IN THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF TENNESEE

CARMEN M. SCHREANE, on behalf Of the United States of America,	)	
Plaintiff/Relator,	)	
-vs-	)	**FILED UNDER SEAL JURY TRIAL DEMANDED**
MEMORIAL HEALTH CARE SYSTEM, and CATHOLIC HEALTH INITIATIVES,	)	
Defendants.	)	

QUI TAM COMPLAINT

RELATOR CARMEN M. SCHREANE brings this qui tam action in the name of the United States of America, by and through counsel undersigned John Iwu, and alleges as follows:

A. SUMMARY INTRODUCTION

1. This is an action by qui tam Relator Carmen M. Schreane (hereinafter "Ms. Schreane"), on behalf of the United States against Defendants Memorial Health Care System (hereinafter "MHCS") and Catholic Health Initiatives (hereinafter "CHI") to recover penalties and damages arising from false statements made regarding physicians leases below fair market value, appraisals and comparables, construction allowances and in engaging in an elaborate quid pro quo scheme

pursuant to which kickbacks were paid to physicians in exchange for referrals to MHCS/CHIand its various Tennessee facilities for prescriptions, surgeries, while billing Medicaid/Medicare for these services. This unethical and illegal scheme was concocted to secure federal and state monies allocated to the states through the Medicaid/Medicaid program.

2. Ms. Schreane was employed by MHCS as a Manager of Contract/Compliance from December 2007 through December 2008. As part of Ms. Schreane's job description, she was reviewed and updated all compliance matters at MHCS.
3. In January 2008, Ms. Schreane was assigned the project of identifying Vendors MHCS/CHI made payments to but did not have a contract with (hereinafter "the Vendor Assignment").[1] By virtue of her job description, Ms. Schreane was privy to intimate details regarding vendor lists, contracts and other pertinent documents and information.
4. By May 2008, six months after Ms. Schreane began the Vendor Assignment, she detected that approximately two to three hundred (200-300) of the twenty five hundred (2500) vendors currently doing business with MHCS/CHI did not have the requisite contracts.
5. Approximately, twenty to thirty (20-30) million dollars in federal and state monies were paid to the said vendors.

[1] Medicare requires that an "Excluded Provider Check" be ran on every vendor doing business with an institution receiving federal and state Medicare funds.

B. PARTIES

6. Relator Carmen M. Schreane is a natural person and citizen of the State of Tennessee.
7. Defendant MHCS is a foreign (Kentucky) corporation that has since 1985 been registered to do business in the State of Tennessee (ID 0157762). Its principal office is in Tennessee.
8. Its main facility is Memorial Hospital. However, in addition to Memorial Hospital it owns and operates Memorial North Park Hospital, Memorial Health Care System includes Memorial Atrium Imaging Center, Memorial Center for Health, Memorial Health Place at Hamilton Place, Memorial Health Place at Hixson, Memorial Home Health, Memorial North Shore Health Center, and Memorial Westside Health Center.
9. Memorial Health Partners, the area's largest physician group, Memorial Health Services, a physician-hospital organization, and Mountain Management, a physician management company are also part of Memorial Health Care System.
10. MHCS may be served with process of this Court through its registered agent: C T Corporation System at 800 S. Gay Street, Suite 201, Knoxville, Tennessee 37929.
11. Defendant CHI is a foreign (Colorado) corporation that has since 1999 been registered to do business in the State of Tennessee (ID0373514). Its principal office is in Denver, Colorado however it maintains an office in Knoxville, Tennessee.
12. CHI is a national nonprofit health organization with headquarters in Denver comprising of 77 hospitals; 40 long-term care, assisted- and residential-living

facilities; and two community health-services organizations in 20 states. One such hospital is Memorial Health Care Services (MHCS).

13. CHI may be served with process of this Court through its registered agent: C T Corporation System, 800 S. Gay Street, Suite 201, Knoxville, Tennessee 37929.

C. JURISDICITON AND VENUE

14. This action arises under the False Claims Act, 31 U.S. C. §§ 3729 et seq.

15. This Court maintains subject matter jurisdiction over this action pursuant to 31 U.S.C. § 3732(a) (False Claims Act), 28 U.S.C. § 1331 (Federal Question Jurisdiction) and 28 U.S.C. § 1367 (Supplemental Jurisdiction).

16. Venue is proper in this Court pursuant to 31 U.S.C. § 3732(a) because (i) MHCS and CHI both reside in this District; (ii) Both MHCS and CHI transact business in this district and did so at all times relevant to this complaint; and as averred below, (iii) Both MHCS and CHI committed acts proscribed by 2828 U.S.C. § 3729 – acts giving rise to this action within this district.

17. Before filing this Complaint, Ms. Schreane served a copy of the same upon the United States, together with a written disclosure statement setting forth and enclosing all material evidence and information it possesses, pursuant to the requirements outlined in 31 U.S.C. § 3739(b)(2).

18. Ms. Schreane has complied with all other conditions precedent to bringing this action.

19. Ms. Schreane is the original source of, and has direct and independent knowledge of, all publicly disclosed information upon which all allegations herein might be based and has voluntarily provided such information to the Government before

filing this action. Specific disclosures include (1) letters to the Department of Health and Human Services ("DHHS") and the Federal Bureau of Investigations ("FBI") as well as documentary proof of the fraud turned over to Agent Edward D. Galloway of Federal Bureau of Investigations.

D. FACTUAL ALLEGATIONS

I. The Federal Anti-Kickback Statute

20. Medicare and Medicaid fraud have cost the federal government billions of dollars. Qui tam (whistleblower) lawsuits filed under the False Claims Act ("FCA"), 31 U.S. C. §§ 3729 et seq., have been responsible for some of the government's biggest health care fraud recoveries. Over the past years, one of the Federal Anti-Kickback Statute has been used as a means of combating Medicare and Medicaid fraud between the Medical Institutions, physicians and vendors.

21. The Anti-Kickback Statute: 42 U.S.C. § 1320a-7b(b) provides: Whoever knowing and willfully solicits or receives any remuneration (including any kickbacks, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind - (1) in return for referring an individual to a person for the furnishing or arranging of any item or service for which payment may be made in whole or in part under a Federal health care program, or (2) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both. Whoever knowing and willfully solicits or receives

any remuneration (including any kickbacks, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person- (1) to refer an individual to a person for the furnishing or arranging of any item or service for which payment may be made in whole or in part under a Federal health care program, or (2) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in who or in part under a Federal health care program, shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

22. The Federal Courts have held, and the Justice Department agrees, that violations of the Anti-Kickback statute gives rise to a FCA violation because, as a condition of participation in the Medicare program, the defendant has agreed to abide by all Medicare Statutes and Regulations (one of which is the Anti-Kickback statute). Section 1877 of the Social Security Act, codified at 42 U.S.C. § I 395nn (hereinafter the "Stark Statute,") prohibits a physician from referring Medicare patients for certain "designated health services ("DHS") to an entity with which he has a "financial relationship" unless an exception applies.

23. When originally enacted in 1989 ("Stark I"), the prohibitions applied only to physicians' referrals for clinical laboratories. Omnibus Budget Reconciliation Act of 1989, P.L. 103-66, § 13562, Social Security Act Amendments of 1994, P.L. 103-432, § 152. In addition to prohibiting certain physician referrals, the Stark Statute prohibits health care entities from presenting or causing to be presented any

Medicare claim for DHS provided as a result of a prohibited referral. 42 U.S.C. § I 395(a)(1)(B).

24. Any entity that collects a Medicare payment for DHS rendered pursuant to a prohibited referral must refund all collected amounts. 42 U.S.C. § 1395nn(g)(2); 42 C.F.R. § 411.353(g). Under the Stark Statute, the United States will not pay for certain items or services prescribed or ordered by physicians who have improper financial relationships with the entities that furnish those items or services. Stated conversely, compliance with the Stark Statute is a condition of payment imposed by the Federal Healthcare Programs.

25. One of the major purposes of the statute was to reduce losses suffered by the Medicare program due to over utilization of services. The Stark Statute broadly defines "financial relationship" to include ownership and investment interest and compensation agreements that involve any direct or indirect remuneration between a physician and an entity providing DHS.

26. A variety of regulatory and statutory exceptions identify specific types of investments and compensation agreements that will not violate its referral and billing prohibitions. Financial relationships between a physician and an entity providing DHS that do not meet a regulatory or statutory exception violate the statute. For example, compensation paid to a referring physician serving as a consultant to a hospital will fall within an exception to the statute if the contract (1) is in writing and signed by the parties; (2) Is for a term of at least a year; (3) Specifies the services covered, covers all the services to be provided by the physician, and the aggregate of such services is reasonable and necessary for the

legitimate business purposes of the hospital; and (4) Sets the payment for contract services in advance, consistent with fair market value for services actually rendered, not taking into account the volume or value of the referrals or other business generated between the parties. 42 U.S.C. § 1395nn(e)(3).

27. Thus, compensation paid to a physician (directly or indirectly) under a personal services arrangement that exceeds fair market value, or for which no actual services are required, triggers the referral and payment prohibitions of Stark II with respect to DHS referred by that physician.

28. Further, a referring physician may lease office space to or from the provider of DHS if certain requirements are met, including the following: The space rented or leased does not exceed that which is reasonable and necessary for the legitimate purposes of the lease or rental. The rental charges are consistent with fair market value. The charges are not determined in a manner that takes into account the volume or value of any referrals. The agreement would be commercially reasonable even if no referrals were made between lessor and lessee.

29. Although Stark II anticipated that HHS would issue regulations interpreting the statute, Stark II is self-implementing. Congress did not require that regulations be promulgated before the statute became enforceable. See 42 U.S.C. § 1395nn(e)(1)(A). When final Stark I regulations were issued in August 1995, their preamble specifically recognized the applicability of much of those regulations to interpret Stark II. See 60 Fed. Reg. 41914, 41916, 41978 (1995); 42 C.F.R. § 411.350-361 (1996).

30. On January 4, 2001, when HHS issued Phase I of final regulations interpreting Stark II, which further clarified that statute and its exceptions, the agency noted in its preamble that the regulations afforded providers until January 4, 2002 to bring certain arrangements into compliance "where [the regulations] proscribe[] conduct not previously prohibited," and that "[i]n the meantime, the statute in its entirety remains in full force and effect …." See 66 Fed. Reg. 856, 861 (2001).

31. Violation of the statute may subject the physician and the billing entity to exclusion from participation in federal health care programs and various financial penalties, including (a) a civil money penalty of $15,000 for each service included in a claim for which the entity knew or should have known that payment should not be made under Section 1395nn(g)(1); and (b) an assessment of three times the amount claimed for a service rendered pursuant to a referral the entity knew or should have known was prohibited. See 42 U.S.C. § 1395nn(g)(3), 1320a-7a(a). Compliance with the Stark Statute is and has been, since January 1, 1995, a condition of payment under the Medicare program. Many different arrangements may implicate the Anti-Kickback and Stark laws. Some of the most common are: a. Cash for patients, b. Marketing Agreements, c. Employee Service Agreements, d. Waivers of co-payments and deductibles, e. Medical Director Agreements, f. Below Fair Market Value Agreements Between Providers and Suppliers, g. Sporting Event Tickets, h. Hospital, Nursing Home and Other Facilities Cost Report Certifications:

32. Many of the cost reports submitted by health care facilities to the Medicare financial intermediary require a certification that the hospital is in compliance

with all federal laws required for reimbursement. If the health care provider is not in compliance, the cost report is a false claim for payment and an argument can be made that the entire cost report is subject to treble damages. i. Drug companies failure to report their true best price for drugs to federal and state payors j. Pharmacies dispensing partial prescriptions and charging for the full amount k. Off-label promotion of drugs: under the provisions of the Food, Drug and Cosmetics Act, a company must specify the intended uses of a product in its new drug application to the FDA. Once approved, the drug may not be marketed or promoted for so-called "off-label" uses - any use not specified in an application and approved by the FDA.

II. The MHCS/CHI Relationship

33. Memorial Health Care System is part of Catholic Health Initiatives, a national health corporation based in Denver, Colorado. Catholic Health Initiatives has under its umbrella 70 hospitals; 43 long-term care, assisted and independent living and residential facilities; and two community-based health organizations located in 19 states.

34. Thus, CHI served as an umbrella organization for MHCS and other medical institutions

35. As part of this arrangement, CHI is intricately involved with the daily operations of MHCS and knew or should have known of the fraud being perpetrated against the United States.

36. Specifically, CHI has auditors, Eden Parker and Lindsey Friddell, onsite at MHCS who oversaw audits and other financial matters both of whom were privy to contracts that were replete with kickbacks and illegality.

37. By virtue of the fact that CHI was closely associated with MHCS, had significant access to its files as well as having staff on MHCS sites charged with overseeing financial matters CHI knew or should have known of the fraudulents acts and omissions perpertrated by MHCS upon the Government and people of the United States, CHI and MHCS conspired to commit the fraudulent acts and omissions alleged in this complaint.

III. Relator Carmen Schreane and the Detection of Fraud

38. Ms. Schreane worked as a TN Manager/Contracts and Compliance, i.e., a Contracts and Compliance Manager for Defendant Memorial Health Care System from December 4, 2007 to December 3, 2008 (see Exhibit 1 is an electronic copy of Ms. Fletcher's annual performance review dated September 2008).

39. By virtue of her position, Ms. Schreane was the only person at Memorial Health System responsible for Contract Management and Contract Management Database (Tractmanager/Meditract). There were only a few individuals in the hospitals who Ms. Schreane believes had access to the contract materials other than her.

40. As a Contracts and Compliance Manager, Ms. Schreane solely managed contracts and the contract database. She performed reports for audits and accessed leases and contracts between vendors/non-physicians and physicians. Ms. Schreane

managed all of Memorial Health System's contracts and ensured that they were in compliance with federal and state health care regulations and laws.

41. Further, Ms. Schreane worked directly with Vice Presidents and Directors for other departments or companies to ensure that all contracted parties are in compliance, aware of expiration notices and any other modification of terms that have been previously agreed upon.

42. On June 25, 2008, Ms. Schreane emailed a disclosure of her Vendor Contract Audit Report to Interim CEO Deb Moore, CHAN Auditor Eden Parker and her Supervisor VP Beverly Gordon West. This report gave established details of vendors who had received payments in multi-million dollar amounts without contracts with Memorial Health Care System.

43. Upon receiving the Vendor Contract Audit Report, Ms. Schreane explains her Supervisor, VP Beverly Gordon West, became furious with her. VP West requested that Ms. Schreane come to her office and asked her what she was doing. When Ms. Schreane began to explain, VP West interrupted her, yelled at her and told her to "just go, just go!" VP West then asked the Insurance Manager to work on the spreadsheet (Vendor Contract Audit Report) to find proof that Ms. Schreane's report findings were false.

44. Henceforth, Ms. Schreane felt intimidated by VP West and VP West began avoiding her and shunning her from her office and her presence.

45. On October 10, 2008 Ms. Schreane sent a request for a **"Complete Investigation into Fraud and Retaliation"** (subject line of letter) via email and copied every important decision maker at Memorial. She filed a grievance

against VP West for retaliation and reported fraud in Physician leases under Fair Market Value among others.

46. On that same morning of October 10, 2008, Ms. Schreane met with the Vice President of Human Resources, Brad Pope and had him telephone conference in CEO Deb Moore and National Vice President CRO Michelle Cooper to discuss the situation.

47. During this time a formal meeting was set for October 13, 2008 in which all persons would further discuss Ms. Fletcher's detection of fraud withMHCS' vendor contracts and physician contracts.

48. After making her formal complaint on October 10, 2008, Ms. Schreane's duties were diminished.

49. On October 20, 2008, Ms. Schreane expressed her concern about her current job tasks and she was offered to be transferred to the basement.

50. Vice President Beverly Gordon West was terminated on October 30, 2008 and Niti Tejani was her interim replacement.

51. On November 14, 2008, Ms. Schreane was assigned the secretarial task of working on filing cabinets.

52. On November 17, 2008, Ms. Schreane sent an email to Kevin Lofton (CHI CEO), MHCS CEO Jim Hobson, CEO Deb Moore, Interim VP Niti Tejani, and HR VP Brad Pope complaining of employment discrimination based on retaliation for whistle blowing, fraud disclosure and race.

53. On November 25, 2008, Ms. Schreane sent a fraud report to the Department of Health and Human Services, disclosing the names of physicians and informing them she had documents for proof.

54. On November 26, 2008, Ms. Schreane filed an Employment Grievance.

55. On December 1, 2008, Ms. Schreane met with VP Niti Tejani and HR VP Brad Pope.

56. At that meeting she was informed that they were in the process of reviewing her grievance; however, they were first going to conduct some investigations into her removal and copying of documents without authorization.

57. On December 1, 2008, Ms. Schreane turned in all documents and emails to Senior FBI Agent Edward D. Gallaway (see attached as Plaintiff's Exhibit 1).

58. On December 2, 2008, Ms. Schreane met with attorney Daniel Reinberg and Jim White of Spears law office. Ms. Fletcher told them that because she was only given 24 hours notice of the meeting and did not have legal representation, then would not be speaking any further.

59. On December 3, 2008, HR VP Brad Pope called Ms. Schreane, terminating her effective December 3rd for violating the corporate confidentiality agreement she signed.

60. Ms. Schreane engaged counsel only after exhausting these other avenues.

IV. The MHCS/CHI Kickback Scheme

61. During Ms. Schreane's tenure with MHCS (December 2007 – December 2008), she acquired firsthand knowledge of false claims described below. Each described act or omission was knowingly committed by MHCS and CHI in an

attempt to secure federal funds through a fraudulent scheme pursuant to which physicians (1) were given leases that were charged at a rate below fair market value (2) paid for less square footage than they were in actual possession and made use of (3) were given construction allowances that were not calculated into their respective lease payments and (4) were allowed to operate other businesses e.g. coffee shops, within the MCHS facility. All these acts or omissions were done knowingly for the sole purpose of securing federal medicare and Medicaid dollars paid by clients' of the said physicians.

V. Specific Instances of Fraud

1. Group/Physicians Leases Below Fair Market Value

62. Most fundamentally, Ms. Schreane has firsthand knowledge that MCHS/CHI engaged in a conscious pattern of charging physicians both individually and as a group at rates for their leases that were patently below fair market value.

63. Specifically, the Physicians at Memorial North Park Professional Office Building I and II sublet office space from MHCS at a prices patently below fair market value and as appraised by Richard Banks and Meridian Corp, both of whom specialize in lease appraisals.

64. More specifically, these physicians were being charged approximately 14.50 per square feet. However, six (6) of the fourteen (14) dollars was allocated to common areas and tax fees wherein the Fair Market Value/Comparables for the same or similar space with other Chattanooga Hospitals was approximately eighteen (18) dollars.

65. The Physicians at Memorial North Park received these kickbacks for close to twenty (20) years.

66. The Chattanooga Heart Institute, comprised of approximately Twenty to Twenty Two (20-22) physicians is another such group of physicians that was given leases below fair market value.

67. More specifically, these physicians were being charged approximately 14.50 per square feet. However, six (6) of the fourteen (14) dollars was allocated to common areas and tax fees wherein the Fair Market Value/Comparables for the same or similar space with other Chattanooga Hospitals was approximately eighteen (18) dollars.

68. In other instances, the Chattanooga Heart Institute physicians were not required to pay condominium association fees as a kickback in exchange for Medicaid/medicare funds from the federal and state government.

69. Some of the Chattanooga Heart Institute physicians involved were Doctors Roger Land and NP OB/BYN both of whom occupied suites 101 and 402 respectively.

70. The Chattanooga Heart Institute conducted approximately Four Hundred (400) surgeries at the MHCS facility annually and received these kickbacks for approximately ten (10) year.

2. Construction/Renovation Allowances

71. Ms. Schreane has firsthand knowledge of the fact that several physicians were given approximately One Hundred to Two Hundred Thousand (100,000.00 – 200,000.00) dollars as renovation/construction allowances as a kickbacks in

exchange for their continued referrals of the hospital, a direct fraud on the federal and state Medicare/Medicaid programs.

72. Specifically, Beacon Health an institution with approximately fifteen to thirty (15-30) physicians received unlawful/illegal kickbacks in the form of construction/renovation allowances in exchange for in exchange for their continued patronage of the hospital, a direct fraud on the federal and state Medicare/Medicaid programs.

73. The Beacon lease is lease number 2008.26221.

74. Drs. Kellie Jolie, Maurice Rawlings and Memorial Health Partners Foundation all received from MHCS/CHI unlawful/illegal kickbacks in the form of construction/renovation allowances in exchange for in exchange for their continued patronage of the hospital, a direct fraud on the federal and state medicare/Medicaid programs.

3. Other Miscellaneous Kickbacks

75. Ms. Schreane has firsthand knowledge of the fact that several physicians received kickbacks in the form of various miscellaneous arrangements the totality of which demonstrates MHCS/CHI's wanton disregard for the law and a consciously calculated scheme concocted to defraud federal Medicare/Medicaid programs.

76. Specifically, Dr. Channapa Chandra who leased offices from MHCS, paid for One Thousand Two Hundred and Eighty (1280) square feet when the actual square footage of the space she occupied was in excess of Eighteen Hundred (1,800) square feet. This was allowed to continue for several years.

77. In addition, Dr. Mena who also leased office space with MHCS, did not pay for storage he used for several years.

78. Dr. Charles Portera Sr., a surgeon by profession and who leased space from MHCS was also owned Bluff District Art Museum, majority owner of Rembrandt Coffee shop located inside the MHCS facility.

79. In line with this arrangement, patients' families were given vouchers for free coffee at Rembrandts with MHCS reimbursing the Coffee Shop for costs incurred.

80. One Rose Gibson, an employee with MHCS was charged with keeping track of the said vouchers.

81. This arrangement is a kickback carefully clothed as a legitimate business practice and is a direct fraud on the federal and state medicare/Medicaid programs.

4. Systematic/Illegal Practices

82. MHCS/CHI made kickbacks identified above, by act or omission, in a systematic attempt, and pursuant to corporate policy, to knowingly cause the payment of federal funds to it by paying physicians kickbacks in exchange for referrals for services provided at MHCS facilities.

83. The crux of the fraudulent scheme was to provide an "incentive" albeit illegal to physicians as a means of securing their business. By securing the physicians business, MHCS and CHI ensured that they received federal Medicare/Medicaid funds that are paid on behalf of patients.

84. MHCS/CHI paid kickbacks to physicians in exchange for referrals. It did so knowing the illegal nature of such actions.

85. The scheme endured for several years, possibly decades.

86. Upon its disclosure by Ms. Schreane, MHCS/CHI concealed the problem for several months.

87. MHCS/CHI refused to take any remedial measures after the fraud was disclosed to its CEO and VP.

88. Rather redress the fraud and illegality disclosed by Ms. Schreane, MHCS/CHI embarked on a plan of action to mute Ms. Schreane's voice through intimidation and a demotion in her duties.

89. Further, it took MHCS the entirety by four (4) months to take any sort of corrective action.

90. Specifically, the fraud was detected and reported on or about June 25, 2008. However, Beverly Gordon West, VP and Ms. Schreane's supervisor and the person most likely to have an intricate knowledge of the scheme was not discharged until October 30, 2008.

91. MHCS went great lengths to conceal the fraud after it was detected in order to maintain an unfair advantage over other medical institutions and to avoid being required to repay funds already paid to it for its payment of kickbacks to physicians.

FIRST CAUSE OF ACTION
(False Claims Act: Presentation of False Claims) (31 U.S.C. § 3729(a)(1))

92. Relator re-alleges and incorporates each of the preceding ¶¶ and allegations as though fully pleaded.

93. Defendants MHCS and CHI are participants of the Federal Medicare program, As part of their participation, both defendants agreed to abide by all Medicare Statutes and Regulations (one of which is the Anti-Kickback statute also known as "Stark Statute,").

94. The Stark Statute prohibits a physician from referring Medicare patients for certain "designated health services ("DHS") to an entity with which he has a "financial relationship" unless an exception applies.

95. MHCS and CHI induced several physicians into referring patients for treatment at its Tennessee facilities in order to secure federal funds through a scheme pursuant to which physicians (1) were given leases that were charged at a rate below fair market value (2) paid for less square footage than they were in actual possession and made use of (3) were given construction allowances that were not calculated into their respective lease payments and (4) were allowed to operate other businesses e.g. coffee shops, within the various MHCS facilities.

96. MHCS and CHI (1) knowingly presented, or caused to presented, to the United States Government, a false or fraudulent claim for payment or approval; (2) knowingly made, used or caused to be made used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; and (3) knowingly made, used, or caused to be made or used, a false record or statement

to conceal, avoid decrease an obligation to pay or transmit money or property to the Government.

97. By virtue of their actions, MHCS and CHI violated the Stark Statute which prohibits health care entities from presenting or causing to be presented any Medicare claim for DHS provided as a result of a prohibited referral (i.e. pursuant to the payment of kickbacks). 42 U.S.C. § I 395(a)(1)(B).

98. Defendants MHCS and CHI authorized and ratified all the violations of the False Claims Act committed by its various officers, agents and employees.

99. The United States Government and the public have been damaged as a result of Defendants CHI and MHCS's violations of the False Claims Act.

100. Relator requests a jury trial on all issues so triable.

<u>SECOND CAUSE OF ACTION</u>
False Claims Act: Making or Using False Record or Statement) (31 U.S.C. § 3729 (a)(2))

101. Plaintiff repeats and re-alleges each allegation in ¶¶ 1 through 100, as if fully set forth herein.

102. The defendants knowingly made, used or caused to be made or used a false record or statements so as to enable it receive monetary payments from the United States.

103. By virtue of the false records or statements made by the defendants, the United States suffered damages and therefore is entitled to treble damages under the False Claims Act, to be determined at trial, plus a civil penalty of $5,000 to $10,000 for each false claim.

<u>THIRD CAUSE OF ACTION</u>
(False Claims Act: Presentation of False Claims) (31 U.S.C. § 3729(a)(1))

104. Plaintiff repeats and re-alleges each allegation in ¶¶ 1 through 103, as if fully set forth herein.

105. The defendants knowingly presented or caused to be presented false or fraudulent claims for payment or approval to the United States.

106. By virtue of the false or fraudulent claims made by the defendants, the United States suffered damages and therefore is entitled to treble damages under the False Claims Act, to be determined at trial, plus a civil penalty of $5,000 to $10,000 for each false claim.

<u>FOURTH CAUSE ACTION</u>
(Conspiracy to Submit False Claims)

107. Relator re-alleges and incorporates the allegations in ¶¶ 1-106 as if fully set forth herein.

108. Defendants combined, conspired, and agreed together to defraud the United States by knowingly submitting false claims to the United States and to its grantees for the purpose of getting the false or fraudulent claims paid or allowed and committed the other overt acts set forth above in furtherance of that conspiracy, all in violations of 31 U.S.C. § 3729(a)(3) causing damage to the United States.

THIRD CAUSE OF ACTION
(Unjust Enrichment)

109. Plaintiff repeats and re-alleges each allegation in ¶¶ 1 through 108, as if fully set forth herein.

110. This is a claim for recovery of monies by which the defendants have been unjustly enriched.

111. By directly or indirectly obtaining government funds to which they were not entitled, the defendants were unjustly enriched, and are liable to account and pay such amounts, or the proceeds or profits there from, which are to be determined at trial, to the United States.

FOURTH CAUSE OF ACTION
(Payment by Mistake)

112. Plaintiff repeats and re-alleges each allegation in ¶¶ 1 through 111, as if fully set forth herein.

113. This a claim for the recovery of monies paid by the United States to the defendants by mistake.

114. The United States, acting in reasonable reliance on the accuracy and truthfulness of the information contained in the cost reports submitted by defendants, paid the MHCS and CHI participant defendants certain sums of money to which they were not entitled, and defendants are thus liable to account and pay such amounts, which are to be determined at trial, to the United States.

<u>FIFTH CAUSE OF ACTION</u>
(Recoupment of Overpayments)

115. Plaintiff United States repeats and re-alleges each allegation in ¶¶ 1 through 114, as if fully set forth herein.

116. This is a claim for common law recoupment, for the recovery of monies unlawfully paid by the United States to the MHCS and CHI, defendants, contrary to statute or regulation.

117. The United States paid the MHCS and CHI participants defendants certain sums of money to which they were not entitled. Defendants are thus liable under the common law of recoupment to account and return such amounts, which are to be determined at trial, to the United States.

<u>SIXTH CAUSE OF ACTION</u>
(Retaliation in Violation of 31 U.S.C. § 3730(h))

118. Relator re-alleges and incorporates the allegations in ¶¶ 1-117 as if fully set forth herein.

119. During the period from October 2008 to present, qui tam plaintiff Schreane was harassed and demoted in her employment by defendant as a result of her lawful acts done in furtherance of this action. Including complaints to corporate officials regarding the false claims described herein. This harassment and demotion wa s in violation of 31 U.S.C. § 3730(h).

120. As a direct and proximate result of this unlawful and discriminatory harassment and demotion, plaintiff has suffered emotional pain and mental anguish, together with serious economic hardship, including lost wages and

special damages associated with her efforts to obtain alternative employment, in an amount to be proven at trial.

WHEREFORE, Relator Carmen Schreane, on behalf of herself and the United States Government, prays;

a. that this Court enter a judgment against Defendant in an amount equal to three times the amount of damages the United States sustained as a result of Defendant's violations of the False Claims Act.

b. that this Court enter a judgment against Defendants for a civil penalty of Ten Thousand (10,000.00) dollars for each of Defendant's violations of the False Claims Act;

c. that Relator Carmen Schreane recover all costs of this action, with interest, including the cost to the United States Government for its expenses related to this action;

d. the Relator Carmen Schreane be awarded all reasonable attorneys' fees in bringing this action;

e. that in the event the United States Government proceeds with this action, Relator Carmen Schreane be awarded an amount for bringing this action of at least fifteen percent (15%) but not more than twenty five percent (25%) of the proceeds of the action;

f. that in the event the United States Government does not proceed with this action, Relator Carmen Schreane be awarded an amount for bringing this action of at least twenty five percent (25%) but not more than thirty percent (30%) of the proceeds of the action;

g. that Relator Carmen Schreane be awarded prejudgment interest;

h. that a trial by jury be held on all issues so triable; and

i. that Relator Carmen Schreane and the United States of America receive all relief to which either or both may be entitled at law or in equity.

Respectfully submitted,

_____/s/John Ben Iwu____
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