DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Roberts/Day/FOIA	12-22-14

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000149	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR cc: Brooks, Mullis Cleared 1/5/15, letter attached.	[ ] Prepare reply for appropriate signature DATE DUE _____ [X] FOIA DATE DUE 1-5-15 [ ] Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
2.			
3.			
4.			

CHRISTIAN & DAVIS LLC

ATTORNEYS AT LAW

December 16, 2014

Brandy Putnam
SC Department of Health and Human Services
Post Office Box 8206
Columbia, SC 29202

RE: Glorified Health and Rehab
8 North Texas Avenue
Greenville, SC 29611
Our File No.: 13-760-MC, Mason

Ms. Putnam:

I am writing pursuant to the Freedom of Information Act to request all documents regarding ownership, control interests, and related entities, including but not limited to, Form 1513 for 2011-2013.

If this cost is going to exceed $100.00, please notify me of same prior to providing me with the information. I would greatly appreciate it if you would provide this information to me within the next 20 days. I look forward to hearing from you.

With kindest regards, I am

Very truly yours,

CHRISTIAN & DAVIS, LLC

Matthew W. Christian
Attorney at Law

MC/jah

P.O. Box 332 Greenville, SC 29602
1007 E. Washington St. Greenville, SC 29601
Phone (864)232-7363 Fax (864)370-3731 www.christiandavislaw.com

SOUTH CAROLINA
Healthy Connections
MEDICAID

Nikki Haley GOVERNOR
Christian L. Soura INTERIM DIRECTOR
P.O. Box 8206 · Columbia, SC 29202
www.scdhhs.gov

TO:

FROM:

SUBJECT: Cost of Processing FOIA Request #

The South Carolina Department of Health and Human Services has received and processed your FOIA request. The cost for processing this information is as follows:

Staff processing time at $10.00 per hour	_____ Hours	$_____
Pages copied at $.10 per page	_____ Pages	$_____
Pages faxed at $.20 per page	_____ Pages	$_____
Shipping and Handling Costs		$_____
Other costs associated with the FOIA request: _____		$_____
Total Amount Due SCDHHS:		$_____

Please remit the above amount to the following address:

Bureau of Fiscal Affairs
South Carolina Department of Health and Human Services
Post Office Box 8297
Columbia, South Carolina 29202-8297

Please contact _____ should you have any questions.

_____ _____
Signature Date:

Log #149

Healthy Connections MEDICAID

Nikki Haley
Christian L. Soura
P.O. Box 8206 Columbia, SC 29202
www.scdhhs.gov

January 5, 2015

VIA EMAIL ONLY: jhutchins@christianandddavis.com

Mr. Matthew W. Christian, Attorney at Law
Christian & Davis, LLC
1007 E. Washington Street
Greenville, South Carolina 29601

Dear Mr. Christian:

This is in response to your request for information from the South Carolina Department of Health and Human Services (DHHS) pursuant to the South Carolina Freedom of Information Act (FOIA) dated December 16, 2014 and received by DHHS on December 12, 2014. Enclosed are copies of all documents regarding ownership, control interests and related entities in reference to Glorified Health and Rehab.

Thank you for your request. If you have any questions, please feel free to contact me at (803)898-0062.

Sincerely,

Constance Holloway
Attorney II
General Counsel

Enclosures

DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT
PART 2

General Instructions

Federal Medicaid regulations (42 CFR 455.100 – .106) require that all Medicaid providers disclose the name, address, and other identifying information for each person with an ownership or control interest in the provider and any subcontractor in which the provider has a 5% or more interest. All applicants, except an individual practitioner or group of practitioners as defined in 42 CFR 455.101, must complete this form in order to enroll as a provider in the Medicaid program. The provider must also screen all employees and subcontractors to determine whether they have been excluded from participation in Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP) and/or all federal health care programs. Any individual or entity that employs or contracts with an excluded provider cannot claim reimbursement from Medicaid for any items or services furnished, authorized, or prescribed by the excluded provider.

Please answer all questions as of the **current date**. If the **"Yes"** block for an item is checked, list the requested additional information in the area provided; attach additional pages and/or documentation as needed, referencing the item number to which the information corresponds. Return the original to the South Carolina Department of Health and Human Services (SCDHHS); retain a copy for your files. Failure to provide this form and/or incomplete information will result in a refusal by SCDHHS to enter into an agreement or contract with any such provider or institution or in termination of existing agreements.

This form is to be completed for all programs established by Title XIX and Title XXI and **must be submitted within 35 days of any changes to provider information.** Completion and submission of this form is a condition of approval or renewal of a contract or agreement between the disclosing entity and SCDHHS. Any substantial delay in completing the form should be reported to SCDHHS.

Disclosure of Social Security Number (SSN): Disclosure of a SSN is used for the purpose of determining whether persons and entities named in an application are federally excluded parties and to verify licensure. **Refusal to provide a SSN will result in rejection of the provider's application to participate in the Medicaid program or termination of any existing provider agreement or contract.**

I. Instructions / Definitions: Providers that must have a National Provider Identifier (NPI) must include the NPI. If currently enrolled in South Carolina Medicaid with multiple NPI numbers, a separate Disclosure of Ownership and Control Interest Statement (SCDHHS Form 1514) must be completed for each NPI number.

I. Identifying Information

[a] Name of Provider (Disclosing Entity): New Glorified Health & Rehab of Greenville, LLC Doing Business As (trade or company name): Glorified Health & Rehab of Greenville			
Street Address 8 North Texas Ave.		City, State, Zip + 4 Greenville, SC 29611-5034	
County Greenville	Provider Number(If Known)	NPI 1144659897	Telephone Number 864-295-1331
[b] Federal Employer Identification Number (FEIN): 46-4020713			

[c] Type of Entity (Applies to either For Profit or Non-Profit)

- [X] Limited Liability Corporation (LLC)
- [ ] Partnership
- [ ] Corporation
- [ ] Business Proprietorship or Company
- [ ] Sole Proprietor
- [ ] Governmental Unit
- [ ] Other (Please specify)_____

II. Instructions / Definitions:

Providers must disclose ownership and control information as required by 42 CFR 455.101 - 104.
Ownership interest is defined as the possession of equity in the capital, the stock or the profits of the disclosing entity. ***A disclosing entity*** is a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent.

Indirect ownership interest means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity. The amount of indirect ownership in the disclosing entity that is held by any other entity is determined by multiplying the percentage of ownership interest at each level. An indirect ownership interest must be reported if it equates to an ownership interest of 5 percent or more in the disclosing entity. Example: If A owns 10 percent of the stock in a corporation that owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership and must be reported.

Control interest is defined as the direction or management of a disclosing entity which may be maintained by any or all of the following devices: the ability or authority, expressed or reserved, to amend or change the corporate identity (i.e. joint venture agreement, unincorporated business status) of the disclosing entity; the ability or authority to nominate or name members of the Board of Directors or Trustees of the disclosing entity; the ability or authority, expressed or reserved, to amend or change the by-laws, constitution, or other operating or management direction of the disclosing entity; the right to control any or all of the assets or other property of the disclosing entity upon the sale or dissolution of that entity; the ability or authority, expressed or reserved, to control the sale of any or all of the indebtedness, to dissolve the entity, or to arrange for the sale or transfer of the disclosing entity to new ownership or control.

Therefore, ***a person with an ownership or control interest*** is a ***person*** or ***corporation*** that –

(a) Has an ownership interest totaling 5 percent or more in a disclosing entity;
(b) Has an indirect ownership interest totaling 5 percent or more in a disclosing entity;
(c) Has a combination of direct and indirect ownership interest equal to 5 percent or more in a disclosing entity;
(d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;
(e) Is an officer or director of a disclosing entity that is organized as a corporation; or
(f) Is a partner in a disclosing entity that is organized as a partnership.

Subcontractor means (a) an individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or, (b) an individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

II. Individuals and Organizations with Ownership or Control Interest

[a] List names, addresses, date of birth and SSN for individuals, or list names, addresses and the FEIN for organizations, having direct or indirect ownership or control interest, **as defined on pg. 2,** in the entity listed in Section I. Attach additional pages, if needed, for any additional names and addresses. **If Sole Proprietor or Business Proprietorship or company is checked in Section I, skip this section.**

Name	Address	Date of Birth (If Individual)	SSN (If Individual)	FEIN
See attached Exhibit A				

[b] Are any persons / entities with ownership or control interest in the provider also owners of other Medicare / Medicaid providers? If yes, list name of the owner from Section II [a] and the name and NPI and/or FEIN for each facility or SSN if an individual provider.

☒ Yes ☐ No

Name of Owner from Section II [a]	Name of Other Provider or Entity	NPI/SSN	FEIN
See attached list			

III. Subcontractors

[a] Please list any subcontractors of the disclosing entity (provider), **as defined on pg. 2,** in which the disclosing entity has a direct or indirect ownership of 5% or more.

☒ Not Applicable

Name of Subcontractor	Address	Date of Birth (If Individual)	SSN (If Individual)	FEIN

[b] List the following information for individuals or organizations having direct or indirect ownership or a control interest, **as defined on pg. 2,** in any subcontractor in which the disclosing entity (provider) has a direct or indirect ownership of 5% or more. Attach additional pages, if needed, for additional names.

Name	Address	Date of Birth (If Individual)	SSN (If Individual)	FEIN

IV. Relationships

Are any of the individuals identified in Sections I, II or III related to each other? ☐ Yes ☒ No

If yes, list the individuals identified and the relationship to each other (spouse, sibling, parent, child, etc).

Name of Person 1	Name of Person 2	Relationship

V. Managing Employees

[a] List current managing employees as indicated below. "Managing employee" means general manager, office or business manager, administrator, director, or other individual who exercises operational or managerial control over the institution, agency, or organization, or who directly or indirectly conducts the day-to-day operations. Attach additional pages, if needed, for additional names.

Name/Title	Address	SS	Date of Birth
Dena Johnson Administrator	8 North Texas Ave. Greenville, SC 29611-5034	[redacted]	2/20/1983

[b] Has there been a change in Administrator, Director of Nursing, or Medical Director within the last year?
☒ Yes ☐ No
If Yes, give date for change: Date / / . List names, titles, and SSN of the prior Administrator, Director of Nursing, or Medical Director.

Name	Title	SSN
Vickie Gallaher - 9/11/13	Director of Nursing	
Heather Burton - 5/12/14	Administrator	
Dr Jayesh Sheth	Medical Director	

VI. Management Company

A management company is defined as any organization that operates and manages a business on behalf of the owner of that business, with the owner retaining ultimate legal responsibility for operation of the facility. If the answer is yes, list the name of the management firm as well as the managing employees of the firm (i.e., CEO, CFO, etc). Attach additional pages, if needed, for additional names.

Is the provider/entity/facility operated by a management company?
☐ Yes ☒ No
If Yes, what is the term of the agreement?
Beginning Date / / to Ending Date / /

Name of Management Co.	Address	FEIN

Name(s) of Managing Employee(s)	SSN	Date of Birth

VII. Instructions / Definitions: Criminal Offenses related to the delivery of services or items under Medicare or Medicaid programs include convictions relating to patient neglect or abuse in connection with the delivery of a health care item or service; felony and/or misdemeanor convictions related to health care fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct; and felony and/or misdemeanor convictions related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

VII. Criminal Offenses

If any of the questions are answered "Yes", list names, addresses, and SSNs for individuals and names, addresses, and FEINs for organizations, or attach documentation or additional pages if needed.

[a] As listed in **Sections II or III**, have any individuals and organizations with a direct or indirect ownership of 5% or more in the disclosing entity (provider), or any subcontractor(s) in which the provider has a direct or indirect ownership of 5% or more, been convicted of a criminal offense related to the involvement of such persons or organizations in any of the programs established by Titles XVIII, XIX, or XXI (Medicare, Medicaid, or SCHIP)?

☐ Yes ☒ No

[b] As listed in **Sections V or VI**, have any directors, officers, agents, or managing employees of the disclosing entity (provider) ever been convicted of a criminal offense related to their involvement in such program established by Titles XVIII, XIX, or XXI (Medicare, Medicaid, or SCHIP)? ☐ Yes ☒ No

Name	Address	SSN/FEIN

VIII. Instructions / Definitions: Sanctions and other adverse actions include any revocation or suspension of a license to provide health care by any State licensing authority; any revocation or suspension of accreditation; and/or any suspension or exclusion from participation in, or any sanction imposed by, a Federal or State health care program, or any debarment from participation in any Federal Executive Branch procurement or non-procurement program.

VIII. Sanctions and Other Adverse Actions

Has your organization, under any current or former name or business identity, or any individuals and organizations listed in **Sections II, III, V, or VI,** ever had a final adverse action imposed against it? If yes, report the individual(s) or organization(s) involved, each final adverse action, when it occurred, and the Federal or State agency or the court/administrative body that imposed the action. ☐ Yes ☒ No

Individual/Organization	Adverse Action	Date	Taken by

IX. Instructions/ Definitions: Changes in provider status are defined as any change in management control. Examples of such changes would include: a change in Medical or Nursing Director, a new Administrator, contracting the operation of the facility to a management corporation, a change in the composition of the ownership, including changes in any partnership arrangement, or any changes of ownership.

IX. Changes in Provider Status

If there has been a change in ownership /partnership within the last year or if you anticipate a change, indicate the date in the appropriate space. If there are no owners (i.e., the provider is a sole proprietorship), check Not Applicable.

[a] Has there been a change in ownership or controlling interest within the last year? If Yes, give date.
☒ Yes - Date: 11/27/2013 ☐ No ☐ Not Applicable

X. Instructions / Definitions: A chain affiliate is any free-standing health care facility that is owned, controlled, or operated under lease or contract by an organization consisting of two or more free-standing health care facilities organized within or across State lines which is under the ownership or through any other devices, control and direction of a private, charitable or propriety. They also include subsidiary organizations and holding corporations. Provider-based facilities, such as hospital-based home health agencies, are not considered to be chain affiliates.

X. Chain Affiliation

[a]. Is this facility chain-affiliated? If Yes, list name, address and FEIN of parent Corporation below.
☒ Yes ☐ No

Name	Address	FEIN
Covenant Dove, LLC	2723 Summer Oaks Dr. Bartlett, TN 38134	208875160

[b]. If the answer to part [a] of this item was "No", was the facility ever affiliated with a chain? If Yes, list name, address and FEIN of parent Corporation.
☐ Yes ☐ No

Name	Address	FEIN

Section II.a Individuals and Organizations with Ownership or Control Interest

Effective November 27, 2013
Exhibit A

New Ark SC Operator Holdings, Inc. 4 West Red Oak Lane, Suite 1, White Plains, NY 10604	90-1020383
4 West Holdings, LLC 4 West Red Oak Lane, Suite 1, White Plains, NY 10604	46-3599732
4 West Investors, LLC 4 West Red Oak Lane, Suite 1, White Plains, NY 10604	46-3666021
JS New Ark TR 5472 Ascot Bend, Boca Raton, FL 33496-1605	46-7036195
DES New Ark TR 5472 Ascot Bend, Boca Raton, FL 33496-1605	46-7032163
HS New Ark TR 5472 Ascot Bend, Boca Raton, FL 33496-1605	46-7033389

Licensed Provider's Officers, each at the following address, are listed below:
2723 Summer Oaks Drive, Bartlett, TN 38134-2858

Charles M. Bagley		10/21/1956
Christopher J Murphy		04/15/1965

Section II[b] Are any persons/entities with ownership interest in the provider also owners of other Medicare/Medicaid providers? If yes, list name of the owner from Section II[a] and the name and NPI and/or FEIN for each facility or SSN if an individual provider.

All owners listed at Section II[a] have an ownership interest in the providers listed below:

Legal Name	EIN
New Capstone Health & Rehab of Easley, LLC	46-3957871
New Diamond Health & Rehab of Simpsonville, LLC	46-4043564
New Trinity Mission Health & Rehab of Edgefield, LLC	46-3951456
New Exalted Health & Rehab of Iva, LLC	46-3970384
New Fellowship Health & Rehab of Anderson, LLC	46-3990525
New Glorified Health & Rehab of Greenville, LLC	46-4020713
New Harvest Health & Rehab of Johns Island, LLC	46-3924898
New Hope Health & Rehab of Marietta, LLC	46-3979788
New Hosanna Health & Rehab of Piedmont, LLC	46-4011141
New Majesty Health & Rehab of Easley, LLC	46-4059615
New Petra Health & Rehab of McCormick, LLC	46-4033193
New Redeemer Health & Rehab of Pickens, LLC	46-4005321

4 West Holding, LLC, 4 West Investors, JS New Ark TR, HS New Ark TR, and DES New Ark TR have an ownership interest in these additional Medicare/Medicaid providers:

Legal Name	EIN
Alpha Health & Rehab of Greer, LLC	38-3789462
Dayspring Health & Rehab of Simpsonville, LLC	38-3789457
Faith Health & Rehab of Aiken, LLC	38-3789448
Manna Health & Rehab of Pickens, LLC	38-3789441
Covenant Dove Healthcare of Orangeburg, LLC	47-1033951
Covenant Dove Healthcare of Greenville, LLC	47-1023920
Covenant Dove Healthcare of Macon, LLC	47-1019644

Certification Statement

You MUST sign and date the certification statement below in order to be enrolled in the Medicaid program. In doing so, you are attesting to meeting and maintaining the Medicaid requirements stated below.

I, the undersigned, certify to the following:

1. I have read the contents of this form, and the information contained herein is true, correct, and complete. If I become aware that any information listed on this form is not true, correct, or complete, I agree to notify Medicaid of this fact within thirty-five (35) days of discovery.

2. I authorize Medicaid to verify the information contained herein. I agree to notify Medicaid of a change in ownership, practice location and/or Final Adverse Action within 35 days of the reportable event. In addition, I agree to notify Medicaid of any other changes to the information on this form within 35 days of the effective date of change. I understand that any change in business structure of this provider may require the submission of a new application.

3. I understand that any deliberate omission, misrepresentation, or falsification of any information contained on this form or contained in any communication supplying information to Medicaid, or any deliberate alteration of any text on this form, may be punished by criminal, civil, or administrative penalties including, but not limited to, the denial or revocation of Medicaid billing privileges, and/or the imposition of fines, civil damages, and/or imprisonment.

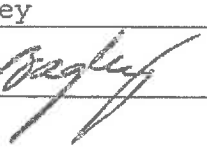
4. I agree to abide by the Medicaid laws, regulations and program instructions that apply to me or to the organization. The Medicaid laws, regulations, and program instructions are available through SCDHHS. I understand that payment of a claim by Medicaid is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions, and on the provider's compliance with all applicable conditions of participation in Medicaid.

5. Neither I, nor any managing employee listed on this form, is currently sanctioned, suspended, debarred, or excluded by the Medicare or State Health Care Program, e.g., Medicaid program, or any other Federal program, or is otherwise prohibited from providing services to Medicaid or other Federal program beneficiaries.

6. I agree that any existing or future overpayment made to me or to the organization(s) listed on this form, by the Medicaid program, may be recouped by Medicaid through the withholding of future payments.

7. I understand that the Medicaid identification number issued to me can only be used by me or by a provider to whom I have reassigned my benefits under current Medicaid regulations, when billing for services rendered by me.

8. I will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicaid, and will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity.

Name of Authorized Representative (Printed or Typed):	Title:
Charles M. Bagley	EVP, Secretary & Treasurer
Signature: 	Date: 9/23/14