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The Quarterly

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MEDICAID PROVIDER RATE REDUCTION CHALLENGES CAN MOVE FORWARD UNDER FEBRUARY 22, 2012 U.S. SUPREME COURT DECISION – INCLUDING PENNSYLVANIA'S YEAR 14 LITIGATION IN U.S. DISTRICT COURT

By: Louis J. Capozzi, Jr., Esquire and Daniel K. Natirboff, Esquire

On October 15, 2009, our Firm filed a class action on behalf of nonpublic Pennsylvania nursing facility providers challenging the implementation of the largest "budget adjustment factor" (BAF) rate reductions in Pennsylvania history. The complaint challenged the approval of the related State Plan Amendment by the Centers for Medicare & Medicaid Services (CMS) as contrary to the requirements of the Federal Administrative Procedures Act (APA) and also sought ancillary relief to stop the Pennsylvania Department of Public Welfare (DPW) from implementing the BAF reductions as contrary to provisions of the Medicaid Act and prohibited under the Supremacy Clause of the U.S. Constitution.

On June 29, 2010, the U.S. District Court for the Middle District of Pennsylvania (Judge John E. Jones, III) denied the Federal Government's motion to dismiss the complaint and denied in part DPW's motion to dismiss the complaint involving DPW. After the parties had submitted cross motions for summary judgment, the U.S. Supreme Court agreed to hear a related series of cases from California involving provider rights to seek relief from 10% rate reductions passed by the California Legislature that had not been approved by CMS, which the U.S. Court of Appeals for the Ninth Circuit enjoined as contrary to the Medicaid Act and prohibited by the Supremacy Clause. CMS subsequently disapproved California's proposed State Plan Amendments. In addition, many of the nursing facility providers involved in the Pennsylvania class action settled their disputes with DPW as part of the Enhanced Supplemental Payments Settlement offered by DPW in February 2011.

At the request of the State and Federal Defendants, on March 16, 2011, Judge Jones ordered all proceedings in the Pennsylvania case stayed pending the outcome of the cases before the U.S. Supreme Court in Douglas, Director, California Department of Health Care Services v. Independent Living Center of Southern California, et al., No. 09-958. On January 19, 2012, Judge Jones ordered the Pennsylvania parties to report back to him within ten days of any decision by the U.S. Supreme in the California cases.

While the California cases were before the U.S. Supreme Court, CMS and California resolved an administrative appeal of CMS's disapproval of the California State Plan Amendments and CMS approved most of the related State Plan Amendments. In a 5-4 opinion issued February 22, 2012, the U.S. Supreme Court determined that, while the CMS approval of related State Plan Amendments did not end the matter, it significantly changed the procedural posture of the cases because the California providers could now seek relief under the APA to resolve all of the issues and because relief under the APA would support national uniform decision-making on such issues. The U.S. Supreme Court therefore did not address the merits of the Ninth Circuit's decisions, but vacated the judgments and remanded the cases back to the Ninth Circuit for additional argument addressing the impact of the CMS approval and the role of APA. The minority opinion thought the court should decide the merits but indicated that APA review was available to decide the issues.

Since the Pennsylvania case always involved review under the APA, the decision in the California cases supports our Firm's approach taken in the Pennsylvania class action. We are reporting back to Judge Jones on the decision and requesting an opportunity to file supplemental briefs supporting our claims for relief taking into account the recent guidance provided by the U.S. Supreme Court. If you have any questions about the status of Pennsylvania class action or the recent decision by the U.S. Supreme Court, contact Daniel K. Natirboff, Esquire at our Firm.

MANAGING AND COLLECTING YOUR ACCOUNTS RECEIVABLE

by Andrew R. Eisemann, Esquire

This is the seventh installment of our firm's series known as "Managing and Collecting Your Accounts Receivable". As you are already aware, the financial survival of most nursing facilities in Pennsylvania depend on how aggressively and effectively their business office managers administer their accounts receivable. This series is devoted solely to the design, management, and improvement of your accounts receivable program and collections efforts. Also, here we share with you tips, legal updates, personal observations, and "lessons learned" to help you improve the effectiveness of your Accounts Receivable Management Program.

I want to focus this installment on a critical player in your efforts to watch your bottom line: the resident's "Legal Representative", or, as some nursing facilities in Pennsylvania refer to this person, the "Responsible Party" or "Designated Representative".

Why do I want to devote this space to a discussion of the Legal Representative? The weakest link in the admissions and account management process that negatively impacts a nursing facility's bottom line is frequently the identification and preparation of a resident's Legal Representative. Furthermore, a court in Pennsylvania recently addressed the liability of a Legal Representative for a nursing facility resident.

1. The Admission Agreement lacks a clear definition, or any definition whatsoever, of a Legal Representative, or it lacks a description of the duties and responsibilities of the Legal Representative;
2. The Admission Agreement properly explains that a Legal Representative will not be held personally liable for the debt, but, it fails to disclose that a Legal Representative can potentially be held financially liable in the amount that he or she fails to transfer from the resident's income or assets despite having access to the resident's resources;
3. The Admission Director identifies the resident on the first page of the Admission Agreement as the Legal Representative, although a member of the resident's family or a friend signs the signature line on the last page of the Admission Agreement;
4. The signature line of the Admission Agreement for the Legal Representative does not identify the signatory as the resident's Legal Representative;
5. The Admission Director fails to identify a Legal Representative or neglects to name the person on the first page of the Admissions Agreement;
6. The Admission Director neglects to have the Legal Representative sign the last page of the Admission Agreement, which is a legally enforceable contract;
7. The Admission Director fails to adequately explain to the Legal Representative his or her duties or responsibilities, including assistance in the MA application process. Or, worse, the Admission Director directs the Legal Representative to not make any payments or escrow the resident's income while Medicaid is pending;
8. The Admission Director fails to adequately explain to the Legal Representative that the Admission Agreement is a legally enforceable and binding contract;
9. The Admission Director or Business Office fails to explain to the Legal Representative the benefits of arranging direct deposit of the resident's Social Security income either as Representative Payee or through the Resident Fund Management System. The same issue applies to the resident's pension income;
10. The Business Office fails to mail a monthly bill to the Legal Representative during the first several months after the facility admits the resident as a matter of policy while MA is pending; and,
11. Finally, the Business Office simply allows the Legal Representative to avoid payment or not cooperate for too long. In other words, the Legal Representative is taking advantage of a disorganized Business Office or its passive attempts at collection.

I am certain that you have experienced one or more of the following situations as a result of the weaknesses above:

1. The family spends the resident's money on non-allowable expenses although the relative or resident truly believes that these expenditures were justified;
2. A relative intentionally or fraudulently diverts the resident's funds for personal consumption or investments;
3. The Legal Representative fails to fully cooperate in the Medicaid application process, including the transfer of financial documents or information; or,
4. Although the CAO directs the Legal Representative to "spend down" the resident's funds to qualify for Medicaid, he or she refuses, even if the amount is nominal. As a result of this last scenario, you're attempting to collect against a private pay resident with insignificant financial resources. There is no generally accepted meaning of the term, "Legal Representative', under the law. The Nursing Home Reform Act of 1987, however, permits the nursing facility to contract with a person who has access to the resident's income and resources to transfer payments from the resident's income and resources. 42 U.S.C. §1396r(c)(5)(B)(ii).

Furthermore, the Pennsylvania Administrative Code permits a resident to name a Legal Representative. 28 Pa. Code §201.24(a). This section of the Code defines the Legal Representative as someone who can make decisions on behalf of the resident, but it does not obligate a Legal Representative to make payments. In addition, this section prevents a nursing facility from naming an employee as a resident's Legal Representative, unless a court appoints the employee as the resident's guardian.

Accordingly, an Admission Agreement must be clear as to the definition, duties, and responsibilities of a Legal Representative to be legally enforceable. If the Admission Agreement is clear, the Legal Representative can be held legally liable for his or her failure to perform his duty to remit payment form the resident's funds. Of course, the Legal Representative may also be held liable personally if he diverts the resident's funds for non-allowable purposes, which requires a court order.

No. As most of you are aware, Medicaid law expressly restricts a nursing facility that is eligible for Medicaid or Medicare reimbursement from requiring a third party guarantee of payment to the facility as a condition of admission or continued stay. A Guarantor is someone who is personally liable for a debt from his or her own assets. An example of a Guarantor is the father who co-signs a car loan for his daughter. The law does not prohibit a third person voluntarily guarantee payment to the nursing facility. I continue to see, however, the term

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MANAGING AND COLLECTING YOUR ACCOUNTS RECEIVABLE... *Continued from Page 2*

Guarantor in admission agreements, admission fact sheets, or account invoices even though the admission agreement does not clearly obligate a third party as a guarantor.

Although Pennsylvania court case law regarding the legal financial liability of a Legal Representative is scarce, the Allegheny County Court of Common Pleas recently addressed this issue in . The opinion of this Court will have a strong persuasive effect on other county courts throughout Pennsylvania. In summary, the Court disallowed the nursing facility's claim against a resident's "Responsible Party" because the Admission Agreement did not "clearly and unambiguously" define the term "Responsible Party" or obligate the Responsible Party to guarantee payment. In fact, the Court expressly preferred the term "Legal Representative", rather than "Responsible Party", because the usage of "Legal Representative" is more widely accepted and defined in state statutes.

Because it is the nursing facility or its management company that drafts the Admission Agreement, the burden is on the nursing facility to ensure the requirements and obligations of a Legal Representative are "clear and unambiguous." Otherwise, the nursing facility's attempts to collect a debt against a Legal Representative in a court may be weakened or unsuccessful.

If you would like more information on how your Admission Agreement can be used or modified to protect your facility's bottom line, including an analysis and revision of the contract terms related to the Legal Representative, you may contact Andrew R. Eisemann at our Firm at andrewe@capozziassociates.com

BRAVING THE DEPTHS OF MEDICAL ASSISTANCE BED REQUEST LAW

by Matthew A. Thomsen, Esquire

Thanks to its nature as hybrid of federal and Commonwealth law, the legal landscape surrounding enrollment and expansion under the Medical Assistance (MA) program may appear to many as a disorganized pile of intermingling code and policy. The mere mention of the Department of Public Welfare's (DPW) current Statement of Policy (SOP) on the matter may fill some people with the sort of dread usually reserved for assembling do-it-yourself furniture or attempting a Saturday crossword puzzle in pen.

Fortunately, a little context goes a long way in understanding how things came to be as they are and how they may well be in the future. With any luck, this article will give you greater clarity (and less dread) with respect to the MA bed process by giving you a brief history of relevant Pennsylvania policy, code, and case law followed by a short analysis of the proposed regulations that loom on the horizon.

A. What Was and Is

The single biggest constraint throughout all past and present versions of Pennsylvania MA law is the requirement that our program be administered "in conformity with Title XIX of the Social Security Act…" 55 Pa.Code § 1101.11(b). Federal authority over Pennsylvania's MA program has existed since it began and stems from the fact that the Commonwealth funds its program in part through federal money. *See Alexander v. Choate*, 469 U.S. 287, 290 n.1 (1985).

a. Certificates of Need End and Statements of Policy Begin

From July 19, 1979 through December 18, 1996, facilities that wished to enroll in the MA program or expand their number of MA beds were required to obtain a Certificate of Need (CON). The CON program required facilities to provide information about project details and the regional need for services as described in the State Health Services Plan and was relied upon by DPW to conform to the requirements of the Social Security Act. In 1992, the Pennsylvania General Assembly decided that no prior approval should be required to open new health care facilities or expand existing ones. As a result, they issued legislation that scheduled the CON requirements to expire four years later. *See* 35 P.S. § 448.904a. Eventually, DPW realized that the lack of any requirements created a risk of increased cost to the MA program. *See* 26 Pa.B. 5996.

As a result, DPW issued a SOP on December 13, 1996 which halted the possibility of enrolling new facilities and cut funding for any facility that expanded too quickly, but allowed for exceptions on a case-by-case basis. *Id.* DPW issued another SOP on January 9, 1998 which explained the exceptions that DPW would consider. *See* 28 Pa.B. 138. Like the expired CON, a facility would have to give information about the proposed program and the impact it would have on the area. Significantly, this SOP relied heavily on DPW's opinion about whether or not a proposal was in the "best interests of the Department." 28 Pa.B. 138 at §1187.21a(c).

b. Challenges by *Millcreek* and *Eastwood*

In 2002, in *Millcreek Manor v. Department of Public Welfare*, 796 A.2d 1020, 1023, the Commonwealth Court ruled that the BHA must consider challenges and evidence pertaining to DPW's Statements of Policy. Then, in 2006, in *Eastwood Nursing and Rehabilitation Center v. Department of Public Welfare*, 910 A.2d 134, 138-9, the court ruled that DPW's SOP was deficient for two reasons. First, because the SOP established new requirements, it was effectively acting like a regulation (the court's "binding norm test"); which DPW was not allowed to do without complying with Pennsylvania statutory requirements for putting regulations into effect (the Commonwealth Documents Law). Second, the *Eastwood* court found that the SOP was inconsistent with requirements in the Medicaid Act and related Federal regulations. In *Eastwood*, the court also noted concerns about DPW's administration of the process that could deny providers due process.

c. Legislative Response and Agency Revision

In response to the *Eastwood* decision, DPW requested that the Pennsylvania General Assembly give DPW statutory authority to limit enrollment and expansion of nursing facilities in the Pennsylvania Medicaid Program through a prior approval process. This authority was granted in Act 16-2007 which added the provision to the Public Welfare Code at 62 P.S. 443.1(8), and authorized DPW to continue to use Statements of Policy to administer the process until DPW put regulations in place by July 1, 2009. On November 1, 2008, DPW proposed amendments to the SOP, 38 Pa.B. 5974; and, on April 3, 2010, 40 Pa. P. 1766, implemented a final version of the new SOP, which is still being used today. On November 6, 2010, DPW finally published proposed regulations on the "Participation

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BRAVING THE DEPTHS OF MEDICAL ASSISTANCE BED REQUEST LAW *Continued from Page 3*

Review Process for Medical Assistance Nursing Facilities," 40 Pa.B. 6405, including provisions for "bed transfer requests" (§ 1187.175) (moving certified beds from one facility to another).

B. What (Probably) Will Be

In the near future, a final version of the Participation Review Process regulations will likely become official. This seems likely because Act 16-2007 limits DPW's authority to put new regulations into effect with a deadline of June 30, 2012. Like the existing SOP, the new regulations will cover circumstances and conditions for enrollment or expansion under the MA program. Whether or not the new regulations sufficiently address the concerns raised in *Eastwood* remains to be determined.

a. Conformity with *Eastwood* Decision

The General Assembly provided DPW with some cover to delay compliance with the Commonwealth Documents Law, leaving the only questions related to this concern in *Eastwood* as those related to DPW's lateness in getting the new rules out and whether the process it follows through to adoption of the final regulations complies with the Law. The additional authority granted to DPW in Act 16 did not change the need for DPW to meet the requirements of the Federal Medicaid Act and related Federal regulations. Given the current trend to increasing States' flexibility in administering their Medicaid Programs, most recently reflected in the changing Federal positions regarding California's efforts to reduce rates that are currently on remand from the U.S. Supreme Court, providers will need to monitor any shifts in Federal policy in order to assess whether DPW's new Participation Review Process meets Federal requirements.

b. Practical Challenges

From a practical standpoint, those facilities that wish to enroll in the MA program or increase their number of beds going forward will still encounter significant barriers to access in addition to the standard information requirements. Provisions that were termed considerations in the SOP have in many instances become requirements. In the proposed new § 1187.177, there are only three ways to show that new beds are needed in the facility's primary service area: insufficient bed capacity, systemic barriers to access, and novel specialized care. For the capacity route, the requesting facility's county or service area must already have greater than 95% overall occupancy. As of the end of 2011, only five counties in Pennsylvania fell in that category. Systemic barriers will be found where MA occupancy for the county is more than 1% below the statewide average. As for novel specialized care, not only would it be more expensive than an ordinary facility, but expansion on this path may be limited to those who jump in first. If everyone has the same equipment and care, it ceases to be novel. The new DPW approach, however, does appear to give providers more flexibility to move beds, including through sales.

If you have questions about DPW's new Participation Review Process, including the new bed transfer review process, you may contact Daniel K. Natirboff, Esquire or Matthew A. Thomsen, Esquire at our Firm.

CAPOZZI & ASSOCIATES, P.C. WELCOMES ...

Paul Van Fleet has joined our Firm as an associate attorney. Paul is a 2011 graduate of The Dickinson Law School at Penn State University, where he was an Articles Editor for the *Penn State Law Review*. He also was a member of the AAJ Trial Team, and was awarded inclusion in the Order of the Barristers for excellence in advocacy. He received his A.B. in Economics from the College of William and Mary in 2006, including overseas study at University of Florence, Italy. Paul is admitted to practice in Pennsylvania. Prior to coming to Capozzi & Associates, Paul served as a paralegal and law clerk at Weiss LLP in Washington, DC, specializing in real estate transactions, business organizations, and large estate and trust administration and litigation; and, as a law clerk at Abom & Kutulakis, LLP in their Carlisle office. His practice with our Firm will focus on real estate and corporate organization. Paul resides in Camp Hill, PA and looks forward to serving clients at Capozzi and Associates, P.C. with the best possible legal representation.

THE CONTINUED EROSION OF THE AT-WILL EMPLOYMENT DOCTRINE

by Brandon S. Williams, Esquire

In a case confirming the maxim that nogood deed goes unpunished, the New Jersey Appellate Division held that form letters sent to an employee approving her tenth maternity leave and outlining the employer's family leave policy created an enforceable employment contract that guaranteed her reinstatement after returning from a one-year leave of absence. Cases like this are becoming more common as courts throughout the country find new ways to impose additional burdens on employers and continue to chip away an employer's right to terminate employees.

In , 22 A.3d 11 (N.J. Super. 2011), despite the fact that the employer's code of business ethics, which was distributed to employees annually, contained a disclaimer indicating that nothing in company policies or related documents constituted a contract for employment, and that the company's practices and procedures further confirmed the company's at-will policy, the Court found that a form letter containing the following explanation of the employer's leave policy constituted a guarantee or reinstatement:

> [Your] unpaid Family Care Leave of Absence from July 22, 2005 through January 22, 2006 is approved and will be counted towards your 12 weeks of 2005 and 2006 Family and Medical Leave Act (FMLA) entitlement . . . This leave is granted with a guarantee of reinstatement up to 12 months to the same or comparable job, including the number of hours and days worked during the week, salary, and benefits prior to the Leave starting. Reinstatement is not guaranteed if your job is declared surplus or the number of hours you request to work at the time of reinstatement is different than when the Leave commenced.

Here, the employee's leave was voluntarily extended an additional six months by the employer. While the Court found that neither the Federal nor the New Jersey Family and Medical Leave Acts were violated by the employer's refusal to reinstate the employee (those statutes only require a reinstatement

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THE CONTINUED EROSION... *Continued from Page 4*

when the employee takes a leave of twelve weeks or less), the language quoted above, coupled with the employee's "reasonable expectations" after being reinstated after nine previous maternity leaves, were determined to have trumped the employer's numerous articulations that employment was at-will.

Whether other courts will follow New Jersey's lead is yet to be seen, but cases like this will certainly result in an upturn in claims filed by dismissed employees. Employers should review all communications with employees and make sure that rights they thought were protected are not inadvertently abandoned in subsequent correspondences with employees.

If you would like to discuss your employment policies and practices, you may contact Brandon S. Williams of our Firm at brandonw@capozziassociates.com.

GOVERNOR SIGNS PENNSYLVANIA CAREGIVER SUPPORT ACT

by Philip C. Warholic, Esquire

On December 22, 2011, Governor Tom Corbett signed HB 210 which amends the Act of December 19, 1990 (P.L.1234, No. 204), known as the Family Caregiver Support Act, which provides benefits and services for eligible caregivers who care for functionally dependent relatives 60 years of age and older, as well as adults with chronic dementia such as Alzheimer's who are 18 years of age and older. It changes the name of the Act to the Pennsylvania Caregiver Support Act, addresses approved out-of-pocket expenses incurred by caregivers, allows reimbursement of non-relative caregivers and adult family members, and makes other changes. The bill is now known as Act 112 of 2011, and took effect in early March.

The new law amends the definition of caregiver to include non-relative caregivers, and removes the requirement that a caregiver must live with the care recipient. The term "primary caregiver" is redefined to delete the requirements that the caregiver be a relative of and reside in the same household as the care receiver. A primary caregiver is the one identified adult family member or other individual who has assumed the primary responsibility for the provision of care needed to maintain the physical or mental health of a care receiver and who does not receive financial compensation for the care provided.

Section 4 of the Act describes the primary person to be served by the Act are unpaid, primary caregivers who provide continuous care to a care receiver. The Dept. of Aging is directed to give priority in awarding assistance paid by lottery funds to primary caregivers who are caring for an adult 60 years or older which chronic dementia.

The law also increases the maximum amount allowable under the program for out-of-pocket expenses from $200 per month to $500 per month. In addition to out-of-pocket expenses, the program also provides grants of up to $2,000 for home modifications such as ramps and chair lifts.

If you would like more information on how the new law may affect your facility, you may contact Philip C. Warholic at our Firm at philipw@capozziassociates.com.

FLAT FEE PRICING

Capozzi & Associates now offers flat fee pricing on certain services designed to assist facilities in meeting federal and state requirements while maintaining control over facility budgets. Take advantage of this opportunity to enhance your internal operations while having control over the cost of such services. Various packages are offered which include basic components for those facilities on a tight budget or more deluxe packages for facilities who want to insure that operational changes are fully integrated into the culture of their organization. Please contact: Dawn L. Richards, Esquire at our Firm for flat fee pricing schedules associated with the following services:

Employee Handbooks

Tiered pricing is available based on your selection of services. Comprehensive and deluxe options are available. Packages allow for planning sessions, preparation of materials, management and/or staff training on site or through interactive media. Annual updates are included, if selected. Handbooks include employment policies and procedures (discrimination, application process, criminal background checks, pre-employment testing), applicable state and federal requirements, benefits, procedures for handling substance abuse, harassment, violence, whistleblowers and much more.

Compliance Programs

Three levels of pricing are offered to assist facilities in implementing policies and procedures related to compliance with required federal and state regulations. Packages include policies related to HIPAA, fraud and abuse, resident rights, document retention, compliance committee and officer responsibilities, monitoring and auditing, and much more. Options include planning sessions, review of existing practices, preparation of materials, and live or narrated education sessions for management and staff.

Admissions Packets

Reduce unnecessary paperwork and streamline your admissions process with one of our flat fee admissions packages. Each includes a review of your current material, creation of a comprehensive packet of documents designed to improve efficiency of the admission process while keeping the facility within a selected budget. All packages provide for updated admissions agreements (in accordance with specific state regulations), statements of resident's rights, fee schedules, required Medicare and Medical Assistance forms and facility specific documents. On site planning and training sessions are available.

National Labor Relations Employee Rights Posters

As of April 30, 2012, most private sector employers will be required to post a notice advising employees of their rights under the National Labor Relations Act. (The original effective date was postponed.) The notice must be posted in a conspicuous place, where other notifications of workplace rights and employer rules and policies are posted. Employers are also required to publish a link to the notice on an internal or external website if other personnel policies or workplace notices are posted there. Capozzi & Associates suggests that employers counter this action by posting an Employer Rights poster in close proximity, to educate employees on the rights they currently possess as non-union staff. Separate posters are available for unionized facilities emphasizing the benefits of non-union status. We offer various options including customized electronic files for printing and posting, narrated training on NLRB requirements for management staff and on-site interactive seminars.

RECENT AND UPCOMING EVENTS:

January 2, 2012 – Capozzi & Associates, P.C. started working out of new offices at 1200 Camp Hill Bypass (Suite 205), across from the Camp Hill Post Office with new mailing address of: P.O. Box 5866, Harrisburg, PA 17110.

January 12, 2012 – (12:00 - 3:00 p.m.) – Louis J. Capozzi, Jr., Esq. and Dawn L. Richards, Esq. presented a program at Presbyterian Senior Living (Dillsburg, PA) on recent NLRB changes in requirements applicable to nursing facilities and on "How Your Employee Handbook Protects Your Bottom Line," as part of a series in cooperation with the regional chapters of Leading Age-PA.

January 25, 2012 – (12:00 – 3:00 p.m.) - Louis J. Capozzi, Jr., Esq. and Dawn L. Richards, Esq. presented a program at Kirkland Village (Bethlehem, PA) on recent NLRB changes in requirements applicable to nursing facilities and on "How Your Employee Handbook Protects Your Bottom Line," as part of a series in cooperation with the regional chapters of Leading Age-PA.

February 10, 2012 – Dawn L. Richard, Esq. presented a full-day seminar as part of Penn State Greater Allegheny's licensing program for nursing home administrators on "The Government's Role in Health Care Policy, Regulation and Reimbursement" at the campus in McKeesport (8:30 a.m. – 5:00 p.m.).

March 23, 2012 – Spring Program of Capozzi & Associates, P.C. Seminar on "Current Issues for Nursing Facilities in Pennsylvania," in Grantville at the John Henry Conference Room at Hollywood Casino, including continuing education credits for NHA's, CPA's, and attorneys. TO REGISTER FOR THE SPRING 2012 PROGRAM, CONTACT ERIN MOTTER AT OUR FIRM – Email: ErinM@CapozziAssociates.com.

March 27, 2012 – Dawn L. Richards, Esq. will be presenting the two-hour "Module 5" program of DPW's required training for personal care administrators on "Local, State and Federal Laws and Regulations Pertaining to the Operation of a Home," at the Penn State Greater Allegheny campus in McKeesport from 3-5 p.m.

April 14, 2012 – Capozzi & Associates, P.C. Adopt-A-Highway Cleanup on I-81 (N&S at Mile 62.5) (Cumberland County between Enola and Wertzville Road).

June 27-29, 2012 – Louis J. Capozzi, Jr., Esq. and Dawn L. Richards, Esq. will be speaking at the 2012 LeadingAge-PA Annual Conference & Exhibitation in Hershey on "National Labor Relations Act: Proposed Changes."

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