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

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UNITED STATES ex rel. VIJAYANT SINGH, M.D., Relators, vs. HUDSON HOSPITAL OPCO, LLC d/b/a CHRIST HOSPITAL, HUMC OPCO, LLC d/b/a HOBOKEN UNIVERSITY MEDICAL CENTER, IJKG OPCO, LLC d/b/a BAYONNE MEDICAL CENTER, CAREPOINT HEALTH MANAGEMENT ASSOCIATES, LLC, IJKG, LLC, SEQUOIA HEALTHCARE MANAGEMENT, LLC, ACHINTYA MOULICK, M.D., WILLIAM PELINO and ABC Corporations 1-3, Defendants.	Case No. ***QUI TAM* COMPLAINT FOR VIOLATIONS OF THE FALSE CLAIMS ACT 31 U.S.C. §§ 3729-3733** **JURY TRIAL DEMANDED** **FILED *IN CAMERA* AND UNDER SEAL PURSUANT TO 31 U.S.C. § 3730(b)(2)**

COMPLAINT FOR DAMAGES AND OTHER RELIEF UNDER THE FALSE CLAIMS ACT

Pursuant to 31 U.S.C. § 3730(b)(1), Relator Vijayant Singh, M.D. ("Relator"), by and through his undersigned counsel, on behalf of the United States of America, brings this civil action under the False Claims Act, 31 U.S.C. § 3729 *et seq.* ("FCA").

Under § 3730(b)(2) of the FCA, this Complaint is to be filed in camera and remain under seal for a period of at least 60 days and shall not be served on the Defendants until the Court so orders. The government may elect to intervene and proceed with the action within 60 days after it receives both the Complaint and the material evidence and information. In support of the Complaint, Relator alleges as follows:

STATEMENT OF THE CASE

1. This case arises out of the defendant hospitals' (a) unlawful refusal to return to the federal government over $50 million in CARES Act Provider Relief Funds, which they had improperly obtained by submitting false claims for reimbursement for diagnosing and treating patients who had not tested positive for COVID-19 and (b) improper use of Provider Relief Funds for purposes unrelated to diagnosing and treating COVID-19 patients.

2. During the spring and summer of 2020, the three CarePoint Health hospitals, Bayonne Medical Center, Christ Hospital and Hoboken University Medical Center (the "CPH Hospitals") applied for and received over $50 million in High Impact Area Distributions from the Provider Relief Fund administered by the United States Department of Health and Human Services to which the hospitals were not entitled.

3. The overpayment occurred because the CPH Hospitals submitted false claims for reimbursement for the cost of treating over 1,200 patients who had not tested positive for COVID-19 or did not otherwise meet HHS inclusion criteria.

4. Beginning in August 2020, Relator, the system Chief Medical Officer and the Chief Hospital Executive for Bayonne Medical Center, repeatedly objected to the CPH Hospitals' retention of Provider Relief Funds to which they were not entitled and demanded that CarePoint return the funds.

5. Although the CPH Hospitals are not entitled to the excess Provider Relief Funds, the hospitals retained the funds over Relator's repeated objections.

6. The CPH Hospitals also received General Distributions and Safety Net Distributions from the Provider Relief Fund.

7. The CPH Hospitals used the Provider Relief Funds for improper purposes unrelated to the cost of diagnosing and treating COVID-19 patients.

8. Bayonne Medical Center and/or CarePoint also entered into a consulting services agreement under which it made consulting payments in exchange for patient referrals in violation of the Anti-Kickback Statute.

9. The various wrongful acts described above violated the False Claims Act.

JURISDICTION AND VENUE; FILING UNDER SEAL

6. This action arises under the FCA to recover damages and attorneys' fees from defendants based on their violations of the FCA.

7. Under §3732 of the FCA, this Court has jurisdiction over actions brought under the FCA. Furthermore, jurisdiction over this action is conferred on this Court by 28 U.S.C. § 1331 because this civil action arises under the laws of the United States.

8. Venue is proper in this district pursuant to § 3732(a) of the FCA, which provides that "any action under §3730 may be brought in any judicial district in which the Defendant or, in the case of multiple Defendants, any one Defendant can be found, resides, transacts business, or in which any act proscribed by §3729 occurred." Defendants regularly conducted substantial business within the District of New Jersey. In addition, the proscribed acts by each of the Defendants occurred in the District of New Jersey. Venue is additionally proper in this district pursuant to 28 U.S.C. § 1391(b)(1)-(2).

9. Under the FCA, this Complaint is to be filed *In Camera* and remain under seal for a period of at least sixty (60) days and shall not be served on Defendants until this Court so orders. The government may elect to intervene and proceed with the action within sixty (60) days after the government receives the Complaint.

THE PARTIES

10. Relator Vijayant Singh, M.D. ("Relator" or "Dr. Singh"), is a medical doctor and resident of Jersey City, New Jersey and former employee of CarePoint Health Management Associates, LLC.

11. Defendant Hudson Hospital Opco, LLC d/b/a Christ Hospital is a for-profit New Jersey limited liability company with a principal place of business at 10 Exchange Place, Jersey City, New Jersey or 308 Willow Avenue, Hoboken, New Jersey.

12. Defendant HUMC Opco, LLC d/b/a Hoboken University Medical Center is a for-profit New Jersey limited liability company with a principal place of business at 308 Willow Avenue, Hoboken, New Jersey.

13. Defendant IJKG-Opco, LLC (IJKG), d/b/a as Bayonne Medical Center, is a for-profit New Jersey limited liability company with a principal place of business at 29th Street at Avenue E, Bayonne, New Jersey or 308 Willow Avenue, Hoboken, New Jersey.

14. Defendant CarePoint Health Management Associates, LLC (CarePoint) is a for-profit New Jersey limited liability company with its principal place of business at 308 Willow Avenue, Hoboken, New Jersey. CarePoint provides professional, administrative and other services to Bayonne Medical Center, Christ Hospital and Hoboken University Medical Center (the "CPH Hospitals").

15. Defendant IJKG, LLC ("IJKG") is a for-profit New Jersey limited liability company with a principal place of business at 29th Street at Avenue E, Bayonne, New Jersey or 308 Willow Avenue, Hoboken, New Jersey. IJKG the parent of IJKG-Opco, LLC. IJKG has historically received management fees from IJKG-Opco pursuant to the IJKG-Opco operating agreement.

16. Defendant Sequoia Healthcare Management, LLC ("Sequoia") is a for-profit New Jersey limited liability company with a principal place of business at 308 Willow Avenue, Hoboken, New Jersey. Sequoia is party to a management services agreement with HUMC and Christ Hospital. Sequoia has historically received management fees from HUMC and Christ Hospital pursuant to that agreement.

17. Defendant Achintya Moulick, M.D. is a resident of Pennsylvania and the Chief Executive Officer (CEO) of CarePoint.

18. Defendant William Pelino is a New York resident and the Chief Financial Officer of CarePoint.

19. Defendant ABC Corporations 1-3 are fictitious corporations or limited liability companies that functioned as an integrated enterprise with the named defendants and/or received the Provider Relief Funds provided by the federal government.

RELATOR'S EMPLOYMENT WITH DEFENDANTS

20. In March 2012, Relator began his employment with CarePoint as an Adult Hospitalist.

21. Shortly after Relator commenced his employment, CarePoint promoted him to Director of Hospitalist Medicine.

22. In December 2012, CarePoint promoted Relator to Chief Medical Officer of CarePoint Health-Bayonne Medical Center (BMC).

23. In 2017, CarePoint promoted Relator to Chief Hospital Executive of BMC.

24. In October 2018, in addition to his role as Chief Hospital Executive of BMC, CarePoint appointed Relator the Chief Medical Officer for CarePoint Health Management Group and Garden State Health Care Associates, the physician practice groups that service the CarePoint hospitals.

25. On August 6, 2021, Relator terminated his employment with CarePoint because of the ongoing and relentless retaliation to which he was being subjected and defendants' ongoing wrongful acts.

THE FALSE CLAIMS ACT

26. The FCA imposes liability upon any person who: (a) "knowingly presents or causes to be presented [to the government] a false or fraudulent claim for payment or approval"; or (b) "knowingly makes, uses, causes to be made or used, a false record or statement material to a false or fraudulent claim." 31 U.S.C. § 3729(a)(1)(A) and (B), as amended.

27. The FCA imposes liability not only for intentionally false or fraudulent conduct, but also where an individual "acts in deliberate ignorance of the truth or falsity of the information" or "in reckless disregard of the truth or falsity of the information." 31 U.S.C. § 3729(b)(1)(A)(ii) or (iii).

28. The FCA defines claim as (A) "any request or demand, whether under a contract or otherwise, for money or property and whether or not the United States has title to the money or property, that (i) is presented to an officer, employee, or agent of the United States; or (ii) is made to a contractor, grantee, or other recipient, if the money or property is to be spent or used on the Government's behalf or to advance a Government program or interest, and if the United States Government (I) provides or has provided any portion of the money or property requested or demanded; or (II) will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded." 31 U.S.C. § 3729(b)(2).

29. The FCA defines material as "having a natural tendency to influence or be capable of influencing the payment or receipt of property or money." 31 U.S.C. § 3729(b)(4).

30. Under the Fraud Enforcement and Recovery Act amendments to the False Claims Act, 31 U.S.C.A. § 3729(a)(1)(G), it is unlawful for a recipient of federal funds to knowingly and improperly avoid an obligation to repay money to the Government.

31. Under 31 U.S.C.A. § 3729(b)(3), the FCA defines "obligation" as "an established duty… arising from… the retention of an overpayment."

THE ANTI-KICKBACK STATUTE

32. The Anti-kickback statute ("AKS") forbids knowingly or willfully offering or receiving remuneration to influence the purchase of goods and services under federal healthcare programs. 42 U.S.C. § 1320a-7b.

33. In particular, the AKS makes it unlawful for a hospital to pay for patient referrals.

34. A violation of the AKS constitutes a false or fraudulent claim under the FCA. 42 U.S.C. §1320a-7b(g).

THE CARES ACT

35. On March 27, 2020, the United States Congress passed the Coronavirus Aid, Relief and Economic Security Act (the "CARES Act"), Pub.L. 116-136, and the Act was signed into law.

36. Among other things, the CARES Act allocated approximately $178 billion in Provider Relief Funds to hospitals and healthcare providers.

37. Approximately $46 billion in General Distributions were paid to eligible providers who billed Medicare fee-for-service in several phases.

38. Over $20 billion in "High Impact Area" payments known as "High Impact Distributions" were allocated to hospitals that had a high number of confirmed COVID-19 positive patient admissions.

39. The initial round of High Impact Distributions was made to hospitals with 100 or more COVID-19 positive patient admissions between January 1, 2020 and April 10, 2020.

40. The payment allocations per hospital was based on the number of COVID-19 positive patient admissions multiplied by $76,975.

41. The second round of High Impact Distributions was made to hospitals with over 160 COVID-19 positive patient admissions between January 1, 2020 and June 1, 2020.

42. The payment allocations were based on a payment of $50,000 per COVID-19 positive patient admission taking into account distributions received during the first round of payments.

43. Approximately $10 billion in Safety Net distributions was allocated to eligible providers in the first round of distributions.

44. A second round of Safety Net distributions of approximately $3 billion was subsequently distributed to qualifying acute care hospitals and children's hospitals.

45. Eligible healthcare providers could only use Provider Relief Funds on allowable expenses, such as costs related to preventing, preparing for and responding to the coronavirus and lost revenues attributable to the coronavirus.

46. All providers retaining funds were required to sign an attestation and accept the Terms and Conditions associated with payment.

47. Among other things, the Terms and Conditions required a provider who received Provider Relief Funds payments to certify that all information, including admissions data, it provided as part of its application for the Payment, as well as information and reports relating to the Payment that it provides in the future, are true, accurate and complete to the best of its knowledge.

48. The Terms and Conditions further required a provider who received Provider Relief Funds to certify that it would use the Funds only on allowable expenses, such as costs related to preventing, preparing for and responding to the coronavirus and lost revenues attributable to the coronavirus.

49. According to HHS guidance, Provider Relief Fund payments that were made in error, or exceed lost revenues or expenses due to COVID-19, or do not otherwise meet applicable legal and program requirements must be returned to HHS, and HHS is authorized to recoup these funds.

50. According to HHS guidance, providers were also to self-report payments received in error to the federal Government.

51. Under 45 C.F.R. § 750.303, a recipient of federal funds must comply with Federal statutes, regulations, and the terms and conditions of the Federal awards, evaluate and monitor the its compliance with statutes, regulations and the terms and conditions of Federal awards and take prompt action when instances of noncompliance are identified including noncompliance identified in audit findings.

CPH HOSPITALS RECEIVE TWICE THE CARES FUNDS TO WHICH THEY WERE ENTITLED

52. On April 24, 2020, the CPH Hospitals applied for Provider Relief Funds based on a count of 930 admissions of patients who tested positive for COVID.

53. On May 7, 2020, the CPH Hospitals received a cumulative total of approximately $76,750,100 in Provider Relief Funds from the Department of Health and Human Services (HHS) based on the April 24, 2020 submission.

54. On June 10, 2020, the CPH Hospitals applied for additional Provider Relief Funds based on a count of 2,452 admissions of patients who tested positive for COVID.

55. On June 15, 2020, the CPH Hospitals received an additional $51,000,000 in Provider Relief Funds from HHS based on the June 10, 2021 submission.

56. In July 2020, the hospital CMOs and IT personnel conducted internal audits that revealed that the CPH Hospitals had applied for and received approximately $55,000,000 to $60,000,0000 in Provider Relief Funds to which the hospitals were not entitled.

57. The overpayment occurred because the CPH Hospitals sought reimbursement for costs related to diagnosing and treating1,214 patients who had not tested positive for COVID and failed to otherwise meet5 HHS inclusion criteria.

58. Those expenses were not allowable under the CARES Act.

59. Nonetheless, on information and belief, at some point between June 15, 2021 and September 2021, CarePoint's Chief Financial Officer, William Pelino, signed the attestation required by the CARES Act.

60. Therein, Pelino certified that all information, including admissions data, the CPH Hospitals provided as part of their application for the PRF funds, was true, accurate and complete to the best of his knowledge.

61. Pelino further certified that the CPH Hospitals would use the Funds only on allowable expenses, such as costs related to preventing, preparing for and responding to the coronavirus and lost revenues attributable to the coronavirus .

RELATOR DEMANDS THAT THE HOSPITALS RETURN THE PROVIDER RELIEF FUNDS OVERPAYMENT

62. On or about August 4, 2020, Relator, the system CMO, and the hospital CMOs formed a CMO task force to review the apparent overpayment of Provider Relief Funds and reconcile the CPH Hospitals' claims using the HHS eligibility definitions.

63. On or about August 6, 2020, CarePoint CFO Pelino told Relator that CarePoint should "prepare the best possible case we can for each patient included in the submission."

64. Relator replied that the CMO task force was using the HHS eligibility criteria to determine eligibility, no other criteria could be used and CarePoint needed to self-report the error and the corrected numbers.

65. On or about August 13, 2020, Relator attended an Executive Committee meeting attended by defendant Achinty A. Moulick, M.D., CarePoint's Chief Executive Officer, defendant William Pelino, CarePoint's Chief Financial Officer, Jennifer Dobin, CarePoint's Executive Vice President, Human Resources, the Chief Hospital Executives (CHE) for Christ Hospital and HUMC and the hospital Chief Medical Officers (CMO).

66. At the meeting, Relator indicated that the CMO audit had confirmed the amount of the overpayments from HHS.

67. Relator stated that CarePoint should self-report the overpayment and return the overpaid Provider Relief Funds to HHS.

68. Marie Duffy, the CHE for Christ Hospital, Thomas Woods, M.D., the Chief Medical Officer for Christ Hospital and Carmelo Milazzo, M.D., the Chief Medical Officer for Hoboken University Medical Center (HUMC), expressed their agreement with Relator's statement that the funds had to be returned.

69. CEO Moulick rejected Relator's position that the CPH Hospitals had to return the excess Provider Relief Funds.

70. CEO Moulick stated that no one should take the "moral high ground" because CarePoint was "going bankrupt" and needed the excess Provider Relief Funds.

71. CEO Moulick made a number of improper excuses for keeping the excess Provider Relief Funds.

72. CEO Moulick asked Relator and the other CHEs and the CMOs to continue reviewing the patient accounts and create other justifications for retaining the stimulus funds.

73. On or about August 17, 2020, Relator emailed the final results of the CMO task force audit to Moulick, the CEO and Pelino, the CFO.

74. The audit confirmed that the CPH Hospitals had sought reimbursement for treating 2,454 COVID patients, when the actual number of patients who had tested positive for COVID was 1,240.

75. CEO Moulick responded to Relator by directing the CMO group to redo their audit and consider patients who were suspected of having COVID but whose diagnosis was not confirmed with a positive test as well as patients who were diagnosed with COVID based on radiological tests.

76. Relator refused to engage in a cover-up.

77. Relator replied in writing that based on the HHS criteria, the CPH Hospitals "cannot include suspected COVID-19 patients at the time of admission without confirmation during hospitalization or prior to June 10th deadline. Additionally, we cannot use radiological diagnosis as confirmation of COVID-19…" (emphasis original).

78. Relator further stated that the CMO task force was confident that the audit results were correct and asked Pelino for the next steps for submitting the corrected numbers.

79. On August 19, 2020, Pelino replied by asking the CMO task force to conduct a second audit.

80. In late August 2020, the CMO task force conducted a second audit.

81. The CMO task force provided the results to Pelino on August 25, 2020 and again on September 15, 2020.

82. The results confirmed that the actual number of COVID cases that should have been included in the June 10, 2020 submission was 1,240 admissions, not the 2,454 admissions that CPH had reported.

83. Although two audits had confirmed that the CPH Hospitals had received approximately twice the amount of Provider Relief Funds for which it was eligible, CarePoint did not return the funds.

84. Rather, on September 18, 2020, Pelino told Relator and the CMO task force to perform yet another review of questionable cases, which would be used in support of an appeal to HMS.

85. On or about September 28, 2020, during a call with Pelino, the hospital CFEs and CMOs and others, Relator reiterated that the September 15, 2020 audit results contained the correct numbers.

86. During the following months, on a number of occasions, Relator asked Moulick and Pelino if the CPH Hospitals had returned the excess Provider Relief Funds.

87. CEO Moulick and CFO Pelino informed Relator that the CPH Hospitals had not returned the funds.

88. On February 26, 2021, Relator submitted a Risk Assessment Report to the Chief Compliance Officer.

89. Therein, Relator identified the CPH Hospitals' failure to return the overpayment of Provider Relief Funds as "Severe/Highly Likely", the most serious rating in CarePoint's risk assessment matrix.

90. As recently as June 15, 2021, Relator was informed that the CPH Hospitals had not returned the overpayment of Provider Relief Funds.

91. On information and belief, Defendants never returned the overpaid Provider Relief Funds.

MISUSE OF PROVIDER RELIEF FUNDS

92. The CPH Hospitals historically operated on very thin margins and at times have prepared to file for bankruptcy.

93. For example, in February 2020, based on concerns that Christ Hospital would file for bankruptcy following certain disclosures that Christ Hospital made to the New Jersey Department of Health in or about October 2019, the New Jersey Department of Health appointed a monitor to oversee Christ Hospital's operations.

94. In November 2019, Bayonne Medical Center began preparing similar disclosures for filing with the Department of Health.

95. In March 2020, CarePoint implemented a reduction in force and began selling assets due to its poor financial condition.

96. In or about October and November 2020, during meetings at Hoboken University Medical Center and Christ Hospital, Moulick instructed Relator and other CHEs to begin spending Provider Relief Funds on capital expenditures unrelated to the cost of diagnosing and treating COVID-19 patients.

97. In addition, in or about December 2020-January 2021, in separate conversations, Moulick and Pelino told Relator and John Gillson, the system Director of Facilities that CarePoint had to spend PRF money for the lobby renovation at Bayonne Medical Center.

98. Beginning in the fall of 2020, the CPH Hospitals went on a spending spree that was inconsistent with their financial condition.

99. During the next ten months, Christ Hospital spent Provider Relief Funds on renovating the hospital lobby, renovating a medical office building, creating a weight loss center, renovating its radiology center and upgrading its catheter lab and stroke lab.

100. Bayonne Medical Center spent Provider Relief Funds on an "Innovation Center."

101. Hoboken University Medical Center spent Provider Relief Funds on a lobby renovation.

102. The funds that the CPH Hospitals used for purposes unrelated to preventing, preparing for and responding to the coronavirus and lost revenues attributable to the coronavirus are in the millions of dollars.

ANTI-KICKBACK STATUTE

103. In November 2020, Bayonne Medical Center and/or CarePoint entered into a consulting services agreement (the "CSA") with Surgicore LLC.

104. The stated purpose of the CSA was to utilize Surgicore's consulting services to create a state-of-the-art perioperative program at Bayonne Medical Center.

105. Surgicore currently owns 9.9% of IJKG Opco LLC d/b/a Bayonne Medical Center.

106. Surgicore has applied to the Department of Health to purchase an additional 39.9% of IJKG Opco LLC.

107. The term of the CSA expires once the Department of Health approves Surgicore's application to acquire an additional 39.9% of IJKG Opco LLC.

108. Following execution of the CSA, Surgicore referred a number of physicians to Bayonne Medical Center for credentialing.

109. Bayonne Medical Center ultimately credentialed over 100 physicians.

110. After the physicians were on-boarded, they began referring a substantial number of cases to Bayonne Medical Center, which have generated over $2 million in monthly revenue.

111. A number of the cases involved patients for whose treatment Bayonne Medical Center received payment from Medicare or Medicaid.

112. Beginning in November 2020, Bayonne Medical Center began paying consulting fees of $250,000 or more per month to Surgicore pursuant to the CSA.

113. The actual consulting work provided has not justified the consulting fees that Bayonne Medical Center has paid to Surgicore.

114. The payments were purportedly based on timesheets submitted to and allegedly reviewed by Moulick, CarePoint's CEO.

115. In or about March 2020, Relator reviewed some of the timesheets that had been submitted.

116. In a number of cases, the names of the persons on the timesheets did not match the names of the consultants whose time was purportedly billed.

117. On information and belief, the payments that Bayonne Medical Center has made to Surgicore have been kickbacks for the cases that the physicians whom Surgicore referred to Bayonne Medical Center have admitted at Bayonne Medical Center.

118. The payments violate the Antikickback Statute, 42 U.S.C. § 1320a-7b.

COUNT I

Violations of False Claims Act – Presentation of False Claims

Against All Defendants

119. Relator realleges and incorporates the prior paragraphs of this Complaint as if fully set forth herein.

120. In performing the acts described above, Defendants, through their own acts or through the acts of officers, employees or agents knowingly and/or recklessly presented, or caused to be presented, to an officer or employee of the United States false or fraudulent claims for payment or approval in violation of 31 U.S.C. § 3729(a)(1)(A).

121. These claims were false and fraudulent because Defendants made claims for reimbursement knowing they had not performed the services for which they claimed reimbursement.

122. These claims were false and fraudulent because Defendants falsely certified that they would use Provider Relief Funds only for expenses allowable by the CARES Act.

123. The United States, unaware of the foregoing circumstances and conduct of the Defendants, made full payments that would otherwise have not been paid and/or were ineligible for payment, which resulted in its being damaged in an amount to be determined.

124. By reason of each Defendants' wrongful conduct, the United States has been damaged by the payment of false and fraudulent claims.

WHEREFORE, Relator respectfully requests this Court to award the following damages to the following parties and against the Defendants:

To the United States:

(1) Three times the amount of actual damages which the United States has sustained as a result of Defendants' conduct;

(2) A civil penalty of not less than $10,781 and not more than $21,562 for each false claim which Defendants presented or caused to be presented to the United States;

(3) Pre- and post-judgment interest; and

(4) All costs incurred in bringing this action.

To Relator:

(1) The maximum amount allowed pursuant to § 3730(d) of the False Claims Act and/or any other applicable provision of law;

(2) Reimbursement for reasonable expenses which Relator incurred in connection with this action;

(3) An award of reasonable attorney's fees and costs; and

(4) Such further relief as this Court deems equitable and just.

COUNT II

Violation of False Claims Act – False Statements

Against All Defendants

125. Relator realleges and incorporates the prior paragraphs of this Complaint as if fully set forth herein.

126. In performing the acts described above, each Defendant, through their own acts or through the acts of officers, employees or agents, knowingly made, used, or caused to be made or used, a false record or statement to get false or fraudulent claims paid or approved by the United States in violation of 31 U.S.C. § 3729(a)(1)(B).

127. Such records or statements include the false attestation regarding services rendered as alleged herein.

128. Such records or statements include the false attestation regarding the use of the Provider Relief Funds received as alleged herein.

129. The United States, unaware of the foregoing circumstances and conduct of the Defendants, made full payments which resulted in its being damaged in an amount to be determined.

130. By reason of each Defendants' wrongful conduct, the United States has been damaged by the payment of false and fraudulent claims.

WHEREFORE, Relator respectfully requests this Court to award the following damages to the following parties and against the Defendants:

To the United States:

(1) Three times the amount of actual damages which the United States has sustained as a result of Defendants' conduct;

(2) A civil penalty of not less than $10,781 and not more than $21,562 for each false record or statement Defendants made to get false or fraudulent claims paid or approved by the Government;

(3) Pre- and post-judgment interest; and

(4) All costs incurred in bringing this action.

To Relator:

(1) The maximum amount allowed pursuant to § 3730(d) of the False Claims Act and/or any other applicable provision of law;

(2) Reimbursement for reasonable expenses which Relator incurred in connection with this action;

(3) An award of reasonable attorney's fees and costs; and

(4) Such further relief as this Court deems equitable and just.

COUNT III

Violation of False Claims Act – Reverse False Claims

Against All Defendants

131. Relator realleges and incorporates the prior paragraphs of this Complaint as if fully set forth herein.

132. In performing the acts described above, the Defendants knowingly and improperly avoided their obligation to reimburse the federal government for monies improperly retained, when they failed to refund overpayments of CARES Act Provider Relief Funds in violation of 31 U.S.C. §3729(a)(1)(G).

133. Through Defendants' actions in improperly retaining funds to which they are not entitled, the United States has been deprived of the use of these monies and is entitled to damages in an amount to be determined.

WHEREFORE, Relator respectfully requests this Court to award the following damages to the following parties and against the Defendants:

(1) Three times the amount of actual damages which the United States has sustained as a result of Defendants' conduct;

(2) A civil penalty of not less than $10,781 and not more than $21,562 for each false record and statement used to conceal the obligation to reimburse the federal government for monies improperly retained;

(3) Pre- and post-judgment interest; and

(4) All costs incurred in bringing this action.

To Relator:

(1) The maximum amount allowed pursuant to § 3730(d) of the False Claims Act and/or any other applicable provision of law;

(2) Reimbursement for reasonable expenses which Relator incurred in connection with this action;

(3) An award of reasonable attorney's fees and costs; and

(4) Such further relief as this Court deems equitable and just.

Respectfully submitted,

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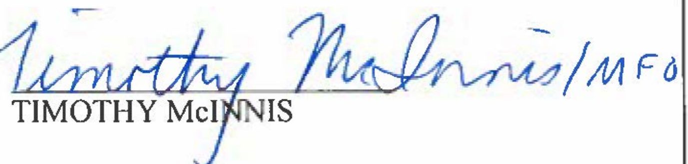
By: 
TIMOTHY McINNIS

Dated: November 5, 2021