

**Department of Health Care Services  
Hospital Quality Assurance Fee Program**

**FINANCIAL RESPONSIBILITY FOR KNOWN AND UNKNOWN OUTSTANDING  
MONETARY OBLIGATIONS TO THE MEDI-CAL PROGRAM**

This Financial Responsibility for Known and Unknown Outstanding Monetary Obligations to the Medi-Cal Program (the **Agreement**) is entered into by and between the Department of Health Care Services (**DHCS**) and [Buyer's Name:]\_\_\_\_\_ (the **New Owner**), and, together with DHCS, known as the **Parties**, effective as of and contingent upon the Change of Ownership (as defined in Section 2 below) of [Hospital name:]\_\_\_\_\_, located at [Physical Address of Hospital:]\_\_\_\_\_ (the **Hospital**).

**WHEREAS**, New Owner may have notified DHCS of the anticipated change in ownership of the Hospital and requested a listing of outstanding monetary obligations, or chose to assume all known and unknown outstanding monetary obligations owed to Medi-Cal by the previous owner of the Hospital without a listing of this information.

**WHEREAS**, New Owner, in compliance with Section 14169.61(d) of California's Welfare and Institutions Code, intends to enter the Hospital into and participate in the Hospital Quality Assurance Fee Program (**HQAF Program**) codified in Article 5.230 (commencing with Section 14169.50) of the Welfare and Institutions Code.

**NOW THEREFORE**, in consideration of the promises made herein, the Parties hereby agree as follows:

- 1) Financial Responsibility for Outstanding Monetary Obligations to Medi-Cal. The New Owner hereby agrees to pay all outstanding monetary obligations of the Hospital and any of its subsidiaries to DHCS in connection with Medi-Cal as defined in Section 14169.61(d)(2) of the Welfare and Institutions Code including but not limited to:
  - a) The previous owner's unpaid HQAF fees and interest established by Article 5.230 (commencing with Section 14169.50 of California's Welfare and Institutions Code);
  - b) Known overpayments that have been asserted by DHCS or its fiscal intermediary by sending a written communication that is received by the Hospital prior to the date that the New Owner becomes the licensee of the Hospital; and,
  - c) Overpayments that are asserted by DHCS or its fiscal intermediary after the date that the New Operator becomes the licensee of the Hospital and

arise from customary reconciliations of payments,<sup>1</sup> including but not limited to cost report settlements, and, except for the overpayments described in subparagraph b) above, shall exclude liabilities arising from the fraudulent or intentionally criminal act of a prior operator if the New Owner did not knowingly participate in or continue the fraudulent or criminal act after becoming the licensee.

- d) Nothing in this Agreement shall be construed to limit or otherwise impact the rights or remedies the New Owner may have against the predecessor owner.
- 2) Change of Ownership. The New Owner became the licensee of the Hospital effective [DATE:]\_\_\_\_\_. The Hospital became certified to participate in Medi-Cal under the new ownership effective [DATE:]\_\_\_\_\_. *Please attach a copy of the hospital license and a copy of the letter from the State granting Medi-Cal Certification to substantiate the dates above.*
- 3) Terms of Payment.
- a) Timing of Payments. The schedule for length and amount of repayments will be at DHCS' discretion.
  - b) Payment Instructions. Each payment by New Owner to DHCS pursuant to this Agreement shall be paid by check made payable to "California Department of Health Care Services" and mailed on or before the due date by first class United States mail, postage prepaid, to the following address: Department of Health Care Services, Safety Net Financing Division, Attn: Hospital Quality Assurance Fee Program, 1501 Capitol Avenue, P.O. Box 997436 MS 4504, Sacramento, California 95899.
  - c) Offset Against Amounts Due. Per Section 14177 of California's Welfare and Institutions Code, DHCS may recover payment not timely made by offsetting such amount against any amount currently due to Hospital or New Owner under the provisions of Chapters 7 or 8 of Division 9, Part 3 of the Welfare and Institutions Code.
- 4) Entire Agreement. This Agreement contains the entire understanding of the Parties hereto with respect to the subject matter contained herein. This Agreement supersedes all prior representations, agreements and understandings, whether oral or written, between the Parties with respect to such subject matter. DHCS Form 9098 is incorporated by reference into this Agreement. If there is a conflict between a requirement in DHCS Form 9098 and this Agreement, then the requirement in DHCS Form 9098 shall control to the extent there is a conflict.

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<sup>1</sup> Customary reconciliation of payments includes Disproportionate Share Hospital payments authorized in Section 14166.11 of California's Welfare and Institutions Code.

- 5) Amendment. This Agreement may not be modified, amended, altered or supplemented except by a written agreement executed by both of the Parties hereto.
- 6) Waiver. Waiver by either party of any breach or failure to comply with any provision of this Agreement by the other party shall not be construed as, or constitute, a continuing waiver of such provision, or a waiver of any other breach of, or failure to comply with, any other provision of this Agreement. No waiver of any such breach or failure of any term or condition of this Agreement shall be effective unless in a written notice signed by the waiving party and delivered, in the manner required for notices generally, to the other party.
- 7) Implementation. Each party to this Agreement agrees to execute and deliver such other documents and instruments and to take such further actions as may be reasonably necessary to carry out fully the intent and purposes of this Agreement.
- 8) Authority. Each individual executing this Agreement on behalf of a party to this Agreement represents and warrants that he or she has authority to execute this Agreement on behalf of such party.
- 9) Governing Law. This Agreement will be governed by and in all respects construed in accordance with the laws of the State of California, or to the extent applicable, federal bankruptcy law. Venue shall be only in counties where the California Attorney General maintains an office.
- 10) Notices. Any notice or other communication required or permitted under this Agreement shall be in writing and shall be deemed effectively given when personally delivered, when received by facsimile, or overnight courier, or five (5) calendar days after being deposited in the United States mail, with postage prepaid thereon, certified or registered mail, return receipt requested, addressed as follows:

DHCS: Department of Health Care Services  
Safety Net Financing Division  
Attn: Hospital Quality Assurance Fee Program  
1501 Capitol Avenue  
P.O. Box 997436, MS 4504  
Sacramento, California 95899

New Owner:

[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
Telephone: [REDACTED]  
Facsimile: [REDACTED]  
E-mail: [REDACTED]

Or such other address as either party may designate by notice hereunder to the other party.

- 11) Successors. This Agreement shall be binding upon and shall inure to the benefit of the Parties hereto and their respective legal representatives, successors and assigns.
- 12) Relationship to HQAF Program. This Agreement shall remain in force until all outstanding Hospital debt specified in Paragraph 1 of this agreement is paid in full regardless of the status of the HQAF Program or the expiration of any HQAF Program Period.
- 13) Headings. The headings of sections and subsections of this Agreement are for convenience of reference only and shall not affect in any way the meaning or interpretation of this Agreement.
- 14) Counterparts; Facsimile Signatures. This Agreement may be signed in any number of counterparts, and such counterparts may include signatures transmitted by facsimile or electronic scan.

[SIGNATURES ON FOLLOWING PAGE]

**IN WITNESS WHEREOF**, the Parties have executed this Agreement on the date set forth below.

**Department of Health Care Services**

Dated: \_\_\_\_\_

By HQAF Program/SNFD/DHCS

Name:

Title:

**AGREED:**

Dated: \_\_\_\_\_

**New Owner**

Signature: \_\_\_\_\_

Name: \_\_\_\_\_

Title: \_\_\_\_\_