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SUPERIOR COURT OF THE STATE OF CALIFORNIA

SONOMA COUNTY

UNLIMITED CIVIL JURISDICTION

MICHELLE BAASS, in her capacity as Director of the California Department Health Care Services, **PLAINTIFF,** **v.** **SONOMA SPECIALTY HOSPITAL, LLC; AMERICAN ADVANCED MANAGEMENT GROUP, INC.; GURPREET SINGH; and DOES 1-5, inclusive,** **DEFENDANTS.**	SCV-270916 Case No. **COMPLAINT FOR RECOUPMENT, BREACH OF CONTRACT, DECLARATORY RELIEF, AND UNJUST ENRICHMENT**

Plaintiff Michelle Baass, Director of the California Department of Health Care Services (DHCS), brings this complaint and request for declaratory relief against defendants Sonoma Specialty Hospital (SSH), American Advanced Management Group (AAMG), and their owner,

Gurpreet Singh, for recoupment, breach of contract, declaratory relief, unjust enrichment, and any and all other relief the Court deems proper.

INTRODUCTION

Medicaid is a federally sponsored program that finances health care coverage for millions of Americans. DHCS administers California's Medicaid program, known as Medi-Cal, which includes the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program available to two types of hospitals: Designated Public Hospitals (DPHs) and District/Municipal Public Hospitals (DMPHs).

As its name suggests, the PRIME program encourages participating hospitals to redesign their delivery system in order to increase their ability to successfully perform under a risk-based alternative payment model (APM) in the long term. Initially, hospitals were required to establish and report performance baselines. This activity was followed by target setting and the implementation and ongoing evaluation of quality improvement interventions. Hospitals that reported their performance baselines or later successfully met quality metrics receive a Medicaid payment, a portion of which is federally funded.

From July 1, 2016 to March 30, 2019, Defendant SSH participated in PRIME. However, on or about April 1, 2019, SSH converted to a private hospital becoming ineligible to continue in the PRIME program. SSH failed to timely notify DHCS of its conversion and breached its Medi-Cal Provider Agreement by improperly accepting federal program funds and by subsequently refusing to remit the amount it was overpaid. Despite SSH's failure and refusal to refund the payment, DHCS has repaid the federal government using state funds. Because SSH, along with its owner and operator, Gurpreet Singh and American Advanced Management Group, Inc., respectively, continue to unjustly retain the PRIME payment, plaintiffs bring this action for recoupment, breach of contract, declaratory relief, and unjust enrichment, and seek restitution of the PRIME funds.

PARTIES

1. Plaintiff Michelle Baass is the Director of DHCS, which is the single state agency charged with oversight of Medi-Cal, including the PRIME program. (Welf. & Inst. Code, §§

10740, 14000 et seq.; see also 42 U.S.C. § 1396a(a)(5).) Director Baass is responsible for enforcing the statutory and regulatory provisions governing the PRIME program. As such, Director Baass is both authorized and required to recover any unauthorized overpayments made to providers participating in the Medi-Cal program. (Welf. & Inst. Code, § 14176; 42 C.F.R. § 431.958.)

2. On information and belief, SSH is a limited liability corporation organized under the laws of the State of California, with its principal place of business located at 501 Petaluma Avenue, Sebastopol, in Sonoma County, California. SSH also operates a licensed acute-care hospital located at the same address. On further information and belief, at all relevant times herein, SSH has been wholly owned by defendant Gurpreet Singh.

3. On information and belief, defendant American Advanced Urgent Cares LLC, as successor-in-interest to AAMG ("AAMG"), is a limited liability corporation organized under the laws of the State of California, with its principal place of business located at 700 17th Street, Suite 201D, Modesto, California. AAMG's business address is the same as that of defendant Gurpreet Singh's gastroenterology practice. On further information and belief, at all relevant times herein, AAMG has been wholly owned by defendant Singh.

4. Defendant Gurpreet Singh is a natural person residing in the State of California. Singh holds a physician's license in California. He is the President and owner of both SSH and AAMG. On information and belief, Singh has maintained sole ownership of SSH and AAMG during all relevant times herein.

5. On information and belief, there is a unity of ownership between SSH and AAMG such that a separate corporate personality does not exist and injustice would result if SSH's unlawful retention of federal funds distributed under the PRIME program are treated as those of the corporation alone, rather than also as those of AAMG or defendant Singh.

6. The true names and capacities of defendants Does 1 through 5, inclusive, are unknown to DHCS, which therefore sues these Does by such fictitious names. DHCS will amend this complaint to show the true names and capacities when the same have been ascertained. DHCS is informed and believes, and on that basis alleges, that each of these fictitiously named

Does 1 through 5, inclusive, are legally responsible in some manner for the acts, omissions, occurrences, and circumstances that form the basis of this lawsuit, and are thereby liable for the violations asserted therein.

7. On information and belief, at all times mentioned herein, each of the defendants were agents, servants, employees, or contractors of each of the remaining defendants and were at all times acting within the course and scope of their authority as such agents, servants, employees, or contractors and with the permission and consent of their co-defendants.

VENUE

8. This is an unlimited civil case in that the amount in dispute exceeds $25,000.00.

9. Venue is proper in Sonoma County because SSH's principal place of business is located at 501 Petaluma Avenue, Sebastopol, in Sonoma County, California. (Code Civ. Proc., § 395.5.)

FACTUAL BACKGROUND

10. Medicaid is a joint federal-state program through which states receive federal financial participation as reimbursement for the costs of furnishing health care services to federally-recognized groups of low-income individuals. (42 U.S.C. §§ 1396, et seq.; *Olszewski v. Scripps Health* (2003) 30 Cal.4th 798, 809.) California's Medicaid program is overseen by the Centers for Medicare and Medicaid Services (CMS) and administered by DHCS. CMS ensures compliance with all applicable federal laws through review and approval of the terms and conditions expressed within California's Medicaid State Plan.

11. When California significantly changes its Medicaid program, it must either (1) amend its Medicaid State Plan, the state's contract with the federal government; or (2) receive an exemption or Medicaid waiver from portions of Title XIX of the Social Security Act by CMS.

12. CMS has granted waivers of statutory Medicaid requirements and authorized expenditures for costs not otherwise matchable for certain types of programs. CMS authorized PRIME under one such waiver - California's Section 1115 Waiver Medi-Cal 2020 Demonstration (Number 11-W00193/9).

13. The PRIME Special Terms and Conditions (STCs) set forth conditions and limitations on the waiver and expenditure authority, and describes in detail the nature, character, and extent of Federal involvement in the Demonstration and the State's obligations to CMS during the life of the Demonstration. DHCS has assisted PRIME entities in claiming federal dollars through the PRIME Program published within the STCs 74-107 and Attachments D, Q and II.

A. PRIME INCENTIVE PAYMENT PROGRAM PARAMETERS

14. The goal of the PRIME program is to incentivize qualifying publicly-owned hospitals to implement innovations in healthcare delivery systems and demonstrate corresponding improvements in health outcomes and access to healthcare services, especially for Medi-Cal beneficiaries with complex healthcare needs. Each participating PRIME entity must meet specified metrics established to measure these outcomes to receive federal funds not otherwise allowable through Medi-Cal.

15. Eligible PRIME entities consist of only two types: Designated Public Hospital (DPH) systems and the District/Municipal Public Hospitals (DMPHs). PRIME "[i]ncentive funds shall be *disbursed solely to eligible* DPH systems or *DMPHs*." (STC 77; STCs Attachment II, Section III; see also Welf. & Inst. Code, § 14184.50, subd. (a)(1).) DPH systems and DMPHs qualified for incentive funding are referred to as "participating PRIME entities." (STCs, Attachment Q and STCs Attachment II).

16. The STCs provide that participating PRIME entities that complete a report evidencing having met specified metrics may receive federal funds if the participating PRIME entity submits an intergovernmental transfer (IGT) of the amount necessary for the nonfederal share of the applicable incentive payment amounts. (See 42 C.F.R. § 433.51.) Upon the receipt of the governmental transfer, DHCS draws the federal funding and pays both the non-federal share and federal shares of the payment to the DPHs or DMPHs as applicable. (STC, Attachment II, Section VII. F.)

17. The continued receipt of federal funding is conditioned on California's compliance with the STC terms and conditions. A copy of the Medi-Cal 2020 Demonstration STC can be

accessed at: https://www.dhcs.ca.gov/provgovpart/Documents/Medi-Cal-2020-STCs-CMS-amended-6.7.18_.pdf. In addition to compliance with the STCs and related Attachments, DHCS must comply with the state law requirements pertaining to the PRIME program. (Welf. & Inst. Code, §§ 14184.50-14184.51; see also *id.* at §§ 14184, subd. (b)(5), 14184.10, subd. (m).) The relevant portions of section 14184.50 detailing the PRIME IGT process are set forth in subdivision (f):

> The nonfederal share of payments under the PRIME program shall consist of voluntary intergovernmental transfers of funds provided by designated public hospitals or affiliated governmental agencies or entities, or district and municipal public hospitals or affiliated governmental agencies or entities, in accordance with this section.

(Welf. & Inst. Code, § 14184.50, subd. (f).)

18. Thus, both the STCs and Welfare and Institutions Code provisions establish that: (1) PRIME eligibility is limited to publicly-owned entities; and (2) payments are made through an IGT of funds.

19. Only public entities are allowed to submit an IGT of funds. (42 C.F.R. § 433.51.)

B. SSH'S CONVERSION FROM PUBLIC TO PRIVATE ENTERPRISE

20. In 2015, the acute care hospital located at 501 Petaluma Avenue, Sebastopol known as Sonoma West Medical Center (Sonoma West), presently known as SSH, was owned by the Palm Drive Healthcare District (Palm Drive District), a local hospital district established pursuant to Health & Safety Code section 32000 et seq., and related provisions of the Government and Elections Codes. (Health & Saf. Code, § 320000, et seq.) Sonoma West, as a District Municipal Public Hospital (DMPH), qualified as a participating entity under PRIME.

21. As set forth above, only two kinds of healthcare providers are eligible for PRIME funding: Designated Public Hospitals (DPH) systems and District/Municipal Public Hospitals (DMPHs). (Welf. & Inst. Code, § 14184.50, subd. (a)(1).) The latter are further defined as "nondesignated public hospitals, as listed in the [Medi-Cal 2020 Demonstration] Special Terms and Conditions, that have an approved project plan under the PRIME program." (Welf. & Inst. Code, § 14184.50, subd. (b)(3).)

22. Sonoma West received PRIME payments by way of an IGT of funds. Between 2016 and 2018, Sonoma West routinely submitted reports on completed metrics and completed IGTs of the non-federal share.

23. On or about August 26, 2018, Palm Drive District and AAMG executed a management services agreement for AAMG to operate the hospital facility under the new name "Sonoma Specialty Hospital."

24. DHCS is informed and believes, and on that basis alleges, that on or about September 8, 2018, Palm Drive District terminated Sonoma West's management of the hospital facility. Also on information and belief, SSH assumed control of the hospital's operations on September 9, 2018.

25. DHCS is informed and believes, and on that basis alleges, that on or about April 18, 2019, SSH and Palm Drive District entered into an agreement to lease the hospital facility.

26. Changes in hospital ownership are reviewed by CMS and the California Department of Public Health (CDPH) as the relevant regulators for licensees. (42 C.F.R. § 489.18; Health & Saf. Code, § 1272.)

27. The Health Care Facility Licensing and Certification database on CDPH's website lists SSH as having been operated as a Limited Liability Company since April 1, 2019.

28. On information and belief, SSH submitted its Change of Ownership Application (also referred to as CHOW) for the hospital facility on or around May 28, 2019. The CHOW indicated that the licensee would be SSH. According to the CHOW, Palm Drive District remained the owner of the property on which the hospital was situated — 501 Petaluma Avenue, Sebastopol, California.

29. On information and belief, the CHOW further represented that the hospital facility was being operated pursuant to a management agreement with AAMG. A copy of the management agreement was included with the CHOW. DHCS is informed and believes, and on that basis alleges, that the CHOW identified Gurpreet Singh as having a "100%" ownership stake in SSH. CMS identified the effective date of the new ownership as April 1, 2019.

30. Through its owner Gurpreet Singh, SSH executed a Medi-Cal Provider Agreement (MPA) with DHCS on or about April 1, 2019. As a condition of participating in any part of Medi-Cal, SSH agreed to comply with all of the terms and conditions set forth in the MPA including the following provision:

> 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.

(See Exhibit A, SSH's MPA ¶ 2, italics added).

31. It is established law that, "the Department's relationship with Medi-Cal providers is in the nature of a contract, the terms of which include and are limited by the laws and regulations applicable to the Medi-Cal program." (*Paramount Convalescent Center Inc. v. Dept. of Health Care Services* (1975) 15 Cal.3d 489; *Cal. Medical Assn. v. Lackner* (1981) 117 Cal.App.3d 552.)

32. Under the terms of the MPA, SSH further agreed that it would 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*." (*Id.* ¶ 4, italics added.) SSH further agreed to "promptly repay" amounts owed pursuant to the MPA, including "amounts owed in accordance with applicable federal and California statues and regulations, and rules and policies of DHCS." (*Id.* ¶ 23.)

C. JULY 2019 IGT AND INELIGIBLE RECEIPT OF FUNDS

33. By letter sent on or about July 1, 2019, DHCS informed SSH that the IGT for the PRIME Demonstration Year 14 (January 2018 – December 2018) was due to DHCS by July 10, 2019. SSH responded to DHCS's letter by sending a check to DHCS dated July 2, 2019, for the amount of $270,075.00. The check indicated that it was for "PUBHOSPINVEST FUND 3172." The check was signed by Gurpreet Singh.

34. SSH's July 2, 2019 check triggered DHCS's process of drawing federal funds to match the qualifying non-federal share of the PRIME funds. On or about July 11, 2019, DHCS withdrew $540,000.00 from PRIME Fund 3172.

35. On or about August 21, 2019, DHCS paid SSH $540,000.00 (Warrant No. 04023336). This amount was intended to reimburse SSH the $270,000 submitted as an IGT and $270,000 in matching federal funds, pursuant to STC, Attachment II, Section VII, F.

36. DHCS subsequently learned that CMS had approved SSH's CHOW application on or around August 29, 2019. CMS' letter to SSH regarding the CHOW identified the effective date of the new ownership as April 1, 2019.

37. On or about October 10, 2019, SSH informed DHCS by email that the facility was formally transferring to for-profit status.

38. Federal regulations require that DHCS refund the federal share within one year of the discovery of an overpayment (42 C.F.R. §§ 433.316, 433.320.) This obligation applies whether or not DHCS is able to recover the overpayment from the provider. (42 C.F.R. § 433.320(a)(3) ["A credit on the Form CMS–64 must be made whether or not the overpayment has been recovered by the State from the provider."].) Having thus discovered the PRIME overpayment, DHCS was obligated to return the FFP to CMS. (42 C.F.R. §§ 433.316, 433.320.)

39. DHCS notified SSH by letter dated January 15, 2020 that it was terminated from the PRIME program effective April 1, 2019, the date the ownership transfer to Gurpreet Singh was deemed effective and SSH converted to a privately owned hospital. DHCS informed SSH that as a private hospital it was no longer an eligible PRIME entity. Further, as a private hospital SSH was precluded from completing an IGT of funds necessary for the nonfederal share of the applicable incentive payment amount pursuant to federal regulations and state statute. Moreover, SSH should neither have completed the IGT of funds for DY 14 Mid-Year on July 2, 2019, nor received PRIME incentive funds. In fact, SSH would not have received these funds but for its failure to notify DHCS of its conversion to a private hospital. (42 C.F.R. § 433.51; Welf. and Inst. Code, § 14184.50(f).) DHCS advised that it would initiate a recoupment for the $270,000 in FFP

that SSH claimed at DY 14 Mid-Year and was otherwise ineligible to receive. DHCS subsequently confirmed that it would begin pursuing recoupment on January 24, 2020.

40. The January 2020 communications from DHCS to SSH initiated the process set forth in 42 C.F.R. section 433.316(c)(1) by putting SSH on notice of the overpayment and for establishing the date of DHCS' discovery for purposes of the determining when DHCS would be required to return the FFP if SSH did not comply with its request.

41. SSH did not respond to this correspondence.

42. DHCS subsequently sent numerous communications to SSH from February 28, 2020 through October 20, 2021 for the recoupment of the overpayment to SSH. To date, SSH has not remitted any payment to DHCS.

D. DHCS' AUTHORITY TO RECOUP AND SSH'S UNJUST ENRICHMENT

43. DHCS is authorized to recoup overpayments received.

44. Pursuant to federal regulations, improper payments are defined as "any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments). (42 C.F.R. § 431.958.) Overpayments include unauthorized amounts paid by the Medicaid program whether paid as a result of inaccurate or improper cost reporting, improper claim submission, unacceptable practices, fraud, abuse, or mistake. (Medicaid Program Integrity Manual Ch. 1.) State law authority to recover overpayments is broad. (Welf. and Inst. Code, §§ 14115.5, 14176, 14177; Cal. Code Regs, tit. 22, § 51458.1.)

45. DHCS sent SSH its repayment-plan options on March 2, 2020 and September 30, 2020. DHCS offered SSH a flexible recoupment option to prevent SSH from having to repay the overpayment of $ 270,000 at one time. Between March 2020 and October 2021, DHCS reached out to SSH numerous times and did not receive any payment.

46. DHCS and SSH personnel exchanged email messages in the Fall of 2020 about the PRIME payment, but SSH continued to withhold the FFP without justification and in violation of law.

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47. On or about July 7, 2021, in performance of its obligations under 42 C.F.R. section 433.320, DHCS returned $270,000.00 through its Quarterly Statement of Expenditures to CMS. DHCS used state funds to repay the FFP of the July 2019 PRIME payment.

48. To date, SSH continues to withhold public funds to which it is not lawfully entitled, and has knowingly failed to reimburse DHCS for those funds, despite repeated demands, in violation of the governing MPA and applicable state and federal law.

FIRST CAUSE OF ACTION
RECOUPMENT OF THE PRIME OVERPAYMENT
(ALL DEFENDANTS)

49. DHCS re-alleges and incorporates by reference each of the paragraphs above as though fully set forth herein.

50. As a participating Medi-Cal provider, SSH agreed to "promptly repay" amounts owed pursuant to the MPA, including "amounts owed in accordance with applicable federal and California statues and regulations, and rules and policies of DHCS." (SSH's MPA ¶ 4.)

51. SSH improperly retained PRIME incentive funds that it would not have received if it had timely notified DHCS of its conversion to a private hospital. (42 C.F.R. § 433.51; Welf. and Inst. Code, § 14184.50(f).)

52. Despite DHCS' numerous attempts to recoup the improper payment, SSH continues to withhold the FFP without justification and in violation of law. As a result, DHCS used state funds to repay the FFP of the July 2019 PRIME payment. (42 C.F.R. §§ 433.316, 433.320.)

53. Under Welfare and Institutions Code section 14176, DHCS may recover a due and payable overpayment made to a provider by means of a repayment agreement executed between such provider and the director, and by any other means available at law. Additionally, California Code of Regulations, title 22, section 51458.1 provides that provides that "[t]he Department shall recover overpayments to providers . . . ." The regulation lists thirteen non-exclusive instances in which DHS may recover overpayments. Relevant here is that payments may be recovered if they are determined to be "[i]n violation of any other Medi–Cal regulation where overpayment has occurred." (Cal. Code Regs., tit. 22, § 51458.1, subd. (a)(13).)

54. DHCS is entitled to repayment from SSH for $270,000. (Welf. and Inst. Code, § 14176; Cal. Code Regs., tit. 22, § 51458.1.)

55. No part of the $270,000 in state funds that DHCS paid to CMS have been repaid by SSH.

SECOND CAUSE OF ACTION
BREACH OF CONTRACT
(ALL DEFENDANTS)

56. DHCS re-alleges and incorporates by reference each of the paragraphs above as though fully set forth herein.

57. As a registered Medi-Cal provider, SSH agreed to comply with the terms of the MPA, including but not limited to:

- Complying with all provisions of Chapter 7 of the Welfare & Institutions Code, which includes the PRIME program; and
- Promptly repaying amounts identified by DHCS as being owed "in accordance with applicable federal and California statutes and regulations, and rules and policies of DHCS."

58. SSH violated the terms of the MPA when, without reason or justification, it claimed public funds from the PRIME program when it was not eligible to participate in PRIME in the first instance. (See Welf. & Inst. Code, § 14184.50, subds. (a)(1) and (f).) SSH further violated the MPA when it failed and refused to return the PRIME payment when requested by DHCS. SSH thereby breached its agreement with DHCS.

59. Despite SSH's breach of the terms of the MPA, DHCS dutifully performed its own lawful obligations with regards to SSH, including but not limited to drawing down FFP and paying SSH both the FFP and SSH's July 2019 payment under the provisions of the PRIME Program.

60. Consistent with 42 C.F.R. section 433.320, DHCS could not wait indefinitely for SSH to refund the money it was not eligible to receive, and was obligated to refund CMS in the

original amount of $270,000.00, despite those funds not being remitted back to DHCS by SSH. DHCS was required to utilize state funds to repay this FFP.

61. SSH's conduct in violation of the MPA thus caused DHCS to experience a loss of state funds in the amount $270,000.00, plus interest.

THIRD CAUSE OF ACTION
DECLARATORY RELIEF (CCP § 1060)
(ALL DEFENDANTS)

62. DHCS re-alleges and incorporates by reference each of the paragraphs above as though fully set forth herein.

63. Code of Civil Procedure section 1060 provides, in relevant part, that: "Any person interested under a written instrument . . . or under a contract, or who desires a declaration of his or her rights or duties with respect to another . . . may, in cases of actual controversy related to the legal rights and duties of the respective parties, bring an original action . . . for a declaration of his or her rights." (Code Civ. Proc. § 1060.) Section 1060 further authorizes such a declaration "either alone or with other relief." (*Ibid.*)

64. An actual controversy exists as to whether SSH's actions in initiating an IGT that did not contain local government funds and refusing to return PRIME funds, which it was ineligible to receive due to SSH's status as a privately-owned hospital, violated the MPA, the STCs, and section 14184.50 of the Welfare & Institutions Code.

65. DHCS has a substantial interest in the resolution of this controversy as it sustained a loss of $270,000.00 in state funds when it was required to reimburse CMS for the same amount because SSH continued to unlawfully hold federal funds for which it was not eligible and which SSH was not entitled to retain.

66. To date, despite repeated demands, SSH has not repaid DHCS the $270,000.00 in state funds that DHCS was forced to repay CMS.

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FOURTH CAUSE OF ACTION
UNJUST ENRICHMENT
(ALL DEFENDANTS)

67. DHCS re-alleges and incorporates by reference each of the paragraphs above as though fully set forth herein.

68. Welfare & Institutions Code section 14184.50, subdivision (f)(2), provides that, upon initiating a PRIME IGT, the "transferring entity shall certify that the transferred funds qualify for federal financial participation pursuant to applicable federal Medicaid laws and the Special Terms and Conditions [for the Medi-Cal 2020 Demonstration], and in the form and manner as required by [DHCS]."

69. SSH abrogated its obligations pursuant to statute and its Medi-Cal Provider Agreement when it initiated the IGT process despite being ineligible to participate in PRIME. (Welf. & Inst. Code, § 14184.50, subd. (f)(2).)

70. Federal regulations require DHCS to repay any overpayment of FFP to CMS within one year from the date the overpayment was discovered. (42 C.F.R. § 433.316(a), (c)(1).) For purposes of this action, the overpayment is the amount paid to SSH despite its being ineligible for such funds under the PRIME program.

71. DHCS has a statutory and contractual right to recover overpayments (Welf. & Inst. Code, § 14176.), and repeatedly asked SSH to return the federal portion of the July 2019 PRIME, to no avail. To date, SSH has failed and refused to return the unauthorized funds.

72. Despite its numerous unsuccessful efforts to recoup the FFP wrongfully held by SSH, DHCS was nonetheless obligated to return $270,000.00 to CMS. (42 C.F.R. § 433.316(b).

73. DHCS used state funds to repay CMS the $270,000.00.

74. SSH has been unjustly enriched by its unlawful retention of the $270,000.00 it was not entitled to receive in the first instance, and by not repaying DHCS as requested, SSH has unjustifiably caused DHCS to expend state funds for the exclusive benefit of SSH.

75. SSH has been unjustly enriched in the amount of $270,000.00.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff respectfully prays that the court enter judgment against Defendants as follows:

1. That judgment be entered in favor of Plaintiff and against Defendants.

2. For a declaration, under Code of Civil Procedure section 1060 that SSH violated section 14184.50, Chapter 7 of the Welfare & Institutions Code.

3. For an award of restitution in the amount of $270,000.00 to DHCS.

4. For such other relief as is just and proper, including an award of pre- and post-judgment interest, attorneys' fees, and costs of suit, if available.

Dated: May 31, 2022

Respectfully submitted,

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Exhibit A

State of California
Health and Human Services Agency

Department of Health Care Services

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

Do not use staples on this form or 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.

For State Use Only

Date: 04/01/19

Legal name of applicant or provider (as listed with the IRS)	Business name (if different than legal name)
SONOMA SPECIALTY HOSPITAL, LLC	SONOMA SPECIALTY HOSPITAL

Provider number (NPI)	Business Telephone Number
1396205050	(707) 823-8511

	City	State	ZIP code (9-digit)
Business address (number, street) 501 PETALUMA AVE	SEBASTOPOL	CA	95472-4281
Mailing address (number, street, P.O. Box number) 501 PETALUMA AVE	SEBASTOPOL	CA	95472-4281
Pay-to address (number, street, P.O. Box number) 501 PETALUMA AVE	SEBASTOPOL	CA	95472-4281
Previous business address (number, street) N/A	N/A	NA	

Taxpayer Identification Number (TIN)**
83-1534467

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:

RECEIVED
MAY 28 2019
Centralized Applications U
Licensing & Certification Pro

* 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.

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.
3. **National Provider Identifier (NPI).** Provider agrees not to submit any treatment authorization requests (TARs) or claims to DHCS using an NPI unless that NPI is appropriately registered for this provider 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 Title 22, California Code of Regulations, Section 51000.40 and 51000.52(b).
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 any Medi-Cal patient 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. In addition, Provider shall not discriminate against Medi-Cal beneficiaries in any manner, including, but not limited to, admission practices, room selection and placement, meals provision and waiting time for surgical procedures. Without exception, Provider shall provide to Medi-Cal patients their specific Medi-Cal benefit Inpatient Services in the same manner as Provider also directly, or indirectly, renders those same services to non-Medi-Cal patients, regardless of payor source.
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. **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 or a claim was submitted. Providers using billing agents shall assure that the billing agents maintain and submit documents required.

9. **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") or the Health, Education and Welfare Unit, 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 or its billing agent from participation in the Medi-Cal program. Provider will be reimbursed for reasonable copy costs as determined by DHCS, CDPH, AG or Secretary.

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.

16. **Provider Fraud or Abuse Convictions and/or Civil Fraud or Abuse Liability.** Provider certifies that it and its owners, officers, directors, employees, and agents, have 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.

17. **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.

18. **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.

19. **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 180 days of billing by Provider, Provider may submit a claim to DHCS but must provide documentation of denial when requested to do so by DHCS. Providers billing for services to beneficiaries who are dual eligible Medicare-Medi-Cal must submit payment denial from Medicare Part A&B with all claims.

20. **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.

21. **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. Providers agree to submit all claims within 60 days of the dates of service but no later than six months to receive full payment. Providers agree to comply with Welfare and Institutions Code Section 14115 and California Code of Regulations, Title 22, Section 51008 and 51008.5.

22. **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.

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)).

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).

26. **Provider Grievances and Complaints.** A provider who has a grievance or complaint concerning the processing or payment of money alleged to be payable for services provided to eligible Medi-Cal beneficiaries shall comply with and exhaust all administrative remedies and procedures outlined in statute, regulation or the Provider Manual, including the following:

    a. The provider and its billing agent shall comply with and exhaust all administrative remedies provided by the Fiscal Intermediary or Contractor prior to filing a court action.

    b. The provider and its billing agent shall comply with and exhaust all proceeding for claims processing outlined in the Provider Manual including all appeal procedures.

    c. The provider and its billing agent shall submit to the Fiscal Intermediary or Contractor all source documentation to support its claim, including but not limited to the source documentation outlined in California Code of Regulations, Title 22, Section 51476.

    d. The provider and its billing agent shall comply with all timeliness requirements including but not limited to those outlined in Welfare and Institutions Code Section 14115 and California Code of Regulations, Title 22, Section 51008 and 51008.5.

27. **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.

28. **Liability of Group Providers.** Provider agrees that, if it is a provider group, 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.

29. **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.

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.

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
   SONOMA SPECIALTY HOSPITAL, LLC
2. Printed name of person signing this declaration on behalf of provider (if an entity or business name is listed in item 1 above)
   [signature]
3. Original signature of provider or representative if this provider is an entity other than an individual person as sole proprietor
   Gurpreet Singh
4. Title of person signing this declaration
   Owner
5. Notary Public (Affix notary seal or stamp in the space below)

RECEIVED
MAY 28 2019
Centralized Applications Unit
Licensing & Certification Program

Executed at: _____, _____ on _____
(City) (State) (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 Acknowledgment 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 e-mail address and telephone number below.

Contact Person's Name (Last, First, Middle)		Gender
Salas, Matthew		☒ Male ☐ Female
Title/Position	**E-mail Address**	**Telephone Number**
Administrator / COO	MSalas@sonomaspecialty.org	(707) 823-8511

Privacy Statement
(Civil Code Section 1798 et seq.)

All information requested on the Application, the disclosure statement, and the provider agreement is mandatory. This information is required by the California Department of Health Care Services and any other California State Departments that are delegated responsibility to administer the Medi-Cal program, by the authority of the Welfare and Institutions Code, Sections 14043 – 14043.75, the California Code of Regulations, Title 22, Sections 51000 – 51451 and the Code of Federal Regulations, Title 42, Part 455. 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. Some or all of this information may also be provided to the California State Controller's Office, the California Department of Justice, the California Department of Consumer Affairs, the California Department of Corporations, the California Franchise Tax Board or other California 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, or as required or permitted by law. For more information or access to records containing your personal information maintained by this agency, contact the Provider Enrollment Division at (916) 323-1945.

ACKNOWLEDGMENT

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California
County of Stanislaus)

On April 19 2019 before me, S. Virk
(insert name and title of the officer)

personally appeared Gurpreet Singh,
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.

S. VIRK
COMM. #2242730
Notary Public - California
Stanislaus County
My Comm. Expires May 14, 2022

Signature _____ (Seal)

RECEIVED
MAY 28 2019
Centralized Applications Unit
Licensing & Certification Program

INSTRUCTIONS FOR THE COMPLETION OF THE MEDI-CAL PROVIDER AGREEMENT (Institutional Provider)

- **Type or print clearly.**
- **Return original and maintain a copy for your records.**
- **The Legal name and Business name must be consistent throughout the Medi-Cal Provider Agreement and any of its attachments.**
- **DO NOT LEAVE any questions, boxes, lines, etc. blank. Enter N/A if not applicable to you. If this document is incomplete, it will be returned to you.**

Page 2 (Please enter the date)

Legal name is the name listed with the Internal Revenue Service (IRS).

Business name is the facility, hospital, agency, or clinic name (name of business/DBA)

Provider Number (NPI) is the ten-digit National Provider Identifier for the business address, as registered with the National Plan and Provider Enumeration System (NPPES).

Business telephone number is the primary business telephone number used at the business address.

Business address is the actual business location including the street name and number, room or suite number or letter, city, state, and nine-digit ZIP code. A post office box or commercial box is not acceptable.

Mailing address is the location at which the applicant or provider wishes to receive general Medi-Cal correspondence. General Medi-Cal correspondence includes bulletin updates and Provider Manual updates.

Pay-to address is the address at which the applicant or provider wishes to receive payment.

Previous business address is the address where the applicant or provider was previously enrolled. If the applicant or provider is not submitting an application for a change of location, enter N/A.

Taxpayer Identification Number is the Taxpayer Identification Number (TIN) issued by the IRS under the name of the applicant or provider.

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1. **Legal name** is the name listed with the IRS.
2. **Printed name** of the person signing this agreement.
3. **Original signature** of the person signing this agreement.
4. **Title** of the person signing this agreement.
5. **Notary Public** box is for Certificate of Acknowledgment, signature and seal of Notary Public. (See California Civil Code Section 1189).