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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 (1) DEBTORS' MOTION FOR AN ORDER APPROVING THE PROPOSED DISCLOSURE STATEMENT; (2) PROPOSED DISCLOSURE STATEMENT, AND (3) PROPOSED CHAPTER 11 PLAN OF LIQUIDATION** Hearing: October 2, 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 Foundation
Affects St. Francis Medical Center of

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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

TABLE OF AUTHORITIES

TABLE OF AUTHORITIES
(continued)

INTRODUCTION

Debtors St. Francis Medical Center (St. Francis Medical Center), St. Vincent Medical Center (St. Vincent Medical Center), and Seton Medical Center (Seton Medical Center) (collectively, Debtors) owe millions of pre-petition Hospital Quality Assurance Fees (HQA Fees). Creditor California Department of Health Care Services (Department), through recoupment, is withholding Medi-Cal payments intended for Debtors to offset the HQA Fee debt liabilities.

Further, 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, Debtors must either pay all of the outstanding HQA Fees incurred, before the closing of the sale, or all 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. As such, Debtors must establish and maintain a trust account in the amount of $70 million for thirty-six 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]

Despite the HQA Fee liabilities and the Medi-Cal overpayments, the Motion for an Order Approving Proposed Disclosure Statement (Motion) (ECF No. 2995), proposed Disclosure Statement (Statement) (ECF No. 2994) and proposed Plan of Liquidation (Plan) (ECF No. 2993) neither disclose nor address such debt liabilities and the Department's recovery thereof, which may affect other creditors and should be fully disclosed. As such, they cannot be approved unless revised or amended accordingly.

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

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. ECF No. 1279. The Department filed its objection to the motion on January 25, 2019. ECF No. 1353. Because of the stipulations requested by Debtors, the Department filed its supplemental objection on September 11, 2019. ECF No. 3043.

On March 29, 2019, the Department filed its Proof of the Claim for its claim against debtor St. Vincent Medical Center, Inc., Seton Medical Center, and St. Francis Medical Center. Proofs of Claim Nos. 62-1, 66-1, and 134-1. On September 6, 2019, the Department filed its amended Proof of Claim for St. Francis Medical Center. Proof of Claim No. 134-2.

On September 3, 2019, Debtors filed their proposed Chapter 11 Plan of Liquidation and proposed Disclosure Statement. ECF Nos. 2993 & 2994. Debtors filed their Motion on September 4, 2019. ECF No. 2995. All three documents are silent as to Debtors' HQA Fee and Medi-Cal overpayment liabilities and the Department's recovery thereof.

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 (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 – 1396c, 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 – 14499.77 (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 – 14087.48 (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 sixty 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).

[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).

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**

See Declaration of Hanh Vo (Vo Decl.), ¶ 11 – 14, ECF No. 3043-1.

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**

See Vo Decl. ¶ 11 – 14, ECF No. 3043-1.

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**

See Vo Decl. ¶ 11 – 14, ECF No. 3043-1.

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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 Medical Center was overpaid **$24,254,503.36** by Medi-Cal for hospital operations. *See* Vo Decl. ¶ 15, ECF No. 3043-1. For St. Francis Medical Center, 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. *See* Vo Decl. ¶ 16, ECF No. 3043-1.

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, ECF No. 3043-2.

ARGUMENT

I. THE MOTION, DISCLOSURE STATEMENT, AND PLAN FAIL TO DISCLOSE AND ADDRESS THE DEPARTMENT'S RIGHT TO RECOVER THE HQA FEE DEBT, WHICH MAY AFFECT OTHER CREDITORS

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 . . . ." See Vo Decl. Exs. 1 & 2, at 1, ECF No. 3043-1. 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 case law and California statute, the Department can recover the unpaid HQA Fees from Medi-Cal payments intended for Debtors and the Buyer through successor joint and several liability. *In re Gardens Regional Hospital and Medical Center, Inc.*, 569 B.R. at 796-797. Accordingly, the Department has recouped the HQA Fee debt by offsetting any HQA Fee liabilities incurred by Debtors against any Medi-Cal payments intended for them.

Further, Debtors' 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 successor joint and severally liability. *See* Department's Supplemental Objection, ECF No. 3043; Supporting Declarations, ECF Nos. 3043-1 and 3043-2.

To the extent that the Department's recovery of the HQA Fee debt affects recovery by other creditors, the Motion, proposed Disclosure Statement, and Plan must be revised or amended accordingly.

II. THE PROPOSED STATEMENT AND PLAN FAIL TO ADDRESS THE DEPARTMENT'S RIGHT TO RECOVER DEBTORS' MEDI-CAL OVERPAYMENTS

As noted above, 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 sixty days after issuance of the first Statement of Accountability or demand for repayment. Cal. Code Regs. title 22, § 51047 (2019).

The Department has determined, for July 1, 2016, through June 30, 2017, based on retroactive claim adjustments, that St. Francis Medical Center was overpaid **$24,254,503.36** by Medi-Cal for hospital operations. See Vo Decl. ¶ 15, ECF No. 3043-1. This debt is in addition to any potential Medi-Cal overpayments that are yet to be determined for St. Francis Medical Center, Seton Medical Center, and St. Vincent Medical Center. *See* Supplemental Objection, ECF No. 3043.

The Department has recouped the Medi-Cal overpayments by withholding Medi-Cal payments to Debtors. In addition, the Department has requested that Debtors establish and maintain a trust account in the amount of $70 million for thirty-six 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 under successor joint and several liability under the Medi-Cal Provider Agreement. *See* Supplemental Objection, ECF No. 3043.

The withholding of Medi-Cal payments as recoupment and the allocation of $70 million to be maintained in a trust account may affect the recovery of other creditors and should be fully disclosed in the Motion and Plan. To the extent that the Department's recovery of the Medi-Cal overpayments affects the recovery of

other creditors, the Motion, proposed Disclosure Statement, and Plan should be revised or amended accordingly.

CONCLUSION

For the foregoing reasons, the Motion, Proposed Statement, and Plan should be rejected by the Court unless Debtor's HQA Fee and Medi-Cal overpayment liabilities are fully disclosed and addressed therein. Otherwise, the Proposed Statement and Plan may provide inaccurate and misleading information to other creditors.

Dated: September 18, 2019

Respectfully submitted,

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/s/ Kenneth K. Wang
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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 (1) DEBTORS' MOTION FOR AN ORDER APPROVING THE PROPOSED DISCLOSURE STATEMENT; (2) PROPOSED DISCLOSURE STATEMENT, AND (3) PROPOSED CHAPTER 11 PLAN OF LIQUIDATION

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 18, 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 **September 18, 2019**, I served the following persons and/or entities at the last known addresses in this bankruptcy case or adversary proceeding by placing a true and correct copy thereof in a sealed envelope in the United States mail, first class, postage prepaid, and addressed as follows.

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3. SERVED BY OVERNIGHT MAIL AND ELECTRONIC MAIL: Pursuant to F.R.Civ.P. 5 and/or controlling LBR, on **September 18, 2019**, I served the following persons and/or entities by overnight mail and electronic mail as follows.

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4. SERVED BY PERSONAL DELIVERY: Pursuant to F.R.Civ.P. 5 and/or controlling LBR, on **September 18, 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

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

September 18, 2019	Stacy McKellar	
Date	*Printed Name*	*Signature*