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SAM-2692

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

**UNITED STATES OF AMERICA,**  
*ex rel.*, **ANTHONY KITE,**

*Plaintiff,*

v.

**Warren Hospital,**  
*et al.*, **[UNDER SEAL]**

*Defendants.*

Hon. Faith S. Hochberg

*Civil Action No. 05-3066 (FSH)*

**FILED EX PARTE**  
**AND UNDER SEAL**

**ORDER**

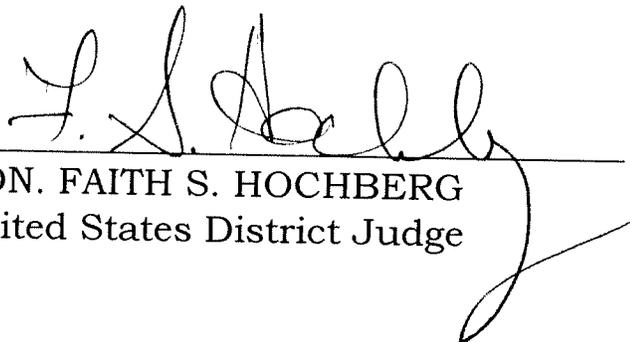
AND NOW, this 6<sup>th</sup> day of Dec. 2007, upon consideration of the United States' ex parte application to disclose the allegations in the relator's qui tam complaint that pertain to Warren Hospital ("Warren"), IT IS HEREBY ORDERED that the ex parte

application of the United States is GRANTED and that the United States is granted permission to disclose publicly the allegations in the relator's Complaint which pertain to Warren. The United States' disclosure may also include any specific allegations whose disclosure has been permitted by previous Orders of this Court. NO OTHER ALLEGATIONS SET FORTH IN THE RELATORS' COMPLAINT MAY BE DISCLOSED PUBLICLY PURSUANT TO THIS ORDER.

IT IS FURTHER ORDERED that the United States' Notice of Settlement And Application to Partially Lift Seal (to which is attached both the redacted Complaint, annexed thereto as Exhibit A, and the Settlement Agreement, annexed thereto as Exhibit B); and this Order may also be publicly disclosed. All other contents of the Court's file in this matter (including, but not limited to the unredacted complaint, any motions filed by the United States for an extension of the investigative period, any motions for partial lifting of the seal, or any orders previously entered in this matter) not previously unsealed

by prior Order of this Court SHALL REMAIN UNDER SEAL and not be made public or served upon Warren or any other defendant.

IT IS SO ORDERED.



A handwritten signature in black ink, appearing to read "F. S. Hochberg", is written over a horizontal line. The signature is fluid and cursive, with a long, sweeping tail that extends downwards and to the right.

HON. FAITH S. HOCHBERG  
United States District Judge

**CHRISTOPHER J. CHRISTIE**

United States Attorney

**STUART A. MINKOWITZ**

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**Warren Hospital,** )  
***et al.*, [UNDER SEAL]** )

*Defendants.* )

) Hon. Faith S. Hochberg

) *Civil Action No. 05-3066 (FSH)*

) NOTICE OF SETTLEMENT

) AND APPLICATION TO

) PARTIALLY LIFT SEAL

) **FILED EX PARTE**

) **AND UNDER SEAL**

**NOTICE OF SETTLEMENT AND  
MOTION TO PARTIALLY LIFT SEAL**

PLEASE BE ADVISED that the United States has settled allegations in another qui tam case that preceded, and are similar to, relator Kite's allegations against defendant Warren Hospital ("Warren"). That settlement agreement is attached hereto as Exhibit 1. Pursuant to that settlement agreement, relator Kite has agreed to

dismiss his allegations against Warren within a 30 day period after December 5, 2007, the date when the Settlement Agreement was executed.

At this time, the United States requests that the court unseal (a) the Settlement Agreement, which is attached hereto as Exhibit 1, (b) a redacted version of relator Kite's Complaint, which is attached hereto as Exhibit 2, and which redacts all of the relator's allegations that do not pertain to Warren or other defendants as to whom disclosure has been permitted by earlier Order of this Court. The United States makes this request so that the relator's allegations against Warren (but not the other defendants in this action), and the terms of the Settlement Agreement between the United States, Warren, and the relators in the qui tam cases, can be made public. Relator Kite's counsel has orally agreed to the United States' request to partially lift the seal. All other contents of the Court's file in this matter (including, but not limited to the unredacted complaint, any motions filed by the United States for an extension of the investigative period, any motions for partial lifting of the seal, or any orders

previously entered in this matter) not previously unsealed by Order of this Court shall remain under seal and not be made public or served upon Warren or any other defendant.

A form of Order is submitted herewith.

Respectfully submitted,

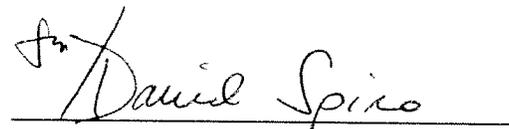
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District of New Jersey

By:

  
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Washington, D.C. 20044  
Telephone: (202) 616-3898

Dated: 12/5, 2007

## SETTLEMENT AGREEMENT

### I. PARTIES

This Settlement Agreement (“Agreement”) is entered into between the following (hereinafter “the Parties”) through their authorized representatives: the United States of America, acting through the United States Department of Justice and on behalf of the Office of Inspector General (“OIG-HHS”) of the Department of Health and Human Services (“HHS”), and the TRICARE Management Activity (“TMA”), through its General Counsel (collectively, “the United States”); Warren Hospital, on behalf of its predecessors, and current and former parent corporations, affiliates, divisions, and subsidiaries<sup>1</sup> (“Warren”); and Relators Peter Salvatori and Sara Iveson (hereafter the “Salvatori Relators”), and Relator Anthony Kite.

### II. PREAMBLE

As a preamble to this Agreement, the Parties agree to the following:

A. Warren Hospital is a 501(c)(3) non-profit community hospital headquartered in Phillipsburg, New Jersey. Warren Hospital, through its current and former parent corporations and/or affiliates, operates or has operated as a hospital facility during some or all of the period between January 1, 1999, and the present.

B. The Salvatori Relators are individual residents of the Commonwealth of Pennsylvania. Relator Anthony Kite is an individual resident of the State of New Jersey. On November 4, 2002, the Salvatori Relators filed a qui tam action that is pending against Warren

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<sup>1</sup> For purposes of this Agreement, Warren Hospital’s parent corporations, affiliates, divisions and subsidiaries shall include the following entities: Warren Hospital, Warren Hospital Health Services Corporation, Warren Healthcare Alliance, PC, Warren PA Professional Alliance, Inc., Hillcrest Emergency Services, PC, Warren Hospital Foundation, Inc., Two Rivers Enterprises, Inc., WH Memorial Parkway Investors, LLC, WH Forks Property Investors, LLC, WH Forks Property Investors Two, LLC, and Hillcrest Management Services Organization, Inc.

and that is captioned: U.S. ex rel. Salvatori and Iveson v. [Under Seal], Case No. 02-8309 (E.D. Pa.) (the "Salvatori Action"). On June 15, 2005, relator Kite filed a qui tam action that is pending against Warren and that is captioned: U.S. ex rel. Kite v. [Under Seal], Case No. 05:CV3066 (D.N.J.). The Kite complaint has been amended once. The Salvatori and Kite actions are collectively referred to below as the "Civil Actions." These actions allege that Warren excessively billed for "outlier" payments, as further described in Paragraph D, below.

C. Warren submitted or caused to be submitted claims for payment to the Medicare Program ("Medicare"), Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395-1395hhh; and the TRICARE Program ("TRICARE"), 10 U.S.C. §§ 1071-1109 (collectively the "Government Health Care Programs").

D. The United States alleges that it has certain civil claims against Warren, as specified in Paragraphs 5, 7, and 8 below, under the False Claims Act, 31 U.S.C. §§ 3729-3733, other federal statutes, and/or common law doctrines, for engaging in the following conduct: (1) from January 1, 1999 through August 7, 2003, Warren Hospital allegedly submitted or caused to be submitted false claims to the Government Health Care Programs for inpatient and outpatient outlier payments by increasing their charges for inpatient and outpatient care such that, when adjusted to costs pursuant to the outlier statute and regulations, these charges no longer reasonably reflected or approximated Warren's actual costs; and (2) from November 1, 2001 through July 1, 2007, Warren Hospital allegedly submitted or caused to be submitted claims to Government Health Care Programs for items and services that were ordered by physicians with whom Warren had a employment relationship, and these claims were false because they were prohibited by Section 1877 of the Social Security Act ("SSA"), 42 U.S.C. § 1395nn (also known as the Stark Statute), and Warren was required to and did certify on cost reports submitted to a

fiscal intermediary for the applicable fiscal years that the items and services identified or summarized in each cost report were not provided or procured in violation of federal referral laws (e.g., the Stark Statute). Hereinafter, the conduct described in this paragraph is collectively referred to as the "Covered Conduct."

E. The United States also contends that it has certain administrative claims against Warren for the Covered Conduct.

F. The Relators contend that they have a claim against the United States under 31 U.S.C. §3730(d) to receive a portion of the Settlement Amount, described in Paragraph 1 below. The Relators have also asserted claims against Warren for payment of reasonable attorney's fees and costs.

G. The United States neither confirms nor denies that Peter Salvatori, Sara Iveson, and/or Anthony Kite are proper relators or that they are entitled to receive a portion of the Settlement Amount under 31 U.S.C. §3730(d).

H. Warren denies the contentions of the United States set out in Paragraphs D and E and the contentions of the Relators in the Civil Actions with respect to Warren. This Agreement is neither an admission of liability by Warren, nor a concession by the United States that its claims are not well founded.

I. To avoid the delay, uncertainty, inconvenience, and expense of protracted litigation of these claims, the Parties reach a full and final settlement as set forth in this Agreement.

### III. TERMS AND CONDITIONS

NOW, THEREFORE, in consideration of the mutual promises, covenants, and obligations set forth below, and for good and valuable consideration as stated herein, the Parties agree as follows:

1. Warren agrees to make payments to the United States that total seven million, five hundred thousand dollars (\$7,500,000), inclusive of interest (the "Settlement Amount"). Warren shall pay the Settlement Amount to the United States pursuant to the schedule set forth in Exhibit A below, which is incorporated into this Agreement by reference. The first payment of the Settlement Amount (i.e., \$260,000) shall be due within ten days of the Effective Date of this Agreement, as that term is defined in Paragraph 32 below. The second payment shall be due three months from the Effective Date of this Agreement, and subsequent payments shall be due at intervals of every three months thereafter. If any of these dates falls on a non-business day, payment shall be due on the first business day thereafter.

All payments of the Settlement Amount shall be made by electronic funds transfer pursuant to written instructions to be provided by Susan Steele, Civil Chief, Office of the United States Attorney for the District of New Jersey, or her successor or designee. Notwithstanding any provision of this Agreement, including the above provision that the Settlement Amount is inclusive of interest, to the extent that the first payment of the Settlement Amount (i.e., \$260,000) is not due under the Agreement by September 15, 2007, interest shall accrue on the entire Settlement Amount at a simple rate of 4.75% per annum from September 15, 2007 until such time as the initial payment is made. This interest, accruing on the entire settlement amount from September 16, 2007 through the date of the first payment, shall be made concurrently with the first payment.

2. Warren further agrees to pay the Salvatori Relators' counsel the sum of thirty thousand dollars (\$30,000) for reasonable attorneys' fees and costs under 31 U.S.C. § 3730(d), which shall be made payable to Vaira & Riley, P.C. This amount shall be paid to the Relators' attorney within ten (10) business days of the Effective Date of this Agreement.

3. The United States agrees that, pursuant to 31 U.S.C. § 3730(d)(1), it shall pay to the Salvatori Relators, through their legal counsel, sixteen (16) percent of the Settlement Amount actually recovered under this Agreement. Payment to the Salvatori Relators is referred to herein as the "Relators' share." The United States agrees that, as soon as feasible after receipt of payment of any portion of the Settlement Amount, the United States will pay to the Salvatori Relators an amount equal to 16 percent of each such payment. All payments of the Relators' share under this Agreement shall be made by electronic funds transfer to an escrow account in the name of the Salvatori Relators in accordance with the written instruction of those Relators' counsel.

4. If Warren fails to make any of the payments at the specified times described in Paragraph 1, above, or Exhibit A, below, then upon written notice to Warren of its default, Warren shall have ten (10) calendar days to cure the default. If the default is not cured within the ten-day period, the United States may elect any of the following non-exclusive options: (a) the remaining unpaid principal portion of the Settlement Amount shall become accelerated and immediately due and payable at a simple rate of 12.625% per annum from the date of default until the date of payment; (b) file an action for specific performance of the Agreement; (c) offset the remaining unpaid balance of the Settlement Amount (inclusive of interest) from any amounts due and owing to Warren and/or any of its facilities, by any department, agency, or agent of the United States; or (d) rescind this Agreement and file suit based on the Covered Conduct. Warren, its former parent corporations, its direct and indirect subsidiaries, divisions, affiliates, corporations, partnerships or other legal entities in which Warren has or had an ownership interest, and the successors and assigns of any of them, including those entities listed in footnote 1 of this Agreement (hereafter, the "Released Warren Entities"), agree not to contest any

collection action undertaken by the United States pursuant to this Paragraph, and to pay the United States all reasonable costs of collection and enforcement of this Agreement, including reasonable attorney's fees and expenses. In the event that the United States opts to rescind this Agreement following a default, the Released Warren Entities agree not to plead, argue, or otherwise raise any defenses under the theories of statute of limitations, laches, estoppel, or similar time-based theories, to any civil or administrative claims that (i) are filed by the United States within 120 calendar days of written notification to Warren that this Agreement has been rescinded, and (ii) relate to the Covered Conduct, except to the extent these defenses were available on November 4, 2002, the date the Salvatori case was originally filed.

5. Subject to the exceptions in Paragraph 10 below, in consideration of the obligations of Warren set forth in this Agreement, conditioned upon Warren's payment in full of the Settlement Amount, and subject to Paragraph 24 below (concerning bankruptcy proceedings commenced within 91 days of the Effective Date of this Agreement or any payment made under this Agreement), the United States (on behalf of itself, its officers, agents, agencies, and departments) hereby releases the Released Warren Entities from any civil or administrative monetary claim the United States has or may have under the False Claims Act, 31 U.S.C. §§ 3729-3733; the Civil Monetary Penalties Law, 42 U.S.C. § 1320a-7a; the civil monetary penalty provisions of the Stark Statute, 42 U.S.C. §§ 1395nn(g)(3) and (4); the Program Fraud Civil Remedies Act, 31 U.S.C. §§ 3801-3812; or the common law and/or equitable theories of recovery for payment by mistake, unjust enrichment, and fraud, for the Covered Conduct.

6. Within 30 days of the Effective Date of this Agreement, the United States will intervene in the Salvatori Action for the limited purpose of seeking dismissal with prejudice of the claims asserted against Warren Hospital in the Salvatori Action. The Salvatori Relators shall

stipulate to such a dismissal with prejudice. The stipulation of dismissal will be conditioned upon Warren's payment in full of the Settlement Amount and receipt of said amount by the United States, and shall specify, if necessary, that the court retains jurisdiction to resolve any ongoing issues regarding the Salvatori Relators' entitlement to a share of the Settlement Amount or to the payment of attorneys' fees. Within 30 days of the Effective Date of this Agreement, Relator Kite shall move to dismiss with prejudice the claims asserted against Warren Hospital in his Complaint, with the dismissal being subject to Warren's payment in full of the Settlement Amount.

7. In consideration of the obligations of Warren Hospital set forth in this Agreement and the Corporate Integrity Agreement ("CIA") entered into between OIG-HHS and Warren Hospital, conditioned upon Warren's payment in full of the Settlement Amount, and subject to Paragraph 24 below (concerning bankruptcy proceedings commenced within 91 days of the Effective Date of this Agreement or any payment made under this Agreement), the OIG-HHS agrees to release and refrain from instituting, directing or maintaining any administrative action seeking exclusion from Medicare, Medicaid, and other Federal health care programs (as defined in 42 U.S.C. § 1320a-7b(f)) against Warren Hospital under 42 U.S.C. § 1320a-7a (Civil Monetary Penalties Law), the civil monetary penalty provisions of the Stark Statute, 42 U.S.C. §§ 1395nn(g)(3) and (4), or 42 U.S.C. §§ 1320a-7(b)(6)(A) and 1320a-7(b)(7) (permissive exclusion for fraud, kickbacks, and other prohibited activities) for the Covered Conduct, except as reserved in Paragraph 10 below, and as reserved in this Paragraph. Notwithstanding the foregoing, in the event of Default, as defined in Paragraph 4 above, OIG-HHS may exclude Warren Hospital from participating in all Federal health care programs until Warren pays the Settlement Amount and reasonable costs as set forth in Paragraph 4 above. OIG-HHS will

provide written notice of any such exclusion to Warren Hospital. In the event of default, Warren Hospital waives any further notice of the exclusion under 42 U.S.C. §§ 1320a-7(b)(6)(A) or 1320a-7(b)(7), and agrees not to contest such exclusion either administratively or in any state or federal court. Reinstatement to program participation after exclusion is not automatic. If at the end of the period of exclusion, Warren Hospital wishes to apply for reinstatement, Warren Hospital must submit a written request for reinstatement to OIG-HHS in accordance with the provisions of 42 C.F.R. §§ 1001.3001-3005. Warren Hospital will not be reinstated unless and until OIG-HHS approves such request for reinstatement. OIG-HHS expressly reserves all rights to comply with any statutory obligations to exclude Warren Hospital from Medicare, Medicaid, and other Federal health care programs under 42 U.S.C. § 1320a-7(a) (mandatory exclusion) based upon the Covered Conduct. Nothing in this Paragraph precludes OIG-HHS from taking action against entities or persons, or for conduct and practices, for which civil, criminal, or administrative claims have been reserved in Paragraph 10 below.

8. In consideration of the obligations of Warren set forth in this Agreement, conditioned upon Warren's payment in full of the Settlement Amount, and subject to Paragraph 24 below (concerning bankruptcy proceedings commenced within 91 days of the Effective Date of this Agreement or any payment made under this Agreement), TMA hereby releases and agrees to refrain from instituting, directing, or maintaining any administrative action seeking exclusion from the TRICARE Program against the Released Warren Entities under 32 C.F.R. § 199.9 for the Covered Conduct, except as reserved in Paragraph 10, below, and as reserved in this Paragraph. TMA expressly reserves authority to exclude Warren, together with its current and former parent corporations, each of its direct and indirect subsidiaries, brother or sister corporations, divisions, current or former owners, affiliates, and the successors and assigns of

any of them, from the TRICARE program under 32 C.F.R. §§ 199.9 (f)(1)(i)(A), (f)(1)(i)(B), and (f)(1)(iii), based upon the Covered Conduct. Nothing in this Paragraph precludes TMA or the TRICARE Program from taking action against entities or persons, or for conduct and practices, for which claims have been reserved in Paragraph 10 below.

9. The Released Warren Entities fully and finally release, compromise, acquit and forever discharge the United States, its agencies, officers, agents, employees, and contractors (and their employees) from any and all claims, causes of action, adjustments, and set-offs of any kind (including, without limitation, any claims for additional outlier payments for the period January 1, 1999 through August 7, 2003) which the Released Warren Entities could have asserted, or may assert in the future, against the United States, its agencies, officers, agents, employees, and contractors (and their employees) arising out of or pertaining to the Covered Conduct, including the United States' investigation, prosecution, or settlement thereof.

10. Notwithstanding any term of this Agreement, specifically reserved and excluded from the scope and terms of this Agreement as to any entity or person (including the Released Warren Entities, the Salvatori Relators, and Relator Kite) are any and all of the following:

- a. Any civil, criminal, or administrative liability arising under Title 26, U.S. Code (commonly referred to as the Internal Revenue Code);
- b. Any criminal liability;
- c. Except as explicitly stated in this Agreement, any administrative liability, including mandatory exclusion from the Federal health care programs;
- d. Any liability to the United States (or its agencies) for any conduct other than the Covered Conduct;

e. Any liability based upon such obligations as are created by the execution of this Agreement;

f. Any liability for express or implied warranty claims or other claims for defective or deficient products or services, including quality of goods and services;

g. Any liability for personal injury or property damage, or for other similar consequential damages, arising from the Covered Conduct;

h. Any liability for failure to deliver goods or services due;

i. Any civil or administrative liability of individuals (including current or former directors, officers, employees, or agents of Warren or the hospital facility) who receive written notification that they are the target of a criminal investigation (as defined in the United States Attorneys' Manual), are indicted, charged, or convicted, or who enter into a plea agreement related to the Covered Conduct; and

j. Any claims of a state arising under Medicaid, or any other provision of law, based on the Covered Conduct.

11. The Salvatori Relators, Relator Kite, and their heirs, successors, attorneys, agents, and assigns agree not to object to this Agreement and agree and confirm that this Agreement is fair, adequate, and reasonable under all the circumstances, pursuant to 31 U.S.C. § 3730(c)(2)(B).

12. Conditioned upon receipt of the Relators' share set forth in Paragraph 2 above, the Salvatori Relators, for themselves individually, and for their heirs, successors, agents, and assigns, fully and finally release, waive, and forever discharge the United States, its officers, agents, and employees, from any claims arising from or relating to 31 U.S.C. § 3730; from any claims arising from the filing of the Salvatori Action insofar as that Action includes allegations

against the Released Warren Entities; from any other claims for a share of the Settlement Amount; and in full settlement of any claims the Salvatori Relators may have under this Agreement. The Salvatori Relators and Relator Kite represent that they have reached a separate agreement which resolves any Relators' share dispute between and among those Relators. Nothing in this Paragraph or any other provision of this Agreement resolves, or in any manner affects, any claims the United States has or may have against the Salvatori Relators or Relator Kite arising under Title 26, U.S. Code (Internal Revenue Code), or any claims arising under this Agreement.

13. Relator Kite, for himself individually, and for his heirs, successors, agents, and assigns, fully and finally releases and waives any rights to a relator's share from the United States pursuant to 31 U.S.C. § 3730, or this Agreement, and furthermore fully and finally releases and waives any other claims arising from or relating to 31 U.S.C. § 3730, any claims arising from the filing of the Kite Action, insofar as that Action includes allegations against the Released Warren Entities, and any claims that Relator Kite may have under this Agreement.

14. The Salvatori Relators and Relator Kite agree to the following:

a. Conditioned upon receipt of the payment of attorneys' fees described in Paragraph 2, and upon the full and complete payment of the Settlement Amount to the United States by Warren, the Salvatori Relators, for themselves, and for their heirs, successors, attorneys, agents, and assigns, agree to release the Released Warren Entities and their current and former directors, officers, employees, agents, and attorneys from any and all claims, liabilities, and demands for causes of action or suits in equity that they have or may have, known or unknown, on behalf of themselves or any other person entity, or thing, including the United States, any state or local government or sovereign, arising from the beginning of time until the

date of this Agreement (“Relators’ Claims”).

b. Further, upon receipt of the payment of attorneys’ fees described in Paragraph 2, and upon the full and complete payment of the Settlement Amount to the United States by Warren, Relator Kite, for himself individually, and for his heirs, successors, agents, and assigns agrees to release the Released Warren Entities and their current and former directors, officers, employees, agents, and attorneys from any and all claims, liabilities, and demands for causes of action or suits in equity that they have or may have, known or unknown, on behalf of themselves or any other person entity, or thing, including the United States or any state or local government or sovereign, arising from the beginning of time until the date of this Agreement (“Relators’ Claims”). The undersigned counsel for Relator Kite acknowledge that this Agreement releases all claims that they may have for attorneys’ fees and expenses against the Released Warren Entities, and represent that they are not aware of any other attorneys who could assert a claim for attorneys’ fees and expenses against the Released Warren Entities for services provided to Relator Kite.

c. The Salvatori Relators and Relator Kite represent that they have not assigned or transferred any of Relators’ Claims to any person, entity, or thing, and covenant and agree not to assert or pursue any of Relators’ Claims in any way, including by offset or recoupment.

15. In consideration of the obligations and promises of the Salvatori Relators and Relator Kite as set forth in this Agreement, the Released Warren Entities hereby fully and finally release the Salvatori Relators and Relator Kite, and their respective heirs, successors, assigns, agents, and attorneys from any claims that the Released Warren Entities has asserted, could have asserted, or may assert in the future against the Salvatori Relators and/or Relator Kite and their attorneys, for any of the Relators’ or Relators’ counsel’s investigation and prosecution of the

## Civil Actions.

16. Warren has provided financial information, including a sworn financial disclosure statement, to the United States ("Financial Information"). The United States has relied on the accuracy and completeness of the Financial Information in reaching this Agreement. Warren warrants that the Financial Information is complete, accurate, and current. Warren further warrants that it did not own or have an interest in any assets at the time that the Financial Information was provided, which were not disclosed to the United States in the Financial Information, except for certain non-material assets that have been sold or acquired in the ordinary course of business. In addition, Warren warrants that it has made no intentional misrepresentation in connection with the Financial Information. In the event that the United States learns of (a) assets in which Warren had an interest at the time of this Agreement that were not disclosed in the Financial Information, or (b) a misrepresentation by Warren in connection with the Financial Information, and in the event such non-disclosure or misrepresentation changes the estimated net worth of Warren as set forth in the Financial Information by one million dollars (\$1,000,000) or more, the United States may, at its option: (i) rescind this Agreement and file suit based on the Covered Conduct or (ii) let the Agreement stand and collect the full Settlement Amount plus one hundred percent (100%) of the value of the net worth of Warren's previously undisclosed asset(s). To the extent that the United States discovers the occurrence of an event encompassed by subparts (a) and/or (b) of this Paragraph, Warren agrees not to contest any collection action undertaken by the United States pursuant to these provisions. In the event that the United States opts to rescind this Agreement, Warren agrees not to plead, argue, or otherwise raise any defenses under the theories of statute of

limitations, laches, estoppel, or similar time-based theories, to any civil or administrative claims that are filed by the United States within one-hundred-twenty (120) calendar days of written notification to Warren that this Agreement has been rescinded, and that relate to the Covered Conduct, except to the extent these defenses were available on November 4, 2002, the date the Salvatori case was originally filed.

17. The Released Warren Entities, together with their current and former parent corporations, direct and indirect subsidiaries, affiliates, and divisions, and the successors and assigns of any of them, waive and shall not assert any defenses they may have to any criminal prosecution or administrative action relating to the Covered Conduct, which defenses may be based in whole or in part on a contention that, under the Double Jeopardy Clause in the Fifth Amendment of the Constitution, or under the Excessive Fines Clause in the Eighth Amendment of the Constitution, this Agreement bars a remedy sought in such criminal prosecution or administrative action. Nothing in this Paragraph or any other provision of this Agreement constitutes an agreement by the United States concerning the characterization of the Settlement Amount for purposes of the Internal Revenue Laws, Title 26 of the United States Code.

18. The Released Warren Entities agree to cooperate fully and truthfully with the United States' investigation of individuals and entities not released in this Agreement that the United States believes may have (a) submitted false claims to the Government Health Care Programs for inpatient and outpatient outlier payments, (b) engaged in conduct resulting in others submitting false claims to the Government Health Care Programs for inpatient and outpatient outlier payments, or (c) engaged in conduct resulting in the submission of claims to the Government Health Care Program in violation of the Stark Statute. Upon reasonable notice, the Released Warren Entities shall encourage, and agree not to impair, the cooperation of its

directors, officers, and employees, and shall use their best efforts to make available, and encourage the cooperation of former directors, officers, and employees for interviews and testimony, consistent with the rights and privileges of such individuals. The Released Warren Entities also agree to furnish to the United States complete and unredacted copies of all documents, reports, memoranda of interviews, and records in their possession, custody, or control requested by the United States in furtherance of its investigation; provided, however, that the Released Warren Entities do not waive any privileges that otherwise may apply to such production and do not agree to furnish to the United States documents that are subject to privileges, and that an obligation of any Released Warren Entity to indemnify and/or defend any director, officer, or employee, which is mandated as a result of law or contract, shall not be construed as a violation of the obligation to cooperate.

19. Any and all payments of the Settlement Amount that Warren must make pursuant to this Agreement shall not be decreased as a result of the denial of claims for payment now being withheld from payment by any Medicare carrier or fiscal intermediary, or any state payer, related to the Covered Conduct. The Released Warren Entities agree not to resubmit to any Medicare carrier or fiscal intermediary, or any state payer, any previously denied claims related to the Covered Conduct, and agree not to appeal any such denials of claims.

20. Warren agrees to the following:

a. Unallowable Costs Defined: That all costs (as defined in the Federal Acquisition Regulation, 48 C.F.R. § 31.205-47 and in Titles XVIII and XIX of the Social Security Act, 42 U.S.C. §§ 1395-1395hhh and 1396-1396v, and the regulations and official program directives promulgated thereunder) incurred by or on behalf of the Released Warren Entities, or their current and former employees, officers and trustees of any of them, in

connection with the following are unallowable costs on government contracts and under the Medicare Program, Medicaid Program, TRICARE Program, and the Federal Employee Health Benefits Program (“FEHBP”):

- (1) the matters covered by this Agreement,
- (2) the United States’ audit(s), civil investigation(s) and litigation of the matters covered by this Agreement,
- (3) The Released Warren Entities’ investigation, defense, and corrective actions undertaken in response to the United States’ audit(s), civil investigation(s), and litigation in connection with the matters covered by this Agreement (including attorneys’ fees),
- (4) the negotiation and performance of this Agreement,
- (5) the payments made pursuant or ancillary to this Agreement, including any costs and attorneys’ fees, and
- (6) the negotiation of, and obligations undertaken pursuant to, the CIA entered into between OIG-HHS and Warren to: (i) retain an independent review organization (“IRO”) to perform annual reviews as described in Section III of the CIA; and (ii) prepare and submit reports to the OIG-HHS. However, nothing in this Paragraph 19(a)(6) that may apply to the obligations undertaken pursuant to the CIA affects the status of costs that are not allowable based on any other authority applicable to the Released Warren Entities. (All costs described or set forth in this Paragraph 20(a) are, hereafter, “Unallowable Costs”).

b. Future Treatment of Unallowable Costs: These Unallowable Costs shall be separately determined and accounted for in non-reimbursable cost centers by Warren, and Warren shall not charge such Unallowable Costs directly or indirectly to any contracts with the

United States or any state Medicaid program, or seek payment for such Unallowable Costs through any cost report, cost statement, information statement or payment request submitted by Warren, or any of its current and former parent corporations, each of their direct and indirect subsidiaries, divisions, affiliates, predecessors, successors and assigns, along with the current and former employees, officers and trustees of any of them to the Medicare, Medicaid, TRICARE, or FEHBP Programs.

c. Treatment of Unallowable Costs Previously Submitted for Payment:

Warren further agrees that, within 90 days of the Effective Date of this Agreement, it shall identify to applicable Medicare and TRICARE fiscal intermediaries, carriers, and/or contractors, and Medicaid and FEHBP fiscal agents, any Unallowable Costs (as defined in this Paragraph) included in payments previously sought from the United States, or any state Medicaid program, including, but not limited to, payments sought in any cost report, cost statement, information report, or payment request already submitted by any of the Released Warren Entities or any of their current and former employees, officers, and trustees, and shall request, and agree, that such cost reports, cost statements, information reports, or payment requests, even if already settled, be adjusted to account for the effect of the inclusion of the unallowable costs. Warren agrees that the United States, at a minimum, shall be entitled to recoup from any of the Released Warren Entities any overpayment, plus applicable interest and penalties, as a result of the inclusion of such Unallowable Costs on previously submitted cost reports, information reports, cost statements, or requests for payment. If any of the Released Warren Entities fails to identify such costs in past-filed cost reports in conformity with this Paragraph, the United States may seek an appropriate penalty or other sanction in addition to the recouped amount.

Any payments due after the adjustments have been made shall be paid to the

United States pursuant to the direction of the Department of Justice and/or the affected agencies. The United States reserves its rights to disagree with any calculations submitted by the Released Warren Entities on the effect of inclusion of Unallowable Costs (as defined in this Paragraph) on the cost reports, cost statement, or information reports of the Released Warren Entities.

d. Nothing in this Agreement shall constitute a waiver of the rights of the United States to audit, examine, or re-examine the books and records of the Released Warren Entities to determine that no Unallowable Costs have been claimed in accordance with the provisions of this Paragraph.

21. This Agreement is intended to be for the benefit of the Parties only. The Parties do not release any claims against any other individual, employee, or entity, except to the extent provided for specifically herein.

22. The Released Warren Entities agree that they waive and shall not seek payment for any of the health care billings covered by this Agreement from any health care beneficiaries or their parents, sponsors, legally responsible individuals, or third party payors. The Released Warren Entities waive any causes of action against these beneficiaries or their parents, sponsors, legally responsible individuals, or any third party payors based upon the claims for payment covered by this Agreement.

23. The Parties expressly warrant that, in evaluating whether to execute this Agreement, they (a) have intended that the mutual promises, covenants, and obligations set forth herein constitute a contemporaneous exchange for new value given to Warren, within the meaning of 11 U.S.C. § 547(c)(1); and (b) have concluded that these mutual promises, covenants, and obligations do, in fact, constitute such a contemporaneous exchange. Further, the Parties warrant that the mutual promises, covenants, and obligations set forth herein are intended

to, and do, in fact, represent a reasonably equivalent exchange of value which is not intended to hinder, delay, or defraud any entity to which Warren was or became indebted to on or after the date of this transfer, within the meaning of 11 U.S.C. § 548(a)(1).

24. In the event that Warren commences, or a third party commences, within 91 days of the Effective Date of this Agreement, or of any payment made hereunder, any case, proceeding, or other action under any law relating to bankruptcy, insolvency, reorganization, or relief of debtors, (a) seeking to have any order for relief of Warren's debts, or seeking to adjudicate Warren as bankrupt or insolvent; or (b) seeking appointment of a receiver, trustee, custodian, or other similar official for Warren for all or any substantial part of Warren's assets, Warren agrees as follows:

a. Warren's obligations under this Agreement may not be avoided pursuant to 11 U.S.C. §§ 547 or 548, and Warren shall not argue or otherwise take the position in any such case, proceeding, or action that: (i) Warren's obligations under this Agreement may be avoided under 11 U.S.C. §§ 547 or 548; (ii) Warren was insolvent at the time this Agreement was entered into, or became insolvent as a result of any payment made to the United States hereunder; or (iii) the mutual promises, covenants, and obligations set forth in this Agreement do not constitute a contemporaneous exchange for new value given to Warren.

b. If Warren's obligations under this Agreement are avoided for any reason, including, but not limited to, through the exercise of a trustee's avoidance powers under the Bankruptcy Code, the United States, at its sole option, may rescind the releases in this Agreement, and bring any civil and/or administrative claim, action, or proceeding against Warren for the claims that would otherwise be covered by the releases provided in Paragraphs 5, 7, and 8 above. Warren agrees that (i) any such claim, action, or proceeding brought by the

United States (including any proceeding to exclude any of the Released Warren Entities from participation in Medicare, Medicaid, or other Federal health care programs) are not subject to an “automatic stay” pursuant to 11 U.S.C. § 362(a) as a result of the action, case, or proceeding described in the first clause of this Paragraph, and that Warren shall not argue or otherwise contend that the United States’ claim, action, or proceeding is subject to an automatic stay; (ii) Warren shall not plead, argue, or otherwise raise any defenses under the theories of statute of limitations, laches, estoppel, or similar theories, to any such civil or administrative claim, action, or proceeding that is brought by the United States within one-hundred-twenty (120) calendar days of written notification to Warren that the releases have been rescinded pursuant to this Paragraph, except to the extent such defenses were available on November 4, 2002, the date the Salvatori case was originally filed; and (iii) the United States has a valid claim against Warren for the Covered Conduct, and the United States may pursue its claims in any case, action, or proceeding referenced in the first clause of this subparagraph.

c. Warren acknowledges that its agreements in this Paragraph are provided in exchange for valuable consideration provided in this Agreement.

25. Each Party shall bear its own legal and other costs incurred in connection with this matter, including the preparation and performance of this Agreement.

26. This Agreement is governed by the laws of the United States. The United States and Warren agree that the exclusive jurisdiction and venue for any dispute arising between the United States and Warren under this Agreement will be in the United States District Court for the District of New Jersey. Notwithstanding the terms of this Paragraph, disputes arising under the CIA shall be resolved exclusively under the dispute resolution provisions in the CIA.

27. This Agreement constitutes the complete agreement between the Parties. This

Agreement may not be amended except by written consent of the affected Parties.

28. The individuals signing this Agreement on behalf of Warren warrant that they are authorized by Warren to execute this Agreement. The United States' signatories represent that they are signing this Agreement in their official capacities and that they are authorized to execute this Agreement. The individuals signing this Agreement on behalf of the Salvatori Relators and Relator Kite represent and warrant that they are authorized by those respective Relators to execute this Agreement.

29. This Agreement may be executed in counterparts, each of which constitutes an original and all of which constitute one and the same agreement.

30. This Agreement is binding on the successors, transferees, heirs, and assigns of Warren.

31. All Parties consent to the United States' disclosure of this Agreement, and information about this Agreement, to the public.

32. This Agreement is effective on the date of signature of the last signatory to the Agreement ("Effective Date"). Facsimiles of signatures shall constitute acceptable, binding signatures for purposes of this Agreement.

IN WITNESS WHEREOF, the parties hereto affix their signatures:

FOR THE UNITED STATES OF AMERICA

DATED: 11/5/07

BY: 

STUART A. MINKOWITZ  
Assistant United States Attorney  
District of New Jersey

DATED: \_\_\_\_\_

BY: \_\_\_\_\_

VIRGINIA A. GIBSON  
Chief, Civil Division  
Assistant United States Attorney  
Eastern District of Pennsylvania

DATED: \_\_\_\_\_

BY: \_\_\_\_\_

DANIEL SPIRO  
Trial Attorney  
Commercial Litigation Branch, Civil Division  
United States Department of Justice

DATED: \_\_\_\_\_

BY: \_\_\_\_\_

LAUREL C. GILLESPIE  
Deputy General Counsel  
Tricare Management Activity  
United States Department of Defense

DATED: \_\_\_\_\_

BY: \_\_\_\_\_

GREGORY E. DEMSKE  
Assistant Inspector General for Legal Affairs  
Office of Inspector General  
United States Department of  
Health and Human Services

IN WITNESS WHEREOF, the parties hereto affix their signatures:

FOR THE UNITED STATES OF AMERICA

DATED: \_\_\_\_\_

BY: \_\_\_\_\_

STUART A. MINKOWITZ  
Assistant United States Attorney  
District of New Jersey

DATED: 11/30/07 <sup>by DAS</sup>

BY: Virginia A. Gibson

VIRGINIA A. GIBSON  
Chief, Civil Division  
Assistant United States Attorney  
Eastern District of Pennsylvania

DATED: 12/5/07

BY: Daniel A. Spiro

DANIEL SPIRO  
Trial Attorney  
Commercial Litigation Branch, Civil Division  
United States Department of Justice

DATED: \_\_\_\_\_

BY: \_\_\_\_\_

LAUREL C. GILLESPIE  
Deputy General Counsel  
Tricare Management Activity  
United States Department of Defense

DATED: \_\_\_\_\_

BY: \_\_\_\_\_

GREGORY E. DEMSKE  
Assistant Inspector General for Legal Affairs  
Office of Inspector General  
United States Department of  
Health and Human Services

IN WITNESS WHEREOF, the parties hereto affix their signatures:  
FOR THE UNITED STATES OF AMERICA

DATED: \_\_\_\_\_

BY: \_\_\_\_\_  
STUART A. MINKOWITZ  
Assistant United States Attorney  
District of New Jersey

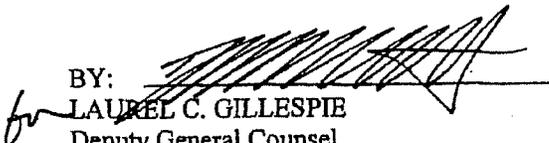
DATED: \_\_\_\_\_

BY: \_\_\_\_\_  
VIRGINIA A. GIBSON  
Chief, Civil Division  
Assistant United States Attorney  
Eastern District of Pennsylvania

DATED: \_\_\_\_\_

BY: \_\_\_\_\_  
DANIEL SPIRO  
Trial Attorney  
Commercial Litigation Branch, Civil Division  
United States Department of Justice

DATED: 30 Nov 07

BY:   
LAUREL C. GILLESPIE  
Deputy General Counsel  
Tricare Management Activity  
United States Department of Defense

DATED: \_\_\_\_\_

BY: \_\_\_\_\_  
GREGORY E. DEMSKE  
Assistant Inspector General for Legal Affairs  
Office of Inspector General  
United States Department of  
Health and Human Services

IN WITNESS WHEREOF, the parties hereto affix their signatures:

FOR THE UNITED STATES OF AMERICA

DATED: \_\_\_\_\_

BY: \_\_\_\_\_

STUART A. MINKOWITZ  
Assistant United States Attorney  
District of New Jersey

DATED: \_\_\_\_\_

BY: \_\_\_\_\_

VIRGINIA A. GIBSON  
Chief, Civil Division  
Assistant United States Attorney  
Eastern District of Pennsylvania

DATED: \_\_\_\_\_

BY: \_\_\_\_\_

DANIEL SPIRO  
Trial Attorney  
Commercial Litigation Branch, Civil Division  
United States Department of Justice

DATED: \_\_\_\_\_

BY: \_\_\_\_\_

LAUREL C. GILLESPIE  
Deputy General Counsel  
Tricare Management Activity  
United States Department of Defense

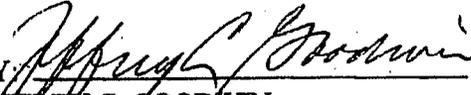
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BY: \_\_\_\_\_

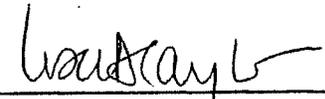
GREGORY E. DEMSKE  
Assistant Inspector General for Legal Affairs  
Office of Inspector General  
United States Department of  
Health and Human Services

FOR WARREN HOSPITAL AND THE RELEASED WARREN ENTITIES

DATED: 11/6/07

BY:   
JEFFREY C. GOODWIN  
President and CEO  
Warren Hospital

DATED: 11/8/07

BY:   
LISA D. TAYLOR, Esq.  
Stern & Kilcullen, LLC  
Counsel for Warren Hospital

FOR THE RELATORS

DATED: \_\_\_\_\_

BY: \_\_\_\_\_  
PETER SALVATORI  
Relator

DATED: \_\_\_\_\_

BY: \_\_\_\_\_  
SARA C. IVESON  
Relator

DATED: \_\_\_\_\_

BY: \_\_\_\_\_  
JOHN E. RILEY, Esq.  
Vaira & Riley, P.C.  
Counsel for Relators Peter Salvatori and  
Sara C. Iveson

FOR WARREN HOSPITAL AND THE RELEASED WARREN ENTITIES

DATED: \_\_\_\_\_

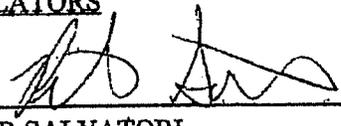
BY: \_\_\_\_\_  
JEFFREY C. GOODWIN  
President and CEO  
Warren Hospital

DATED: \_\_\_\_\_

BY: \_\_\_\_\_  
LISA D. TAYLOR, Esq.  
Stern & Kilcullen, LLC  
Counsel for Warren Hospital

FOR THE RELATORS

DATED: 11-5-2007

BY:  \_\_\_\_\_  
PETER SALVATORI  
Relator

DATED: \_\_\_\_\_

BY: \_\_\_\_\_  
SARA C. IVESON  
Relator

DATED: \_\_\_\_\_

BY: \_\_\_\_\_  
JOHN E. RILEY, Esq.  
Vaira & Riley, P.C.  
Counsel for Relators Peter Salvatori and  
Sara C. Iveson

**FOR WARREN HOSPITAL AND THE RELEASED WARREN ENTITIES**

DATED: \_\_\_\_\_

BY: \_\_\_\_\_  
JEFFREY C. GOODWIN  
President and CEO  
Warren Hospital

DATED: \_\_\_\_\_

BY: \_\_\_\_\_  
LISA D. TAYLOR, Esq.  
Stern & Kilcullen, LLC  
Counsel for Warren Hospital

**FOR THE RELATORS**

DATED: \_\_\_\_\_

BY: \_\_\_\_\_  
PETER SALVATORI  
Relator

DATED: Nov. 6, 2007

BY: *Sara C. Iveson*  
SARA C. IVESON  
Relator

DATED: \_\_\_\_\_

BY: \_\_\_\_\_  
JOHN B. RILEY, Esq.  
Vain & Riley, P.C.  
Counsel for Relators Peter Salvatori and  
Sara C. Iveson

FOR WARREN HOSPITAL AND THE RELEASED WARREN ENTITIES

DATED: \_\_\_\_\_

BY: \_\_\_\_\_  
JEFFREY C. GOODWIN  
President and CEO  
Warren Hospital

DATED: \_\_\_\_\_

BY: \_\_\_\_\_  
LISA D. TAYLOR, Esq.  
Stern & Kilcullen, LLC  
Counsel for Warren Hospital

FOR THE RELATORS

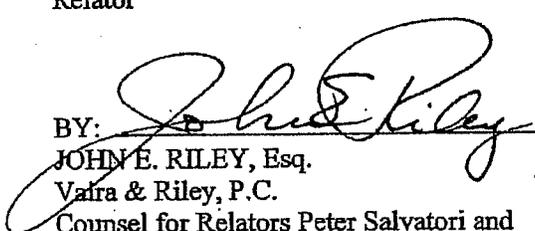
DATED: \_\_\_\_\_

BY: \_\_\_\_\_  
PETER SALVATORI  
Relator

DATED: \_\_\_\_\_

BY: \_\_\_\_\_  
SARA C. IVESON  
Relator

DATED: Nov. 6 2007

BY:   
JOHN E. RILEY, Esq.  
Vavra & Riley, P.C.  
Counsel for Relators Peter Salvatori and  
Sara C. Iveson

DATED: 11/6/2007

BY: *Anthony Kite*  
ANTHONY KITE  
Relator

DATED: Nov. 6, 2007

BY: *Jonathan S. Berck*  
JONATHAN S. BERCK, Esq.  
Jonathan S. Berck, L.L.C.  
Counsel for Relator Anthony Kite

DATED: 11/6/2007

BY: *Larry Zoglin*  
ERIKA A. KELTON, Esq.  
LARRY P. ZOGLIN, Esq.  
Phillips & Cohen, L.L.P.  
Counsel for Relator Anthony Kite

**EXHIBIT A**

Payments of the Settlement Amount shall be made as follows in accordance with Paragraph III.1 of the Settlement Agreement:

<b><u>Quarter</u></b>	<b><u>Payment</u></b>
1	\$260,000 <sup>2</sup>
2	\$260,000
3	\$260,000
4	\$260,000
5	\$260,000
6	\$300,000
7	\$550,000
8	\$550,000
9	\$550,000
10	\$550,000
11	\$550,000
12	\$550,000
13	\$550,000
14	\$550,000
15	\$250,000
16	\$250,000
17	\$250,000
18	\$250,000
19	\$250,000
20	<u>\$250,000</u>
	\$7,500,000

---

<sup>2</sup> This \$260,000 amount, plus any interest accruing on the entire Settlement Amount from September 16, 2007, is also due on the date of the first payment.



Erika A. Kelton  
Larry P. Zoglin  
PHILLIPS & COHEN LLP  
2000 Massachusetts Ave NW  
Washington, D.C. 20036  
Tel: (202) 833-4567

FILED  
DISTRICT COURT  
2022 FEB 22 P 3:43

Jonathan S. Berck, LLC  
1560 Broadway, 10th Floor  
New York, New York 10036  
Tel: (212) 812-2165

Attorneys for [Under Seal]

UNITED STATES DISTRICT COURT  
FOR THE DISTRICT OF NEW JERSEY

UNITED STATES OF AMERICA	)	
EX REL. [UNDER SEAL]	)	C.A. No. 05-CV-3066 (FSH)
	)	
	)	
Plaintiffs,	)	
v.	)	
	)	AMENDED COMPLAINT
[UNDER SEAL]	)	
	)	
Defendants	)	
_____	)	

**FILED IN CAMERA AND UNDER SEAL**  
**Pursuant To 31 U.S.C. § 3730(b)(2)**

UNITED STATES DISTRICT COURT  
FOR THE DISTRICT OF NEW JERSEY

UNITED STATES OF AMERICA, ex rel.  
ANTHONY KITE,

Plaintiffs,

vs.

[REDACTED]

RARITAN BAY MEDICAL  
CENTER

[REDACTED]

WARREN HOSPITAL;

[REDACTED]

Defendants.

) Case No. 05-CV-3066 (FSH)

) AMENDED COMPLAINT FOR  
) VIOLATION OF FEDERAL FALSE  
) CLAIMS ACT [31 U.S.C. §3729 et seq.]

) JURY TRIAL DEMANDED  
) (FILED IN CAMERA AND UNDER SEAL)

---

Plaintiff-Relator Anthony Kite, through his attorneys Phillips & Cohen LLP and Jonathan S. Berck, LLC, on behalf of the United States of America, for his Complaint against defendants

[REDACTED]

[REDACTED]

[REDACTED]  
[REDACTED]  
[REDACTED] Raritan Bay Medical Center; [REDACTED]  
[REDACTED] Warren Hospital; [REDACTED]  
[REDACTED]  
[REDACTED] alleges based upon personal knowledge, relevant documents, and information and belief, as follows.

**I. INTRODUCTION**

1. This is an action to recover damages and civil penalties on behalf of the United States of America arising from false and/or fraudulent statements, records, and claims made and caused to be made by defendants and/or their agents, employees and co-conspirators in violation of the Federal False Claims Act, 31 U.S.C. §§ 3729 *et seq.*, as amended (“the FCA”).

2. This case involves a scheme to defraud the federal Medicare and Medicaid programs out of hundreds of millions of dollars. The defendants are [REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

3. Medicare is the federal program that provides health care insurance to the nation’s aged and disabled. Medicaid is a joint federal-state public assistance program providing for payment of medical expenses for the indigent and disabled. Medicare and Medicaid are administered by the Centers for Medicare & Medicaid Services (“CMS”), within the United States Department of Health and Human Services (“HHS”).

4. The fraudulent scheme alleged in this Complaint involves the Medicare and Medicaid "Outlier" payment systems. The Medicare and Medicaid Outlier payment systems are methods by which Medicare and Medicaid provide additional reimbursement for hospital expenses incurred in caring for the most costly patients to treat. Without this provision, hospitals would be reluctant to treat seriously ill patients for whom the cost of treatment will greatly exceed normal payment rates.

5. Each time a hospital incurs costs to treat a Medicare patient that far exceed the amount the hospital would be paid under normal reimbursement guidelines, the hospital is eligible to receive special compensation in the form of Medicare Outlier payments. Under Medicare law, Outlier payments are triggered when the costs for treating a particular patient diagnosis exceed a predetermined amount specified by CMS and revised annually (the "Outlier Threshold"). A number of state Medicaid programs make Outlier payments on a similar basis to the Medicare program.

6. The [REDACTED] defendants in this case implemented a scheme [REDACTED] [REDACTED] to inflate hospital charges to artificially high levels, so that the hospitals' "costs" would appear to exceed the Outlier Threshold for the treatment of thousands of patients that were, in truth, normal-cost patients. As a result of this scheme, the [REDACTED] defendants received hundreds of millions of dollars in Medicare and Medicaid Outlier payments to which they were not entitled, in violation of the FCA. [REDACTED]  
[REDACTED]

7. The FCA was originally enacted during the Civil War, and was substantially amended in 1986. Congress enacted the 1986 amendments to enhance and modernize the

government's tools for recovering losses sustained by frauds against it. The amendments were intended to create incentives for individuals with knowledge of fraud against the government to disclose the information without fear of reprisals or government inaction, and to encourage the private bar to commit resources to prosecuting fraud on the government's behalf.

8. The FCA prohibits knowingly presenting (or causing to be presented) to the federal government a false or fraudulent claim for payment or approval. 31 U.S.C. §3729(a)(1). In addition, it prohibits knowingly making or using a false or fraudulent record or statement to get a false or fraudulent claim paid or approved by the federal government. 31 U.S.C. §§3729(a)(2). Any person who violates the FCA is liable for a civil penalty of up to \$11,000 for each violation, plus three times the amount of the damages sustained by the United States. 31 U.S.C. §3729(a)(7).

9. The FCA allows any person having information about an FCA violation to bring an action on behalf of the United States, and to share in any recovery. The FCA requires that the Complaint be filed under seal for a minimum of 60 days (without service on the defendant during that time) to allow the government time to conduct its own investigation and to determine whether to join the suit.

10. Based on these provisions, qui tam Plaintiff and Relator Anthony Kite seeks to recover all available damages, civil penalties, and other relief for FCA violations alleged herein, in every jurisdiction to which defendants' misconduct has extended.

## **II. PARTIES**

11. Plaintiff/Relator Anthony Kite ("Relator") is a resident of Princeton, New Jersey. He has worked for over twenty-five years in the field of healthcare financial management. Since

1999 he has worked as a private consultant, providing strategic and financial consulting services to hospital senior management and governing boards. Prior to 1999 he held several positions with New Jersey hospitals, including Chief Financial Officer (1991-99); Director of Finance (1987-91); and Director of Budgets and Reimbursement (1980-87).

12. [REDACTED]

13. [REDACTED]

14. [REDACTED]

15. [REDACTED]

16. [REDACTED]

[REDACTED]

17. [REDACTED]

[REDACTED]

18. [REDACTED]

J [REDACTED]  
t [REDACTED]

19. [REDACTED]

[REDACTED]

20. [REDACTED]

[REDACTED]

21. [REDACTED]

[REDACTED]

22. [REDACTED]

[REDACTED]

23. [REDACTED]

[REDACTED]

24. [REDACTED]

[REDACTED]

25. Defendant Raritan Bay Medical Center ("Raritan") is a non-profit New Jersey corporation with its principal place of business in Perth Amboy, New Jersey. Raritan operates two acute care community hospitals: the 388-bed Raritan Bay Medical Center (Perth Amboy Division) and the 113-bed Raritan Bay Medical Center (Old Bridge Division).

26. [REDACTED]

[REDACTED]

27. [REDACTED]

28. [REDACTED]

29. Defendant Warren Hospital ("Warren") is a non-profit New Jersey corporation with its principal place of business in Phillipsburg, New Jersey. Warren is a community hospital licensed for 214 beds.

30. [REDACTED]

31. [REDACTED]

32. [REDACTED]

33. [REDACTED]

[REDACTED]

[REDACTED]

**III. JURISDICTION AND VENUE**

34. This Court has jurisdiction over the subject matter of this action pursuant to 28 U.S.C. §1331, 28 U.S.C. §1367, and 31 U.S.C. §3732, the latter of which specifically confers jurisdiction on this Court for actions brought pursuant to 31 U.S.C. §§3729 and 3730. Under 31 U.S.C. §3730(e), there has been no statutorily relevant public disclosure of the “allegations or transactions” in this Complaint.

35. This Court has personal jurisdiction over the defendants pursuant to 31 U.S.C. §3732(a) because that section authorizes service of process “at any place within or outside the United States” and because one or more of the defendants can be found in, reside, and transact business in this judicial district.

36. Venue is proper in this judicial district pursuant to 31 U.S.C. §3732(a) because one or more of the defendants can be found in, reside, and transact business in this district. At all times relevant to this Complaint, one or more defendants regularly conducted substantial business within this district and maintained employees and offices in this district. In addition, statutory violations, as alleged herein, occurred in this district.

**IV. APPLICABLE LAW**

**A. Applicable Medicare Law**

**1. Medicare Background**

37. Medicare was created in 1966 when Title XVIII of the Social Security Act was adopted. Medicare has two parts: Parts A and B. Part A, the Basic Plan of Hospital Insurance,

provides certain benefits covering inpatient hospital services, nursing facility services, home health services, and hospice services. Medicare Part B covers the cost of physicians' services and certain other medical services not covered by Part A.

38. Hospitals that wish to participate in the Medicare program must execute a contract, known as a provider agreement, with CMS. Upon information and belief, each hospital defendant in this case has executed a provider agreement with CMS. Provider agreements are executed upon a provider's initial enrollment into the Medicare program, upon renewal, and upon any change in its business structure.

39. In the provider agreement, each hospital certifies that it will adhere to the Medicare laws, regulations, and program instructions. The provider agreement also requires each hospital to acknowledge that any deliberate omission, misrepresentation or falsification of any communication supplying information to CMS may be punished by criminal, civil or administrative penalties, including fines, civil damages and/or imprisonment.

## **2. The Medicare Prospective Payment System**

40. Before describing the Medicare Outlier payment system, it is first necessary to understand the standard Medicare method for reimbursing medical services, called the Prospective Payment System ("PPS"). Medicare has a PPS for inpatient services and a separate PPS for outpatient services.

41. In 1983, CMS implemented the inpatient PPS ("IPPS") for virtually all ordinary hospitals, also referred to as "acute care hospitals". The IPPS pays participating hospitals fixed, predetermined amounts for defined services.

42. Under the IPPS, each patient's condition is classified into one of over 520 Diagnosis-Related Groups ("DRG"). For each DRG, CMS has assigned a numeric weight that reflects the amount of resources needed, on average, to treat a patient with the corresponding diagnosis. In general, a hospital's payment for treating a specific patient is determined by multiplying the numeric weight for the DRG for the patient's condition by a standardized amount. The standardized amount is based on the average resources used to treat cases in a particular DRG and is adjusted to take into account regional wage rates as well as certain other factors.

43. The normal IPPS payment may also be supplemented with add-ons applicable to teaching hospitals or hospitals that treat a disproportionately large share of low-income patients. In addition to reimbursement of operating costs, hospitals can recover capital expenditures through a separate DRG calculation.

44. Medicare's outpatient PPS ("OPPS") was first implemented in 2000. The OPSS applies to hospital outpatient departments, community mental health centers, and for some services provided by comprehensive outpatient rehabilitation facilities, home health agencies, and services provided to hospice patients for the treatment of a non-terminal illness. The OPSS operates similarly to the inpatient PPS, but with a different classification system. The OPSS is based on ambulatory payment classifications ("APCs") that group outpatient services into categories for payment. CMS has created approximately 800 APCs.

45. Each APC has a relative weight based on its median cost of service nationwide. A conversion factor translates the relative weights into dollar payment amounts. In general, a hospital's payment for providing an outpatient service is determined by multiplying the numeric

weight for that APC by a standardized amount, adjusted to take into account regional wage rates as well as certain other factors.

### **3. The Medicare Outlier Payment System**

46. Although the PPS system assumes that fixed payments based on cases of average complexity will provide adequate compensation to efficiently run hospitals, Congress recognized that there may be instances where the actual cost of a patient's care far exceeds the allowed DRG or APC payment. Accordingly, the Social Security Act provides for extra payments (in addition to payments received under PPS) for especially costly hospital stays. These extra amounts are referred to as "Outliers."

47. Medicare Outlier payments are designed to supplement standard PPS payments "for extraordinarily high-cost cases." See 42 C.F.R. § 412.84. According to CMS, "[t]his additional payment is designed to protect the hospital from large financial losses due to unusually expensive cases." 68 Fed. Reg. 10420, 10421 (March 5, 2003). The Outlier payment is meant to "approximate the marginal cost of care." See 42 U.S.C. § 1395ww(d)(5)(A)(iii).

48. A hospital is eligible to receive Medicare Outlier payments when the costs it incurs to treat a Medicare patient exceed the normal PPS payment by a fixed amount, called the "Outlier Threshold," the exact magnitude of which is established by CMS on an annual basis. Hospitals receive Outlier payments "in any case where charges, adjusted to cost," exceed the Outlier Threshold. See 42 U.S.C. § 1395ww(d)(5)(A)(ii).

49. For inpatient services, CMS uses a computer algorithm that automatically sets the Outlier Threshold each year at an amount that is projected to generate total Outlier payments for inpatient services equal to 5.1 percent of total payments under the IPPS. If the amount paid out to

hospitals in Outlier payments exceeds the 5.1 percent target for the year, then the threshold is raised for all participating hospitals in subsequent years. The inpatient Outlier Threshold for 2000 was set at \$14,600; was raised to \$17,550 for 2001; was raised to \$21,025 for 2002; and, then, it was raised again to \$33,560 for 2003. See 68 Fed. Reg. 34494, 34496 (June 9, 2003). For 2004, following changes in the Outlier rules described below, the Outlier Threshold was set at \$31,000. For 2005, it has been set at \$25,800.

50. The Medicare outpatient Outlier mechanism, established by the Balanced Budget Refinement Act of 1999, operates similarly to the inpatient Outlier mechanism; however, the outpatient Outlier Threshold is set at a fixed percentage (updated annually) above the applicable APC payment for a service.

51. The Medicare Outlier system is predicated on the assumption, and CMS directives affirmatively require, that a hospital's charges be reasonably and consistently related to its costs of providing the services. See, e.g., Medicare Provider Reimbursement Manual, Part I, §§ 2202 – 2203; see also 42 C.F.R. § 413.53(b)(2)(ii) (“Implicit in the use of charges as the basis for apportionment is the objective that charges for services be related to the cost of the services”).

52. Every hospital lists its charges for each item or service that the hospital provides in a document commonly referred to as the “charge master.” For example, the charge master might list the charge for a particular prescription medicine at \$25 per dosage, a blood test at \$150, single occupancy standard hospital room at \$1,500 per day, and the use of an operating room for a 4-hour surgical procedure at \$7,500. The charges can act as a proxy for a hospital's costs if there is a rational relationship between a hospital's charges and its underlying costs.

53. Each hospital has a “cost-to-charge ratio” or “CCR.” The CCR is an average, and can be used to transform a charge into a cost. As an illustration, if a hospital’s CCR is 0.25 and its charges for a patient total \$40,000, then its costs to treat that patient would be approximately \$10,000. A hospital’s CCR is a key component of the Outlier payment because Medicare determines a hospital’s eligibility for Outlier payments based upon the hospital’s “adjusted costs,” i.e., the hospital’s charges multiplied by its CCR.

54. The Medicare Outlier payment for inpatient services is 80 percent of the difference between the hospital’s adjusted costs for treating a patient (calculated by multiplying its charges times its CCR), less the sum of the IPPS payment and the Outlier Threshold. In equation form, this is shown as:  $\text{Outlier Payment} = 80\% \times [(\text{Charges} \times \text{CCR}) - \text{IPPS Payment} - \text{Outlier Threshold}]$ . In this equation, “Charges” refers to the hospital’s charges for services provided to the patient; the IPPS payment is the standard DRG payment plus any applicable add-ons (e.g., indirect medical education, disproportionate share of low income patients); and the Outlier Threshold is the amount established annually by CMS.

55. The Medicare Outlier payment for *outpatient* services is set at a fixed percentage (updated annually) of the difference between (i) the hospital’s adjusted costs for the outpatient service (calculated by multiplying actual charges times the hospital’s outpatient CCR) less (ii) the Outpatient Outlier Threshold (calculated as a multiple of the applicable APC payment for the service).

56. Prior to October 2003, CMS regulations required that the CCR be derived from the hospital’s latest “settled Cost Report,” as audited by a CMS’ fiscal intermediary. Because the

process of “settling” a Cost Report typically takes several years, this method of deriving the CCR created a time-lag between a hospital’s current CCR and the CCR used in the Outlier formula.

57. As alleged more fully below, the hospital defendants in this case took advantage of this time lag to defraud Medicare by rapidly increasing charges far in excess of any corresponding increase in costs. When the inflated charges were multiplied by the hospital’s *historical* CCR, this led to artificially high “adjusted costs.” The adjusted costs were artificially high because the hospital’s *actual* CCR after the charge increases was much lower than the historical CCR. (Charge increases unaccompanied by equivalent cost increases will lower the CCR.) By rapidly increasing charges and continuing to use the higher, historical CCR to compute the hospitals’ “adjusted costs,” the hospital defendants were able to convert large numbers of normal-cost cases into Outlier cases and caused Medicare to pay the hospitals Outlier payments to which they were not entitled.

58. The Medicare statute makes clear that hospitals are not entitled to receive Outlier payments by artificially increasing charges unrelated to costs, as the hospital defendants did in this case. The statute provides, *inter alia*, that hospitals “may request . . . [Outlier] payments in any case where *charges, adjusted to cost* exceed [the cutoff point].” 42 U.S.C. § 1395ww(d)(5)(A)(ii) (emphasis added). The requirement that charges be “adjusted to cost” demonstrates Congress’ intent that charges be adjusted to reflect actual incurred costs in order to determine eligibility for Outlier payments. This is further demonstrated by the next section of the statute, which states that the amount of outlier payments “shall be determined by the Secretary [of HHS] and shall . . . approximate the marginal cost of care beyond the cutoff point. . . .” 42 U.S.C. § 1395ww(d)(5)(A)(iii). Under this provision, Outlier payments are limited to the approximate

costs that a hospital incurs in excess of the standard Medicare payment plus the fixed Outlier Threshold amount. These two clauses of the statute, among others, make clear that a hospital may obtain Outlier payments only for extraordinarily costly cases, and only then in an amount that approximates the marginal additional cost incurred by the hospital.

59. Effective October 1, 2003, CMS changed its regulations to eliminate the “time lag” referred to above. In the new regulations, CMS permits Medicare fiscal intermediaries to calculate Outlier payments using the hospital's CCR from its most recent full-year cost reporting period, whether or not the Cost Report is settled. In other words, the CCR is calculated based on current cost and charge data in interim Cost Reports, as opposed to final, settled Cost Reports. By requiring the use of current cost and charge data, the regulations substantially eliminate the opportunity of hospitals to defraud the system by artificially inflating charges, since increased charges will lower the current CCR, which in turn lowers the hospital's adjusted costs.

60. Another provision of the Medicare regulations that the defendants in this case also exploited was a safety net provision for hospitals. Under this provision, if a hospital's CCR deviated significantly from the nationwide average CCR (defined in the regulations as three standard deviations from the mean of the log distribution of CCRs for all hospitals), then CMS would assign a statewide average CCR to the hospital instead of the hospital-specific CCR. CMS' rationale for using a statewide average in these circumstances was its belief that a hospital-specific CCR falling far outside the normal range was “unreasonable and probably due to faulty data reporting or entry.” 53 Fed. Reg.38476, 38508 (Sept. 30, 1988).

61. In certain instances, the [REDACTED] defendants in this case drove their prices so high that their CCRs eventually fell below the range that was considered reasonable under the

Medicare regulations, thus triggering use of the statewide average CCR. In these circumstances, use of the statewide average CCR was not due to any data reporting or entry errors, but the intentional conduct of the [REDACTED] defendants.

62. Use of the statewide average CCR benefited the [REDACTED] defendants since it, like the historical CCR, was invariably higher than the hospital's actual CCR (which had been driven down by inflated charges). Use of the higher statewide CCR inflated the hospital's adjusted costs, resulting in excessive Outlier payments.

63. Effective August 8, 2003, CMS also changed the safety net provision of the Outlier regulations. Under the current regulations, CMS uses the statewide average CCR only when the hospital's reported CCR is significantly *higher* than the statewide average, not if it is significantly *lower* than the statewide average. Thus, under current law, inflated charges that drive down a hospital's CCR would not trigger use of the statewide CCR.

#### **B. Applicable Medicaid Law**

64. Medicaid was established in 1965 under Title XIX of the Social Security Act as a joint Federal and State program. Medicaid provides medical assistance to low-income persons who are age 65 or over, blind, disabled, or members of families with dependent children and to qualified pregnant women and children. Each State administers its Medicaid program in accordance with a State plan approved by CMS, which is responsible for the program at the Federal level. Within broad Federal rules, each State decides eligible groups, types and range of services, payment levels for services, and administrative and operating procedures.

65. During the time period covered by this Complaint, a number of State Medicaid programs paid Outlier payments for high-cost Medicaid patients, in a manner similar to the

Medicare Outlier payment system described above. Examples of States that paid Medicaid Outlier payments include the following:

**1. Pennsylvania Medicaid Outlier Payment Program**

66. Pennsylvania's Medicaid program provides Outlier payments to hospitals that incur unusually high costs for Medicaid patients. For certain DRGs, primarily neonatal and burn cases, Pennsylvania makes cost Outlier payments that are based on the estimated cost of the claim; for all other DRGs, Pennsylvania makes day Outlier payments that are based on the length of stay.

67. Pennsylvania Code, 55 Pa. Code § 1163.56, entitled "Outliers," identifies the specific criteria under which Pennsylvania makes day and cost Outlier payments for Medicaid inpatient hospital claims. Subsections (a) through (e) define the requirements and payment methodology for day Outlier payments. Subsections (f) through (j) define the requirements and payment methodology for cost Outlier payments. The amount of cost Outlier payments is calculated as the estimated cost (total charges multiplied by the hospital-specific cost-to-charge ratio) less a threshold amount (150 percent of the DRG base amount). Estimated costs above the threshold are reimbursed as cost Outlier payments. 55 Pa. Code § 1163.56(f)-(j).

68. Like the federal Medicare program, Pennsylvania's Medicaid program converts billed charges to estimated costs using a cost-to-charge ratio to determine whether a claim qualifies as an extraordinary high-cost case. The CCR is calculated from financial data that providers submit annually.

69. During the period covered by this Complaint, the CCR used by the Pennsylvania Medicaid program was generally derived from the Medicaid cost report from three years earlier.

Because Pennsylvania Medicaid used an outdated CCR, ██████████ hospitals operating in Pennsylvania were able to convert a number of normal-cost cases into Outlier cases by dramatically increasing their charges relative to costs. This caused the Medicaid program in Pennsylvania to overpay these hospitals for Medicaid cost Outlier payments. Overpayments by the Medicaid program in Pennsylvania damaged both the Pennsylvania and United States Treasuries, since the Medicaid program is jointly financed by the state and federal governments.

## **2. Other States' Medicaid Outlier Payment Programs**

70. During the time period covered by this Complaint, a number of other States paid Medicaid Outlier payments in a manner similar to that described above. See, e.g., New York Codes, Rules And Regulations, 10 NYCRR § 86-1.51, 1.55; Code Of Massachusetts Regulations, 114.1 CMR § 33.11; Code Of Delaware Regulations, CDR 40-800-113; Illinois Administrative Code, 89 Ill. Adm. Code § 148.130, 149.105(c)(1); California Code Of Regulations, 22 CCR § 51551. This list is intended to be illustrative, and not exhaustive.

71. To the extent that the inflated-charging scheme alleged in this Complaint was implemented by hospitals in these and other States that paid Medicaid Outlier payments, the scheme damaged and defrauded the federal-state Medicaid program in the manner described above.

### **C. Medicare Uniform Charge Requirement**

72. Medicare rules prohibit providers from billing Medicare beneficiaries at a higher or different fee schedule rate than non-Medicare patients. Section 2203 of the Medicare Provider Reimbursement Manual states in pertinent part:

2203. PROVIDER CHARGE STRUCTURE AS BASIS FOR APPORTIONMENT

To assure that Medicare's share of the provider's costs equitably reflects the costs of services received by Medicare beneficiaries, the intermediary, in determining reasonable cost reimbursement, evaluates the charging practice of the provider to ascertain whether it results in an equitable basis for apportioning costs. So that its charges may be allowable for use in apportioning costs under the program, each facility should have an established charge structure which is applied uniformly to each patient as services are furnished to the patient and which is reasonably and consistently related to the cost of providing the services. . . . Hospitals which have subproviders and hospital-based SNFs [Skilled Nursing Facilities] must also maintain uniform charges across all payer categories, as well as like charges for like services across each provider setting, in order to properly apportion costs.

*Medicare Provider Reimbursement Manual*, Part I, §2203. (Emphasis added.) The requirement that each hospital maintain a uniform charge structure that applies to all patients prevents "cross-subsidization," i.e., Medicare bearing the costs of non-Medicare patients and vice-versa.

73. Providers may be excluded from Medicare and other federal and state health programs if they violate the uniform charge requirement. See 42 U.S.C. §1320a-7(b)(6)(A) (grounds for exclusion include submitting or causing to be submitted bills "containing charges . . . substantially in excess of [the provider's] usual charges . . . for such services.")

74. [REDACTED] hospitals [REDACTED] violated the Medicare uniform charge requirement in a number of different ways. Among other practices, [REDACTED] hospitals dramatically raised their prices for patient services but did not make reasonable efforts to collect the price increases from self-paying and other charge-paying customers. For example, [REDACTED] hospitals deeply discounted the prices for self-paying and other charge-paying customers, and also routinely wrote off these patients' unpaid bills without making reasonable collection efforts. See, e.g., ¶¶ 102-03, 105(e) below. This disparate treatment of Medicare patients versus charge-paying patients violated the Medicare uniform charge requirement and disqualified these hospitals from receiving Medicare reimbursement for their Medicare patients.

**V. Defendants Fraudulently Manipulated the Outlier System**

**A. Summary of Defendants' Fraudulent Conduct**

75. As noted above, Medicare determines a hospital's eligibility for Outlier payments based upon the hospital's adjusted costs, which are computed by multiplying the hospital's charges times the hospital's CCR. Various State Medicaid programs follow a similar procedure. As CMS has consistently stated, "the use of hospital-specific cost-to-charge ratios is essential to ensure that outlier payments are made only for cases that have extraordinarily high costs, and not merely high charges." 68 Fed. Reg. at 10423 (March 5, 2003) (citing 53 Fed. Reg. 38476, 38503 (Sept. 30, 1988)).

76. The [REDACTED] defendants in this case fraudulently manipulated the Outlier payment system by engaging in an inflated-charging scheme [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

77. Under the [REDACTED] scheme, hospitals artificially inflated their billed charges to exorbitant levels, far out of proportion to any cost increases incurred by the hospitals. The hospitals then adjusted these charges, for Medicare reimbursement purposes (and for Medicaid reimbursement purposes in those States that paid Medicaid Outlier payments), by using CCRs that predated the charge increases. Since the CCRs that predated the charge increases were much higher than the hospitals' *actual* CCRs following the charge increases, the scheme inflated the hospitals' adjusted costs.

78. By submitting these inflated adjusted costs to Medicare and, where applicable, to Medicaid, the [REDACTED] defendants misrepresented to Medicare and Medicaid that their actual costs had increased in proportion to their increased charges. In this manner, the [REDACTED] defendants transformed ordinary or average-cost patients into Outlier patients, even though the costs actually incurred by the hospitals to treat those patients fell within the normal range and, therefore, did not entitle the hospitals to receive Outlier payments.

79. To illustrate the impact of this practice, assume that in 2001 a hospital's latest audited CCR (from 1999) is 0.30. Assume further that the hospital decides to double its charges even though its costs actually have remained constant. After doubling its charges, its "real" CCR is 0.15. If a patient incurs \$300,000 in charges for a hospitalization, the hospital's actual costs to treat that patient are \$45,000 ( $0.15 \times \$300,000$ ). However, if the hospital adjusts its charges by using the CCR from its 1999 Cost Report (i.e., 0.30) that predates the recent increase in charges, the hospital's adjusted costs would be \$90,000 ( $\$300,000 \times .30$ ). Thus, the overall effect of this conduct would be to artificially inflate - in this case double - the hospital's adjusted costs from \$45,000 to \$90,000, while the hospital's actual costs remained constant. In most instances, such a large increase in the hospital's adjusted costs would convert an average-cost patient into an Outlier patient. (The actual determination of eligibility for Outlier payments would also depend upon the amount of the PPS payment to the hospital and the Outlier Threshold.)

80. Over time, the inflated-charging scheme defrauded the Outlier system in an additional manner. When the inflated charges were eventually reflected in a settled Cost Report (typically about two years after the charges were in effect), the hospital's CCR would fall precipitously (since the CCR had to be computed based on the charges in the most recent settled

Cost Report). Sometimes the CCR fell so low that it triggered use of the statewide average CCR. The statewide average CCR was invariably higher than the hospital's actual CCR, since the latter was driven down by the inflated charges. Using the higher statewide average CCR to compute a hospital's Outlier payments, rather than the more accurate hospital-specific CCR, again resulted in the payment of excessive Outlier payments to the [REDACTED] defendants.

B. [REDACTED]

81. [REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

82. [REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

83. [REDACTED]  
[REDACTED]  
[REDACTED]

[REDACTED]

84. [REDACTED]

[REDACTED]

85. [REDACTED]

[REDACTED]

86. [REDACTED]

[REDACTED]

87. [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

88.

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

89.

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

90.

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

91.

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

**C. Relator's Discovery Of The Inflated-Charging Scheme**

92. Relator first discovered the fraudulent practices alleged in this Complaint while working as a consultant [REDACTED]. By way of background, Relator has worked in the field of healthcare financial management for 25 years. See ¶ 11 above. Since 1999, Relator has worked as a private consultant providing strategic planning and financial management advice for a number of New Jersey hospitals.

93. Relator's first exposure to the fraudulent practices alleged herein was in 2002. At that time, Relator was engaged as a consultant by defendant Warren Hospital ("Warren"). In the course of examining the books and records of Warren for purposes of his engagement, Relator discovered that the hospital's Medicare Outlier payments had increased dramatically from 2000 to 2001. In 2000, Warren received \$4.8 million in inpatient Outlier payments; in 2001, its Outlier payments jumped nearly 100 percent, to \$9.43 million.

94. At the time, Relator could find no logical explanation for this extraordinary jump in Warren's Outlier payments, i.e., there was not a corresponding increase in patient costs or in the overall number of Medicare patients at the hospital. Nor was there any change in Medicare regulations or agency practice concerning the Outlier payment system during that time period. Relator took note of the jump in Outlier payments at Warren but did not investigate the matter further, since it was beyond the scope of his particular assignment. At the time, Relator was aware that Besler was doing consulting work for Warren, but at that time Relator did not connect Besler or Shusko with the abrupt rise in Warren's Outlier payments.

95. The following year, 2003, Relator was engaged to perform consulting work for [REDACTED]. In the course of examining the books and records of [REDACTED] for purposes of his engagement, Relator discovered a spike in Outlier payments similar to what he had observed at Warren. From 2000 to 2001, [REDACTED] inpatient Outlier payments increased almost 400 percent, from \$1.27 million to \$5.14 million. From 2001 to 2002, [REDACTED] Outlier payments more than doubled, from \$5.14 million to \$12.94 million. Like at Warren, this rate of increase could not be accounted for by any logical explanation related to actual Medicare usage, patient costs, or change in Medicare regulations.

96. Relator found the similarity between what he observed at Warren and [REDACTED] very curious, since Warren and [REDACTED] were unrelated hospitals with entirely separate management. Relator was aware, however, of one common link between the two hospitals: both used [REDACTED] a consultant. Relator questioned whether the marked jump in Outlier payments could be attributable in some way to the consulting advice of [REDACTED].

97. The following year, 2004, the picture became clearer. In 2004, Relator was engaged to perform consulting work for [REDACTED]. In the course of examining the books and records of [REDACTED] for purposes of this engagement, Relator discovered the same pattern that he had observed at Warren and [REDACTED]. From 2000 to 2001, [REDACTED] inpatient Outlier payments increased over 300 percent, from \$3.87 million to \$12.60 million; and between 2001 and 2002, its Outlier payments nearly doubled from \$12.60 million to \$22.14 million. Like at Warren and [REDACTED] this extraordinary rate of increase could not be accounted for by any logical explanation. However, the one common thread was that [REDACTED] was providing consulting services to all three hospitals.

98. After discovering the same pattern of unaccounted-for, dramatic increases in Outlier payments [REDACTED] Relator began to look more deeply into the matter. Relator's investigation included, *inter alia*, (1) speaking with contacts at [REDACTED] [REDACTED] and (2) checking what he learned from those contacts against various data and information sources available to Relator.

99. The first prong of Relator's investigation involved making inquiries among his many contacts [REDACTED] [REDACTED]. During his 25 years working in healthcare financial management in New Jersey, Relator has developed a large number of work colleagues, friends, and acquaintances [REDACTED] [REDACTED]. During the course of discussions with contacts at [REDACTED] Relator learned the following core allegations:

a. The dramatic increases in Outlier payments that Relator had observed at Warren, [REDACTED] were the result of an inflated-charging scheme. Specifically, the hospitals were inflating patient charges to fictitious levels, while using CCRs that predated the charge increases to compute the hospitals' adjusted costs for Medicare reimbursement purposes. In this manner, the hospitals were able to push their adjusted costs for treating ordinary-cost patients above the Medicare Outlier Threshold.

b. [REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

[REDACTED] (The minutes of an April 30, 2001 meeting of the Finance Committee of Warren Hospital confirm that the scheme was marketed in this manner. See ¶ 109 below.)

c. [REDACTED]

[REDACTED]

d. [REDACTED]

[REDACTED]

[REDACTED]

e. [REDACTED]

[REDACTED]

[REDACTED]

100. [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

101. [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

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[REDACTED]

[REDACTED]

102.

[REDACTED]

103.

[REDACTED]

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[REDACTED]

[REDACTED]

104. Building on the information that he gathered from speaking with contacts in the industry, Relator next proceeded to review the Medicare Cost Reports [REDACTED]. As described in more detail below, the Cost Reports showed a distinctive pattern and practice of conduct [REDACTED] that lent credibility to the information that Relator had learned from his contacts.

D. [REDACTED]

105. [REDACTED]

a. [REDACTED]

b. [REDACTED]

[Redacted text block]

c.

[Redacted text block]

d.

[Redacted text block]

e.

[Redacted text block]

f.

[Redacted text block]

g.

[REDACTED]

h.

[REDACTED]

106.

[REDACTED]

107.

[REDACTED]

**1. Warren Hospital**

108. As noted above, Relator's first exposure to the fraudulent scheme alleged herein was in 2002, when Relator was working as a consultant for Warren. See ¶¶ 93-94 above.

109. Subsequently, after contacts in the industry had alerted Relator to the role of Besler and Shusko in the inflated-charging scheme, Relator went back to Warren and examined the minutes of meetings of the Finance Committee of the Warren Hospital Board of Trustees during the 2001 time period. These minutes establish the beginning date of the scheme at Warren as April 30, 2001. According to the minutes, at the April 30, 2001 meeting, the Warren Hospital Administration presented to the Finance Committee a proposal [REDACTED] that is believed to be the inflated-charging scheme described herein. According to the minutes, the

proposal was entitled "Competitive Charge Analysis." The minutes of the meeting state in pertinent part:

Competitive Charge Analysis: Administration presented a proposal by [REDACTED] to conduct a limited review of certain aspects of the Hospital's reimbursement and pricing structure to determine if there are appropriate measures that the Hospital can implement to (1) ensure that reimbursement from various payers reflects better the Hospital's costs in delivering healthcare services, (2) to be more appropriately reimbursed for services the Hospital provides, and (3) to help the Hospital fulfill its mission to the community. Because of the proprietary nature of the project, the "Consultants" require Warren Hospital to sign a confidentiality agreement, which would prohibit us (and those with knowledge of the project) from disclosing information to any other providers. Warren has signed the agreement.

Specifically, Administration made a recommendation to accept the proposal in order to increase the current year reimbursement from all payers by adjusting the hospital's charge structure. Such proposal could yield an additional \$4.3 million in approved/collected revenues per year. . . .

At the following meeting of the Finance Committee, dated May 30, 2001, the Finance Committee recommended immediate implementation of the "Competitive Charge Analysis" proposal.<sup>3</sup>

110. The "additional \$4.3 million" in revenues per year promised by Besler and Shusko were more than realized in each of the first two years of the inflated-charging scheme.

111. According to Warren's Medicare Cost Reports, in 2000 [REDACTED] [REDACTED] Warren received \$4.8 million in inpatient Outlier payments. In 2001, its inpatient Outlier payments jumped nearly 100 percent, to \$9.43 million, or a \$4.63 million increase over the previous year. In 2002, Warren's Outlier payments jumped again, to \$14.36 million, or a \$4.97 million increase over the previous year. The \$14.36 million in

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<sup>3</sup> The "Competitive Charge Analysis" essentially established a target charge based upon the regional, statewide and national market. [REDACTED] presented the [REDACTED] with the proposition that they could raise their charges at least to and in many cases a certain percentage above the market average. In many cases, [REDACTED] was in fact escalating the market averages by selling the majority of hospitals in a region on the inflated-charging scheme, thereby perpetuating the scheme every year from at least 2001 through 2003.

Outlier payments received by Warren in 2002 represented an astounding 72 percent of its total IPPS payments for that year.<sup>4</sup>

112. The Cost Reports submitted by Warren do not disclose the existence of, or any details concerning, the inflated-charging scheme at Warren. However, when viewed in light of all of the other information gathered by Relator, Warren's Cost Reports take on greater significance. For example, the Cost Reports show that:

a. From 2000 to 2003, Warren increased its charges by a total of 209 percent, while its aggregate expenses increased by a total of only 51 percent.<sup>5</sup> Viewed in conjunction with all of the other evidence gathered by Relator, the disparity between the increase in charges versus increase in expenses at Warren during the 2000-2003 time period indicates that Warren was inflating charges not to recoup increased expenses but to reap windfall profits from the Outlier system.

b. From 2000 to 2003, while Warren increased its charges by 209 percent, its allowance for unpaid charges -- i.e., the amount written off on its books for unpaid charges -- increased by over 280 percent. The fact that Warren was writing off unpaid charges at an even faster rate than its charges increased suggests that Warren was not collecting most or all of the increased charges from its charge-paying customers. This supports the conclusion that Warren

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<sup>4</sup> As used herein, the phrase "total IPPS payments" refers to all Medicare payments under the IPPS system, exclusive of add-ons (e.g., payments for graduate medical education, indirect medical education, and disproportionate share payments.) As noted in ¶ 49 above, CMS sets the Outlier Threshold each year at an amount that is projected to generate total Outlier payments for inpatient services equal to 5.1 percent of total IPPS payments.

<sup>5</sup> A sizeable portion of the aggregate 51 percent increase in expenses was due to (1) the increase in bad debt expenses that resulted from the enormous charge increases, and (2) the contingency consulting fees paid to ██████████. When these two items are excluded, the percentage increase in expenses is significantly less. Relator estimates that the percentage increase in expenses at Warren between 2000 and 2003, net of bad debt expenses and the ██████████ fees, was approximately one-half of the aggregate 51 percent increase in expenses. This analysis applies to the discussion of every hospital below. That is, the percentage increase in aggregate expenses reported for each hospital would be reduced by approximately one-half, once bad debt expenses and the ██████████ fees are deducted from the calculation.

treated the increased charges as fictitious charges when the charges were applied to charge-paying customers.

113. The inflated-charging scheme at Warren defrauded Medicare of millions of dollars in inpatient Outlier payments and millions of dollars in outpatient Outlier payments between 2001 and 2003. In addition, Warren's charging practices violated Medicare's uniform charge requirement and caused Medicare to pay Warren millions of dollars in reimbursement payments to which Warren was not entitled.

2. [REDACTED]

114. [REDACTED]  
[REDACTED]  
[REDACTED]

115. [REDACTED]  
[REDACTED]

116. [REDACTED]  
[REDACTED]

[REDACTED]

[REDACTED]

117. [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

a. [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

b. [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

118. [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

3. [REDACTED]

119.

[REDACTED]

120.

[REDACTED]

121.

[REDACTED]

a.

[REDACTED]

b.

a

[REDACTED]

[REDACTED]

[REDACTED]

122.

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

4.

[REDACTED]

123.

[REDACTED]

[REDACTED]

[REDACTED]

124.

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

a.

[REDACTED]

125.

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

126.

[REDACTED]

127.

[REDACTED]

a.

[REDACTED]

[REDACTED]

b.

[REDACTED]

[REDACTED]

128.

[REDACTED]

[REDACTED]

[Redacted]

b. [Redacted]

129. [Redacted]

[Redacted]

[Redacted]

[Redacted]

[Redacted]

130. [Redacted]

a. [Redacted]

[Redacted]

[Redacted]

[Redacted]

[Redacted]

[Redacted]

[Redacted]

b. [Redacted]

[Redacted]

c. [Redacted]

[Redacted]

131. [Redacted]

[Redacted]

[Redacted]

[REDACTED]

[REDACTED]

c. [REDACTED]

132. [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

133. [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

134. [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

5. [REDACTED]

135.

[REDACTED]

136.

[REDACTED]

a.

[REDACTED]

137.

[REDACTED]

138.

[REDACTED]

a.

[REDACTED]

[Redacted]

b. [Redacted]

[Redacted]

c. [Redacted]

[Redacted]

139. [Redacted]

[Redacted]

[Redacted]

[Redacted]

[Redacted]

b. [Redacted]

140. [Redacted]

[Redacted]

141. [Redacted]

[Redacted]

[Redacted]

[Redacted]

[Redacted]

a. [Redacted]

[Redacted]

[Redacted]

[Redacted]

[Redacted text block]

b. [Redacted text block]

c. [Redacted text block]

142. [Redacted text block]

[Redacted text block]

6. [Redacted text block]

143. [Redacted text block]

[Redacted text block]

144. [Redacted text block]

[Redacted text block]

a. [Redacted text block]

[Redacted text block]

[REDACTED]

b. [REDACTED]

[REDACTED]

c. [REDACTED]

[REDACTED]

145. [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

7. [REDACTED]

146. [REDACTED]

[REDACTED]

[REDACTED]

147. [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

a. [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

b. [REDACTED]

[REDACTED]

c. [REDACTED]

[REDACTED]

148. [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

8. [REDACTED]

149. [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

150. [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

a.

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

b.

[REDACTED]

[REDACTED]

c.

[REDACTED]

[REDACTED]

151.

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

9.

[REDACTED]

152.

[REDACTED]

[REDACTED]

153.

[REDACTED]

[REDACTED]

[REDACTED]

154. [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

E. [REDACTED]

155. [REDACTED]

[REDACTED], Relator examined the charging practices of all [REDACTED] hospitals.

Relator's analysis indicated that most of the hospitals [REDACTED]

[REDACTED] had *not* gamed the Outlier system in the manner described in this complaint, *i.e.*, their Outlier revenues remained relatively constant from year to year, and when significant year-to-year increases occurred, these were attributable to cost increases or increased Medicare utilization.

156. Relator discovered, however, that [REDACTED] exhibited a pattern of fraudulent conduct similar to that described above, *i.e.*, their Outlier payments showed a dramatic increase in or about 2001 without a corresponding increase in actual costs or Medicare utilization. [REDACTED]

[REDACTED] Raritan Bay Hospital; [REDACTED]

[REDACTED]

157.

[REDACTED]

In either case, [REDACTED] are liable for fraudulently causing the Medicare program to pay [REDACTED] Outlier payments to which they were not entitled. The conduct of [REDACTED] is summarized below.

a. [REDACTED]

b. [REDACTED]

c. [REDACTED]

[REDACTED]

d. Raritan Bay Hospital ("Raritan"). In 2000, Raritan received \$14.93 million in Outlier payments. In 2001, its Outlier payments jumped to \$26.06 million, representing 60 percent of its total IPPS payments for that year. In 2002, Raritan's Outlier jumped again, to \$40.62 million, representing an extraordinary 90.6 percent of its total IPPS payments for that year. In 2003, Outlier payments declined somewhat, but its Outlier payments were still 53.5 percent of its total IPPS payments.

e. [REDACTED]

f. [REDACTED]

158. Medicare Cost Reports submitted by the [REDACTED] hospitals do not disclose the existence of, or any details concerning, the inflated-charging scheme at [REDACTED] hospitals. However, when viewed in light of all of the other information gathered by Relator, these Cost Reports support the conclusion that the sudden increase in Outlier payments [REDACTED] during the 2001-2003 time period was due to the inflated-charging scheme described in this complaint. Among other information, the Cost Reports show that:

a. During the relevant time period, the increase in charges [REDACTED] was *far larger* than the hospital's increase in expenses. This indicates [REDACTED] inflating charges not to recoup increased expenses but to reap windfall profits from the Outlier system.

b. During the relevant time period, the allowance for unpaid charges [REDACTED] increased at an even faster rate than the [REDACTED] charges increased. This indicates [REDACTED] writing off most or all of the charge increases when the charges were applied to charge-paying customers.

159. Between 2001 and 2003, the inflated-charging scheme [REDACTED] hospitals defrauded Medicare of millions of dollars [REDACTED]. In addition, the charging practices [REDACTED] violated Medicare's uniform charge requirement and caused Medicare to pay [REDACTED] millions of dollars in reimbursement payments to which [REDACTED] not entitled.

F. [REDACTED]

160. [REDACTED]

[REDACTED]

161. [REDACTED]

[REDACTED]

1. [REDACTED]

162. [REDACTED]

[REDACTED]

163. [REDACTED]

[REDACTED]

[REDACTED]

a. [REDACTED]

[REDACTED]

[REDACTED]

b. [REDACTED]

[REDACTED]

c. [REDACTED]

[REDACTED]

164. [REDACTED]

[REDACTED]

165. [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

2. [REDACTED]

166. [REDACTED]

[REDACTED]

167. [REDACTED]

[REDACTED]

[REDACTED]

a. [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

b. [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

c. [REDACTED]

[REDACTED]

[REDACTED]

168.

[REDACTED]

169.

[REDACTED]

3.

[REDACTED]

170.

[REDACTED]

[REDACTED]

[REDACTED]

171.

[REDACTED]

[REDACTED]

a.

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

b.

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

c.

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

172.

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

4. [REDACTED]

173. [REDACTED]

[REDACTED]

**VI. DAMAGES**

174. As a result of the inflated-charging scheme described in this complaint, the defendants submitted or caused to be submitted [REDACTED] false or fraudulent claims for Outlier payments to the Medicare and Medicaid programs between 2001 and 2004. The false or fraudulent claims submitted by defendants caused the federal and state governments to pay defendants [REDACTED] millions of dollars in inpatient and outpatient Outlier payments to which defendants were not entitled. In addition, defendants' charging practices violated Medicare's uniform charge requirement and caused Medicare to pay defendants [REDACTED] millions of dollars in reimbursement payments to which defendants were not entitled.

175. [REDACTED]

[REDACTED]

**Count I**  
**False Claims Act 31 U.S.C. §§3729(a)(1) and (a)(2)**

176. Relator repeats and realleges each and every allegation contained in paragraphs 1 through 175 above as though fully set forth herein.

177. This is a claim for treble damages and penalties under the False Claims Act, 31 U.S.C. §3729, et seq., as amended.

178. By virtue of the acts described above, defendants knowingly presented or caused to be presented, false or fraudulent claims to officers, employees or agents of the United States Government for payment or approval under the Medicare program, within the meaning of 31 U.S.C. §3729(a)(1).

179. By virtue of the acts described above, defendants knowingly made, used, or caused to be made or used false or fraudulent records and statements, and omitted material facts, to get false and fraudulent claims paid or approved under the Medicare program, within the meaning of 31 U.S.C. §3729(a)(2).

180. The United States, unaware of the falsity of the records, statements and claims made or caused to be made by the defendants, paid and continues to pay the claims that would not be paid but for defendants' unlawful conduct.

181. By reason of the defendants' acts, the United States has been damaged, and continues to be damaged, in substantial amount to be determined at trial.

182. Additionally, the United States is entitled to the maximum penalty of \$11,000 for each and every false and fraudulent claim made and caused to be made by defendants arising from their unlawful conduct as described herein.

**Count II**  
**False Claims Act 31 U.S.C. §§3729(a)(1) and (a)(2)**

183. Relator repeats and realleges each and every allegation contained in paragraphs 1 through 175 above as though fully set forth herein.

184. This is a claim for treble damages and penalties under the False Claims Act, 31 U.S.C. §3729, et seq., as amended.

185. By virtue of the acts described above, defendants knowingly presented or caused to be presented, false or fraudulent claims to officers, employees or agents of the United States Government for payment or approval under the Medicaid program, within the meaning of 31 U.S.C. §3729(a)(1).

186. By virtue of the acts described above, defendants knowingly made, used, or caused to be made or used false or fraudulent records and statements, and omitted material facts, to get false and fraudulent claims paid or approved under the Medicaid program, within the meaning of 31 U.S.C. §3729(a)(2).

187. The United States, unaware of the falsity of the records, statements and claims made or caused to be made by the defendants, paid and continues to pay the claims that would not be paid but for defendants' unlawful conduct.

188. By reason of the defendants' acts, the United States has been damaged, and continues to be damaged, in substantial amount to be determined at trial.

189. Additionally, the United States is entitled to the maximum penalty of \$11,000 for each and every false and fraudulent claim made and caused to be made by defendants arising from their unlawful conduct as described herein.

**Count III**  
**False Claims Act 31 U.S.C. §§3729(a)(3)**

190. Relator repeats and realleges each and every allegation contained in paragraphs 1 through 175 above as though fully set forth herein.

191. This is a claim for treble damages and penalties under the False Claims Act, 31 U.S.C. §3729, et seq., as amended.

192. By virtue of the acts described above, defendants [REDACTED] conspired [REDACTED] [REDACTED] to defraud the United States by inducing the United States to pay or approve false and fraudulent claims, within the meaning of 31 U.S.C. §3729(a)(3). The co-conspirators, moreover, took substantial steps in furtherance of the conspiracy, inter alia, by making false and fraudulent statements and representations and by failing to disclose material facts.

193. By reason of the defendants' acts, the United States has been damaged, and continues to be damaged, in substantial amount to be determined at trial.

194. Additionally, the United States is entitled to the maximum penalty of \$11,000 for each and every violation of 31 U.S.C. §3729(a)(3) as described herein.

**Prayer**

WHEREFORE, Relator prays for judgment against the defendants as follows:

1. that defendants cease and desist from violating 31 U.S.C. §3729 et seq.;
2. that this Court enter judgment against defendants in an amount equal to three times the amount of damages the United States has sustained because of defendants' actions, plus a civil penalty of not less than \$5,000 and not more than \$11,000 for each violation of 31 U.S.C. §3729;

3. that Relator be awarded the maximum amount allowed pursuant to §3730(d) of the False Claims Act;

4. that Relator be awarded all costs of this action, including attorneys' fees and expenses; and

5. that Relator and the United States recover such other relief as the Court deems just and proper.

**Demand for Jury Trial**

Pursuant to Rule 38 of the Federal Rules of Civil Procedure, Relator hereby demands a trial by jury.

Dated: February 22, 2006

By: \_\_\_\_\_

JS  
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Attorneys for Qui Tam Plaintiff Anthony Kite

**Certificate of Service**

This is to certify that on this 22<sup>nd</sup> day of February, 2006, I caused a true copy of the foregoing "Amended Complaint" to be served by first class mail, postage prepaid, to :

Stuart Minkowitz  
Assistant U.S. Attorney  
District of New Jersey  
970 Broad Street, Suite 700  
Newark, NJ 07102

Daniel Spiro  
U.S. Department of Justice  
PO Box 261  
Ben Franklin Station  
Washington, D.C. 20044



**Jonathan S. Berck**

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