EXHIBIT B.3

Arkansas
State Claims Commission
APR 20 2017
RECEIVED

Please Read Instructions on Reverse Side of Yellow copy

Please print in ink or type

BEFORE THE STATE CLAIMS COMMISSION

Of the State of Arkansas

Do Not Write in These Spaces	
Claim No.	17-0664-CC
Date Filed (Month) (Day) (Year)	April 20, 2017
Amount of Claim $	20,200.00
Fund	DHS
	Unpaid Bill

☐ Mr.
☐ Mrs.
☐ Ms.
☐ Miss

Preferred Family Healthcare Inc. (PFH), Claimant
Formerly Alternative Opportunities Inc (AO)

vs.

State of Arkansas, Respondent

Arkansas Department of Human Service

COMPLAINT

PFH Formerly AO (Name), the above named Claimant, of 1111 S Glenstone Ste 3-100 (Street or R.F.D. & No.) Springfield (City)

MO (State) 65804 (Zip Code) 417-883-8911 (Daytime Phone No.) County of Greene represented by ______ (Legal Counsel, if any, for Claim)

of ______ (Street and No.) ______ (City) ______ (State) ______ (Zip Code) ______ (Phone No.) ______ (Fax No.), says:

State agency involved: AR Dept of Human Services Amount sought: $20,200.00

Month, day, year and place of incident or service: June 1, 2015 - June 30, 2015

Explanation: We submitted invoice BHAO12NEL on 7-16-15 for payment on PO 4501568828. This has never paid due to a change in payments. We submitted a detailed payment summary to Steven Dankins and Cathy Dial. They agreed the $20,200 was never paid. We are resubmitting for payment

As parts of this complaint, the claimant makes the statements, and answers the following questions, as indicated: (1) Has claim been presented to any state department or officer thereof? Yes (Yes or No); when? 07 (Month) 16 (Day) 2015 (Year); to whom? AR Dept of Human Services - Divi of Behavioral Health (Department); and that the following action was taken thereon: ______

and that $ ______ was paid thereon: (2) Has any third person or corporation an interest in this claim? ______; if so, state name and address

______ (Name) ______ (Street or R.F.D. & No.) ______ (City) ______ (State) ______ (Zip Code)

and that the nature thereof is as follows: ______; and was acquired on ______, in the following manner:

THE UNDERSIGNED states on oath that he or she is familiar with the matters and things set forth in the above complaint, and that he or she verify believes that they are true.

Marilyn Nolan
(Print Claimant/Representative Name)

[signature]
(Signature of Claimant/Representative)

SWORN TO and subscribed before me at PFH Springfield (City), MO (State)

on this 17th (Date) day of April (Month), 2017 (Year)

[signature]
(Notary Public)

(SEAL) BONITA G. NICHOLS
Notary Public, Notary Seal
State of Missouri
Christian County
Commission # 14060770
My Commission Expires January 22, 2018

My Commission Expires: January (Month) 22 (Day) 2018 (Year)

SF1- R7/99

Bill To: **Arkansas Department of Human Services/Division of Behavioral Health Services**
4800 West 7th Street
Little Rock, Arkansas 72205
Telephone: (501) 686-9164 FAX: (501) 686-9035

BASIC SERVICES PROGRAM PLAN-PART B
MONTHLY PAYMENT AUTHORIZATION

CENTER:

Name: Alternative Opportunities Inc.
Health Resources of Arkansas
Address: 1111 S. Glenstone Ste 3-100
City: Springfield State: MO ZIP: 65801
P.O. #: 4501516833 Vendor #: 600004801

Current Date: 2/2/2017
Invoice #: BSPA12NW-A
For the Period of: 6/1/2015
Through: 6/30/2015

Funding Information	Amounts
Total Annual Allocation	$259,513.00
Plus: Mid Year Allocation Increase	$0.00
Less: Mid Year Allocation Reduction	$0.00
Net Payable Allocation	$259,513.00
Amount Received Year to Date	
Monthly BSP Part B Allocation	$20,200.00
Current Month Basic Services Program - Plan Part B Request:	$20,200.00
DHS USE: Adjustment Description:	
Total Billed Net:	

CERTIFICATION AND SIGNATURE:
By signing this invoice, I certify that the above stated information is correct to the best of my knowledge.
I also certify that services have been performed in accordance with the contract and all it's attachments.

[signature] 2-1-17
Executive Director or Designee Date

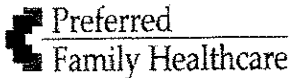
PROFESSIONAL SERVICES:

Amount:
Internal Order:
Cost Center:
Material #:
General Ledger:
P.O. Line #:
Document #:

Amount:
Internal Order:
Cost Center:
Material #:
General Ledger:
P.O. Line #:
Document #:

Approved for Payment: Date

Revised: July, 2010



Karyn Stone <kstone@pfh.org>

Re: $20,200 Discrepancy in BSPA PO 4501516833

1 message

Karyn Stone <kstone@pfh.org> Thu, Feb 2, 2017 at 3:12 PM
To: Chevonne Banks <Chevonne.Banks@dhs.arkansas.gov>
Cc: Tom Weber <tweber@pfh.org>, Martha Hurt <mhurt@pfh.org>, Letha Dial <Letha.Dial@dhs.arkansas.gov>

Thank you Chevonne for all of your help. i greatly appreciate it.

On Thu, Feb 2, 2017 at 3:10 PM, Chevonne Banks <Chevonne.Banks@dhs.arkansas.gov> wrote:

Hi Karen,

Please submit an additional State Claims Commission for the $20,200. This will bring the total of both claims to $74,831.00.

Thanks!

Chevonne Banks

Accounting Coordinator

AR Department of Human Services

Division of Behavioral Health Services

4800 West 7th Street

Little Rock, AR 72205

Phone: 501-683-6972

Fax: 501-686-9182

chevonne.banks@dhs.arkansas.gov

This email may contain sensitive information.

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From: Karyn Stone [mailto:kstone@pfh.org]
Sent: Wednesday, February 01, 2017 7:57 AM
To: Chevonne Banks
Cc: Tom Weber; Martha Hurt
Subject: $20,200 Discrepancy in BSPA PO 4501516833

Hi Chevonne-

I have attached a recap of all $10,100 payments that we show received from the State of Arkansas for July 1, 2014 - June 30, 2015. I have also included the billing date, vendor number on invoice, purchase order on invoice, date paid, check number and amount paid. I also included a copy of the cash payments summary sent to us from the state for this same time period on the second tab. I highlighted all payments for $10,100 in green.

After matching up all payments from the state with our invoices, I do not show a duplicate payment for any invoices. I did submit a corrected invoice for $54,631 to the State Claims Commission yesterday for PO 4501516833. I am just trying to resolve the additional $20,200. Would you please review the attached spreadsheet and let me know if you show any payments that I do not. If we agree on these payments, would you please let me know what we need to do to submit paperwork for the additional $20,200?

Again, thank you for all of your help with this matter.

--

Karyn Stone

HRA Accountant

Preferred Family Healthcare (formerly Alternative Opportunities)

1111 S. Glenstone

Springfield, MO 65804

Phone (417) 869-8911 ext. 160

Fax (417) 869-1625

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--

Karyn Stone
HRA Accountant
Preferred Family Healthcare (formerly Alternative Opportunities)
1111 S. Glenstone
Springfield, MO 65804
Phone (417) 869-8911 ext. 160
Fax (417) 869-1625

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State Claims Commission
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BEFORE THE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

ALTERNATIVE OPPORTUNITIES **CLAIMANT**

v. **CLAIM NO. 17-0664-CC**

STATE OF ARKANSAS
DHS/DBHS **RESPONDENT**

ANSWER

Comes now the Respondent, Arkansas Department of Human Services, Division of Behavioral Health Services, by its attorney, Nick Windle for its Answer states:

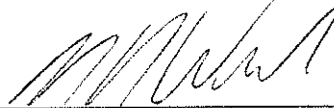
1. Respondent admits liability in the amount of $20,200.00. Payment should be made as follows:

Agency Number:	0710
Cost Center:	417906
Internal Order:	HZ1X00XX
Fund:	PWP3500
Fund Center:	896

WHEREFORE, Respondent prays this claim be paid in the amount of $20,200.00 and for all other proper relief to which Respondent may be entitled.

Respectfully submitted,

ARKANSAS DEPARTMENT
OF HUMAN SERVICES
OFFICE OF CHIEF COUNSEL

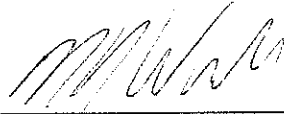


Nick R. Windle, No. 2010060
Attorney at Law
P.O. Box 1437 – Slot S260
Little Rock, Arkansas 72203-1437
Telephone: (501) 320-6351
Fax: (501) 682-1390
E-mail: Nicholas.Windle@DHS.Arkansas.Gov

CERTIFICATE OF SERVICE

I, undersigned, do hereby certify that on this 27th day of April, 2017, a true and correct copy of the foregoing pleading was sent to the following individual via U.S. mail.

Marilyn Nolan
Preferred Family Healthcare, Inc.
1111 S. Glenstone Avenue, Suite 3-100
Springfield, MO 65804



Nick Windle

BEFORE THE ARKANSAS STATE CLAIMS COMMISSION

PREFFERED FAMILY HEALTHCARE, INC.
F/K/A ALTERNATIVE OPPORTUNITIES INC. **CLAIMANT**

VS **CLAIM NO. 17-0664-CC**

ARAKNSAS DEPARTMENT OF HUMAN SERVICES-
DIVISION OF BEHAVORIAL HEALTH SERVICES **RESPONDENT**

ORDER

This claim was filed by Preferred Family Healthcare, Inc. f/k/a Alternative Opportunities Inc. against the Arkansas Department of Human Services–Division of Behavioral Health Sciences (the "Respondent") for an unpaid bill in the amount of $20,200.00.

The Respondent filed an Answer on April 20, 2017, admitting liability in the amount of $20,200.00

The Claims Commission **hereby unanimously allows this claim in the amount of $20,200.00 and will include the claim in a claims bill to the 91st General Assembly of the Arkansas State Legislature for subsequent approval and payment.**

IT IS SO ORDERED.

Henry C. Kinslow

ARKANSAS STATE CLAIMS COMMISSION

Dexter Booth
Henry Kinslow, Co-Chair
Bill Lancaster
Sylvester Smith
Mica Strother, Co-Chair

DATE: May 5, 2017

<u>Notice(s) which may apply to your claim</u>

(1) A party has forty (40) days from the date of this Order to file a Motion for Reconsideration or a Notice of Appeal with the Claims Commission. Ark. Code Ann. § 19-10-211(b). If a Motion for Reconsideration is denied, that party then has twenty (20) days from the date of the denial of the Motion for Reconsideration to file a Notice of Appeal with the Claims Commission. Ark. Code Ann. § 19-10-211(b)(3). A decision of the Claims Commission may only be appealed to the General Assembly. Ark. Code Ann. § 19-10-211(a).

(2) If a Claimant is awarded less than $15,000.00 by the Claims Commission at hearing, that claim is held forty (40) days from the date of disposition before payment will be processed. *See* Ark. Code Ann. § 19-10-211(b). <u>Note</u>: This does not apply to agency admissions of liability and negotiated settlement agreements.

(3) Awards or negotiated settlement agreements of $15,000.00 or more are referred to the General Assembly for approval and authorization to pay. Ark. Code Ann. § 19-10-215(b).