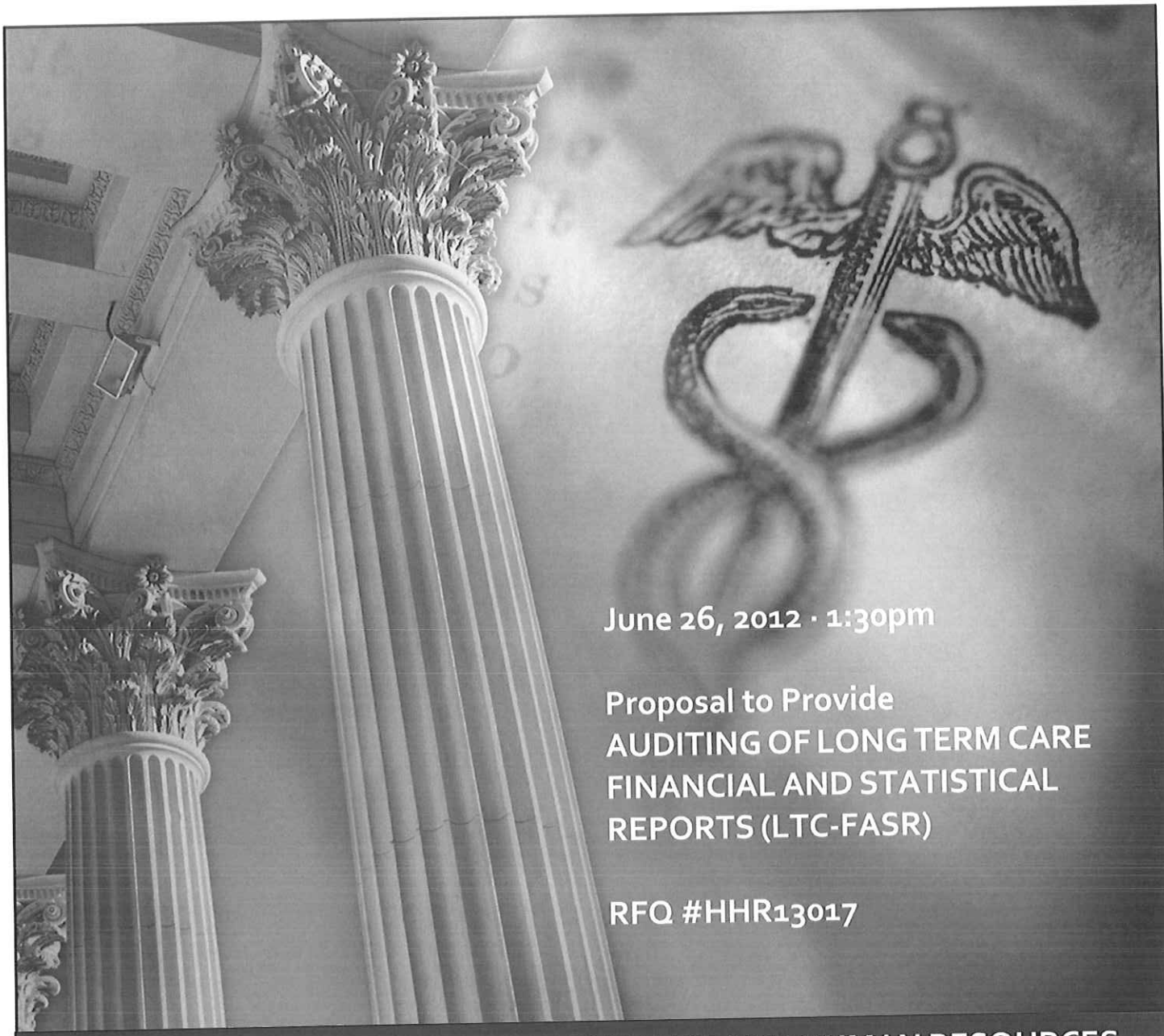

June 26, 2012 · 1:30pm

Proposal to Provide AUDITING OF LONG TERM CARE FINANCIAL AND STATISTICAL REPORTS (LTC-FASR)

RFQ #HHR13017

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Prepared by –

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Certified Public Accountants and Consultants

TRANSMITTAL LETTER

June 26, 2012

Ms. Roberta Wagner
Department of Administration
Purchasing Division
Building 15
2019 Washington Street, East
Charleston, West Virginia 25305

Re: Proposal in Response to RFQ #HHR13017: Auditing of Long Term Care Financial and Statistical Reports (LTC-FASR)

Dear Ms. Wagner:

The current economic climate is forcing every state to contemplate budget cuts to their Medicaid programs while simultaneously addressing the pressures associated with an increasing number of recipients. In addition, the Centers for Medicare & Medicaid Services (CMS) is escalating its oversight of state Medicaid agencies and is holding each agency increasingly accountable for the funds supplied by the Federal Government.

States that are proactive in ensuring the fiscal integrity of their Medicaid programs will be better prepared when their programs are audited by the Federal Government. In fact, CMS, the Office of Inspector General (OIG), and the Government Accountability Office (GAO) have made no secret that they are coming to visit states, that they are targeting specific areas of exposure, and that they will be resolute in their efforts to hold states accountable. States have been duly informed that cost-based provider reimbursements must be based on "audited" records (42 CFR 447.202) and that states will be held accountable for payments which exceed provider-specific limits, as defined through various rules, regulations and state plan language.

The West Virginia Department of Health and Human Resources' (DHHR) Office of Accountability and Management Reporting (OAMR) seeks a team with the necessary audit and program expertise to help them navigate the changing Medicaid landscape and to assist in the protection of taxpayer dollars. PHBV Partners LLP (PHBV) (formerly Clifton Gunderson LLP) is that team and we are very pleased to present this proposal in response to *Request for Quotation (RFQ) #HHR13017*. We are confident that PHBV can successfully accomplish your service objectives and add value to OAMR's operations in the process.

When you retain PHBV for Medicaid audit services, you not only retain a firm that has vast experience with projects of this size and scope, you also retain a firm with direct experience in dealing with providers. As a result of our experience, there will be little learning curve, and we will be ready to start on day one. PHBV's experience and skill sets are invaluable and cannot be duplicated by any other firm. We seek long-term relationships that add value to our clients and we will exceed your expectations under this procurement. Your success is our top priority.

We have structured our bid per the instructions in the RFQ. In addition, we make no exceptions to the Terms and Conditions included in the RFQ.

We look forward to working with OAMR to assure the integrity, equity, and fiscal efficiency of your Medicaid program. If you require additional information or would like an oral presentation of our capabilities, please contact us at 804-270-2200 or Chuck.Smith@phbvpartners.com.

Very truly yours,
PHBV PARTNERS LLP

Charles T. Smith, III, CPA
Partner

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EXECUTIVE SUMMARY

UNDERSTANDING OF THE PROJECT REQUIREMENTS

The State of West Virginia Department of Health and Human Services, Office of Accountability and Management Reporting (OAMR) is seeking a qualified Certified Public Accounting Firm to provide examination engagements of Long Term Care Financial and Statistical Reports (LTC-FASR). An examination will ensure that the costs reported by the providers are accurate, allowable, and in accordance with West Virginia Medicaid Manuals and all other applicable laws, rules and regulations.

OAMR needs an ethical contractor whose professional staff are educated and trained in governmental accounting and auditing standards as well as the specific laws, regulations and rules concerning West Virginia Medicaid reimbursement. As OAMR works to meet its goals, you will require the service of a uniquely insightful and well-rounded team. One with:

- Knowledge of West Virginia regulations and provider operations to ensure the accurate reimbursement of costs and the prompt recovery of provider overpayments
- Depth of local and national health care resources and insight, including a firm-wide focus on serving Medicaid entities
- New and innovative approaches to changes in technology, reimbursement methodologies and budgetary environments
- Open lines of communication with OAMR and the provider community
- Leaders that stay on the forefront of issues that may affect OAMR, presenting economical solutions in anticipation of any needs
- Strict adherence to the rules governing the handling and security of Protected Health Information
- Experience in the identification fraudulent activities and report them to proper authorities
- Low staff turnover and a commitment to engagement team continuity

PHBV is that team.

OUR HISTORY SERVING MEDICAID AGENCIES

PHBV Partners has served health care regulatory and enforcement agencies and worked with Medicare and Medicaid agencies for more than 40 years. Our experience in providing health care assurance and consulting services to state Medicaid programs, Medicare, and the Department of Justice (DOJ) is unrivaled. We, as a firm, have performed full and limited scope audits (Medicaid compliance audits), claim reviews, cost settlements, and rate setting for just about every provider type in numerous states. We have represented Medicaid and Medicare in various levels of appeals throughout the country, and we have assisted the DOJ and state Medicaid Fraud Control Units in both civil and criminal actions related to health care fraud. Additionally, we have provided health care consulting services to multiple state and federal clients.

Performing cost settlement and audits for Medicaid agencies and Medicare intermediaries is a primary service from which our health care practice has grown into national prominence. We offer a full menu of services designed to help our State and Federal clients succeed with every part of their operations. This menu includes:

- Reimbursement methodology design and implementation
- Establishment of provider reimbursement rates
- Financial and performance audits of Medicare and Medicaid Managed Care Organizations (MCOs)
- Medicaid policy consulting
- Detection of fraud, waste, abuse and improper payments through claim/billing reviews
- Representation of states before CMS, DOJ, and OIG
- Medicaid performance audits and consulting engagements
- Assistance with CMS and OIG audit findings
- Medicaid Management Information System (MMIS) audits
- Disproportionate Share Hospital (DSH) audits
- Appeal representation and expert witness testimony
- Eligibility Payment Error Rate Measurement (PERM) activities
- CMS 64 – Quarterly Expense Report reviews
- Medicaid funding consulting including provider assessment plans
- State Plan Amendment assistance
- State Auditor assistance
- Medicaid Agency operations consulting

AN IDEAL FIT: WHY PHBV PARTNERS IS BEST SUITED TO SERVE OAMR

PHBV possesses the full spectrum of qualities needed to best help OAMR meet its goals at a very competitive rate. Our greatest strengths correspond to your most critical needs.

- **Specialized Health Care Insight and Resources.** As one of the nation's largest certified public accounting and consulting firms specializing in regulatory health care compliance, PHBV has the experience and resources to most effectively identify opportunities and areas to be strengthened. We can provide OAMR with immediate access to one of the country's largest and most knowledgeable health care teams.
- **Unparalleled Communication and Proactive Leadership.** OAMR will benefit from a high level of hands-on service from our team's senior professionals. Our senior level professionals are involved and immediately available

Why Choose PHBV Partners?

We have a proven track record in performing compliance audits for governmental agencies. In addition, we have a track record of more than 25 years providing audit services to State Health Agencies including DHHR. We have continuously met our clients' goals and objectives and will approach your audits with the same philosophy.

throughout the entire audit process. Our approach ensures that all members of the engagement team will stay abreast of key issues at OAMR, and take an active role in addressing them.

- **A Focus on Providing Consistent, Dependable Service to Government Entities.** Our primary focus is on serving government entities. This translates to more consistent, dependable customer service for OAMR.
- **Cost Effectiveness.** Because we rely on experienced professionals to deliver our compliance audit services, we are capable of providing you with the needed assurance and process improvement recommendations in less time. Less time on the job translates to less cost.

MANDATORY REQUIREMENTS: VENDOR EXPERIENCE/CAPABILITIES

1. PHBV Partners LLP

PHBV has been in business for over 15 years, with over 10 years experience conducting governmental audits. PHBV Partners LLP was created on January 2, 2012 after 50 years as Clifton Gunderson LLP, one of the nations' top accounting firms. Clifton Gunderson and LarsonAllen, ranked as two of the nation's top 20 certified public accounting and consulting firms, agreed to merge as of January 2, 2012. The new firm is named CliftonLarsonAllen (CLA).

PHBV is the separate legal entity that will service our regulatory health care clients at the State and Federal Government levels, including OAMR should our bid be successful. All of our clients will continue to receive the high quality, responsive audit and consulting services to which they are accustomed. It should be noted neither PHBV nor CLA have any West Virginia Long Term Care provider clients.

Nationally recognized as experts in the area of health care audit, compliance and consulting, PHBV currently service health care audit, compliance, and/or consulting contracts with the states of Alabama, Arkansas, Connecticut, Colorado, Delaware, Georgia, Maryland, Massachusetts, Michigan, Mississippi, Nevada, New Hampshire, New Jersey, Oklahoma, Oregon, Rhode Island, South Carolina, Tennessee, Texas, Virginia, Washington, West Virginia, and the District of Columbia. In addition, we have provided compliance-related services in the past to the states of Illinois, Indiana, Kansas, Kentucky, Montana, Nebraska, New Mexico, North Carolina, North Dakota, Ohio, Vermont, and Wisconsin. At the Federal level, PHBV provides audit and consulting services to CMS. Also, we remain the "firm of choice" to provide health care related litigation support services to the DOJ, including the Federal Bureau of Investigation (FBI).

Specifically relevant to this engagement, in the last ten years, we have performed nursing home cost report audits for the following state Medicaid agencies.

State Agency	Period of Performance
Virginia Department of Medical Assistance Services	1995 - Present
Nevada Division of Health Care Financing and Policy	2004 - Present
Mississippi Division of Medicaid	2006 - Present
Alabama Medicaid Agency	2008 - Present
North Carolina Division of Medical Assistance	2004 - 2009
Maryland Department of Health and Mental Hygiene	1980 - 2004
Indiana Family and Social Services Administration	1986 - 2009
Ohio Department of Job and Family Services	1999 - 2006

In addition, to illustrate PHBV's experience, we have provided a matrix on the following page which summarizes our current and past work governmental health care clients. Please note that since our first submission of this proposal in January 2012, we have acquired the following new clients:

- **Colorado Department of Health Care Policy and Financing.** We were awarded a four year contract to audit Hospitals, Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs). In addition, we were contracted to audit the State's Audits Disproportionate Share Hospitals (DSH) program.
- **Washington State Auditor.** We were awarded a contract to conduct a performance audit of the Washington Health Care Authority's Medicaid Managed Care System.
- **Virginia Department of Medical Assistance Services.** We were awarded a three year contract to perform PERM and PERM-like eligibility reviews.
- **Centers for Medicare & Medicaid Services.** We were awarded a contract to complete attestation engagements for the financial information of Medicare MCOs, MAOs (Medicare Advantage Organizations) and PDPs (Prescription Drug Plans). This is the fifth consecutive contract that we have been awarded for this scope of work.

PHBV Partners LLP Sample Client Listing	Dates of Service	Medicaid Desk/Field Audits	Performance Audits	Managed Care Financial Audits	Patient Pmnt/Copay Audits	Consulting Reviews	Medicare/Medicaid Settlements	DRG Reimbursement Consulting	Provider Cost/Payment Analysis	Rate Setting Programs	Payment Rate Development	Review of Medicaid Admin Services Contractors	SAS 70 Reviews	Fraud/Litigation Support	Expert Witness Testimony/ Legal Representation	Medical Claims Review	CPO Audits	Information Systems Audits	Billing Reviews	Regulatory Consulting	DOH Compliance/Consulting	Program Integrity	CMS 64 Consulting	PERM Consulting	MMIS Review	CPE Enrollment	Risk Assessment
Alabama Medicaid Agency	2008-present	✓									✓										✓		✓			✓	
Arkansas Department of Human Services	2009-present																				✓						
Centers for Medicare & Medicaid Services	1992-present	✓	✓	✓		✓							✓	✓	✓	✓	✓		✓			✓					✓
Colorado Departmentof Health Care Policy and Financing	1998-2007, 2010-present		✓				✓									✓					✓						
Connecticut Department of Social Services	2011-present																				✓						
District of Columbia Department of Health	2009-2010	✓																			✓						
Georgia Department of Community Health	2009-present																										
Illinois Department of Healthcare and Family Services	2001-2008												✓						✓								
Indiana Family and Social Services Administration	1986-2009, 2012-present	✓			✓	✓	✓			✓								✓									
Kansas Health Policy Authority	2006-present	✓									✓												✓		✓		
Maryland Department of Health and Mental Hygiene	1980-2004, 2004-present	✓		✓	✓		✓		✓	✓					✓					✓							
Maryland Health Care Commission	2006-present															✓											
Massachusetts - Univ. of Mass. Medical School	2008-present										✓										✓						
Michigan Department of Community Health	2008-present																				✓			✓			
Mississippi Division of Medicaid	2006-present	✓					✓								✓				✓	✓	✓	✓	✓	✓	✓		
Nevada Department of Health and Human Services	2004-2006, 2007-present	✓	✓		✓	✓	✓														✓						
New Hampshire Department of Health and Human Services	2009-present																				✓						
New Jersey Department of Health and Senior Services	2011-present	✓				✓																					
North Carolina Department of Health and Human Services	2004-2009	✓					✓	✓		✓											✓						
North Dakota Department of Human Services	2008																				✓						
Oklahoma Health Care Division	2009-present																				✓						
Ohio Department of Job and Family Services	1999-2006	✓			✓										✓												
Oregon Department of Human Service	2009-present																				✓						
Rhode Island Department of Human Services	2010-present																				✓						
South Carolina Department of Health and Human Services	2006-present	✓																			✓						
Tennessee Bureau of Tenn Care	2005-present								✓												✓						
Texas Health and Human Service Commission	2004-present		✓	✓								✓	✓			✓		✓			✓				✓		✓
Vermont Agency of Human Services	2010-2011																				✓						
Virginia Department of Medical Assistance Services	1995-present	✓		✓	✓		✓	✓	✓						✓						✓	✓		✓			
Washington Department of Health and Human Services	2009-present	✓																			✓						
West Virginia Bureau for Medical Services	2010-present																				✓						
US Department of Justice - AUSA and FBI	1996-present													✓	✓												

PHBV

2. Licensing

PHBV is a licensed CPA firm in West Virginia (Permit #F0486).

Below are ten licensed individuals demonstrating that we meet the mandatory requirements to have at least ten accounting professionals and five of those holding CPA certification valid in West Virginia. Per the June 2008 CPA Mobility Legislative Law passed in the State of West Virginia, engagement team members licensed in Virginia, Maryland and Indiana (those offices most likely to work on this project) have practice privileges in West Virginia. These licenses can be verified on the Web sites of the applicable state licensing board.

Partner/Employee	Title	Home State	CPA License #
Sheryl Pannell	Managing Partner	Virginia	11090
Mark Hilton	Partner	Maryland	12519
Bob Bullen	Partner	Maryland	11874
Frank Vito	Partner	Texas	n/a *(TX does not provide license numbers)*
Charles T. Smith, III	Partner	Virginia	24730
Andy Ranck	Partner	Maryland	31402
John Kraft	Partner	Maryland	15656
David Ricks	Senior Manager	Virginia	19646
Emily Wale	Senior Manager	Indiana	CP10100071
Kelly Bultema	Manager	Virginia	35526

Overall, PHBV has nine Partners, 17 Senior Managers, 39 Managers, and 96 Professional Staff.

3. Experience: Cost Report Audits

PHBV has a long and successful history performing cost report audits, examinations and reviews of all types of providers. Below is a summary of some of our successes:

Virginia Department of Medical Assistance Services
For DMAS, we currently perform desk audits, cost settlements, and field audits for all providers and provider types with cost reporting responsibility. We also perform rate setting services for these providers. Provider types included in the scope of our work are nursing facilities, ICFs/MR, federally qualified health centers (FQHC), rural health clinics (RHC) and hospitals. We also perform all of the Patient Fund Account audits, provide support during provider appeals, and provide consultation on developments in the Medicaid program.

Nevada Division of Health Care Financing and Policy
We perform cost report reviews of nursing facilities, hospitals, rural health clinics and ICF/MRs. We also perform patient fund account reviews and compliance audits of Nevada hospitals.

Mississippi Division of Medicaid
We perform examinations (under AICPA & GAGAS) of hospital and long-term care facility cost reports. We also perform post-payment reviews of claims to ensure compliance with billing manuals. We also perform the annual DSH audit.

North Carolina Division of Medical Assistance
We performed desk audits and/or field audits of selected Medicaid services to determine whether provider financial and statistical records are reasonable and allowable under relevant Federal and State regulations. Provider types included in the scope of our work were Nursing Facilities, Intermediate Care Facility for the Mentally Retarded (ICF/MRs), Hospitals (Inpatient, Outpatient, State-owned, Non-State Public, Teaching, and Critical Access), Home Offices/Related Organizations, FQHCs, RHCs, and Physician Practice Plans of Affiliated Teaching Hospitals. We issued audit and agreed-upon procedures reports.

Alabama Medicaid Agency
We currently perform cost report audits of nursing facilities and provide assistance with their CMS-64 reporting. We also evaluated the performance of Alabama's Medicaid Agency's Financial Management Division, Reimbursement Division and Program Integrity Division. The focus of the engagement was to review and assess budgeting, forecasting, financial reporting, and work-flow processes. We also made recommendations of how each division could improve their effectiveness, including the introduction of new audit approaches.

New Jersey Department of Health and Senior Services (DHSS)
For DHSS, we conduct the audits, the appeals and the re-openings of cost reports submitted by hospitals located in the State of New Jersey for providing care to Medicaid patients. We also perform financial report audits of licensed New Jersey Ambulatory Care Facilities and patient eligibility charity care audits for all New Jersey Disproportionate Share Hospitals (DSH).

Colorado Department of Health Care Policy and Financing (HCPF)
For HCPF, we prepare cost audits of hospital cost reports for the purpose of inpatient and outpatient hospital reimbursement, as well prepare cost audits of Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) cost reports for the purpose of FQHC and RHC reimbursement. In addition, we audit Disproportionate Share Hospital payments.

Georgia Department of Community Health
We perform audits and settlements of hospital cost reports to ensure that hospitals are properly identifying and allocating allowable costs to appropriate cost centers.

South Carolina Department of Health and Human Services
We perform examinations of the State's Disproportionate Share Hospital (DSH) program. The examinations are performed to satisfy the requirements in the CMS rule to implement section 1001(d) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) which establishes new reporting and auditing requirements for State Disproportionate Share Hospital payments. We also conduct agreed-upon procedures to calculate Medicaid cost settlements for South Carolina hospitals.

Maryland Department of Health and Mental Hygiene
We performed field and desk review engagements for psychiatric hospitals, chronic hospitals, rehabilitation hospitals, children's hospitals, nursing facilities, ICFs/MR, alcoholic Type D facilities, home health agencies, and FQHCs. In addition, we provided the initial and final rate setting services. Finally, we participated in informal and formal appeal hearings and testified as expert witnesses.

Indiana Family and Social Services Administration
We performed audits of more than 600 Medicaid providers annually, including nursing facilities, community residential facilities for the developmentally disabled (CRFs/DD), ICFs/MR, and home health agencies. We provided support during provider appeals, performed special projects, and offered consultation on developments in the Medicaid program. In addition, we performed consulting reviews of managed care providers and community mental health centers participating in the Indiana Mental Health Funds Recovery Program. PHBV also evaluated the performance of Indiana's MMIS system contractor.

Ohio Department of Job and Family Services (ODJFS)
For ODJFS, we performed full and limited scope agreed-upon procedures of Medicaid nursing facility and ICFs/MR cost reports at locations throughout the State. The reviews analyzed costs and other data for proper reporting in accordance with Generally Accepted Accounting Principles, Government Auditing Standards, CMS Provider Reimbursement Manual, and the Ohio Administrative Code. Cost adjustments impacted prospectively determined rates.

We have included Project Profiles in *Appendix A: Project Profiles* which provide further details of the work performed and references for a selection of these clients.

4. Experience with Regulators

PHBV affords every client with the benefit of direct communication with high-level regulators and policy makers throughout the nation. Our relationships with CMS, the U.S. Department of Justice (DOJ), the U.S. Department of Health and Human Services Office of Inspector General (OIG), and other regulatory agencies often enables us to garner unparalleled insight and the ability to effectively communicate complex matters in a concise, well-received manner. This value-added service enables us to provide our clients with unparalleled access, timely insight, and the benefit of solid relationships that have been built through years of professional dialogue and successful service. Our services are just one example of the comprehensive, full-service, client-focused approach that our firm takes in order to surpass our competitors and to contribute to the ongoing success of each state health care agency client.

Medicaid agencies are increasingly held accountable by a variety of oversight bodies including CMS, HHS-OIG, State Legislatures, State Auditors, and provider advocacy groups. From time to time, our clients request our assistance to help address concerns raised by these stakeholders. Below is a sample of projects for which we have provided such guidance:

Alabama Medicaid Agency
We assisted Alabama in discussions with CMS regarding the funding of their hospital reimbursement program. We were able to leverage our relationships at CMS to facilitate discussions ensuring the reimbursement and funding mechanisms to be implemented by a State Plan Amendment were amenable to all stakeholders. We also provided technical expertise to assess the impact of proposed changes on both the provider community and the state.

Mississippi Division of Medicaid
We have provided assistance with Medicaid policy issues and responses to proposed rule changes issued by CMS (including expert witness testimony before the State Legislature). In addition, we have conducted risk assessments of the Mississippi's SCHIP Program and the MMIS. Further, we performed a review of the Division's Bureau of Program Integrity and Supplemental Drug Rebate Program. Lastly, we assisted the Division of Medicaid in the completion and reconciliation of the CMS 64 Report. This reconciliation resulted in the identification of $100 million of Federal funds that were due to the State.

Nevada Division of Health Care Financing and Policy
We have consulted with Nevada on a variety of topics, including a review of their Audit Unit, provider tax programs, and risk assessments of proposed State Plan Amendments. In particular, we were engaged to review provider tax program proposals submitted by hospital groups to ensure they were in the best interest of the state and that they would be in compliance with Federal criteria; thus, meeting CMS approval.

Virginia Department of Medical Assistance Services (DMAS)
We worked with DMAS' Program Integrity Division during the Virginia Joint Legislative Audit and Review Commission (JLARC) evaluation of the division. This included helping DMAS prepare formal responses to JLARC inquiries.

Michigan Department of Community Health (DCH)
We successfully worked with CMS and DCH to develop an acceptable alternate PERM eligibility review reporting schedule due to the fact that Michigan started their review late within the PERM cycle. We are proud to report that we were able to meet both the proposed interim reporting milestones, and complete the project by the original due date.

We have included Project Profiles in *Appendix A: Project Profiles* which provide further details of the work performed and references for a selection of these clients.

5. Knowledge of Laws and Regulations

Specific to Nursing Facility Cost Reports
The nature of this work requires significant expertise with bodies of knowledge not generally possessed by CPA firms – that is, the West Virginia Code, the Medicaid Provider Manuals, the West Virginia State Medicaid Plan, the Code of Federal Regulations, and the Provider Reimbursement Manual (CMS Pub. 15-1). Our proposed key staff members possess over 65 years combined health care experience, most of which involve the interpretation and application of these rules and regulations.

The nature of this work also necessitates an in-depth understanding of numerous reimbursement methodologies. Whether cost-based, price-based, retrospective, prospective, DRG (Diagnosis-Related Group), FRV (Fair Rental Value), or some combination, we understand it and have audited it. In addition, when States contemplate changes to nursing facility reimbursement methodologies, we have assisted in those efforts.

In previous sections, we have indicated other states (Virginia, Nevada, Mississippi, Alabama, North Carolina, etc.) where we have experience performing similar services to those requested by this RFQ. In each state, we have become experts with regards to their cost reporting and reimbursement mechanisms. It is this experience that allows us to quickly become experts when beginning work with a new state.

Relating to the Regulatory Health Care Environment

PHBV is proactive in its efforts to be at the forefront of legislative and regulatory measures that affect our clients. We regularly schedule meetings with CMS leaders at regional offices and their central office in Baltimore, Maryland. Further, we continue to meet with key members of Congress and their staff in order to insure that we are aware of proposed legislation before it is adopted and we habitually monitor key court cases that may impact Medicaid programs. Over the last several years, we have seen the implementation of many federal and state rules leading to change and requiring specialized services that we can provide. This includes DSH auditing, PERM, an increased focus on fraud, waste and abuse, and a continued shift towards managed care. Examples of the services we have provided are as follows:

Disproportionate Share Hospital (DSH) Audits - Multiple States

We have been conducting DSH audit work longer than any other firm in the Nation, as we were the first firm in the nation to be engaged by a state to audit pursuant to the Draft Rule (August 2005) and Final Rule (December 2008). In addition to West Virginia, we have worked with 19 other Medicaid programs to provide DSH audit services, including:

Alabama	Arkansas	Colorado	Connecticut
District of Columbia	Massachusetts	Michigan	Mississippi
Nevada	New Hampshire	Oklahoma	Oregon
Rhode Island	South Carolina	Tennessee	Texas
Vermont	Virginia	Washington	

Payment Error Rate Measurement (PERM) Reviews – Multiple States

We are currently engaged to perform reviews for Michigan, Delaware, Mississippi and Virginia. As an example, PHBV is currently completing PERM-like reviews of Michigan's CHIP program for FY 2010. The Medicaid PERM and CHIP Perm-like engagements required an understanding of Michigan's claims processing and eligibility systems to sample and select cases and to review eligibility determinations over a 12-month period. The results of reviewed Medicaid claims were used to determine Michigan's eligibility error rate for reporting to CMS. The results of the reviewed CHIP claims are being used to help Michigan determine corrective actions that may be beneficial in reducing future PERM error rates.

Medicaid Managed Care Audits – Multiple States
We have performed audits of Medicaid Managed Care Organizations (MCOs) in Texas, Nevada, Virginia and Maryland. As an example, for State of Texas Health and Human Services Commission (HHSC), PHBV performs risk assessments for Medicaid MCOs on behalf of HHSC. We identify program vulnerabilities through interviews, observations, comparisons with best practices in other states and manual and computerized analysis of data. These identified vulnerabilities form the basis for the areas of emphasis in future performance, information technology, and financial related verifications. PHBV has also provided performance, information technology, and financial related verifications of the State of Texas Medicaid and Children's Health Insurance Plan contractors including claims payment, eligibility, enrollment, and quality review. We also perform Texas' annual DSH audit.

Maryland Health Care Commission (MHCC)
For the MHCC, we audit reimbursement applications submitted to the Maryland Trauma Physician Services Fund. This Fund provides reimbursement to trauma physicians for uncompensated care provided to trauma patients, as well as, reimbursing trauma centers for expenses associated with having trauma physicians on-call and available to provide trauma care. For the MHCC, we test the accuracy of the reimbursement applications for eligible trauma physicians and level II and III trauma centers designated by the Maryland Institute for Emergency Medical Services Systems. We also audit Trauma Equipment Grants and perform an annual review of Maryland Health Insurance Partnership Health Plan Participants. In addition, we recently performed a financial statement audit and penetration testing/security effectiveness testing of CRISP (Chesapeake Regional Information System for our Patients). CRISP is formally designated Maryland's statewide Health Information Exchange by MHCC.

CMS: Audit Medicaid Integrity Contractor (Audit MIC)
As a subcontractor to Health Integrity, LLC (HI), an Audit Medicaid Integrity Contractor (MIC), we perform audit activities required by the Medicaid Integrity Program in 35 states. These audits review claims for all types of Medicaid providers to ensure they were paid in accordance with applicable Federal and state law, regulations and guidance. PHBV provides all levels of experienced audit staff, as well as performs the audit management function.

Federal Bureau of Investigation/U.S. Department of Justice
PHBV assists the FBI Headquarters' Health Care Fraud Unit in investigating health care fraud cases. PHBV is the Federal Bureau of Investigation's CPA "firm of choice" for supporting their local field offices across the country investigating health care fraud cases.

The DOJ contracts with PHBV through Lockheed Martin to provide litigation support services to the local FBI offices across the country in health care fraud investigations. The Lockheed Martin contract with the DOJ is the Automated Litigation Support (ALS) Contract (otherwise known as the Mega contract).

PHBV is assisting the FBI in a broad spectrum of criminal health care fraud investigations. As part of our duties, we have assisted FBI Special Agents, FBI Financial Analysts, Assistant United States Attorneys, DOJ Commercial Litigation Trial Attorneys, State Attorneys, Chief Investigators of Medicaid Fraud Control Units, U.S. Department of the Treasury Special

Agents, U.S. Department of Treasury Intelligence Analysts, U.S. Food and Drug Administration Office of Criminal Investigations Special Agents, U.S. Department of Health and Human Services Office of Inspector General Special Agents, National Insurance Crime Bureau Agents, and Government Statisticians and Medical Experts. We will continue to assist other field offices on an ongoing basis.

CMS: Medicare Drug Integrity Contractor (MEDIC)
PHBV is a subcontractor to Health Integrity, LLC (HI) to perform program integrity work for the Medicare Part D Program. The HI contract began in November of 2005 through the Enrollment and Eligibility MEDIC (EEM). The HI team was extended the option to perform as the MEDIC for the Southeast region at the conclusion of the EEM contract. The HI team is currently the benefit integrity MEDIC for the entire United States.

CMS: Zone Program Integrity Contractor (ZPIC)
PHBV is a subcontractor to Health Integrity (HI) as the Zone Program Integrity Contractor (ZPIC) for Zone 4 which encompasses Texas, New Mexico, Colorado, and Oklahoma. The ZPIC is responsible for ensuring the integrity of all Medicare-related claims under Parts A and B (hospital, skilled nursing, home health, provider and durable medical equipment claims), Part C (Medicare Advantage health plans), Part D (prescription drug plans) and coordination of Medicare-Medicaid data matches (Medi-Medi).

CMS: Medicare Advantage/Prescription Drug Plan Contractor
PHBV has multiple contracts with CMS to perform examinations of Medicare Advantage Organizations (MA) and Prescription Drug Plans (PDP) for Contract Years 2006, 2007, 2008 and 2009 to provide assurance that Part C and Part D payments were proper, organizations' self reported information used to determine payment amounts was valid and correct, and that risk sharing calculations were in accordance with applicable regulations. Procedures include evaluation of base year data reported on the bids, review of direct medical expenses, related party transactions and administrative expenses, evaluation of financial solvency, review the four payment mechanisms for Part D (direct subsidy, low income subsidy, reinsurance subsidy and risk sharing) by obtaining the Prescription Drug Events (PDEs) data and supporting documentation, review of Direct/Indirect Remuneration including drug rebates (DIR) and TrOOP (True Out-of-Pocket Costs) to ensure the amounts were reported appropriately, and review a sample of PDEs for various attributes including duplicate payments and potential secondary payors.

We have included Project Profiles in *Appendix A: Project Profiles* which provide further details of the work performed and references for a selection of these clients.

6. Appeals Representation

When a provider disputes the interpretation and application of rules and regulations and exercises the right to appeal, PHBV will continue to support OAMR by delivering to each appeal a unique blend of knowledge, experience and common sense so providers receive proper reimbursement.

PHBV has been providing appeals assistance to various state agencies since 1982. Details of how our staff has participated in the appeals processes are as follows:

Commonwealth of Virginia Department of Medical Assistance Services— Provider Reimbursement and Program Integrity Divisions

Since 1995, our senior-level staff has provided extensive Medicaid appeals/litigation support. This work was performed for a number of different provider types including nursing facilities, hospitals, hospice, home health, residential treatment centers (A, B & C), psychiatric service providers, physicians, treatment foster care - case management, personal and respite care, private duty nursing, rehabilitation (inpatient and outpatient), Intellectual Disability/MR Waiver services, durable medical equipment, and laboratories. The appeals services provided include:

- Preparation of case summaries that address each disputed matter, including the validity of the appeals filed,
- Representing the Department in informal fact finding conferences,
- Coordinating and transferring documents and positions with Providers and DMAS informal appeals agents in post conference communications,
- Research and presentation of federal and state regulations to support the DMAS position
- Prepare evidentiary documents, and review of other contents, to be included with formal case summaries,
- Meeting with Department counsel for witness preparation and for examination/cross-examination strategies,
- Providing expert testimony on behalf of the Department at the formal administrative hearings.
- Assisting Department counsel in post-hearing communications, and
- Answering questions and providing guidance to counsel for circuit court appeals.

Additionally, we have testified in federal court in support of the Commonwealth's prosecution of fraudulent health care providers.

Mississippi Division of Medicaid

Since 2006, our partners and senior managers participate in the appeals process for nursing facility and hospital cost report audit appeals, as well as claim reviews. The services provided include:

- Assisting the agency with responses to administrative appeal requests,
- Reviewing formal case documents,

- Preparing evidentiary documents, and
- Providing expert testimony on formal appeals.

Ohio Department of Job and Family Services
For more than seven years, we assisted the State of Ohio Attorney General's office with appeals related to nursing facility audits. This includes:

- Providing research assistance and guidance in preparing for the informal and formal appeals case,
- Reviewing formal case documents, and
- Providing expert witness testimony on formal appeals cases.

Nevada Division of Health Care Financing and Policy
Since 2004, we have participated in the administrative appeals processes relating to cost report audits of nursing homes, critical access hospitals, hospital based skilled nursing facilities and intermediate care facilities for the intellectually disabled. This includes:

- Receiving and logging initial appeal requests,
- Preparing responses to issues identified in the Provider's intent to appeal,
- Reviewing /requesting additional documentation,
- Computing revisions to the Notice of Program Reimbursement, and related documents as necessary, and
- Assisting the agency administrator with preparations for all hearings.

State of Maryland Department of Health and Mental Hygiene (1980 – 2004)
For more than 20 years, our partners and senior-level staff provided extensive Medicaid appeals consulting and litigation support for this agency. This work was performed for a number of different provider types including hospitals, residential treatment centers, alcohol and drug treatment centers, FQHCs and Home Health Agencies (HHA). The appeals consulting services provided included:

- Preparation of informal position papers for state attorneys and Medicaid personnel,
- Preparation of formal position papers for presentation to the Maryland Hospital Appeal Board,
- Research and consultation on complex reimbursement issues,
- Assistance with appeal negotiations and settlement agreements,
- Preparation of hearing exhibits,
- Providing assistance to state attorneys on examination and cross-examination strategies, and
- Expert witness testimony before the Maryland Hospital Appeal Board and the Maryland Office of Administrative Hearings.

Indiana Family and Social Services Administration
For more than ten years, our partners and senior-level staff participated in the appeals processes for long term care facility cost report audit appeals. The appeals consulting services provided for this agency included:

- Having preliminary discussions with Providers regarding potential appeal issues,
- Preparation of exhibits and other documents supporting the agency findings,
- Reviewing formal cases with general counsel,
- Providing expert testimony in formal cases, and
- Assisting the state's general counsel in preparing for both informal and formal hearings.

North Carolina Department of Medical Assistance
For more than five years, our partners and senior managers provided appeals services to this agency for hospitals, nursing facilities, ICF/MR facilities, Home Health. The appeals consulting services provided included:

- Preparation of position papers outlining issues/ adjustments under appeal (for hospitals, nursing facilities, ICF/MR facilities, and home health, etc.), the applicable regulations or department published guidance and conclusions reached,
- Representation of the agency in administrative conference settings as subject matter experts,
- Representation of the agency in mediation settings (when issues could not be resolved through the administrative conference process) as subject matter experts, and
- Testified as witnesses for agency in court for formal cases when issues could not be resolved through the mediation process.

We have included Project Profiles in *Appendix A: Project Profiles* which provide further details of the work performed and references for a selection of these clients.

7. Value through Audit Process

The measurement of value in a contractual relationship depends on the priorities of the customer. Our history with State Medicaid Agencies has shown a desire for highly specialized services aimed towards achieving both a significant Return On Investment (ROI) as well as gaining insight that leads to policy, program and administrative change; therefore helping increase the overall effectiveness of their Medicaid program.

Below are a listing of approaches and prior projects that demonstrate our experience and ability to bring value to our clients. It must be noted that our overall approach to client service is to maintain open lines of communication and keep our clients up to date on news and events that may impact their operations. For example, we share information gained through meetings with Federal regulators, or we share best practices employed by our other state clients. These are not defined projects which appear on our invoices, but rather the added value our clients gain from our relationship.

Audit-Related

The following highlights the audit-related value that we deliver to our clients:

- For every taxpayer dollar spent for our services to our clients, we reduce actual reimbursements many times over. For example, for the Commonwealth of Virginia Department of Medical Assistance Services' Provider Reimbursement Unit, for every taxpayer dollar spent on our services, we reduced actual reimbursements by almost six dollars, which is equivalent to a 600 percent return on investment.
- We identify issues and propose solutions to both our clients and providers that result in future cost avoidance.
- Our specialized experience provides for very little learning curve, few demands on our clients' resources, and few start-up delays.
- We employ risk-based approaches and nurture a flexible team-based culture to focus resources on those areas with the highest risk of errors leading to significant overpayments.

Policy-, Program-, Finance-, and Budgeting-Related

The following highlights a few of the policy-, program-, finance-, and budgeting-related value that we deliver to our clients:

- We possess institutional knowledge of State and Federal Medicaid programs that would be expensive and time consuming to duplicate.
- We have conducted evaluations of state Medicaid agency audit units (Alabama and Nevada, for example), Program Integrity units (Alabama and Virginia, for example), and provider reimbursement units (Arkansas, for example). Each of these evaluations not only identified strengths and areas for improvement, but presented recommended solutions.
- We have assisted states in the preparation and reconciliation of CMS-64 reports (Alabama, Mississippi and Massachusetts, for example)
- We have assisted states in the development and CMS approval of provider tax/assessment programs (Alabama, Virginia and Nevada, for example)
- We have assisted in the development and implementation of new reimbursement methodologies (Virginia and North Carolina, for example)
- We have helped develop and draft State Plan Amendments (Virginia, Nevada and Alabama, for example)
- We have performed risk assessments and audits of state Medicaid Management Information Systems (Mississippi, Indiana, and Nevada, for example)

We feel the best way to fully understand how we provide value is to speak with some of our existing clients. We encourage you to contact them. We have limited our list of references here to five agencies that are the most relevant to this contract due to similar services provided to each. Numerous additional references appear in the Project Profiles in *Exhibit A: Project Profiles.*

Commonwealth of Virginia, Department of Medical Assistance Services	
Customer Name and Address	Provider Reimbursement Division Department of Medical Assistance Services Commonwealth of Virginia 600 East Broad Street, Suite 1300 Richmond, Virginia 23219
Customer Contact and Title	Ms. Mary Hairston Healthcare Reimbursement Manager
Contact Phone Number	804-225-4587 Mary.Hairston@dmas.virginia.gov
Scope of Services of Contract	For the Virginia Department of Medical Assistance Services, we currently perform desk audits, cost settlements, and field audits for all providers and provider types with cost reporting responsibility. We also perform rate setting services for the provider types indicated below. Provider types included in the scope of our work includes nursing facilities, ICFs/MR, rehabilitation agencies, FQHCs, RHCs, and hospitals. We also perform all of the Patient Fund Account audits, provide support during provider appeals, and provide consultation on developments in the Medicaid program.
Contract Type	Fixed Fee and Hourly
Contract Size	Approximately 100 Field Audits, 125 PFA Audits, 115 Appeals, and 1,200 Cost Settlements. Also includes approximately 6,500 hours of other consulting.
Contract Period	1993-present

South Carolina Department of Health and Human Services	
Customer Name and Address	South Carolina Department of Health and Human Services 1801 Main Street, Room 633 Columbia, South Carolina 29201
Customer Contact and Title	Mr. Jeff Saxon Bureau Chief, Reimbursement, Methodology & Policy
Contact Phone Number	803-898-1023 saxon@scdhhs.gov
Scope of Services of Contract	We conduct agreed-upon procedures to calculate Medicaid cost settlements for South Carolina hospitals. We also perform an examination of the State's DSH program. The examination is performed to satisfy the requirements in the CMS rule to implement section 1001(d) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) which establishes new reporting and auditing requirements for State Disproportionate Share Hospital payments.
Contract Type	Fixed Fee
Contract Size	Approximately 65 Hospitals annually
Contract Period	2006 - 2015

Mississippi Division of Medicaid	
Customer Name and Address	Mississippi Division of Medicaid Walter Sillers Building, 550 High Street, Suite 1000 Jackson, Mississippi 39201
Customer Contact and Title	Mr. Richard Roberson Special Assistant to the Executive Director
Contact Phone Number	601-359-6118 Richard.Roberson@medicaid.ms.gov
Scope of Services of Contract	We perform the following services for the Medicaid agency: • Perform verification procedures on critical data elements used by Mississippi health care providers for Medicaid reimbursements, as requested by the Division • Perform verification procedures of Medicaid DSH payments, including an Upper Payment Limit (UPL) analysis • Develop and submit Audit Plan and Audit Materials • Complete Audits and Desk Reviews • Provide training to Division of Medicaid staff as requested • Provider other special accounting consulting services as requested.
Contract Type	Hourly
Contract Size	Approximately 12,000 hours annually
Contract Period	2006 - 2012

Nevada Division of Health Care Financing and Policy	
Customer Name and Address	Nevada Division of Health Care Financing and Policy 1100 E. William Street, Suite 101 Carson City, Nevada 89701
Customer Contact and Title	Ms. Janice Prentice Chief, Rates & Cost Containment Unit
Contact Phone Number	775-684-3791 jprentice@dhcfp.nv.gov
Scope of Services of Contract	We are currently engaged by the Department of Health and Human Services, Division of Health Care Financing and Policy to perform DSH audits, compliance audits of 15 Nevada hospitals (performed every other year), cost report reviews of Nursing Facilities, Critical Access Hospitals, RHCs and ICF/MRs, patient fund account reviews, and various consulting projects, which have included audits of Medicaid MCOs, performance audits of the MMIS contractor and review of the states provider tax program.
Contract Type	Fixed Fee
Contract Size	Approximately 8,600 hours for SFY 2011
Contract Period	2004-present

Alabama Medicaid Agency	
Customer Name and Address	Alabama Medicaid Agency 501 Dexter Avenue P.O. Box 5624 Montgomery, Alabama 36103-5624
Customer Contact and Title	Stephanie Azar Acting Commissioner
Contact Phone Number	334-242-5600 stephanie.azar@medicaid.alabama.gov
Scope of Services of Contract	We are currently engaged by Alabama to evaluate the performance of Alabama's Medicaid Agency's Financial Management Division. The focus of the engagement was to review and assess budgeting, forecasting, financial reporting, and work-flow processes.
Contract Type	Fixed Fee
Contract Size	Approximately 7,500 hours
Contract Period	2008-present

MANDATORY REQUIREMENTS: SCOPE OF WORK

1. Auditing Standards

We will perform all engagements and issue all reports in accordance with attestation standards established by the American Institute of Certificated Public Accountants (AICPA) as well as Government Auditing Standards issued by the Comptroller General of the United States.

2. Financial and Compliance Audit Engagements

If the successful bidder, PHBV will perform financial and compliance audit engagements, as requested, of semi-annual LTC-FASRs in accordance with the standards established by the AICPA and the standards applicable to financial audits contained in Government Auditing Standards issued by the Comptroller General of the United States.

We will issue an opinion on the fair presentation, in conformity with generally accepted accounting principles and the rules and regulations established by the West Virginia Department of Health and Human Resources, of the financial and statistical information submitted in the LTC-FASRs for each facility examined along with a list of findings of noncompliance as described below.

Additionally, we will issue a report on compliance and internal control in accordance with Government Auditing Standards.

3. Pre-Engagement Planning

PHBV takes pride in its planning process for examination field work. We recognize that a well-planned examination will benefit OAMR. Planning and preliminary work include the following steps:

- Gain an understanding of the provider through a review of available information
- Review the results of the desk review and prior year reviews to identify any corrective actions taken by the provider to address findings and recommendation
- Review the results of analytical procedures performed during the desk review process
- Perform engagement specific risk assessment
- Conduct internal engagement planning meetings to review the engagement planning guide, noting materiality and the areas of focus
- Critically review the general ledger
- Establish a timeline including completion dates for fieldwork and delivery of reports
- Meet with OAMR to establish the procedures to be performed and to demonstrate our understanding of the examination
- Initiate communications with the provider to schedule the examination and request information

4. Examination Approach

Our examination procedures will, at a minimum, include the procedures outlined in the OAMR Audit Guide. We are fully aware that issues may arise for which there is not a specific procedure in the OAMR Audit Guide. In such instances, we will develop the necessary procedures to address the specific audit risk. Further, some of the OAMR Audit Guide procedures may not be applicable or cost-effective after an evaluation of audit risk. In such instances, we will recommend alternative procedures so as long as they meet the audit objective, and we will employ them only after OAMR approval.

Our examination process is organized into three components:

1. Pre-fieldwork Planning and Preliminary Work (See #3 above)
2. Verification of Cost Report Financial and Statistical Data (Fieldwork)
3. Post Fieldwork Wrap-up and Reporting

Fieldwork

Our examinations involve making inquiries of provider personnel to obtain explanations of questioned costs, assessing the reasonableness of provider explanations, reviewing adequate supporting documentation for reported costs, and communicating progress and results to the provider. The nature, timing and extent of the procedures performed depend on the results of the planning process and risk assessment.

With the continuing advancement of electronic communication, many procedures can be performed off-site (at PHBV offices). Providers will be able to send documentation to the engagement team through the use of a secure FTP site. The value, however, of being able to see something in person and to have direct face-to-face access to auditees will not be overlooked. Thus, we will continually assess risks throughout the audit and strike the right balance of off-site and on-site procedures.

These procedures include:

- An entrance conference with provider personnel to determine key contacts, the availability of previously requested information, and to answer any questions
- A review of applicable contracts, leases, loan documentation and board of directors' minutes
- Facility tours to verify square feet statistics, space usage and asset existence.
- Substantive testing of identified high risk areas, which includes the review of source documentation. This may include vouching expenses against invoices, reviewing patient day counts against census and revenue information, testing statistical information against source documentation, making specific inquires of provider personnel, and an overall evaluation of the provider's facility and operations.
- Ongoing communications to share findings with OAMR and the provider before an exit conference
- An exit conference at the conclusion of fieldwork to discuss proposed findings and to discuss the status of missing documentation

Post Fieldwork Wrap-up and Reporting
The final part of the examination process is the final review and report preparation. Any additional documentation submitted by the provider is reviewed during this process and the provider is notified of any revisions to the findings presented at the exit conference. Each field audit goes through three levels of review, the first by a Manager and the second by a Partner, and a third by an unassociated Partner to ensure compliance with professional standards. This also ensures the delivery of a quality product with well-supported and well-researched findings in compliance with the manual, regulations, and state law. PHBV will issue a comprehensive draft report to OAMR for their review with access to well documented, supporting workpapers. After review and comments from OAMR, we will submit the revised report to OAMR for release to the Provider.

Potential Challenges
We expect some challenges. While these challenges have been typical in performing Medicaid examinations and have sometimes hindered the examination process, they have never prevented us from completing the required tasks satisfactorily. Our preferred solution is to work with the providers to resolve any of the challenges we encounter. It has been our experience that we normally are able to work through these issues without having to involve OAMR personnel. However, we will always advise OAMR when problems arise and seek its assistance, as necessary, to reach resolution.

Most CPA firms are accustomed to working only in the environment of their client, a more welcome and friendly atmosphere. The nature of this work requires the ability and experience to work on a day-to-day basis in potentially confrontational environments. Some problems that could impact the examination process are related to provider issues. Whether by design or an innocent oversight, providers may not return scheduling calls, they may not provide information in a reasonable amount of time, they may claim ignorance, or they might just resist the examination. Developing mutual professional respect and employing proactive communications are two keys to mitigating potential problems.

Our policy has always been to have extensive communications with the client and the provider community. We believe that good communications are the key to successful dealings with providers and obtaining their cooperation.

Resources
We will use a mix of managers, senior associates, and associates to perform the examination procedures. All of these individuals are led by a partner whose main job is to ensure all technical and professional requirements are met, and that we are preparing a quality product.

General Consulting
From time to time, the client may need specialized consulting or accounting services. The contractor needs to make available, on short notice, the appropriate level of professionals to satisfy the needs of OAMR. We are proud that we can bring our extensive resources, our knowledge of OAMR and West Virginia Medicaid issues, and our dedication to our clients.

5. Deliverables
We will conduct each engagement on an individual facility basis, and will complete up to eight semi-annual LTC-FASRs or cost reports. We will issue a separate report for each engagement in which we will express an opinion as to the completeness and accuracy of the information submitted on the LTC-FASRs in accordance with the West Virginia Medicaid Provider Manuals and all applicable laws, rules and regulations.

Our report will include the following elements:

- Independent accountants' examination report and report in accordance with Government Auditing Standards
- A definitive list of findings of non-compliance, numbered sequentially and including the following elements:
    - Criteria
    - Condition (to include cost report period, ITC-FASR cost center charged, page/line mapping to ITC/FASR field(s) affected, account number(s) and description(s) (from West Virginia long Term Care Medicaid Chart of Accounts), amount originally reported on the LTC-FASR, correct amount, and quantification of increase or decrease necessary to adjust for cost or census error).
    - Cause
    - Effect or Potential Effect
    - Recommendation
- Status of prior findings (if any)

Our workpaper files will support our findings and adequately document the steps taken to meet the objectives of the engagement, in accordance with professional standards.

6. Chain Facilities Examination

We understand that our examination of facilities that share a common ownership or control (i.e. Chain Facilities) will generally be performed together as a group and will include in the examination home office or other costs that have been allocated among the facilities and included in the LTC-FASRs submitted for those facilities. OMAR will receive the benefit that PHBV has previously audited several of the home office chains and already has a respectful relationship with the provider contacts at these home offices.

7. Hospital-Based Facilities

We understand that our examinations of facilities that are owned by or located within a hospital (i.e. Hospital-Based Facilities) are to include in the examination any hospital costs allocated to the long term care facility and included in the LTC-FASR submitted for those facilities. PHBV also has prior experience auditing these types of facilities.

8. Staffing

As mentioned previously PHBV is dedicated to providing health care compliance audits, examinations and consulting services for State and Federal agencies. With more than 40 years of relevant experience, we have the expertise and resources to perform the engagement without reliance

on OAMR staff for the performance of any audit related work or clerical support necessary for completion of the engagement.

9. Knowledge of West Virginia Medicaid Provider Manuals

PHBV is already well versed in the reimbursement principles shared by many states. In preparation for this engagement, we will continue to familiarize ourselves with *Chapter 500, Volume 15 "Nursing Facility Services"* as well as the West Virginia Medicaid Long Term Care Chart of Accounts. We understand that the OAMR staff shall be available to assist in provision of information and explanations, as well as interpretations of rules and regulations as they pertain to audit findings and results of audit tests. We will contact OAMR with any questions as to interpretation of rules and regulations as necessary.

10. Fraudulent Activities

Should any fraudulent activity be uncovered during the course of our audit, we will immediately notify OAMR in writing. Fraudulent acts include but are not limited to: criminal acts; fraudulent transactions; intentional abuse of WV Medicaid funding; irregularities; misrepresentations by facility management; or any issues that would cause delays in the issuance of the engagement report or an adverse opinion. The *Generally Accepted Governmental Auditing Standards* will be complied with while performing these engagements.

11. Appeals Representation

We are prepared and experienced in providing representation and consultation for all levels of provider appeals of our work both during and after our contract. We understand that this may include administrative hearings, evidentiary hearings, and judicial reviews as well as other legal proceedings not individually listed here. The cost of the appeals representation is included in the price of the engagements and we understand that no additional compensation will be made whether the timing is within or subsequent to the term of this contract.

12. Draft Copy of Report

We will meet with OAMR representatives upon completion of each engagement and will provide at that time a draft copy of the report for the engagement (or engagements for Chain Facilities). We understand that any necessary changes must be discussed and agreed upon before final acceptance. We will be prepared with supporting workpapers to discuss each finding and to perform additional work at the request of OAMR for any areas not sufficiently explained or findings not sufficiently quantified. In the event that changes or additional work are deemed necessary a subsequent draft will be submitted and discussed with OAMR.

13. Final Report Revisions

We will issue the final draft of the report to OAMR and OAMR will transmit that draft report to the facility. We understand that facility will have ten business days from receipt to provide additional information to the vendor to mitigate or resolve the findings.

14. Final Report Preparation

We will be responsible for final report preparation, editing and printing. This includes providing OAMR with three copies of the final report for each engagement as well as one copy of the engagement workpapers resulting from the examination.

15. Retention of Workpapers

We will retain all workpapers and reports, at our expense, for a minimum of five years. After the five years have elapsed documents are to be delivered and surrendered unto the OAMR.

16. Rules and Regulations

We will be available to OAMR, as needed, to assist in adapting the engagement procedures to accommodate rule and regulation changes as they affect the rate determination and audit process on an as-needed basis.

17. Completion of Audit Fieldwork

We will complete audit fieldwork and submit draft audit reports for OAMR quality review no later than 90 days before contract expiration date. We understand that any audits not submitted by this date will not be considered complete and therefore, final outstanding payments will be withheld. Final drafts submitted by 90 day deadline will be quality reviewed and upon acceptance by OAMR as final, OAMR will authorize approval of final payment.

18. Fixed Fee for Engagements

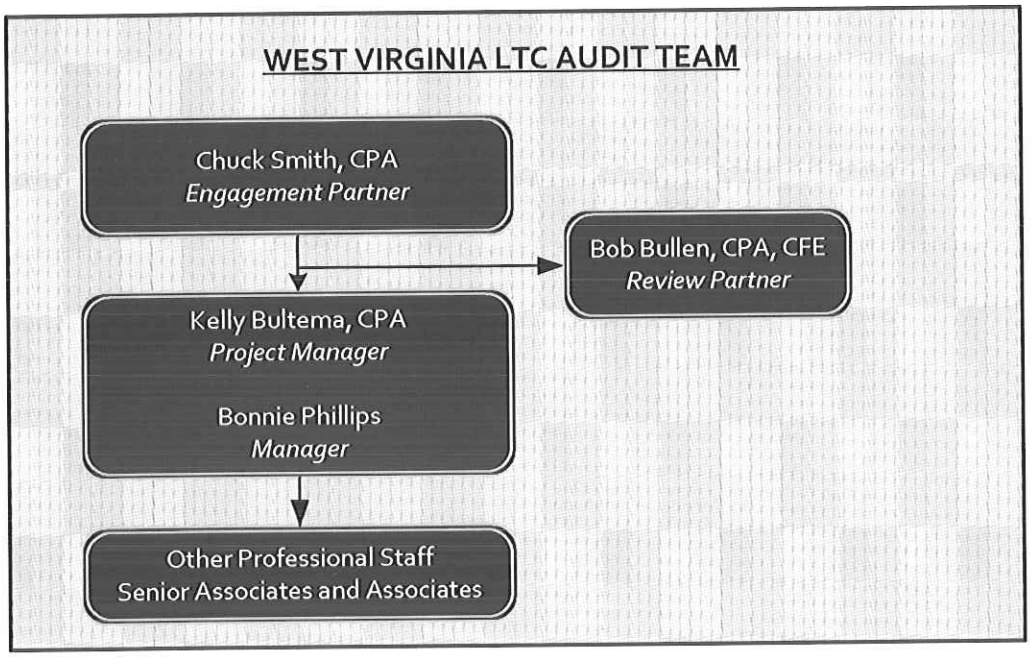
We have completed RFQ Cost Quote (Attachments 1-3) and have included as *Appendix B: Cost Quote.*

19. Key Personnel

At PHBV, we know our clients will not be successful unless we provide them with the highest quality, responsive, and experienced Medicaid audit staff. We, as a firm and individually, pride ourselves on our professionals' depth of experience and we will provide that same high level of expertise to OAMR. All key personnel dedicated to this contract have direct, hands-on experience performing auditing and consulting services for state Medicaid agencies and the CMS.

PROPOSED STAFF ORGANIZATION CHART

Below is our functional organizational chart of our proposed engagement team:



STAFF QUALIFICATIONS AND RESUMES

Engagement Partner

As Engagement Partner, Charles T. Smith, III, CPA, will have overall responsibility for our services provided to OAMR. He will be the contact person for OAMR regarding all matters related to this contract. He will be available for all monthly on-site meetings, or as requested, with OAMR.

Mr. Smith has 17 years of experience in Medicaid auditing and consulting services. He has managed our Medicaid contracts with Virginia and North Carolina and has hand-on experience with field audits, appeals support services and program integrity consulting. Mr. Smith is a Certified Public Accountant in good standing and licensed to practice in West Virginia through the CPA Mobility Act. As a partner of PHBV, he is authorized to act of behalf of the firm.

Our Professionals

We will staff this project in order to exceed your expectations. The following is a brief summary of our key staff and their roles. Please see *Appendix B: Professional Resumes* for additional details. Should we be the successful bidder, these professionals will be the key personnel involved with the project.

Team Member	Role in Project	Years of Health Care Experience	Qualifications
Charles T. Smith, III, CPA *Engagement Partner*	Mr. Smith will have overall responsibility for the project including contract issues and will help oversee the audits.	17	Mr. Smith's first 10 years with PHBV were spent working on our Virginia Medicaid contract. First, he performed field audits of nursing facilities, and then he managed the appeals support services. Mr. Smith spent four years managing our audit contract with North Carolina, and the last three years have been spent providing Program Integrity services to the Federal Government.
Robert Bullen, CPA, CFE *Review Partner*	Mr. Bullen will conduct a quality control review of the reports issued.	28	Mr. Bullen is a partner with over 28 years of experience relating exclusively to health care related audit and compliance services and applying Medicare and Medicaid principles of reimbursement. His clients have included CMS, State of Maryland Department of Health and Mental Hygiene, North Carolina Division of Medical Assistance, South Carolina Health & Human Services, Commonwealth of Virginia Department of Medical Assistance Services, and State of Maryland Health Care Commission.
Kelly Bultema, CPA *Project Manager*	Ms. Bultema will manage the day to day activities of the contract include the oversight of examination field work and supervision of the staff.	11	Ms. Bultema has provided a variety of services to State Medicaid agencies since joining PHBV 11 years ago. This includes performing, leading and supervising field audits as well as defending cost settlement and audit results through the administrative appeals process. Ms. Bultema has also testified as an expert witness.
Bonnie Phillips, *Manager*	Ms. Phillips will provide additional technical leadership and assist Ms. Bultema with the examination field work.	11	Ms. Phillips' 11 years of experience including audit and consulting work (including DSH audits and consulting, mental health fund recoveries, and nursing facility audits) for the state agencies of Alabama, Mississippi, South Carolina, Ohio, Indiana and Illinois.

Staff Training

Our partners and professional staff are required to participate in 40 hours of continuing professional education each year. The majority of our health care staff exceeds that requirement. Specifically, each of our staff members participates in an Internal Training Program. This consists of the following four levels:

- **Staff 1** *(for Associate Level Professionals):* This program covers basic accounting and auditing updates and reviews including independence, assurance services, and specialization. It includes such health care topics as Overview and Structure of Government Health Care Reimbursement Systems, Government Health Care Terms, and Medicare Cost Reports for SNFs, HHAs, Hospitals, and Home Offices.
- **Staff 2** *(for Senior Associate Level Professionals*): This program covers advanced accounting and auditing updates and reviews such as audit planning and analytical procedures. It includes such health care topics as Dealing with Adversarial Communication and An Overview of State Reimbursement Policies.
- **Staff 3** *(for Senior Associate Level Professionals*): This program also covers advanced accounting and auditing updates and reviews including audit efficiency techniques and information technology. It includes such health care topics as Medicare Update, Medicaid Update, and Overview of Health Care Fraud.
- **Staff 4** *(for Manager Level Professionals*): This program is geared toward individuals in supervisory roles and covers such issues as leadership, motivation, effective communication, and high-performance teams.

In addition to the Internal Training Program, PHBV sustains our team's knowledge through our Advanced Education Program. As part of the Advanced Education Program, our professionals attend an annual Health Care Conference. This conference is designed to provide an in-depth update to the participants on current health care related issues, so they can continue to provide quality client service. The topics and speakers are geared toward the services we provide to federal and state government health care agencies. Past topics covered include Medicaid and Medicare updates, fraud, and HIPAA.

In addition, our professionals routinely attend relevant national health care conferences to stay current with trends and issues. These conferences have included:

- American Health Lawyers Association: Long Term Care and the Law
- American Health Lawyers Association: Institute on Medicare and Medicaid Payment Issues
- National Association for Medicaid Program Integrity (NAMPI)
- National Association of State Human Services Finance Officers (HSFO)
- National Association of Medicaid Directors: Annual Conference
- National Health Care Anti-Fraud Association: Annual Training Conference
- Health Care Compliance Association: Annual Meeting

We also conduct local office training sessions that are specific to our Medicaid clients. Recent topics have included:

- Proper Reporting of Insurance Expense
- Working Capital Interest

- Best Practices in Auditing: Asking the Right Questions and Documenting Accurate Results
- Fieldwork Basic Training
- Field work Job Set-up training Basic Medicaid and Medicare Training for New Hires
- Appeals Training for Field Staff
- Adjustment Reports and Regulations

Presentations

The success of our internal training programs and our hands-on training, is evidenced through the opportunities that our Partners, Senior Managers and Managers routinely have to present to national associations, provider groups, state employees, and other stakeholders. In addition, they provide Continuing Professional Education (CPE) compliant training at internal conferences. Below is just a select sample of our most recent presentations.

Topic	Date	Audience
Health Care Fraud: The Government's Response	May 2012	VSCPA Health Care Industry Symposium
Auditing 101	April 2012	CMS Regional Offices
Disproportionate Share Hospital (DSH) Auditing	April 2012	Rhode Island Hospitals
Why Audit MCOs?	February 2012	Medicaid Program Institute
Introduction to the Part C and D Payment Process	December 2011	CMS- Center for Program Integrity
DSH Auditing	September 2011	Massachusetts Hospitals
Introduction to the Part C and Part D Payment Process	September 2011	National Benefit Integrity Medicare Drug Integrity Contractor
Health Insurance Exchanges	August 2011	National Association of State Human Services Finance Officers
DSH Auditing and CMS Reviews	August 2011	National Association of State Human Services Finance Officers
Health Care Reform	August 2011	Virginia Society of Certified Public Accountants, Richmond Chapter
DSH Audit Training	August 2011	State of Pennsylvania Bureau of Audits
Medicaid Managed Care Auditing and Accountability	August 2011	National Association for Medicaid Program Integrity Annual Conference
Parts C & D Information Exchange	May 2011	CMS PI Field Offices/ Law Enforcement
Developing Risk Assessments and Work Plans	February 2011	NHCAA Institute for Health Care Fraud Prevention, Health Care Policy & Reform Update
Medicaid Reimbursement for Special Education Services	February 2011	Virginia Association of School Business Officials

LTC Non-Compliance

The Project Director will notify OAMR immediately of any noncompliance by LTC Providers to submit requested information necessary to complete the audit. We understand that, as covered in *Section 514* of the West Virginia Nursing Facility Provider Manual:

- Records found to be incomplete or missing at the time of the scheduled on-site visit must be delivered within 48 hours or an amount of time mutually agreed upon with the audit staff at the exit conference
- Provider costs found to be unsubstantiated will be disallowed and considered an overpayment.
- Failure of Providers to submit records will not be justification for late submission by vendor of expected audit report deliverables.

Appendix A: Project Profiles

Commonwealth of Virginia

Department of Medical Assistance Services
Cost Settlements/Field Verifications of Medicaid Providers

Project Requirements	PHBV completed cost settlement and rate setting for the following provider types: nursing homes, nursing homes with Specialized Care, hospitals, hospitals based sub-providers, Intermediate Care Facilities for the Mentally Retarded, Federally Qualified Health Clinics, rural health clinics, and home offices to ensure compliance with Medicaid and Medicare regulations, principles, and policies. Perform desk audit consisting of an analysis of the submitted cost reports from both a clerical and professional perspective. Determine the completeness and reasonableness of the submitted data using the Uniform Desk Review Program, Automated Desk Review Reports, and the Desk Preview/Review Program.
Technical Approach Taken	• Verify submitted data using the Completeness Review Checklist to ensure that all information has been submitted. When an incomplete cost report is identified, notify the provider that their rate may be cut and give them an opportunity to correct the deficiency. Once everything has been received, enter the date the cost report is deemed complete into DMAS' Cost Report Tracking System (CRTK) and the cost report is uploaded into the DMAS system. • Perform desk review on all provider cost reports utilizing the Uniform Desk Review Program (UDR). The UDR allows for both a clerical and professional analysis of the cost report to ensure mathematical accuracy, tracing of amounts on the cost report to the provider's financial reports and supporting documentation, verifying computations on all submitted documents and preparing the Automated Desk Review (ADR) Reports. • Perform follow-up analysis on any variances noted on the system generated ADR Reports comparing prior year settled data to current year as filed report. • Assigned desk analyst performs a professional review to ensure that the provider's cost report has been prepared in compliance with Generally Accepted Accounting Principles, Center for Medicare and Medicaid Services (CMS) guidelines in terms of allowability and classification of costs, and ultimately, in accordance with DMAS regulations, policies and procedures. • Review financial statements for important reimbursement issues such as new financing, related parties, legal issues, sale/purchase of assets and going concern issues. • Prepare a comparative analysis of costs and statistical information to the prior year. Areas of focus to include expenses and expense groupings, reclassification of expenses between cost centers, adjustment to expenses, changes in statistical basis and prior period adjustment reports. • Review provider's relationship to the various ceilings and limitation. • After a detailed managerial review, issue a Notice of Amount of Program

	Reimbursement (NPR). The NPR includes the desk audit adjustment report, the revised cost report, the amount of any settlement due to or from the provider and the breakdown of the new reimbursement rate. • Revise prior year cost reports based on field verifications and appeal decisions. Prepare and issue revised NPRs.
Periods of Performance	• First Contract: July 1993 - December 1994 • Second Contract: January 1995 - December 31, 1995 • Third Contract: January 1996 - December 1996 • Fourth Contract: January 1997 - December 1999 • Fifth Contract: January 2000 - December 2005 • Sixth Contract: January 2006 - December 2008 (with three annual renewal options) • First Contract Extension: January 2009 – December 2009 • Second Contract Extension: January 2010 – December 2010 • Third Contract Extension: January 2011 – December 2011 • Seventh Contract: December 2011- present
Deliverables	• Notice of Amount of Program Reimbursement • Settlement Summary • Adjustment Reports • Revised Cost Reports • Monthly Add-pay Report
References	Mr. William Lessard Director, Provider Reimbursement Division Department of Medical Assistance Services Commonwealth of Virginia Suite 1300 600 East Broad Street Richmond, Virginia 23219 804-225-4593 william.lessard@dmas.virginia.gov

Commonwealth of Virginia

Department of Medical Assistance Services

PFA Field Verifications of Medicaid Providers

Project Requirements	Perform agreed-upon procedures on behalf of DMAS on appropriate Personal Fund Account (PFA) records and billings submitted to DMAS for reimbursement for participating long-term care facilities including nursing homes, long-term care units in hospitals, long-term care facilities operated by the Department of Mental Health and Mental Retardation, and Intermediate Care Facilities for the Mentally Retarded. The review ensures compliance with Medicaid and Medicare regulations, principles, and policies concerning proper management of resident resources, review records for proper application of resident patient pay amounts, and identify credit balances in the provider accounts receivables. Approximately 311 providers of various provider types, including nursing homes, long term stay hospitals, ICF/MRs.
Technical Approach Taken	• PFA Verifications are completed for each long-term care facility approximately once every two years. Pre-field planning includes reviewing prior verification findings, obtaining Medicaid claims data, performing analytical procedures on the claims data, and scheduling the verification with the provider. On-site testing is then performed, and an exit conference is held on the last day of fieldwork to discuss all proposed corrections and other management report comments with provider representatives. A report of agreed upon procedures is issued, which includes a detailed discussion of findings • Perform follow-up procedures on data submitted by the provider, to assure compliance with recommended changes from the PFA verification, and report to the Department on the results of the follow-up • These verifications are performed by professional staff. They are reviewed by a Partner, Senior Manager or Manager. Partner or Senior Manager performs a final review, and a pre-issuance review is performed by a Partner or Senior Manager. • DMAS representatives are kept informed of progress and any unusual and/or major issues concerning claims processing problems, possible recipient or provider fraud, Department of Social Services problems, problems regarding the DMAS Estate Recovery Unit notification of resources disbursed to families upon death of recipients, and unusual payments on accounts receivable to Third Parties at DMAS are referenced to the appropriate agency • Maintain liaison with the various DMAS units as well as work with the Medicaid Fraud Control Unit in cases of provider and/or provider staff fraud issues.
Periods of Performance	• First Contract: May 1995 - December 1995 • Second Contract: January 11996 - December , 1996 • Third Contract: January 1997 - December 1999 • Fourth Contract: January 2000 - December 2005

	• Fifth Contract: January 2006 - December 2008 (with three annual extensions) • First Contract Extension: January 2009 – December 2009 • Second Contract Extension: January 2010 – December 2010 • Third Contract Extension: January 2011 – December 2011 • Seventh Contract: December 2011- present
Deliverables	• Report on agreed-upon procedures • Findings Letters • Monthly Progress Reports
References	Mr. William Lessard Director, Provider Reimbursement Division Department of Medical Assistance Services Commonwealth of Virginia Suite 1300 600 East Broad Street Richmond, Virginia 23219 804-225-4593 william.lessard@dmas.virginia.gov

Commonwealth of Virginia

Department of Medical Assistance Services
Consulting Services

Project Requirements	Represent Medicaid program during the informal provider appeals process, testify as an expert witness in formal appeals, and be a resource to DMAS attorneys. Perform special projects as directed by DMAS including data gathering and manipulation, research, processing Freedom of Information requests, and giving technical advice. Provide general consultation on an as needed/requested basis. Approximately 650 providers of various provider types, including nursing homes, hospitals, FQHCs, RHCs, ICF/MRs.
Technical Approach Taken	• Prepare case summaries in response to providers' requests for informal appeals and submit them within statuary timeframes • Attend Informal Fact Finding Conferences to present and defend Department actions. Prepare responses to provider submissions during the course of the informal appeal, and be a resource to DMAS informal appeals agents • Preparation of case summaries includes extensive research in the Virginia Administrative Code, Code of Federal Regulations and Medicare's Provider Reimbursement Manual, in addition to discussing the issues with staff who performed settlements and/or field verifications • All informal appeals correspondence is reviewed by a Senior Manager prior to issuance • Assists DMAS attorneys with the preparation of formal appeals, including preparing evidentiary matter, help attorneys gain understanding of technical issues, and prepare testimony • Testify as an expert witness during formal appeals. Assist DMAS attorneys with post hearing briefs, including addressing technical aspects and performing research • Meet with DMAS representatives to gain an understanding of the objectives of special projects and end user results • Work with DMAS representative to determine proper course of action and set deadlines • Update and design Virginia Medicaid cost reporting forms to reflect changes in reimbursement methodologies • Process Freedom of Information Act requests
Periods of Performance	• First Contract: May 1995 - December 1995 • Second Contract: January 1996 - December 1996 • Third Contract: January 1997 - December 1999 • Fourth Contract: January 2000 - December , 2005 • Fifth Contract: January 2006 - December 2008 (with three annual renewal options)

	• First Contract Extension: January 2008 – December 2009 • Second Contract Extension: January 2009– December 2010 • First Contract Extension: January 2010 – December 2011 • Seventh Contract: December 2011- present
Deliverables	• Case Summaries • Other Appeals Correspondence • Results of Specialized Projects in agreed-to format • Monthly Progress Reports
References	Mr. William Lessard Director, Provider Reimbursement Division Department of Medical Assistance Services Commonwealth of Virginia Suite 1300 600 East Broad Street Richmond, Virginia 23219 804-225-4593 william.lessard@dmas.virginia.gov Mr. Samuel Metallo, Appeals Division Director Department of Medical Assistance Services Commonwealth of Virginia 600 East Broad Street, Suite 1300 Richmond, Virginia 23219 804-786-1501 samuel.metallo@dmas.virginia.gov

Commonwealth of Virginia

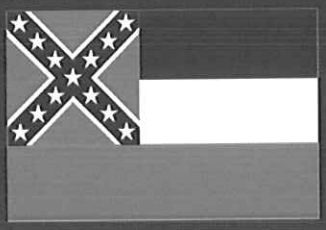
Department of Medical Assistance Services

Provider Review Unit Services

Project Requirements	Provide assistance to the Program Integrity Division, Provider Review Unit, of The Department of Medical Assistance Services with the development of a provider risk assessment tool and provider review program to streamline and unify the review process. Performed an efficiency study of the unit. Perform claims reviews of hospice providers, residential treatment centers, and other provider types. Our work has resulted in significant savings to the Virginia Medicaid program.
Technical Approach Taken	• Completion of the eligibility PERM-like (Eligibility Review Project) review for the FY 2007 (Phase I) and 2008 (Phase II) review cycles. We were responsible for writing the sampling plan that was approved by CMS. In addition, we were also responsible for stratifying the eligibility records and selecting the monthly samples. The case files were reviewed to determine if the eligibility decision as been appropriate. Finally, we were also responsible for completing and uploading all required reports to CMS. • Complete the verification procedures utilizing the provider review program. This includes obtaining claims history for the specified period of review, requesting and reviewing provider documentation to support claims history, recalculating allowable paid amount and noting any instances of non-compliance with program regulations. • Final review performed by a senior manager, with a pre-issuance review performed by the engagement partner. • Issue overpayment determination letter, with schedule of overpayment determination detail, to the provider upon completion of verification procedures. Also, notify DMAS Fiscal Division and Training Unit of any overpayment amounts and detail of errors identified. • Upon provider request, perform reconsideration of initial verification procedures. Reconsideration includes documenting the provider's request and reviewing any additional documentation submitted by the provider. • Issue reconsideration overpayment determination letter, with schedule of overpayment determination detail, to the provider upon completion of reconsideration procedures. Also, notify DMAS Fiscal Division of the overpayment amount resulting after the reconsideration process. Represent DMAS at informal hearings related to the determined overpayments. • Keep DMAS representatives informed of progress and consult with them on any unusual and/or major issues.
Periods of Performance	• First Contract: November 1, 2005 - June 30, 2006 • Second Contract: July 1, 2006 – June 30, 2007

	• Third Contract: August 1, 2007 – July 30, 2010 (with three annual renewal option years) • Option Year 1: August 2010-July 2011 • Option Year 2: August 2011-July 2012
Deliverables	• Provider's schedule of overpayment determination detail, by recipient • DMAS schedule of overpayment determination detail, by year • Provider's notification of overpayment determination • Fiscal Division "Authorization to Recover Provider Overpayment" form • Training Unit memo for provider education • Report on how to improve efficiency and operations • Deliver case summaries for the informal and formal appeal process
References	Mr. Louis Elie Director, Program Integrity Division Department of Medical Assistance Services Commonwealth of Virginia Suite 1300 600 East Broad Street Richmond, Virginia 23219 804-786-5590 louis.elie@dmas.virginia.gov Ms. Cheryl Roberts Deputy Director, Programs and Operations Department of Medical Assistance Services Suite 1300 600 East Broad Street Richmond, Virginia 23219 804-786-6147 cheryl.roberts@dmas.virginia.gov

State of Mississippi



Office of the Governor, Division of Medicaid

Medicaid Accounting and Reimbursement Consulting Services

Project Requirements	Provide the State with Medicaid program reimbursement policy and operational consulting services including, but not limited to: expert legislative testimony, facilitating communication with senior CMS staff, detailed analysis of OIG findings, and recommendations regarding audit initiatives. Examination of Medicaid providers in order to assess the appropriateness of costs claimed in association with providing Medicaid services.
Technical Approach Taken	Review of nursing facility cost reports submitted to the Division of Medicaid to establish per diem rates for reimbursement. Steps include: • Conduct pre-engagement planning meetings prior to fieldwork. • Data analysis to highlight areas where the Medicaid cost report appears to be outside of expected norms. • Inspection of physical facility for indications of improper cost reporting and/or substandard care. • Review of resident census to ensure proper reporting. • Vouching of expenses (on a sample basis) reported on the Medicaid cost report for validity, reasonableness, proper classification, and allowability. • Examination of home office expenses, including the home office allocations and expense detail for proper allocation methodology and expense validity. • Review of statistics used to allocate costs (as applicable). • Review resident billings for discounting. • Recalculate per diem rates and outpatient reimbursement percentages. Review of hospital Medicare cost reports submitted to the Division of Medicaid to establish per diem rates for reimbursement. Steps include: • Conduct pre-engagement planning meetings prior to fieldwork. • Data analysis to highlight areas where the Medicare cost report appears to be outside of expected norms. • Inspection of physical facility for indications of improper cost reporting and/or substandard care. • Review of resident census to ensure proper reporting. • Vouching of expenses (on a sample basis) reported on the Medicare cost report for validity, reasonableness, proper classification, and allowability.

- Examination of home office expenses, including the home office allocations and expense detail for proper allocation methodology and expense validity.
- Review of statistics used to allocate costs.
- Recalculate per diem rates and outpatient reimbursement percentages.
- Review uninsured cost data submitted by hospitals to the Division of Medicaid to support their Disproportionate Share Hospital (DSH) allotment. Steps include:
- Verify the Medicare Cost-to-Charge Ratio.
- Select a statistically valid sample of uninsured charges and payments.
- Review documentation to validate uninsured charges. The documentation consists of collection notes, claim detail, charity care applications, billing records, etc.
- Review documentation, including accounts receivable detail, to validate uninsured payments.

Review claims submitted to the Division of Medicaid by therapy providers, mental health facilities, and hospitals for reimbursement. Steps include:

- Conduct pre-engagement planning meetings prior to fieldwork.
- Data analysis to highlight areas where reimbursement appears to be outside of expected norms.
- Data analysis for duplicate billings.
- Select statistical valid sample of claims.
- Inspection of physical facility to gain understanding of the services provided.
- Review documentation to validate submitted claims. This documentation consists of, but are not limited to, medical records, physician orders, treatment plans, eligibility verifications, physician notes, test results (laboratory tests, x-ray, EKG, etc.), and therapy notes.

Evaluated performance of the Program Integrity bureau within the Division of Medicaid. Steps included:

- Interview key personnel.
- Examine processes used to identify possible cases of fraud and abuse.
- Examine audit techniques to maximize return to DOM.
- Assess the relationship between the Program Integrity department and the Medicaid Fraud Control Unit.
- Assess compliance with federal and state regulations.

Risk assessment of the State Children's Health Insurance Payments (SCHIP) Program. Steps included:

- Interview key personnel.
- Review contractual requirements between the Division of Medicaid, the Department of Finance Administration, and the contractor of the SCHIP program.
- Assess compliance with federal and state regulations.

Evaluated the performance of the contractor responsible for maintaining the Medicaid Management Information System (MMIS). Steps included:

- Interview key personnel.
- Review contractual requirements between the Division of Medicaid and the contractor of the MMIS system.
- Assess compliance with federal and state regulations.

	Review of Medicaid and uninsured data submitted by a large regional trauma center (located in Memphis, Tennessee) to the State of Mississippi for DSH and UPL reimbursement. Steps included: • Review of submitted Medicaid and uninsured claims for reasonableness and allowability under Mississippi State Plan guidelines • Verification of cost-to-charge ratio from the Medicare cost report used in the calculation for DSH reimbursement Review of the Medicaid's Supplemental Drug Rebate Program to verify the payments received by drug companies were appropriate. Assisted the Division of Medicaid in preparing the State's response to the proposed rule (now final but under moratorium) issued by CMS regarding Intergovernmental Transfers (IGTs), Certified Public Expenditures (CPEs), and limiting government providers to cost. Expert witness testimony was also provided to the Mississippi Legislature Medicaid Committee regarding this rule
Periods of Performance	• Initial contract: July 2006 - June 2008 (w/ 2 one-year renewal options) • First Contract Extension: July 1, 2007 – June 30, 2008 • Second Contract Extension: July 1, 2008 – June 30, 2009 • Third Contract Extension: July 1, 2009 – June 30, 2012
Deliverables	• Draft Consulting Report • Final Consulting Report • Detailed analysis and modeling of provider costs and profitability • Oral presentations to legislature, senior staff, and providers
References	Mr. Richard Roberson, Special Assistant to the Executive Director State of Mississippi Office of the Governor Division of Medicaid Walter Sillers Building 550 High Street, Suite 1000 Jackson, Mississippi 39201 601- 359-6118 Richard.Roberson@medicaid.ms.gov

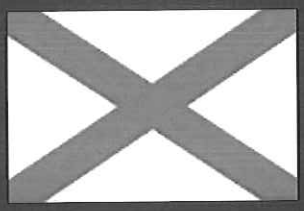
State of Michigan

Department of Community Health

Payment Error Rate Measurement Eligibility Reviews

Project Requirements	Perform the State's eligibility portion of the Payment Error Rate Measurement (PERM) review of Medicaid for Federal fiscal year 2009. In addition, conduct eligibility reviews of the State Children's Health Insurance Program (CHIP) for the Federal fiscal year 2010.
Technical Approach Taken	• Confirm understanding of the claims processing and eligibility systems. • Perform a preliminary review of case files for a variety of beneficiary types to obtain a better understanding of the overall eligibility process. • Stratify eligibility data to select monthly samples. • Review eligibility cases for each monthly sample to identify any errors made in the eligibility decisions. • Submit the required PERM reports to CMS on a monthly basis. • Serve as a representative to CMS on behalf of the Department to Support the state in all matters relating to the PERM eligibility review.
Periods of Performance	October 2008 - present
Deliverables	• Weekly Status Reports • Sampling Report (PETT Report) submitted to CMS • Active and Negative Findings Report (PETT Report) submitted to CMS • Claim Payment Report (PETT Report) submitted to CMS • Corrective Actions/Recommendations based on review findings • Draft and Final Consulting Report
Reference	Mr. Dan Ridge, Manager State of Michigan Department of Community Health Medical Services Administration Eligibility Quality Assurance 400 S. Pine Street, 5th Floor Lansing, Michigan 48913 517-241-7556 ridgedan@michigan.gov

State of Alabama



Medicaid Agency
Medicaid Accounting and Consulting Services

Project Requirements	Evaluate the performance of Alabama's Medicaid Agency's Financial Management Division. The focus of the engagement was to review and assess budgeting, forecasting, financial reporting, and work-flow processes
Technical Approach Taken	• Interview key personnel. • Review operating policies and procedures. • Analyze the budgeting process and assess the current fiscal year budget. • Analyze the forecasting process. • Evaluate the completed CMS-37 Report for the quarter ending December 31, 2008. • Evaluate the CMS-64 Report prepared for the period ending December 31, 2008. • Assess the performance of the Provider Audit and Reimbursement Division. • Identify weaknesses related to the work-flow processes, such as accounts receivable, cash collection, and accounts payable.
Periods of Performance	May 2008 – Present
Deliverables	• Draft Consulting Report • Final Consulting Report
References	Dr. R. Bob Mullins, Commissioner Alabama Medicaid Agency 501 Dexter Avenue P.O. Box 5624 Montgomery, Alabama 36103-5624 334-242-5600 R.Bob.Mullins@medicaid.alabama.gov

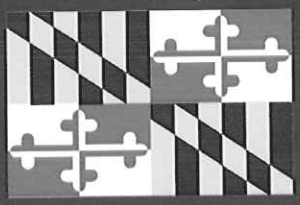
State of South Carolina

Department of Health and Human Services

Disproportionate Share Hospital Program Agreed-Upon Procedures Services/ Cost Settlements

Project Requirements	Perform agreed-upon procedures of the Disproportionate Share Hospital (DSH) program. Procedures performed satisfy the requirements in the CMS proposed rule to implement section 1001(d) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) which establishes new reporting and auditing requirements for State Disproportionate Share Hospital payments.
Technical Approach Taken	South Carolina currently has 61 hospitals that qualify for Medicaid DSH payments. PHBV validates DSH Survey data on a hospital-specific basis in order to assess the State's compliance with applicable federal and state regulations. Three levels of testing are performed: • Hospital Desk Procedures • Hospital On-Site Procedures • State Procedures
Periods of Performance	January 2006 - Present
Deliverables	• Draft Agreed-Upon Procedures Report • Final Agreed-Upon Procedures Report
References	Mr. Jeff Saxon Bureau Chief, Reimbursement, Methodology & Policy Finance and Admin., South Carolina Dept of Health and Human Services 1801 Main Street, Room 633 Columbia, South Carolina 29201 803-898-1023 saxon@scdhhs.gov

State of Maryland

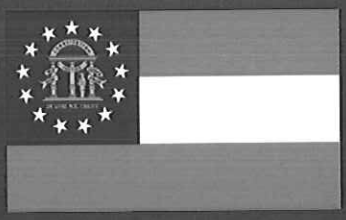


Maryland Health Care Commission
Audits of Reimbursement Applications

Project Requirements	PHBV was contracted by the Maryland Health Care Commission to test the accuracy of the reimbursement applications as follows: • Trauma physicians are eligible for reimbursement from the Maryland Trauma Physician Services Fund for providing trauma care to patients without health insurance. The Fund provides reimbursement to trauma physicians for uncompensated care provided to trauma patients. It reimburses trauma centers for expenses associated with having trauma physicians on-call and available to provide trauma care. Trauma physicians may apply to the Fund for uncompensated care services after they have exhausted their collection policies in seeking payment. • The seven Level II and III trauma centers designated by the Maryland Institute for Emergency Medical Services Systems are eligible for reimbursement for having certain trauma physicians on-call at the trauma center Our procedures included the following: • Develop audit plan, including work program, which will confirm that applications for uncompensated care reimbursement conform to law • Develop audit plan, including work program, which will confirm the accuracy of on-call applications • On-site audits of sample of trauma physician practices to ensure that information submitted was supported by clinical and billing information held by physician practices that rendered the care • On-site audits of trauma centers to ensure that information submitted for on-call expenses accurately reflect the costs of providing on-call stipends to trauma physicians
Technical Approach Taken	Based upon the requirements of the contract and discussions with Maryland Health Care Commission personnel, detailed project plans and work programs were prepared to: • Perform on-site engagement at selected trauma centers and trauma physician practices utilizing the approved work programs to determine whether reported information was accurate; whether the submitted on-call expenses tied back to supporting documentation; whether other parties were responsible for the uncompensated care; and, whether collection policies were followed • Issue reports for each trauma center and physician practice reporting the findings of our procedures

Periods of Performance	• First Contract: April 2004 – September 2005 • Second Contract: September 2005 - October 2008 • Third Contract: November 2008 - October 2010 • Fourth Contract: October 2010 – November 2012
Deliverables	Draft and final reports for each trauma center
References	Mr. Ben Steffen Deputy Director, Data Systems and Analyst Maryland Health Care Commission 4160 Patterson Avenue Baltimore, Maryland 21215 410-764-3460 bsteffen@mhcc.state.md.us Mr. William Chan Health Policy Analyst Maryland Health Care Commission 4160 Patterson Avenue Baltimore, Maryland 21215 410-764-3374 wchan@mhcc.state.md.us

State of Georgia



Department of Community Health
Audit of Medicaid Cost Reports

Project Requirements	We performed audits and settlements to ensure that hospitals are properly identifying and allocating allowable costs to appropriate cost centers. Specifically, we performed Medicaid settlement adjustments for backlogged cases, as well as current hospital cost reports.
Technical Approach Taken	• 1. Perform audits of provider cost statements and records that are required by State and Federal statutes, including Title XVIII and Title XIX and related rules and regulations governing the Medicaid program. • 2. Comply with generally accepted accounting and auditing standards and procedures applicable to providers of medical services in a review of the adequacy of the application of Title XIX laws and regulations to the providers' cost review. • 3. Complete the preliminary desk review within 30 days after receipt of the cost report from the provider. If a final settlement will be made after the desk review, the report should identify any settlement amount. • 4. Complete the field audit, in accordance with generally accepted audit standards, if determined necessary by the desk review unless precluded by circumstances beyond Contractor's control. A report on the field audit including a copy of the audit adjustments must be provided to the Department within thirty (30) days after the review is completed. • 5. Prepare a status report at the commencement of the Contract and monthly thereafter in accordance with the criteria prescribed in Deliverables, item number 4. Monthly reports are due to DCH within ten (10) business days after the end of every month. • 6. Contractor shall notify DCH on the 15th day of each month of the hospitals that do not submit their cost reports within the five (5) months period or within six (6) months if the grace period is applied. As filed, reports will be provided to DCH upon receipt and acceptance. • 7. Within 10 days after the end of each quarter, submit an itemized billing for all audit activities including field audits, desk reviews and work in process during the quarter at the contracted hourly rate, including travel. • 8. Provide written notice within ten (10) days of the discovery and continue to give information on a timely basis to the DCH concerning any significant, unusual and questionable reimbursement problems arising during the course of desk review or field audit involving Title XIX funds. The Contractor will invite DCH to participate in all pertinent discussions. • 9. Transmit to DCH within ten (10) calendar days; any information discovered relating to suspected fraud and abuse of the Medicaid program.

	• 10. Assist the Department in the establishment of a defense of all actions, hearings, or appeals involving the common audit program for Title XIX. Contractor will provide the personnel (at the composite hourly rate) who will make available their working papers in all such matters. The Contractor shall support its recommendations in any subsequent administrative or judicial hearing. • 11. Provide consultative services for reimbursement and settlement activities, including assisting the providers in filing and working reports, recommending improvements to internal controls and advising on questionable items or reimbursable costs.
Periods of Performance	August 14, 2009 to current date
Deliverables	• 1. Contractor must submit a final detailed work plan prior to implementation that includes all of the activities required to begin work under this contract. The final plan must contain a project timeline with milestones and steps necessary to implement the audits. The final detailed work plan must be submitted to DCH within fifteen (15) calendar days of the execution of the contract. • 2. A draft Disaster Contingency Plan including all the requirements noted in Technical Section 2.4 shall be submitted to the DCH Program Manager for review and approval within fifteen (15) days of contract execution. The final approved Disaster Contingency Plan must be submitted to DCH as a formal Agreement deliverable within ten (10) working days of receiving DCH's required revisions to the draft. • 3. Contractor must submit an initial status report within fifteen (15) calendar days of the execution of the contract. • 4. Contractor must submit a monthly status report to DCH due no later than ten (10) business days after the end of every month. The monthly status report shall include at a minimum the following items: a) number of provider cost report statements received during the month; b) number of provider cost report audits completed during the month; c) number of desk reviews completed; d) number of field audit reviews completed; e) number of provider cost report audits not completed during the month. • 5. Contractor shall notify DCH monthly of hospitals that do no submit their cost reports within the five (5) month period, six (6) months if the grace period is applied. Contractor will provide DCH with reports as filed upon receipt and acceptance. • 6. Within thirty (30) days after the completion of a desk audit or field audit, Contractor must submit a report of the audit including a copy of the audit adjustments. • 7. Within ten (10) days of discovery, Contractor must provide DCB written notice concerning any significant, unusual and questionable reimbursement problems arising during the course of desk review or field audit involving Title XIX funds. Contractor shall invite DCB to participate in all pertinent discussions. • 8. Within ten (10) days of discovery, Contractor must transmit to DCB any information relating to suspected fraud and abuse of the Medicaid program.
References	Mr. David Riddle Georgia Department of Community Health 2 Peachtree Street, NW- 39th Floor Atlanta, Georgia 30303-3159 404- 657-7120 driddle@dch.ga.gov

State of Nevada

Department of Health and Human Services
Disproportionate Share Hospital (DSH) Audits

Project Requirements	PHBV has been engaged by the State of Nevada to perform the DSH audits for state plan rate years 2005, 2006, 2007 and 2008. Conducted agreed upon procedures of Nevada's DSH program to verify the DSH payments were in compliance with the Nevada State Plan and Federal laws and regulations. The engagement was performed to determine whether individual hospitals qualified for DSH payments based upon the criteria set forth in the Social Security Act and the payments to individual hospitals did not exceed the limits imposed by the Omnibus Budget Reconciliation Act (OBRA) of 1993.
Technical Approach Taken	• Agreed upon procedures of submitted Medicaid and uninsured claims for reasonableness and allowability under Nevada State Plan guidelines. • Verification of cost-to-charge ratios from the Medicare cost report used in the calculation for DSH reimbursement • Verification of the DSH reimbursement methodology for compliance with the State Plan and Federal laws and regulations • Compared the amount of uninsured costs claimed to the amount of DSH payment received by each hospital
Periods of Performance	• May 2009 – present
Deliverables	• Draft of Agreed Upon Procedures Report • Final Agreed Upon Procedures Report
References	Ms. Janice Prentice State of Nevada Division of Health Care Financing and Policy 1100 E. William Street, Suite 119 Carson City, Nevada 89701 775-684-3791 jprentice@dhcfp.nv.gov

State of Nevada

Department of Health and Human Services
Patient Trust Fund (PTF) Verifications

Project Requirements	Perform agreed-upon procedures on behalf of the Department of Health and Human Services, Division of Health Care Financing and Policy (DHCFP) on appropriate Personal Trust Fund Account (PTF) records for participating long-term care facilities including nursing homes and Intermediate Care Facilities for the Mentally Retarded. The review ensures compliance with Medicaid and Medicare regulations, principles, and policies concerning proper management of resident resources, and review records for proper application of resident patient pay amounts. Approximately 46 providers of including nursing homes and ICF/MRs.
Technical Approach Taken	• PTF Verifications are completed for each long-term care facility approximately once every two years. Pre-field planning includes reviewing prior verification findings, obtaining Medicaid claims data, reviewing the provider's response to the prior verification findings, and scheduling the verification with the provider. On-site testing is then performed to review compliance with the state and federal regulations. An exit conference is held on the last day of fieldwork to discuss the draft report and other management report comments with provider representatives. A report of agreed upon procedures is issued, which includes a detailed discussion of findings • Perform follow-up procedures on data submitted by the provider, to assure compliance with recommended changes from the PTF verification, and report to the Department on the results of the follow-up • These verifications are performed by professional staff. They are reviewed by a Partner, Senior Manager or Manager. Partner or Senior Manager performs a final review, and a pre-issuance review is performed by a Partner or Senior Manager • DHCFP representatives are kept informed of progress and any unusual and/or major issues concerning claims processing problems, possible recipient or provider fraud, eligibility determination problems, problems regarding the Estate Recovery Unit notification of resources disbursed to families upon death of recipients • Maintain liaison with the various DHCFP units as well as provide information to the Medicaid Fraud Control Unit in cases of provider and/or provider staff fraud issues.
Periods of Performance	• First Contract: January 2009 – December 2009 • Second Contract: January 2010 – December 2010 • January 2011 – June 2013

Deliverables	• Report on agreed-upon procedures • Findings Letters • Monthly Status Reports
References	Ms. Janice Prentice State of Nevada Division of Health Care Financing and Policy 1100 E. William Street, Suite 119 Carson City, Nevada 89701 775-684-3791 jprentice@dhcfp.nv.gov

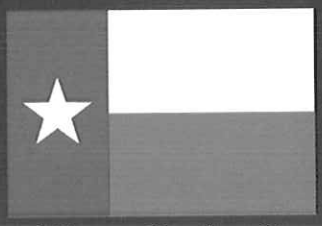
State of Nevada

Department of Health and Human Services
Field Verifications of Medicaid Providers

Project Requirements	Perform agreed-upon procedures on behalf of the Department of Health and Human Services, Division of Health Care Financing and Policy (DHCFP) which include field verifications for the following provider types: nursing homes, Intermediate Care Facilities for the Mentally Retarded, Federally Qualified Health Clinics, hospital based skilled nursing facilities, and Critical Access Hospitals to ensure compliance with Medicaid and Medicare regulations, principles, and policies.
Technical Approach Taken	• Prior to the cost report due date blank cost report forms and payment data are sent to the provider along with instructions on completing the cost report. • Conduct field verification pre-field planning procedures to gain an understanding of potential issues and assess risk. This includes reviewing the prior period adjustments, prior period appeals, and current period cost report. This also includes performing analytical procedures, assessing the risk that the cost report expenses are overstated, identifying expenses for further review, and identifying other issues that require further analysis. Conduct an engagement planning meeting between the senior manager and/or manager and all staff assigned to the verification to discuss the potential risk that the expenses on the cost report are over stated and other potential issues. Review payment data and Medicaid utilization, develop materiality levels, and formulate the verification plan. Pre-field planning also includes requesting needed documentation from the provider thirty days prior to the start of field work and obtaining "up-front" documentation such as the General Ledger to promote efficiency. • Perform verification based on the assessed risk utilizing the DHCFP verification program to determine whether the statistical information is accurate; whether the submitted expenses are reasonable, necessary, related to patient care, allowable, adequately documented, and properly classified; and whether any income should be offset against expenses. Address issues that are all or in part unique to Nevada, such as the providers relationship to the Direct Care Floor. Hold exit conference on the last day of fieldwork to discuss all proposed adjustments and Findings Letter comments with provider representatives. • Perform post-field procedures including accepting and evaluating additional provider information submitted within regulatory time frames, making revisions to adjustments as necessary, and keeping the provider informed of all changes. • Finalize adjustment reports noting questioned costs and regulatory citations. Apply final adjustments to the cost report, issue a Notice of Program Reimbursement (NPR) to the provider, respond to any appeals filed by the provider, and upon receipt of a signed NPR or 30 days after the issuance of a Final Decision transmit a final report package to DHCFP.

	• Staff auditors perform field verifications. A Senior Manager or a Manager performs a detailed review. A Senior Manager/Partner performs a final review. • Constantly evaluate and update field verification processes to ensure efficiency and effectiveness and that designed procedures are relevant to the current environment. • Provide support for the Medicaid Fraud Control Unit on an as needed basis. • Keep DHCFP representatives informed of progress and consult with them on any unusual and/or major issues.
Periods of Performance	• First Contract: January 2009 – December 2009 (with First Health Services) • Second Contract: January 2010 – December 2010 • January 2011 – June 2013
Deliverables	• Finalized reports and supporting documentation • Findings Letters • Monthly Status Reports
References	Ms. Janice Prentice State of Nevada Division of Health Care Financing and Policy 1100 E. William Street, Suite 119 Carson City, Nevada 89701 775-684-3791 jprentice@dhcfp.nv.gov

State of Texas



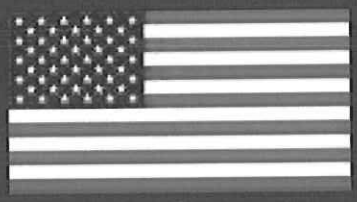
Health and Human Services Commission

MCO Risk Assessments/DSH

Project Requirements	PHBV was engaged to provide risk assessments to assist the Texas Health and Human Services Commission (HHSC) to identify areas in each managed care organization (MCO) contract that may pose a business risk to the State of Texas (State) and that may merit performance audit coverage. Risk assessments of 14 MCOs were conducted. For the State of Texas, we performed a risk assessment of the State's DSH program. We also conducted an agreed upon procedures engagement to review the reliability of reported uninsured charges reported by five large urban hospitals participating in the DSH program. As part of our risk assessment of the DSH program, we performed an analysis of the Department's current rules, policies and procedures, including the State Plan under Title XIX of the Social Security Act, an assessment of the risk of non-compliance with current and proposed DSH rules promulgated by CMS; an assessment of the risk that the State's current DSH program operational practices do not ensure compliance with established policies and procedures; and an analysis and assessment of the risk that the underlying hospital cost data submitted to the Department may not be reliable. We also provided HHSC with proposed responses to mitigate the risks that we had identified. For the agreed-upon procedures engagement at the selected hospitals, through interviews, observations, and manual and computerized analysis of data, we reviewed each selected hospital's policy and procedures for uninsured care days, indigent care, and charity charges to ascertain compliance with DSH conditions of participation; determine whether the hospital claims for uninsured care were accurately reported in accordance with criteria mutually agreed to with HHSC and based on the Code of Federal Regulations (CFR) and the Texas Administrative Code (TAC); projected inaccuracies identified in our statistically valid samples over the entire populations of claims; and provided HHSC with a written report of the outcome of the accuracy of the hospital claims for uninsured data.
Technical Approach Taken	In identifying the areas of risks, PHBV reviewed: • The related Request for Proposal published by HHSC • The proposal submitted by each individual MCO • The contract between HHSC and each MCO • Subcontracts between each MCO and other service contractors • Monthly reports on MCO operations and performance that were submitted to HHSC • Other supporting information HHSC staff or MCO staff felt would be useful in gaining a general understanding of the MCOs' operations and delivery of services

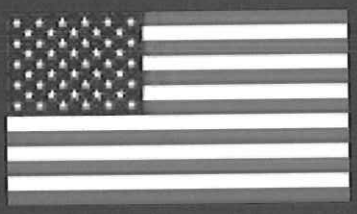
	We built a list of potential risk areas for each MCO based upon contract requirements and information provided by, and interviews with the MCO staff and HHSC staff
Periods of Performance	• Initial Contract: August 2005 – December 2005 • First Contract Extension: January 2006 – December 2006 • Second Contract Extension: January 2007 – December 2007 • Third Contract Extension: January 2008 – December 2008 • Fourth Contract Extension: January 2009 – August, 2009 • New Contract: 2009-present
Deliverables	Risk assessment/accuracy reports
References	Mr. Max Mrasek Procurement Project Manager, Contract Administration Texas Health and Human Services Commission 11209 Metric Boulevard Austin, Texas 78758 512-491-1316 max.mrasek@hhsc.state.tx.us

Centers for Medicare & Medicaid Services

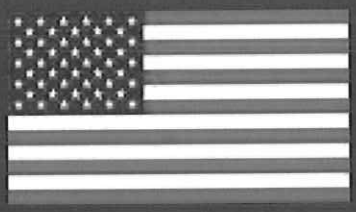


Medicaid Integrity Audit Contractor (Audit MIC)

Project Requirements	Part of Health Integrity, LLC's team awarded IDIQ to conduct audit activities required by the Medicaid Integrity Program provisions in the Deficit Reduction Act. Work may include auditing of paid claims for items or services furnished, or administrative services rendered, under a State plan under Title XIX, including: cost reports, consulting contracts, and risk contracts under section 1903 (m) of Title XIX. Also, identifying overpayments to individuals or entities receiving Federal funds under Title XIX.
Technical Approach Taken	• Assist Health Integrity in conducting audits of Medicaid providers identified by either CMS or the Review of Provider MIC. Such activities shall include desk reviews and on-site reviews of paid claims for items or services furnished, or administrative services rendered, under a State plan under Title XIX, including: cost reports, consulting contracts, and risk contracts in accordance with approved protocols, work plans and procedures. • Meet with Health Integrity's project director and other subcontractors and consultants for project meetings through teleconferences and face-to-face meetings as scheduled; • Provide audit expertise via teleconference on an as-needed basis.
Periods of Performance	December 2007-present
References	Ms. Sandra S. Love MS, RHIA, COO Health Integrity, LLC 9240 Centreville Road Easton, Maryland 21601 410-763-6242 loves@healthintegrity.org

Centers for Medicare & Medicaid Services  *MEDIC*	
Project Requirements	Part of Health Integrity LLC's multi-disciplinarian team formed to combat fraud, waste and abuse in the Medicare Part D program.
Technical Approach Taken	• Participate in biweekly calls discussing beneficiary complaints and determining appropriate actions for pursuing complaints. • Assist in creating an audit plan for targeting audits of Prescription Drug Plans (PDP's) and pharmacies. • Anticipate participating in financial related benefit integrity audits of PDP's and pharmacies.
Periods of Performance	November 2005-present
References	Ms. Sandra S. Love MS, RHIA, Senior Vice President Health Integrity, LLC 9240 Centreville Road Easton, Maryland 21601 410-763-6242 slove@dfmc.org

Centers for Medicare & Medicaid Services



Zone Program Integrity Contractor (ZPIC)

Project Requirements	Part of Health Integrity, LLC's multi-disciplinarian team formed to combat fraud, waste and abuse in the Medicare program for Zone 4 (Texas, Oklahoma, Colorado and New Mexico). The ZPIC is responsible for the detection, deterrence and prevention of fraud, waste, and abuse across Medicare Parts A, B, Durable Medical Equipment (DME), Home Health (HH) and Hospice (H) for this Zone.
Technical Approach Taken	• Assist Health Integrity in conducting onsite reviews for Beneficiary Protection and Benefit Integrity issues to support a fraud and abuse investigation directed by Health Integrity. Such activities shall include provider and IT systems reviews at provider sites in accordance with approved protocols, work plans and procedures. • Meet with Health Integrity's project director and other subcontractors and consultants for project meetings through teleconferences and face-to-face meetings as scheduled; • Provide audit expertise via teleconference on an as-needed basis.
Periods of Performance	October 2008-present
References	Ms. Sandra S. Love MS, RHIA, Senior Vice President Health Integrity, LLC 9240 Centreville Road Easton, Maryland 21601 410-763-6242 slove@dfmc.org

Appendix B: Cost Quote

Attachment 1
HHR13017 Auditing of Long Term Care Financial and Statistical Reports (LTC-FASR)
WEST VIRGINIA DHHR OAMR
COST QUOTE FOR STANDARD FACILITY ENGAGEMENT
YEAR 1 ALL-INCLUSIVE COST SHEET

FACILITY	All-Inclusive Per Engagement Cost	General Location
1. Eagle Pointe	$13,840.00	Home Office (Indianapolis, IN)
2.Weirton Medical Center	$13,300.00	Hospital Based SNF
3.Guardian Elder Care at Wheeling	$13,300.00	Hospital Based SNF
4.Arbors at Fairmont	$13,840.00	Home Office (Milwaukee, WS)
5.Broaddus Hospital-Mansfield Place	$13,300.00	Hospital Based SNF
6.Greenbrier Manor	$12,160.00	
7.Pleasant Valley Nursing and Rehabilitation Center	$13,300.00	Hospital Based SNF
8.Good Samaritan Society- Barbour County	$13,840.00	Home Office (Sioux Falls, SD)
9.Montgomery General Elderly Care Center	$13,300.00	
10.Grant Memorial Hospital	$13,300.00	Hospital Based SNF
11.Montgomery General Hospital Extended Care	$13,300.00	Hospital Based SNF
12.Morgan County War Memorial Hospital	$13,300.00	Hospital Based SNF
13.Minnie Hamilton health Care Center, Inc.	$13,300.00	Hospital Based SNF
14.Roane General Hospital	$13,300.00	Hospital Based SNF
15.St. Josephs Hospital of Buckhannon, Inc.	$13,300.00	Hospital Based SNF
16.Summers County ARH	$13,300.00	Hospital Based SNF
17.Summersville Memorial Hospital	$13,300.00	Hospital Based SNF
SUBTOTAL STANDARD ENGAGEMENTS COST Year 1	$226,580.00	

Attachment 2
HHR 13017 Auditing of Long Term Care Financial and Statistical Reports (LTC-FASR)
WEST VIRGINIA DHHR OAMR
COST QUOTE FOR STANDARD FACILITY ENGAGEMENT
YEAR 2 ALL-INCLUSIVE COST SHEET

FACILITY	All-Inclusive Per Engagement Cost	General Location
1. Heartland of Charleston	$13,840.00	Chain Home Office Toledo, OH.
2. Heartland of Beckley WV, LLC	$13,840.00	
3. Heartland of Keyser	$13,840.00	
4. Heartland of Clarksburg	$13,840.00	
5. Heartland of Martinsburg	$13,840.00	
6. Heartland of Preston County	$13,840.00	
7. Heartland of Rainelle WV, LLC	$13,840.00	
8. SunBridge Care & Rehabilitation For Dunbar	$13,840.00	Chain Home Office (Albuquerque, NM)
9. SunBridge Care & Rehabilitation For Salem	$13,840.00	
10. SunBridge Care & Rehabilitation for Pine Lodge	$13,840.00	
11. SunBridge Care & Rehabilitation for Putnam	$13,840.00	
12. Sunbridge New Martinsville Health Care Center	$13,840.00	
13. SunBridge Care & Rehabilitation for Parkersburg	$13,840.00	
14. SunBridge Care & Rehabilitation for Glenville	$13,840.00	
15. Holbrook Nursing Home	$12,160.00	
16. Nella's Inc.	$12,160.00	
17. Nellas Nursing Home, Inc.	$12,160.00	
SUBTOTAL STANDARD ENGAGEMENTS COST Year 2	$230,240.00	

Attachment 3
HHR 13017 Auditing of Long Term Care Financial and Statistical Reports (LTC-FASR)
WEST VIRGINIA DHHR OAMR
COST QUOTE FOR STANDARD FACILITY ENGAGEMENT
YEAR 3 ALL-INCLUSIVE COST SHEET

FACILITY	All-Inclusive Per Engagement Cost	General Location
1. Huntington Health & Rehabilitation	$13,840.00	Home Office-Houston, TX
2. Golden LivingCenter-Glasgow	$13,840.00	Chain- Home Office (Ft. Smith, AR)
3. Golden LivingCenter-Morgantown	$13,840.00	
4. Golden LivingCenter-Riverside	$13,840.00	
5. Hampshire Memorial Hospital	$13,300.00	Hospital Based SNF
6. The Maples	$12,160.00	
7. Clarksburg Nursing & Rehabilitation Center	$13,840.00	Chain-Home Office (Charleston, WV)
8. McDowell Nursing & Rehabilitation Center	$13,840.00	
9. Summers Nursing & Rehabilitation Center	$13,840.00	
10. Fayette Nursing & Rehabilitation Center	$13,840.00	
11. E.A. Hawse Nursing & Rehabilitation Center	$13,840.00	
12. Lincoln Nursing & Rehabilitation Center	$13,840.00	
13. Cameron Nursing & Rehabilitation Center	$13,840.00	
14. Wayne Nursing & Rehabilitation Center	$13,840.00	
15. Webster Nursing & Rehabilitation Center	$13,840.00	
16. Wyoming Nursing & Rehabilitation Center	$13,840.00	
17. Mercer Nursing & Rehabilitation Center	$13,840.00	
SUBTOTAL STANDARD ENGAGEMENTS COST Year 3	$233,060.00	

SUMMARY OF ALL COSTS

GRAND TOTAL 3-YEAR CONTRACT COSTS (SUM OF YEARS 1-3) $ $689,880.00

Evaluation of Bids: Cost evaluations will be based on the total contract cost for three years. Award of the contract will be based on the lowest cost bid of the vendor who meets or exceeds the specifications and requirements. It is preferred that all vendors complete the attached pricing pages for years 1-3 rather than submitting a separate quote.

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HHR 13017 Auditing of Long Term Care Financial and Statistical Reports (LTC-FASR)
WEST VIRGINIA DHHR OAMR
COST QUOTE FOR STANDARD FACILITY ENGAGEMENT
ALL-INCLUSIVE COST SHEET
SIGNATURE PAGE:

Vendor Name: PHBV Partners LLP

Vendor Address: 4461 Cox Road

Suite 210

Remit to Address: Same as above

Phone #: 888-832-0856

Fax #: 804-270-0820

E-mail: Chuck.Smith@phbvpartners.com

Signature: Charles T. Smith IV 6/22/12
Date

Appendix C: Professional Resumes

Charles T. Smith, III, CPA

Partner – PHBV Partners
Richmond, Virginia

AREAS OF SPECIALIZATION

- Compliance auditing, including audits of health care providers with an emphasis on Medicaid and Medicare regulation compliance and reimbursement issues

RELEVANT EXPERIENCE

- **Centers for Medicare and Medicaid Services, Medicaid Integrity Group (2009 – present)**
  - Audit Manager for Audit Medicaid Integrity Contractor ("MIC") for two CMS task orders.
  - Partner in charge of PHBV's subcontracting relationship with Health Integrity, LLC, who is the Audit MIC.
  - Lead PHBV staff in the completion of Medicaid post-payment reviews of claims as directed by CMS.

- **Commonwealth of Virginia - Department of Medical Assistance Services (1995-present)**
  - Managed the representation of Virginia Department of Medical Assistance Services during the provider appeals process. This includes preparing position papers defending cost report adjustments, and explaining the regulatory basis for those adjustments. The duties also include attending informal fact finding conferences to present and defend cost report adjustments, and testifying as an expert witness during formal administrative appeals. The testimony as an expert witness includes both direct and cross-examinations
  - Managed Virginia Medicaid cost report agreed upon procedures of nursing facilities, outpatient rehabilitation facilities (including those associated with community service boards), and federally qualified health clinics
  - These duties include determining the appropriate staffing levels, developing audit strategies and budgets, maintaining proper level of supervision, and communication with both Department of Medical Assistance Services and provider representatives
  - Performed detailed research of reimbursement issues. This research requires an extensive understanding of the U.S. Code of Federal Regulations, Provider Reimbursement Manual, the Code of Virginia, and the Virginia Administrative Code
  - Analyzes costs submitted by Virginia healthcare providers for conformity with detailed reimbursement regulations and principles
  - Managed cost report audits of adult care residences for the Virginia Department of Social Services; Managed a study of costs incurred by Virginia personal care providers

- **State of North Carolina - Department of Health and Human Services (2005-present)**
  - Managed North Carolina Medicaid cost report audits and agreed upon procedures of nursing facilities, non-public critical access hospitals, freestanding rural health clinics, hospital-based rural health clinics, teaching hospitals, federally qualified health centers, physician practice plans of teaching hospitals, state-owned psychiatric hospitals, state-owned intermediate care facilities for the mentally retarded, and state-owned nursing facilities. These duties included determining the appropriate staffing levels, developing

audit strategies and budgets, maintaining proper level of supervision, and communication with both Division of Medical Assistance and provider representatives.
    - Managed North Carolina Medicaid agreed-upon procedures of public hospitals. This included the verification of public expenditures reported on hospital cost reports, which are used to certify public expenditures, as well as determine the cost reimbursement for outpatient services. In addition, these reviews verify uninsured charges and payment information submitted on the North Carolina Supplemental Schedule A, which are used to determine DSH allocations

- **General (1995-present)**
    - Managed the day-to-day activities of PHBV's Audit Contract with the North Carolina Department of Health and Human Services, Division of Medical Assistance. This included communicating with DMA representatives regarding contractual, billing and provider issues. This also involves setting expectations and guiding PHBV staff so as to meet those expectations.
    - Managed the day-to-day operations of PHBV's Raleigh office, including human resource issues and acting as the liaison with centralized administrative functions.
    - Manages the completion of engagement reviews and written evaluations of staff auditors
    - Participates in firm-wide training for health care staff

EDUCATION

- Bachelor of Science, Business Administration, Mary Washington College, Fredericksburg, VA

PROFESSIONAL CERTIFICATIONS

- Certified Public Accountant, Virginia, 24730

PROFESSIONAL ORGANIZATIONS

- American Institute of Certified Public Accountants, Member
- Virginia Society of Certified Public Accountants, Member

CONTINUING PROFESSIONAL EDUCATION

- Minimum of 40 hours of continuing professional education annually, which include the following:
    - Annual firm-wide Audit and Accounting Update
    - Annual firm-wide Team Health Care Conference
    - National Association of Medicaid Program Integrity Annual Conference
    - Ethics - Virginia Society of CPAs
    - Practitioner's Audit and Accounting Updates - AICPA
    - Various Other CPE courses

Robert M. Bullen, CPA, CFE

Partner - PHBV Partners
Baltimore, Maryland

Mr. Bullen is a partner with over 28 years of experience relating exclusively to health care related audit and compliance services and applying Medicare and Medicaid principles of reimbursement. Mr. Bullen's clients have included the Centers for Medicare and Medicaid Services, State of Maryland Department of Health and Mental Hygiene, North Carolina Division of Medical Assistance, South Carolina Health & Human Services, Commonwealth of Virginia Department of Medical Assistance Services, and State of Maryland Health Care Commission.

AREAS OF SPECIALIZATION

- Health care auditing and accounting services with an emphasis on Medicaid and Medicare reimbursement, and compliance audits of providers and their home offices
- Financial related audits of Managed Care Organizations
- Health care litigation support services
- Regulatory consultation services
- Performance audits

YEARS OF EXPERIENCE

- 28 years (all with PHBV)

RELEVANT EXPERIENCE

Centers for Medicare & Medicaid Services (CMS) (2005-present)

- Partner responsible for overseeing various contracts with the Division of Capitated Plan Audits to perform examinations of financial information submitted by Medicare Advantage Organizations and Prescription Drug Plans for Contract Years 2006 - 2009. Broad areas examined include base period data, prescription drug events (PDEs) and medical claims, direct and indirect remuneration data (rebates), non-benefit expenses and solvency.
- Partner responsible for overseeing the contract with the Center for Medicare, Program Compliance and Oversight Group to conduct performance and compliance audits of Medicare Advantage and Prescription Drug Plan Sponsoring Organizations.
- Partner responsible for overseeing the contract with the Division of Capitated Plan Audits to perform Agreed Upon Procedures financial reviews of Medicare Prescription Drug Plans for Contract Year 2006.
- Partner responsible for overseeing the contract with the Office of Research, Development and Information to perform an Agreed Upon Procedures Review of a disease management organization to validate operational procedures and expenditures relating to their participation in the BIPA Disease Management Demonstration.
- Partner responsible for overseeing the subcontract with Granite Dolphin Actuarial Services to perform examinations of bid forms submitted by Medicare Advantage and Prescription Drug Plan sponsors for the Centers for Medicare and Medicaid Services, Office of the Actuary for contract years 2007 - 2010.

- Partner responsible for overseeing the contract with the Office of the Actuary to perform examinations of bid forms submitted by Medicare Advantage and Prescription Drug Plan sponsors for the 2006 contract period.
- Partner responsible for overseeing the contract with the Division of Capitated Plan Audits to perform examinations of 2005 Adjusted Community Rate Worksheets prepared by nineteen Medicare Advantage Organizations.
- Partner responsible for overseeing the contract with the Center for Beneficiary Choices, Medicare Advantage Group to perform examinations of 2004 Adjusted Community Rate Worksheets prepared by ten Medicare Advantage Organizations

State of Nevada – Division of Health Care Financing and Policy (2010-Present)

- Successfully managed the performance audits and administrative expense audits of the two Managed Care Organizations that participate in the State of Nevada's Medicaid and Children's Health Insurance Program. The performance audits covered the effectiveness of the Compliance Program, Program Integrity and Fraud and Abuse Safeguards, Encounter Data Validation, Third Party Liability and Stop Loss. The administrative expense audits tested the accuracy and allowability of the administrative expenses reported to the Nevada Division of Insurance on their Annual Statements.

State of North Carolina - Department of Health and Human Services (2007-2009)

- Partner responsible for overseeing the contract with North Carolina Medicaid to perform cost report audits and agreed upon procedures of nursing facilities, non-public critical access hospitals, freestanding rural health clinics, hospital-based rural health clinics, teaching hospitals, federally qualified health centers, physician practice plans of teaching hospitals, state-owned psychiatric hospitals, state-owned intermediate care facilities for the mentally retarded, and state-owned nursing facilities. Responsibilities include reviewing completed engagements, supervising staff, interaction with Division of Medical Assistance personnel and report preparation.

Maryland Health Care Commission (2001-present)

- Partner responsible for overseeing audits of on-call, stand-by, and trauma equipment applications submitted to the Maryland Trauma Physician Services Fund administered by the Maryland Health Care Commission. The Fund also provides reimbursement to trauma physicians for uncompensated care provided to trauma patients.
- Partner responsible for overseeing annual review of Maryland Health Insurance Partnership health plan participants.

State of Maryland Department of Health and Mental Hygiene - Medicaid Program (1983-2006)

- Partner responsible for overseeing the Auditing, Accounting and Consulting Services contract with Maryland Medicaid to perform cost report audits and rate setting of various provider types to assure that Medical Assistance reimbursements occur in compliance with State and Federal laws and regulations. Provider types include nursing homes, chronic hospitals, residential treatment centers, psychiatric hospitals, State facilities, and mental health providers. This oversight included the administrative aspects of the contract, interaction with Program personnel as well as coordination of the nursing home cost report verifications.

State of Maryland HealthChoice Program (2002-2006)

- Successfully managed the annual agreed upon procedures engagements of all Managed Care Organizations that participate in the State of Maryland HealthChoice program. These engagements include the review of medical and administrative expenditures as well as the issuance of reports for each MCO reporting the findings of our procedures.

Health Integrity, LLC (2006-Present)

- Partner responsible for overseeing the Medicare Drug Integrity Contractor (MEDIC) contract as a subcontractor to Health Integrity, LLC to perform program integrity work for the Medicare Part D Program.
- Partner responsible for overseeing the Zone Program Integrity Contractor (ZPIC) Zone 4 contract (Texas, New Mexico, Colorado and Oklahoma) as a subcontractor to Health Integrity, LLC. The ZPIC is responsible for ensuring the integrity of all Medicare-related claims under Parts A and B and coordination of Medicare-Medicaid data matches (Medi-Medi).
- Partner responsible for overseeing the Audit MIC (Medicaid Integrity Contractor) contracts as a subcontractor to Health Integrity, LLC. The Audit MIC performs field audits and desk audits of Medicaid providers to identify overpayments. Health Integrity is currently the Audit MIC for 2 Regions covering 23 states.

U.S. Department of Justice (2006-2007)

- Health Care Litigation Support Services for the United States Attorneys' Office in the District of Colorado

Massachusetts Executive Office of Health and Human Services (2008-2010)

- Partner responsible for overseeing contract to review all major financial reporting functions related to the Commonwealth's Medicaid program. The review focused on the accuracy of the CMS 64 preparation process, including recommendations for improvement and assistance with implementing and documenting the approved recommendations as well as reconciling the Medicaid draws to Medicaid-reimbursable MassHealth expenditures.

State of Kansas Department of Social and Rehabilitation Services (2006)

- Partner responsible for overseeing the agreed upon procedures review of the Medicaid Rehabilitative Treatment claiming and reporting process for Child Welfare, Family Preservation and Targeted Case Management

City of Baltimore - Maryland Municipal Health Services Program (1992-2007)

- Successfully managed the coordination of audits of Baltimore City clinics that participated in the Municipal Health Services Program.

City of San Jose, California - Municipal Health Services Program (1998-2007)

- Successfully managed the coordination of audits of clinics that participated in the program.

City of Milwaukee - Municipal Health Services Program (2001-2007)

- Successfully managed the coordination of audits of clinics that participated in the program.

State of Maryland - Developmental Disabilities Administration (1995-present)

- Responsible for oversight of annual cost reports for Baltimore and Washington, DC office not-for-profit clients that are funded through DDA.

Commonwealth of Virginia (1994-1996)
- Coordinated and supervised Medicaid cost report audits.

Centers for Medicare & Medicaid Services - Philadelphia Regional Office (1991-1994)
- Successfully managed the State Performance Evaluation and Comprehensive Test of Reimbursement Under Medicaid (SPECTRUM) of Long Term Care Facilities in West Virginia
- Successfully managed the SPECTRUM review of private nursing homes and acute care hospitals in Delaware
- Project director for the review of Medicaid reimbursable costs at state-operated long term care facilities in the District of Columbia and Virginia

Centers for Medicare & Medicaid Services - New York Regional Office (1990)
- Team leader for the SPECTRUM review of the New Jersey Medical Assistance Program

State of Montana (1988-1989)
- Coordinated the Medicaid cost report audits of 33 nursing homes

State of Indiana Department of Public Welfare (1986-1990)
- Supervised cost report audits

EDUCATION
- Bachelor of Science degree with a major in accounting, University of Baltimore

PROFESSIONAL CERTIFICATIONS
- Certified Public Accountant, Maryland
- Certified Fraud Examiner

PROFESSIONAL ORGANIZATIONS
- American Institute of Certified Public Accountants - member
- Maryland Association of Certified Public Accountants - member
- American Health Lawyers Association - member
- Association of Certified Fraud Examiners – member
- Health Care Compliance Association – member

HONORS/AWARDS
- PHBV/Clifton Gunderson Leadership Career Program

SPEAKING ENGAGEMENTS
- Medicaid Integrity Institute, "Why Audit MCOs?"
- Healthcare Financial Management Association Regulatory Update "Maryland Medicaid Nursing Home Payment System", Ellicott City, Maryland
- Health Facilities Association of Maryland Regulatory Update, Baltimore, Maryland

CONTINUING PROFESSIONAL EDUCATION

- Formal training through a balance of internal and external programs including nationally sponsored programs of the American Institute of Certified Public Accountants and other organizations.
- In excess of 40 hours annually
- Will receive in excess of 24 hours annually and 80 hours in total every two years qualified under Generally Accepted Government Auditing Standards

Kelly Bultema, CPA

Manager - PHBV Partners
Richmond, Virginia

AREAS OF SPECIALIZATION

- Compliance auditing, including audits of health care programs with an emphasis on Medicare and Medicaid regulation compliance and reimbursement issues. Audits include detailed testing of new construction costs, financing and/or refinancing, and debt structuring.
- Performs audit and consulting services for the Centers for Medicare & Medicaid Services (CMS)
- Performs SAS70 reviews
- Performs internal audit services

RELEVANT EXPERIENCE

- **Commonwealth of Virginia - Department of Medical Assistance Services - Division of Provider Reimbursement**
    - Field Verification (2001-present)
        - Supervises audits of Medicaid and Medicare cost reports filed by health care providers. Responsibilities include the review of necessary audit adjustments related to plant, direct and indirect patient care costs based on Medicaid and Medicare regulations.
        - Experienced with health care providers that have issues of related party transactions, change of ownership, direct assignment of capital costs, unnecessary borrowings, and home office allocations
        - Provides Medicaid specific training to field staff based on the regulations and sections of the audit program

    - Appeals Consulting (2009-present)
        - Serves as the representation of Virginia Department of Medical Assistance Services during the provider appeals process. This included preparing position papers defending cost report adjustments, and explaining the regulatory basis for those adjustments.
        - The duties also included attending informal fact finding conferences to present and defend cost report adjustments
        - Testifying as an expert witness during formal administrative appeals. The testimony as an expert witness included both direct and cross-examinations.
        - Performed detailed research of reimbursement issues. This research requires an extensive understanding of the U.S. Code of Federal Regulations, Provider Reimbursement Manual, the Code of Virginia, and the Virginia Administrative Code.

- **State of Nevada – Department of Health and Human Services (2005 - 2006)**
    - Assisted with planning and performance of state of Nevada hospital compliance audits

- **Centers for Medicare & Medicaid Services (CMS) (2001-2006)**
  - Participated in SAS-70 review and accounts receivable agreed-upon procedures of Medicare contractors for CMS

- **Virginia Department of Transportation (2003 - 2006)**
  - Performs internal audit services in the areas of payroll, employment staffing and compensation, and capital outlay compliance with GASB 34

EDUCATION

- Bachelor of Science, Accounting, Virginia Polytechnic Institute & State University

PROFESSIONAL CERTIFICATIONS

- Certified Public Accountant, Virginia, 35526

PROFESSIONAL ORGANIZATIONS

- Virginia Society of Certified Public Accountants, Member

CONTINUING PROFESSIONAL EDUCATION

- Minimum of 40 hours of continuing professional education annually, which include the following:
  - Annual firm-wide Audit and Accounting Update
  - Annual firm-wide Team Health Care Conference
  - Long Term Care and the Law - American Health Lawyers Association
  - Ethics - Virginia Society of CPAs
  - Practitioner's Audit and Accounting Updates - AICPA
  - Various Other CPE courses

Bonnie Phillips, MPA

Manager – PHBV Partners
Indianapolis, Indiana

AREAS OF SPECIALIZATION

- Medicaid audits of nursing facilities, community residential facilities for the developmentally disabled (CRFs/DD), and intermediate care facilities for the mentally retarded (ICFs/MR), and home health agencies
- Audits of Medicare Prescription Drug Plans (PDPs)
- Audits of Medicare Advantage Organizations (MAOs)
- Audits of Medicare fiscal intermediaries and carriers
- Audits of hospital uninsured claims for the Disproportionate Share Hospital (DSH) program
- Consulting services for the Indiana Mental Health Funds Recovery Program
- Billing reviews of nursing facilities and CRF/DDs
- Auditing services for financial institutions

RELEVANT EXPERIENCE

- **State of Mississippi** - Office **of the Governor - Division of Medicaid (2006-present)**
  - Perform and review audits of nursing homes for the Mississippi Division of Medicaid. This includes auditing the costs, revenues, balance sheet, and days reported on the Medicaid Cost Report.
  - Perform and review engagements to review the allowability of claims under the Disproportionate Share (DSH) program. This included a review of the Medicare Cost-to-Charge Ratio and an examination of the uninsured claims.
  - Review Medicare cost reports in reference to Medicaid reimbursement issues.
  - Supervise and review work of assistants: teaching workpaper format, technical aspects of audit, and written communication skills.
  - Complete written evaluations of staff.
  - Communicate with provider personnel.
  - Maintain up-to-date knowledge of the Medicaid and Medicare program regulations.

- **State of Alabama – Alabama Medicaid Agency (2008-present)**
  - Perform and review audits of nursing homes for the Mississippi Division of Medicaid. This includes auditing the costs, revenues, balance sheet, and days reported on the Medicaid Cost Report.
  - Perform and review engagements to review the allowability of claims under the Disproportionate Share (DSH) program. This included a review of the Medicare Cost-to-Charge Ratio and an examination of the uninsured claims.
  - Supervise and review work of assistants: teaching workpaper format, technical aspects of audit, and written communication skills.
  - Complete written evaluations of staff.
  - Communicate with provider personnel.
  - Maintain up-to-date knowledge of the Medicaid and Medicare program regulations.

- **Centers for Medicare and Medicaid Services (CMS) (2008-present)**
  - Perform evaluation of Medicare Advantage Organizations (MAOs) and Prescription Drug Plans (PDPs) under Medicare Part C and Part D. The review consists of examining the contractor's actual costs in comparison to estimated bid costs.

- **State of Indiana - Family and Social Services Administration (2001-2008)**
  - Perform and review engagements to review the Medicaid cost report audits of nursing facilities, home health agencies, community residential facilities for the developmentally disabled, and intermediate care facilities for the mentally retarded.
  - Review Medicare cost reports in reference to Medicaid reimbursement issues.
  - Supervise and review work of assistants: teaching workpaper format, technical aspects of audit, and written communication skills.
  - Complete written evaluations of staff.
  - Communicate with provider personnel.
  - Maintain up-to-date knowledge of the Medicaid and Medicare program regulations.

- **State of Indiana - Family and Social Services Administration (2003-present)**
  - Perform and review engagements to provide consulting services for the Indiana Mental Health Funds Recovery Program under the Division of Mental Health and Addiction.
  - Review Medicare cost reports in reference to Medicaid reimbursement issues.
  - Supervise and review work of assistants: teaching workpaper format, technical aspects of audit, and written communication skills.
  - Complete written evaluations of staff.
  - Communicate with provider personnel.
  - Maintain up-to-date knowledge of the Medicaid and Medicare program regulations.

- **State of Illinois - Department of Healthcare and Family Services (2004-2008)**
  - Perform and review billing reviews of nursing homes, facilities for the developmentally disabled, and hospice under the Illinois Medicaid System. This includes reviewing billing documentation and census documentation to verify the Medicaid program has paid appropriately.
  - Supervise and review work of assistants: teaching workpaper format, technical aspects of audit, and written communication skills.
  - Complete written evaluations of staff.
  - Communicate with provider personnel.

- **State of Ohio - Department of Job and Family Services (2001-2007)**
  - Perform and review audits of nursing homes and intermediate care facilities for the mentally-retarded (ICFs/MR), community residential facilities for the developmentally disabled (CRFs/DD), and home offices under the Ohio Medicaid program.
  - Review Medicare cost reports in reference to Medicaid reimbursement issues.
  - Supervise and review work of assistants: teaching workpaper format, technical aspects of audit, and written communication skills.
  - Complete written evaluations of staff.
  - Communicate with provider personnel.

- Maintain up-to-date knowledge of the Medicaid and Medicare program regulations.

- **State of South Carolina – Department of Health and Human Services (2007-present)**
  - Perform and review audits of hospitals to analyze the provider's reimbursement for the Disproportionate Share (DSH) program. This includes a review of the Medicare Cost-to-Charge Ratio and an examination of the uninsured claims.
  - Supervise and review work of assistants: teaching workpaper format, technical aspects of audit, and written communication skills.
  - Communicate with provider personnel.

- **Office of Inspector General for the U.S. Department of Health and Human Services (2001-2003)**
  - Perform audit of Fiscal Intermediary and Carrier Financial Statements submitted on behalf of the Centers of Medicare and Medicaid Services (CMS). Duties included review of internal control procedures and verification of reported balances for cash, accounts receivable, and accounts payable.
  - Communicate with CMS, Fiscal Intermediary, and Carrier personnel regarding project issues.

EDUCATION

- Master of Professional Accountancy, Indiana University, 2006
- Bachelor of Science degree with a major in accounting, Indiana University, 2001

PROFESSIONAL ORGANIZATIONS

- Healthcare Financial Management Association – member
- American Health Lawyers Association – member
- Indiana CPA Society – member

PRESENTATIONS

- Indiana Mental Health Funds Recovery Program – Engagement Overview", Indianapolis, 2010, 2011, 2012
- "Mississippi Medicaid Nursing Facility Cost Report Preparation, Documentation & Verification Process", Jackson, MS, 2009
- "Implementation of Disproportionate Share Hospital Adjustment Payments Audit Rule", Jackson, MS, 2010
- Nursing facility training for the Mississippi Division of Medicaid audit staff, Jackson, MS, 2011

CONTINUING PROFESSIONAL EDUCATION

- Minimum of 40 hours of continuing professional education annually, which include the following:
  - Annual Firm-wide Audit and Accounting Update
  - Annual Firm-wide Team Health Care Conference
  - Long Term Care and the Law
  - Health Services Financial Officers Annual Conference
  - Various Other CPE courses

Appendix D: Forms

RFQ No. HHR13017

STATE OF WEST VIRGINIA
Purchasing Division

PURCHASING AFFIDAVIT

West Virginia Code §5A-3-10a states: No contract or renewal of any contract may be awarded by the state or any of its political subdivisions to any vendor or prospective vendor when the vendor or prospective vendor or a related party to the vendor or prospective vendor is a debtor and the debt owed is an amount greater than one thousand dollars in the aggregate.

DEFINITIONS:
"Debt" means any assessment, premium, penalty, fine, tax or other amount of money owed to the state or any of its political subdivisions because of a judgment, fine, permit violation, license assessment, defaulted workers' compensation premium, penalty or other assessment presently delinquent or due and required to be paid to the state or any of its political subdivisions, including any interest or additional penalties accrued thereon.

"Debtor" means any individual, corporation, partnership, association, limited liability company or any other form or business association owing a debt to the state or any of its political subdivisions. "Political subdivision" means any county commission; municipality; county board of education; any instrumentality established by a county or municipality; any separate corporation or instrumentality established by one or more counties or municipalities, as permitted by law; or any public body charged by law with the performance of a government function or whose jurisdiction is coextensive with one or more counties or municipalities. "Related party" means a party, whether an individual, corporation, partnership, association, limited liability company or any other form or business association or other entity whatsoever, related to any vendor by blood, marriage, ownership or contract through which the party has a relationship of ownership or other interest with the vendor so that the party will actually or by effect receive or control a portion of the benefit, profit or other consideration from performance of a vendor contract with the party receiving an amount that meets or exceed five percent of the total contract amount.

EXCEPTION: The prohibition of this section does not apply where a vendor has contested any tax administered pursuant to chapter eleven of this code, workers' compensation premium, permit fee or environmental fee or assessment and the matter has not become final or where the vendor has entered into a payment plan or agreement and the vendor is not in default of any of the provisions of such plan or agreement.

Under penalty of law for false swearing (***West Virginia Code*** §61-5-3), it is hereby certified that the vendor affirms and acknowledges the information in this affidavit and is in compliance with the requirements as stated.

WITNESS THE FOLLOWING SIGNATURE

Vendor's Name: PHBV Partners LLP

Authorized Signature: Charles T. Smith III Charles T. Smith, Partner Date: 6/22/2012

State of MARYLAND

County of BALTIMORE, to-wit:

Taken, subscribed, and sworn to before me this 22 day of JUNE, 2012.

My Commission expires MARCH 10, 2016.

AFFIX SEAL HERE

LINDA P. KROMM NOTARY PUBLIC BALTIMORE COUNTY, MD

NOTARY PUBLIC Linda P. Kromm

042

Vendor Preference is not applicable to PHBV Partners

Rev. 09/08

State of West Virginia

VENDOR PREFERENCE CERTIFICATE

Certification and application* is hereby made for Preference in accordance with ***West Virginia Code***, §5A-3-37. (Does not apply to construction contracts). ***West Virginia Code***, §5A-3-37, provides an opportunity for qualifying vendors to request (at the time of bid) preference for their residency status. Such preference is an evaluation method only and will be applied only to the cost bid in accordance with the ***West Virginia Code***. This certificate for application is to be used to request such preference. The Purchasing Division will make the determination of the Resident Vendor Preference, if applicable.

1. **Application is made for 2.5% resident vendor preference for the reason checked:**
___ Bidder is an individual resident vendor and has resided continuously in West Virginia for four (4) years immediately preceding the date of this certification; **or,**
___ Bidder is a partnership, association or corporation resident vendor and has maintained its headquarters or principal place of business continuously in West Virginia for four (4) years immediately preceding the date of this certification; or 80% of the ownership interest of Bidder is held by another individual, partnership, association or corporation resident vendor who has maintained its headquarters or principal place of business continuously in West Virginia for four (4) years immediately preceding the date of this certification; **or,**
___ Bidder is a nonresident vendor which has an affiliate or subsidiary which employs a minimum of one hundred state residents and which has maintained its headquarters or principal place of business within West Virginia continuously for the four (4) years immediately preceding the date of this certification; **or,**

2. **Application is made for 2.5% resident vendor preference for the reason checked:**
___ Bidder is a resident vendor who certifies that, during the life of the contract, on average at least 75% of the employees working on the project being bid are residents of West Virginia who have resided in the state continuously for the two years immediately preceding submission of this bid; **or,**

3. **Application is made for 2.5% resident vendor preference for the reason checked:**
___ Bidder is a nonresident vendor employing a minimum of one hundred state residents or is a nonresident vendor with an affiliate or subsidiary which maintains its headquarters or principal place of business within West Virginia employing a minimum of one hundred state residents who certifies that, during the life of the contract, on average at least 75% of the employees or Bidder's affiliate's or subsidiary's employees are residents of West Virginia who have resided in the state continuously for the two years immediately preceding submission of this bid; **or,**

4. **Application is made for 5% resident vendor preference for the reason checked:**
___ Bidder meets either the requirement of both subdivisions (1) and (2) or subdivision (1) and (3) as stated above; **or,**

5. **Application is made for 3.5% resident vendor preference who is a veteran for the reason checked:**
___ Bidder is an individual resident vendor who is a veteran of the United States armed forces, the reserves or the National Guard and has resided in West Virginia continuously for the four years immediately preceding the date on which the bid is submitted; **or,**

6. **Application is made for 3.5% resident vendor preference who is a veteran for the reason checked:**
___ Bidder is a resident vendor who is a veteran of the United States armed forces, the reserves or the National Guard, if, for purposes of producing or distributing the commodities or completing the project which is the subject of the vendor's bid and continuously over the entire term of the project, on average at least seventy-five percent of the vendor's employees are residents of West Virginia who have resided in the state continuously for the two immediately preceding years.

Bidder understands if the Secretary of Revenue determines that a Bidder receiving preference has failed to continue to meet the requirements for such preference, the Secretary may order the Director of Purchasing to: (a) reject the bid; or (b) assess a penalty against such Bidder in an amount not to exceed 5% of the bid amount and that such penalty will be paid to the contracting agency or deducted from any unpaid balance on the contract or purchase order.

By submission of this certificate, Bidder agrees to disclose any reasonably requested information to the Purchasing Division and authorizes the Department of Revenue to disclose to the Director of Purchasing appropriate information verifying that Bidder has paid the required business taxes, provided that such information does not contain the amounts of taxes paid nor any other information deemed by the Tax Commissioner to be confidential.

Under penalty of law for false swearing (West Virginia Code, §61-5-3), Bidder hereby certifies that this certificate is true and accurate in all respects; and that if a contract is issued to Bidder and if anything contained within this certificate changes during the term of the contract, Bidder will notify the Purchasing Division in writing immediately.

Bidder: PHBV Partners LLP Signed: Charles T. Smith Charles T. Smith

Date: 6/22/12 Title: Partner

Check any combination of preference consideration(s) indicated above, which you are entitled to receive.

State of West Virginia
Department of Administration
Purchasing Division
2019 Washington Street East
Post Office Box 50130
Charleston, WV 25305-0130

Request for Quotation

RFQ NUMBER	PAGE
HHR13017	1

ADDRESS CORRESPONDENCE TO ATTENTION OF:
ROBERTA WAGNER
304-558-0067

VENDOR
RFQ COPY
TYPE NAME/ADDRESS HERE
PHBV Partners LLP
4461 Cox Road, Suite 210
Glen Allen, VA 23060

SHIP TO
HEALTH AND HUMAN RESOURCES
INTERNAL CONTROL & POLICY
DEVELOPMENT
ONE DAVIS SQUARE, SUITE 401
CHARLESTON, WV
25301 304-558-7314

DATE PRINTED	TERMS OF SALE	SHIP VIA	F.O.B.	FREIGHT TERMS
05/30/2012				

BID OPENING DATE: 06/26/2012 BID OPENING TIME 01:30PM

LINE	QUANTITY	UOP	CAT. NO.	ITEM NUMBER	UNIT PRICE	AMOUNT
				**********		
				MAND. PRE-BID MEETING ON JUNE 14, 2012 AT 9:30 AM IN CONFERENCE ROOM 93 AT ONE DAVIS SQUARE, CHARLESTON, WV 25301		
				**********		
0001	1	JB		961-20		
				PROFESSIONAL AUDITING SERVICES - CPA		

REQUEST FOR QUOTATION

TO PROVIDE A CPA FIRM CONTRACTED AUDITS OF MEDICAID LONG TERM CARE NURSING HOME PROVIDER COST REPORTS, FOR DHHR, OFFICE OF ACCOUNTABILITY AND MANAGEMENT REPORTING (OAMR).

****PLEASE NOTE THAT THIS IS A RE-BID OF HHR12070****
EXHIBIT 3

LIFE OF CONTRACT: THIS CONTRACT BECOMES EFFECTIVE ON UPON AWARD AND EXTENDS FOR A PERIOD OF ONE (1) YEAR OR UNTIL SUCH "REASONABLE TIME" THEREAFTER AS IS NECESSARY TO OBTAIN A NEW CONTRACT OR RENEW THE ORIGINAL CONTRACT. THE "REASONABLE TIME" PERIOD SHALL NOT EXCEED TWELVE (12) MONTHS. DURING THIS "REASONABLE TIME" THE VENDOR MAY TERMINATE THIS CONTRACT FOR ANY REASON UPON GIVING THE DIRECTOR OF PURCHASING 30 DAYS

SEE REVERSE SIDE FOR TERMS AND CONDITIONS

SIGNATURE	TELEPHONE	DATE
Charles T. Smith III	888-832-0856	6/22/12
TITLE Partner	FEIN 45-3942786	ADDRESS CHANGES TO BE NOTED ABOVE

WHEN RESPONDING TO RFQ, INSERT NAME AND ADDRESS IN SPACE ABOVE LABELED 'VENDOR'

State of West Virginia
Department of Administration
Purchasing Division
2019 Washington Street East
Post Office Box 50130
Charleston, WV 25305-0130

Request for Quotation

RFQ NUMBER	PAGE
HHR13017	2

ADDRESS CORRESPONDENCE TO ATTENTION OF:
ROBERTA WAGNER
304-558-0067

VENDOR
RFQ COPY
TYPE NAME/ADDRESS HERE
PHBV Partners LLP
4461 Cox Road, Suite 210
Glen Allen, VA 23060

SHIP TO
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WRITTEN NOTICE.

UNLESS SPECIFIC PROVISIONS ARE STIPULATED ELSEWHERE IN THIS CONTRACT DOCUMENT, THE TERMS, CONDITIONS AND PRICING SET HEREIN ARE FIRM FOR THE LIFE OF THE CONTRACT.

RENEWAL: THIS CONTRACT MAY BE RENEWED UPON THE MUTUAL WRITTEN CONSENT OF THE SPENDING UNIT AND VENDOR, SUBMITTED TO THE DIRECTOR OF PURCHASING THIRTY (30) DAYS PRIOR TO THE EXPIRATION DATE. SUCH RENEWAL SHALL BE IN ACCORDANCE WITH THE TERMS AND CONDITIONS OF THE ORIGINAL CONTRACT AND SHALL BE LIMITED TO TWO (2) ONE (1) YEAR PERIODS.

CANCELLATION: THE DIRECTOR OF PURCHASING RESERVES THE RIGHT TO CANCEL THIS CONTRACT IMMEDIATELY UPON WRITTEN NOTICE TO THE VENDOR IF THE COMMODITIES AND/OR SERVICE SUPPLIED ARE OF AN INFERIOR QUALITY OR DO NOT CONFORM TO THE SPECIFICATIONS OF THE BID AND CONTRACT HEREIN.

OPEN MARKET CLAUSE: THE DIRECTOR OF PURCHASING MAY AUTHORIZE A SPENDING UNIT TO PURCHASE ON THE OPEN MARKET, WITHOUT THE FILING OF A REQUISITION OR COST ESTIMATE, ITEMS SPECIFIED ON THIS CONTRACT FOR IMMEDIATE DELIVERY IN EMERGENCIES DUE TO UNFORESEEN CAUSES (INCLUDING BUT NOT LIMITED TO DELAYS IN TRANSPORTATION OR AN UNANTICIPATED INCREASE IN THE VOLUME OF WORK.)

BANKRUPTCY: IN THE EVENT THE VENDOR/CONTRACTOR FILES FOR BANKRUPTCY PROTECTION, THIS CONTRACT IS AUTOMATICALLY NULL AND VOID, AND IS TERMINATED WITHOUT FURTHER ORDER.

SEE REVERSE SIDE FOR TERMS AND CONDITIONS

SIGNATURE	TELEPHONE	DATE
Charles T. Smith III	888-832-0856	6/22/12
TITLE Partner	FEIN 45-3942786	ADDRESS CHANGES TO BE NOTED ABOVE

WHEN RESPONDING TO RFQ, INSERT NAME AND ADDRESS IN SPACE ABOVE LABELED 'VENDOR'

State of West Virginia
Department of Administration
Purchasing Division
2019 Washington Street East
Post Office Box 50130
Charleston, WV 25305-0130

Request for Quotation

RFQ NUMBER	PAGE
HHR13017	3

ADDRESS CORRESPONDENCE TO ATTENTION OF:
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WRITTEN QUESTIONS SHALL BE ACCEPTED THROUGH CLOSE OF BUSINESS ON 06/15/2012. QUESTIONS MAY BE SENT VIA USPS, FAX, COURIER OR E-MAIL. IN ORDER TO ASSURE NO VENDOR RECEIVES AN UNFAIR ADVANTAGE, NO SUBSTANTIVE QUESTIONS WILL BE ANSWERED ORALLY. IF POSSIBLE, E-MAIL QUESTIONS ARE PREFERRED. ADDRESS INQUIRIES TO:

ROBERTA WAGNER
DEPARTMENT OF ADMINISTRATION
PURCHASING DIVISION
2019 WASHINGTON STREET EAST
CHARLESTON, WV 25311

FAX: 304-558-4115
E-MAIL: ROBERTA.A WAGNER@WV.GOV

REV. 3/88
ANY INDIVIDUAL SIGNING THIS BID IS CERTIFYING THAT: (1) HE OR SHE IS AUTHORIZED BY THE BIDDER TO EXECUTE THE BID OR ANY DOCUMENTS RELATED THERETO ON BEHALF OF THE BIDDER, (2) THAT HE OR SHE IS AUTHORIZED TO BIND THE BIDDER IN A CONTRACTUAL RELATIONSHIP, AND (3) THAT THE BIDDER HAS PROPERLY REGISTERED WITH ANY STATE AGENCIES THAT MAY REQUIRE REGISTRATION.

PURCHASING CARD ACCEPTANCE: THE STATE OF WEST VIRGINIA CURRENTLY UTILIZES A VISA PURCHASING CARD PROGRAM WHICH IS ISSUED THROUGH A BANK. THE SUCCESSFUL VENDOR MUST ACCEPT THE STATE OF WEST VIRGINIA VISA PURCHASING CARD FOR PAYMENT OF ALL ORDERS PLACED BY ANY STATE

SEE REVERSE SIDE FOR TERMS AND CONDITIONS

SIGNATURE	TELEPHONE	DATE
Charles J. Smith III	888-832-0856	6/22/12
TITLE: Partner	FEIN: 45-3942786	ADDRESS CHANGES TO BE NOTED ABOVE

WHEN RESPONDING TO RFQ, INSERT NAME AND ADDRESS IN SPACE ABOVE LABELED 'VENDOR'

State of West Virginia
Department of Administration
Purchasing Division
2019 Washington Street East
Post Office Box 50130
Charleston, WV 25305-0130

Request for Quotation

RFQ NUMBER	PAGE
HHR13017	4

ADDRESS CORRESPONDENCE TO ATTENTION OF:
ROBERTA WAGNER
304-558-0067

VENDOR
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PHBV Partners LLP
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LINE	QUANTITY	UOP	CAT. NO.	ITEM NUMBER	UNIT PRICE	AMOUNT

AGENCY AS A CONDITION OF AWARD.

REV 07/16/2007

VENDOR PREFERENCE CERTIFICATE

THIS TEAM EXHIBIT HAS BEEN REPLACED BY THE ONLINE VERSION WHICH IS AVAILABLE HERE: HTTP://WWW.STATE.WV.US/ADMIN/PURCHASE/VRC/VENPREF.PDF

MANDATORY PRE-BID

A MANDATORY PRE-BID WILL BE HELD ON 06/14/2012 AT 9:30 AM IN AT ONE DAVIS SQUARE, CHARLESTON, WV 25301. INTERESTED PARTIES ARE REQUIRED TO ATTEND THIS MEETING. FAILURE TO ATTEND THE MANDATORY PRE-BID SHALL RESULT IN DISQUALIFICATION OF THE BID. NO ONE PERSON MAY REPRESENT MORE THAN ONE BIDDER.

AN ATTENDANCE SHEET WILL BE MADE AVAILABLE FOR ALL POTENTIAL BIDDERS TO COMPLETE. THIS WILL SERVE AS THE OFFICIAL DOCUMENT VERIFYING ATTENDANCE AT THE MANDATORY PRE-BID. FAILURE TO PROVIDE YOUR COMPANY AND REPRESENTATIVE NAME ON THE ATTENDANCE SHEET WILL RESUL IN DISQUALIFICATION OF THE BID. THE STATE WILL NOT EXCEPT ANY OTHER DOCUMENTATION TO VERIFY ATTENDANCE. THE BIDDER IS RESPONSIBLE FOR ENSURING THEY HAVE COMPLETED THE INFORMATION REQUIRED ON THE ATTENDANCE SHEET. THE PURCHASING DIVISION AND THE STATE AGENCY WILL NOT ASSUME ANY RESPONSIBILITY FOR ANY BIDDERS FAILURE TO COMPLETE THE PRE-BID ATTENDANCE SHEET. IN ADDITION, WE REQUEST THAT ALL POTENTIAL BIDDERS INCLUDE THEIR E-MAIL ADDRESS AND FAX NUMBER.

ALL POTENTIAL BIDDERS ARE REQUESTED TO ARRIVE PRIOR TO THE STARTING TIME FOR THE PRE-BID. BIDDERS WHO ARRIVE

SEE REVERSE SIDE FOR TERMS AND CONDITIONS

SIGNATURE	TELEPHONE	DATE
Charles T. Smith III	888-832-0856	6/22/12
TITLE Partner	FEIN 45-3942786	ADDRESS CHANGES TO BE NOTED ABOVE

WHEN RESPONDING TO RFQ, INSERT NAME AND ADDRESS IN SPACE ABOVE LABELED 'VENDOR'

State of West Virginia
Department of Administration
Purchasing Division
2019 Washington Street East
Post Office Box 50130
Charleston, WV 25305-0130

Request for Quotation

RFQ NUMBER	PAGE
HHR13017	5

ADDRESS CORRESPONDENCE TO ATTENTION OF:
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TYPE NAME/ADDRESS HERE
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DATE PRINTED	TERMS OF SALE	SHIP VIA	F.O.B.	FREIGHT TERMS
05/30/2012				

BID OPENING DATE: 06/26/2012 BID OPENING TIME 01:30PM

LINE	QUANTITY	UOP	CAT. NO.	ITEM NUMBER	UNIT PRICE	AMOUNT

LATE, BUT PRIOR TO THE DISMISSAL OF THE TECHNICAL PORTION OF THE PRE-BID WILL BE PERMITTED TO SIGN IN. BIDDERS WHO ARRIVE AFTER CONCLUSION OF THE TECHNICAL PORTION OF THE PRE-BID, BUT DURING ANY SUBSEQUENT PART OF THE PRE-BID WILL NOT BE PERMITTED TO SIGN THE ATTENDANCE SHEET.

NOTICE

A SIGNED BID MUST BE SUBMITTED TO:

DEPARTMENT OF ADMINISTRATION
PURCHASING DIVISION
BUILDING 15
2019 WASHINGTON STREET, EAST
CHARLESTON, WV 25305-0130

PLEASE NOTE: 5 CONVENIENCE COPIES WOULD BE APPRECIATED.

THE BID SHOULD CONTAIN THIS INFORMATION ON THE FACE OF THE ENVELOPE OR THE BID MAY NOT BE CONSIDERED:

SEALED BID

BUYER:----------RW/FILE 22----------

RFQ. NO.:---------HHR13017----------

BID OPENING DATE:---06/26/2012----------

BID OPENING TIME:-----1:30 PM----------

SEE REVERSE SIDE FOR TERMS AND CONDITIONS

SIGNATURE	TELEPHONE	DATE
[signature]	888-832-0856	6/22/12
TITLE Partner	FEIN 45-3942786	ADDRESS CHANGES TO BE NOTED ABOVE

WHEN RESPONDING TO RFQ, INSERT NAME AND ADDRESS IN SPACE ABOVE LABELED 'VENDOR'

State of West Virginia
Department of Administration
Purchasing Division
2019 Washington Street East
Post Office Box 50130
Charleston, WV 25305-0130

Request for Quotation

RFQ NUMBER	PAGE
HHR13017	6

ADDRESS CORRESPONDENCE TO ATTENTION OF:
ROBERTA WAGNER
304-558-0067

VENDOR
RFQ COPY
TYPE NAME/ADDRESS HERE
PHBV Partners LLP
4461 Cox Road, Suite 210
Glen Allen, VA 23060

SHIP TO
HEALTH AND HUMAN RESOURCES
INTERNAL CONTROL & POLICY
DEVELOPMENT
ONE DAVIS SQUARE, SUITE 401
CHARLESTON, WV
25301 304-558-7314

DATE PRINTED	TERMS OF SALE	SHIP VIA	F.O.B.	FREIGHT TERMS
05/30/2012				

BID OPENING DATE: 06/26/2012 BID OPENING TIME 01:30PM

LINE	QUANTITY	UOP	CAT. NO.	ITEM NUMBER	UNIT PRICE	AMOUNT
	PLEASE PROVIDE A FAX NUMBER IN CASE IT IS NECESSARY TO CONTACT YOU REGARDING YOUR BID:					
	804-270-2311					
	CONTACT PERSON (PLEASE PRINT CLEARLY):				Charles T. Smith	
	****** THIS IS THE END OF RFQ HHR13017 ****** TOTAL:					

SEE REVERSE SIDE FOR TERMS AND CONDITIONS

SIGNATURE	TELEPHONE	DATE
Charles T. Smith III	888-832-0856	6/22/12
TITLE: Partner	FEIN: 45-3942786	ADDRESS CHANGES TO BE NOTED ABOVE

WHEN RESPONDING TO RFQ, INSERT NAME AND ADDRESS IN SPACE ABOVE LABELED 'VENDOR'

State of West Virginia
Department of Administration
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Solicitation

NUMBER	PAGE
HHR13017	1

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DATE PRINTED
06/21/2012

BID OPENING DATE: 06/26/2012 BID OPENING TIME 01:30PM

LINE	QUANTITY	UOP	CAT. NO.	ITEM NUMBER	UNIT PRICE	AMOUNT
				ADDENDUM NO. 1		
	1. QUESTIONS AND ANSWERS ATTACHED. 2. ADDITIONAL TERMS & CONDITIONS ATTACHED. 3. ADDENDUM ACKNOWLEDGEMENT IS ATTACHED. THIS DOCUMENT SHOULD BE RETURNED AND RETURNED WITH YOUR BID. FAILURE TO SIGN AND RETURN MAY RESULT IN DISQUALIFICATION OF YOUR BID.					
				END OF ADDENDUM NO. 1		
0001	1	JB		961-20		
	PROFESSIONAL AUDITING SERVICES - CPA					
	****** THIS IS THE END OF RFQ HHR13017 ****** TOTAL:					

SIGNATURE Charles T. Smith III | TELEPHONE 888-832-0856 | DATE 6/22/12
TITLE Partner | FEIN 45-3942786 | ADDRESS CHANGES TO BE NOTED ABOVE

WHEN RESPONDING TO SOLICITATION, INSERT NAME AND ADDRESS IN SPACE ABOVE LABELED 'VENDOR'

ADDENDUM ACKNOWLEDGEMENT FORM
SOLICITATION NO.: IIHR13017

Instructions: Please acknowledge receipt of all addenda issued with this solicitation by completing this addendum acknowledgment form. Check the box next to each addendum received and sign below. Failure to acknowledge addenda may result in bid disqualification.

Acknowledgment: I hereby acknowledge receipt of the following addenda and have made the necessary revisions to my proposal, plans and/or specification, etc.

Addendum Numbers Received:
(Check the box next to each addendum received)

[x]	Addendum No. 1	[ ]	Addendum No. 6
[ ]	Addendum No. 2	[ ]	Addendum No. 7
[ ]	Addendum No. 3	[ ]	Addendum No. 8
[ ]	Addendum No. 4	[ ]	Addendum No. 9
[ ]	Addendum No. 5	[ ]	Addendum No. 10

I understand that failure to confirm the receipt of addenda may be cause for rejection of this bid. I further understand that that any verbal representation made or assumed to be made during any oral discussion held between Vendor's representatives and any state personnel is not binding. Only the information issued in writing and added to the specifications by an official addendum is binding.

PHBV Partners LLP
Company

Authorized Signature

June 22, 2012
Date

NOTE: This addendum acknowledgement should be submitted with the bid to expedite document processing.
Revised 6/8/2012

PHBV|partners

PHBV Partners LLP
Timonium Corporate Center
9515 Deereco Road, Suite 500
Timonium, MD 21093
410-308-8184 | fax 804-270-2311
www.phbvpartners.com

7-2-12

To: Roberta Wagner From: Susan Quinn

Fax: 304-558-3970 Date: June 26, 2012

Phone: Pages: (Including cover sheet) 2

Re: Sol MHR 13017 CC:

☐ Urgent ☐ For Review ☐ Please Reply

Good afternoon —

Per your email, attached is a signed copy of Addendum No. 2.

Thanks,

Susan

RECEIVED
2012 JUN 27 PM 3:56
WV PURCHASING DIVISION

ADDENDUM ACKNOWLEDGEMENT FORM
SOLICITATION NO.: HHR13017

Instructions: Please acknowledge receipt of all addenda issued with this solicitation by completing this addendum acknowledgment form. Check the box next to each addendum received and sign below. Failure to acknowledge addenda may result in bid disqualification.

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Addendum Numbers Received:
(Check the box next to each addendum received)

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[✓]	Addendum No. 2	[ ]	Addendum No. 7
[ ]	Addendum No. 3	[ ]	Addendum No. 8
[ ]	Addendum No. 4	[ ]	Addendum No. 9
[ ]	Addendum No. 5	[ ]	Addendum No. 10

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PHBV PARTNERS LLP
Company

Charles T. Smith II
Authorized Signature

JUNE 26, 2012
Date

NOTE: This addendum acknowledgement should be submitted with the bid to expedite document processing.

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Timonium, MD 21093
410-308-8184 | fax 804-270-2311
www.phbvpartners.com

RECEIVED
2012 JUL -6 PM 2:06
WV PURCHASING DIVISION

To: Roberta Wagner
From: Susan Quinn
Fax: 304-558-3970
Date: July 6, 2012
Phone:
Pages: 2 (Including cover sheet)
Re:
CC:

☐ Urgent ☐ For Review ☐ Please Reply

Ms. Wagner –

Acknowledgement of Addendum #3 for Sol. No. HHR13017 to add to our already submitted proposal.

Please let me know if you have any questions.

Thanks,

Susan

ADDENDUM ACKNOWLEDGEMENT FORM
SOLICITATION NO.: HHR13017

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PHBV PARTNERS LLP
Company

Authorized Signature

7/6/12
Date

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Revised 6/8/2012