IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW JERSEY

UNITED STATES OF AMERICA and the States of DELAWARE, FLORIDA, GEORGIA, ILLINIOS, LOUISIANA, MASSACHUSETTES, MICHIGAN, MINNESOTA, NEW HAMPSHIRE, NEW JERSEY, NEW YORK, TEXAS, VIRGINIA, and WISCONSIN, *ex rel.* JANE DOE AND MARY ROE, Plaintiffs, -against- COMPASSIONATE CARE HOSPICE, COMPASSIONATE CARE HOSPICE FOUNDATION, INC., MILTON M. HECHING, JUDITH I. GREY, STELLA J. HARDY and CATHY A. STAUFFER. Defendants.	**Filed under seal pursuant to the False Claims Act, 31 U.S.C. § 3730(b)(2), and applicable state False Claims Acts** Civ. Action: 10-3484 (RBK)

SECOND AMENDED COMPLAINT AND DEMAND FOR JURY TRIAL

1. This is a *qui tam* civil action by plaintiff-relators Jane Doe and Mary Roe (fictitious plaintiff-party names of persons whose true identities have been provided to the United States and collectively referred to as "Relators"), on their own behalf, and on behalf of the United States under the False Claims Act ("FCA"), 31 U.S.C. §§ 3729 et seq., and on behalf of the individual states of Delaware, Florida, Georgia, Illinois, Louisiana, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey, New York, Texas, Virginia and Wisconsin ("States") under their respective state false claims acts ("State FCAs") against Compassionate Care Hospice ("CCH"), Compassionate Care Hospice Foundation, Inc. ("CCH Foundation"), Milton M. Heching ("Heching"), Judith I. Grey ("Grey"), Stella J. Hardy ("Hardy") and Cathy A. Stauffer ("Stauffer") (collectively "Defendants"). Relators seek treble damages, civil penalties, and other

relief from Defendants for falsely and fraudulently billing the Medicare, Medicaid and CHAMPUS/TRICARE government health care insurance programs for services and items provided or purportedly provided to hospice patients throughout the United States (collectively referred to as the "Qui Tam Action"). Jane Doe and Mary Roe individually also allege claims exclusively in their own name against Defendant CCH under the anti-retaliation provisions of the FCA, 31 U.S.C. § 3730(h), and the anti-retaliation provisions of the State of New Jersey false claims act ("NJ FCA"), N.J. Stat. § 2A:32C-10, as well as, the State of New Jersey's Conscientious Employee Protection Act ("CEPA"), N.J. Stat. § 34:19-3 (collectively referred to as the "Retaliation Claims"). Pursuant to 31 U.S.C. § 3730(b)(2), and comparable provisions in the State FCAs, this Complaint and related commencement materials are filed in camera and under seal.

NATURE AND OVERVIEW OF ACTION

2. From at least as early as in or about 2004 until on or about May 19, 2009, Defendants: (a) knowingly presented, and caused to be presented to an officer and employee of the United States Government false and fraudulent claims for payment and approval; (b) knowingly made, used, and caused to be made and used, false records and statements to get false and fraudulent claims paid and approved by the Government; (c) conspired to defraud the Government by getting false and fraudulent claims allowed or paid, and (d) knowingly made, used, and caused to be made and used, a false record or statement to conceal, avoid, and decrease an obligation to pay or transmit money or property to the Government, in violation of 31 U.S.C. §§ 3729(a)(1), (2), (3) and (7) of the False Claims Act (prior to its amendment on May 20, 2009).

3. Likewise, from on or about May 20, 2009 until the filing of this Complaint, Defendants: (a) knowingly presented, or caused to be presented, a false and fraudulent claim for

payment or approval; (b) knowingly made, used, and caused to be made and used, a false record or statement material to a false or fraudulent claim; (c) conspired to commit a violation of subparagraphs (A), (B),…and (G) of § 3729(a)(1); and (d) knowingly made, used, and caused to be made and used, a false record or statement material to an obligation to pay and transmit money and property to the Government, and knowingly concealed and knowingly and improperly avoided and decreased an obligation to pay and transmit money and property to the Government, in violation of 31 U.S.C. §§ 3729(a)(1)(A), (B), (C) and (G) of the False Claims Act (as amended on May 20, 2009).

4. The foregoing conduct also violated comparable provisions in the State FCAs.

5. More specifically, Defendants engaged in a scheme to defraud Medicare, Medicaid and CHAMPUS/TRICARE in order to obtain reimbursements for the provision of hospice services and items to beneficiaries of these government health care insurance programs for which Defendants were not entitled. Among other steps taken to further this scheme to defraud, Defendants:

a. Knowingly maintain patients (primarily nursing home patients) on "continuous care," (i.e., the most costly level of hospice services), who do not meet its criteria, as set forth in 42 C.F.R. §§ 418.202 - 418.204;

b. Falsely certify that patients are terminally ill pursuant to 42 C.F.R. §§ 420, 422, when in fact they are not terminally ill, by, among other things: altering patient medical records, forging physician signatures, altering dates on medical records, causing CCH physicians to sign hospice certifications and recertifications for patients whom they have never seen;

c. Fail to remove patients from hospice care when they no longer qualify for it under 42 C.F.R. §§ 420, 422, and instead falsely recertify such patients as qualified to continue to

receive hospice care, so that patients typically are maintained on hospice for the entire certification period—regardless of their actual qualifications for such services;

d. Intentionally bill for services that were never provided;

e. Deliberately fail to explain to potential patients (or their guardians) the true nature of hospice care (i.e., it is exclusively palliative care in lieu of curative treatment, which the patient agrees to forego), as required by 42 C.F.R. § 418.24, and thus fail to obtain the requisite voluntary and informed consent or authorization for hospice care;

f. Engage in unlawful marketing activities, including targeting nursing homes as sources for patients and then offering their employees medical equipment, food and perquisites, and, in effect, free staff to assist the nursing homes in managing their residents, in violation of Medicare and Medicaid's anti-kickback statute ("AKS"), 42 U.S.C. § 1320a-7b(b)(2)(A) and (B). Upon information and belief, as many as 80% of CCH's hospice patients were nursing home residents at the time they were enrolled in CCH's hospice care; often such patients were identified and targeted after CCH employees unlawfully obtained their medical records from the nursing homes, in violation of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the regulations promulgated there under, which prohibit the use of such records for marketing purposes without first obtaining the patient's consent, see 45 C.F.R. § 164.508. CCH also unlawfully pays bonuses to recruiters based on the number of patients they successfully enlist for hospice care; and

g. Falsify records to make it appear that Defendants have met hospice care regulations requiring the utilization of volunteers when, in fact, they have not met such volunteer requirements set forth in 42 C.F.R. § 418.70. For example, Defendants list medical students as

volunteers when, in fact, they are actually functioning as medical school interns and post medical school resident doctors.

6. Each of the foregoing activities is contrary to, or in violation of, one or more of conditions of payment for Medicare, Medicaid and CHAMPUS/TRICARE, thus rendering all billing for reimbursement for the corresponding services and items false and fraudulent under the FCA and State FCAs.

7. As a result of the above-described conduct, Defendants unlawfully obtained substantial Medicare, Medicaid and CHAMPUS/TRICARE payments, in an amount to be determined at trial.

8. Additionally, on or about July 20, 2008, Defendant CCH terminated Relator Mary Roe's employment after she voiced opposition to her supervisor to creating required hospice care records (medical staff evaluations) that she knew were false and fraudulent, in violation of 31 U.S.C. § 3730(h) and N.J. Stat. §§ 2A:32C-10 and. 34:19-3. Mary Roe has suffered economic loss and other injuries as a result of this unlawful retaliation.

9. Additionally, on or about November 16, 2010, Relator Jane Doe terminated her employment with Defendant CCH following a long and sustained period of work place harassment by her supervisors and others for (a) speaking up about fraudulent Medicare billing practices and (b) overtly refusing to go along with such practices, in violation of 31 U.S.C. § 3730(h) and N.J. Stat. §§ 2A:32C-10 and. 34:19-3. Jane Doe has suffered economic loss and other injuries as a result of this unlawful retaliation.

PARTIES, PERSONS, AND ENTITIES

10. The United States funds the Medicare Program and administers it through the Department of Health and Human Services ("HHS"), Centers for Medicare and Medicaid

("CMS"). The United States and each individual state jointly fund the Medicaid Program in the respective 50 states. CMS oversees the Medicaid Program nationally, but each of the 50 state governments administers the program in its state. The United States funds the CHAMPUS/TRICARE Program and administers it through the Department of Defense.

11. Relator Jane Doe resides in Pennsylvania. She has been a licensed registered nurse since 1988. Beginning in or about 2007, Jane Doe began working as a registered nurse for CCH on a per diem (as needed) basis in the Bensalem, Pennsylvania office. In 2008, Jane Doe switched to working for CCH on a full time basis as a registered nurse providing health care services to hospice patients. Beginning in or about December 2008, Jane Doe started speaking up at bi-weekly CCH team meetings (which were regularly attended by CCH's regional director, clinical coordinator and medical director, as well as other CCH employees) where she pointed out specific patients who were not medically eligible for hospice service (because of insufficient symptoms and/or the lack of any need for managing the patients' care) and stated in sum and in substance that Medicare should not be billed for hospice care provided to these patients. Also, beginning in or about 2009, on numerous occasions (as many as 40 or more), Jane Doe directly refused an order from her supervisors to falsely a medical record that would be used to support a fraudulent Medicare bill (essentially, asking Jane Doe to add more or worse symptoms in the patients' medical charts than were warranted by the patients' true conditions). For example, in 2009 a CCH medical director and a clinical coordinator told Jane Doe to omit from patient MS' medical chart the results of an Albumin test (which show a normal range) and Jane Doe refused to do so. As another example, in or about November 2010, a CCH clinical coordinator told Jane Doe to complete and backdate hospice service recertifications for patient MG who was seen by a per diem nurse when Jane Doe was on

vacation and Jane Doe refused. The clinical coordinator, who had previously chastised Jane Doe for being "resistant" to CCH's directives to falsify medical records, responded by threatening Jane Doe that if she did not prepare the recertifications she "would be written up." As a result of this specific threat, as well as, the long period of retaliatory work place harassment that had preceded it (which included, but was not limited to, not receiving cell phone reimbursements, not receiving regular pay increases, having letters of gratitude from patient family members withheld from her personnel file, not receiving backup and case load assistance from licensed practical nurses and the like, being forced to come into the office to prepare her care plans and for other unnecessary reasons, having her notes at team meetings scrutinized by clerical staff, receiving harassing phone calls from clinical directors demanding that she create or augment unnecessary records or data, being "double teamed" by clinical coordinators overseeing her work, and being assigned to the worst nursing home) Jane Doe terminated her employment with CCH on or about November 16, 2010.

12. Relator Mary Roe resides in Pennsylvania. She has been a licensed registered nurse since 1987. Beginning on or about January 29, 2009, Mary Roe began working at CCH in a supervisory position as clinical coordinator in the Bensalem, Pennsylvania office. Mary Roe was terminated on July 20, 2009 after she objected to her supervisor to signing CCH medical staff evaluations, that CCH was required to make and retain, certifying that she had personally evaluated registered nurses and certified nurse assistants (which included a representation that she had actually observed the nurses and certified nurse assistants caring for patients), when, in fact, Mary Roe had not evaluated or observed the CCH medical staff members in question. When Mary Roe asked CCH officers and legal counsel why she was being terminated, she was

told she "wasn't a good fit." This was a pretext, as Mary Roe had many years of steady employment at other hospice facilities, including in clinical supervisory and managerial roles.

13. Defendant CCH is an "enterprise," within the meaning of 18 U.S.C. § 1961(4), whose management, central operations and headquarters are located at 600 Highland Drive, Suite 624 in Westhampton, New Jersey, 08060 ("CCH Headquarters"), and whose telephone number is (609) 265-2430. CCH provides for-profit hospice care services through affiliated entities that it forms and controls, and which are separately created and organized under the laws of various states as corporations, limited liability corporations, limited partnerships or similar business structures ("CCH Affiliates"), each of which typically has a separate National Provider Identity ("NPI") number for Medicare billing purposes, as well as a separate Medicaid provider number for the state in which the facility operates, including the following entities that provide hospice care services in the indicated states:

Compassionate Care Hospice of Delaware, LLC (DE)
Compassionate Care Hospice of The Delmar Peninsula, LLC (DE)
Compassionate Care Hospice of Miami Dade, Inc. (FL)
Compassionate Care Hospice of Florida, Inc. (FL)
Compassionate Care Hospice of Savannah, LLC (GA)
Compassionate Care Hospice of Atlanta, LLC (GA)
Compassionate Care Hospice of Central Georgia, LLC (GA)
Compassionate Care Hospice of Illinois, LLC, (IL)
Compassionate Care Hospice Group Ltd, (IL)
Compassionate Care Hospice of Kansas City, LLC (KS)
Compassionate Care Hospice of Central Louisiana, LLC (LA)
Compassionate Care Hospice of Massachusetts, LLC (MA)
Compassionate Care Hospice of Southeastern Massachusetts, LLC (MA)
Compassionate Care Hospice of Michigan, LLC (MI)
Compassionate Care Hospice of Minnesota, LLC (MN)
Compassionate Care Hospice of Missouri, LLC (MO)
Compassionate Care Hospice of New Hampshire, LLC (NH)
Compassionate Care Hospice of Central New Jersey LLC (NJ)
Compassionate Care Hospice of Clifton, LLC (NJ)
Compassionate Care of Marlton, LLC (NJ)
Compassionate Care Hospice of Northern New Jersey, LLC (NJ)

Compassionate Care Hospice of Northwestern LLC (NJ)
Compassionate Care Hospice of New York, LLC (NY)
Compassionate Care Hospice, LLC (OK)
Compassionate Care Hospice of Northwestern Pennsylvania, LLC (PA)
Compassionate Care Hospice of Pittsburgh, LLC (PA)
Compassionate Care Hospice – Stroudsburg (PA)
Compassionate Care Hospice of Pennsylvania LLC (PA)
Compassionate Care Hospice LP (PA)
Compassionate Care Hospice of Gwynedd, Inc. (PA)
Compassionate Care Hospice of South Carolina, LLC (SC)
Compassionate Care Hospice of The Hills, LLC (SD)
Compassionate Care Hospice of The Midwest, LLC (SD)
Compassionate Care Hospice of Houston, LLC (TX)
Compassionate Care Hospice of North Texas, LLC (TX)
Compassionate Care Hospice of Byran Taxes, LLC (TX)
Compassionated Care Hospice of Southeastern Texas, LLC (TX)
Compassionate Care Hospice of The Chesapeake Bay, LLC (VA)
Compassionate Care Hospice of Wisconsin, LLC (WI).

Upon information and belief, CCH is also in the process of opening a hospice facility in Ohio as of the filing of this Complaint. CCH provides hospice care services through the above Affiliates in long-term care nursing homes, skilled nursing facilities, assisted living facilities, acute care hospitals and patients' homes. Upon information and belief nearly all of CCH's revenues for hospice services are derived from reimbursements from the Medicare and Medicaid, and to a lesser degree CHAMPUS/TRICARE, Programs. According to its website, CCH has been providing hospice services since in or about 1993, and approximately 70% of its revenues for hospice services come from Medicare, with managed care and Medicaid providing the remainder. CCH also provides hospice services to veterans of the armed services through Veterans Outreach programs at the following locations: Bensalem, Pennsylvania, Scranton, Pennsylvania, Georgia, Michigan, Toms River, New Jersey, Brooklyn, New York, Boston, Massachusetts, Wisconsin, Illinois and Kansas. Upon information and belief, CCH's aggregate revenues from hospice services for fiscal year 2009 exceeded $53 million. In addition to hospice

services, CCH offers home health and palliative care at some of its locations. Upon further information and belief CCH and its Affiliates use a common back account maintained at JP Morgan Chase Bank.

14. Compassionate Care Hospice Group, Ltd. ("CCH Group"), one of the above CCH Affiliates, is a for profit corporation that was organized under the laws of Illinois on or about May 27, 2003. CCH Group is reported as in "not good standing" with Illinois' secretary of state as of the date of this filing. CCH Group's last known address is 5901 North Cicero Avenue, Suite 608, Chicago, Illinois 60646, which is also the address of CCH Affiliate Compassionate Care Hospice of Illinois, LLC, as well as, an entity known as Colonia Funding Group, LLC ("Colonial Funding"), which, upon information and belief, is (or was) a for profit entity mortgage lender and real estate financer organized under the laws of Illinois that was "involuntarily dissolved" on June 1, 2004.

15. Defendant CCH Foundation is a not for profit, Section 501(c)(3) entity, founded in 2005, whose EIN is 20-1035181, and whose office address is 11 Impendence Way, Newark, Delaware, 19713. CCH Foundation's telephone number is (302) 368-8944 and its website address is www.companiatecarehospicefoundation.com. Upon information and belief CCH Foundation was formed and is controlled by Defendant Heching. Defendant Grey is listed on its Forms 990 as Vice President and Defendant Stauffer has, at various times, been listed as its President and Treasurer.

16. Upon information and belief, Defendant Heching resides at 3420 West Arthur Avenue, Lincolnwood, Illinois 60712-3808, telephone (847) 675-8856, and in Naples, Florida. According to public statements attributed to him, in 1993 Heching and Isadore Goldberg (who upon information and belief is deceased) co-founded "Compassionate Care Hospice" (it is

unclear precisely which specific entity, if any, this name refers to). Upon information and belief, Heching is the owner and Chief Executive Officer, or equivalent, of CCH. Heching is also listed on Illinois corporate filings as the President of CCH Group, and Bella Heching, who, upon information and believe is Heching's wife, is listed as its secretary. Heching and Bella Heching, as well as Isadore Goldberg are (or were) members or officers of Colonial Funding. Heching and Isadore Goldberg are (were) also purported owners of a fictitious entity known as Compassionate Care Management under which name they also operate CCH.

17. Upon information and belief Defendant Grey resides at 7 Deer Run, Rockaway, New Jersey, 07866-1300, and her telephone number is (973) 625-7268. Upon further information and belief Grey is the Chief Operating Officer, or equivalent, of CCH and has responsibility for all financial functions there.

18. Upon information and belief Defendant Hardy resides at 126 Richard Mine Road, Dover, New Jersey, 07801-1611, and her telephone number is (973) 442-9739. Upon further information and belief Hardy is the Director of Quality and Compliance, or equivalent, at CCH and has responsibility for overseeing all clinical functions at CCH.

19. Upon information and belief Defendant Stauffer resides at 202 Sleepy Hollow Court, Newark, Delaware, 19711, and her telephone number is (302) 239-2858. Upon further information and belief Stauffer is the Executive Director of one or more CCH Affiliate and a Senior Vice President, or equivalent, of CCH, as well as the President and Treasurer of Defendant CCH Foundation.

JURISDICTION AND VENUE

20. This Court has subject matter jurisdiction over the claims alleged in this Complaint under 28 U.S.C. §§ 1331 (Federal question), 1345 (United States as plaintiff) and 31

U.S.C. § 3732(a) (False Claims Act). Jurisdiction over the state law claims arises under 31 U.S.C. § 3723(b) (jurisdiction over state claims arising from the same transaction or occurrence as an action under the FCA), and 28 U.S.C. § 1367(a) (supplemental jurisdiction).

21. This Court has personal jurisdiction over Defendants pursuant to 31 U.S.C. § 3732(a) because Defendants can be found, resides, and transacts business in the District of New Jersey and because an act proscribed by 31 U.S.C. § 3729 occurred within this District. Title 31, United States Code, Section 3732(a) further provides for nationwide service of process.

22. Upon information and belief, this action is not a related action based on the facts underlying any pending action, within the meaning of 31 U.S.C. § 3730(b)(5). *United States of America ex rel Kappenman v. Compassionate Care Hospice of the Midwest, L.L.C.*, D.S.D. docket number Civ 09-4039 (KES) (the "Kappenman Action"), which was pending at the time Relators' initial and first amended complaint were filed, was dismissed by order filed July 25, 2012.

23. The Qui Tam Action is not precluded by any provisions of the FCA's jurisdictional bar, 31 U.S.C. § 3730(e). The Qui Tam Action is not brought by a current or former member of the armed services against another member of the armed services arising out of such person's service in the armed forces. 31 U.S.C. § 3730(e)(1). Nor, is it brought against a member of Congress, the judiciary or a senior executive branch official and based upon evidence or information already known to the Government. 31 U.S.C. § 3730(e)(2).

24. Upon information and belief, this Complaint is not based upon allegations or transactions that are the subject of a civil suit or an administrative civil money penalty proceeding in which the United States is already a party, within the meaning of 31 U.S.C. § 3730(e)(3), including the *Kappenman Action*.

25. Upon information and belief, substantially the same allegations or transactions alleged in this action have not been publicly disclosed in: (i) a Federal criminal, civil, or administrative hearing in which the Government or its agent is a party, including the *Kappenman Action*; (ii) in a congressional, Government Accountability Office, or other Federal report, hearing, audit, or investigation; or (iii) from the news media, within the meaning of 31 U.S.C. § 3730(e)(4)(A). Alternatively, Relators are "original sources" of the information, within the meaning of that subsection. More specifically, Relators either: (i) prior to a public disclosure under subsection (e)(4)(a), voluntarily disclosed to the Government the information on which allegations or transactions in a claim are based; or (2) have knowledge that is independent of and materially adds to the publicly disclosed allegations or transactions, and have voluntarily provided the information to the Government before filing an action under this section, within the meaning of 31 U.S.C. § 3730(a)(4)(B). Further, the Relators are original sources of the information, in that the Relators either (i) prior to a public disclosure under subsection 31 U.S.C.§ 3730(e)(4)(a) voluntarily disclosed to the Government the information on which allegations or transactions in a claim are based, or (2) have knowledge that is independent of and materially adds to the publicly disclosed allegations or transactions, and have voluntarily provided the information to the Government before filing this action.

26. Venue is proper in the District of New Jersey under 28 U.S.C. §§ 1391(b) and (c), and 31 U.S.C. § 3732(a), because: (a) the Defendants reside in this District, (b) a substantial part of the events or omissions giving rise to the violations of 31 U.S.C. § 3729 alleged in the Complaint occurred in this District, or (c) because at least one of Defendants can be found in this District and there is no district in which the action may otherwise be brought.

THE FALSE CLAIMS ACT

27. At all times relevant to this Complaint prior to May 20, 2009, the FCA provided, in pertinent part, that:

> (a) Any person who
>
> (1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government a false or fraudulent claim for payment or approval;
>
> (2) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government;
>
> (3) conspires to defraud the Government by getting a false or fraudulent claim allowed or paid; [or]
>
> ***
>
> (7) knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government,
> ***
> is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000,[1] plus 3 times the amount of damages which the Government sustains because of the act of that person...
>
> (b) For purposes of this section, the terms "knowing" and "knowingly" mean that a person, with respect to information...(1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.

31 U.S.C. §3729.

[1]The minimum and maximum penalties were increased in September 1999 to $5,500 and $11,000, respectively, pursuant to the Federal Civil Penalties Inflation Adjustment Act of 1990 (Pub. L. 101-410, 104 State. 890, as amended by the Debt Collection Improvement Act of 1996, Pub. L. 104-134, 110 Stat. 1321).

28. Effective May 20, 2009, the FCA was amended so that it provides,, in pertinent part, that:

> (a) Liability for certain acts.
>
> (1) In general….any person who—
>
> (A) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;
>
> (B) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim;
>
> (C) conspires to commit a violation of subparagraph (A), (B),…or (G); [or]
>
> ***
> (G) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government,
> . . . .
> is liable to the United States Government for a civil penalty of not less than $ 5,000 and not more than $ 10,000, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C. 2461 note; Public Law 104-410), plus 3 times the amount of damages which the Government sustains because of the act of that person.
>
> (b) Definitions. For purposes of this section—
>
> (1) the terms "knowing" and "knowingly"—
> (A) mean that a person, with respect to information—
> (i) has actual knowledge of the information;
> (ii) acts in deliberate ignorance of the truth or falsity of the information; or
> (iii) acts in reckless disregard of the truth or falsity of the information; and
> (B) require no proof of specific intent to defraud;
>
> (2) the term "claim"—
> (A) means any request or demand, whether under a contract or otherwise, for money or property and whether or not the United States has title to the money or property, that—
> (i) is presented to an officer, employee, or agent of the United States; or
> (ii) is made to a contractor, grantee, or other recipient, if the money or property is to be spent or used on the Government's behalf or to advance a

Government program or interest, and if the United States Government—
(I) provides or has provided any portion of the money or property requested or demanded; or
(II) will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded; and
(B) does not include requests or demands for money or property that the Government has paid to an individual as compensation for Federal employment or as an income subsidy with no restrictions on that individual's use of the money or property;

(3) the term "obligation" means an established duty, whether or not fixed, arising from an express or implied contractual, grantor-grantee, or licensor-licensee relationship, from a fee-based or similar relationship, from statute or regulation, or from the retention of any overpayment; and

(4) the term "material" means having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property.

29. The Social Security Act also provides, in pertinent part:

(b)(2) Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person—

(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, or

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $ 25,000 or imprisoned for not more than five years, or both.****

(g) Kickbacks. In addition to the penalties provided for in this section or section 1128A [42 USCS § 1320a-7a], a claim that includes items or services resulting from a violation of this section constitutes a false or fraudulent claim for purposes of subchapter III of chapter 37 of title 31, United States Code [31 USCS §§ 3721 et seq.].

42 U.S.C. § 1320a-7b.

30. The May 20, 2009 amended version of the FCA further provides, in pertinent part, that:

> (h) Relief from retaliatory actions.
>
> (1) In general. Any employee, contractor, or agent shall be entitled to all relief necessary to make that employee, contractor, or agent whole, if that employee, contractor, or agent is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment because of lawful acts done by the employee, contractor, or agent on behalf of the employee, contractor, or agent or associated others in furtherance of other efforts to stop 1 or more violations of this subchapter [31 USCS §§ 3721 et seq.].

31 U.S.C. § 3730(h).

NEW JERSEY FALSE CLAIM ACT

31. New Jersey's FCA provides, in pertinent part:

> a. No employer shall make, adopt, or enforce any rule, regulation, or policy preventing an employee from disclosing information to a State or law enforcement agency or from acting to further a false claims action, including investigating, initiating, testifying, or assisting in an action filed or to be filed under this act.
>
> b. No employer shall discharge, demote, suspend, threaten, harass, deny promotion to, or in any other manner discriminate against an employee in the terms and conditions of employment because of lawful acts done by the employee on behalf of the employee or others in disclosing information to a State or law enforcement agency or in furthering a false claims action, including investigation for, initiation of, testimony for, or assistance in an action filed or to be filed under this act.
>
> c. An employer who violates subsection b. of this section shall be liable for all relief necessary to make the employee whole, including reinstatement with the same seniority status such employee would have had but for the discrimination, two times the amount of back pay, interest on the back pay, compensation for any special damage sustained as a result of the discrimination, and, where appropriate, punitive damages. In addition, the defendant shall be required to pay litigation costs and reasonable attorney's fees associated with an action brought under this section. An employee may bring an action in the Superior Court for the relief provided in this subsection.

d. An employee who is discharged, demoted, suspended, harassed, denied promotion, or in any other manner discriminated against in the terms and conditions of employment by his employer because of participation in conduct which directly or indirectly resulted in a false claim being submitted to the State shall be entitled to the remedies under subsection c. of this section if, and only if, both of the following occurred:

(1) The employee voluntarily disclosed information to a State or law enforcement agency or acts in furtherance of a false claims action, including investigation for, initiation of, testimony for, or assistance in an action filed or to be filed.

(2) The employee had been harassed, threatened with termination or demotion, or otherwise coerced by the employer or its management into engaging in the fraudulent activity in the first place.

N.J. Stat. § 2A:32C-10.

NEW JERSEY CONSIENCIOUS EMPLOYEE PROTECTION ACT

32. New Jersey's CEPA provides:

An employer shall not take any retaliatory action against an employee because the employee does any of the following:

a. Discloses, or threatens to disclose to a supervisor or to a public body an activity, policy or practice of the employer, or another employer, with whom there is a business relationship, that the employee reasonably believes:

(1) is in violation of a law, or a rule or regulation promulgated pursuant to law, including any violation involving deception of, or misrepresentation to, any shareholder, investor, client, patient, customer, employee, former employee, retiree or pensioner of the employer or any governmental entity, or, in the case of an employee who is a licensed or certified health care professional, reasonably believes constitutes improper quality of patient care; or

(2) is fraudulent or criminal, including any activity, policy or practice of deception or misrepresentation which the employee reasonably believes may defraud any shareholder, investor, client, patient, customer, employee, former employee, retiree or pensioner of the employer or any governmental entity;

b. Provides information to, or testifies before, any public body conducting an investigation, hearing or inquiry into any violation of law, or a rule or regulation promulgated pursuant to law by the employer, or another employer, with whom

there is a business relationship, including any violation involving deception of, or misrepresentation to, any shareholder, investor, client, patient, customer, employee, former employee, retiree or pensioner of the employer or any governmental entity, or, in the case of an employee who is a licensed or certified health care professional, provides information to, or testifies before, any public body conducting an investigation, hearing or inquiry into the quality of patient care; or

c. Objects to, or refuses to participate in any activity, policy or practice which the employee reasonably believes:

(1) is in violation of a law, or a rule or regulation promulgated pursuant to law, including any violation involving deception of, or misrepresentation to, any shareholder, investor, client, patient, customer, employee, former employee, retiree or pensioner of the employer or any governmental entity, or, if the employee is a licensed or certified health care professional, constitutes improper quality of patient care;

(2) is fraudulent or criminal, including any activity, policy or practice of deception or misrepresentation which the employee reasonably believes may defraud any shareholder, investor, client, patient, customer, employee, former employee, retiree or pensioner of the employer or any governmental entity; or

(3) is incompatible with a clear mandate of public policy concerning the public health, safety or welfare or protection of the environment.

N.J. Stat. § 34:19-3.

HOSPICE REIMBURSEMENT UNDER THE MEDICARE PROGRAM

33. Medicare is a federally funded and administered insurance program created under Title XVIII of the Social Security Act that provides health benefits for elderly and disabled individuals. See 42 U.S.C. §§ 1395 et seq. and 42 C.F.R. Parts 400-1004. Medicare Part A provides for basic in-patient hospital services, nursing home and, since in or about 1983, hospice care. Part A also covers home health services in some instances.

34. The Medicare Program is administered through private organizations contracted by HHS. Prior to 2003, Part A was administered by organizations known as "fiscal

intermediaries." Medicare fiscal intermediaries are now called "Medicare Administrative Contractors." 42 U.S.C. §§ 1395h(a), 1395u(a), 1395kk-1.

35. The Medicare Program operates by reimbursing health care providers for the cost of services and ancillary items at determined rates. All hospice providers, such as CCH, submit their claims for reimbursement to the Medicare Administrative Contractors, who review, approve and issue payments to the providers for claimed amounts as appropriate.

36. Medicare reimbursements are made out of the federal Medicare Trust Fund.

37. The Medicare Trust Fund is supposed to reimburse health care providers of hospice care, such as Defendants, at established rates and only for those services: (1) to eligible Medicare beneficiaries who meet specified hospice criteria, and (2) that are actually provided and are medically necessary for the health of the patient and that are ordered specifically by a physician, using appropriate medical judgment and acting in the best interest of the patient. The Medicare Trust Fund relies on the implied representations of the suppliers of Medicare services that the services billed by the providers were medically necessary for the patient and were actually performed as billed and compensable by Medicare. Medicare requires that the service had to be physically performed and billed according to Medicare policies and procedure codes.

38. According to Title XVIII, § 1861 (dd) of the Social Security Act, the term "hospice care" means the following items and services provided to a terminally ill individual by, or by others under arrangements made by, a hospice program under a written plan (for providing such care to such individual) established and periodically reviewed by the individual's attending physician and by the medical director (and by the interdisciplinary group described in paragraph (2)(B)) of the program—

(A) nursing care provided by or under the supervision of a registered professional nurse,

(B) physical or occupational therapy, or speech-language pathology services,
(C) medical social services under the direction of a physician,
(D)(i) services of a home health aide who has successfully completed a training program approved by the Secretary and
(ii) homemaker services,
(E) medical supplies (including drugs and biologicals) and the use of medical appliances, while under such a plan,
(F) physicians' services,
(G) short-term inpatient care (including both respite care and procedures necessary for pain control and acute and chronic symptom management) in an inpatient facility meeting such conditions as the Secretary determines to be appropriate to provide such care, but such respite care may be provided only on an intermittent, nonroutine, and occasional basis and may not be provided consecutively over longer than five days,
(H) counseling (including dietary counseling) with respect to care of the terminally ill individual and adjustment to his death, and
(I) any other item or service which is specified in the plan and for which payment may otherwise be made under this title.
The care and services described in subparagraphs (A) and (D) may be provided on a 24-hour, continuous basis only during periods of crisis (meeting criteria established by the Secretary) and only as necessary to maintain the terminally ill individual at home.

39. In short, Medicare beneficiaries who choose hospice care receive non-curative, palliative medical and support services by a hospice's interdisciplinary team ("IDT") for their terminal illness.

40. Hospice patients effectively forsake all curative services related to the diagnosis that underlies their admission into hospice care. Accordingly, Medicare rules and regulations mandate that the decision to enter into hospice care must be made with informed and voluntary consent or authorization.

41. Hospice care is available for two 90-day periods and an unlimited number of 60-day periods during the remainder of the hospice patient's lifetime. However, a beneficiary may voluntarily terminate his hospice election period.

42. Hospice care providers can submit Medicare claims for the qualified services in either electronic or hard paper form. If they choose the electronic option hospice care providers

must use is a standard Electronic Data Interchange ("EDI") format, which is technically called the ANSI ASC X12N 837 Professional, Institutional and Dental Healthcare Claim, and more commonly is known as the "837." If they choose the hard copy option, hospice care providers must use the UB-04/CMS Form 1450 ("CMS Form 1450") (formerly known as the "UB-92"). Regardless of which format is used, a hospice care provider makes a number of certifications and attestations when they submit them to Medicare Program via the Medicare administrative contractors, chief among them are that the service was medically necessary and was actually provided. As used in this Complaint, the 837 and CMS Form 1450 are collectively referred to as the Medicare Claim Form.

43. Among other things, hospice care providers must list on the Medicare Claim Form the diagnosis which corresponds to the patients' admission into hospice care. Diagnostic codes are taken from a commonly accepted source known as the ICD-9-CM. Upon information and belief, the most common diagnosis used by CCH for its hospice patients is "Debility Not Otherwise Specified" (or "Debility NOS"), and its ICD-9-CM diagnostic code is 799.3.

44. Medicare reimburses hospices at daily rates for one of four levels of care based on the patient meeting specified criteria. The four levels of care, CMS revenue code and daily rate of reimbursement as of October 2009, are:

Routine Home Care, Revenue code 0651 ($142.91)
Continuous Home Care, Revenue code 0652 ($834.10 Full 24 hours; $34.75 hourly))
Inpatient Respite Care, Revenue code 0655 ($147.83)
General Inpatient Care, Revenue code 0656 ($635.74)

45. The criteria for the above levels of hospice care are set forth in, among things, CMS Medicare Beneficiary Policy Manual, Ch. 9, ("Coverage of Hospice Services Under

Hospital Insurance"), § 40 et seq. ("Benefit Coverage"). Broadly, the four levels of care are defined by Medicare for billing purposes as follows:

> **Routine Home Care** - The hospice is paid the routine home care rate for each day the patient is under the care of the hospice and not receiving one of the other categories of hospice care. This rate is paid without regard to the volume or intensity of routine home care services provided on any given day, and is also paid when the patient is receiving outpatient hospital care for a condition unrelated to the terminal condition.
>
> **Continuous Home Care** - The hospice is paid the continuous home care rate when continuous home care is provided. This rate is paid only during a period of crisis and only as necessary to maintain the terminally ill individual at home. The continuous home care rate is divided by 24 hours in order to arrive at an hourly rate. A minimum of eight hours must be provided. Nursing care must be provided for at least half of the period of care and must be provided by either a registered nurse or licensed practical nurse. Parts of an hour are identified through the reporting of time for continuous home care days in 15 minute increments and these increments are used in calculating the payment rate. Only patient care provided during the period of crisis is to be reported. Payment is based upon the number of 15-minute increments that are billed for 32 or more units. Rounding to the next whole hour is no longer applicable. Units should only be rounded to the nearest increment. Billing for CHC should not reflect nursing shifts and non-direct patient increments (e.g. meal beaks, report, education of staff). Continuous home care is not intended to be used as respite care.
> The hospice provides a minimum of eight hours of care during a 24-hour day, which begins and ends at midnight. This care need not be continuous, i.e., four hours could be provided in the morning and another four hours in the evening, but care must reflect the needs of an individual in crisis. The care must be predominantly nursing care provided by either a registered nurse (RN) or licensed practical nurse (LPN). In other words, at least half of the hours of care are provided by the RN or LPN. Homemaker or home health aide (also known as a hospice aide) services may be provided to supplement the nursing care.
> Care by a home health aide and/or homemaker may not be discounted or provided "at no charge" in order to qualify for continuous home care. The care provided by all members of the interdisciplinary and/or home health team must be documented in the medical record regardless if that care does or does not compute into continuous home care.
>
> **Inpatient Respite Care** - The hospice is paid at the inpatient respite care rate for each day on which the beneficiary is in an approved inpatient facility and is receiving respite care. Payment for respite care may be made for a maximum of five continuous days at a time including the date of admission but not counting the date of discharge. Payment for the sixth and any subsequent days is to be made at the routine home care rate. More than one respite period (of no more than five days each) is allowable in a single billing period. If the beneficiary dies under inpatient respite care, the day of death is paid at the inpatient respite care rate.

General Inpatient Care - Payment at the inpatient rate is made when general inpatient care is provided.

46. Medicare regulations establish a per-patient cap on overall hospice care reimbursement. The hospice aggregate cap amount for the 2009 cap year is $23,014.50. The cap amount is calculated according to §1814(i)(2)(B) of the Social Security Act. The cap amount for a given year is $6,500 multiplied by the change in the Consumer Price Index for All Urban Consumers (CPI-U) medical care expenditure category, from the fifth month of the 1984 accounting year (March 1984) to the fifth month the current accounting year (in this case, March 2009).

47. In order to lawfully receive reimbursements for hospice care under the Medicare program, a number of conditions and criteria must be met by both the provider and beneficiary. These are set forth in, among other sources: 42 CFR Part 418 ("Hospice Conditions of Participation"); CMS Hospice Manual; CMS Medicare Beneficiary Policy Manual, Ch. 9, ("Coverage of Hospice Services Under Hospital Insurance"); and CMS Medicare Claims Processing Manual, Ch. 11 ("Processing Hospice Claims").

48. Among other conditions, to lawfully receive hospice care reimbursement hospice services must be reasonable and necessary for the palliation or management of the terminal illness and related conditions. Not only must the patient have a terminal illness, but his or her life expectancy must be six months or less. The individual must elect hospice care and a certification that the individual is terminally ill must be completed by the patient's attending physician (if there is one), and the Medical Director (or the physician member of the Interdisciplinary Team (IDT)). Nurse practitioners serving as the attending physician may not certify or re-certify the terminal illness. A plan of care must be established before services are

provided. To be covered, services must be consistent with the plan of care. Certification of terminal illness is based on the physician's or medical director's clinical judgment regarding the normal course of an individual's illness. See 42 C.F.R. §§ 418.3, 418.22, and 418.20.

HOSPICE REIMBURSEMENT UNDER THE MEDICAID PROGRAM

49. The Medicaid Program was created under Title XIX of the Social Security Act to provide "medical assistance to individuals and families whose resources are insufficient to meet the costs of necessary medical services." 42 U.S.C. § 1396. Hospice care is an optional benefit under the Medicaid program. In order to qualify for hospice care reimbursement a participating hospice must meet the Medicare conditions of participation for hospices and have a valid provider agreement. See CMS Medicaid Manual, §§ .4305 et seq.

50. In order to receive Medicaid reimbursements, health care providers, such as CCH submit claims to the individual state Medicaid agencies for reimbursement. 42 U.S.C. § 1396a(a)(23), (a)(32). The specific claim form providers generally use to bill the various state Medicaid agencies for hospice care is the CMS Form 1450 (or its electronic equivalent).

51. The states in turn receive grants from the federal government to cover a substantial portion of the Medicaid reimbursement (typically around 50%). 42 U.S.C. § 1396. State Medicaid administrators obtain the federal government's share of such costs and expenses by submitting quarterly Forms CMS-64 to CMS.

52. The federal government pays Medicaid claims through a continuing line of credit certified to the Secretary of the Treasury in favor of the state payee. 42 C.F.R. § 430.30(d)(3), (4). The federal government authorizes the state payee to draw Federal funds as needed to pay the Federal share of disbursements, 42 C.F.R. § 430.30(d)(3). The state can draw down on those funds only to pay the Medicaid claims of health care providers. 42 C.F.R. § 430.30(d). The

funds made available to the state thus remain federal funds, in a Federal Reserve account, until they are drawn by the state and used to pay a provider's claim.

53. The federal government also approves the claims submitted and paid through the Medicaid program. When a state presents its Form CMS-64, i.e., the quarterly report of actual expenditures, to CMS the amounts of any fraudulent claims the state paid will be included in those reports. Based on the information in the reports, CMS determines and approves whether the claims that the state paid with federal funds were appropriate. If CMS determines that certain claims paid by the state were improper, CMS may recoup the amount of the erroneously expended funds by reducing the amount of money provided to the state during the next quarter.

54. The Form CMS-64 constitutes the United States' means for approving and paying the amount of federal funds expended by the state. Where a Medicaid provider improperly bills the state, the state in turn includes the improperly billed amounts in the Forms CMC-64. Under such circumstances, by filing a false or fraudulent claim with the state Medicaid program, the provider causes the state to file a claim and/or statement with the federal government which is correspondingly false and fraudulent.

55. Like Medicare, Medicaid covers four levels of care into which each day of care is classified:

> Routine Home Care ($143.10),
> Continuous Home Care ($834.43 Full 24 hours of care; $34.77 hourly rate),
> Inpatient Respite Care ($155.61), or
> General Inpatient Care ($635.74)

See Social Security Act § 1814(i)(2)(B); Medicaid Manual § 4306; and CMS Letter to All Associate Regional Administrators, Division of Medicaid, dated September 25, 2009, from Terry Pratt, Acting Director ("Correction to Annual Change in Medicaid Hospice Payment Rates"). Medicaid has criteria similar to Medicare for the levels of care and reimburses providers for

them at different rates (the federal fiscal year daily rates, before regional wage adjustments, are shown in the parentheses above). Like Medicare, Medicaid also places ceilings on the maximum number of days for certain levels of care and, at the state's option, overall caps on hospice payments. A hospice must refund any excess Medicaid payments it receives. *Id*. at §§ 4306.5 and .4308.

HOSPICE REIMBURSEMENT UNDER THE CHAMPUS/TRICARE PROGRAM

56. The Civilian Health and Medical Program of the Uniformed Services ("CHAMPUS") (now known as "TRICARE"), 10 U.S.C. §§ 1071-1106 (referred to herein as "CHAMPUS/TRICARE Program"), provides benefits for health care services furnished by civilian providers, physicians and suppliers to members of the Uniformed Services and to spouses and children of active duty, retired and deceased members. The CHAMPUS/TRICARE Program is administered by the Department of Defense and funded by the Federal Government. The CHAMPUS/TRICARE Program pays for, among other services and items, hospice care.

57. Hospice care providers use the CMS Form 1450 (or its electronic equivalent) to bill the CHAMPUS/TRICARE Program for hospice care services and goods.

58. The conditions for hospice care reimbursement under the CHAMPUS/TRICARE Program are the same or similar to those for Medicare.

SPECIFIC FACTUAL ALLEGATIONS RE CCH'S FRAUDULENT SCHEME

59. At all times relevant to this Complaint, CCH provided hospice services to elderly patients as well as patients that qualified for Medicaid and sought reimbursements from the Medicare and Medicaid Program. Many of the claims CCH submitted are false and fraudulent because they are for services that are unnecessary pursuant to the Medicare Program.

60. The key management in the Bensalem, Pennsylvania office is Kathy Moskowitz, RN (a regional director of CCH), Rosemarie Poole, RN (clinical director of the Bensalem, Pennsylvania office), and Christina Dorian, RN (clinical director of the Bensalem, Pennsylvania office).

61. Despite the fact that each CCH location is separately incorporated, the main office located in Westhampton, New Jersey ("Main Office") tightly controls all CCH entities. CCH's Corporate Office creates and maintains policies and procedures for each of its locations.

62. On May 17, 2010, Ms. Moskowitz informed Jane Doe that each CCH location is run the exact same way.

63. Mary Roe participated in meetings via telephone and in person with representatives from other CCH locations regarding data on patient discharges for the different CCH facilities.

64. The Corporate Office exercises control over all situations where a patient is prescribed a medication that would result in a cost to CCH.

65. The Corporate Office also handles all instances where Medicare submits a request for additional information.

A. Excessive and Improper Continuous Level of Care

66. Pursuant to 42 C.F.R. §§418.202 - 418.204, continuous care may only be provided during periods of crisis and only as necessary to maintain a terminally ill patient at home:

> Nursing care may be covered on a continuous basis for as much as 24 hours a day during periods of crisis as necessary to maintain an individual at home. Either homemaker or home health aide services or both may be covered on a 24-hour continuous basis during periods of crisis but care during these periods must be predominantly nursing care. A

> period of crisis is a period in which the individual requires continuous care to achieve palliation or management of acute medical symptoms.

42 CFR § 418.204.

67. Continuous care is around the clock for a patient in crisis (such as uncontrolled severe symptoms, seizures, hemorrhaging, and highly unstable vital signs).

68. Beginning in approximately the spring of 2009, CCH's Bensalem office began sending CNAs and LPNs daily to nursing homes (such as Greenleaf Nursing Home) to provide continuous care services. Currently, CCH sends two to three LPNs or CNAs per day to nursing homes, depending on staffing. These CCH employees work continuous care shifts at the nursing homes whether there is a patient qualifying for continuous care or not (generally there is not). They do not manage patients with any symptoms requiring continuous care. Instead, these CNAs and LPNs are sent because they are a good marketing tool for CCH with the nursing homes, allowing CCH to have continuous access to nursing homes.

69. Upon information and belief, CCH sends continuous care services to nursing homes primarily in order to encourage the nursing homes to refer patients to CCH. Rosemary Poole, clinical coordinator for the Bensalem office, informed Relator Mary Roe that continuous care at nursing homes was a good "marketing tool" for CCH.

70. Instead of using continuous care to manage a patient in a crisis situation as required pursuant to 42 C.F.R. § 418.204, patients receiving continuous care from CCH are far from being in a "crisis situation." For example, some continuous care patients in nursing homes have been observed by Relators playing bingo with friends, watching television with other residents and going to the dining room for lunch.

71. In order to appear compliant with CMS criteria for continuous care, CNAs and LPNs are instructed by management to write symptoms that were managed even when no symptoms have been managed.

72. Additionally, dates are also altered on patient charts so that Medicare or Medicaid will reimburse CCH for the continuous care. On January 29, 2010, for example, Gwen Bing, a CCH LPN in the Bensalem office worked from 10:00 p.m. until 2:00 a.m. on a continuous care shift. Ms. Dorian instructed Jamie Kessler, a data entry clerk in the Bensalem office, to change the date of services performed so that CCH would be reimbursed. Ms. Dorian's shift had occurred on two separate days and the times were change to January 30, 2010 from 12:00 a.m. to 2:00 a.m. and 8:00 a.m. to 12:00 p.m.

73. In short, CCH seeks reimbursement from Medicaid and Medicare for unnecessary continuous care services and creates bogus medical records to make it appear that such services were medically necessary, when in fact they were not.

B. Fraudulently Certifying Patients for Hospice Care Admissions

74. CCH executives, including the Corporate Office clinical director and individual clinical directors, overtly pressure CCH employees to "find a way" to enroll ineligible Medicare and Medicaid beneficiaries on hospice service.

75. CCH has established an office environment where personnel fear reprisal, including termination, if Medicare/Medicaid patient census levels are not maintained at increasingly higher levels.

76. CCH brings patients on for hospice service for the initial certification period regardless of whether or not they qualify for hospice care. After the patients are brought on for

hospice service, CCH management instructs its case managers to come up with a reason that would make the patient eligible for hospice care.

77. In order to qualify for hospice care, a patient must the meet requirements of 42 C.F.R. §418.22 ("the individual's prognosis is for a life expectancy of 6 months or less if the terminal illness runs its normal course" C.F.R. §418.22 (b)(1)). Pursuant to 42 U.S.C. § 1395 (dd)(3)(A), the Hospice Medical Director and the patient's primary physician must certify that the patient's life expectancy is less than 6 months if the patient's disease runs its natural course." Id.

78. For the initial 90 day period, the certification must be from the medical director of the hospice or the physician member of the hospice interdisciplinary group; and the patient's attending physician. 42 C.F.R. § 418.22 (c)(1)(i) and (ii).

79. CCH enlists patients for hospice care who do not meet the requirements for hospice care and ultimately recertifies them for successive periods of care. In order to obtain reimbursement from Medicare and Medicaid, CCH instructs its staff to:

a. Forge physicians' signatures on certifications and/or recertifications (by cutting and pasting signatures from other documents).

b. Alter nursing notes on patient charts to include false symptoms.

c. Forge physicians' signatures on care plans (by cutting and pasting signatures from other documents).

d. Fraudulently use an earlier diagnosis as the basis for CCH to qualify the patient for hospice care through Medicare and Medicaid.

e. Generate a baseless medical history.

f. Cause CCH staff physicians to substantiate the terminal prognosis when patients failed to exhibit any objective signs or symptoms of a terminal illness.

80. The written certification that the prospective hospice patient has a life expectancy of 6 months or less if the disease runs its normal course must be done within two days after the period of care begins. If the hospice cannot obtain the written certification (for the initial certification period) within 2 calendar days after a period begins, it must obtain an oral certification within 2 calendar days and obtain the written certification before it submits a claim for payment. 42 C.F.R. § 418.22 (a)(3).

81. In order to comply with the certification requirement, CCH instructs physicians to back date documents and instructs staff to white out dates and change them so that they comply with the requirements.

82. 42 C.F.R. §418.56(b) requires the hospice IDT in collaboration with the attending physician to establish a plan of care. Creating a plan of care for each patient is a condition of participation, and hence payment, for the Medicare and Medicaid programs. 42 C.F.R. § 418.50.

83. In violation of CMS regulations, a physician or medical director does not create the plan of care for patients at CCH. Registered nurses provide the information to physicians who then sign the plan of care. Alternatively, the plan of care is created solely by the RN and the physician's signature is forged on the document.

84. For example, on June 18, 2009, Relator Mary Roe attended a meeting of CCH clinical directors where CCH management was also present, including Defendant Hardy and Ms. Montalvo. At this meeting, Defendant Hardy passed out a list of company-wide live discharges. The chart showed the number of discharges and broke them down by category (i.e., revocations, no longer meets criteria, transfer to another agency, etc.). The clinical directors expressed

concern and anxiety over the number of live patients that were discharged. CCH management made it clear at the meeting that their business objective is to bring on as many patients as possible to hospice care and to maintain the patients on service as long as possible, regardless of meeting CMS-imposed regulations.

85. If a CCH registered nurse informs management that a patient does not meet hospice criteria, CCH management will demand that the nurse find a way to maintain the patient on service. Often when one RN raises questions about a patient meeting hospice criteria, CCH management will send out another CCH RN to ensure symptoms are reported in the patient's chart that would enable them to maintain the patient on hospice service.

86. CCH instructs its employees to admit patients despite the fact that they do not meet the criteria set forth in 42 C.F.R. § 418.22. This often simultaneously occurs when the patient does not want hospice services.

87. For example, Ms. Moskowitz wanted to admit patient L.G., a patient with renal disease who did not qualify for hospice services and did not want to discontinue his dialysis.

88. Ms. Moskowitz ultimately admitted patient L.G. with a diagnosis of Debility NOS (despite the fact he did not meet the criteria) and agreed to cause CCH to pay for his dialysis.

89. Upon information and belief, the vast majority of CCH patients are admitted with a diagnosis of Decline in Health Status (i.e., Debility NOS with ICD-9-CM diagnostic billing code 799.3). In order to qualify for a decline in health status, the progression of the patient's disease must be documented by worsening clinical status, symptoms, signs and laboratory results.

90. On June 6, 2008, CCH instructed some of its RNs on how to document Debility NOS so that CCH's requests for reimbursement from Medicare or Medicaid would not be questioned.

91. CCH registered nurses were told at this meeting to document the glass as "half empty" not "half full," implying that the negative aspect of patients' conditions were to be deceptively overstated.

92. Patients that do not meet the qualifications of Debility NOS are routinely admitted to, and maintained on, hospice service at CCH.

93. A proper Debility NOS diagnosis requires a nutritional impairment as evidenced by a Body Mass Index (BMI) below 22 kg/m_2.

94. One patient, M.S., a Medicare patient with Downs Syndrome, was admitted by CCH for hospice services with a diagnosis of debility despite the fact that she weighed over 200 pounds and remained on service for over 2 years.

95. Despite the fact that M.S. had a chronic respiratory condition during the time she remained on service at CCH, she was not given needed curative treatment because CCH did not want her hospice services to be discontinued.

C. Fraudulently Recertifying Patients for Continued Hospice Care

96. Pursuant to 42 C.F.R. § 418.21, after the initial 90 day period of care a hospice patient may elect an additional 90 day period of hospice care provided the patient meets the requirements set forth in 42 C.F.R. § 418.22. After the expiration of the additional 90 day period, the patient may elect additional 60 day periods of hospice care provided the patients meets the requirements set forth in 42 C.F.R. § 418.22.

97. CCH uses the same or similar improper practices to falsely recertify patients for continued hospice care as it does for initial admissions, as described above.

D. Intentionally Billing for Services and Goods Not Provided

98. CCH also submits reimbursement requests to Medicare and Medicaid for services that were not actually performed.

99. For example, CCH billed for dietary consultations and massage therapies for patient S.B. despite the fact that those services were not performed.

100. Additionally, when a nursing facility patient on service with CCH is admitted to an acute care hospital for treatment for conditions unrelated to the hospice admission diagnosis, CCH will often keep the patient on hospice service, billing Medicaid or Medicare, despite the fact that CCH staff does not visit the patient during their hospital stay.

101. For example, patient A.L. was hospitalized from July 2-7, 2009. CCH billed for hospice services for this patient for this time period despite the fact that CCH did not provide services to him during his hospitalization.

E. Failing to Obtain Proper Patient Elections for Hospice Services

102. Pursuant to the requirements of 42 C.F.R. §§ 418.3 and 418.24, the patient or patient's legal representative must execute a hospice election form which includes the statement that the patient or his/her legal representative has been fully informed as to the "palliative" rather than "curative" nature of hospice care.

103. CCH staff is instructed by management to inform the patient or their representative that hospice is simply "supplemental care," thus fraudulently misrepresenting the true nature of hospice care in an effort to increase the number of patients on service with CCH.

104. Additionally, rather than have their legal representatives sign their hospice election forms, CCH patients in nursing homes have been signed onto service by nursing home personnel.

F. Using Illegal Marketing Schemes

105. CCH uses paid marketers to target private nursing home facilities to aggressively look for new hospice patients. CCH marketers obtain the nursing home's permission to go through residents' charts to look for prospect hospice service patients, without the patients' knowledge or authorization. This violates use of patient medical records for marketing purposes violates HIPPA.

106. The private nursing home facilities welcome CCH employees because they provide additional assistance with the patients and thereby reduce nursing home staff requirements.

107. CCH also provides durable medical equipment to the private nursing home facilities as a "reward" for referring new patients.

108. At Greenleaf Nursing Home, for example, CCH provides a low air loss bed (which CCH rents) for each hospice patient at Greenleaf regardless of whether the patient meets Medicare requirements for a low air loss bed.

109. CCH personnel also have in-service calls with nursing home personnel to which the CCH employees, at the company's direction, bring food and similar items.

110. Additionally, CCH patient recruiters go to low income areas to find people to bring on to service. Upon information and belief, these recruiters often tell prospective hospice patients or their families that CCH offers "extra help" with household chores, errands and housekeeping instead of informing them of the true nature of hospice care, as required by 42

C.F.R. § 418.24. Upon information and belief, CCH patient recruiters are paid bonuses based on the number of patients they recruit.

111. Providing things of value to nursing home personnel and paying bonuses to CCH recruiters violates the Social Security Act's Anti-Kickback Statute and results in FCA violations for the services or goods provided as a result of such unlawful conduct.

G. Falsifying Utilization of Volunteers

112. Pursuant to 42 C.F.R. § 418.70 (c) CCH must maintain volunteers as a condition of participation in the Medicare hospice program. The purpose of the volunteer requirement is to decrease the costs for Medicare and Medicaid.

113. Volunteers, according to the Medicare State Operations Manual, Appendix M, are defined as "hospice employees to facilitate compliance with core services requirement."

114. Medicare reporting requirements mandate that CCH maintain detailed records of its volunteer services. For example, under 42 C.F.R. § 1395 (dd)(2)(E) i and ii, CCH must list the number of active volunteers, the number of patients serviced by those volunteers, the cost savings amount for the patient and family services, the cost savings amount resulting from volunteers working in administrative positions, the number of hours worked by volunteers, the total cost savings resulting from using volunteers, the number of volunteer training sessions and the percentage of volunteer hours in relation to the total patient care time.

115. Instead of utilizing volunteers pursuant to the requirements of 42 C.F.R. § 418.70 (c), CCH falsely lists medical students performing their required hospice rotations as CCH's volunteers.

H. Miscellaneous Part 418 Violations

116. Defendants further violated the Federal and State FCAs by presenting claims that falsely and fraudulently certified compliance with all applicable laws and regulations, when, in fact, CCH regularly violated a host of other conditions of participation and payment in 42 C.F.R. Part 418, including, but not limited to those listed below.

117. At CCH's urging, Greenleaf nursing home administrator Campbell signs hospice election forms for residents even though he does not have the required power of attorney or legal authorization to do so, e.g., patients R.B and M.S.

118. There have been times when "no drugs were available," as CCH patient care tape recordings indicate.

119. Due to an excessively high turnover rate, CCH distributes an updated list of employees at their Bensalem facility team meetings held every two weeks.

120. Upon information and belief, approximately 80 to 90 percent of CCH's patient charts do not have history and physical documentation ("H&Ps").

121. CCH does not maintain required documentation, such as patient medical charts, and cause employees to create and back date such records after the fact, e.g., patient R.S.

122. CCH nurses' standard case loads regularly exceed 12 patients. Relator Jane Doe's case load has been between 16 and 22 patients. CCH employee John Velasco's load at the Fair Acres facility has been as high as 27 patients. CCH tries to compensate for excessive case loads by assigning LPNs to do all of the second of the required twice-weekly visits. However, LPNs are not permitted by CMS regulations to make recommendations for, or manage, patient care.

123. Upon information and belief, CCH inpatient days often exceed 20% of hospice days for beneficiaries, and patient charts are altered to under report such inpatient days.

124. Inpatient violations have occurred at CCH's Deer Meadows facility.

125. Routinely there are not RNs on each shift to provide direct care. CCH RNs are used almost exclusively to supervise less costly certified nurse assistants and other paramedical staff.

126. CCH patients use Hospice Pharmacia, but they do not come into the pharmacy, nor present the required admissions profile or monthly reviews.

127. There have been instances when CCH RNs have requested, but been denied, crisis care to manage symptoms for home patients. Rather, CCH uses crisis care almost exclusively for patients in nursing home facilities.

J. CCH's Hospice Care Utilization Rates

128. CMS collects and publishes utilization data for hospice care, including, admission diagnoses, level of care; length of stay ("LOS"), live patient discharges, etc.

129. Given that CCH is a large, national for-profit hospice care provider with a Director of Quality Assurance and Compliance, its employees and representatives know, or should know, the sum and substance of CMS' published utilization reports and data.

130. Upon information and belief, CCH's utilization data are far above the national averages, including: (a) the number and percentage of patients admitted to hospice under the diagnosis Debility Not Otherwise Specified; (b) the number and percentage of patients receiving continuous home care; (c) the average patient LOS and number of recertifications; (d) the number of live patients who were discharged from hospice and the length of time between their admissions into hospice and their deaths, and (e) per patient and overall hospice care charges.

131. The foregoing CCH utilization data not only reflect the combined effect of Defendants' submission of false and fraudulent claims (i.e., excessive and improper charges to Medicare, Medicaid and CHAMPUS/TRICARE), but also establish Defendants' knowledge of their improper billing practices.

Count 1

31 U.S.C. § 3729(a) (pre-2009 Amendment))
(Medicare)

132. Relators realleged the foregoing allegations.

133. From at least as early as in or about 2004 until on or about May 19, 2009, Defendants: (a) knowingly presented, and caused to be presented to an officer and employee of the Medicare Program false and fraudulent claims for payment and approval; (b) knowingly made, used, and caused to be made and used, false records and statements to get false and fraudulent claims paid and approved by the Medicare Program; (c) conspired to defraud the Medicare Program by getting false and fraudulent claims allowed or paid, and (d) knowingly made, used, and caused to be made and used, a false record or statement to conceal, avoid, and decrease an obligation to pay or transmit money or property to the Medicare Program, in violation of 31 U.S.C. §§ 3729(a)(1), (2), (3) and (7) of the False Claims Act (prior to its amendment on May 20, 2009).

134. If the government of the United States had known that Defendants were fraudulently altering patient charts and /or falsifying entries on patient charts; forging physicians' signatures and/or pre dating and/or post dating certifications, recertifications and care plans, falsely documenting that the patients consented to hospice treatment, falsely certifying that services were performed when in fact they were not and falsely representing that it maintained

volunteers to get false or fraudulent claims paid, and the other unlawful conduct alleged herein, it would not have paid the claims.

135. The United States has been damaged by the Defendants' wrongful conduct.

Count 2
31 U.S.C. § 3729(a)(1) (as amended 2010)
(Medicare)

136. Relators reallege the foregoing allegations.

137. From on or about May 20, 2009 until the filing of this Complaint, in connection with the Medicare Program Defendants: (a) knowingly presented, or caused to be presented, a false and fraudulent claim for payment or approval; (b) knowingly made, used, and caused to be made and used, a false record or statement material to a false or fraudulent claim; (c) conspired to commit a violation of subparagraphs (A), (B),…and (G) of § 3729(a)(1); and (d) knowingly made, used, and caused to be made and used, a false record or statement material to an obligation to pay and transmit money and property to the Medicare Program, and knowingly concealed and knowingly and improperly avoided and decreased an obligation to pay and transmit money and property to the Medicare Program, in violation of 31 U.S.C. §§ 3729(a)(1)(A), (B), (C) and (G) of the False Claims Act (as amended on May 20, 2009).

138. If the government of the United States had known that Defendants were fraudulently altering patient charts and /or falsifying entries on patient charts; forging physicians' signatures and/or pre dating and/or post dating certifications, recertifications and care plans, falsely documenting that the patients consented to hospice treatment, falsely certifying that services were performed when in fact they were not and falsely representing that it maintained volunteers to get false or fraudulent claims paid, and the other unlawful conduct alleged herein, it would not have paid the claims.

139. The United States has been damaged by the Defendants' wrongful conduct.

Count 3
31 U.S.C. § 3729(a) (pre-2009 Amendment)
(Medicaid)

140. Relators reallege the foregoing allegations.

141. From at least as early as in or about 2004 until on or about May 19, 2009, Defendants: (a) knowingly presented, and caused to be presented to an officer and employee of the Medicare Program false and fraudulent claims for payment and approval; (b) knowingly made, used, and caused to be made and used, false records and statements to get false and fraudulent claims paid and approved by the Medicare Program; (c) conspired to defraud the Medicare Program by getting false and fraudulent claims allowed or paid, and (d) knowingly made, used, and caused to be made and used, a false record or statement to conceal, avoid, and decrease an obligation to pay or transmit money or property to the Medicare Program, in violation of 31 U.S.C. §§ 3729(a)(1), (2), (3) and (7) of the False Claims Act (prior to its amendment on May 20, 2009).

142. If the government of the United States had known that Defendants were altering patient charts and /or falsifying entries on patient charts; forging physicians' signatures and/or pre dating and/or post dating certifications, recertifications and care plans, falsely documenting that the patients consented to hospice treatment, falsely certified that services were performed when in fact they were not and falsely representing that it maintained volunteers to get false or fraudulent claims paid, and the other unlawful conduct alleged herein, it would not have paid the claims.

143. The United States has been damaged by the Defendants' wrongful conduct.

Count 4
31 U.S.C. § 3729(a)(1) (as Amended 2010)
(Medicaid)

144. Relators reallege the foregoing allegations.

145. From on or about May 20, 2009 until the filing of this Complaint, in connection with the Medicare Program Defendants: (a) knowingly presented, or caused to be presented, a false and fraudulent claim for payment or approval; (b) knowingly made, used, and caused to be made and used, a false record or statement material to a false or fraudulent claim; (c) conspired to commit a violation of subparagraphs (A), (B),…and (G) of § 3729(a)(1); and (d) knowingly made, used, and caused to be made and used, a false record or statement material to an obligation to pay and transmit money and property to the Medicare Program, and knowingly concealed and knowingly and improperly avoided and decreased an obligation to pay and transmit money and property to the Medicare Program, in violation of 31 U.S.C. §§ 3729(a)(1)(A), (B), (C) and (G) of the False Claims Act (as amended on May 20, 2009).

146. If the government of the United States had known that Defendants were fraudulently altering patient charts and /or falsifying entries on patient charts; forging physicians' signatures and/or pre dating and/or post dating certifications, recertifications and care plans, falsely documenting that the patients consented to hospice treatment, falsely certifying that services were performed when in fact they were not, and falsely representing that it maintained volunteers to get false or fraudulent claims paid, and the other unlawful conduct alleged herein, it would not have paid the claims.

147. The United States has been damaged by the Defendants' wrongful conduct.

Count 5
Del. Code Tit. 6, § 1201(a)(1)

148. Relators reallege the foregoing allegations.

149. The Delaware False Claims and Reporting Act, Del. Code Ann. tit 6 § 1201(a)(1), provides that any person who:

> (a)(1) Knowingly presents, or causes to be presented, directly or indirectly, to an officer or employee of the Government a false or fraudulent claim for payment or approval;
>
> shall be liable to the Government for a civil penalty of not less than $5,500 and not more than $11,000 for each act constituting a violation of this section, plus 3 times the amount of actual damages which the Government sustains because of the act of that person.

150. From at least 2004 to the present, the Defendants knowingly submitted claims to the Delaware Medicaid program for reimbursement for hospice services that were not necessary and/or were not actually performed and/or did not meet the requirements set forth in 42 CFR §§ 418.21, 418.22, 418.24, 418.54, 418.68, 418.70, 418.74, and 418.202-204. In order to ensure its fraudulent claims were paid, Defendants fraudulently altered patient charts and /or falsified entries on patient charts; forged physicians' signatures and/or pre dated and/or post dated certifications, recertifications and care plans; falsely documented that the patients consented to hospice treatment; falsely certified that services were performed when in fact they were not; and falsely represented that it maintained volunteers.

151. Each claim for reimbursement for such services represents a false or fraudulent claim for payment under the statute.

152. If the government of Delaware had known that Defendants were altering patient charts and /or falsifying entries on patient charts; forging physicians' signatures and/or pre dating and/or post dating certifications, recertifications and care plans, falsely documenting that patients

consented to hospice treatment, falsely certifying that services were performed when in fact they were not, and falsely representing that it maintained volunteers to get false or fraudulent claims paid, it would not have paid the claims.

153. The state of Delaware has been damaged by the Defendants' wrongful conduct.

Count 6
Del. Code Tit. 6, § 1201(a)(2)

154. The Relators reallege the foregoing allegations.

155. The Delaware False Claims and Reporting Act, Del. Code Ann. tit. 6, § 1201(a)(2), provides that any person who:

> (a)(2) Knowingly makes, uses or causes to be made or used, directly or indirectly, a false record or statement to get a false or fraudulent claim paid or approved;
>
> shall be liable to the Government for a civil penalty of not less than $5,500 and not more than $11,000 for each act constituting a violation of this section, plus 3 times the amount of actual damages which the Government sustains because of the act of that person.

156. From at least 2004 to the present, Defendants knowingly submitted claims to the Delaware Medicaid program for reimbursement for hospice services that were unnecessary, not actually performed, and did not meet the requirements set forth in 42 CFR §§ 418.21, 418.22, 418.24, 418.54, 418.68, 418.70, 418.74, and 418.202-204. In order to ensure its fraudulent claims were paid, Defendants fraudulently altered patient charts and /or falsified entries on patient charts; forged physicians' signatures and/or pre dated and/or post dated certifications, recertifications and care plans; falsely documented that the patients consented to hospice treatment; falsely certified that services were performed when in fact they were not; and falsely represented that it maintained volunteers.

157. Each claim for reimbursement for hospice services as a result of Defendants' fraudulent practices for reimbursement for such hospice services that were not performed or that it falsely represented that it complied with the requirements set forth in 42 CFR §§ 418.21, 418.22, 418.24, 418.54, 418.68, 418.70, 418.74, and 418.202-204 represent false or fraudulent records or statements under the statute that were used to get a false claim paid or approved.

158. If the government of Delaware had known that Defendants were fraudulently altering patient charts and /or falsifying entries on patient charts; forging physicians' signatures and/or pre dating and/or post dating certifications, recertifications and care plans, falsely documenting that the patients consented to hospice treatment, falsely certifying that services were performed when in fact they were not and falsely representing that it maintained volunteers to get false or fraudulent claims paid, it would not have paid the claims.

159. The state of Delaware has been damaged by the Defendants' wrongful conduct.

Count 7
Fla. Stat. § 68.082(2)(a)

160. Relators reallege the foregoing allegations.

161. The Florida False Claims Act, Fla. Stat. ' 68.082(2)(a), provides that any person who:

> (a) Knowingly presents or causes to be presented to an officer or employee of an agency a false claim for payment or approval; Yis liable to the state for a civil penalty of not less than $5,000 and not more than $10,000 and for treble the amount of damages the agency sustains because of the act or omission of that person.

162. From at least 2004 to the present, Defendants knowingly submitted claims to the Florida Medicaid program for reimbursement for hospice services that were not necessary and/or were not actually performed, and did not meet the requirements set forth in 42 CFR §§ 418.21,

418.22, 418.24, 418.54, 418.68, 418.70, 418.74, and 418.202-204. In order to ensure its fraudulent claims were paid, Defendants fraudulently altered patient charts and /or falsified entries on patient charts; forged physicians' signatures and/or pre dated and/or post dated certifications, recertifications and care plans; falsely documented that the patients consented to hospice treatment; falsely certified that services were performed when in fact they were not; and falsely represented that it maintained volunteers.

163. Each claim for reimbursement represents a false or fraudulent claim for payment under the statute.

164. If the government of Florida had known that Defendants were altering patient charts and /or falsifying entries on patient charts; forging physicians' signatures and/or pre dating and/or post dating certifications, recertifications and care plans, falsely documenting that patients consented to hospice treatment, falsely certifying that services were performed when in fact they were not, and falsely representing that it maintained volunteers to get false or fraudulent claims paid, it would not have paid the claims.

165. The state of Florida has been damaged by the Defendants' wrongful conduct.

Count 8
Fla. Stat. § 68.082(2)(b)

166. Relators reallege the foregoing allegations.

167. The Florida False Claims Act, Fla. Stat. § 68.082(2)(b), provides that any person who:

> (b) Knowingly makes, uses, or causes to be made or used a false record or statement to get a false or fraudulent claim paid or approved by an agency; Y
>
> is liable to the state for a civil penalty of not less than $5,000 and not more than $10,000 and for treble the amount of damages the agency sustains because of the act or omission of that person.

168. From at least 2004 to the present, Defendants knowingly submitted claims to the Florida Medicaid program for reimbursement for hospice services that were not necessary and/or were not actually performed and did not meet the requirements set forth in 42 C.F.R. §§ 418.21, 418.22, 418.24, 418.54, 418.68, 418.70, 418.74, and 418.202-204. In order to ensure its fraudulent claims were paid, Defendants fraudulently altered patient charts and/or falsified entries on patient charts; forged physicians' signatures and/or pre dated and/or post dated certifications, recertifications and care plans, falsely documented that the patients consented to hospice treatment; falsely certified that services were performed when in fact they were not; and falsely represented that it maintained volunteers.

169. Each claim for reimbursement for hospice services as a result of Defendants' fraudulent practices for reimbursement for such hospice services that were not performed or that it falsely represented that it complied with the requirements set forth in 42 CFR §§ 418.21, 418.22, 418.24, 418.54, 418.68, 418.70, 418.74, and 418.202-204 represent false or fraudulent records or statements under the statute that were used to get a false claim paid or approved.

170. If the government of Florida had known that Defendants were fraudulently altering patient charts and /or falsifying entries on patient charts; forging physicians' signatures and/or pre dating and/or post dating certifications, recertifications and care plans, falsely documenting that the patients consented to hospice treatment, falsely certifying that services were performed when in fact they were not and falsely representing that it maintained volunteers to get false or fraudulent claims paid, it would not have paid the claims.

171. The state of Florida has been damaged by Defendants' wrongful conduct.

Count 9
Ga. Code Ann. Art. 7B, Ch. 4, Tit. 49

172. Relators reallege the foregoing allegations.

173. The Georgia State False Medicaid Claims Act, Ga. Code Ann. § 49-4-168, *et seq*., provides at § 49-4-168.1, that:

> (a) Any person who:
>
> (1) Knowingly presents or causes to be presented to the Georgia Medicaid program a false or fraudulent claim for payment or approval;

shall be liable to the State of Georgia for a civil penalty of not less than $5,500.00 and not more than $11,000.00 for each false or fraudulent claim, plus three times the amount of damages which the Georgia Medicaid program sustains because of the act of such person.

174. From at least 2004 to the present, Defendants knowingly submitted claims to the Georgia Medicaid program for reimbursement for hospice services that were not necessary and/or were not actually performed and did not meet the requirements set forth in 42 C.F.R. §§ 418.21, 418.22, 418.24, 418.54, 418.68, 418.70, 418.74, and 418.202-204. In order to ensure its fraudulent claims were paid by the Georgia Medicaid program, Defendants fraudulently altered patient charts and/or falsified entries on patient charts; forged physicians' signatures and/or pre dated and/or post dated certifications, recertifications and care plans; falsely documented that the patients consented to hospice treatment; falsely certified that services were performed when in fact they were not; and falsely represented that it maintained volunteers.

175. Each claim for reimbursement for such prescriptions represents a false or fraudulent claim for payment under the statute.

176. If the government of Georgia had known that Defendants were fraudulently altering patient charts and /or falsifying entries on patient charts; forging physicians' signatures

and/or pre dating and/or post dating certifications, recertifications and care plans, falsely documenting that the patients consented to hospice treatment, falsely certifying that services were performed when in fact they were not and falsely representing that it maintained volunteers to get false or fraudulent claims paid, it would not have paid the claims.

177. The state of Georgia has been damaged by the Defendants' wrongful conduct.

Count 10
Ga. Code Ann. Art. 7B, Ch. 4, Tit. 49

178. Relators reallege the foregoing allegations.

179. The Georgia State False Medicaid Claims Act, Ga. Code Ann. § 49-4-168, *et seq*., provides at § 49-4-168.1, that:

> (a) Any person who:
>
> (2) Knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Georgia Medicaid program;

180. shall be liable to the State of Georgia for a civil penalty of not less than $5,500.00 and not more than $11,000.00 for each false or fraudulent claim, plus three times the amount of damages which the Georgia Medicaid program sustains because of the act of such person.

181. From at least 2004 to the present, Defendants knowingly submitted claims to the Georgia Medicaid program for reimbursement for hospice services that were not necessary and/or were not actually performed and did not meet the requirements set forth in 42 C.F.R. §§ 418.21, 418.22, 418.24, 418.54, 418.68, 418.70, 418.74, and 418.202-204. In order to ensure its fraudulent claims were paid, Defendants fraudulently altered patient charts and/or falsified entries on patient charts; forged physicians' signatures and/or pre dated and/or post dated certifications, recertifications and care plans, falsely documented that the patients consented to

hospice treatment; falsely certified that services were performed when in fact they were not; and falsely represented that it maintained volunteers.

182. Each claim for reimbursement for hospice services as a result of Defendants' fraudulent practices for reimbursement for such hospice services that were not performed or that it falsely represented that it complied with the requirements set forth in 42 C.F.R. §§ 418.21, 418.22, 418.24, 418.54, 418.68, 418.70, 418.74, and 418.202-204 represent false or fraudulent records or statements under the statute that were used to get a false claim paid or approved.

183. If the government of Georgia had known that Defendants were fraudulently altering patient charts and /or falsifying entries on patient charts; forging physicians' signatures and/or pre dating and/or post dating certifications, recertifications and care plans, falsely documenting that the patients consented to hospice treatment, falsely certifying that services were performed when in fact they were not and falsely representing that it maintained volunteers to get false or fraudulent claims paid, it would not have paid the claims.

184. The state of Georgia has been damaged by Defendants' wrongful conduct.

Count 11
740 Ill. Comp. Stat. § 175/3 (a)(1)

185. Relators reallege the foregoing allegations.

186. The Illinois Whistleblower Reward and Protection Act, 740 Ill. Comp. Stat. § 175/3(a)(1), provides that any person who:

> (1) knowingly presents, or causes to be presented, to an officer or employee of the State or member of the Guard a false or fraudulent claim for payment or approval;
>
> . . .is liable to the State for a civil penalty of not less than $5,000 and not more than $10,000, plus 3 times the amount of damages which the State sustains because of the act of that person.

187. From at least 2004 to the present, Defendants knowingly submitted claims to the Illinois Medicaid program for reimbursement for hospice services that were not necessary and/or were not actually performed and did not meet the requirements set forth in 42 C.F.R. §§ 418.21, 418.22, 418.24, 418.54, 418.68, 418.70, 418.74, and 418.202-204. In order to ensure its fraudulent claims were paid by the Illinois Medicaid program, Defendants fraudulently altered patient charts and/or falsified entries on patient charts; forged physicians' signatures and/or pre dated and/or post dated certifications, recertifications and care plans; falsely documented that the patients consented to hospice treatment; falsely certified that services were performed when in fact they were not; and falsely represented that it maintained volunteers.

188. Each claim for reimbursement for such prescriptions represents a false or fraudulent claim for payment under the statute.

189. If the government of Illinois had known that Defendants were fraudulently altering patient charts and /or falsifying entries on patient charts; forging physicians' signatures and/or pre dating and/or post dating certifications, recertifications and care plans, falsely documenting that the patients consented to hospice treatment, falsely certifying that services were performed when in fact they were not and falsely representing that it maintained volunteers to get false or fraudulent claims paid, it would not have paid the claims.

190. The state of Illinois has been damaged by the Defendants' wrongful conduct.

Count 12
740 Ill. Comp. Stat. § 175/3(a)(2)

191. Relators reallege the foregoing allegations.

192. The Illinois Whistleblower Reward and Protection Act, 740 Ill. Comp. Stat. § 175/3(a)(2), provides that any person who:

> (2)knowingly makes, uses or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the State;
>
> . . .is liable to the State for a civil penalty of not less than $5,000 and not more than $10,000, plus 3 times the amount of damages which the State sustains because of the act of that person.

193. From at least 2004 to the present, Defendants knowingly submitted claims to the Illinois Medicaid program for reimbursement for hospice services that were not necessary and/or were not actually performed and did not meet the requirements set forth in 42 C.F.R. §§ 418.21, 418.22, 418.24, 418.54, 418.68, 418.70, 418.74, and 418.202-204. In order to ensure its fraudulent claims were paid, Defendants fraudulently altered patient charts and/or falsified entries on patient charts; forged physicians' signatures and/or pre dated and/or post dated certifications, recertifications and care plans, falsely documented that the patients consented to hospice treatment; falsely certified that services were performed when in fact they were not; and falsely represented that it maintained volunteers.

194. Each claim for reimbursement for hospice services as a result of Defendants' fraudulent practices for reimbursement for such hospice services that were not performed or that it falsely represented that it complied with the requirements set forth in 42 C.F.R. §§ 418.21, 418.22, 418.24, 418.54, 418.68, 418.70, 418.74, and 418.202-204 represent false or fraudulent records or statements under the statute that were used to get a false claim paid or approved.

195. If the government of Illinois had known that Defendants were fraudulently altering patient charts and /or falsifying entries on patient charts; forging physicians' signatures and/or pre dating and/or post dating certifications, recertifications and care plans, falsely

documenting that the patients consented to hospice treatment, falsely certifying that services were performed when in fact they were not and falsely representing that it maintained volunteers to get false or fraudulent claims paid, it would not have paid the claims.

196. The state of Illinois has been damaged by Defendants' wrongful conduct.

Count 13
Mass. Gen. Laws Ch. 12, § 5B(1)

197. Relators reallege the foregoing allegations.

198. The Massachusetts False Claims Act, M.G.L. Ch. 12, § 5B(1), provides that any person who:

> (1) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;
>
> . . .shall be liable to the commonwealth or political subdivision for a civil penalty of not less than $5,000 and not more than $10,000 per violation, plus three times the amount of damages, including consequential damages, that the commonwealth or political subdivision sustains because of the act of that person.

199. From at least 2004 to the present, Defendants knowingly submitted claims to the Commonwealth of Massachusetts Medicaid program for reimbursement for hospice services that were not necessary and/or were not actually performed and did not meet the requirements set forth in 42 C.F.R. §§ 418.21, 418.22, 418.24, 418.54, 418.68, 418.70, 418.74, and 418.202-204. In order to ensure its fraudulent claims were paid by the Commonwealth of Massachusetts Medicaid program, Defendants fraudulently altered patient charts and/or falsified entries on patient charts; forged physicians' signatures and/or pre dated and/or post dated certifications, recertifications and care plans; falsely documented that the patients consented to hospice

treatment; falsely certified that services were performed when in fact they were not; and falsely represented that it maintained volunteers.

200. Each claim for reimbursement for such prescriptions represents a false or fraudulent claim for payment under the statute.

201. If the government of the Commonwealth of Massachusetts had known that Defendants were fraudulently altering patient charts and /or falsifying entries on patient charts; forging physicians' signatures and/or pre dating and/or post dating certifications, recertifications and care plans, falsely documenting that the patients consented to hospice treatment, falsely certifying that services were performed when in fact they were not and falsely representing that it maintained volunteers to get false or fraudulent claims paid, it would not have paid the claims.

202. The Commonwealth of Massachusetts has been damaged by the Defendants' wrongful conduct.

Count 14
Mass. Gen. Laws Ch. 12, § 5B(2)

203. Relators reallege the foregoing allegations.

204. The Massachusetts False Claims Act, M.G.L. Ch. 12, § 5B(2), provides that any person who:

> (2) knowingly makes, uses, or causes to be made or used, a false record or statement to obtain payment or approval of a claim by the commonwealth or any political subdivision thereof;
>
> . . .shall be liable to the commonwealth or political subdivision for a civil penalty of not less than $5,000 and not more than $10,000 per violation, plus three times the amount of damages, including consequential damages, that the commonwealth or political subdivision sustains because of the act of that person

205. From at least 2004 to the present, Defendants knowingly submitted claims to the Commonwealth of Massachusetts Medicaid program for reimbursement for hospice services that were not necessary and/or were not actually performed and did not meet the requirements set forth in 42 C.F.R. §§ 418.21, 418.22, 418.24, 418.54, 418.68, 418.70, 418.74, and 418.202-204. In order to ensure its fraudulent claims were paid, Defendants fraudulently altered patient charts and/or falsified entries on patient charts; forged physicians' signatures and/or pre dated and/or post dated certifications, recertifications and care plans, falsely documented that the patients consented to hospice treatment; falsely certified that services were performed when in fact they were not; and falsely represented that it maintained volunteers.

206. Each claim for reimbursement for hospice services as a result of Defendants' fraudulent practices for reimbursement for such hospice services that were not performed or that it falsely represented that it complied with the requirements set forth in 42 C.F.R. §§ 418.21, 418.22, 418.24, 418.54, 418.68, 418.70, 418.74, and 418.202-204 represent false or fraudulent records or statements under the statute that were used to get a false claim paid or approved.

207. If the government of the Commonwealth of Massachusetts had known that Defendants were fraudulently altering patient charts and /or falsifying entries on patient charts; forging physicians' signatures and/or pre dating and/or post dating certifications, recertifications and care plans, falsely documenting that the patients consented to hospice treatment, falsely certifying that services were performed when in fact they were not and falsely representing that it maintained volunteers to get false or fraudulent claims paid, it would not have paid the claims.

208. The Commonwealth of Massachusetts has been damaged by Defendants' wrongful conduct.

Count 15
Mich. Comp. Laws Ch. 400]

209. Relators reallege the foregoing allegations.

210. The Michigan Medicaid False Claims Act, MCL § 400.603, provides:

> A person shall not knowingly make or cause to be made a false statement or false representation of a material fact in an application for Medicaid benefitsY [or] for use in determining rights to a Medicaid benefit.
>
> It further provides that:
>
> A person, having knowledge of the occurrence of an event affecting Y[the] initial or continued right of any other person on whose behalf he has appliedYshall not conceal or fail to disclose that event with intent to obtain a benefit to which the person or any other person is not entitled or in an amount greater than that to which the person or any other person is entitled.
>
> Under § 400.612,
>
> A person who receives a benefit which the person is not entitled to receive by reason of fraud or making a fraudulent statement or knowingly concealing a material fact shall forfeit and pay to the state a civil penalty equal to the full amount received plus triple the amount of damages suffered by the state as a result of the conduct by the person.

211. From at least 2004 to the present, Defendants knowingly submitted claims to the Michigan Medicaid program for reimbursement for hospice services that were not necessary and/or were not actually performed and did not meet the requirements set forth in 42 C.F.R. §§ 418.21, 418.22, 418.24, 418.54, 418.68, 418.70, 418.74, and 418.202-204. In order to ensure its fraudulent claims were paid by the Michigan Medicaid program, Defendants fraudulently altered patient charts and/or falsified entries on patient charts; forged physicians' signatures and/or pre dated and/or post dated certifications, recertifications and care plans; falsely documented that the patients consented to hospice treatment; falsely certified that services were performed when in fact they were not; and falsely represented that it maintained volunteers.

212. Each claim for reimbursement for such prescriptions represents a false or fraudulent claim for payment under the statute.

213. If the government of the state of Michigan had known that Defendants were fraudulently altering patient charts and /or falsifying entries on patient charts; forging physicians' signatures and/or pre dating and/or post dating certifications, recertifications and care plans, falsely documenting that the patients consented to hospice treatment, falsely certifying that services were performed when in fact they were not and falsely representing that it maintained volunteers to get false or fraudulent claims paid, it would not have paid the claims.

214. The state of Michigan has been damaged by the Defendants' wrongful conduct.

Count 16
Mich. Comp. Laws Ch. 400

215. Relators reallege the foregoing allegations.

216. The Michigan Medicaid False Claim Act, MCL § 400.607, provides :

> A person shall not make or present or cause to be made or presented to an employee or officer [of the state] a claim . . . upon or against the state, knowing the claim to be false . . . .
>
> A person shall not make or present or cause to be made or presented a claim . . . which he or she knows falsely represents that the goods or services for which the claim is made were medically necessary . . . .

Under § 400.612,

> A person who receives a benefit which the person is not entitled to receive by reason of fraud or making a fraudulent statement or knowingly concealing a material fact shall forfeit and pay to the state a civil penalty equal to the full amount received plus triple the amount of damages suffered by the state as a result of the conduct by the person.

217. From at least 2004 to the present, Defendants knowingly submitted claims to the Michigan Medicaid program for reimbursement for hospice services that were not necessary

and/or were not actually performed and did not meet the requirements set forth in 42 C.F.R. §§ 418.21, 418.22, 418.24, 418.54, 418.68, 418.70, 418.74, and 418.202-204. In order to ensure its fraudulent claims were paid, Defendants fraudulently altered patient charts and/or falsified entries on patient charts; forged physicians' signatures and/or pre dated and/or post dated certifications, recertifications and care plans, falsely documented that the patients consented to hospice treatment; falsely certified that services were performed when in fact they were not; and falsely represented that it maintained volunteers.

218. Each claim for reimbursement for hospice services as a result of Defendants' fraudulent practices for reimbursement for such hospice services that were not performed or that it falsely represented that it complied with the requirements set forth in 42 C.F.R. §§ 418.21, 418.22, 418.24, 418.54, 418.68, 418.70, 418.74, and 418.202-204 represent false or fraudulent records or statements under the statute that were used to get a false claim paid or approved.

219. If the government of Michigan had known that Defendants were fraudulently altering patient charts and /or falsifying entries on patient charts; forging physicians' signatures and/or pre dating and/or post dating certifications, recertifications and care plans, falsely documenting that the patients consented to hospice treatment, falsely certifying that services were performed when in fact they were not and falsely representing that it maintained volunteers to get false or fraudulent claims paid, it would not have paid the claims.

220. The state of Michigan has been damaged by Defendants' wrongful conduct.

Count 17
N.J. Rev. Stat. Ann. § 2A:32C-3(a)

221. Relators reallege the foregoing allegations.

222. The New Jersey False Claims Act, N.J. Rev. Stat. Ann. § 2a:32C-3, provides:

> A person shall be jointly and severally liable to the State for a civil penalty of not less than and not more than the civil penalty allowed under the federal False Claims Act (31 U.S.C.s.3729 et seq.), as may be adjusted in accordance with the inflation adjustment procedures prescribed in the Federal Civil Penalties Inflation Adjustment Act of 1990, Pub.L.101-410, for each false or fraudulent claim, plus three times the amount of damages which the State sustains, if the person commits any of the following acts:
>
> a. Knowingly presents or causes to be presented to an employee, officer or agent of the State, or to any contractor, grantee, or other recipient of State funds, a false or fraudulent claim for payment or approval.

223. From at least 2004 to the present, Defendants knowingly submitted claims to the New Jersey Medicaid program for reimbursement for hospice services that were not necessary and/or were not actually performed and did not meet the requirements set forth in 42 C.F.R. §§ 418.21, 418.22, 418.24, 418.54, 418.68, 418.70, 418.74, and 418.202-204. In order to ensure its fraudulent claims were paid by the New Jersey Medicaid program, Defendants fraudulently altered patient charts and/or falsified entries on patient charts; forged physicians' signatures and/or pre dated and/or post dated certifications, recertifications and care plans; falsely documented that the patients consented to hospice treatment; falsely certified that services were performed when in fact they were not; and falsely represented that it maintained volunteers.

224. Each claim for reimbursement for such prescriptions represents a false or fraudulent claim for payment under the statute.

225. If the government of the state of New Jersey had known that Defendants were fraudulently altering patient charts and /or falsifying entries on patient charts; forging physicians' signatures and/or pre dating and/or post dating certifications, recertifications and care plans, falsely documenting that the patients consented to hospice treatment, falsely certifying that services were performed when in fact they were not and falsely representing that it maintained volunteers to get false or fraudulent claims paid, it would not have paid the claims.

226. The state of New Jersey has been damaged by the Defendants' wrongful conduct.

Count 18
N.J. Rev. Stat. Ann. § 2A:32C-3(b)

227. Relators reallege the foregoing allegations.

228. The New Jersey False Claims Act, N.J. Rev. Stat. Ann. § 2a:32C-3, provides:

> A person shall be jointly and severally liable to the State for a civil penalty of not less than and not more than the civil penalty allowed under the federal False Claims Act (31 U.S.C.s.3729 et seq.), as may be adjusted in accordance with the inflation adjustment procedures prescribed in the Federal Civil Penalties Inflation Adjustment Act of 1990, Pub.L.101-410, for each false or fraudulent claim, plus three times the amount of damages which the State sustains, if the person commits any of the following acts:
>
> b. Knowingly makes, uses, or causes to be made or used a false record or statement to get a false or fraudulent claim paid or approved by the State.

229. From at least 2004 to the present, Defendants knowingly submitted claims to the New Jersey Medicaid program for reimbursement for hospice services that were not necessary and/or were not actually performed and did not meet the requirements set forth in 42 C.F.R. §§ 418.21, 418.22, 418.24, 418.54, 418.68, 418.70, 418.74, and 418.202-204. In order to ensure its fraudulent claims were paid, Defendants fraudulently altered patient charts and/or falsified entries on patient charts; forged physicians' signatures and/or pre dated and/or post dated certifications, recertifications and care plans, falsely documented that the patients consented to hospice treatment; falsely certified that services were performed when in fact they were not; and falsely represented that it maintained volunteers.

230. Each claim for reimbursement for hospice services as a result of Defendants' fraudulent practices for reimbursement for such hospice services that were not performed or that it falsely represented that it complied with the requirements set forth in 42 C.F.R. §§ 418.21,

418.22, 418.24, 418.54, 418.68, 418.70, 418.74, and 418.202-204 represent false or fraudulent records or statements under the statute that were used to get a false claim paid or approved.

231. If the government of New Jersey had known that Defendants were fraudulently altering patient charts and /or falsifying entries on patient charts; forging physicians' signatures and/or pre dating and/or post dating certifications, recertifications and care plans, falsely documenting that the patients consented to hospice treatment, falsely certifying that services were performed when in fact they were not and falsely representing that it maintained volunteers to get false or fraudulent claims paid, it would not have paid the claims.

232. The state of New Jersey has been damaged by Defendants' wrongful conduct.

Count 19
N.Y. St. Fin. Law § 189(1)(a)

233. Relators reallege the foregoing allegations.

234. The New York False Claims Act, N.Y. St. Fin. Law § 189(1)(a), provides that: any person who:

> knowingly presents, or causes to be presented, to any employee, officer or agent of the state or a local government, a false or fraudulent claim for payment or approval;
>
> shall be liable (I) to the state for a civil penalty of not less than six thousand dollars and not more than twelve thousand dollars, plus three times the amount of damages which the state sustains because of the act of that person;

235. From at least 2004 to the present, Defendants knowingly submitted claims to the New York Medicaid program for reimbursement for hospice services that were not necessary and/or were not actually performed and did not meet the requirements set forth in 42 C.F.R. §§ 418.21, 418.22, 418.24, 418.54, 418.68, 418.70, 418.74, and 418.202-204. In order to ensure its fraudulent claims were paid by the New York Medicaid program, Defendants fraudulently

altered patient charts and/or falsified entries on patient charts; forged physicians' signatures and/or pre dated and/or post dated certifications, recertifications and care plans; falsely documented that the patients consented to hospice treatment; falsely certified that services were performed when in fact they were not; and falsely represented that it maintained volunteers.

236. Each claim for reimbursement for such prescriptions represents a false or fraudulent claim for payment under the statute.

237. If the government of the state of New York had known that Defendants were fraudulently altering patient charts and /or falsifying entries on patient charts; forging physicians' signatures and/or pre dating and/or post dating certifications, recertifications and care plans, falsely documenting that the patients consented to hospice treatment, falsely certifying that services were performed when in fact they were not and falsely representing that it maintained volunteers to get false or fraudulent claims paid, it would not have paid the claims.

238. The state of New York has been damaged by the Defendants' wrongful conduct.

Count 20
N.Y. St. Fin. Law § 189(1)(b)

239. Relators reallege the foregoing allegations.

240. The New York False Claims Act, N.Y. St. Fin. Law § 189(1)(b) provides, with exceptions not pertinent to this complaint, that:

> any person who:
>
> (b) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the state or a local government;
>
> shall be liable: (I) to the state for a civil penalty of not less than six thousand dollars and not more than twelve thousand dollars, plus three times the amount of damages which the state sustains because of the act of that person;

241. From at least 2004 to the present, Defendants knowingly submitted claims to the New York Medicaid program for reimbursement for hospice services that were not necessary and/or were not actually performed and did not meet the requirements set forth in 42 C.F.R. §§ 418.21, 418.22, 418.24, 418.54, 418.68, 418.70, 418.74, and 418.202-204. In order to ensure its fraudulent claims were paid, Defendants fraudulently altered patient charts and/or falsified entries on patient charts; forged physicians' signatures and/or pre dated and/or post dated certifications, recertifications and care plans, falsely documented that the patients consented to hospice treatment; falsely certified that services were performed when in fact they were not; and falsely represented that it maintained volunteers.

242. Each claim for reimbursement for hospice services as a result of Defendants' fraudulent practices for reimbursement for such hospice services that were not performed or that it falsely represented that it complied with the requirements set forth in 42 C.F.R. §§ 418.21, 418.22, 418.24, 418.54, 418.68, 418.70, 418.74, and 418.202-204 represent false or fraudulent records or statements under the statute that were used to get a false claim paid or approved.

243. If the government of New York had known that Defendants were fraudulently altering patient charts and /or falsifying entries on patient charts; forging physicians' signatures and/or pre dating and/or post dating certifications, recertifications and care plans, falsely documenting that the patients consented to hospice treatment, falsely certifying that services were performed when in fact they were not and falsely representing that it maintained volunteers to get false or fraudulent claims paid, it would not have paid the claims.

244. The state of New York been damaged by Defendants' wrongful conduct.

Count 21
Tex. Hum. Res. Code § 36.002(1)-(2)

245. Relators reallege the foregoing allegations.

246. The Texas Medicaid Fraud Prevention Law, Tex. Hum. Res. Code § 36.001(1), provides that a person commits an unlawful act if the person:

> (1) knowingly or intentionally makes or causes to be made a false statement or misrepresentation of a material fact:
>
> on an application for a contract, benefit, or payment under the Medicaid program; or (B) that is intended to be used to determine a person's eligibility for a benefit or payment under the Medicaid program.

247. From at least 2004 to the present, Defendants knowingly submitted claims to the Texas Medicaid program for reimbursement for hospice services that were not necessary and/or were not actually performed and did not meet the requirements set forth in 42 C.F.R. §§ 418.21, 418.22, 418.24, 418.54, 418.68, 418.70, 418.74, and 418.202-204. In order to ensure its fraudulent claims were paid by the Texas Medicaid program, Defendants fraudulently altered patient charts and/or falsified entries on patient charts; forged physicians' signatures and/or pre dated and/or post dated certifications, recertifications and care plans; falsely documented that the patients consented to hospice treatment; falsely certified that services were performed when in fact they were not; and falsely represented that it maintained volunteers.

248. Each claim for reimbursement for such prescriptions represents a false or fraudulent claim for payment under the statute.

249. If the government of the state of Texas had known that Defendants were fraudulently altering patient charts and /or falsifying entries on patient charts; forging physicians' signatures and/or pre dating and/or post dating certifications, recertifications and care plans, falsely documenting that the patients consented to hospice treatment, falsely certifying that

services were performed when in fact they were not and falsely representing that it maintained volunteers to get false or fraudulent claims paid, it would not have paid the claims.

250. The state of Texas has been damaged by the Defendants' wrongful conduct.

Count 22
Tex. Hum. Res. Code § 36.002(4)(B)

251. Relators reallege the foregoing allegations.

252. The Texas Medicaid Fraud Prevention Law, Tex. Hum. Res. Code § 36.002(4)(B), provides that a person commits an unlawful act if the person:

> (4) knowingly or intentionally makes, causes to be made, induces, or seeks to induce the making of a false statement or misrepresentation of material fact concerning:
>
> ...(B) Information required to be provided by a federal or state law, rule, regulation, or provider agreement pertaining to the Medicaid program;

253. From at least 2004 to the present, Defendants knowingly submitted claims to the Texas Medicaid program for reimbursement for hospice services that were not necessary and/or were not actually performed and did not meet the requirements set forth in 42 C.F.R. §§ 418.21, 418.22, 418.24, 418.54, 418.68, 418.70, 418.74, and 418.202-204. In order to ensure its fraudulent claims were paid, Defendants fraudulently altered patient charts and/or falsified entries on patient charts; forged physicians' signatures and/or pre dated and/or post dated certifications, recertifications and care plans, falsely documented that the patients consented to hospice treatment; falsely certified that services were performed when in fact they were not; and falsely represented that it maintained volunteers.

254. Each claim for reimbursement for hospice services as a result of Defendants' fraudulent practices for reimbursement for such hospice services that were not performed or that it falsely represented that it complied with the requirements set forth in 42 C.F.R. §§ 418.21,

418.22, 418.24, 418.54, 418.68, 418.70, 418.74, and 418.202-204 represent false or fraudulent records or statements under the statute that were used to get a false claim paid or approved.

255. If the government of Texas had known that Defendants were fraudulently altering patient charts and /or falsifying entries on patient charts; forging physicians' signatures and/or pre dating and/or post dating certifications, recertifications and care plans, falsely documenting that the patients consented to hospice treatment, falsely certifying that services were performed when in fact they were not and falsely representing that it maintained volunteers to get false or fraudulent claims paid, it would not have paid the claims.

256. The state of Texas has been damaged by Defendants' wrongful conduct.

Count 23
Va. Code Ann. § 8.01-216.3(A)(1)

257. Relators reallege the foregoing allegations.

258. The Virginia Fraud Against Taxpayers Act, Va. Code Ann. § 8.01-216.3(A)(1), provides that any person who:

> Knowingly presents, or causes to be presented, to an officer or employee of the Commonwealth a false or fraudulent claim for payment or approval;. . .
>
> shall be liable to the Commonwealth for a civil penalty of not less than $5,000 and not more than $10,000, plus three times the amount of damages sustained by the Commonwealth.

259. From at least 2004 to the present, Defendants knowingly submitted claims to the Commonwealth of Virginia Medicaid program for reimbursement for hospice services that were not necessary and/or were not actually performed and did not meet the requirements set forth in 42 C.F.R. §§ 418.21, 418.22, 418.24, 418.54, 418.68, 418.70, 418.74, and 418.202-204. In order to ensure its fraudulent claims were paid by the Virginia Medicaid program, Defendants fraudulently altered patient charts and/or falsified entries on patient charts; forged physicians'

signatures and/or pre dated and/or post dated certifications, recertifications and care plans; falsely documented that the patients consented to hospice treatment; falsely certified that services were performed when in fact they were not; and falsely represented that it maintained volunteers.

260. Each claim for reimbursement for such prescriptions represents a false or fraudulent claim for payment under the statute.

261. If the government of the Commonwealth of Virginia had known that Defendants were fraudulently altering patient charts and /or falsifying entries on patient charts; forging physicians' signatures and/or pre dating and/or post dating certifications, recertifications and care plans, falsely documenting that the patients consented to hospice treatment, falsely certifying that services were performed when in fact they were not and falsely representing that it maintained volunteers to get false or fraudulent claims paid, it would not have paid the claims.

262. The Commonwealth of Virgin has been damaged by the Defendants' wrongful conduct.

Count 24
Va. Code Ann. § 8.01-216.3(A)(2)

263. Relators reallege the foregoing allegations.

264. The Virginia Fraud Against Taxpayers Act, Va. Code Ann. § 8.01-216.3(A)(2), provides that any person who:

> Knowingly makes, uses or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Commonwealth;
>
> . . .shall be liable to the Commonwealth for a civil penalty of not less than $5,000 and not more than $10,000, plus three times the amount of damages sustained by the Commonwealth.

265. From at least 2004 to the present, Defendants knowingly submitted claims to the Virginia Medicaid program for reimbursement for hospice services that were not necessary and/or were not actually performed and did not meet the requirements set forth in 42 C.F.R. §§ 418.21, 418.22, 418.24, 418.54, 418.68, 418.70, 418.74, and 418.202-204. In order to ensure its fraudulent claims were paid, Defendants fraudulently altered patient charts and/or falsified entries on patient charts; forged physicians' signatures and/or pre dated and/or post dated certifications, recertifications and care plans, falsely documented that the patients consented to hospice treatment; falsely certified that services were performed when in fact they were not; and falsely represented that it maintained volunteers.

266. Each claim for reimbursement for hospice services as a result of Defendants' fraudulent practices for reimbursement for such hospice services that were not performed or that it falsely represented that it complied with the requirements set forth in 42 C.F.R. §§ 418.21, 418.22, 418.24, 418.54, 418.68, 418.70, 418.74, and 418.202-204 represent false or fraudulent records or statements under the statute that were used to get a false claim paid or approved.

267. If the government of the Commonwealth of Virginia had known that Defendants were fraudulently altering patient charts and /or falsifying entries on patient charts; forging physicians' signatures and/or pre dating and/or post dating certifications, recertifications and care plans, falsely documenting that the patients consented to hospice treatment, falsely certifying that services were performed when in fact they were not and falsely representing that it maintained volunteers to get false or fraudulent claims paid, it would not have paid the claims.

268. The Commonwealth of Virginia has been damaged by Defendants' wrongful conduct.

Count 25
Wisconsin False Claims for Medical Assistance Law, Wis. Stat. § 20.931(2)(a)

269. Relators reallege the foregoing allegations.

270. The Wisconsin False Claims for Medical Assistance Law, Wis. Stat. § 20.931(2)(a) provides in pertinent part:

> ...any person who does any of the following is liable to this state for 3 times the amount of the damages sustained by this state because of the actions of the person, and shall forfeit not less than $5,000 nor more than $10,000 for each violation:
>
> (a) Knowingly presents or causes to be presented to any officer, employee, or agent of this state a false claim for medical assistance.
>
> (b) Knowingly makes, uses, or causes to be made or used a false record or statement to obtain approval or payment of a false claim for medical assistance.

271. From at least 2004 to the present, Defendants knowingly submitted claims to the Wisconsin Medicaid program for reimbursement for hospice services that were not necessary and/or were not actually performed and did not meet the requirements set forth in 42 C.F.R. §§ 418.21, 418.22, 418.24, 418.54, 418.68, 418.70, 418.74, and 418.202-204. In order to ensure its fraudulent claims were paid by the Wisconsin Medicaid program, Defendants fraudulently altered patient charts and/or falsified entries on patient charts; forged physicians' signatures and/or pre dated and/or post dated certifications, recertifications and care plans; falsely documented that the patients consented to hospice treatment; falsely certified that services were performed when in fact they were not; and falsely represented that it maintained volunteers.

272. Each claim for reimbursement for such prescriptions represents a false or fraudulent claim for payment under the statute.

273. If the government of the state of Wisconsin had known that Defendants were fraudulently altering patient charts and /or falsifying entries on patient charts; forging physicians' signatures and/or pre dating and/or post dating certifications, recertifications and care plans, falsely documenting that the patients consented to hospice treatment, falsely certifying that services were performed when in fact they were not and falsely representing that it maintained volunteers to get false or fraudulent claims paid, it would not have paid the claims.

274. The state of Wisconsin has been damaged by the Defendants' wrongful conduct.

Count 26
Wisconsin False Claims for Medical Assistance Law, Wis. Stat. § 20.931(2)(b)

275. Relators reallege the foregoing allegations.

276. The Wisconsin False Claims for Medical Assistance Law, Wis. Stat. § 20.931(2)(b) provides in pertinent part:

> . ..any person who does any of the following is liable to this state for 3 times the amount of the damages sustained by this state because of the actions of the person, and shall forfeit not less than $5,000 nor more than $10,000 for each violation:
>
> (b) Knowingly makes, uses, or causes to be made or used a false record or statement to obtain approval or payment of a false claim for medical assistance.

277. From at least 2004 to the present, Defendants knowingly submitted claims to the Wisconsin Medicaid program for reimbursement for hospice services that were not necessary and/or were not actually performed and did not meet the requirements set forth in 42 C.F.R. §§ 418.21, 418.22, 418.24, 418.54, 418.68, 418.70, 418.74, and 418.202-204. In order to ensure its fraudulent claims were paid, Defendants fraudulently altered patient charts and/or falsified

entries on patient charts; forged physicians' signatures and/or pre dated and/or post dated certifications, recertifications and care plans, falsely documented that the patients consented to hospice treatment; falsely certified that services were performed when in fact they were not; and falsely represented that it maintained volunteers.

278. Each claim for reimbursement for hospice services as a result of Defendants' fraudulent practices for reimbursement for such hospice services that were not performed or that it falsely represented that it complied with the requirements set forth in 42 C.F.R. §§ 418.21, 418.22, 418.24, 418.54, 418.68, 418.70, 418.74, and 418.202-204 represent false or fraudulent records or statements under the statute that were used to get a false claim paid or approved.

279. If the government of the state of Wisconsin had known that Defendants were fraudulently altering patient charts and /or falsifying entries on patient charts; forging physicians' signatures and/or pre dating and/or post dating certifications, recertifications and care plans, falsely documenting that the patients consented to hospice treatment, falsely certifying that services were performed when in fact they were not and falsely representing that it maintained volunteers to get false or fraudulent claims paid, it would not have paid the claims.

280. The state of Wisconsin has been damaged by Defendants' wrongful conduct.

Count 27
Louisiana False Claims Act

281. Relators reallege the foregoing allegations.

282. Louisiana's Medical Assistance Programs Integrity Law, La. R.S. 46:438.3, provides, in part::

> A. No person shall knowingly present or cause to be presented a false or fraudulent claim.

> B. No person shall knowingly engage in misrepresentation or make, use, or cause to be made or used, a false record or statement to obtain payment for a false or fraudulent claim from the medical assistance programs' funds.
>
> C. No person shall knowingly make, use, or cause to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the medical assistance programs.
>
> D. No person shall conspire to defraud, or attempt to defraud, the medical assistance programs through misrepresentation or by obtaining, or attempting to obtain, payment for a false or fraudulent claim.
>
> E. (1) No person shall knowingly submit a claim for goods, services, or supplies which were medically unnecessary or which were of substandard quality or quantity.
>
> (2) If a managed care health care provider or a health care provider operating under a voucher system under the medical assistance programs fails to provide medically necessary goods, services, or supplies or goods, services, or supplies which are of substandard quality or quantity to a recipient, and those goods, services, or supplies are covered under the managed care contract or voucher contract with the medical assistance programs, such failure shall constitute a violation of Paragraph (1) of this Subsection.
>
> (3) "Substandard quality" in reference to services applicable to medical care as used in this Subsection shall mean substandard as to the appropriate standard of care as used to determine medical malpractice, including but not limited to the standard of care provided in R.S. 9:2794.].

283. From at least 2004 to the present, Defendants knowingly submitted claims to the Louisiana Medicaid program for reimbursement for hospice services that were not necessary and/or were not actually performed and did not meet the requirements set forth in 42 C.F.R. §§ 418.21, 418.22, 418.24, 418.54, 418.68, 418.70, 418.74, and 418.202-204. In order to ensure its fraudulent claims were paid, Defendants fraudulently altered patient charts and/or falsified entries on patient charts; forged physicians' signatures and/or pre dated and/or post dated certifications, recertifications and care plans, falsely documented that the patients consented to

hospice treatment; falsely certified that services were performed when in fact they were not; and falsely represented that it maintained volunteers.

284. Each claim for reimbursement for hospice services as a result of Defendants' fraudulent practices for reimbursement for such hospice services that were not performed or that it falsely represented that it complied with the requirements set forth in 42 C.F.R. §§ 418.21, 418.22, 418.24, 418.54, 418.68, 418.70, 418.74, and 418.202-204 represent false or fraudulent records or statements under the statute that were used to get a false claim paid or approved.

285. If the government of the state of Louisiana had known that Defendants were fraudulently altering patient charts and /or falsifying entries on patient charts; forging physicians' signatures and/or pre dating and/or post dating certifications, recertifications and care plans, falsely documenting that the patients consented to hospice treatment, falsely certifying that services were performed when in fact they were not and falsely representing that it maintained volunteers to get false or fraudulent claims paid, it would not have paid the claims.

286. The state of Louisiana has been damaged by Defendants' wrongful conduct.

Count 28
Minnesota False Claims Act

287. Relators reallege the foregoing allegations.

288. Minnesota's FALSE CLAIMS ACT, Minn. Stat. § 15C.01 et seq., provides, in part:

> 15C.02 LIABILITY FOR CERTAIN ACTS.
> (a) A person who commits any act described in clauses (1) to (7) is liable to the state or the political subdivision for a civil penalty of not less than $5,500 and not more than $11,000 per false or fraudulent claim, plus three times the amount of damages that the state or the political subdivision sustains because of the act of that person...:

> (1) knowingly presents, or causes to be presented, to an officer or employee of the state or a political subdivision a false or fraudulent claim for payment or approval;
> (2) knowingly makes or uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the state or a political subdivision;
> (3) knowingly conspires to either present a false or fraudulent claim to the state or a political subdivision for payment or approval or makes, uses, or causes to be made or used a false record or statement to obtain payment or approval of a false or fraudulent claim;...or
> (7) knowingly makes or uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the state or a political subdivision.

289. From at least 2004 to the present, Defendants knowingly submitted claims to the Minnesota Medicaid program for reimbursement for hospice services that were not necessary and/or were not actually performed and did not meet the requirements set forth in 42 C.F.R. §§ 418.21, 418.22, 418.24, 418.54, 418.68, 418.70, 418.74, and 418.202-204. In order to ensure its fraudulent claims were paid, Defendants fraudulently altered patient charts and/or falsified entries on patient charts; forged physicians' signatures and/or pre dated and/or post dated certifications, recertifications and care plans, falsely documented that the patients consented to hospice treatment; falsely certified that services were performed when in fact they were not; and falsely represented that it maintained volunteers.

290. Each claim for reimbursement for hospice services as a result of Defendants' fraudulent practices for reimbursement for such hospice services that were not performed or that it falsely represented that it complied with the requirements set forth in 42 C.F.R. §§ 418.21, 418.22, 418.24, 418.54, 418.68, 418.70, 418.74, and 418.202-204 represent false or fraudulent records or statements under the statute that were used to get a false claim paid or approved

291. If the government of the state of Minnesota had known that Defendants were fraudulently altering patient charts and /or falsifying entries on patient charts; forging physicians'

signatures and/or pre dating and/or post dating certifications, recertifications and care plans, falsely documenting that the patients consented to hospice treatment, falsely certifying that services were performed when in fact they were not and falsely representing that it maintained volunteers to get false or fraudulent claims paid, it would not have paid the claims.

292. The state of Minnesota has been damaged by Defendants' wrongful conduct.

Count 29
New Hampshire False Claims Act

293. Relators reallege the foregoing allegations.

294. New Hampshire's False Claims Against the Department Act, 167:61-b, provides:

> Any person shall be liable to the state for a civil penalty of not less than $5,000 and not more than $10,000, plus 3 times the amount of damages that the state sustains because of the act of that person, who:
> (a) Knowingly presents, or causes to be presented, to an officer or employee of the department, a false or fraudulent claim for payment or approval.
> (b) Knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the department.
> (c) Conspires to defraud the department by getting a false or fraudulent claim allowed or paid.
> (d) Has possession, custody, or control of property or money used, or to be used, by the department and, intending to defraud the department or willfully to conceal the property, delivers, or causes to be delivered, less property than the amount for which the person receives a certificate or receipt.
> (e) Knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the department.
> (f) Is a beneficiary of an inadvertent submission of a false claim to the department, who subsequently discovers the falsity of the claim, and fails to disclose the false claim to the department within a reasonable time after discovery of the false claim.

295. From at least 2004 to the present, Defendants knowingly submitted claims to the New Hampshire Medicaid program for reimbursement for hospice services that were not

necessary and/or were not actually performed and did not meet the requirements set forth in 42 C.F.R. §§ 418.21, 418.22, 418.24, 418.54, 418.68, 418.70, 418.74, and 418.202-204. In order to ensure its fraudulent claims were paid, Defendants fraudulently altered patient charts and/or falsified entries on patient charts; forged physicians' signatures and/or pre dated and/or post dated certifications, recertifications and care plans, falsely documented that the patients consented to hospice treatment; falsely certified that services were performed when in fact they were not; and falsely represented that it maintained volunteers.

296. Each claim for reimbursement for hospice services as a result of Defendants' fraudulent practices for reimbursement for such hospice services that were not performed or that it falsely represented that it complied with the requirements set forth in 42 C.F.R. §§ 418.21, 418.22, 418.24, 418.54, 418.68, 418.70, 418.74, and 418.202-204 represent false or fraudulent records or statements under the statute that were used to get a false claim paid or approved

297. If the government of the state of New Hampshire had known that Defendants were fraudulently altering patient charts and /or falsifying entries on patient charts; forging physicians' signatures and/or pre dating and/or post dating certifications, recertifications and care plans, falsely documenting that the patients consented to hospice treatment, falsely certifying that services were performed when in fact they were not and falsely representing that it maintained volunteers to get false or fraudulent claims paid, it would not have paid the claims.

298. The state of New Hampshire has been damaged by Defendants' wrongful conduct.

Count 30
CHAMPUS/TRICARE Federal False Claims Act Violations

299. Relators reallege the foregoing allegations.

300. From at least as early as in or about 2004 until on or about May 19, 2009, Defendants: (a) knowingly presented, and caused to be presented to an officer and employee of the CHAMPUS/TRICARE Program false and fraudulent claims for payment and approval; (b) knowingly made, used, and caused to be made and used, false records and statements to get false and fraudulent claims paid and approved by the CHAMPUS/TRICARE Program; (c) conspired to defraud the CHAMPUS/TRICARE Program by getting false and fraudulent claims allowed or paid, and (d) knowingly made, used, and caused to be made and used, a false record or statement to conceal, avoid, and decrease an obligation to pay or transmit money or property to the CHAMPUS/TRICARE Program, in violation of 31 U.S.C. §§ 3729(a)(1), (2), (3) and (7) of the False Claims Act (prior to its amendment on May 20, 2009). And,

301. From on or about May 20, 2009 until the filing of this Complaint, in connection with the CHAMPUS/TRICARE Program Defendants: (a) knowingly presented, or caused to be presented, a false and fraudulent claim for payment or approval; (b) knowingly made, used, and caused to be made and used, a false record or statement material to a false or fraudulent claim; (c) conspired to commit a violation of subparagraphs (A), (B),…and (G) of § 3729(a)(1); and (d) knowingly made, used, and caused to be made and used, a false record or statement material to an obligation to pay and transmit money and property to the CHAMPUS/TRICARE Program, and knowingly concealed and knowingly and improperly avoided and decreased an obligation to pay and transmit money and property to the CHAMPUS/TRICARE Program, in violation of 31 U.S.C. §§ 3729(a)(1)(A), (B), (C) and (G) of the False Claims Act (as amended on May 20, 2009).

302. If the government of the United States had known that Defendants were fraudulently altering patient charts and /or falsifying entries on patient charts; forging physicians'

signatures and/or pre dating and/or post dating certifications, recertifications and care plans, falsely documenting that the patients consented to hospice treatment, falsely certifying that services were performed when in fact they were not, and falsely representing that it maintained volunteers to get false or fraudulent claims paid, and the other unlawful conduct alleged herein, it would not have paid the claims.

303. The United States has been damaged by the Defendants' wrongful conduct.

Count 31
Relator Mary Roe's Retaliation Claim Against Defendant CCH

304. Relator Mary Roe realleges the foregoing allegations.

305. On or about July 20, 2009, Defendant CCH terminated Relator Mary Roe's employment after she voiced objection to her supervisor to being asked to falsify required hospice records, in violation of the anti-retaliation provisions in the Federal FCA, 31 U.S.C. § 3730(h) and New Jersey FCA, N.J. Stat. § 2A:32C-10, as well as New Jersey's CEPA, N.J. Stat. § 34:19-3.

306. Relator Mary Roe has been damaged by Defendant CCH's unlawful conduct.

Count 32
Relator Jane Doe's Retaliation Claim Against Defendant CCH

307. Relator Jane Doe realleges the foregoing allegations.

308. On or about November 16, 2010, Defendant CCH constructively terminated Relator Jane Doe's employment after a prolonged period of work place harassment, which harassment was in retaliation for Jane Doe having pointed out CCH's fraudulent Medicare billing practices to its supervisors and others and for Jane Doe having overtly refused to assist in such practices, in violation of the anti-retaliation provisions in the Federal FCA, 31 U.S.C. §

3730(h) and New Jersey FCA, N.J. Stat. § 2A:32C-10, as well as New Jersey's CEPA, N.J. Stat. § 34:19-3.

RELIEF DEMANDED

WHEREFORE, Relators, acting on behalf of and in the name of the United States of America and the State plaintiffs, and on their own behalf, demand judgment as follows against the Defendants as follows:

A. For the United States against Defendants for treble the amount of damages to Government Health Care Programs, including, but not limited to, Medicare, Medicaid and CHAMPUS/TRICARE, from the fraudulent schemes alleged above, plus maximum civil penalties of Eleven Thousand Dollars ($11,000.00) for each false claim;

B. For the United States against Defendants for disgorgement of the profits earned a result of its illegal conduct;

C. For Relators for the maximum relator's share amount allowed pursuant to 31 U.S.C. § 3730(d), as well as, reasonable expenses, attorney fees and costs incurred by Relators;

D. For all costs of the federal FCA civil action;

E. For Relators and the United States for such other and further relief as the court deems appropriate;

F. For Relators and the state Plaintiffs against Defendants jointly and severally in an amount equal to three times the amount of damages that Delaware, Florida, Georgia, Indiana, Illinois, Louisiana, Massachusetts, Minnesota, New Hampshire, New Jersey, New York, Virginia, and Wisconsin have sustained, respectively, as a result of Defendants' actions, as well as the applicable statutory maximum civil penalty against Defendants for each violation of each state's FCA;

G. For Relators and the state of Texas against Defendants in an amount equal to two times the amount of damages that Texas has sustained as a result of Defendants' actions, as well as a civil penalty against the Defendants of a statutory maximum for each violation of Tex. Hum. Res. Code § 36.002;H. For Relators and the state of Michigan against Defendants for a civil penalty equal to one time the loss caused to the Michigan Medicaid program as a result of the Defendants' actions, plus damages equal to three times such loss;

I. For Relators for the maximum amount allowed as a Relators' share pursuant to the state FCAs as follows:

(1) Del. Code Ann. Tit. 6, § 1205
(2) Fla. Stat. § 68.085
(3) Ga. Code Ann. § 49-4-168.2(i)
(4) 740 Ill. Comp. Stat. § 175/4(d); IC 5-11-5.5
(5) Mass. Gen. Laws Ch. 12, § 5F
(6) Mich. Comp. L. Ch. 400
(7) N.J. Rev. Stat. S.A. § 2A:32C-7(a) and (d)
(8) N.Y. St. Fin. Law § 190(6)
(9) Tex. Hum. Res. Code § 36.110
(10) Va. Code Ann. § 8.01-216.7
(11) Wis. Stat. § 20.931(11)
(12) La. R.S. 46:439.1, et seq.
(13) Minn. Stat. § 15C.01, et seq.
(14) N.H. 167:61-b, et seq.

J. For Relators for all costs and expenses associated with the supplemental state claims, including attorneys' fees and costs;

K. For the State plaintiffs and Relators for all such other relief as the court deems appropriate.

L For Relator Mary Roe, all direct, indirect and consequential damages, as well as attorneys' fees and costs permitted by the Federal FCA, 31 U.S.C. § 3730(h), N J FCA, N.J. Stat. § 2A:32C-10, New Jersey's CEPA, N.J. Stat. § 34:19-3, including, but not limited to, two times

lost compensation and benefits. And,

M For Relator Jane Doe, all direct, indirect and consequential damages, as well as attorneys' fees and costs permitted by the Federal FCA, 31 U.S.C. § 3730(h), N J FCA, N.J. Stat. § 2A:32C-10, New Jersey's CEPA, N.J. Stat. § 34:19-3, including, but not limited to, two times lost compensation and benefits.

DEMAND FOR JURY TRIAL

Pursuant to Fed.R.Civ.P. 38, Relators hereby demand trial by jury.

Dated: River Edge, New Jersey
December 14, 2015

Respectfully submitted,

BRICKFIELD & DONAHUE

/s/ Paul B. Brickfield

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