Filed 6/5/12 Vinnitskaya v. Allen CA2/8

NOT TO BE PUBLISHED IN THE OFFICIAL REPORTS

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

SECOND APPELLATE DISTRICT

DIVISION EIGHT

LARISA VINNITSKAYA, Plaintiff, Cross-defendant and Respondent, v. JAMES ALLEN et al., Defendants, Cross-complainants and Appellants.	B235240 (Los Angeles County Super. Ct. No. BC 415904)

APPEAL from the judgment of the Superior Court of Los Angeles County. James R. Dunn, Judge. Affirmed.

Maier Schoch, Eric R. Maier and Louis E. Shoch for Defendants, Cross-complainants and Appellants.

Treyzon & Associates, Boris Treyzon and Natela Shenon for Plaintiff, Cross-defendant and Respondent.

This is an appeal from a judgment entered after a two-day court trial on a complaint and cross-complaint that arose from plaintiff's sale of her business to defendants. The business was a home health care business, and most of the revenues came from Medicare. The parties made two contracts, one for the sale of the assets without any liabilities being assumed, and the second for the sale of the accounts receivable. The trial court found the defendants breached the contract for the purchase of the accounts receivable. It was undisputed the contract called for payment of $350,000, and defendants paid only $50,000. Therefore, the court found defendants owed plaintiff $300,000 for breach of the contract to purchase the accounts receivable. The award of $300,000 to plaintiff is not challenged on appeal.

The court found in favor of defendants on their cross-complaint for breach of the contract for sale of the assets of the business and awarded defendants $203,339.70 to be offset against the $300,000 awarded to plaintiff. Defendants had not agreed to assume any liabilities incurred during plaintiff's operation of the business. The court found defendants proved they incurred liability for various debts of plaintiff, including delinquent taxes, bounced checks, unpaid bills, and a Medicare chargeback incurred in the ordinary course of business.

The court did not award defendants an additional $237,515 they agreed to pay Medicare in settlement of a claim that Medicare had paid $1.8 million for fraudulent billings. Neither the complaint nor cross-complaint is included in the record on appeal, but it appears to us that defendants primarily relied on their causes of action for fraud and negligent misrepresentation to seek recovery of the additional $237,515. The trial court found defendants did not prove their fraud and negligent misrepresentation claims. At oral argument, defendants contended they also sought recovery of the $237,515 on a breach of contract cause of action. The trial court addressed those claims as well, finding defendants did not prove either that plaintiff breached the warranty to disclose a potential Medicare liability or that plaintiff breached the covenant of good faith and fair dealing.

Our review of the reporter's transcript and the court's statement of decision indicates that defendants relied primarily on their fraud and misrepresentation theories at

trial to recover the $237,515. On appeal, defendants do not contend there is no substantial evidence to support the court's finding that they failed to prove fraud or negligent misrepresentation. Instead, defendants argue that it does not matter whether or not they proved fraud or misrepresentation because the $237,515 was recoverable as an undisclosed liability incurred during plaintiff's operation of the business that is recoverable on their breach of contract claim.

The trial court's statement of decision, which we quote at some length below, includes a detailed recitation of the facts based on which the court found defendants did not prove the $237,515 was recoverable due to fraud or misrepresentation. As stated above, defendants do not contend there is no substantial evidence to support that finding. It is not clear to us that defendants asked the court to award this sum on their breach of contract cause of action, but the trial court found plaintiff did not breach the covenant of good faith and fair dealing, and defendants did not prove the $237,515 was an undisclosed liability that plaintiff had a contractual duty to disclose. Defendants have failed to demonstrate on appeal that no substantial evidence supports these findings. We therefore affirm the judgment.

THE TRIAL COURT'S STATEMENT OF DECISION

We set forth below the part of the trial court's statement of decision dealing with the claims for recovery of the $237,515 that defendants paid to settle the Medicare claim.

1. The Claims

"Plaintiff Vinnitskaya sold her home health care agency LA Best Health Care, Inc., funded primarily by Medicare, to defendant Allen for $450,000, plus accounts receivable of $350,000 under a separate handwritten agreement signed at the close of escrow. She received the $450,000 for the business, and $50,000 as the first installment on the accounts receivable. She is suing on the complaint in breach of contract for the balance of $300,000 in accounts receivable due under the handwritten contract. Defendant Allen, the purchaser of the business, claims that plaintiff fraudulently failed to disclose that the business was under investigation by Medicare for fraudulent billing or other improper activities, and that there were also breaches of the typewritten contract of

sale regarding warranties that there were no taxes due or other liabilities outstanding. After escrow closed defendant Allen was contacted by Medicare and advised that as a result of an investigation conducted by its contractor Trust Solutions, alleged fraudulent activities had been found and that substantial sums of money were owed back to Medicare. Defendant sues plaintiff on a cross-complaint alleging breach of contract, breach of the covenant of good faith and fair dealing, fraud and negligent misrepresentation. Defendant alleges that he is owed the sum of $490,856.59 consisting of a combination of the Medicare assessment to repay based on the alleged improper activities[] (which was ultimately settled for $237,515), . . . a refund for what he claims as an overpayment for accounts receivable of ($50,000), Los Angeles City taxes due of $34,918, bounced checks of $9,740.69 and unpaid bills from suppliers CareWest ($15,000) and Arrowhead Insurance ($7,642.01) which defendant claims were unpaid by plaintiff at the time escrow closed."

2. Factual Background

"Plaintiff's business LA Best Health Care, Inc. hired nurses to go to homes of patients needing home health care. Plaintiff Vinnitskaya testified that assignments were made on the recommendation of doctors and that it was they who made the determinations of the necessity for the nursing services. Nurses would report any inconsistent or problematic behavior to the doctors. Ms. Vinnitskaya herself did not visit the patients, and her business was audited regularly by Medicare, the County and private insurance companies. She ran her business on a paper billing basis, with accounts payable in 90 days. In late July 2008 she was visited by several persons from a company called Trust Solutions with which she was not familiar. They said they were conducting an audit and asked over a period of three days for copies of nurse files, resumes, and over a hundred patient charts. She testified that it was usual for audits to be conducted without advance notice, as this one was. She was never accused of any wrongdoing during these visits, and said that she gave them everything that they requested. She never heard from them again at any time, and in particular, at any time before escrow closed."

3. The Cross-complaint

"The court finds no competent, admissible evidence of fraud or negligent misrepresentation committed by plaintiff. No one from Medicare or Trust Solutions testified in the trial, and the documents which suggested that there was any fraud committed in connection with plaintiff's business were inadmissible hearsay. Also, plaintiff testified that it was the doctors who made the decisions regarding the necessity of the services, and defendant introduced no evidence to contradict that testimony, or any expert testimony to suggest that those decisions were made by plaintiff's company. As noted above, defendant testified that he was not particularly interested in the past operations of the business, and apparently never made an effort to determine how decisions were made to bill Medicare, or if there was any collusion or other connection between plaintiff and any of the doctors making those determinations.

"Apparently at some point defendant hired a private investigator to contact Trust Solutions, but that investigator did not testify and apparently defendant had claimed attorney-client privilege regarding his findings during earlier pre-trial proceedings. He apparently was engaged by another attorney who defendant hired to sue plaintiff but was later fired. Although there were a few directly inconsistent statements from the parties (e.g.[,] about whether or not [and] how many times defendant called plaintiff after he received the Medicare letter, and whether she was willing to help him if he had only asked), the court found that the testimony of the plaintiff was credible. She testified confidently and directly for the most part throughout the trial. Although English is not her first language it did not appear that a language barrier played any significant role in this case, and defendant made no such claim. Although the court does not find that defendant Allen made any intentional[ly] false statements in his testimony, he was often defensive and based much of his testimony on assumptions, thus detracting from his credibility. Undoubtedly he was upset when he got the letter from Medicare and assumed that he had been intentionally defrauded by plaintiff. But the evidence is that Mr. Allen is an experienced and sophisticated businessman, having spent over thirty years in the investment banking business and two years in law school. Although he testified that he

did his due diligence, it consisted almost exclusively of questions and answers to plaintiff, and only approximately one hour with plaintiff's accountant. There is no evidence that he ever contacted Medicare to check out the status of plaintiff's business. He never had the banking records until after the close of escrow. Although he testified that plaintiff never showed him the Trust Solutions documents, plaintiff testified that she showed him all the binders and documents that were on a shelf in the business office, and that the Trust Solutions documents were among them. Either they were not there, or defendant did not recognize them for what they were, but there is no direct evidence that plaintiff withheld them from defendant. Nor is there any evidence that plaintiff was negligent in her disclosures or discussions with defendant about the sale.

"The court does not find that defendant/cross-complainant has met his burden of proof on his breach of covenant claim. There is no independent evidence to show that plaintiff did anything to interfere with the performance of the contract sufficient to support a claim for breach of the covenant of good faith and fair dealing. While defendant may believe that plaintiff defrauded him, and Medicare may believe that there was somehow fraud involved in the services provided by plaintiff's business, no evidence was presented to prove that if there was fraud, plaintiff participated in it. Further, plaintiff testified without contradiction that Trust Solutions never made any accusations against her during the audit (defendant calls it an investigation, but the terminology used makes no difference in the court's analysis), and plaintiff testified that she was never contacted by Trust Solutions after the audit in any way. Thus, there is no evidence that she was aware of their finding or that they were making any claims of fraud against her. Moreover, there is evidence that plaintiff extended 90 days credit to defendant for payment in their transaction, a gesture that would be unlikely had plaintiff believed that there would soon be a fraud accusation against her business. Were that the case, one would have expected her to demand immediate payment, or certainly payment in less than 90 days. Although it is not clear why defendant did not engage in a more complete due diligence investigation, it may be explained by his general lack of interest in the prior operating history of the business, and in his statement during the trial that the most

important thing to him was obtaining the Medicare license. If getting the license was the primary focus, then more thorough due diligence may have suffered as a result.

"Defendant contends that the Trust Solutions visits were an 'investigation' within the meaning of the escrow disclosure statement, and therefore plaintiff failed to disclose a pending 'investigation.' However as noted above, there is no evidence that there were accusations or allegations against plaintiff from either Trust Solutions or Medicare which would have put her on notice that these visits were any different from the visits from Medicare and the County, and simply constituted an audit."

DISCUSSION

On appeal, defendants ask us to enter a new judgment (or order the trial court to enter a new judgment) awarding them an additional $237,515 in damages, leaving a net judgment in their favor of $140,854.70. Defendants contend we may exercise our independent judgment to interpret the contract de novo as having been breached, because the $237,515 was a liability of the business incurred during plaintiff's operation and the contract provides defendants will not assume any liabilities. It does not appear to us that defendants argued to the trial court the additional $237,515 was a liability incurred during plaintiff's operation of the business that was recoverable on the same basis as the other Medicare chargebacks, unpaid taxes, bounced checks and unpaid bills. Our task is not to make new findings of fact and conclusions of law on a theory of the case that was not tried to the court below. (*H. Moffat Co. v. Rosasco* (1953) 119 Cal.App.2d 432, 440; (*Hayward Lbr. & Inv. Co. v. Ford* (1944) 64 Cal.App.2d 346, 353 [As a general rule, "an appellate court will consider only such points or objections as were raised in the trial court, and this rule precludes a party from asserting on appeal, claims to relief not asserted or asked for in the court below"].)

The trial court thoroughly summarized the facts supporting its findings that the $237,515 was not recoverable from plaintiff on the claims of fraud, negligent misrepresentation, or breach of the covenant of good faith and fair dealing. The trial court's statement of decision also addressed defendants' claim that the $237,515 was recoverable on the theory that plaintiff breached the warranty to disclose that the business

was under investigation by Medicare for fraudulent billing. The trial court found there was no evidence that plaintiff was on notice at any time before the sale that the Trust Solutions audit was any different than previous audits or that Trust Solutions or Medicare suspected wrongdoing. Thus, the trial court made findings of fact and conclusions of law addressing, and rejecting, all of defendants' theories for recovery of the $237,515. Defendants do not contend there is no substantial evidence to support the trial court's findings. Defendants have not asserted any legal basis for us to substitute our judgment for the conclusion of the trial court that defendants did not prove the $237,515 was a reimbursable liability that was incurred through the fault of plaintiff.

DISPOSITION

The judgment is affirmed. Plaintiff is to recover her costs on appeal.

GRIMES, J.

WE CONCUR:

BIGELOW, P. J.

RUBIN, J.