HEALING HEARTS COUNSELING CENTER, LLC
RICHLAND COUNTY

COMPLIANCE EXAMINATION REPORT

FOR THE PERIOD JANUARY 1, 2016 THROUGH DECEMBER 31, 2017

OHIO AUDITOR OF STATE
KEITH FABER

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HEALING HEARTS COUNSELING CENTER, LLC
RICHLAND COUNTY

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OHIO AUDITOR OF STATE
KEITH FABER

Medicaid Contract Audit
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INDEPENDENT AUDITOR'S REPORT ON COMPLIANCE WITH REQUIREMENTS OF THE MEDICAID PROGRAM APPLICABLE TO SELECT BEHAVIORAL HEALTH SERVICES

Ohio Department of Medicaid
50 West Town Street, Suite 400
Columbus, Ohio 43215

RE: Healing Hearts Counseling Center, LLC
Ohio Medicaid Number: 0134918

We were engaged to examine Healing Hearts Counseling Center LLC's (the Provider's) compliance with specified Medicaid requirements for provider qualifications, documentation and authorization for individual and group counseling and documentation and authorization for alcohol/drug screen-lab analysis of specimens (lab) services during the period of January 1, 2016 through December 31, 2017. In addition, we tested provider qualifications and documentation for counseling services, alcohol and/or drug assessment services and case management services for two dates of service.

The Provider entered into an agreement (the Provider Agreement) with the Ohio Department of Medicaid (ODM) to provide services to Medicaid recipients and to adhere to the terms of the agreement, state statutes and rules and federal statutes and rules, including the duty to maintain records supporting claims for payments made by Ohio Medicaid.

Our responsibility is to express an opinion on the Provider's compliance with the specified Medicaid requirements based on conducting the examination in accordance with attestation standards established by the American Institute of Certified Public Accountants. An examination involves performing procedures to obtain evidence about whether the Provider complied with the specified requirements. The nature, timing and extent of the procedures selected depend on our judgment, including an assessment of the risks of material noncompliance, whether due to fraud or error. Our examination does not provide a legal determination on the Provider's compliance with the specified requirements.

Internal Control over Compliance

The Provider is responsible for establishing and maintaining effective internal control over compliance with the Medicaid requirements. We did not perform any test of the internal controls and we did not rely on the internal controls in determining our examination procedures. Accordingly, we do not express an opinion on the effectiveness of the Provider's internal control over compliance.

Basis for Disclaimer of Opinion

As described in the attached Compliance Examination Report, the Provider displayed disregard for the security of passwords used to gain access into its electronic health record (EHR) system. In addition, there was no documentation to support the Medicaid payments for 139 of the 786 selected services (18 percent) nor was there authorization for 195 of 594 services (33 percent) tested. As such we were unable to gain sufficient reliance on the integrity of the EHR system or on the documentation to determine the Provider's compliance with specified Medicaid requirements. Nor were we able to satisfy ourselves as to the Provider's compliance with these requirements by other examination procedures.

In addition, the Provider declined to submit a signed representation letter acknowledging responsibility for complying with the terms of the Provider Agreement, Revised Code, Administrative Code, and federal statutes and rules; knowledge of any actual, suspected, or alleged fraud or noncompliance with laws or regulations affecting compliance with Medicaid requirements; provision of all relevant information and access to information and personnel in connection with this compliance examination; disclosure of all known matters contradicting its compliance with the Medicaid requirements and any communication from regulatory agencies or others affecting its Medicaid compliance, and disclosures of any known events subsequent to the compliance examination period that would have a material effect on Medicaid compliance.

Disclaimer of Opinion

Because of the limitation on the scope of our examination discussed in the preceding paragraph, the scope of our work was not sufficient to enable us to express, and we do not express, an opinion on the Provider's compliance with the specified Medicaid requirements for the period of January 1, 2016 through December 31, 2017.

Our testing was limited to the specified Medicaid requirements detailed in the Compliance Examination Report. We did not test other requirements and, accordingly, we do not express an opinion on the Provider's compliance with other requirements.

We calculated improper Medicaid payments in the amount of in the amount of $1,338,094.67. This finding plus interest in the amount of $101,218.61 (as of September 3, 2019, 2019) totaling $1,439,313.28, is due and payable to the ODM upon its adoption and adjudication of this examination report. Services billed to and paid by the ODM, which are not validated in the records, are subject to recoupment through the audit process. *See* Ohio Admin. Code § 5160-1-27 In addition, if fraud, waste and abuse[1] are suspected or apparent, the ODM and/or the office of the attorney general will take action to gain compliance and recoup inappropriate or excess payments in accordance with rule 5160-1-27 of the Administrative Code.

This report is intended solely for the information and use of the ODM and other regulatory and oversight entities, and is not intended to be, and should not be used by anyone other than these specified parties.

Keith Faber
Auditor of State
Columbus, Ohio

September 3, 2019

[1] "Fraud" is an "intentional deception, false statement, or misrepresentation made with the knowledge that the deception, false statement, or misrepresentation could result in some unauthorized benefit to oneself or another person". "Waste and abuse" are "practices that are inconsistent with professional standards of care; medical necessity; or sound fiscal, business, or medical practices; and that constitutes an overutilization of Medicaid covered services and result in an unnecessary cost to the Medicaid program." Ohio Admin. Code § 5160-1-29(A)

COMPLIANCE EXAMINATION REPORT

Background

Title XIX of the Social Security Act, known as Medicaid, provides federal cost-sharing for each State's Medicaid program. The rules and regulations that providers must follow are specified in the Ohio Administrative Code and the Ohio Revised Code. The fundamental concept underlying the Medicaid program is medical necessity of services: defined as services which are necessary for the prevention, diagnosis, evaluation or treatment of an adverse health condition. *See* Ohio Admin. Code § 5160-1-01(A) and (B)

Medicaid providers must "maintain all records necessary and in such form so as to fully disclose the extent of services provided and significant business transactions" for a period of six years from receipt of payment or until any audit initiated within the six year period is completed. Providers must furnish such records for audit and review purposes. Ohio Admin Code § 5160-1-17.2(D) and (E)

During the examination period, the Provider received total payments from the Ohio Medicaid program of $4,854,849 billed under two provider numbers.

Addiction Services

Under the number 0134918, the Provider is identified as an Ohio Department of Alcohol and Drug Addiction Services (ODADAS) certified treatment program[2] and was paid $4,795,616 for 57,992 services including the following:

- 16,969 lab services (procedure code H0003);
- 12,539 group counseling services (procedure code H0005);
- 11,372 case management services (procedure code H0006);
- 5,938 intensive outpatient program services (procedure code H0015);
- 5,523 individual counseling services (procedure code H0004);
- 5,006 medical/somatic (ambulatory setting) services (procedure code H0016);
- 609 alcohol and/or drug assessment services (procedure code H0001); and
- 36 alcohol/drug services-crisis intervention-outpatient services (procedure code H0007).

Mental Health Services

Under the number 0206873, the Provider is identified as an Ohio Department of Mental Health (ODMH) certified community mental health agency and was paid $59,233 for 552 services. We did not examine any services related to this Medicaid number.

Purpose, Scope, and Methodology

The purpose of this examination was to determine whether the Provider's Medicaid claims for payment complied with Ohio Medicaid regulations. Please note that all rules and code sections relied upon in this report were those in effect during the examination period and may be different from those currently in effect.

[2] In 2013, the State of Ohio consolidated the Department of Alcohol and Drug Addiction Services (ODADAS) with the Department of Mental Health (ODMH) into one single agency, the Department of Mental Health and Addiction Services. After this consolidation occurred, Ohio Admin. Code § 3793:2 was consolidated into Ohio Admin. Code § 5122-27.

Purpose, Scope, and Methodology (Continued)

The scope of the engagement was limited to addiction services, specifically individual and group counseling and labs. In addition, we selected two dates of service and expanded the scope to also include alcohol and/or drug assessments and case management services. The scope included services that the Provider billed with dates of service from January 1, 2016 through December 31, 2017 and received payment.

We received the Provider's claims history from the Medicaid database of services billed to and paid by Ohio's Medicaid program. We judgmentally selected two dates of service, April 7, 2016 and November 2, 2017, and extracted all individual and group counseling (procedure codes H0004 and H0005), alcohol and/or drug assessments (procedure code H0001) and case management services (procedure code H0006) billed with those dates of service to test in their entirety (Test of Two Dates of Service). See **Table 1**. From the remaining population we extracted all labs (procedure code H0003) and all individual and group counseling (procedure codes H0004 and H0005). We used a statistical sampling approach to facilitate a timely and efficient examination of the Provider's services as permitted by Ohio Admin. Code § 5160-1-27(B)(1).

We calculated attribute sample sizes for these two categories of services and selected a simple random sample for each. The sampling unit for the lab services sample was a service while the sampling unit for the individual and group counseling services sample was a recipient date of service (RDOS). An RDOS is defined as all services for a given recipient on a specific date of service. The sample sizes are shown in **Table 1**. The counseling services sample contained 86 individual counseling services and 228 group counseling services for a total of 308 services.

Table 1

Universe	Population Size	Sample Size	Selected Services
Test of Two Dates of Service	192 services		192
Lab Services Sample	16,969 services	286 services	286
Counseling Services Sample	16,176 RDOS	286 RDOS	308
Total Services Tested			**786**

A notification letter was sent to the Provider setting forth the purpose and scope of the examination. During the entrance conference the Provider described its documentation practices, personnel related procedures and billing process. We sent preliminary results and subsequently the Provider submitted additional documentation which we reviewed for compliance prior to the completion of our fieldwork.

Results

While at the Provider's office we requested documentation from its EHR system. The employee assisting us could not log into the system on the computer because she was logged into the same system on a different computer in another location. She then indicated she could access the system with a different employee's password and that she had the password because she was assisting the employee with service documentation. At that point, the Director of Operations and Finance entered the room and was asked by the owner to log into the system and he verbally provided his password in the presence of others. Upon our inquiry, he stated that the entire management team has access to all employee passwords.

Results (Continued)

We also noted that some of the electronic signatures in the EHR did not reflect any professional credentials. The Provider indicated this was due to an error when the employee was originally set-up in the system.

In addition, we noted 64 instances in which the duration of a group counseling session recorded in the EHR system did not agree to the duration on the manual billing sheet. The Provider indicated this was due to an error when the billing template for this group was set-up in the system.

Due to the aforementioned issues with the EHR system, we were unable to gain assurance over the reliability of records produced from it and the errors and improper payments noted below reflect a conservative approach. Accordingly, users of this report should be aware that the actual errors and improper payments may be greater.

While certain services had more than one error, only one finding was made per service. The noncompliance and basis for our findings is discussed below in more detail.

Test of Two Dates of Service

We judgmentally selected two dates of service and all individual and group counseling, alcohol and/or drug assessments and case management services billed on those dates to determine if there was more than one service documented as rendered by the same practitioner at the same time. We found no overlapping services by the same practitioner but did find two instances of overlapping services for the same recipient. We also tested all services for provider qualification and service documentation requirements.

We examined 192 services and found 90 errors. The identified errors in 37 services resulted in an improper payment of $3,479.67.

Lab Services Sample

We examined 286 services and found 237 errors. Of the services examined, 39 (13.6 percent) did not have either the required a physician's order or a lab result to indicate the service was rendered. The improper payments identified for 193 of 286 services from our random sample were projected across the Provider's total population of lab services. This resulted in a projected improper payment amount of $687,067 with a 95 percent degree of certainty that the true population improper payment amount fell within the range of $631,929 to $742,204 (+/- 8.03 percent). A detailed summary of our statistical sample and projection results is presented in **Appendix I**.

Counseling Services Sample

We examined 86 individual counseling services (procedure code H0004) and 222 group counseling services (procedure code H0005). We performed a post stratification and projected the results of the sample by service. This resulted in a projected improper payment amount of $209,357 for individual counseling services and $438,191 for group counseling services for a combined total projected improper payment amount of $647,548 as described below.

Individual Counseling Services

We examined 86 services and found 69 errors. The improper payments identified for 50 of 86 RDOS from our statistical random sample were projected across the Provider's population of paid individual counseling RDOS (less those services examined in the test of two dates of service). This resulted in a projected improper payment amount of $255,673 with a precision of plus or minus $155,375 at the 95 percent confidence level.

Results (Continued)

Since the precision percentage achieved was greater than our procedures require for use of a point estimate, the results were re-stated as a single tailed lower limit estimate (equivalent to methods used in Medicare audits), and an improper payment was made for $209,357. This allows us to say that we are 95 percent certain that the population improper payment amount is at least $209,357. A detailed summary of our statistical sample and projection results is presented in **Appendix II**.

Group Counseling Services

We examined 222 services and found 142 errors. The improper payments identified for 99 of 222 RDOS from our statistical random sample were projected across the Provider's population of paid group counseling RDOS (less those services examined in the test of two dates of service). This resulted in a projected improper payment amount of $502,611 with a precision of plus or minus $76,860 at the 95 percent confidence level. Since the precision percentage achieved was greater than our procedures require for use of a point estimate, the results were re-stated as a single tailed lower limit estimate (equivalent to methods used in Medicare audits), and an improper payment was made for $438,191. This allows us to say that we are 95 percent certain that the population improper payment amount is at least $438,191. A detailed summary of our statistical sample and projection results is presented in **Appendix III**.

Rule References

Ohio Admin. Code §§ 5160-30-01, 5160-30-02, 5160-30-03 and 5160-30-04, in effect during this examination period, contained the requirements to be an eligible provider, coverage and limitation policies, billable services, and reimbursement for alcohol and other drug treatment services. These Medicaid rules reference specific sections of Ohio Admin. Code § 3793:2 related to alcohol and drug addiction programs delivered by ODADAS certified/licensed programs as requirements for services billed to the ODM.[3] In addition, general reimbursement principles for the Medicaid program include that the service is determined medically necessary as defined in rule 5160-1-01 of the Administrative Code. Conditions of medical necessity include that the service meets generally accepted standards of medical practice and is clinically appropriate in its type, frequency, extent, duration, and delivery setting.

A. Provider Qualifications

Per Ohio Admin. Code § 5160-1-17.2, in signing the Medicaid provider agreement, the Provider agrees that the individual practitioner or employee of the company is not currently subject to sanction under Medicare, Medicaid, or Title XX; or, is otherwise prohibited from providing services to Medicaid beneficiaries.

We identified 32 individuals who rendered services in the selected services and compared their names to the Office of Inspector General exclusion database and the Ohio Department of Medicaid exclusion or suspension list. We found no matches on an exclusion or suspension list.

We compared the qualifications of the same 32 individuals to the list of qualified practitioners in Ohio Admin. Code § 3793:2-1-08. We also verified via the Ohio e-License Center website that their professional credentials were current and valid on the first date of service in the sample and were active during the remainder of the examination period.

[3] Ibid.

A. Provider Qualifications (Continued)

We found one individual who rendered services but did not hold one of the required credentials to perform the paid service. The Provider explained that it had an on-the-job training process for individuals pursing or considering licensure. One group counseling service in the sample was co-facilitated by this unqualified individual. This matter was reported to the applicable licensing board and no improper payment was associated with this non-compliance.

Recommendation:

The Provider should develop and implement procedures to ensure that all personnel meet applicable requirements prior to rendering direct care services. The Provider should address the identified issue to ensure compliance with the Medicaid rules and avoid future findings.

B. Service Documentation

Service documentation for addiction services shall include recipient identification, date of service delivery, length of time of service delivery, type of service, summary of what occurred during the service and dated original signature and credentials of the staff member providing the service. *See* Ohio Admin. Code §§ 3793:2-1-06(P) and 5122-27-04(E)

For errors where units paid exceeded the documented duration, the improper payment was based on the unsupported units.

Test of Two Dates of Service

We reviewed 192 services and identified the following errors:

- 16 services (8 percent) in which there was no documentation to support the payment;
- 12 services in which the units paid exceeded the documented duration;
- 7 services in which the documentation did not contain a description of services rendered;
- 2 services in which the documentation did not contain the time span;
- 2 services in which the documented time span overlapped the time span for a second service for the same recipient on the same date; and
- 1 service in which the documentation did not contain the signature of the rendering provider.

These 40 errors are included in the improper payment of $3,479.67.

Lab Services Sample

We reviewed 286 services and identified 67 (23 percent) services in which there was no documentation to support the payment. These 67 errors are included in the projected improper payment amount of $687,067.

Counseling Services Sample

We reviewed 308 services and identified the following errors:

- 56 services (18 percent) in which there was no documentation to support the payment;
- 20 services in which the documentation did not contain the signature of the rendering provider;
- 14 services in which the documentation did not contain a description of the service rendered;
- 12 services in which the units paid exceeded the documented duration; and
- 7 services in which the documentation did not contain the time span.

These 109 errors are included in the projected improper payment of $647,548.

B. Service Documentation (Continued)

In addition, we noted 14 instances in which the duration of a group counseling session recorded in the EHR system did not agree to the duration recorded on the manual billing sheet. As a conservative approach to the conflicting information, we applied the manual billing sheets in our testing and did not identify an improper payment for instances in which the billing sheet was not supported by the clinical record (EHR). The users of this report are cautioned that the improper payment may be higher than calculated in this report.

Recommendation:

The Provider should develop and implement procedures to ensure that all service documentation fully complies with the requirements contained in Ohio Medicaid rules. In addition, the Provider should implement a quality review process to ensure that documentation is present, and the actual duration of service delivery is complete and accurate prior to submitting claims for payment.

We also noted instances in which the documentation did not include the credentials of the practitioner rendering the service; however, we were able to obtain the credentials from other documentation. The Provider should ensure documentation contains all required elements, including the credential of the rendering practitioner. The Provider should also ensure templates in the EHR system are accurate prior to being made available for use.

The Provider should address the identified issues to ensure compliance with the Medicaid rules and avoid future findings.

C. Authorization to Provide Services

Within seven days of completion of the assessment or at the time of the first face-to-face contact following the assessment, providers shall develop an individual treatment plan based on the assessment for clients receiving behavioral health services, drug assessment services and case management services. The treatment plan shall contain the frequency, duration and type of treatment services, the signature of the staff member that developed the plan, and the original signature of the client and be included in the individual's client record. *See* Ohio Admin. Code §§ 3793:2-1-06(L) and 5122-27-04

In addition, per Ohio Admin. Code § 5160-30-02 a physician must order the lab in order for Medicaid to cover the service.

Lab Services Sample

The Provider described its practice to obtain lab orders as the physician signed a generic order, copies were produced, and the practitioner who developed the treatment plan manually added the name of the recipient and effective date for the order on a copy. This practice resulted in orders with effective dates prior to or after the physician's employment span, ranging from one to 155 days. This practice raises questions as to whether each test performed was appropriate and necessary for the recipient's personal set of clinical circumstances.

We examined 286 services and identified the following errors:

- 148 services (52 percent) in which there was no order to authorize the service;
- 20 services in which the order included an effective date outside of the employment span of the physician who signed it; and
- 2 services in which the order reflected an effective date after the date the lab service was rendered.

These 170 errors are included in the projected improper payment amount of $687,067.

C. Authorization to Provide Services (Continued)

Counseling Services Sample

We examined treatment plans for 308 services and found the following errors:

- 47 services (15 percent) in which there was no individual treatment plan to cover the date of service;
- 34 services in which the treatment plan did not contain the signature of the practitioner who developed the plan;
- 5 services that were not authorized on the treatment plan; and
- 2 services in which the treatment plan did not contain the frequency and duration for the planned services.

These 88 errors are included in the projected improper payment amount of $647,548.

Recommendation:

The Provider should develop and implement controls to ensure that all individual treatment plans and physicians' orders are completed prior to services being rendered. The Provider should address this issue to ensure compliance with Medicaid rules and avoid future findings.

Official Response

The Provider was afforded an opportunity to respond to this report. The full response can be obtained by contacting the Provider at 680 Park Avenue West, Suite 204, Mansfield, Ohio 44906. We did not examine the Provider's response and, accordingly, we express no opinion on it.

The Provider disagrees with the results as we did not examine records produced after the field work for this compliance examination was completed. In addition, the Provider disagrees with the criteria applied regarding individual treatment plans and indicates that an individual treatment plan is not required to bill the Medicaid program. The response cites 2019 guidance from the Ohio Department of Mental Health and Addiction Services that indicates that a current individual treatment plan is not required to be a certified behavioral health provider. The Provider also questioned the use of the term "improper payment". The Provider did not respond to any of the recommendations contained in the report.

Auditor of State Conclusion

The Provider was afforded multiple opportunities to submit documentation and was aware of the time frame for the final submission of records. The Provider directly pulled many of the supporting documents and sent additional records in response to our final request. At that time, the Provider communicated to us that it could not locate additional records. We examined all received documentation for compliance. Months later, after receiving the draft report and requesting an extension, the Provider claimed to have found over 1,100 documents. We did not examine these 1,100 documents as we can place no reliability on them. Ohio Admin. Code § 5160-1-17.2 requires providers to furnish all records necessary and in such form so as to fully disclose the extent of services for audit and review purposes and further states that failure to supply requested records within 30 days shall result in withholding of Medicaid payments and may result in termination from the Medicaid program. The time frames followed in the compliance examination allowed for a period greater than the 30 days.

For a compliance examination, we apply the rules that were in effect on the date of service. We reviewed the criteria applied in the examination and found no basis to change the results. Compliance examinations identify improper payments which are payments that do not meet statutory, regulatory, administration or other legally applicable requirements. The specified users of this report are the ODM and other agencies that have oversight of the Medicaid program.

APPENDIX I

Summary of Lab Services Sample

POPULATION
The population is all paid lab services, net of any adjustments, with dates of service during the examination period.

SAMPLING FRAME
The sampling frame for this sample is paid and processed claims from the Medicaid Information Technology System (MITS).

SAMPLE UNIT
The primary sampling unit was a service.

SAMPLE DESIGN
We used a simple random sample.

Description	Results
Number of Population Services Provided	16,969
Number of Population Services Sampled	286
Number of Population Services Sampled with Errors	193
Total Medicaid Amount Paid for Population	$1,018,140
Amount Paid for Population Services Sampled	$17,160
Projected Population Overpayment Amount	$687,067
Upper Limit Overpayment Estimate at 95% Confidence Level	$742,204
Lower Limit Overpayment Estimate at 95% Confidence Level	$631,929
Precision of Population Overpayment Projection at the 95% Confidence Level	$55,137 (+/-8.03%)

Source: Analysis of MITS information and the Provider's records

APPENDIX II

Summary of Individual Counseling Services Sample

POPULATION
The population is all paid individual counseling services, less certain excluded services, net of any adjustments, with dates of service during the examination period.

SAMPLING FRAME
The sampling frame for this sample is paid and processed claims from MITS.

SAMPLE UNIT
The primary sampling unit was an RDOS.

SAMPLE DESIGN
We used a simple random sample.

Description	Results
Number of Population RDOS Provided	4,964
Number of Population RDOS Sampled	86
Number of Population RDOS Sampled with Errors	50
Number of Population Services Provided	6,178
Number of Population Services Sampled	86
Number of Population Services Sampled with Errors	50
Total Medicaid Amount Paid for Population	$550,562.10
Amount Paid for Population Services Sampled	$7,375.16
Estimated Overpayment (Point Estimate)	$255,673
Precision of Overpayment Estimate at 95% Confidence Level	$55,375
Precision of Overpayment Estimate at 90% Confidence Level	$46,315
Single-tailed Lower Limit Overpayment Estimate at 95% Confidence Level (Calculated by subtracting the 90 percent overpayment precision from the point estimate) (Equivalent to the estimate used for Medicare Audits)	$209,357

Source: Analysis of MITS information and the Provider's records

APPENDIX III

Summary of Group Counseling Services Sample

POPULATION
The population is all paid group counseling services, less certain excluded services, net of any adjustments, with dates of service during the examination period.

SAMPLING FRAME
The sampling frame for this sample is paid and processed claims from MITS.

SAMPLE UNIT
The primary sampling unit was an RDOS.

SAMPLE DESIGN
We used a simple random sample.

Description	Results
Number of Population RDOS Provided	11,212
Number of Population RDOS Sampled	222
Number of Population RDOS Sampled with Errors	99
Number of Population Services Provided	11,742
Number of Population Services Sampled	222
Number of Population Services Sampled with Errors	99
Total Medicaid Amount Paid for Population	$1,219,879.67
Amount Paid for Population Services Sampled	$23,453.54
Estimated Overpayment (Point Estimate)	$502,611
Precision of Overpayment Estimate at 95% Confidence Level	$76,860
Precision of Overpayment Estimate at 90% Confidence Level	$64,420
Single-tailed Lower Limit Overpayment Estimate at 95% Confidence Level (Calculated by subtracting the 90 percent overpayment precision from the point estimate) (Equivalent to the estimate used for Medicare Audits)	$438,191

Source: Analysis of MITS information and the Provider's records

OHIO AUDITOR OF STATE
KEITH FABER

HEALING HEARTS COUNSELING CENTER

RICHLAND COUNTY

CLERK'S CERTIFICATION
This is a true and correct copy of the report which is required to be filed in the Office of the Auditor of State pursuant to Section 117.26, Revised Code, and which is filed in Columbus, Ohio.

Susan Babbitt

CLERK OF THE BUREAU

CERTIFIED
MARCH 31, 2020

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