FILED
AHCA
AGENCY CLERK
2016 SEP 19 A 10:46

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

QUALITY TOTAL CARE, LLC fdba THE CROSSINGS,

Petitioner,

vs.

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Respondent,

_____/

DOAH Case No.: 16-3847
Invoice No.: NH16624
Provider No.: 026939500
RENDITION NO.: AHCA-16-0697-S-MDA

FINAL ORDER

THE PARTIES resolved all disputed issues and executed a Settlement Agreement. The parties are directed to comply with the terms of the attached settlement agreement, attached hereto and incorporated herein as **Exhibit "1**." Based on the foregoing, this file is **CLOSED**.

DONE and ORDERED on this the 14 day of Sept., 2016, in Tallahassee, Florida.

for Justin Senior

ELIZABETH DUDEK, SECRETARY
Agency for Health Care Administration

A PARTY WHO IS ADVERSELY AFFECTED BY THIS FINAL ORDER IS ENTITLED TO A JUDICIAL REVIEW WHICH SHALL BE INSTITUTED BY FILING ONE COPY OF A NOTICE OF APPEAL WITH THE AGENCY CLERK OF AHCA, AND A SECOND COPY ALONG WITH FILING FEE AS PRESCRIBED BY LAW, WITH THE DISTRICT COURT OF APPEAL IN THE APPELLATE DISTRICT WHERE THE AGENCY MAINTAINS ITS HEADQUARTERS OR WHERE A PARTY RESIDES. REVIEW PROCEEDINGS SHALL BE CONDUCTED IN ACCORDANCE WITH THE FLORIDA APPELLATE RULES. THE NOTICE OF APPEAL MUST BE FILED WITHIN 30 DAYS OF RENDITION OF THE ORDER TO BE REVIEWED.

Michael B. Kornhauser, Esq.
Fuerst Ittleman David & Joseph, PL
1001 Brickell Bay Drive
32nd Floor
Miami, FL 33131
mkornhauser@fuerstlaw.com
(Electronic Mail)
Attorney for Provider

Katrina Derico-Harris
Accounting Services Supervisor II
Bureau of Financial Services
(Electronic Mail)

Bureau of Health Quality Assurance
Agency for Health Care Administration
(Electronic Mail)

Stuart Williams, General Counsel
Agency for Health Care Administration
(Electronic Mail)

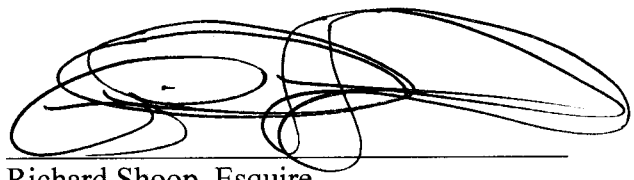
Michael Murphy, Financial Administrator
Bureau of Financial Services
(Electronic Mail)

Shena Grantham, Chief
Medicaid Medicaid Admin.
Litigation Counsel
(Electronic Mail)

Joseph G. Hern, Jr., Esquire
Assistant General Counsel
(Electronic Mail)

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing has been furnished to the above named addressees by Electronic Mail on this the 19th day of September, 2016.



Richard Shoop, Esquire
Agency Clerk
State of Florida
Agency for Health Care Administration
2727 Mahan Drive, Building #3
Tallahassee, Florida 32308-5403
PH: (850) 412-3689/FAX: (850) 921-0168

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

DOAH CASE NO.: 16-3847
INVOICE NO.: NH 16624
PROVIDER NO.: 026939500

vs.

QUALITY TOTAL CARE, LLC DBA THE CROSSING,

Respondent.
_____/

SETTLEMENT AGREEMENT

Petitioner, the **STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION** ("AHCA" or "Agency"), and Respondent, **QUALITY TOTAL CARE, LLC DBA THE CROSSING** ("PROVIDER"), by and through the undersigned, hereby stipulate and agree as follows:

1. The parties enter into this Settlement Agreement ("Agreement") for the purpose of memorializing the resolution of this matter.

2. PROVIDER was a Medicaid provider in the State of Florida, provider number 026939500, during the relevant period.

3. PROVIDER was issued a remittance voucher dated August 18, 2012.

4. The remittance identified an overpayment (account receivable) in the amount of $11,682.85 and Notice was sent to PROVIDER dated August 27, 2012. A second Notice was sent dated March 21, 2016. Copies of the Notices are attached hereto and labeled Composite Exhibit A.

5. On April 8, 2016, in response to the Agency's Notice, PROVIDER filed a *Request for Formal Hearing.* On July 5, 2016, the Agency Clerk forwarded the matter to the Division of Administrative Hearings.

6. Subsequent to the *Request for Formal Hearing*, and after further review of additional documentation during the pendency of litigation, the Agency determined that the overpayment amount should be adjusted to zero dollars ($0.00).

7. PROVIDER and AHCA agree that this agreement resolves and settles this case completely and releases both parties from any administrative or civil liabilities arising from the findings relating to the matters referenced in Composite Exhibit A.

8. AHCA reserves the right to enforce this Agreement under the laws of the State of Florida, the Rules of the Medicaid Program, and all other applicable rules and regulations.

9. This settlement does not constitute an admission of wrongdoing or error by either party with respect to this case or any other matter.

10. The signatories to this Agreement, acting in a representative capacity, represent that they are duly authorized to enter into this Agreement on behalf of the respective parties.

11. This Agreement shall be construed in accordance with the provisions of the laws of Florida. Venue for any action arising from this Agreement shall be in Leon County, Florida.

12. This Agreement constitutes the entire agreement between PROVIDER and AHCA, including anyone acting for, associated with or employed by them, concerning all matters and supersedes any prior discussions, agreements or understandings; there are no promises, representations or agreements between PROVIDER and AHCA other than as set forth herein. No modification or waiver of any provision shall be valid unless a written amendment to the Agreement is completed and properly executed by the parties.

13. This is an Agreement of Settlement and Compromise, made in recognition that the parties may have different or incorrect understandings, information and contentions as to facts and law, and with each party compromising and settling any potential correctness or incorrectness of its understandings, information and contentions as to facts and law, so that no misunderstanding or misinformation shall be a ground for rescission hereof.

14. PROVIDER expressly waives in this matter its right to any hearing pursuant to sections 120.569 or 120.57, Florida Statutes, the making of findings of fact and conclusions of law by the Agency, and all further and other proceedings to which it may be entitled by law or rules of the Agency regarding this proceeding and any and all issues raised herein. PROVIDER further agrees that it shall not challenge or contest any Final Order entered in this matter which is consistent with the terms of this settlement agreement in any forum now or in the future available to it, including the right to any administrative proceeding, circuit or federal court action or any appeal.

15. PROVIDER does hereby discharge the State of Florida, Agency for Health Care Administration, and its employees, agents, representatives, and attorneys of and from all claims, demands, actions, causes of action, suits, damages, losses and expenses, of any and every nature whatsoever, arising out of or in any way related to this matter, AHCA's actions herein, including, but not limited to, any claims that were or may be asserted in any federal or state court or administrative forum, including any claims arising out of this agreement.

16. The parties agree to bear their own attorney's fees and costs.

17. This Agreement is and shall be deemed jointly drafted and written by all parties to it and shall not be construed or interpreted against the party originating or preparing it.

18. To the extent that any provision of this Agreement is prohibited by law for any reason, such provision shall be effective to the extent not so prohibited, and such prohibition shall not affect any other provision of this Agreement.

19. This Agreement shall inure to the benefit of and be binding on each party's successors, assigns, heirs, administrators, representatives and trustees. As to PROVIDER, this Agreement also specifically releases PROVIDER, its officers, directors, principals, owners, shareholders, members, and related entities and all entities which has since operated under the fictitious name "The Crossings" as to matters addressed in Composite Exhibit A.

20. All times stated herein are of the essence of this Agreement.

21. This Agreement shall be in full force and effect upon execution by the respective parties in counterpart.

QUALITY TOTAL CARE, LLC
DBA THE CROSSING,

Dated: Aug 11, 2016

(Signed) Authorized Representative of
Quality Total Care, LLC dba
The Crossing

BY: Marline C Dunseau, CFO
(Print Name and Title)

Dated: August 16th, 2016

(Signed) Attorney for **Quality Total Care, LLC dba The Crossing**

BY: Michael B. Kornhauser, Esq.
(Print Name and Title)

AGENCY FOR HEALTH CARE ADMINISTRATION
2727 Mahan Drive, Bldg. 3, Mail Stop #3
Tallahassee, FL 32308-5403

Justin Senior
Deputy Secretary for Medicaid

Dated: 9/18, 2016

Stuart F. Williams, Esquire
General Counsel

Dated: 9/12, 2016

Shena L. Grantham, Esquire
Chief Counsel, Medicaid Administrative Litigation

Dated: 9/12, 2016

Joseph G. Hern, Jr., Esquire
Attorney, Medicaid Admin. Litigation

Dated: 8/16, 2016

RICK SCOTT
GOVERNOR

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION
Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

CERTIFIED MAIL RECEIPT REQUESTED:
91 7108 2133 3937 6303 1743

August 27, 2012

Nursing Home Administrator
Quality Total Care, LLC
4445 Pine Forest Drive
Lake Worth, FL 33463

Dear Administrator:

You have been notified by the Office of Medicaid Cost Reimbursement Analysis of adjustments to your Medicaid reimbursement rates on the remittance voucher run dated: **8/18/12.**
The adjustments resulted from changes in your cost reports. This action has resulted in a balance due to the Agency in the amount of **$11,682.85** for provider number **026939500/** invoice number **NH16624.**

If payment is not received, or arranged for, within 30 days of receipt of this letter, the Agency shall withhold Medicaid payments in accordance with the provisions of Chapter 409.913(27), F.S. Furthermore, pursuant to Sections 409.913(25) and 409.913(15), F.S., failure to pay in full, or enter into and abide by the terms of any repayment schedule set forth by the Agency may result in termination from the Medicaid Program. Likewise, failure to comply with all sanctions applied or due dates may result in additional sanctions being imposed. If the overpayment cannot be recouped by this office, Florida law authorizes referral of your account to the Department of Health and to a collection agency. All costs incurred by the Agency resulting from collection efforts will be added to your balance. Additionally, be advised that this referral does not relieve you of your obligation to make payment in full or contact this office to arrange mutually agreeable repayment terms.

In addition, amounts due to the Agency shall bear interest at ten percent (10%) per annum from the date of this letter on the unpaid balance until the account is paid in full. The interest accrual will not be assessed if payment is received by the Agency within 30 days.

You have the right to request a formal or informal hearing pursuant to Section 120.569, F.S. If a request for a formal hearing is made, the petition must be made in compliance with Section 28-106.201, F.A.C. and mediation may be available. If a request for an informal hearing is made, the petition must be made in compliance with rule Section 28-106.301, F.A.C. Additionally, you are hereby informed that if a request for a hearing is made, the petition must be **received by the Agency** within twenty-one (21) days of receipt of this letter. **For more information regarding your hearing and mediation rights, please see the attached Notice of Administrative Hearing and Mediation Rights.**

Composite Ex. A

Please include a copy of the enclosed remittance advice to assure proper posting of payments to your provider account.

Should you have any questions regarding the Medicaid provider account balance information contained in this notice, please contact Sharon Dixon (850) 412-3839. Questions regarding the reimbursement rate changes should be directed to Stephen Russell, Office of Medicaid Cost Reimbursement, at (850) 412-4106.

Sincerely,

Sharon Dixon

Sharon Dixon
Medicaid Accounts Receivable

SLD

August 27, 2012

PLEASE INCLUDE THIS REMITTANCE ADVICE WITH YOUR PAYMENT

Remit Payment to:

Agency for Health Care Administration
Medicaid Accounts Receivable MS# 14
2727 Mahan Drive Bldg. 2 Ste. 200
Tallahassee, FL 32308
Attn: Sharon Dixon

FROM:

Quality Total Care, LLC
4445 Pine Forest Drive
Lake Worth, FL 33463

Provider No. 026939500
Invoice No. NH16624

STATEMENT OF ACCOUNT

CERTIFIED MAIL: 91 7108 2133 3937 6303 1743

VOUCHER RUN DATE: 8/18/12

BALANCE DUE: $11,682.85

PAYMENT IS DUE WITHIN 30 DAYS FROM THE DATE OF THIS LETTER.

Amount Enclosed: $_____

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

CERTIFIED MAILRECEIPT REQUESTED:
91 7199 9991 7032 4032 4032 1934

2ND ATTEMPT

March 21, 2016

Attn: Nursing Home Administrator
QUALITY TOTAL CARE, LLC
4445 PINE FOREST DR
LAKE WORTH, FL 33463

RE: Provider No. 0269395-00 Invoice No. NH16624

Dear Administrator:

You had been notified by the Office of Medicaid Cost Reimbursement Analysis of adjustments to your Medicaid reimbursement rates on the remittance voucher run dated: 08/18/2012.
The adjustments resulted from changes to your cost reports. This action has resulted in a balance due to the Agency in the amount of $11,682.85.

Please note, your account is now past due and interest has accrued. As of 03/21/2016 interest has accrued in the amount of $4,058.59 increasing the balances to **$15,741.44.** If payment is not received, or arranged for, within 30 days of receipt of this letter, the Agency shall withhold Medicaid payments in accordance with the provisions of Chapter 409.913(27), F.S. Furthermore, pursuant to Sections 409.913(25) and 409.913(15), F.S., failure to pay in full, or enter into and abide by the terms of any repayment schedule set forth by the Agency may result in termination from the Medicaid Program. Likewise, failure to comply with all sanctions applied or due dates may result in additional sanctions being imposed. If the overpayment cannot be recouped by this office, Florida law authorizes referral of your account to the Department of Health and to a collection agency. All costs incurred by the Agency resulting from collection efforts will be added to your balance. Additionally, be advised that this referral does not relieve you of your obligation to make payment in full or contact this office to arrange mutually agreeable repayment terms.

Please be aware that section 409.913 (16), Florida Statutes, requires the Agency to impose the sanction of termination for cause against any provider who voluntarily relinquishes its Medicaid provider number or an associated license, or allows the associated licensure to expire after receiving written notice that the agency is conducting, or has conducted, an audit, survey, inspection, or investigation and that a sanction of suspension or termination will or would be imposed for noncompliance discovered as a result of the audit, survey, inspection, or investigation.

PLEASE INCLUDE THIS REMITTANCE ADVICE WITH YOUR PAYMENT

Remit Payment to:

Agency for Health Care Administration
Medicaid Accounts Receivable MS # 14
2727 Mahan Drive Bldg. 2 Ste. 200
Tallahassee, FL 32317-3749
Attn: Katrina Derico - Harris

FROM:
QUALITY TOTAL CARE, LLC
4445 PINE FOREST DR.
LAKE WORTH , FL 33463

Provider No. 0269395-00
Invoice No. NH16624

STATEMENT OF ACCOUNT

CERTIFIED MAIL: **91 7199 9991 7032 4032 1934**

VOUCHER RUN DATE: **08/18/2016**

BALANCE DUE: **$15,741.44**

PAYMENT IS DUE WITHIN 30 DAYS FROM THE DATE OF THIS LETTER.

Amount Enclosed: $_____

sanction of suspension or termination will or would be imposed for noncompliance discovered as a result of the audit, survey, inspection, or investigation.

In addition, amounts due to the Agency shall bear interest at ten percent (10%) per annum from the date of this letter on the unpaid balance until the account is paid in full. The interest accrual will not be assessed if payment is received by the Agency within 30 days.

You have the right to request a formal or informal hearing pursuant to Section 120.569, F.S. If a request for a formal hearing is made, the petition must be made in compliance with Section 28-106.201, F.A.C. and mediation may be available. If a request for an informal hearing is made, the petition must be made in compliance with rule Section 28-106.301, F.A.C. Additionally, you are hereby informed that if a request for a hearing is made, the petition must be **received by the Agency** within twenty-one (21) days of receipt of this letter. **For more information regarding your hearing and mediation rights, please see the attached Notice of Administrative Hearing and Mediation Rights.**

Please include a copy of the enclosed remittance advice to assure proper posting of payments to your provider account.

Should you have any questions regarding the Medicaid provider account balance information contained in this notice, please contact Katrina Derico-Harris (850) 412-3822. Questions regarding the reimbursement rate changes should be directed to Lisa Smith, Office of Medicaid Cost Reimbursement, at (850) 412-4114.

Sincerely,

Jane Okoye
Medicaid Accounts Receivable