IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF MISSISSIPPI
EASTERN DIVISION

UNITED STATES OF AMERICA,
ex rel., SHIRLEY E. DAVIS

PLAINTIFF

V. CIVIL ACTION NO. ____________________

RURAL HEALTHCARE DEVELOPERS, INC.,
RURAL HEALTHCARE DEVELOPERS OF MISSISSIPPI, LLC,
RURAL HEALTHCARE DEVELOPERS OF SMITH COUNTY, LLC,
HEALTHCARE FOUNDATION OF NORTHWEST MISSISSIPPI, INC.,
HEALTHCARE FOUNDATION FOR RURAL HEALTHCARE DEVELOPERS, INC.,
KING'S DAUGHTERS HOSPITAL OF YAZOO CITY, INC.,
SOUTH CAMERON MEMORIAL HOSPITAL CORPORATION,
FLINT RIVER HOSPITAL,
PATIENTS' CHOICE MEDICAL CENTER OF HUMPHREYS COUNTY, LLC,
PATIENTS' CHOICE MEDICAL CENTER OF CLAIBORNE COUNTY, LLC,
PATIENTS' CHOICE MEDICAL CENTER OF CHICKASAW COUNTY, LLC,
PATIENTS' CHOICE MEDICAL CENTER OF CHOCTAW COUNTY, LLC,
PATIENTS' CHOICE MEDICAL CENTER OF SMITH COUNTY, LLC,
PATIENTS' CHOICE MEDICAL CENTER OF ERIN, TENNESSEE, LLC, and
RAYMOND L. SHOEMAKER

DEFENDANTS

FILED UNDER SEAL

COMPLAINT
(JURY TRIAL REQUESTED)

Qui tam relator, Shirley E. Davis, by her undersigned attorneys, hereby alleges as follows:

1. This is a civil action brought on behalf of the United States of America against the defendants named herein to recover damages and civil penalties under the False Claims Act, 31 U.S.C. §§ 3729-3732, as amended by the False Claims Act Amendments of 1986 and the Fraud Enforcement and Recovery Act of 2009. Relator Shirley Earnestine Davis ("Davis"), acting on behalf of the United States, brings this civil action under the

qui tam provisions of the False Claims Act.

Venue and Jurisdiction

2. This Court has jurisdiction over this action pursuant to 28 U.S.C. § 1345 and 31 U.S.C. §§ 3730(b) and 3732(a).

3. Venue is proper in this district pursuant to 28 U.S.C. § 1391(b) and (c) and 31 U.S.C. § 3732(a). Defendants, or certain of them, were doing business in this District at all times material to this action, and the claims set forth in this Complaint arose, at least in part, in this District.

The Parties

4. *Qui tam* relator Davis is an adult citizen of the United States, a resident of Canton, Mississippi, and an elderly beneficiary of both the Medicare and the Medicaid health care programs funded by the United States Government. From at least October of 2009 through at least November of 2010, Davis attended as a patient, either two times or three times each week, a purported "intensive outpatient" program established and managed by Defendant Rural Healthcare Developers, Inc., and conducted in the name of Defendant Kings Daughters Hospital of Yazoo City, Mississippi, at a

location in Canton, Mississippi. Claims to Medicare and the Mississippi Medicaid Division for substantial payments to the Defendants, for the services purportedly performed for Davis by the Defendants, are among the false claims alleged in this action.

5. Defendant Rural Healthcare Developers, Inc. (hereafter, "RHD"), is a Mississippi for-profit corporation established in 2006, which since that time has maintained its operational headquarters in or near Tupelo, Mississippi, and thus within the Northern District of Mississippi. From that headquarters, it has since that time established, managed, and operated numerous outpatient "behavioral health units" at locations in Mississippi, Tennessee, Georgia and Louisiana. RHD's Chief Executive Officer and Registered Agent throughout all that time has been, and remains, Defendant Raymond L. ("Ray") Shoemaker, who may be served with process at his principal address of 2553 Main Street, Plantersville, Mississippi.

6. Defendant Rural Healthcare Developers of Mississippi, LLC (hereafter "RHD of Mississippi"), is a Mississippi limited liability company established in 2008.

It may be served through its Registered Agent and Member, Ray Shoemaker, at his principal address of 2553 Main Street, Plantersville, Mississippi. Each reference below to the term "RHD and its affiliates" is meant herein to include, among others, Defendant Rural Healthcare Developers of Mississippi, LLC.

7. Defendant Rural Healthcare Developers of Smith County, LLC (hereafter "RHD of Smith County"), is a Mississippi limited liability company established in 2010.

It may be served through its Registered Agent and Member, Ray Shoemaker, at his principal address of 2553 Main Street, Plantersville, Mississippi. Each reference below to the term "RHD and its affiliates" is meant herein to include, among others, Defendant RHS of Smith County.

8. Defendant Healthcare Foundation of Northwest Mississippi, Inc. (hereafter "HFNWM"), is a Mississippi limited liability company established in 2005. It may be served through its Registered Agent and Member, Ray Shoemaker, at his principal address of 2553 Main Street, Plantersville, Mississippi.

Each reference below to the term "RHD and its affiliates" is meant herein to include, among others, Defendant Healthcare Foundation of Northwest Mississippi, Inc.

9. Defendant Healthcare Foundation for Rural Healthcare Developers, Inc. (hereafter "HFRHD"), is a Mississippi limited liability company established in 2008.
It may be served through its Registered Agent and Member, Ray Shoemaker, at his principal address of 2553 Main Street, Plantersville, Mississippi.
Each reference below to the term "RHD and its affiliates" is meant herein to include, among others, Defendant Healthcare Foundation for Rural Healthcare Developers, Inc.

10. Defendant King's Daughters Hospital of Yazoo City, Inc. (hereafter "King's Daughters"), is a Mississippi corporation established in 1991. It may be served through its Registered Agent Lonnie Graeber, at his principal address of 823 Grand Avenue, Yazoo City, Mississippi.
Each reference below to the term "Hospital Defendants" shall include, among others, the Defendant King's Daughters.

11. Defendant South Cameron Memorial Hospital Corporation

(hereafter "South Cameron Memorial"), is a Louisiana corporation established in 1997.

It may be served through its Registered Agent Elton L. Williams, Jr., at his principal address of 1701 Oak Park Boulevard, Lake Charles, Louisiana 70601. Each reference below to the term "Hospital Defendants" shall include, among others, the Defendant South Cameron Memorial.

12. Defendant Flint River Hospital (hereafter "Flint River"), is a Georgia entity located at 509 Sumter Street in Montezuma, Georgia, and may be served at that address through service on its Administrator and Chief Executive Officer, Paul Jones. Each reference below to the term "Hospital Defendants" shall include, among others, the Defendant Flint River.

13. Defendant Patients' Choice Medical Center of Humphreys County, LLC

(hereafter "PC of Humphreys County"), is a Mississippi limited liability company established in 2008. It may be served through its Registered Agent and Member, Ray Shoemaker, at his principal address of 2533 Main Street, Plantersville, Mississippi 38862. Each reference below to the term "Hospital Defendants" shall include, among others, the Defendant PC of

Humphreys County.

14. Defendant Patients' Choice Medical Center of Claiborne County, LLC

(hereafter "PC of Claiborne County"), is a Mississippi limited liability company established in 2008. It may be served through its Registered Agent and Member, Ray Shoemaker, at his principal address of 2533 Main Street, Plantersville, Mississippi 38862. Each reference below to the term "Hospital Defendants" shall include, among others, the Defendant PC of Claiborne County.

15. Defendant Patients' Choice Medical Center of Chickasaw County, LLC

(hereafter "PC of Chickasaw County"), is a Mississippi limited liability company established in 2008. It may be served through its Registered Agent and Member, Ray Shoemaker, at his principal address of 2533 Main Street, Plantersville, Mississippi 38862. Each reference below to the term "Hospital Defendants" shall include, among others, the Defendant PC of Chickasaw County.

16. Defendant Patients' Choice Medical Center of Choctaw County, LLC (hereafter "PC of Choctaw County"), is a Mississippi limited liability company

established in 2008. It may be served through its Registered Agent and Member, Ray Shoemaker, at his principal address of 2533 Main Street, Plantersville, Mississippi 38862. Each reference below to the term "Hospital Defendants" shall include, among others, the Defendant PC of Choctaw County.

17. Defendant Patients' Choice Medical Center of Smith County, LLC (hereafter "PC of Smith County"), is a Mississippi limited liability company established in 2010. It may be served through its Registered Agent and Member, Ray Shoemaker, at his principal address of 2533 Main Street, Plantersville, Mississippi 38862. Each reference below to the term "Hospital Defendants" shall include, among others, the Defendant PC of Smith County.

18. Defendant Patients' Choice Medical Center of Erin, Tennessee, LLC (hereafter "PC of Erin, Tennessee"), is a Tennessee limited liability company established in 2008. It may be served through its Registered Agent, WT&C Corporate Services, Inc., at 2525 W. End Avenue, Suite 1500, Nashville, Tennessee 37203. Each reference below to the term "Hospital Defendants" shall include, among others, the Defendant PC of Erin, Tennessee.

19. Defendant Raymond L. Shoemaker (hereafter "Shoemaker"), is an adult citizen of the United States who resides in Lee County, Mississippi, and/or in Humphreys County, Mississippi, and may be served with process at either 2533 Main Street, Plantersville, Mississippi, or 500 CCC Road, Belzoni, Mississippi. Shoemaker, as

founder and Chief Executive Officer of RHD and its affiliates, personally designed and executed the schemes described below, and personally caused all of the false claims challenged herein to be submitted, knowing that they were all legally false claims.

The Law

20. The False Claims Act (FCA) provides in pertinent part that:

> (a) Any person who (1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval; (2) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; (3) conspires to defraud the Government by getting a false or fraudulent claim paid or approved by the Government; ... or (7) knowingly makes, uses, or causes to be made or used , a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government,
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> is liable to the United States Government for a civil penalty of not less than $5,500 and not more than $11,000, plus 3 times the amount of damages which the Government sustains because of the act of that person....
> (b) For purposes of this section, the terms "knowing" and "knowingly" mean that a person, with respect to

> information (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent is required.

31 U.S.C. § 3729.

21. The Anti-Kickback Statute, 42 U.S.C. § 1320a-7b(b), arose out of congressional concern that financial inducements to those who can influence healthcare decisions would result in goods and services being provided that are medically unnecessary, of poor quality, or even harmful to a vulnerable patient population. To protect the integrity of the program from these difficult-to-detect harms, Congress enacted a *per se* prohibition against the payment of kickbacks in any form, regardless of whether the particular kickback gave rise to overutilization or poor quality of care. First enacted in 1972, Congress strengthened the statute in 1977 and 1987 to ensure that kickbacks masquerading as legitimate transactions did not evade its reach. *See* Social Security Amendments of 1972, Pub. L. No. 92-603,

§§ 242(b) and ©; 42 U.S.C. § 1320a-7b, Medicare-Medicaid Antifraud and Antiabuse Amendments, Pub. L. No. 95-142; Medicare and Medicaid Patient and Program Protection Act of 1987, Pub. L. No. 100-93. As of January 1, 1997, the prohibition on kickbacks also applied to the Tricare program.

22. One of the purposes of the Anti-Kickback Statute is to ensure that health care providers compete for business based on the quality of care provided to patients and the efficiency with which such services are provided. When important health care decisions are influenced by improper inducements, competition among health care providers is drastically diminished. Those providers who abide by the law and refuse to provide improper remuneration in exchange for referrals lose business to unscrupulous providers who provide illegal inducements in order to get Medicare and Medicaid business. As a result of violations of the Anti-Kickback Statute, honest providers that provide high quality care to Medicare beneficiaries are deprived of the opportunity to compete fairly for business and consequently suffer economic loss.

23. The Anti-Kickback Statute prohibits any person or entity from offering or accepting remuneration to induce or reward any person from

referring, recommending, or arranging for federally-funded medical services, including services provided under the Medicare and Medicaid programs:

(b) Illegal remunerations

> (1) whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind-
> (A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, or
> (B) 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 no more than $25,000 or imprisoned for not more than five years, or both.

> (2) whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind, to any person to induce such person
> -
> (A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, or
> (B) to purchase, lease, order, or arrange for or recommend purchasing, leasing or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal Health care

program,

shall be guilty of a felony and upon conviction thereof, shall be fined no more than $25,000 or imprisoned for not more than five years, or both.

42 U.S.C. § 1320a-7b(b). Violation of the statute can also subject the perpetrator to exclusion from participation in Federal health care programs and, effective August 6, 1997, civil monetary penalties of $50,000 per violation and three times the amount of remuneration paid. 42 U.S.C. § 1320(a)-7(b)(7) and 42 U.S.C. § 1320a-7(a)(7).

Medicare and Outpatient Psychiatric Services

24. The United States, through the Department of Health and Human Services ("HHS") and its component agency, the Centers for Medicare and Medicaid Services ("CMS"), administers the Medicare Part A and Medicare Part B programs. Generally, hospitals are reimbursed through the Medicare Part A program, and physicians are reimbursed through the Medicare Part B program. The United States also pays for health care services through numerous other health care programs, including Medicaid and CHAMPUS (or "Tricare").

25. Hospitals, physicians, and other health care providers who participate in the Medicare program, as well as other federal health care programs, are required to enter into contracts or "provider agreements" with HHS. Under the terms of these provider

agreements, hospitals, physicians, mental health professionals, and other participating health care providers certify that they will comply with all laws, regulations, and guidance concerning proper practices for Medicare providers. Compliance with these provider agreements is a condition for participation in, and receipt of payments from, the Medicare program.

26. Each of the Hospital Defendants completed and submitted a CMS-855A form as part of its enrollment with the Medicare Program. Through the submission of that form, each of the Hospital Defendants certified to HHS that they would "abide by the Medicare laws, regulations and program instructions that apply to this provider...." The Hospital Defendants certified further that they "understand that payment of a claim by Medicare is conditioned upon the claim and the underlying transaction complying with such laws, regulations and program instructions (including, but not limited to, the Federal anti-kickback statute and the Stark law), and on the provider's compliance with all applicable conditions of participation in Medicare."

27. One of the services paid for under the Medicare Part B program is outpatient hospital psychiatric services. These outpatient services provide active treatment to individuals with mental disorders, and all such services must be rendered "incident to" a physician's service and be reasonable and necessary for the diagnosis and treatment of the patient's condition. "Incident to" services are defined as those services furnished as an integral, although incidental, part of a physician's personal professional services in the course of diagnosis or treatment of an illness or injury. In order to satisfy

the "incident to" requirement, physicians must provide direct supervision of all services billed to Medicare and/or Medicaid. If outpatient psychiatric services are rendered off-site from the hospital, then the supervising physician must be in constant attendance at the off-site location in order for the services to be eligible for Medicare coverage.

28. Along with certain other outpatient psychiatric services, Medicare Part B pays for group psychotherapy led by doctors or certain other licensed professionals allowed by the state to conduct group therapy. These services must satisfy the criteria to be billed "incident to" the services of a physician, and a physician must provide direct supervision as described above.

29. In order to be covered by Medicare, services must be reasonably expected to improve the patient's condition. As each of the Defendants knew, therapy comprised primarily of activity, social, or recreational therapy did not and does not constitute medically necessary psychiatric services, and therefore is not eligible for reimbursement under the Medicare Program (or for secondary payment under the Medicaid Program). Likewise, and as the Defendants also knew, psychosocial programs or services which provide only a structured environment, socialization, and/or vocational rehabilitation are not covered by Medicare.

30. Medicare does not cover the costs of meals or transportation provided to participants in outpatient psychiatric programs.

31. Medicare and Medicaid providers are prohibited by law from offering or

providing to a Medicare or Medicaid beneficiary any item of value which the provider knows or should know is likely to influence the beneficiary's selection of a particular provider, practitioner, or supplier of Medicare or Medicaid payable items or services. Offering valuable gifts to beneficiaries in order to influence their choice of a Medicare or Medicaid provider raises quality and cost concerns. The use of "giveaways" to attract business also favors large providers with greater financial resources for such activities, disadvantaging smaller providers and businesses. Any gifts, giveaways, or "freebies" exceeding $10 per item or $50 annually per patient constitute unlawful inducements.

32. Although group therapy is covered under Medicare Part B, Medicare does not pay for the full cost of group therapy. During the relevant time period, the percentage of Medicare-approved charges paid by the Medicare each year has fluctuated. In 2010, for instance, Medicare paid 55% of the Medicare-approved charge. The remaining amount of the Medicare-approved charge is paid by patients, either directly out of their pockets or through Medicaid or other supplemental insurance.

33. Many of the beneficiaries for whom the Defendants billed group therapy services to Medicare, including the Relator, also were covered under state Medicaid programs. The States of Louisiana, Mississippi, Georgia and Tennessee (through its "Tenncare" program) maintain federally-approved Medicaid programs to reimburse health care charges made by physicians and other health care providers for the treatment of low-income beneficiaries. When a

patient is covered by both Medicare and Medicaid, Medicare is considered the primary payor and Medicaid pays the portion of charges not paid by Medicare. Even though state Medicaid programs are state-run, the federal government funds a substantial percentage of each Medicaid payment. For the States of Louisiana, Mississippi, Georgia, and Tenneessee, the percentage of each Medicaid payment paid by the federal government ranges up to 76% in Mississippi.

Defendants' Scheme

34. Defendants have engaged in a pattern of conduct that has resulted in the submission of thousands of false claims to the United States through the Medicare and Medicaid programs. As a result of this conduct, Defendants have received from the United States millions of dollars to which they were not entitled.

35. Beginning in 2007, RHD and its affiliates and officers have engaged in a scheme with the Hospital Defendants pursuant to which thousands of false claims knowingly have been submitted to Medicare and Medicaid for group therapy services which were not covered by and thus not payable by Medicare or Medicaid because 1) they were not properly rendered "incident to" a physician's services; 2) the "services" provided were comprised primarily of activity, social, or recreational therapy and therefore were not covered under or payable by Medicare as reimbursable outpatient group psychotherapy; 3) Defendants provided excessive gifts to beneficiaries in order to

insure their continued participation in Defendants' bogus therapy program; and 4) the financial relationship between RHD (and its affiliates) on the one hand, and the Hospital Defendants on the other hand, violated the federal anti-kickback statute. One-hundred percent of such outpatient group psychotherapy claims submitted to Medicare and/or Medicaid since 2007 were knowingly false claims under the federal False Claims Act, and would not have been paid by Medicare or Medicaid had personnel responsible for the payment of such claims known of the scheme described herein.

Failure to Provide Group Therapy "Incident To" a Physician's Services

36. In furtherance of the scheme described herein, RHD (and its affiliates) and the Hospital Defendants entered into agreements pursuant to which RHD agreed to use facility space purportedly controlled by the Hospital Defendants to provide bogus therapy services which the Hospital Defendants each agreed to bill to Medicare Part B (and the respective Medicaid programs) as outpatient group psychotherapy. In exchange for the agreement of the Hospital Defendants to (a) prepare and submit bills and claims for group therapy services to Medicare and Medicaid with the use of the Hospital Defendants' own provider numbers as if the Hospital Defendants were delivering and supervising those services, (b) refer patients to RHD's so-called "Senior Life Solutions" facilities, RHD and its affiliates agreed to allow the hospitals to keep a fraction of all amounts paid by Medicare (as the primary payor), Medicaid (as a supplemental payor), and/or other private insurance (also as a supplemental payor) in response to the Hospital Defendants' claims for the bogus therapy activities operated in fact by RHD and its affiliates. Each

reference hereafter to "Senior Life Solutions facilities" shall mean all of the locations and activities resulting from those agreements and arrangements.

37. All such claims were submitted to Medicare as if the Hospital Defendants themselves had provided legitimate outpatient group psychotherapy services, when in fact all staff involved in the bogus therapy program, including physicians, were controlled by RHD and its affiliates.

38. Despite the fact that the bogus therapy services provided by RHD and its affiliates were billed as outpatient "hospital services," the offices in which RHD's Senior Life Solutions facilities operated were not in fact departments of or operated by the Hospital Defendants, and in some instances were not even located in the same vicinity as the Hospital Defendants. The Senior Life Solutions facility where Relator Davis received purported services from RHD was located, for instance, at 1360 East Peace Street in Canton, Madison County, Mississippi, which is not even in the same County as the location of the Hospital Defendant which falsely represented to Medicare and Medicaid that it had been providing services, namely Defendant Kings Daughters Hospital (which is located in Yazoo County, Mississippi).

39. In order to be reimbursable under Medicare Part B, outpatient group psychotherapy services must be rendered "incident to" the services of a physician. In order to qualify as reimbursable "incident to" services, group therapy must be directly supervised by a physician. When outpatient psychiatric services are rendered off-site from a hospital, the supervising physician must be in constant attendance throughout the

period of therapy at the off-site location in order for such therapy services to be compensable.

40. Pursuant to the Defendants' scheme, and with the knowledge and participation of RHD and its affiliates and the Hospital Defendants, there was not constant psychiatrist presence at any of the Senior Life Solutions facilities at any time since the Defendants' scheme began resulting in claims in 2007. At the Senior Life Solutions facility attended by Relator Davis, for instance, a physician appeared only once every two weeks. In the course of those appearances, the physician, Dr. Parveen Kumar, would meet for a few minutes with Ms. Davis and separately with each of the other twenty or so patients, ask them substantially the same few factual questions he had asked each such patient on each prior such occasion, and provide no individualized therapy, medication or other medical treatment. Although in order to make it appear on records that Ms. Davis was medically in need of mental therapy services the Senior Life Solutions staff falsely recorded a diagnosis of "depression" on records pertaining to Ms. Davis, Ms. Davis in fact never suffered from clinical depression, and was never the subject of any individualized therapy, discussion, or treatment for actual clinical depression.

41. The same Dr. Parveen Kumar was the only psychiatrist who appeared at any of the Senior Life Solutions facilities located in Mississippi. Kumar would attend each such facility no more often than once per week. Kumar was not actively practicing medicine or otherwise present at the locations of the Defendant Hospitals, apart from his

once-per-week presence at the Senior Life Solutions facilities themselves. The services at this facilities were therefore not "incident to" any physician services by Dr. Kumar or otherwise.

42. The Hospital Defendants, as the entities submitting claims to Medicare Part B under their Medicare provider numbers, were legally and professionally responsible for insuring proper physician supervision at each of the Senior Life Solutions facilities. They failed to do so.

43. In order to maximize their profits, Defendants refused to spend the money necessary to provide constant physician presence at the Senior Life Solutions facilities where group therapy services were allegedly being provided.

44. As a result of the conduct set forth herein, all claims submitted to Medicare Part B (as primary payor) and state Medicaid programs (as secondary payor) for group therapy services provided at the Senior Life Solutions facilities when a physician was not physically present at the Senior Life Solutions facilities were false claims under the federal False Claims Act. All such claims represented that services had been provided by a physician or "incident to" a physician's services, and all such representations were false. Had the Medicare or Medicaid contractors responsible for processing claims for outpatient group therapy known that the services were not provided incident to the care of a physician, those claims would not have been paid.

45. All such claims to Medicare described in the preceding paragraph were submitted to Medicare by the Hospital Defendants on a UB-92 form (also known as a

HCFA-1450 form) and include an implied certification that the services billed to Medicare were properly reimbursable under applicable Medicare laws and regulations. Truthful certification is a condition of payment from Medicare, and the claims at issue would not have been paid absent these certifications. *Because use by each Hospital Defendant of its explicit statements on its earlier CMS-855A enrollment form was an integral part of each presentation of each such claim for payment, each such claim used a statement that the underlying transaction complied with Medicare laws and regulations, and that such compliance was a condition met by any such claim for payment, and therefore each such claim for that additional reason used a false statement in order get each such false claim paid.* Because the group therapy services described herein were not properly rendered "incident to" a physician's services, each and every claim described in the preceding paragraph submitted via a UB-92 form was a false claim in violation of the federal False Claims Act.

"Therapy" Provided by Defendants Was Not Covered by Medicare or Medicaid

46. While Medicare Part B does cover legitimate outpatient group

psychotherapy, Medicare expressly excludes from coverage any course of therapy comprised primarily of activity, social, or recreational therapy. Likewise, Medicare expressly excludes from coverage psychosocial programs or services which provide only a structured environment, socialization, and/or vocational rehabilitation.

47. Beginning in 2007 and continuing until this time, the Defendants have all engaged in a scheme pursuant to which Medicare and Medicaid beneficiaries are induced to visit the Senior Life Solutions facilities on a daily or otherwise regular basis. At the Senior Life Solutions facilities, these beneficiaries are kept busy by non-physician staff members with social activities including bingo (including the awarding of "prizes" for winning at bingo, such as plastic beads and household cleaning products), bead-making crafts, throwing of a "beach ball" within the group, and physical exercises. Other substantial periods of time during the purported "therapy" activities are consumed with serving and eating a "free" breakfast, a "free" hot lunch, and a mid-afternoon snack. No such activities are participated in or supervised by any physician at the Senior Life Solutions facilities. While non-physician staff members periodically distribute and discuss printed sheets addressing behavioral issues in very general terms, no therapy is regularly offered which is responsive to the particular psychological needs or diagnoses of particular participants in the sessions.

48. The immediately preceding paragraph indeed describes the sessions in which Relator Davis participated at the Senior Life Solutions facility to which she was assigned, and was typical of the activities which have taken place since 2007 at all such

Senior Life Solutions facilities. No such activities or purported therapy sessions are covered or payable by Medicare or Medicaid, as the Defendants knew.

49. Despite the fact that the group activities conducted at the Senior Life Solutions facilities did not constitute legitimate outpatient group psychotherapy and are not covered by Medicare, Defendants knowingly presented, or cause to presented, thousands of false claims to Medicare (and ultimately Medicaid as a secondary payor) for outpatient group therapy. Representative samples of those claims are reflected on the claim dates, amounts, and descriptions included on claims made by Defendant Kings Daughters to Medicare and Medicaid for purported "group therapy - IOP" services claimed to have been rendered to Relator Davis by Kings Daughters and included as "Exhibit A" hereto. The *daily* charge made to Medicare and Medicaid for such "intensive outpatient program" services was $843.00, as Exhibit A also reflects. As a result of that scheme and those thousands of such claims, the Defendants have received from Medicare and Medicaid millions of dollars to which they are not entitled under the law. One hundred percent of the claims arising out of attendance at all such Senior Life Solutions facilities by all Medicare and Medicaid beneficiaries since and including 2007 were indeed knowingly false claims, which the Defendants intended to be paid by Medicare and Medicaid with funds of the United States Government.

50. As a result of the conduct set forth herein, all claims submitted to Medicare Part B (as primary payor) and state Medicaid programs (as secondary payor) for group therapy services provided at the Senior Life Solutions facilities are false claims under the

federal False Claims Act, because the group activities conducted at the defendant facilities were and are not covered by Medicare. Defendants represented to Medicare on all such claims that therapy of the type covered by Medicare was provided, but all of those representations were false. Had the Medicare contractors responsible for processing claims for outpatient group therapy known that the services were not of the type covered by Medicare, those claims would not have been paid.

51. All such claims to Medicare described in the preceding paragraph were submitted to Medicare by the Hospital Defendants on a UB-92 form (also known as a HCFA-1450 form) and included an implied certification that the services billed to Medicare were properly reimbursable under applicable Medicare laws and regulations. Truthful certification was and is a condition of payment from Medicare, and the claims at issue would not have been paid absent these certifications. Because use by each Hospital Defendant of its explicit statements on its earlier CMS-855A enrollment form was an integral part of each presentation of each such claim for payment, each such claim used a statement that the underlying transaction complied with Medicare laws and regulations, and that such compliance was a condition met by any such claim for

payment, and therefore each such claim for that additional reason used a false statement in order get each such false claim paid. Because the group activities conducted at the defendant facilities did not constitute covered outpatient group psychotherapy, each and every claim described in the preceding paragraph submitted via a UB-92 form was a false claim in violation of the federal False Claims Act.

Illegal Inducements to Patients

52. In order to induce Medicare and/or Medicaid beneficiaries to participate in the same bogus group therapy scheme, RHD and its affiliates provided beneficiaries with remuneration in the form of free transportation, meals, and prizes. For each patient, the value of these meals and prizes has been substantially more than $50 per year.

53. When providing these inducements to Medicare and/or Medicaid beneficiaries, Defendants knew or should have known that the inducements were likely to influence the beneficiaries' decisions to participate in the Defendants' bogus group therapy scheme.

54. A standard marketing practice of RHD and its affiliates was to induce senior citizens to participate in group activities at the Senior Life Solutions facilities by offering and providing them with free transportation to and from the Senior Life Solutions facilities each day. All beneficiaries who participated in the group activities at the Senior Life Solutions facilities also received a free breakfast, a free hot lunch, and a

free afternoon snack during each and every day they were in attendance. In order to induce such beneficiaries to remain at the Senior Life Solutions facilities throughout much of the day of purported therapy, participating beneficiaries therefore received each month meals "free" to them, the value of which exceeded $100 per month per beneficiary. These offers to prospective patients of free transportation and free meals were widely communicated and marketed by the Defendants through marketing representatives and written solicitations, including the solicitation leaflet attached hereto as Exhibit B (promising ""Free Transportation - Meals Provided" if solicited beneficiaries will appear at the Senior Life Solutions facilities daily).

55. Relator Davis in the fall of 2009 was personally solicited by an RHD marketer to participate in the Senior Life Solutions facility in Canton at a time when she was playing bingo at the "Club Room" of the apartment complex where she resides (at no expense to anyone, and certainly not to the Medicare or Medicaid systems). The RHD marketer promised Davis that "Medicare's going to pay for it" if she participates in the Defendants' program, that she would be able to play bingo there, that she would receive "three meals a day" at no expense to her, and that the program would be "lots of fun" for Davis. Davis thereafter was indeed picked up at her home in Canton, Mississippi by an RHD multi-passenger van each morning, and transported to the Canton facility of RHD, and then returned to her home each afternoon, at no charge to her. She was also fed a cooked breakfast, a cooked lunch, and an afternoon snack during each day of her attendance at the Senior Life Solutions facility in Canton. The Defendants knew that such

inducements would likely influence such beneficiaries' decisions to participate throughout the day in the Defendants' bogus group therapy activities.

56. As a result of the further conduct set forth herein, all claims submitted since and including 2007 to Medicare Part B (as primary payor) and state Medicaid programs (as secondary payor) for group therapy services provided at the Senior Life Solutions facilities for group therapy are false claims under the federal False Claims Act, because the beneficiaries who received those services were illegally induced by the Defendants to attend the bogus therapy sessions.

57. Each such claim represented that the services provided were reimbursable under the Medicare program, but each such representation was false, because the excessive inducements described herein rendered the services non-reimbursable. Had the Medicare contractors responsible for processing claims for outpatient group therapy known that the services resulted from improper inducements, those claims would not have been paid.

58. All such claims to Medicare described in the preceding paragraphs were submitted to Medicare by the Hospital Defendants on a UB-92 form (also known as a HCFA-1450 form) and included an implied certification that the services billed to Medicare were properly reimbursable under applicable Medicare laws and regulations. Truthful certification is a condition of payment from Medicare, and the claims at issue would not have been paid absent these certifications. Because use by each

Hospital Defendant of its explicit statements on its earlier CMS-855A enrollment form was an integral part of each presentation of each such claim for payment, each such claim used a statement that the underlying transaction complied with Medicare laws and regulations, and that such compliance was a condition met by any such claim for payment, and therefore each such claim for that additional reason used a false statement in order get each such false claim paid. Because the participation of all of the beneficiaries who participated in Defendants' bogus group therapy was illegally induced by Defendants, each and every claim described in the preceding paragraph submitted via a UB-92 form was a false claim in violation of the federal False Claims Act.

Kickbacks from RHD and the Facilities to the Hospitals

59. RHD and its affiliates entered agreements with each of the Hospital Defendants through which RHD would organize, market and operate the bogus therapy sessions at each of the Senior Life Solutions facilities, in exchange for allowing and authorizing the Hospital Defendants the economically valuable opportunity to submit claims to Medicare and Medicaid in the Hospital Defendants' own names and provider

numbers, and to keep an agreed fraction of the resulting proceeds from Medicare and Medicaid, disbursing the remaining fraction to RHD and its affiliates.

60. The Hospital Defendants, in exchange for those economically valuable opportunities, agreed with RHD and its affiliates to submit such claims in their hospitals' names and with their hospital provider numbers, to refer patients and prospective patients to the Senior Life Solutions facilities for participation in the bogus therapy sessions, and to allow RHD and its affiliates to (mis)represent to beneficiaries that such facilities were operated by such local hospitals, without having to incur costs to operate the Senior Life Solutions facilities (and indeed without incurring any financial risk at all).

61. That exchange of value for an agreement to make referrals violated and continues to violate the federal Anti-Kickback Statute. All of the claims resulting from remuneration to the Hospital Defendants in exchange for the use of their Medicare numbers and in conjunction with referrals to RHD and/or the Senior Life Solutions facilities were tainted by this scheme, and each such claim was a legally false claim within the meaning of 31 U.S.C. § 3729 et seq. If the Medicare contractors responsible for handling these claims had known of the kickback scheme described above, or the falsity of the certification statements in the enrollment documents of the Hospital Defendants, no such claims would have been paid. *Because use by each Hospital Defendant of its explicit statements on its earlier CMS-855A*

enrollment form was an integral part of each presentation of each such claim for payment, each such claim used a statement that the underlying transaction complied with Medicare laws and regulations, and that such compliance was a condition met by any such claim for payment, and therefore each such claim for that additional reason used a false statement in order get each such false claim paid.

COUNT I

Claim By and on Behalf of the United States under the False Claims Act (Presenting False Claims)

62. Plaintiff realleges and incorporates by reference paragraphs 1 through 61 as though fully set forth herein.

63. This is a claim under the False Claims Act, 31 U.S.C. §§ 3729-33, as amended.

64. The Plaintiff/Relator, Shirley E. Davis, has standing to maintain this action by virtue of 31 U.S.C. §3730(b).

65. By virtue of the acts described herein, the Defendants knowingly presented false or fraudulent claims for payment, or knowingly caused false or fraudulent claims for

payment to be presented, to officials of the United States Government in violation of 31 U.S.C. § 3729(a)(1), as amended.

66. By virtue of the false claims presented or caused to be presented by the Defendants, the United States has suffered actual damages and is entitled to recover three times the amount by which it is damaged, plus civil money penalties of not less than $5,500 and not more than $11,000 for each of the false claims presented or caused to be presented, and other monetary relief as appropriate.

COUNT II

Claim By and on Behalf of the United States under the False Claims Act (False Records or Statements)

67. Plaintiff realleges and incorporates by reference paragraphs 1 through 61 as though fully set forth herein.

68. This is a claim on behalf of the United States under the False Claims Act, 31 U.S.C. §§ 3729-33, as amended.

69. The Plaintiff/Relator, Shirley E. Davis, has standing to maintain this action by virtue of 31 U.S.C. §3730(b).

70. By virtue of the acts described above and the Defendants' uses of, or activities causing to be used, false records and statements to get false and fraudulent claims paid and approved by the Government, Defendants caused to be made or used false records or statements to get false or fraudulent claims paid or approved by an agency of the United States

Government, in violation of 31 U.S.C. § 3729(a)(2).

71. By virtue of, and as a result of, the false records and statements used to get false claims paid by the Government, the United States has suffered actual damages and is entitled to recover three times the amount by which it is damaged, plus civil money penalties of not less than $5,500 and not more than $11,000 for each of the false claims presented or caused to be presented, and other monetary relief as appropriate.

COUNT III

Claim By and on Behalf of the United States under the False Claims Act (Conspiracy to Submit False Claims)

72. This is a claim under the False Claims Act, 31 U.S.C. §§ 3729-33, as amended.

73. Plaintiff realleges and incorporates by reference paragraphs 1 through 61 as though fully set forth herein.

74. By reason of the foregoing with respect to Defendants' fraudulent scheme, Defendants conspired together and with others to present false statements and false claims and otherwise to defraud the government in order to get false or fraudulent claims paid by Medicare and Medicaid, in violation of 31 U.S.C. § 3729(a)(3), as amended. In furtherance of the conspiracy,

Defendants acted through overt acts described above, in order to effect the objects of the conspiracy alleged herein.

75. By virtue of the false claims presented or caused to be presented by Defendants pursuant to this conspiracy, the United States has suffered actual damages and is entitled to recover three times the amount by which it is damaged, plus civil money penalties of not less than $5,500 and not more than $11,000 for each of the false claims presented or caused to be presented, and other monetary relief as appropriate.

PRAYER FOR RELIEF

WHEREFORE, the United States demands and prays that judgment be entered in favor of the United States:

1. On Counts I - III, under the False Claims Act, against Defendants for treble the amount of the United States' actual damages (including investigative costs), plus civil penalties as are allowable by law for each false claim or record and for all costs of this civil action;

2. For all costs of this civil action; and

3. For such other and further relief as the Court deems just and equitable.

WHEREFORE, Relator Shirley E. Davis demands and prays that judgment be entered in her favor:

1. On Counts I - III, under the False Claims Act, for a percentage of all civil penalties and damages obtained from Defendants pursuant to 31 U.S.C. § 3730, reasonable attorney's fees, and all costs incurred against Defendants; and

2. Such other relief as the Court deems just and proper.

This, the 12th day of May, 2011.

Respectfully submitted,

J. Brad Pigott (Mississippi Bar #4350)
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