce the reimbursements for which PAMC was eligible. *Id.* at 1215–16. PAMC's reimbursements had been reduced because it had submitted certain required data 28 minutes late. *Id.* at 1216. In challenging the Secretary's decision to reduce its reimbursement eligibility, PAMC argued, among other things, that it had substantially complied with the terms of its Medicare Provider Agreement. *Id.* at 1220. The Ninth Circuit rejected PAMC's attempt to avail itself of the contract doctrine of "substantial compliance":

> [T]he whole notion of importing contract doctrines into an area that is a complex statutory and regulatory scheme is problematic. We have, on occasion, stated that providers and others have contracts with the government in this area, but our decisions have turned on the regulatory regime rather than on contract principles. *See, e.g., United States v. Bourseau,* 531 F.3d 1159, 1162, 1169–70 (9th Cir.2008); *Pac. Coast Med. Enters. v. Harris,* 633 F.2d 123, 125 n. 1, 133–35 (9th Cir.1980). As the Eleventh Circuit Court of Appeals held when hospitals complained of legislative impairment of their contract rights in this area because they had agreements with the Secretary: "Upon joining the Medicare program, however, the hospitals received a statutory entitlement, not a contractual right." *Mem'l Hosp. v. Heckler,* 706 F.2d 1130, 1136 (11th Cir.1983); *see also Bennett v. Ky. Dep't of Educ.,* 470 U.S. 656, 669, 105 S.Ct. 1544, 1552, 84 L.Ed.2d 590 (1985) (stating that while states had "grant agreements" with the federal government and those had a "contractual aspect," the program should not be viewed like a "bilateral contract" and should not "be construed most strongly against the drafter" (internal quotation marks omitted)); *cf. Sebelius v. Auburn Reg'l Med. Ctr.,* —— U.S. ——, ——, 133 S.Ct. 817, 828–29, 184 L.Ed.2d 627 (2013) (declining to apply equitable tolling principles to time set by Secretary for appealing to the Board); *Kaiser Found.*

In support of its argument that the Provider Agreements are executory contracts, DHCS cites the observation made in *Gardens II* that Medicare Provider Agreements "are similar in many respects to … [a] Medi-Cal Provider Agreement." *Gardens II*, 569 B.R. at 799 n.12. DHCS then cites decisions holding that Medicare Provider Agreements are executory contracts. As discussed in greater detail below, the Court does not find the decisions cited by DHCS to be persuasive, because they reached the conclusion that Medicare Provider Agreements are executory contracts without meaningful analysis.

[7] Because the Medi-Cal program is funded in part by federal funds, reimbursement entitlements under Medi-Cal must be consistent with the provisions of the Medicare statute. *See generally* 42 U.S.C. § 1396a (setting forth requirements applicable to state medical assistance plans such as Medi-Cal).

> *Hosps.,* 649 F.3d at 1160 (declining to apply excusable neglect equitable analysis to Board's dismissal of case for "failure to timely submit a position paper").

PAMC, Ltd. v. Sebelius, 747 F.3d 1214, 1221 (9th Cir. 2014).

Other courts have been even more explicit in stating that a Medicare Provider Agreement is not a contract. In *Mem'l Hosp. v. Heckler*, cited with approval in *PAMC*, hospitals argued that new legislation reducing their Medicare reimbursement entitlements constituted "an unconstitutional taking of their property without just compensation in violation of the fifth amendment, because it would abrogate a vested contractual right to Medicare reimbursement." *Heckler*, 706 F.2d 1130, 1136 (11th Cir. 1983). The *Heckler* court squarely rejected the hospitals' contention that their Medicare Provider Agreements were contracts: "Upon joining the Medicare program, however, the hospitals received a statutory entitlement, not a contractual right." *Heckler*, 706 F.2d at 1136.

Significantly, the *Heckler* court observed that "[c]ourts have upheld retroactive adjustments in the Medicare reimbursement system." *Id.* It emphasized that such retroactive adjustments were permissible precisely because Medicare Provider Agreements were not contracts. *Id.* A similar result was reached in *Germantown Hosp. & Med. Ctr. v. Heckler*, 590 F. Supp. 24, 30–31 (E.D. Pa. 1983), *aff'd sub nom. Germantown Hosp. & Med. Ctr. v. Schweiker*, 738 F.2d 631 (3d Cir. 1984), in which the court held:

> There is no contractual obligation requiring [the Department of Health and Human Services] to provide Medicare reimbursement. Rather, upon joining the Medicare program, providers gain a statutory entitlement to reimbursement. Thus the amount of reimbursement is governed not by contract but by statute; specifically the Medicare Act's "reasonable cost" provisions.

Germantown, 590 F.Supp. at 30–31. *See also Greater Dallas Home Care All. v. United States*, 10 F. Supp. 2d 638, 647 (N.D. Tex. 1998) ("Plaintiffs argue that the Medicare participation agreements … are essentially contracts. The Court disagrees and finds that the participation agreements are not contracts, for the right to receive payments under the Medicare Act is a manifestation of Government policy and, as such, is a statutory rather than a contractual right.").

Similarly, in *Guzman v. Shewry*, the Ninth Circuit held that a Medi-Cal Provider Agreement was not a contract. 552 F.3d 941 (9th Cir. 2009). In *Guzman*, a physician sought a preliminary injunction to prevent the DHCS from temporarily suspending him from the Medi-Cal program. *Id.* at 946. Among other things, the physician argued that because his suspension deprived him of the ability to receive reimbursement for treating Medi-Cal patients, he had been deprived of his right to contract with the state. *Id.* at 954. Rejecting this argument, the court held that "[p]articipation in the Medi-Cal program entitles Guzman to reimbursement for treating patients who receive Medi-Cal benefits; it does not involve bidding on government contracts." *Id.*

In addition, the Provider Agreements lack a key feature found in all contracts—obligations imposed on both parties to the agreements. The Provider Agreements impose no obligations upon the DHCS. The only obligations spoken of in the Provider Agreements pertain to the Debtors. Even these obligations do not constitute consideration for contract purposes, since they

merely restate the Debtors' pre-existing legal obligations.[8] As this Court has previously held, "an agreement to comply with applicable law is a gratuitous promise which does not provide the consideration necessary to make a contract enforceable." *Gardens II*, 569 B.R. at 797.

DHCS cites a number of cases in which courts have held that Medicare Provider Agreements are executory contracts. These authorities are not persuasive, because the issue of whether the provider agreements were executory contracts versus statutory entitlements was not litigated. Instead, the courts simply assumed, without meaningful analysis, that the provider agreements were executory contracts.

For example, in *In re University Medical Center*, 973 F.2d 1065 (3d Cir. 1992), the Third Circuit assumed that a Medicare Provider Agreement was an executory contract, even though the Third Circuit had ruled eight years prior in *Germantown Hosp. & Med. Ctr. v. Schweiker*, 738 F.2d 631, 632 (3d Cir. 1984) that Medicare Provider Agreements are statutory entitlements, not contracts. In *Germantown*, the court rejected the argument that a reduction in Medicare reimbursement rates impaired the contract rights of the Medicare providers. *Id.* The *University Medical Center* decision contained no discussion of *Germantown* and made no attempt to reconcile *Germantown*'s holding that reductions to Medicare reimbursement rates did not amount to a breach of contract. Similarly, in *In re Heffernan Memorial Hospital District*, 192 B.R. 228, 231 n.4 (Bankr. S.D. Cal. 1996), the issue was not litigated and the debtor appeared to concede that the provider agreement was an executory contract. Likewise, in *In re St. Johns Home Health Agency, Inc*., 173 B.R. 238 (Bankr. S.D. Fla. 1994), the debtor conceded that the provider agreement was an executory contract, and the Bankruptcy Court disregarded prior binding Eleventh Circuit precedent rejecting the contention that a provider agreement gave the provider "a vested contractual right to Medicare reimbursement." *Mem'l Hosp. v. Heckler*, 706 F.2d 1130, 1136 (11th Cir. 1983).

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[8] DHCS cites a number of provisions within the Provider Agreement that it claims constitute consideration sufficient to render the Provider Agreements contractual in nature. But all of the following the provisions cited by DHCS are restatements of legal obligations imposed upon the Debtors by federal law, federal regulations, state law, or state regulations:

1) Debtors will be subject to the sanctions available to DHCS if they fail to comply with applicable law.
2) To submit a treatment authorization request, the Debtors must use a National Provider Identifier ("NPI") that is appropriately registered and is compliant with all NPI requirements.
3) Debtors cannot engage in conduct inimical to public health, morals, welfare, or safety.
4) Debtors cannot refuse healthcare services based upon race, color, ancestry, marital status, national origin, gender, age, economic status, or physical or mental disability.
5) Only qualified medical personnel may provide healthcare services.
6) Any overpayments must be repaid by the Debtors in accordance with applicable statutes and regulations.
7) Debtors are subject to certain automatic and permissive suspensions and mandatory and permissive exclusions.

B. The Provider Agreements Can Be Sold Free and Clear of Liens, Claims, and Interests Pursuant to § 363(f)(5)

Having found that the Provider Agreements are not contracts and therefore are not subject to assumption and assignment under § 365, the Court must determine whether the Provider Agreements can be sold free and clear of liens, claims, and interests under § 363(f).

Courts have held that interests such as the Provider Agreements constitute "property of the estate" under § 541 that may be sold under § 363. In *Matter of Fugazy Exp., Inc.*, 124 B.R. 426, 430 (S.D.N.Y. 1991), the court held that a license issued by the Federal Communications Commission was property of the estate, notwithstanding a provision within the Federal Communications Act providing that the Act did not create ownership rights in licenses. The holding is consistent with Ninth Circuit precedent stating that "[g]overnment licenses, as a general rule, are considered to be 'general intangibles' under the Uniform Commercial Code, 'i.e., personal property interests in which security interests may be perfected.'" *MLQ Inv'rs, L.P. v. Pac. Quadracasting, Inc.*, 146 F.3d 746, 749 (9th Cir. 1998).

The Court finds that the Provider Agreements are akin to a license issued by a government agency, and therefore that the Provider Agreements may be sold under § 363. The Provider Agreements create a statutory entitlement to bill the Medi-Cal program for providing Medi-Cal services. *See Guzman*, 552 F.3d at 954 (stating that "[p]articipation in the Medi-Cal program entitles [physician] Guzman to reimbursement for treating patients who receive Medi-Cal benefits"). This right to receive reimbursement for providing healthcare services is a property interest.

DHCS contends that the Hospitals hold no property interest in the Provider Agreements and that as a result, the Provider Agreements cannot be sold under § 363. In support of its position, DHCS cites *Erickson v. U.S. ex rel. Dep't of Health & Human Servs.*, 67 F.3d 858, 862 (9th Cir. 1995), in which the court held that a physician convicted of submitting false claims to Medicare did "not possess a property interest in continued participation in Medicare, Medicaid, or the federally-funded state health care programs." *Id.*

DHCS ignores the difference between a property interest in the right to *continue* to participate in Medi-Cal and a property interest in the *existing* right to bill Medi-Cal for providing services. *Erickson* stands for the unremarkable proposition that a provider who engages in criminal conduct has no right to continue as a provider. No one disputes that if the Hospitals violated Medi-Cal statutes or regulations, their right to continue as Medi-Cal Providers could be suspended. But at present, the Provider Agreements are in good standing and the Hospitals have the right to receive reimbursements for providing services to Medi-Cal beneficiaries. It is this right that amounts to a property interest.

The Provider Agreements may be sold free and clear of the liabilities which DHCS contends attach to the Provider Agreements. This includes the alleged liabilities for approximately $30 million in unpaid HQA Fees and $25 million in Medi-Cal overpayments (collectively, the "Liabilities").[9]

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[9] The Debtors object to declaration testimony submitted by Hanh Vo with respect to the amount of the Liabilities. As a result of its determination that the Provider Agreements may be sold free and clear of the Liabilities, it is not necessary for the Court to adjudicate the amount of the Liabilities at this time. Because the Court has not considered the Vo declaration in reaching its decision, the Court does not rule upon the Debtors' evidentiary objection. *See Operating Engineers' Pension Trust Fund v. Clark's Welding & Mach.*, 688 F. Supp. 2d 902, 907 (N.D.

Section 363(f)(1) provides that a sale of estate property may be "free and clear of any interest in such property of an entity other than the estate" if certain conditions are satisfied. As this Court has previously explained:

> The Bankruptcy Code does not define the phrase "interest in ... property" for purposes of § 363(f). The Third Circuit has held that the phrase "interest in ... property" is "intended to refer to obligations that are connected to, or arise from, the property being sold." *Folger Adam Sec., Inc. v. DeMatteis/MacGregor JV*, 209 F.3d 252, 259 (3d Cir. 2000). That conclusion is echoed by *Collier on Bankruptcy*, which observes a trend in caselaw "in favor of a broader definition [of the phrase] that encompasses other obligations that may flow from ownership of the property." 3 Alan N. Resnick & Henry J. Sommer, *Collier on Bankruptcy* ¶ 363.06[1] (16th ed. 2017).
>
> Courts have held that interests in property include monetary obligations arising from the ownership of property, even when those obligations are imposed by statute. For example, in *Mass. Dep't of Unemployment Assistance v. OPK Biotech, LLC (In re PBBPC, Inc.)*, 484 B.R. 860 (1st Cir. BAP 2013), the court held that taxes assessed by Massachusetts under its unemployment insurance statutes constituted an "interest in ... property." The taxes were computed based on the Debtor's "experience rating," which was determined by the number of employees it had terminated in the past. *Id.* at 862. Because the Debtor had terminated most of its employees prior to selling its assets, its experiencing rating, and corresponding unemployment insurance tax liabilities, were very high. *Id.* The *PBBPC* court held that the experience rating was an interest in property that could be cut off under § 363(f). *Id.* at 869–70. Similarly, in *United Mine Workers of Am. Combined Benefit Fund v. Leckie Smokeless Coal Co. (In re Leckie Smokeless Coal Co.)*, 99 F.3d 573, 581, the court held that monetary obligations imposed by the Coal Industry Retiree Health Benefit Act of 1992 constituted an "interest in ... property" within the meaning of § 363(f).

In re Gardens Reg'l Hosp. & Med. Ctr., Inc., 567 B.R. 820, 825–26 (Bankr. C.D. Cal. 2017), *appeal dismissed,* No. 2:16-BK-17463-ER, 2018 WL 1229989 (C.D. Cal. Jan. 19, 2018).

The Liabilities are an "interest in property" within the meaning of § 363(f). The Liabilities arise because the Hospitals have elected to exercise their statutory entitlement to provide medical services, and receive reimbursement for providing such services, under the Provider Agreements. As such, the Liabilities are a monetary obligation arising from the ownership of property (the property being the reimbursement rights associated with the Provider Agreements).

The Provider Agreements may be sold free and clear of the Liabilities only if one or more of the conditions specified in § 363(f)(1)–(5) is satisfied. Here, the Court finds that § 363(f)(5) is satisfied. Under § 363(f)(5), property may be sold free and clear of an interest, if the entity holding the interest "could be compelled, in a legal or equitable proceeding, to accept a money satisfaction of such interest."

The interest that DHCS holds in the Provider Agreements is its right to receive payment of the Liabilities. DHCS could be compelled to accept a money satisfaction of its interest in a legal or equitable proceeding. In fact, receiving a money satisfaction is and has been DHCS' objective

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Cal. 2010) ("Because the Court does not rely on the statements in this declaration, it is not necessary for the Court to rule on these objections.").

all along. Throughout these cases, DHCS has withheld funds payable to the Hospitals to recover the Liabilities.[10] That DHCS would accept a money satisfaction is apparent in its briefing. DHCS states that the Debtors must "pay the debt through the proceeds of the sale" or "within five days of the closing of the sale," and that the Debtors "must establish and maintain a trust account in the amount of $70 million for 36 months for potential reimbursement to [DHCS] of any Medi-Cal overpayment …."[11]

The case of *In re P.K.R. Convalescent Centers, Inc.*, 189 B.R. 90, 91 (Bankr. E.D. Va. 1995) is directly on point. In *In re PKR Convalescent Centers*, the court approved the sale of a nursing home, free and clear of the interest held by the Virginia Department of Medical Assistance Service (the "DMAS"), pursuant to § 363(f)(5). The interest in question was DMAS' right under Virginia law to recapture, upon the sale of the nursing home, depreciation payments it had previously made to the operators of the nursing home. The court held that DMAS' interest would be extinguished if it received the $1.7 million in depreciation recapture payments it was owed under the statute, and that accordingly, DMAS could be compelled, in a legal or equitable proceeding, to accept a money satisfaction of its interest. *Id.* at 94.

As was the case in *PKR Convalescent Centers*, DHCS' interest in the Provider Agreements would be extinguished if it received the payments it contends it is owed on account of the Liabilities. Consequently, DHCS could be compelled to accept a money satisfaction of its interest. The Provider Agreements may be sold free and clear of DHCS' interest under § 363(f)(5).

The Debtors request that the order on the Motion state that DHCS' recoupment rights against SGM, if any, must be first exercised against payments due to the Debtors from Medi-Cal, then against funds held by the Debtors generated by past interim Medi-Cal payments, and then against any sale proceeds generated by the sale of the Provider Agreement. The issue of the applicability of recoupment subsequent to the sale of the Provider Agreements free and clear of claims and interests has not been sufficiently briefed. The Court declines to decide the issue at present, without prejudice to the ability of interested parties to raise the issue by way of motion.

DHCS requests that the order on the Motion be stayed for 14 days, pursuant to Bankruptcy Rule 6004(h). The purpose of Bankruptcy Rule 6004(h) is to provide sufficient time for an objecting party to appeal before an order can be implemented. The sale to SGM is not expected to close until mid-to-late October 2019. Because the Provider Agreements will not be transferred to SGM until the sale closes, the stay imposed by Bankruptcy Rule 6004(h) is not necessary to protect DHCS' right to appeal.

III. Conclusion

Based upon the foregoing, the Debtors are authorized to sell the Provider Agreements to SGM, free and clear of claims, interests, and encumbrances, pursuant to § 363(f)(5). The Debtors shall submit an order consistent with this Memorandum of Decision.

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[10] DHCS asserts that its withholdings are authorized under the equitable principle of recoupment. As the issue is not presently before it, the Court expresses no opinion on whether the withholdings were permissible under recoupment principles.

[11] Doc. No. 3043 at 10.

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Date: September 26, 2019

Ernest M. Robles
United States Bankruptcy Judge

EXHIBIT "6"

Attorney or Party Name, Address, Telephone & FAX Nos., State Bar No. & Email Address

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☐ Individual *appearing without an attorney*
☒ *Attorney for:* Debtors and Debtors In Possession

FOR COURT USE ONLY

UNITED STATES BANKRUPTCY COURT
CENTRAL DISTRICT OF CALIFORNIA - LOS ANGELES DIVISION

In re:
VERITY HEALTH SYSTEM OF CALIFORNIA, INC., et al.,
Debtors and Debtors In Possession.

● 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
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☐ 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, LLCLiquidation Corporation, a California corporation,

Debtors and Debtors In Possession.

CASE NO.: 2:18-bk-20151-ER;Jointly administered with:
Case No. 2:18-bk-20162-ER
Case No. 2:18-bk-20163-ER
Case No. 2:18-bk-20164-ER
Case No. 2:18-bk-20165-ER
Case No. 2:18-bk-20167-ER
Case No. 2:18-bk-20168-ER
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Case No. 2:18-bk-20175-ER
Case No. 2:18-bk-20176-ER
Case No. 2:18-bk-20178-ER
Case No. 2:18-bk-20179-ER
Case No. 2:18-bk-20180-ER
Case No. 2:18-bk-20181-ER

CHAPTER: 11

NOTICE OF LODGMENT OF ORDER IN BANKRUPTCY CASE RE: (*title of motion*[1]):
Debtors' Bid Procedures Motion [Docket No. 1279]

PLEASE TAKE NOTE that the order titled Order Authorizing Debtors to Sell Medi-Cal Provider Agreements, Free and Clear of Interests Asserted by the California Department of Health Care Services, Pursuant to Sections 363(b) and (f)(5) was lodged on (*date*) 10/08/2019 and is attached. This order relates to the motion which is docket number 1279.

[1] Please abbreviate if title cannot fit into text field.

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Attorneys for the Chapter 11 Debtors and Debtors In Possession

UNITED STATES BANKRUPTCY COURT
CENTRAL DISTRICT OF CALIFORNIA - LOS ANGELES DIVISION

In re

VERITY HEALTH SYSTEM OF CALIFORNIA, INC., *et al.*,

Debtor and Debtor In Possession.

☒ 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
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☐ 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.

Lead Case No. 2:18-bk-20151-ER

Jointly Administered With:
Case No. 2:18-bk-20162-ER
Case No. 2:18-bk-20163-ER
Case No. 2:18-bk-20164-ER
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Case No. 2:18-bk-20178-ER
Case No. 2:18-bk-20179-ER
Case No. 2:18-bk-20180-ER
Case No. 2:18-bk-20181-ER

Chapter 11 Cases
Hon. Judge Ernest M. Robles

ORDER AUTHORIZING DEBTORS TO SELL MEDI-CAL PROVIDER AGREEMENTS, FREE AND CLEAR OF INTERESTS ASSERTED BY THE CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES, PURSUANT TO §§ 363(b) and (f)(5)

Hearing:
Date: September 25, 2019
Time: 10:00 a.m. (Pacific Time)
Location: Courtroom 1568
255 E. Temple Street
Los Angeles, CA

DENTONS US LLP
601 SOUTH FIGUEROA STREET, SUITE 2500
LOS ANGELES, CALIFORNIA 90017-5704
(213) 623-9300

On January 17, 2019, Verity Health System Of California, Inc. and the above-referenced affiliated debtors, the debtors and debtors in possession (collectively, the "Debtors") filed the *Debtors' Notice of Motion and Motion for the Entry of (I) an Order (i) Approving Form of Asset Purchase Agreement for Stalking Horse Bidder and for Prospective Overbidders; (2) Approving Auction Sale Format, Bidding Procedures and Stalking Horse Bid Protections; (3) Approving Form of Notice to be Provided to Interested Parties; (4) Scheduling a Court Hearing to Consider Approval of the Sale to the Highest Bidder; and (5) Approving Procedures Related to the Assumption of Certain Executory Contracts and Unexpired Leases; and (II) an Order (A) Authorizing the Sale of Property Free and Clear of All Claims, Liens and Encumbrances* [Docket No. 1279] (the "Sale Motion"). In the Sale Motion, the Debtors sought an order granting, among other things, authority to sell certain property free and clear of claims, interests, and encumbrances, pursuant to §§ 363(b) and (f) of title 11 of the United States Code (the "Bankruptcy Code"),[1] to Strategic Global Management, Inc. ("SGM").

On March 22, 2019, the California Department of Health Care Services ("DHCS") filed *Creditor California Department of Health Care Services's Objection to Notice of Counterparties to Executory Contracts and Unexpired Leases of the Debtors That May Be Assumed and Assigned* [Docket No. 1879] (the "Initial DHCS Objection"). In the Initial DHCS Objection, the DHCS argued that the California Medical Assistance Program ("Medi-Cal") Provider Agreements between the Debtors and DHCS (the "Provider Agreements") could not be sold to SGM free and clear of claims, interests, and encumbrances.

On April 10, 2019, the Debtors filed the *Debtors' Memorandum in Support of Entry of an Order: (A) Authorizing the Sale of Property Free and Clear of all Claims, Liens and Encumbrances; (B) Authorizing the Assumption and Assignment of Designated Executory Contracts and Unexpired Leases; and (C) Granting Related Relief* [Doc. No. 2115] (the "Sale Brief") in support of the Sale Motion.

[1] Unless otherwise noted, all references to "§" and "section" herein are to sections of the Bankruptcy Code; all references to "Bankruptcy Rules" are to provisions of the Federal Rules of Bankruptcy Practice; all references to "LBR" are to provisions of the Local Bankruptcy Rules of the United States Bankruptcy Court for the Central District of California.

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On April 17, 2019, the Court held a hearing on the Sale Motion. On May 2, 2019, the Court entered the *Order (A) Authorizing the Sale of Certain of the Debtors' Assets to Strategic Global Asset Management, Inc. Free and Clear of Liens, Claims, Encumbrances, and Other Interests; (B) Approving the Assumption and Assignment of an Unexpired Lease Related Thereto; and (C) Granting Related Relief* [Docket No. 2306] (the "Sale Order"). Pursuant to the Sale Order, the Court granted the Sale Motion and continued the hearing the Initial DHCS Objection to determine whether the Sale Order effectuated a transfer of the Provider Agreements free and clear of claims, interests, and encumbrances. *See* Sale Order, ¶ 31 at 24-25. Further, the Court provided that "[n]othing in this Sale Order shall apply to Medi-Cal Provider Agreements until and unless there is a Court order approving a settlement between the Debtors and DHCS or a Court order resolving the DHCS's objections." *Id.* The Court set the continued hearing on June 5, 2019, at 410:00 a.m. (Pacific Time), which was ultimately continued to September 25, 2019, at 10:00 a.m. (Pacific Time) (the "Hearing"), by stipulation between the Debtors and DHCS. *See id.*; *see also* Docket Nos. 2278, 2377, 2606, 2686, 2856, 2928.

On September 11, 2019, the DHCS filed *Creditor California Department of Health Care Services's Supplemental Objection to (1) Debtors' Motion for 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* [Docket No. 3043] (together with the Initial DHCS Objection, the "DHCS Objections").

On September 18, 2019, the Debtors filed the *Debtors' Reply to California Department of Health Care Services Objection to Debtors' Sale of Assets to Strategic Global Management* [Docket No. 3095] (the "Debtors' Reply"). On the same date, the Official Committee of Unsecured Creditors filed the *Official Committee of Unsecured Creditors' Reply to Creditor California Department of Health Care Services's Supplemental Objection to Sale* [Docket No. 3093] (the "Committee's Reply").

On September 25, 2019, at 10:00 a.m. (Pacific Time), the Court held the Hearing. Appearances were as set forth on the record of the Hearing.

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On September 26, 2019, the Court filed its *Memorandum of Decision Authorizing Debtors to Sell Medi-Cal Provider Agreements, Free and Clear of Interests Asserted by the California Department of Health Care Services, Pursuant to § 363(f)(5)* [Docket No. 3146] (the "Memorandum Decision"), which is fully incorporated herein by this reference.

The Court, having considered the Sale Motion and the Sale Brief, the DHCS Objections, the Debtors' Reply, the Committees' Reply; having considered the statements, arguments, and representations of counsel, as set forth on the record of the Hearing; incorporating herein by this reference the findings of fact and conclusions of law set forth in the Sale Order; and for the reasons set forth in the Memorandum Decision, which are fully incorporated herein by this reference,

HEREBY ORDERS AS FOLLOWS:

1. The Debtors are authorized to transfer the Provider Agreements to SGM, free and clear of claims, interests, and encumbrances pursuant to §§ 363(b) and (f)(5) and the Sale Order.

2. The DHCS Objections are overruled in their entirety.

3. The stay provided pursuant to Bankruptcy Rule 6004(h) is waived with respect to this Order and the Memorandum Decision.

4. DHCS shall not adjust, offset, lien or recoup any payments owing to SGM and other SGM affiliates (collectively, "SGM Buyers") which are assigned any rights in connection with the transfer of the Medi-Cal Provider Agreements for St. Francis Medical Center Provider Agreement No. 148769215; the St. Vincent Medical Center Provider Agreement No. 1124004304; the Seton Medical Center Provider Agreement No. 1154428688; and the St. Vincent Dialysis Center Provider Agreement No. CDC70030F, and all other Provider Agreements for any of the aforesaid Hospitals or Dialysis Center and the SGM acquisition of the Hospitals and St. Vincent Dialysis Center (collectively, the "Assets") pursuant to the Sale Motion ("SGM Sale") after the transfer of the Assets (the "Transfer Effective Date"), or make any claims against any of the SGM Buyers or any of their assets, including, without limitation, any assets acquired by any of the SGM Buyers pursuant to the SGM Sale, for any obligations, liabilities, claims or other interests against the Debtors related to periods on or before the Transfer Effective Date ("Pre-Transfer Effective Date Liabilities") including without limitation for Pre-Transfer Effective Date Liabilities under or related

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to (a) the Medi-Cal Program, and (b) ,without prejudice to the rights of the Debtors or the SGM Buyers as provided for in the Asset Purchase Agreement [Docket No. 2305-1] by and among the Debtors and SGM, the Hospital Quality Assurance Fees Program, California Welfare & Institutions Code, § 14169.52(a) et. seq. or similar or successor statutes ("HQAF Program"). None of the SGM Buyers shall be required to execute the Successor Liability Form, or otherwise assume or accept responsibility, for or with respect to any Pre-Transfer Effective Date Liabilities, in conjunction with the completion of the SGM Sale and to effectuate the assignment or other transfer of any Medi-Cal Provider Agreements to the SGM Buyers in connection with the SGM Sale, or otherwise as a condition or requirement for any of the SGM Buyers to participate in the Medi-Cal Program or the HQAF Program.

IT IS SO ORDERED.

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(213) 623-9300

EXHIBIT "7"

Attorney or Party Name, Address, Telephone & FAX Nos., State Bar No. & Email Address	FOR COURT USE ONLY
Jennifer M. Kim, SBN 178364 Kenneth K. Wang, SBN 201823 California Office of the Attorney General 300 S. Spring Street, No. 1702 Los Angeles, CA 90013 Jennifer.Kim@doj.ca.gov Kenneth.Wang@doj.ca.gov Telephone: 213-269-6217 Fax: 916-731-2125 ☐ *Individual appearing without attorney* ☒ *Attorney for:* California Dept. of Health Care Services	

UNITED STATES BANKRUPTCY COURT
CENTRAL DISTRICT OF CALIFORNIA - LOS ANGELES DIVISION

In re: In re: Verity Health System of California, Inc., et al., Debtor(s).	CASE NO.:2:18-bk-20151-ER ADVERSARY NO.: (*if applicable*) CHAPTER: 11
Plaintiff(s) (*if applicable*). vs. Defendant(s) (*if applicable*).	**NOTICE OF APPEAL AND STATEMENT OF ELECTION**

Part 1: Identify the appellant(s)

1. Name(s) of appellant(s): Creditor California Department of Health Care Services

2. Position of appellant(s) in the adversary proceeding or bankruptcy case that is the subject of this appeal:

For appeals in an adversary proceeding.

☐ Plaintiff
☐ Defendant
☐ Other (*describe*):

For appeals in a bankruptcy case and not in an adversary proceeding.

☐ Debtor
☒ Creditor
☐ Trustee
☐ Other (*describe*):

1820151191009000000000006

Part 2: Identify the subject of this appeal

1. Describe the judgment, order, or decree appealed from:
   Memorandum of Decison Authorizing Debtors to Sell Medi-Cal Provider Agreements, Free and Clear of Interests Asserted by the California Department of Health Care Services, Pursuant to Section 363(F)(5) (Attached). Notice of Appeal is pursuant to Federal Rules of Bankruptcy Procedure, Rule 8002(a)(2).
2. The date the judgment, order, or decree was entered: 09/26/2019

Part 3: Identify the other parties to the appeal

List the names of all parties to the judgment, order, or decree appealed from and the names, addresses, and telephone numbers of their attorneys (*attach additional pages if necessary*):

1. Party: Debtors St. Francis Medical Center, Seton Medical Center, and St. Vincent Medical Center

   Attorney:

   Samuel R. Maizel
   Tania M. Moyron
   Dentons US LLP
   601 South Figueroa Street, Suite 2500
   Los Angeles, CA 90017-5704
   (213)892-2910 - Phone

2. Party: Official Committee of Unsecured Creditors of Verity Health System of California, Inc., et al.

   Attorney:

   Gregory A. Bray
   Mark Shinderman
   Milbank, LLP
   2029 Century Park East, 33rd Floor
   Los Angeles, CA 90067
   (424) 386-4000 - Phone

Part 4: Optional election to have appeal heard by District Court (applicable only in certain districts)

If a Bankruptcy Appellate Panel is available in this judicial district, the Bankruptcy Appellate Panel will hear this appeal unless, pursuant to 28 U.S.C. § 158(c)(1), a party elects to have the appeal heard by the United States District Court. If an appellant filing this notice wishes to have the appeal heard by the United States District Court, check below. Do not check the box if the appellant wishes the Bankruptcy Appellate Panel to hear the appeal.

☒ Appellant(s) elect to have the appeal heard by the United States District Court rather than by the Bankruptcy Appellate Panel.

Part 5: Sign below

/s/ Kenneth K. Wang Date: 10/08/2019
Signature of attorney for appellant(s) (or appellant(s) if not represented by an attorney)

Fee waiver notice: If appellant is a child support creditor or its representative and appellant has filed the form specified in § 304(g) of the Bankruptcy Reform Act of 1994, no fee is required.

[**Note to inmate filers:** If you are an inmate filer in an institution and you seek the timing benefit of Fed. R. Bankr. P. 8002(c)(1), complete Director's Form 4170 (Declaration of Inmate Filing) and file that declaration along with the Notice of Appeal.]

ADDITIONAL PARTY TO THE APPEAL

Gary E. Klausner, Esq. (counsel for Buyer, Strategic Global Management, Inc.)
Levene, Neale, Bender, Yoo & Brill, LLP
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FOR PUBLICATION

FILED & ENTERED

SEP 26 2019

CLERK U.S. BANKRUPTCY COURT
Central District of California
BY gonzalez DEPUTY CLERK

UNITED STATES BANKRUPTCY COURT

CENTRAL DISTRICT OF CALIFORNIA

LOS ANGELES DIVISION

In re: Verity Health System of California, Inc., *et al.*,

Debtors and Debtors in Possession.

☒Affects All Debtors

☐ Affects Verity Health System of California, Inc.
☐ Affects O'Connor Hospital
☐ Affects Saint Louise Regional Hospital
☐ Affects St. Francis Medical Center
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☐ 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.,

Lead Case No.: 2:18-bk-20151-ER
Chapter: 11

MEMORANDUM OF DECISION AUTHORIZING DEBTORS TO SELL MEDI-CAL PROVIDER AGREEMENTS, FREE AND CLEAR OF INTERESTS ASSERTED BY THE CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES, PURSUANT TO § 363(F)(5)

Jointly Administered With:
Case No. 2:18-bk-20162-ER;
Case No. 2:18-bk-20163-ER;
Case No. 2:18-bk-20164-ER;
Case No. 2:18-bk-20165-ER;
Case No. 2:18-bk-20167-ER;
Case No. 2:18-bk-20168-ER;
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Case No. 2:18-bk-20175-ER;
Case No. 2:18-bk-20176-ER;
Case No. 2:18-bk-20178-ER;
Case No. 2:18-bk-20179-ER;
Case No. 2:18-bk-20180-ER;
Case No. 2:18-bk-20181-ER;

Chapter 11 Cases.

Date: September 25, 2019

Time: 10:00 a.m.

Location: Ctrm. 1568
Roybal Federal Building
255 East Temple Street
Los Angeles, CA 90012

At issue is whether Medi-Cal Provider Agreements (the "Provider Agreements") entered into between four hospitals (the "Hospitals") and the California Department of Health Care Services (the "DHCS") are executory contracts which must be transferred pursuant to § 365 of the Bankruptcy Code, or statutory entitlements that may be transferred free and clear of successor liability under § 363 of the Bankruptcy Code.[1] If the Provider Agreements are executory contracts, the DHCS may be entitled to receive payments potentially in excess of $50 million in connection with the transfer of the Provider Agreements to the purchaser of the Hospitals. By contrast, if the Provider Agreements are statutory entitlements, they can be transferred to the purchaser free and clear of claims and interests under § 363, meaning that the DHCS would receive no payments in connection with the transfer. For the reasons set forth below, the Court finds that the Provider Agreements are statutory entitlements.[2]

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[1] Unless otherwise indicated, all "Civil Rule" references are to the Federal Rules of Civil Procedure, Rules 1–86; all "Bankruptcy Rule" references are to the Federal Rules of Bankruptcy Procedure, Rules 1001–9037; all "Evidence Rule" references are to the Federal Rules of Evidence, Rules 101–1103; all "LBR" references are to the Local Bankruptcy Rules of the United States Bankruptcy Court for the Central District of California, Rules 1001-1–9075-1; and all statutory references are to the Bankruptcy Code, 11 U.S.C. §§101–1532.

[2] The Court considered the following papers in adjudicating this matter:

1) Debtors' Memorandum in Support of Entry of an Order: (A) Authorizing the Sale of Property Free and Clear of all Claims, Liens and Encumbrances; (B) Authorizing the Assumption and Assignment of Designated Executory Contracts and Unexpired Leases; and (C) Granting Related Relief [Doc. No. 2115] (the "Sale Motion");
2) Creditor California Department of Health Care Services's Objection to Notice to Counterparties to Executory Contracts and Unexpired Leases of the Debtors that May be Assumed and Assigned [Doc. No. 1879];
3) 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 [Doc. No. 3043];
4) Official Committee of Unsecured Creditors' Reply to Creditor California Department of Health Care Services's Supplemental Objection to Sale [Doc. No. 3093];
5) Debtors' Reply to California Department of Health Care Services Objection to Debtors' Sale of Assets to Strategic Global Management [Doc. No. 3095];
   a) Objection to 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 [Doc. No. 3115];
   b) Declaration of Anita Chou in Support of Debtors' Reply to the California Department of Health Care Services' Objection to Debtors' Sale of Assets to Strategic Global Management [Doc. No. 3112]; and
   c) Notice of Debtors' Request to Bifurcate Hearing Regarding California Department of Health Care Services' Objection to Debtors' Sale of Assets to Strategic Global Management [Doc. No. 3113].

I. Facts

On August 31, 2018 (the "Petition Date"), Verity Health Systems of California ("VHS") and certain of its subsidiaries (collectively, the "Debtors") filed voluntary petitions for relief under Chapter 11 of the Bankruptcy Code. On August 31, 2018, the Court entered an order granting the Debtors' motion for joint administration of the Debtors' Chapter 11 cases.[3]

On May 2, 2019, the Court entered an order approving the sale of substantially all of the assets of four of the Debtors' hospitals—St. Francis Medical Center, St. Vincent Medical Center, St. Vincent Dialysis Center, and Seton Medical Center (collectively, the "Hospitals")—to Strategic Global Management, Inc. ("SGM").[4]

Each of the Hospitals has executed a Provider Agreement with DHCS. The Asset Purchase Agreement (the "APA") [Doc. No. 2305-1] which governs the sale of the Hospitals to SGM provides that the sale cannot close unless issues regarding alleged financial defaults existing under each Provider Agreement have been resolved.[5]

Pursuant to Cal. Welf. & Inst. Code § 14169.52(a), each of the Hospitals is required to pay a quarterly Hospital Quality Assurance Fee (an "HQA Fee") to the DHCS, which is assessed regardless of whether the hospital participates in the Medi-Cal Program. *See* Cal. Welf. & Inst. Code § 14169.52(a) (imposing the HQA Fee upon "each general acute care hospital that is not an exempt facility"). As this Court has previously explained, the "HQA Fee allows California to obtain more healthcare funds from the federal government, which generally matches state Medi–Cal contributions dollar-for-dollar." *In re Gardens Reg'l Hosp. & Med. Ctr., Inc.*, 569 B.R. 788, 791 (Bankr. C.D. Cal. 2017), *aff'd,* No. 2:16-BK-17463-ER, 2018 WL 1354334 (B.A.P. 9th Cir. Mar. 12, 2018) ("*Gardens II*").

According to the DHCS, the Debtors are liable for approximately $30 million in HQA Fees attributable to the Hospitals. DHCS asserts that the Provider Agreements associated with each Hospital cannot be transferred to SGM unless the Debtors first assume the Provider Agreements under § 365 of the Bankruptcy Code. In the process of assuming the Provider Agreements, the Debtors would be required to cure the unpaid HQA Fees, or provide adequate assurance that the unpaid HQA Fees would be promptly cured.

The Debtors receive Medi-Cal fee-for-service payments on account of medical services provided to Medi-Cal beneficiaries by the Hospitals. DHCS asserts that the Debtors are liable for approximately $25 million in Medi-Cal fee-for-service overpayments, and that such overpayments must also be cured in connection with the assumption of the Provider Agreements. The Debtors dispute the validity of the audit that resulted in the calculation of the overpayments.

The Debtors contend that the Provider Agreements are not contracts and that it is therefore unnecessary for the Debtors to assume the Provider Agreements under § 365 in order to transfer the agreements to SGM. According to the Debtors, the Provider Agreements are a statutory entitlement to participate in the Medi-Cal program and should be treated as licenses that can be sold, free and clear of claims, interests, and encumbrances, pursuant to § 363(f). In support of the contention that the Provider Agreements are not contracts, Debtors argue that the Provider Agreements do not impose any obligations upon the DHCS. Debtors maintain that the only obligations existing under the Provider Agreements are those that are already imposed under applicable law, and that an agreement to comply with applicable law "is a gratuitous promise

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[3] Doc. No. 17.

[4] Doc. No. 2306 (the "SGM Sale Order").

[5] APA at ¶ 8.7.

which does not provide the consideration necessary to make a contract enforceable." *Gardens II*, 569 B.R. at 797.

The Official Committee of Unsecured Creditors (the "Committee") agrees with the Debtors that the Provider Agreements are not contracts. Like the Debtors, the Committee takes the position that the Provider Agreements are assets of the Debtors' respective estates that can be sold free and clear of all interests pursuant to § 363(f).

II. Discussion

If the Provider Agreements are executory contracts, they can be transferred to SGM only if they are first assumed by the Debtors. To assume an executory contract, the Debtors must either cure all defaults under the contract, or provide adequate assurance that the defaults will be cured promptly. § 365(b).

An executory contract is "a contract that neither party has finished performing." *Mission Prod. Holdings, Inc. v. Tempnology, LLC*, 139 S. Ct. 1652, 1657, 203 L. Ed. 2d 876 (2019). Of course, an agreement that is not a contract can never qualify as an executory contract.

Terms not defined in the Bankruptcy Code have the meaning accorded to such terms under nonbankruptcy law. *See Mission Prod. Holdings,* 139 S.Ct. at 1661 ("And 'breach' is neither a defined nor a specialized bankruptcy term. It means in the Code what it means in contract law outside bankruptcy."). The Bankruptcy Code does not define the term "contract," so the term has the same meaning under § 365 of the Bankruptcy Code as it does under non-bankruptcy law. As the Supreme Court has explained, "[p]roperty interests are created and defined by state law. Unless some federal interest requires a different result, there is no reason why such interests should be analyzed differently simply because an interested party is involved in a bankruptcy proceeding." *Butner v. United States,* 440 U.S. 48, 55, 99 S. Ct. 914, 918, 59 L. Ed. 2d 136 (1979).

A. The Provider Agreements Are Not Contracts

The first issue the Court must confront, then, is whether the Provider Agreements are contracts. The Court finds that they are not.[6]

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[6] In *Gardens II*, the Court found that under the principle of equitable recoupment, DHCS could withhold Medi-Cal and supplemental quality assurance payments owed to a debtor, for the purpose of recovering unpaid hospital quality assurance fees owed by the debtor. *Gardens II* did not decide whether a Medi-Cal Provider Agreement was a contract or a statutory entitlement akin to a license, as the issue did not affect the outcome of the decision:

> The Court finds that, regardless of whether the Provider Agreement is considered a license or contract, the Debtor's HQA Fee liability and entitlement to Medi-Cal Payments would still arise from the same transaction or occurrence.... As discussed previously, the Debtor's acknowledgment in the Provider Agreement that unpaid HQA Fees could be withheld from its Medi-Cal Payments establishes the necessary logical relationship between the Debtor's fee liabilities and its payment entitlements. That logical relationship exists whether the Provider Agreement is classified as a license or a contract.

Gardens II, 569 B.R. at 799.

The Court's determination of whether the Provider Agreements are contracts is informed by decisions involving Medicare Provider Agreements. For purposes of this issue, there are no meaningful differences between the Provider Agreements and a Medicare Provider Agreement. Both types of agreements allow hospitals to obtain reimbursement from the government for providing healthcare services. In both cases, the hospitals' reimbursement entitlement is dictated by the Medicare statute and the regulations promulgated thereunder.[7]

In *PAMC, Ltd. v. Sebelius*, 747 F.3d 1214, 1221 (9th Cir. 2014), the Ninth Circuit declined to apply the contract doctrine of "substantial compliance" to a Medicare Provider Agreement. In that case, PAMC, a hospital, appealed the decision of the Secretary of the Department of Health and Human Services to reduce the reimbursements for which PAMC was eligible. *Id.* at 1215–16. PAMC's reimbursements had been reduced because it had submitted certain required data 28 minutes late. *Id.* at 1216. In challenging the Secretary's decision to reduce its reimbursement eligibility, PAMC argued, among other things, that it had substantially complied with the terms of its Medicare Provider Agreement. *Id.* at 1220. The Ninth Circuit rejected PAMC's attempt to avail itself of the contract doctrine of "substantial compliance":

> [T]he whole notion of importing contract doctrines into an area that is a complex statutory and regulatory scheme is problematic. We have, on occasion, stated that providers and others have contracts with the government in this area, but our decisions have turned on the regulatory regime rather than on contract principles. *See, e.g., United States v. Bourseau,* 531 F.3d 1159, 1162, 1169–70 (9th Cir.2008); *Pac. Coast Med. Enters. v. Harris,* 633 F.2d 123, 125 n. 1, 133–35 (9th Cir.1980). As the Eleventh Circuit Court of Appeals held when hospitals complained of legislative impairment of their contract rights in this area because they had agreements with the Secretary: "Upon joining the Medicare program, however, the hospitals received a statutory entitlement, not a contractual right." *Mem'l Hosp. v. Heckler,* 706 F.2d 1130, 1136 (11th Cir.1983); *see also Bennett v. Ky. Dep't of Educ.*, 470 U.S. 656, 669, 105 S.Ct. 1544, 1552, 84 L.Ed.2d 590 (1985) (stating that while states had "grant agreements" with the federal government and those had a "contractual aspect," the program should not be viewed like a "bilateral contract" and should not "be construed most strongly against the drafter" (internal quotation marks omitted)); *cf. Sebelius v. Auburn Reg'l Med. Ctr.*, —— U.S. ——, ——, 133 S.Ct. 817, 828–29, 184 L.Ed.2d 627 (2013) (declining to apply equitable tolling principles to time set by Secretary for appealing to the Board); *Kaiser Found.*

In support of its argument that the Provider Agreements are executory contracts, DHCS cites the observation made in *Gardens II* that Medicare Provider Agreements "are similar in many respects to … [a] Medi-Cal Provider Agreement." *Gardens II*, 569 B.R. at 799 n.12. DHCS then cites decisions holding that Medicare Provider Agreements are executory contracts. As discussed in greater detail below, the Court does not find the decisions cited by DHCS to be persuasive, because they reached the conclusion that Medicare Provider Agreements are executory contracts without meaningful analysis.

[7] Because the Medi-Cal program is funded in part by federal funds, reimbursement entitlements under Medi-Cal must be consistent with the provisions of the Medicare statute. *See generally* 42 U.S.C. §1396a (setting forth requirements applicable to state medical assistance plans such as Medi-Cal).

> *Hosps.*, 649 F.3d at 1160 (declining to apply excusable neglect equitable analysis to Board's dismissal of case for "failure to timely submit a position paper").

PAMC, Ltd. v. Sebelius, 747 F.3d 1214, 1221 (9th Cir. 2014).

Other courts have been even more explicit in stating that a Medicare Provider Agreement is not a contract. In *Mem'l Hosp. v. Heckler*, cited with approval in *PAMC*, hospitals argued that new legislation reducing their Medicare reimbursement entitlements constituted "an unconstitutional taking of their property without just compensation in violation of the fifth amendment, because it would abrogate a vested contractual right to Medicare reimbursement." *Heckler*, 706 F.2d 1130, 1136 (11th Cir. 1983). The *Heckler* court squarely rejected the hospitals' contention that their Medicare Provider Agreements were contracts: "Upon joining the Medicare program, however, the hospitals received a statutory entitlement, not a contractual right." *Heckler*, 706 F.2d at 1136.

Significantly, the *Heckler* court observed that "[c]ourts have upheld retroactive adjustments in the Medicare reimbursement system." *Id.* It emphasized that such retroactive adjustments were permissible precisely because Medicare Provider Agreements were not contracts. *Id.* A similar result was reached in *Germantown Hosp. & Med. Ctr. v. Heckler*, 590 F. Supp. 24, 30–31 (E.D. Pa. 1983), *aff'd sub nom. Germantown Hosp. & Med. Ctr. v. Schweiker*, 738 F.2d 631 (3d Cir. 1984), in which the court held:

> There is no contractual obligation requiring [the Department of Health and Human Services] to provide Medicare reimbursement. Rather, upon joining the Medicare program, providers gain a statutory entitlement to reimbursement. Thus the amount of reimbursement is governed not by contract but by statute; specifically the Medicare Act's "reasonable cost" provisions.

Germantown, 590 F.Supp. at 30–31. *See also Greater Dallas Home Care All. v. United States*, 10 F. Supp. 2d 638, 647 (N.D. Tex. 1998) ("Plaintiffs argue that the Medicare participation agreements … are essentially contracts. The Court disagrees and finds that the participation agreements are not contracts, for the right to receive payments under the Medicare Act is a manifestation of Government policy and, as such, is a statutory rather than a contractual right.").

Similarly, in *Guzman v. Shewry*, the Ninth Circuit held that a Medi-Cal Provider Agreement was not a contract. 552 F.3d 941 (9th Cir. 2009). In *Guzman*, a physician sought a preliminary injunction to prevent the DHCS from temporarily suspending him from the Medi-Cal program. *Id.* at 946. Among other things, the physician argued that because his suspension deprived him of the ability to receive reimbursement for treating Medi-Cal patients, he had been deprived of his right to contract with the state. *Id.* at 954. Rejecting this argument, the court held that "[p]articipation in the Medi-Cal program entitles Guzman to reimbursement for treating patients who receive Medi-Cal benefits; it does not involve bidding on government contracts." *Id.*

In addition, the Provider Agreements lack a key feature found in all contracts—obligations imposed on both parties to the agreements. The Provider Agreements impose no obligations upon the DHCS. The only obligations spoken of in the Provider Agreements pertain to the Debtors. Even these obligations do not constitute consideration for contract purposes, since they

merely restate the Debtors' pre-existing legal obligations.[8] As this Court has previously held, "an agreement to comply with applicable law is a gratuitous promise which does not provide the consideration necessary to make a contract enforceable." *Gardens II*, 569 B.R. at 797.

DHCS cites a number of cases in which courts have held that Medicare Provider Agreements are executory contracts. These authorities are not persuasive, because the issue of whether the provider agreements were executory contracts versus statutory entitlements was not litigated. Instead, the courts simply assumed, without meaningful analysis, that the provider agreements were executory contracts.

For example, in *In re University Medical Center*, 973 F.2d 1065 (3d Cir. 1992), the Third Circuit assumed that a Medicare Provider Agreement was an executory contract, even though the Third Circuit had ruled eight years prior in *Germantown Hosp. & Med. Ctr. v. Schweiker*, 738 F.2d 631, 632 (3d Cir. 1984) that Medicare Provider Agreements are statutory entitlements, not contracts. In *Germantown*, the court rejected the argument that a reduction in Medicare reimbursement rates impaired the contract rights of the Medicare providers. *Id.* The *University Medical Center* decision contained no discussion of *Germantown* and made no attempt to reconcile *Germantown*'s holding that reductions to Medicare reimbursement rates did not amount to a breach of contract. Similarly, in *In re Heffernan Memorial Hospital District*, 192 B.R. 228, 231 n.4 (Bankr. S.D. Cal. 1996), the issue was not litigated and the debtor appeared to concede that the provider agreement was an executory contract. Likewise, in *In re St. Johns Home Health Agency, Inc.*, 173 B.R. 238 (Bankr. S.D. Fla. 1994), the debtor conceded that the provider agreement was an executory contract, and the Bankruptcy Court disregarded prior binding Eleventh Circuit precedent rejecting the contention that a provider agreement gave the provider "a vested contractual right to Medicare reimbursement." *Mem'l Hosp. v. Heckler*, 706 F.2d 1130, 1136 (11th Cir. 1983).

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[8] DHCS cites a number of provisions within the Provider Agreement that it claims constitute consideration sufficient to render the Provider Agreements contractual in nature. But all of the following the provisions cited by DHCS are restatements of legal obligations imposed upon the Debtors by federal law, federal regulations, state law, or state regulations:

1) Debtors will be subject to the sanctions available to DHCS if they fail to comply with applicable law.
2) To submit a treatment authorization request, the Debtors must use a National Provider Identifier ("NPI") that is appropriately registered and is compliant with all NPI requirements.
3) Debtors cannot engage in conduct inimical to public health, morals, welfare, or safety.
4) Debtors cannot refuse healthcare services based upon race, color, ancestry, marital status, national origin, gender, age, economic status, or physical or mental disability.
5) Only qualified medical personnel may provide healthcare services.
6) Any overpayments must be repaid by the Debtors in accordance with applicable statutes and regulations.
7) Debtors are subject to certain automatic and permissive suspensions and mandatory and permissive exclusions.

B. The Provider Agreements Can Be Sold Free and Clear of Liens, Claims, and Interests Pursuant to § 363(f)(5)

Having found that the Provider Agreements are not contracts and therefore are not subject to assumption and assignment under § 365, the Court must determine whether the Provider Agreements can be sold free and clear of liens, claims, and interests under § 363(f).

Courts have held that interests such as the Provider Agreements constitute "property of the estate" under § 541 that may be sold under § 363. In *Matter of Fugazy Exp., Inc.*, 124 B.R. 426, 430 (S.D.N.Y. 1991), the court held that a license issued by the Federal Communications Commission was property of the estate, notwithstanding a provision within the Federal Communications Act providing that the Act did not create ownership rights in licenses. The holding is consistent with Ninth Circuit precedent stating that "[g]overnment licenses, as a general rule, are considered to be 'general intangibles' under the Uniform Commercial Code, 'i.e., personal property interests in which security interests may be perfected.'" *MLQ Inv'rs, L.P. v. Pac. Quadracasting, Inc.*, 146 F.3d 746, 749 (9th Cir. 1998).

The Court finds that the Provider Agreements are akin to a license issued by a government agency, and therefore that the Provider Agreements may be sold under § 363. The Provider Agreements create a statutory entitlement to bill the Medi-Cal program for providing Medi-Cal services. *See Guzman*, 552 F.3d at 954 (stating that "[p]articipation in the Medi-Cal program entitles [physician] Guzman to reimbursement for treating patients who receive Medi-Cal benefits"). This right to receive reimbursement for providing healthcare services is a property interest.

DHCS contends that the Hospitals hold no property interest in the Provider Agreements and that as a result, the Provider Agreements cannot be sold under § 363. In support of its position, DHCS cites *Erickson v. U.S. ex rel. Dep't of Health & Human Servs.*, 67 F.3d 858, 862 (9th Cir. 1995), in which the court held that a physician convicted of submitting false claims to Medicare did "not possess a property interest in continued participation in Medicare, Medicaid, or the federally-funded state health care programs." *Id.*

DHCS ignores the difference between a property interest in the right to *continue* to participate in Medi-Cal and a property interest in the *existing* right to bill Medi-Cal for providing services. *Erickson* stands for the unremarkable proposition that a provider who engages in criminal conduct has no right to continue as a provider. No one disputes that if the Hospitals violated Medi-Cal statutes or regulations, their right to continue as Medi-Cal Providers could be suspended. But at present, the Provider Agreements are in good standing and the Hospitals have the right to receive reimbursements for providing services to Medi-Cal beneficiaries. It is this right that amounts to a property interest.

The Provider Agreements may be sold free and clear of the liabilities which DHCS contends attach to the Provider Agreements. This includes the alleged liabilities for approximately $30 million in unpaid HQA Fees and $25 million in Medi-Cal overpayments (collectively, the "Liabilities").[9]

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[9] The Debtors object to declaration testimony submitted by Hanh Vo with respect to the amount of the Liabilities. As a result of its determination that the Provider Agreements may be sold free and clear of the Liabilities, it is not necessary for the Court to adjudicate the amount of the Liabilities at this time. Because the Court has not considered the Vo declaration in reaching its decision, the Court does not rule upon the Debtors' evidentiary objection. *See Operating Engineers' Pension Trust Fund v. Clark's Welding & Mach.*, 688 F. Supp. 2d 902, 907 (N.D.

Section 363(f)(1) provides that a sale of estate property may be "free and clear of any interest in such property of an entity other than the estate" if certain conditions are satisfied. As this Court has previously explained:

> The Bankruptcy Code does not define the phrase "interest in ... property" for purposes of § 363(f). The Third Circuit has held that the phrase "interest in ... property" is "intended to refer to obligations that are connected to, or arise from, the property being sold." *Folger Adam Sec., Inc. v. DeMatteis/MacGregor JV*, 209 F.3d 252, 259 (3d Cir. 2000). That conclusion is echoed by *Collier on Bankruptcy*, which observes a trend in caselaw "in favor of a broader definition [of the phrase] that encompasses other obligations that may flow from ownership of the property." 3 Alan N. Resnick & Henry J. Sommer, *Collier on Bankruptcy* ¶ 363.06[1] (16th ed. 2017).
>
> Courts have held that interests in property include monetary obligations arising from the ownership of property, even when those obligations are imposed by statute. For example, in *Mass. Dep't of Unemployment Assistance v. OPK Biotech, LLC (In re PBBPC, Inc.)*, 484 B.R. 860 (1st Cir. BAP 2013), the court held that taxes assessed by Massachusetts under its unemployment insurance statutes constituted an "interest in ... property." The taxes were computed based on the Debtor's "experience rating," which was determined by the number of employees it had terminated in the past. *Id.* at 862. Because the Debtor had terminated most of its employees prior to selling its assets, its experiencing rating, and corresponding unemployment insurance tax liabilities, were very high. *Id.* The *PBBPC* court held that the experience rating was an interest in property that could be cut off under § 363(f). *Id.* at 869–70. Similarly, in *United Mine Workers of Am. Combined Benefit Fund v. Leckie Smokeless Coal Co. (In re Leckie Smokeless Coal Co.)*, 99 F.3d 573, 581, the court held that monetary obligations imposed by the Coal Industry Retiree Health Benefit Act of 1992 constituted an "interest in ... property" within the meaning of § 363(f).

In re Gardens Reg'l Hosp. & Med. Ctr., Inc., 567 B.R. 820, 825–26 (Bankr. C.D. Cal. 2017), *appeal dismissed,* No. 2:16-BK-17463-ER, 2018 WL 1229989 (C.D. Cal. Jan. 19, 2018).

The Liabilities are an "interest in property" within the meaning of § 363(f). The Liabilities arise because the Hospitals have elected to exercise their statutory entitlement to provide medical services, and receive reimbursement for providing such services, under the Provider Agreements. As such, the Liabilities are a monetary obligation arising from the ownership of property (the property being the reimbursement rights associated with the Provider Agreements).

The Provider Agreements may be sold free and clear of the Liabilities only if one or more of the conditions specified in § 363(f)(1)–(5) is satisfied. Here, the Court finds that § 363(f)(5) is satisfied. Under § 363(f)(5), property may be sold free and clear of an interest, if the entity holding the interest "could be compelled, in a legal or equitable proceeding, to accept a money satisfaction of such interest."

The interest that DHCS holds in the Provider Agreements is its right to receive payment of the Liabilities. DHCS could be compelled to accept a money satisfaction of its interest in a legal or equitable proceeding. In fact, receiving a money satisfaction is and has been DHCS' objective

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Cal. 2010) ("Because the Court does not rely on the statements in this declaration, it is not necessary for the Court to rule on these objections.").

all along. Throughout these cases, DHCS has withheld funds payable to the Hospitals to recover the Liabilities.[10] That DHCS would accept a money satisfaction is apparent in its briefing. DHCS states that the Debtors must "pay the debt through the proceeds of the sale" or "within five days of the closing of the sale," and that the Debtors "must establish and maintain a trust account in the amount of $70 million for 36 months for potential reimbursement to [DHCS] of any Medi-Cal overpayment ...."[11]

The case of *In re P.K.R. Convalescent Centers, Inc.*, 189 B.R. 90, 91 (Bankr. E.D. Va. 1995) is directly on point. In *In re PKR Convalescent Centers*, the court approved the sale of a nursing home, free and clear of the interest held by the Virginia Department of Medical Assistance Service (the "DMAS"), pursuant to § 363(f)(5). The interest in question was DMAS' right under Virginia law to recapture, upon the sale of the nursing home, depreciation payments it had previously made to the operators of the nursing home. The court held that DMAS' interest would be extinguished if it received the $1.7 million in depreciation recapture payments it was owed under the statute, and that accordingly, DMAS could be compelled, in a legal or equitable proceeding, to accept a money satisfaction of its interest. *Id.* at 94.

As was the case in *PKR Convalescent Centers*, DHCS' interest in the Provider Agreements would be extinguished if it received the payments it contends it is owed on account of the Liabilities. Consequently, DHCS could be compelled to accept a money satisfaction of its interest. The Provider Agreements may be sold free and clear of DHCS' interest under § 363(f)(5).

The Debtors request that the order on the Motion state that DHCS' recoupment rights against SGM, if any, must be first exercised against payments due to the Debtors from Medi-Cal, then against funds held by the Debtors generated by past interim Medi-Cal payments, and then against any sale proceeds generated by the sale of the Provider Agreement. The issue of the applicability of recoupment subsequent to the sale of the Provider Agreements free and clear of claims and interests has not been sufficiently briefed. The Court declines to decide the issue at present, without prejudice to the ability of interested parties to raise the issue by way of motion.

DHCS requests that the order on the Motion be stayed for 14 days, pursuant to Bankruptcy Rule 6004(h). The purpose of Bankruptcy Rule 6004(h) is to provide sufficient time for an objecting party to appeal before an order can be implemented. The sale to SGM is not expected to close until mid-to-late October 2019. Because the Provider Agreements will not be transferred to SGM until the sale closes, the stay imposed by Bankruptcy Rule 6004(h) is not necessary to protect DHCS' right to appeal.

III. Conclusion

Based upon the foregoing, the Debtors are authorized to sell the Provider Agreements to SGM, free and clear of claims, interests, and encumbrances, pursuant to § 363(f)(5). The Debtors shall submit an order consistent with this Memorandum of Decision.

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[10] DHCS asserts that its withholdings are authorized under the equitable principle of recoupment. As the issue is not presently before it, the Court expresses no opinion on whether the withholdings were permissible under recoupment principles.

[11] Doc. No. 3043 at 10.

Case 2:18-bk-20151-ER Doc 3127 Filed 09/13/19 Entered 09/13/19 13:58:41 Desc
Main Document Page 11 of 11

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Date: September 26, 2019

Ernest M. Robles
United States Bankruptcy Judge

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:

NOTICE OF APPEAL AND STATEMENT OF ELECTION

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 **October 9, 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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2. SERVED BY UNITED STATES MAIL:

Pursuant to F.R.Civ.P. 5 and/or controlling LBR, on **October 9, 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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4. SERVED BY PERSONAL DELIVERY: Pursuant to F.R.Civ.P. 5 and/or controlling LBR, on **October 9, 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.

October 9, 2019	Stacy McKellar	
Date	*Printed Name*	*Signature*

EXHIBIT "8"

Docket #3330 Date Filed: 10/9/2019

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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 OPPOSITION TO THE PROPOSED ORDER [ECF NO. 3322]** 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

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Affects Verity Holdings, LLC
Affects De Paul Ventures, LLC
Affects De Paul Ventures – San Jose Dialysis, LLC,

Debtors and Debtors in Possession.

INTRODUCTION

Debtors' proposed order with regard to the Court's Memorandum of Decision (Memo) on the transfer of their Medi-Cal Provider Agreement is overreaching and self-gratuitous. It extends far beyond the findings and plain language stated in the Memorandum. Thus, Debtors' proposed order, which deviates from the plain language of the Memorandum, must be modified by the Court.

ARGUMENT

The Court issued the Memorandum on September 26, 2019, and instructed Debtors to submit an order "consistent" with the Memorandum. Memorandum, ECF No. 3146. Twelve days later, on October 8, 2019, Debtors lodged their proposed order for the Memorandum. Proposed Order, ECF No. 3322. The proposed order is not "consistent" with the Memorandum. It overreaches by inserting gratuitous terms, to, for example, prohibit the Department's recoupment after the sale.

A. THE COURT DECLINED TO DECIDE ON THE RECOUPMENT ISSUE

In the Memorandum, the Court emphasized that the issue of applicability of recoupment subsequent to the transfer of Medi-Cal Provider Agreements had "not been sufficiently briefed." Thus, it "decline[d] to decide the [recoupment] issue at present, without prejudice to the ability of interested parties to raise the issue by way of motion." Memorandum 10, ECF No. 3146.

Contrary to and despite the Court's plain reservation on the recoupment issue, the proposed order seeks to prohibit the Department's recoupment after the transfer. It states:

> 4. DHCS [Department] shall not adjust, offset, lien or recoup any payments owing to SGM [Buyer] and other SGM affiliates (collectively, "SGM Buyers") which are assigned any rights in connection with the transfer of the Medi-Cal Provider Agreements . . . after the transfer of the assets . . . .

Proposed Order 3, ECF No. 3322.

Accordingly, the proposed order overreached on the recoupment issue. Thus, any reference to the recoupment must be stricken from the proposed order.

B. THE PROPOSED ORDER ALSO OVERREACHED ON OTHER ISSUES NOT CONSIDERED BY THE COURT

The parties did not brief, nor did the Court, consider the nature of the forms or agreements that SGM must sign, after the sale, with regard to the transfer of Debtors' Medi-Cal Provider Agreements.

As a preliminary matter, the Medi-Cal Provider Agreements, include Debtors', specifically require the provider to "comply with the . . . terms and conditions" therein, including the successor joint and successor liability." Declaration of Hanh Vo, Ex. 5, ¶ 37, ECF No. 3043-1.

As the Court noted in *Gardens*, "to become entitled to receive Medi-Cal payments for providing treatment to Medi-Cal beneficiaries, the Debtor was required to enter into a Provider Agreement with DHCS." *In re Gardens Regional Hospital and Medical Center, Inc*., 569 B.R. 788, 796 (Bankr. C.D. Cal. 2017). By signing the Medi-Cal Provider Agreements, Debtor specifically agreed to the successor joint liability provision therein. Affirmed by this Court in *Gardens*, the Debtors' eligibility to participate in the Medi-Cal program was conditioned upon their agreement to the terms in the Medi-Cal Provider Agreement. *Id*. The Medi-Cal Provider Agreement, by the law laid down by this Court, creates a logical relationship between the Medi-Cal debt and payment benefits on the Debtors' Provider Agreements. *Id*, at 796-797.

Here, because the Court refrained from addressing the recoupment issue in the Memorandum, no provision that relates to recoupment in any way should be included in the order, including the provision below, which seeks to bar any recovery by the Department, after the sale, even by recoupment.

///

> None of the SGM Buyers shall be required to execute the Successor Liability Form, or otherwise assume or accept responsibility, for or with respect to any Pre-Transfer Effective Date Liabilities, in conjunction with the completion of the SGM Sale and to effectuate the assignment or other transfer of any Medi-Cal Provider Agreements to the SGM Buyers in connection with the SGM Sale, or otherwise as a condition or requirement for any of the SGM Buyers to participate in the Medi-Cal Program or the HQAF program.

Proposed Order 4, ECF No. 3322.

Rather than overreaching, the proposed order should be consistent by tracking the language of the Memorandum, simply stating:

[THE COURT] HEREBY ORDERS AS FOLLOWS:

1. The Debtors are authorized to transfer the Provider Agreements to SGM, free and clear of claims, interests, and encumbrances pursuant to §§ 363 (f)(5).
2. The DHCS Objections are overruled in their entirety.
3. Because the Provider Agreements will not be transferred to SGM until the sale closes, the stay imposed by Bankruptcy Rule 6004(h) is not necessary to protect DHCS's right to appeal.

CONCLUSION

Given the foregoing, the Court cannot adopt the Debtors' proposed order with regard its Memorandum of Decision on the transfer of their Medi-Cal Provider Agreements.

Dated: October 9, 2019

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
JENNIFER M. KIM
Supervising Deputy Attorney General

/s/ Kenneth K. Wang
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LA2018602105

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 OPPOSITION TO THE PROPOSED ORDER [ECF NO. 3322]

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 **October 9, 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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2. <u>SERVED BY UNITED STATES MAIL</u>:

Pursuant to F.R.Civ.P. 5 and/or controlling LBR, on **October 9, 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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Hon. Ernest M. Robles
United States Bankruptcy Court
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Los Angeles, CA 90012

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

October 9, 2019	Cecilia Apodaca	/s/ Cecilia Apodaca
Date	*Printed Name*	*Signature*

CERTIFICATE OF SERVICE

1. I hereby certify that on February 13, 2020, I electronically filed the foregoing document with the Clerk of the Court for the United States District Court for the Central District of California using the CM/ECF system.

2. I further certify that parties of record to this appeal who either are registered CM/ECF users, or who have registered for electronic notice, or who have consented in writing to electronic service, will be served through the CM/ECF system.

3. I further certify that some of the parties of record to this appeal may not have not consented to electronic service. I have served the foregoing documents by the means set forth below:

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Dated: February 13, 2020

/s/ Gary E. Klausner
GARY E. KLAUSNER