UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION

UNITED STATES EX REL, DR. G. DARYL HALLMAN	:	CIVIL ACTION NO: **1:11CV825**
	:	JUDGE: **BARRETT**
Plaintiff-Relator	:	
vs.	:	
MILLENNIUM RADIOLOGY, INC.	:	
	:	**RELATOR'S SECOND AMENDED**
and	:	**COMPLAINT WITH JURY DEMAND**
MERCY HEALTH PARTNERS OF SOUTHWEST OHIO, MERCY HOSPITALS WEST, AN OHIO NON-PROFIT CORPORATION D/B/A MERCY FRANCISCAN HOSPITAL	:	
Defendants	:	

I. INTRODUCTION

1. This is a *qui tam* action brought by Relator Dr. G. Daryl Hallman ("Relator"), for himself and on behalf of the United States, to recover damages and civil penalties arising from the participation by Defendants Millennium Radiology, Inc. ("MRI"), Mercy Health Partners of Southwest Ohio, and Mercy Hospitals West, an Ohio non-profit corporation d/b/a Mercy Franciscan Hospital ("MHP") in a "pay for play" scheme in violation of the Anti-Kickback Statute ("AKS"), 42 U.S.C. § 1320a-7b and the False Claims Act, 31 U.S.C. §§ 3729, *et seq.* ("FCA").

2. From at least August 4, 2006 through the present MHP and MRI have participated, and continue to participate, in an exclusive referral and marketing system in

violation of the AKS in which MHP allowed MRI to present claims to the United States for Part B radiology services for illegal patient referrals directed to MRI by MHP. In return for the continuous flow of patient referrals at various MHP hospital facilities, MRI agreed to provide to MHP free physician administrative services in excess of a million dollars to MHP and solicited third party physicians for referrals of patients to MHP. MHP, in turn, presented thousands of claims for payment to the United States for Part A facility and outpatient fees associated with the treatment of the patients generated by MHP's and MRI's marketing and solicitation of referrals. This relationship encouraged MRI to order unnecessary procedures to compensate it for the unpaid administrative and solicitation services and encouraged MHP to develop practices that increased the greater utilization of services of hospital-based physicians payable under Medicare Part B.

3. For the period of time referred to in paragraph 2 above, MRI and MHP knew that their conduct was both illegal and not protected by any applicable AKS safe harbor. MRI and MHP knowingly presented or caused to be presented hundreds of thousands of false claims for payment or approval to federal health care programs, and in return they were paid millions of dollars by the United States for these false claims.

4. At the time these false claims were submitted for payment, MRI and MHP certified that there was no violation of the AKS in violation of 31 U.S.C. 3729, *et seq*.

5. Pursuant to the FCA, the Relator, on behalf of the United States, seeks recovery of damages and civil penalties for MRI's and MHP's presentment of false and improper charges and claims for payment to the Medicare, Medicaid and TRICARE programs.

6. The original complaint was filed under seal on November 22, 2011 without

service of process on MRI and MHP. A first amended complaint was filed on December 20, 2011. This second amended complaint is being filed by the Relator to further identify, expand and state with additional particularity, the factual basis upon which Relator relies to assert that the Defendants have committed and continue to commit fraud upon the United States. Both the original and the first amended complaint remained under seal until the United States gave notice of its intent to decline to intervene and the Court's removal of the seal that had existed since November of 2011.

II. JURISDICTION AND VENUE

7. This action arises under the FCA.

8. Jurisdiction over this action is provided by 31 U.S.C. § 3732(a) and 28 U.S.C. § 1331.

9. Venue is proper in this district by 31 U.S.C. § 3732(a). It is also proper because MRI and MHP reside and transact business within this district, and, as part of that business, both have presented hundreds of thousands of false claims for payment to the United States and received millions of dollars in payments to which they were not entitled.

10. Under 31 U.S.C. § 3730 both the original complaint and the first amended complaint were filed in camera. None of the allegations in the complaint, the first amended complaint, this second amended complaint, the disclosure statement, or the subsequent disclosures to the United States, was based upon any public disclosure as defined under the FCA.

III. THE PARTIES AND RELATED ENTITIES AND INDIVIDUALS

11. The real party in interest for the claims in this action is the United States of America.

12. Relator is a resident of the State of Kentucky, and he is a Board Certified Radiologist licensed to practice medicine in both Kentucky and Ohio. Relator was an employee of MRI from April 2005 through April 30, 2011. He has first-hand knowledge of the facts alleged herein and brings this action under 31 U.S.C. § 3730(b).

13. On November 4, 2011, Relator, as an "original source," voluntarily disclosed the fraudulent scheme to the United States Attorney for the Southern District of Ohio pursuant to 31 U.S.C. § 3730(b)(2) before filing the complaint, the first amended complaint, and the second amended complaint. Relator has continued to provide additional information to the United States upon which this second amended complaint is based. The facts and circumstances alleged in this second amended complaint have not been publically disclosed prior to their disclosure to the United States.

14. MRI is an Ohio professional medical corporation that engages in the practice of radiology. Radiology is a medical speciality which uses many imaging modalities such as computer radiography, ultrasound, computed tomography, magnetic resonance imaging, positron emission tomography, nuclear medicine, mammography, and interventional radiography to create images for diagnosis, treatment, monitoring, and outcome prediction of disease. Millennium Radiology, Inc., a MRI predecessor, was originally formed by Dr. Kevin Aukerman under his individual name as a professional corporation. In the early 2000's the name of the professional corporation was changed to Mt. Airy Medical Imaging, Inc., and in the spring of 2009, Mt. Airy Medical Imaging, Inc. changed its name to Millennium Radiology, Inc. Throughout the various name changes the three entities used the same federal tax identification number.

15. MRI is sometimes referred to as a "hospital-based" physician group because its

physician services are provided almost exclusively on a hospital's premises for patients referred to it by a partner hospital or the physicians who have staff privileges at the hospital. Other hospital-based physicians include anesthesiologists and pathologists. As a general rule the livelihood of a hospital-based physician group depends upon patient referrals it receives from its hospital partner, and MRI's livelihood depended upon and still depends on the patient referrals it receives from MHP.

16. MRI's physician shareholder members, management personnel and attorney include the following:

a. Dr. Kevin Aukerman ("Aukerman"). Aukerman is MRI's President.

b. Pamela Zipperer-Davis ("Zipperer-Davis"). Zipperer-Davis has been extensively involved in the greater Cincinnati health care community as a physician practice executive for at least the last 15 years. In 2008, Zipperer-Davis began consulting with MRI. In 2009, she was hired by it as the Chief Executive Officer ("CEO"). She remained the CEO until mid 2011 when she took a full time position with a St. Elizabeth Hospital Physician Group in Northern Kentucky. She has continued to act as a consultant for and employee of MRI throughout 2011, 2012 and 2013 years.

c. Dr. Scott Welton ("Welton"). Welton is MRI's Secretary and Treasurer. Welton has been an employee of MRI since 2006. He is a shareholder of MRI, and he has been the Medical Director for Mercy Hospital Mt. Airy ("Mercy/Mt. Airy") since February 1, 2007.

d. Dr. Theodore Kleimeyer ("Kleimeyer"). Kleimeyer was a shareholder of Queen City Radiology, the predecessor radiology group that serviced Mercy Hospital Western Hills ("Mercy/Western Hills"). In 2006, Queen City Radiology merged with MRI, and at that

time Kleimeyer became an employee of MRI. Kleimeyer has been the Medical Director for Mercy/Western Hills since August 2006.

e. Dr. Christian Fisher ("Fisher"). Fisher is a shareholder and employee of MRI. He works at both Mercy/Western Hills and Mercy/Mt. Airy.

f. Dr. Mekasha Getachew ("Getachew"). Getachew is a shareholder and employee of MRI since 2006, and he has worked at both Mercy/Western Hills and Mercy/Mt. Airy. Getachew has prepared marketing materials and given lectures relating to the services provided by MRI at Mercy/Mt. Airy to primary care physicians and oncologists in order to increase the patient radiology referrals to Mercy from these third party physicians.

g. Dr. Peter Kanistros ("Kanistros"). Kanistros is a shareholder and employee of MRI, and he works at both Mercy/Western Hills and Mercy/Mt. Airy.

h. Dr. George Wagner ("Wagner"). Wagner is an employee of MRI, and he works primarily at the Mercy/Western Hills location.

i. Dr. Jeremy Gilliam ("Gilliam"). Gilliam is a shareholder and employee of MRI since 2008, and he works at both Mercy/Western Hills and Mercy/Mt. Airy. He has prepared marketing materials and given lectures about the services provided by MRI at Mercy to primary care physicians and oncologists in order to increase the patient radiology referrals to Mercy from those physicians.

j. Michael DeFrank ("DeFrank"). DeFrank is an attorney located in Northern Kentucky who represents physician groups relating to the negotiation of contracts with various hospital entities throughout the Northern Kentucky and Cincinnati areas, and he specializes in health care law. Between the years 2009 through 2013 DeFrank represented MRI

in its contract negotiations with MHP.

17. Mercy Health Partners of Southwest Ohio, Mercy Hospitals West, an Ohio nonprofit corporation d/b/a Mercy Franciscan Hospital and Mercy Western Hills ("MHP"), does business under the name of Mercy Health Partners. MHP operates six full service hospitals throughout Cincinnati, including the hospitals located at Mercy/Western Hills, Mercy/Mt. Airy, Mercy/Fairfield, Mercy/Anderson, Mercy/Clermont and the Jewish Hospital. A new hospital identified as Mercy West is scheduled to open in the fall of 2013. MHP also operates the freestanding hospital facilities of Harrison Medical Center-Western Hills, Cincinnati PET Scan-Mt. Airy, Westside CT Scan-Mt. Airy Hospital and Mercy Medical Imaging-White Oak (hereinafter referred to as the "freestanding facilities"). MHP also provides long term care at its facilities known as St. Theresa, the Franciscan Terrace and West Park.

18. The individuals primarily involved on MHP's behalf in the fraudulent conduct in violation of federal law include the following:

a. Patrick Kowalski ("Kowalski'). From 2006-2011 Kowalski was Mercy/Western Hills' CEO, and he was responsible for the day to day activities of that hospital. Kowalski negotiated the 2006 Professional Services Agreement ("2006 Agreement") between MRI and Mercy/Western Hills. In January 2011, he became the Chief Operating Officer ("COO") of the Cincinnati westside market for MHP, and he was responsible for the day-to-day operations of two westside hospitals, Mercy/Western Hills and Mercy/Mt. Airy. He was also the person primarily responsible on MHP's behalf in negotiating the June 2011 Professional Services Agreement ("2011 Agreement") between MRI and MHP for all of MHP's facilities located in western Cincinnati.

b. Paul Hiltz ("Hiltz"). From 2006-2011 Hiltz was Mercy/Mt. Airy's CEO, and he is President of Mercy Health Select, a division of MHP.

c. Kevin Cook ("Cook"). From 2006 through June of 2009 Cook was the Vice President of Operations at Mercy/Mt. Airy, and he reported directly to Hiltz. He currently is working in Toledo, Ohio as the CEO of the Mercy Hospital system in Northern Ohio.

d. Jason Wessel ("Wessel"). Wessel was the Radiology Imaging Manager for Mercy/Mt. Airy. He signed the 2007 contract addendum agreement ("2007 Addendum") between MRI and Mercy/Mt. Airy which materially altered the prior 2002 Professional Services Agreement ("2002 Agreement") previously entered into by MRI and Mercy/Mt. Airy.

e. Rodney Reider ("Reider"). Reider is a former Mercy/Mt. Airy CEO who negotiated and executed the 2002 Agreement.

f. Rob Brown ("Brown"). Brown replaced Wessel, and he is the Director of Imaging Services for Mercy/Mt. Airy.

g. Joe Kappa ("Kappa"). Kappa is the Director of Imaging Services for Mercy/Western Hills.

h. Roland Cruickshank ("Cruickshank"). Cruickshank replaced Cook as the Vice President of Operations at Mercy/Mt. Airy, and in 2009 and 2010 he was involved in organizing and directing MRI physicians to solicit radiology referrals from third party physicians for MHP.

IV. THE LAW

A. The False Claims Act (31 U.S.C. §§ 3729-33)

19. The FCA provides for the award of treble damages and civil penalties against any

person for, inter alia, knowingly causing the submission of false or fraudulent claims for payment to the United States Government or making or using false statements which are material to false or fraudulent claims paid by the United States. In 2009, the FCA was amended in the Fraud Enforcement Recovery Act ("FERA"), and those amendments took effect as if enacted on June 7, 2008.

20. Prior to FERA's enactment, the FCA provided in relevant part:

> "(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 allowed or paid.
>
> . . .
>
> is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, plus 3 times the amount of damages which the Government sustains because of the act of that person . . .
>
> (b) For purposes of this section, the terms "knowing" and "knowingly" mean that a person, with respect to information (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required."

31 U.S.C. § 3729.

21. When the FERA was enacted, the FCA was amended to include the following pertinent revisions:

> "(a) (1) any person who – (A) knowingly presents or causes to be presented a false or fraudulent claim for payment on appeal; (B)

> knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim; (C) conspires to commit a violation of subparagraphs (A), (B) or . . . (G) is liable to the United States for a civil penalty of not less than $5,000 and not more than $10,000 as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990. (28 U.S.C. 2461 note; Public Law 104-410), plus 3 times the amount of damages which the government sustains because of the act of the person.
>
> * * *
>
> (b) For purposes of this section, (1) the terms "knowing" and "knowingly" – (A) mean that a person, with respect to information – (i) has actual knowledge of the information; (ii) acts in deliberate ignorance of the truth or falsity of the information; or (iii) acts in reckless disregard of the truth or falsity of the information; and (B) requires no proof of specific intent to defraud;"

31 U.S.C. § 3729 (May 2009).

22. The standard of proof under both versions of the FCA is a preponderance of the evidence. 31 U.S.C. § 3731(c).

B. <u>The Anti-Kickback Statute (42 U.S.C. §§ 1320a-7b(b)(1) and (b)(2))</u>

23. The AKS prohibits any person or entity from making or accepting payment to induce or reward any person for referring, recommending, or arranging for federally-funded medical services, including services provided under the Medicare, Medicaid, and (as of January 1, 1997) TRICARE programs.

24. The AKS provides in pertinent part:

> "(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 not 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 not more than $25,000 or imprisoned for not more than five years, or both."

42 U.S.C. § 1320a-7b(b)(1) and 42 U.S.C. § 1320a-7b(b)(2).

25. Once proof of each element of the AKS is established, the burden shifts to the

Defendants to prove that its conduct is protected by a "safe harbor" exception. *United States Ex Rel. Gale v. Omnicare, Inc.*, 2013 U.S. Dist. LEXIS 102658 at para. 17, fn. 57 (N.D. Ohio, July 23, 2013) citing to *United States v. Rogan*, 459 F. Supp.2d 692, 716 (N.D. Illinois 2006) aff'd. 517 F.3d 449 (7th Cir. 2008).

26. On March 23, 2010, Congress passed Public Law 111-148, the Patient Protection Affordable Care Act ("PPACA") which amended the AKS. Specifically, by the PPACA (H.R. 3590, Section 6402), Congress added the following provisions to the AKS.

> "(g) In addition to the penalties provided for in this section or section 1128A, a claim that includes items or services resulting from a violation of this section constitutes a false or fraudulent claim for purposes of subchapter III of chapter 37 of title 31, United States Code.
>
> (h) With respect to violations of this section, a person need not have actual knowledge of this section or specific intent to commit a violation of this section."

27. By the PPACA Congress also added a requirement that any overpayment to a person by the United States for a false claim must be reported and returned by no later than 60 days after the date the overpayment is identified or the date any corresponding cost report is due. This provision makes any such overpayments returned after the deadline for reporting and returning an "obligation" for purposes of the FCA, and it is a basis for the collection of significant damages and penalties under the FCA. H.R. 3590, Section 6402.

28. As a result of the amendments to the AKS referenced in paragraphs 26 and 27 above, every violation of the AKS alleged herein is a violation of the FCA, and these violations subject MRI and MHP to significant financial penalties and recoupment of all monies paid to them by the United States. Furthermore, it is not necessary that MRI and MHP or their agents

had and/or have actual knowledge of the AKS's requirements or a specific intent to commit a violation of AKS in order to be found to have violated the AKS. Relator is only required to demonstrate that MRI and MHP intended to perform the actions and engage in the conduct that violated the AKS.

29. The AKS imposes liability on the parties on both sides of an impermissible "kickback" transaction or "kickback" relationship, and the AKS does not include any requirement that a Relator prove that any such transaction or relationship harmed a patient or resulted in unnecessary procedures. The AKS also prohibits any arrangement where just one purpose of the remuneration received by one side to the relationship is to obtain money for the referral of services or to induce further referrals or recommendations. *United States v. Borrasi*, 639 F.3d 774, 782 (7th Cir. 2011); *United States v. McClatchey*, 217 F.3d 823 (10th Cir. 2000); *United States v. Lahue*, 261 F.3d 993 (10th Cir. 2001); *United States v. Greber*, 760 F.2d 68 (3rd Cir. 1985); and *United States v. Kats*, 871 F.2d 105 (9th Cir. 1989).

30. The issue of what constitutes remuneration is the touchstone for determining whether a violation under the AKS has occurred. Remuneration is the transfer of anything of value. It includes providing a person an opportunity to earn money, and it can be indirect and covert. See, *United States of America, ex rel Fry v. The Health Alliance of Greater Cincinnati, et al.*, 2008 U.S. Dist. Lexis 102411 at ¶¶ 17-20 (S.D. Ohio, Dec. 18, 2008).

31. The AKS also contains statutory exceptions, called "safe harbors," that exempt certain transactions from its prohibitions. However, each safe harbor has clear and specific standards, and the AKS requires strict compliance with those standards.

32. Personal Services and Management Contracts can be permissible under an AKS

safe harbor, and hospital-based physicians who are radiologists may rely upon appropriate personal service agreements to claim that their actions in directing the flow of patient referrals to a hospital-based physician group by the hospital do not violate the AKS. But this "safe harbor" requires strict compliance with the following conditions:

> "(d) *Personal services and management contracts*. As used in section 1128B of the Act, "remuneration" does not include any payment made by a principal to an agent as compensation for the services of the agent, as long as all of the following seven standards are met–
>
> (1) The agency agreement is set out in writing and signed by the parties.
>
> (2) The agency agreement covers all of the services the agent provides to the principal for the term of the agreement and specifies the services to be provided by the agent.
>
> * * *
>
> (5) The aggregate compensation paid to the agent over the term of the agreement is set in advance, is consistent with fair market value in arms-length transactions and is not determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties for which payment may be made in whole or in part under Medicare, Medicaid, or other federal health care programs.
>
> (6) The services performed under the agreement do not involve the counselling or promotion of a business arrangement or other activity that violates any State or Federal law."

33. From at least August 4, 2006 through the present, this "safe harbor" did not protect MRI's and MHP's unlawful conduct at the Mt. Airy, Western Hills and freestanding facilities for multiple reasons.

34. Several of the agreements between MHP and MRI were not in writing. None of

those agreements covered all of the services provided by MRI to MHP. The aggregate compensation identified in the agreements is not consistent with the fair market value of the services provided by MRI. Finally, MRI and MHP engaged in substantial activities for the promotion of a business arrangement between the two parties for the purpose of inducing additional illegal patient referrals.

C. Federal Health Care Programs

35. In 1965 Congress enacted Title XVIII of the Social Security Act, known as the Medicare Program, to pay for the costs of certain health care services. Entitlement to Medicare is based on age, disability, or affliction with end-stage renal disease. *See* 42 U.S.C. §§ 426, 426A.

36. Part A of the Medicare Program authorizes payment for institutional care, including for care provided at hospitals, skilled nursing facilities, and home health care. *See* 42 U.S.C. §§ 1395c-1935i-4.

37. Part B of the Medicare Program authorizes payment for outpatient health care expenses, including physician fees. These fees are administered through Medicare carriers, and payments are made through a trust fund ("the Medicare Trust Fund"). See, 42 U.S.C. §§ 1395j-1395w-4.

38. MRI and MHP derived and continue to derive substantial revenue from the Medicare Program.

39. The Department of Health and Human Services ("HHS") has overall responsibility for the administration and supervision of the Medicare Program. The Center for Medicare and Medicaid Services ("CMS") is an agency of HHS, and it is directly responsible for the administration of the Medicare Program. CMS delegates its responsibility to process claims

and to make disbursements from the Medicare Trust Fund on behalf of the United States to certain contractual agents.

40. Payment of Part A claims made by hospitals under the Medicare Program are administered by fiscal intermediaries. In Ohio the fiscal intermediaries are Palmetto GBA and National Government Services.

41. Payment of Part B physician and outpatient hospital claims made under the Medicare Program are paid separate and apart from hospital Part A claims pursuant to a Medicare Program reimbursement schedule.

D. Other Federally Funded Health Insurance Programs

42. Federal health care programs include any plan or program that provides health benefits directly or indirectly through insurance or that are otherwise funded directly in whole or in part by the United States Government. 42 U.S.C. § 1320a-7b(f)(1). These include military benefits through the TRICARE program, the Federal Employees Health Benefit Program, and other federally funded insurance (excluding federal workers compensation claims).

43. State Medical Assistance (or "Medicaid") programs are also federal health care programs. See, 42 U.S.C. § 1320a-7b(f)(2).

E. Provider Agreement

44. Medicare Program providers, including MRI and MHP, are required to enter into provider agreements with the federal government.

45. Hospitals that meet Medicare Program requirements enter into provider agreements pursuant to forms UB-92 and CMS-855(A). Pursuant to those agreements, hospitals must also reconcile payments made throughout the year by the submission of a year-end cost

report identified as CMS-2552. Likewise, physicians and their corporate entities that participate in the program must enter into provider agreements through the use of forms CMS-855(B) and CMS-855(I), and present claims pursuant to a form CMS-1500. The most recent claims for both hospitals and physicians are presented electronically.

46. Under the terms of the provider agreements referred to in paragraph 45, above, a Medicare Program provider certifies that it will comply with all laws and regulations governing the Medicare Program, including the AKS and the FCA in connection with the claims it submits for payment relating to services provided to patients in which reimbursement is sought from a federal health care program.

F. Implied Certification

47. Certification of compliance with the AKS is a prerequisite for hospitals, physicians, and their corporate entities to obtain a government benefit such as Medicare and other payments from federal health care programs.

48. The false certification of compliance with the AKS by MHP and MRI creates liability under the FCA.

49. Prior to March 23, 2010, this judicial district and other judicial districts recognized that violations of the AKS are a basis for a FCA lawsuit.

50. Under the implied certification theory, each time a claim is submitted pursuant to an improper referral, that claim is a separate and illegal kickback that is actionable under the FCA. See, *United States ex rel Augustine v. Century Health Services*, 289 F.3d 409, 415 (6th Cir. 2002).

51. In connection with the false claims that are the subject of the original, first, and

second amended complaints, MRI and MHP certified that they had complied with the AKS and the FCA in presenting those claims for payment from a federal health care program.

52. By statute, since March 23, 2010, each submission of a claim by these Defendants to the United States for payment that is the subject of the second amended complaint is an AKS violation, and, as a matter of law, each claim is a separate violation of the FCA.

G. Since 1991 The United States Has Declared That A Financial Arrangement Between A Hospital And Its Hospital-Based Physicians That Requires Physicians To Provide Goods And Services At Less Than Fair Market Value To Hospitals In Return For Access To The Hospital's Patients Who Are Insured Under A Federal Health Program Is A Violation Of The AKS.

Initial 1991 HHS/OIG Pronouncement Relating To A Hospital's Practice Of Trading Patient Access In Return For Free Administrative Services From It's Hospital-Based Physician

53. The AKS prohibits MHP from trading its access to its federally insured patients to MRI, its hospital-based radiology provider, in return for discounted or free radiology medical director services for MHP.

54. The Inspector General for the Office of Inspector General ("OIG") issues Management Advisory Reports ("MAR") which are designed to furnish notice to the public regarding a significant problem recognized by the OIG under the AKS and to call attention to an abuse which the OIG believes has the potential for causing harm to the United States Medicaid program.

55. In 1991 Richard Kusserow, the then Inspector General for the OIG, issued a MAR relating to the potential applicability of the AKS to certain financial arrangements between hospitals and hospital-based physicians that are at risk of being violations of the AKS. A copy of the 1991 MAR is attached hereto as Exhibit "1" and incorporated herein.

56. By the 1991 MAR, the OIG made clear that financial arrangements between a hospital and hospital-based physicians such as radiologists, anesthesiologists, and pathologists which require physicians to provide goods and services at less than fair market value to hospitals can constitute a violation of federal law. In short, the focus of the MAR is the remuneration made to hospitals from physicians. (MAR at p. 1).

57. Specifically, in the 1991 MAR the OIG stated that hospital-based physicians such as anesthesiologists, pathologists and radiologists are dependent on their positions at a hospital to obtain referrals from other specialists practicing at the hospital. (MAR at p. 1). The OIG warned the medical community that the AKS proscriptions apply to those who can materially influence the flow of Medicare and Medicaid business. ("Hospitals are in such a position with respect to hospital-based physicians since they typically can name who will be the recipient of the flow of business generated at the hospital." (MAR at pp. 1-2)).

58. In the 1991 MAR, the OIG issued findings and conclusions.

59. One of the OIG's conclusions is that a hospital that provides no or token reimbursement to hospital-based physicians for Part A services in return for the opportunity to perform or bill for Part B services at that hospital can violate the AKS because the hospital-based physician is providing compensation that exceeds the fair market value of the services the hospital provides to the hospital-based physician under the financial arrangement between the two. (MAR at p. 4). It also can violate the AKS because the free administrative and clinical medical director duties are intended to provided the radiologists with referrals from the other physicians on the hospital's medical staff. (MAR at p. 4).

60. The significant problems and conflicts foreseen by the OIG in financial

arrangements where hospital-based physicians offer their services to hospitals at below fair market value include the following:

- Hospitals may award the exclusive contract based on improper financial considerations instead of traditional considerations centering on professional qualifications of the physician.
- In addition, the remuneration gives hospitals a financial incentive to develop policies and practices which encourage greater utilization of the services of hospital-based physicians payable under Medicare Part B.
- Hospital-based physicians faced with lowered incomes may be encouraged to do more procedures in order to offset the payments to the hospitals.
- The foregoing problems are among the recognized purposes of having the AKS on the books in the first place. (MAR at p. 4).

61. In the 1991 MAR the OIG advises that, in order to avoid potential legal liability, all contracts between hospitals and hospital-based physicians should comply with all safe harbor provisions that may apply under the contract between the parties. All contracts between hospitals and hospital-based physicians should be based on the fair market value of services. The nature and value of all services performed should be stated separately and fair market value should be documented. (Exhibit 1, January 31, 1991 letter from Kusserow to Wilensky).

1993 Summary Of OIG Activities On Medicare

62. In 1993 the OIG issued a *Summary of OIG Activities on Medicare,* and in that summary it stated that there existed a long standing problem in the Medicare Program regarding financial relationships between hospital-based physicians and its partner hospital. A copy of the

Summary is attached hereto as Exhibit "2" and incorporated herein. Specifically, the OIG found that some hospitals are requiring kickbacks, both direct and indirect, from their hospital-based physicians because the physicians depend on hospitals for the referral of patients. (Exhibit 2 at p. 15). Further, the OIG recommended that the Medicare Program notify hospitals and hospital-based physicians about potential legal liability regarding financial agreements that were inconsistent with the fair market value of their services. (Exhibit 2 at p. B-2).

1998 OIG Compliance Guidelines For Hospitals

63. In 1998 the OIG published its compliance program guidelines for hospitals in a Federal Register notice at Vol. 63 No. 35/Monday, February 23, 1998, pp. 8987-8998. A copy of the guidelines is attached hereto as Exhibit "3" and incorporated herein. The compliance program guidelines were authored by June Gibbs Brown, the Inspector General.

64. The compliance program guidelines included principles that are applicable to a wide variety of organizations, including hospitals that provide health care services to beneficiaries of Medicare and Medicaid, and all other Federal Health Care programs.

65. The compliance program was issued, in part, to assist hospitals in developing effective internal controls that promote adherence to applicable federal law. Specifically, the OIG identified several "risk areas" in the operation of a hospital that deserved extra emphasis. One of the significant areas of risk for an AKS violation identified by the OIG is the financial relationship between a hospital and its hospital-based physician. (Exhibit 3 at p. 8990). ("...[A]nother OIG concern with respect to the AKS is hospital financial arrangements with hospital-based physicians that compensate physicians for less than the fair market value of services they provide to hospitals . . . [e]xamples of such arrangements that may violate the Anti-

Kickback Statute are token or no payment for Part A supervision and management services... ." (Exhibit 3 at p. 8990, fn. 25).

66. In ensuring that no confusion existed relating to the exposure of hospital-based physicians and hospitals for financial arrangements that may violate the AKS, the OIG wrote:

> "5. *Anti-Kickback and Self-Referral Concerns.* The hospital should have policies and procedures in place with respect to compliance with Federal and State anti-kickback statutes, as well as the Stark physician self-referral law. Such policies should provide that:
>
> * * *
>
> The hospital does not enter into financial arrangements with hospital-based physicians that are designed to provide inappropriate remuneration to the hospital in return for the physician's ability to provide services to Federal heath care program beneficiaries at that hospital.
>
> Further, the policies and procedures should reference the OIG's safe harbor regulations, clarifying those payment practices that would be immune from prosecution under the anti-kickback statute. See 42 CFR 1001.952."

(Exhibit 3 at p. 8992).

The 2005 Guidelines

67. In January 2005 the OIG issued its Supplemental Compliance Program Guidelines ("Supplemental Guidelines") for Hospitals in the Federal Registrar Volume 70, No. 19, pages 4858 through 4876. A copy of the Supplemental Guidelines is attached hereto as Exhibit "4" and incorporated herein. The Supplemental Guidelines were issued to help hospitals identify significant risk areas as it relates to the request and receipt by a hospital of federal funds. The OIG wrote:

> "Hospitals should also be aware of the Federal anti-kickback statute, section 1128B(b) of the Act, and the constraints it places on business arrangements related directly or indirectly to items or services reimbursable by any Federal health care program, including, but not limited to, Medicare and Medicaid. The anti-kickback statute prohibits in the health care industry some practices that are common in other business sectors, such as offering gifts to reward past or potential new referrals."

(Exhibit 4 at p. 4863).

68. By the Supplemental Guidelines the OIG once again stressed that financial arrangements between hospitals and traditional hospital-based physicians are subject to scrutiny for violations of the AKS. (Exhibit 4 at p. 486).

69. Consistent with its position since 1991, the OIG recognized that hospitals are in a position to influence the flow of business to physicians, and their arrangements with physicians can violate the AKS if the hospital solicits or receives something of value – or the physicians offer or pay something of value – in exchange for access to the hospitals federal health care program business. (Exhibit 4 at p. 4867).

70. These illegal kickbacks referred to in paragraph 69, above, may take a variety of forms, including the hospital compensating physicians less than the fair market value for goods or services provided to the hospital by the physicians. (Exhibit 4 at p. 4867).

71. According to the OIG, arrangements that require physicians to provide Medicare Part A supervision and management services for token or no payment in exchange for the ability to provide physician-billable Medicare Part B services at the hospital is a form of an illegal kickback. (Exhibit 4 at p. 4867). Further, the OIG made clear that these types of arrangements, which include uncompensated or below market arrangements for goods or services by the

hospital-based physician to the hospital, are subject to compliance with the AKS.

> "In cases where a hospital is the referral source for other providers or suppliers, it would be prudent for the hospital to scrutinize carefully any remuneration flowing to the hospital from the provider or supplier to ensure compliance with the anti-kickback statute, using the principles outlined above. Remuneration may include, for example, free or below-market-value items and services or the relief of a financial obligation."

(Exhibit 4 at p. 4868).

72. The OIG indicated that compliance with an AKS "safe harbor" is voluntary and that, although failure to comply with a "safe harbor" is not illegal *per se*, arrangements that are not covered by a "safe harbor" will be strictly scrutinized and evaluated on a case by case basis. Furthermore, when a hospital or hospital-based physician relies on a "safe harbor" provision as protection from an AKS violation, it/he has the burden of establishing that it strictly complied with all applicable conditions set out in the relevant safe harbor because "[m]en must turn square corners when they deal with the government." See, *United States ex rel., Compton v. Midwest Specialities*, 142 F. 3d 296, 302 (6th Cir. 1998).

H. Percentage Compensation Arrangements For Marketing Services Between Hospital And "Hospital-Based" Physicians Implicate The AKS.

73. Marketing and advertising activities by hospital-based physicians can be violations of the AKS. 56 Fed. Reg. at 35974 (July 29, 1991).

74. In the preamble to the 1991 Final Safe Harbor Rules, OIG explained that on its face the AKS prohibits offering or accepting remuneration for purposes of arranging for or recommending purchasing, leasing or ordering any service or item payable under the Medicare Program or Medicaid. 56 Fed. Reg. at 35952 (July 29, 1991).

75. In OIG Advisory Opinion No. 94-8 (April 15, 1998), D. McCarty Thornton, Chief Counsel to the Inspector General, identified several terms of financial arrangements which violate the AKS. Specifically, Thornton stated that arrangements which include financial incentives to increase patient referrals which do not have safeguards against over utilization of medical services, or include financial incentives that increase the risk of abusive billing practices, are subject to AKS violations.

76. Most recently, in OIG Advisory Opinion No. 10-23 (November 4, 2010), Lewis Morris, Chief Counsel to the Inspector General, indicated that any arrangement where fees are paid on the basis of successful orders for items and services is inherently subject to abuse because the fees are directly linked to business generated by the solicitor. An arrangement in which the marketeer receives fees based upon successful marketing efforts is subject to AKS scrutiny. Thus, an arrangement in which payment is premised on the volume or value of services ordered, i.e. patient referrals, the greater the financial incentive to increase the number of tests for services related to the promotional efforts and, as a result, these arrangements are subject to the AKS.

77. As will be demonstrated herein, MHP and MRI entered into several agreements between 2008 through 2011 which resulted in percentage compensation arrangements for MRI employees that were directly related to MRI's uncompensated marketing and solicitation activities on MHP's behalf, and these arrangements violated the AKS.

V. THE FACTUAL BASIS SUPPORTING RELATOR'S ASSERTION THAT THE DEFENDANTS HAVE VIOLATED THE AKS WHICH RESULTED IN THE SUBMISSION OF CLAIMS FOR PAYMENT TO THE UNITED STATES IN VIOLATION OF THE FALSE CLAIMS ACT

A. MRI Enters Into A Written Agreement With MHP In 2002 For Its Mt. Airy Campus Which Expires on February 1, 2008.

78. On February 1, 2002, MRI entered into the 2002 Agreement with MHP to be the exclusive provider of radiology services for MHP's Mt. Airy campus. A copy of the 2002 Agreement is attached hereto as Exhibit "5" and incorporated herein. These services included radiological examinations, interpretations, consultations, imaging, and interventional procedures for persons brought to the hospital for treatment, and radiological consultation services to MHP's medical staff. Under the agreement MRI's status was that of an independent contractor.

79. Under the 2002 Agreement, MHP was obligated to provide all equipment and staff in order to perform radiology duties at the hospital.

80. The term of the 2002 Agreement was three years with an additional three year renewal provision. On February 1, 2005, the 2002 Agreement was renewed, and by its terms it expired on February 1, 2008.

81. Under the 2002 Agreement, in return for the exclusive right to perform all radiology services at MHP Mt. Airy, MRI was required to provide a medical director of radiology services to the hospital. The medical director was responsible for performing an extensive number of the medical and administrative duties on behalf of MHP, and he was required to devote 7.5 hours per week on Mercy's behalf which was equivalent to 390 hours per year. (Exhibit 5 at Section 2.03.D). Further, the radiology medical director was responsible for

overseeing the industry standards and guidelines applicable to the hospital's radiology department. A copy of Pamela Zipperer-Davis' deposition excerpts, p. 155/23-25, is attached hereto as Exhibit "6" and incorporated herein.

82. MHP needed the medical director's oversight to ensure that its radiology department was meeting the applicable national and local standards and so that it could bill insurance companies including the Medicare Program for the Part A technical fees associated with the radiology services performed at MHP. (Exhibit 6 at p. 153/11-19).

83. The first Medical Director of Radiology Services for MHP Mt. Airy was Aukerman. Pursuant to a written contract, the amount of payment due from MHP to MRI for the services provided by Aukerman as the medical director was $40,000 per year. (Exhibit 5 at Section 2.03(D)). The $40,000 per year payment calculated by Mercy/Mt. Airy was the low-end of the fair market value of the medical director services to be provided by Aukerman in 2002. (Exhibit 6 at p. 175/23).

84. During the years 2002 through 2005 Mercy/Mt. Airy paid MRI $40,000 per year for Aukerman's medical director services performed on Mercy/Mt. Airy's behalf. A copy of Kevin Aukerman's 3/7/12 deposition excerpts, p. 10/18-21, is attached hereto as Exhibit "7" and incorporated herein.

85. In order to obtain the payment of $40,000 Aukerman submitted time sheets to Mercy for the hours he spent performing the medical director duties for Mercy/Mt. Airy. (Exhibit 7 at p. 9/18-21).

86. Aukerman remained the medical director for several years. He was replaced by another MRI physician named Dr. Steven Kruis ("Kruis"). (Exhibit 7 at p. 11/5-7).

87. Aukerman relinquished the medical director duties to Kruis because he was spending more time performing the medical director duties than the 7.5 hours per week required under the 2002 Agreement. (Exhibit 7 at p. 12/8-24). Specifically, Aukerman admitted that being the medical director required him to perform a significant amount of extra work. (Exhibit 7 at pp. 15/22-24, 17/21-24).

88. MRI, through Kruis, continued to perform the medical director duties on behalf of Mercy/Mt. Airy without additional compensation and below market value for those services in order to be a "good partner" with Mercy. (Exhibit 7 at pp. 15/22-16/1).

89. In mid 2006, Hiltz, as Mercy/Mt. Airy's CEO, and Cook, as Mercy/Mt. Airy's COO, reviewed all of the written agreements relating to the Mercy/Mt. Airy operations in an effort to reduce the expenses of the hospital. The MRI/Mercy/Mt. Airy 2002 Agreement was reviewed. A copy of Paul Hiltz's deposition excerpts, pp. 18/24-19/22, is attached hereto as Exhibit "8" and incorporated herein.

90. In that review Cook told Hiltz that Mercy/Mt. Airy was paying a medical director fee to MRI under the 2002 Agreement and that payment was unusual and should be reduced. (Exhibit 8 at pp. 21/4-23).

91. At that time Hiltz did not know why the amount of $40,000 per year had been agreed upon as the value of the medical director services to be performed on behalf of Mercy/Mt. Airy. (Exhibit 8 at p. 22/14-21).

92. In February of 2007, the 2002 Agreement was amended by the parties ("the 2007 Amendment"). A copy of the 2007 Addendum is attached hereto as Exhibit "9" and incorporated herein. Pursuant to the 2007 Amendment the annual compensation due MRI for medical director

services was reduced to $12,000 per year even though the duties to be performed by the Medical Director remained exactly the same as those duties required in the 2002 Agreement which was below fair market value. (Exhibit 7 at pp. 25/12-27/25). The reduction of fees occurred notwithstanding the plain language of the 2002 Agreement which stated that the Medical Director fee payment was to be increased annually in accordance with the Consumer Price Index. (Exhibit 5 at Section 2.03(D)).

93. The reduction in the medical director fee payment from MRI to Mercy/Mt. Airy is also a violation of MHP's written fair market value policies applicable to medical director agreements between MHP and its contracted physicians.

94. In 2005 and 2006, Catholic Health Partners ("CHP"), the parent for MHP, enacted hospital policies which required MHP, including Mercy/Mt. Airy and Mercy/Western Hills, to perform a fair market value analysis relating to payments made by the hospital pursuant to agreements it entered into with physicians. A copy of Kevin Cook's deposition excerpts, pp. 21/7-16, 22/6-23/6, is attached hereto as Exhibit "10" and incorporated herein. In any financial agreement negotiated between MHP and its radiologists it was standard operating procedure to obtain a fair market value analysis of the services to be performed under the agreement. (Exhibit 10 at pp. 21/15-16, 39/11-24). This fair market value policy applied to the MHP/radiologist relationship even though radiologists do not refer patients to the hospital. (Exhibit 10 at pp. 39/16-40/6).

95. According to Cook, this standard procedure existed in order to protect MHP from any kind of federal law violation, i.e. Stark, from unfairly (or illegally) compensating physicians. (Exhibit 10 at p. 21/17-22).

96. Cook stated that, prior to reducing the money to be paid to MRI under the 2002 Agreement for medical director services, a fair market value analysis as it relates to the value of the medical director duties performed by MRI was required under Mercy's standard procedure. (Exhibit 10 at pp. 21/7-22/23).

97. Cook expected a fair market value analysis to be undertaken relating to the 2007 reduction of the medical director fees payable by MHP previously established under to the 2002 Agreement. (Exhibit 10 at pp. 22/7-23, 40/17-20).

98. Ignoring its own fair market value policies, neither Cook nor anyone else at MHP performed any fair market value analysis justifying the reduction of the $40,000 medical director fee to $12,000 per year and ultimately to zero. (Exhibit 10 at p. 23/7-9). Instead, MHP/Mt. Airy, through its CEO Hiltz and COO Cook, unilaterally decided to reduce the MRI medical director fees because he does not like paying them, they are expensive and payment of those fees was not a good model. (Exhibit 8 at pp. 70/3-9, 70/19-71/5).

99. In January 2007, Welton, MRI's Treasurer and Secretary, replaced Kruis as the Radiology Medical Director for Mercy/Mt. Airy. During 2007, MHP/Mt. Airy paid MRI a total of $10,000 of the $12,000 that was owed to MRI under the 2007 Addendum for Medical Director services.

100. On February 1, 2008, the 2002 Agreement and 2007 Addendum expired, and no other written agreement existed between February 1, 2008 through June 14, 2011 between Mercy/Mt. Airy and MRI relating to the provision of radiology services at Mercy/Mt. Airy.

101. Accordingly, from February 1, 2008 through June 14, 2011, no "safe harbor" existed to protect the conduct of and relationship between MHP and MRI relating to MHP's

successful efforts in violation of the AKS to direct unlawful radiology referrals to MRI at MHP's Mt. Airy facility.

102. In 2008, MHP/Mt. Airy paid MRI the below fair market amount of $6,000 for the medical director services provided by Welton. The last payment made by Mercy/Mt. Airy to MRI occurred in June of 2008.

103. Between June of 2008 through the present, MHP/Mt. Airy has not paid MRI anything for the medical director services performed on its behalf by Welton.

104. MHP/Mt. Airy, through CEO Hiltz, acknowledges that the medical director services performed by Welton are valuable, but it did not pay for those services because that is MHP's standard practice not to pay for them. (Exhibit 8 at pp. 68/3-70/22). However, neither Mercy/Mt. Airy nor Hiltz is able to articulate any legitimate or legal reason why Mercy/Mt. Airy failed to make any payment to MRI for Welton's medical director duties he has performed at MHP/Mt. Airy since June of 2008. In fact, Hiltz admits that the contracted amount of medical director services required from MRI remain the same as those provided before 2007. (Exhibit 8 at pp. 30/3-31/11; Exh. 9 at ¶ 2).

105. MHP's decision to stop making payments to MRI is a violation of the applicable law identified herein and the fair market value policies that existed at MHP/Mt. Airy since 2006. The decision of MHP not to pay the medical director fees was done by MHP for the purpose of inducing MRI to offer free medical director services in exchange for allowing MRI to have access to MHP's federally insured patient base.

B. MRI Entered Into A Separate Written Agreement With Mercy/Western Hills In Which MRI Agrees To Forfeit Any Medical Director Service Payments In Exchange For Access To Mercy/Western Hills' Federally Insured Patient Population.

106. On August 4, 2006, MRI entered into a separate written agreement ("the 2006 Agreement") with MHP to provide radiology services to MHP for its Western Hills branch. A copy of the 2006 Agreement is attached hereto as Exhibit "11" and incorporated herein. The 2006 Agreement by its terms was not applicable to any other health care facility other than MHP's Western Hills' hospital. The term of the 2006 Agreement was three years, and the agreement automatically renewed for an additional three year term.

107. By the 2006 Agreement, MRI was awarded the opportunity to provide radiological examinations, interpretations, consultations, imaging and interventional procedures for persons brought to MHP Western Hills for treatment, as well as all radiological consultation services to MHP's medical staff. MRI's status was that of an independent contractor, not an employee, agent, partner with Mercy/Western Hills. (Exhibit 11 at Section 8.01).

108. Under the 2006 Agreement MRI was required to provide a MRI employee at the MHP Western Hills branch to perform medical director duties similar to those that Welton provided at MHP's Mt. Airy branch.

109. Kleimeyer, an employee of MRI, was appointed as the Medical Director for Radiology at MHP Western Hills, and MHP did not pay MRI any compensation for the medical director services Kleimeyer provided.

110. Patrick Kowalski, the CEO for Mercy/Western Hills, was the person who negotiated the primary responsibilities to the 2006 Agreement on Mercy's behalf.

111. Prior to entering into the 2006 Agreement, Kowalski did not perform any study or

hire any third person to provide an opinion as to the fair market value of the medical director services to be provided by MRI under that Agreement. A copy of Patrick Kowalski's deposition excerpts, pp. 34/9-15, 50/5-11, is attached hereto as Exhibit "12" and incorporated herein.

112. MHP's failure to have any fair market value analysis relating to the 2006 Agreement was not a simple oversight, it was a deliberate decision which violated the AKS.

113. Kowalski states that, even though the medical director duties performed by MRI have value to the hospital, (Exhibit 12 at p. 56/11-25), there was no reason to pay compensation for hospital-based medical director services because the medical group (MRI) has access to an entire "book of business," and that is their professional fee. (Exhibit 12 at pp. 53/10-55/10). A book of business means the provision of radiology services and readings at a hospital. (Exhibit 12 at p. 54/6-8)).

114. According to Kowalski, because MRI was given the opportunity to bill for its professional fees relating to the patients who come to the hospital, MHP did not pay a medical director fee for the clinical and administrative duties performed by MRI on Mercy's behalf. (Exhibit 12 at pp. 54/23-55/10).

115. The MRI doctors who provided medical director services to MHP were compensated by the money MRI received for the services MRI provides to patients MHP refers to MRI and any unnecessary procedures MRI ordered for those patients.

116. Between August 2006 through June 14, 2011, MHP refused to pay any compensation to MRI for Kleimeyer's medical director duties.

117. From August 4, 2006 to the present, MHP ignored its own policies and decided not to do a fair market value analysis in order to support its decision to not pay MRI for the

medical director services Kleimeyer provided over a five year period.

118. From August 4, 2006 to the present MHP did nothing with respect to its financial arrangements with MRI to comply with the legal and internal MHP policy requirements for physician compensation, it did nothing to determine the fair market value of the medical director services provided by MRI, and it did not negotiate the fair value of the financial arrangements in an arms length transaction.

119. Therefore, no "safe harbor" existed to protect the business relationship between MHP and MRI from being a violation of the AKS because Kowalski admited that the payment to MRI for its free medical director duties performed on MHP's behalf was patient access for MRI at MHP and MRI's opportunity to earn money from the treatment of those patients.

120. MHP continued its violation of the law in the operation of its freestanding facilities known as Harrison Medical Center-Western Hills, Cincinnati PET Scan-Mt. Airy, Westside CT Scan-Mt. Airy Hospital and Mercy Medical Imaging-White Oak. MHP and MRI had no written agreement under which MRI was to provide medical director services at these facilities.

121. Nevertheless, MHP required that MRI perform those administrative services at the freestanding facilities which enabled MHP to operate these freestanding facilities and bill the United States for the services performed at these facilities.

C. MRI Enters Into A Third Separate Written Agreement In 2011 With MHP To Provide Radiology Services To All Of Its Patients At Its West Side Of Cincinnati Facilities In Exchange For Which MRI Agrees To Forfeit Any Medical Director Service Payments.

122. In late 2008, MRI and MHP initiated negotiations relating to an extension of the

Mercy/Mt. Airy Professional Services Agreement and the provision of radiology services for all of MHP's facilities on the west side of Cincinnati.

123. On October 27, 2008, Zipperer-Davis and Cook met to discuss the negotiation of the new professional services agreement.

124. In a November 4, 2008 memorandum Zipperer-Davis stressed that a significant issue for MRI was the payment of fees by Mercy to MRI for medical director duties. This issue was one that Zipperer-Davis asked Mercy to address and pay every year of her association with MRI. (Exhibit 6 at pp. 159/11-161/5). A copy of the November 4th memorandum is attached hereto as Exhibit "13" and incorporated herein.

125. Kowalski was MHP's point person in connection with the negotiation of the new agreement with MHP which was executed on June 14, 2011 ("2011 Agreement"). A copy of the 2011 Agreement is attached hereto as Exhibit "14" and incorporated herein. (Exhibit 8 at p. 39/8-12).

126. During the course of those negotiations, Kowalski did not perform any fair market value analysis of the medical director services being provided by MRI to Mercy/Western Hills or Mercy/Mt. Airy or the other freestanding facilities. (Exhibit 12 at p. 50/5-11). Once again, MHP did not do the fair market value analysis because it's position was that MRI's opportunity to bill for the professional fees relating to the patients referred to MRI by the hospital was sufficient compensation for the medical director services performed by MRI on MHP's behalf. (Exhibit 12 at pp. 54/23-55/10).

127. From 2009 through 2011, MRI was represented by Attorney Michael DeFrank.

128. During the negotiations relating to the 2011 Agreement, numerous drafts of the

proposed agreement were exchanged between MHP's attorneys and DeFrank on behalf of MRI. In 2010, MRI submitted a draft in which it requested the payment of the medical director fees by MHP to MRI. A copy of the submitted draft is attached hereto as Exhibit "15" and incorporated herein. (Exhibit 15 at p. 12). Specifically, MRI requested:

> "As compensation for the medical director services, Mercy shall pay group $200 per hour for the services of the medical directors subject to maximum annual compensation of $150,000. Group shall submit monthly invoices to Mercy for the medical director services using the format attached as K."

(Exhibit 15 at p. 12).

129. MHP returned the document in a draft dated "8-25-2010" in which the request for medical director compensation was deleted. (Exhibit 15 at p. 12).

130. Between September 3 and October 8, 2010, Zipperer-Davis met with DeFrank to discuss the issues surrounding the proposed 2011 Agreement. During the meeting, Zipperer-Davis brought a copy of a "8-25-2010 draft" of the 2011 Agreement.

131. At the meeting DeFrank told Zipperer-Davis that it was illegal for MHP to require MRI to perform services at no cost to the hospital because he believed nonpayment of the medical director fees by MHP could be illegal. (Exhibit 6 at pp. 352/1-355/9). DeFrank's opinion is consistent with the OIG's compliance program warnings issued to hospitals between 1991 and 2005. Further, both Zipperer-Davis and DeFrank believed that $200.00 per hour reflected the fair market value for MRI's medical director services it provided to Mercy for which Mercy was paying zero. (Exhibit 6 at pp. 339/10-340/9).

132. Based on her conversation with DeFrank relating to the medical director compensation, Zipperer-Davis wrote in the margin of the 8-25-10 draft agreement "illegal not to

be paid." (Exhibit 6 at pp. 354/24-355/9; Exhibit 15 at p. 12).

133. Zipperer-Davis informed Aukerman of DeFrank's advice, but he did nothing to follow up with Zipperer-Davis relating to the legality of MHP's conduct because he was busy doing other things. The legality issue was one that Zipperer-Davis should handle. (Exhibit 7, 3/7/12 dep., at pp. 89/17-99/14).

134. On October 8, 2010, the MRI corporate representatives, including Zipperer-Davis, Aukerman, Welton and Kleimeyer, met with Kowalski and Hiltz, MHP's highest ranking officers, at the Mercy/Western Hills location. Prior to the meeting, Zipperer-Davis identified in the 8-25-10 draft the issues that were important to MRI in its negotiation with MHP. These issues included the formation of a business partnership with MHP, establishing a long-term relationship with MHP, and the payment by MHP to MRI of bonuses, medical director fees, recruitment reimbursement, and stipends. (Exhibit 6 at p. 322/2-20).

135. During the October meeting, Zipperer-Davis told Kowalski and Hiltz that she had been advised by Attorney DeFrank that the nonpayment of the medical director fees by Mercy may be illegal. (Exhibit 6 at pp. 335/3-336/17; 352/10-20). She also told Kowalski and Hiltz that it was DeFrank's opinion that it could be illegal for MRI to perform these services for free. (Exhibit 6 at p. 335/14-23).

136. Even though Kowalski understood that the medical director services had value, he told Zipperer-Davis "we understand and that's something Mercy's legal will have to answer." (Exhibit 6 at pp. 337/11-16; 339/2-7; 352/21-353/2).

137. In a telephone conversation with Zipperer-Davis and Aukerman, Kowalski discussed the medical director fee issue. (Exhibit 12 at pp. 46/8-23; 47/14-49/25). During that

conversation Kowalski told Zipperer-Davis that MHP had not historically paid medical director fees, but it would look into the issue and explore options. (Exhibit 12 at p. 48/8-11).

138. Thereafter, Hiltz and Kowalski discussed the payment of medical fees to MRI between themselves, and Kowalski believed that no medical director fee should be paid because he had historically not paid them. (Exhibit 12 at pp. 48/8-11; 49/22-23). Ultimately, Kowalski and Hiltz decided that no medical director fees would be paid to MRI in the 2011 Agreement because MHP was "just not going to pay them" and he had not historically paid for those services. (Exhibit 12 at pp. 57/1-58/7).

139. MHP did not obtain any third party legal opinion or perform an analysis of the value of the assets, rental space or personnel it provided MRI as a result of MRI's status as a "hospital-based" physician group that would justify the non-payment of the medical director fees to MRI under the 2011 Agreement. (Exhibit 12 at pp. 34/9-15; 50/5-11).

140. In June 2011, MHP and MRI entered into the 2011 Agreement. Despite recognizing the illegality of eliminating any compensation to MRI for the medical director and patient solicitation services it provided, the 2011 Agreement did not provide for the payment for those services by MHP. Further, by the 2011 Agreement MHP excluded cardiology nuclear readings by MRI as part of the Agreement's exclusivity provision of the radiology services to be performed by MRI.

141. In June 2011, MHP purchased a cardiology group and hired the cardiologists as employees to read and perform the nuclear cardiology procedures at its various hospital facilities thereby establishing what is referred to as the Heart Institute. These procedures to be performed by the cardiologists at the Heart Institute included echocardiograms, stress tests and other various

nuclear medical readings.

142. As a result of the purchase of the cardiology group and the establishment of the Heart Institute, MHP is able to bill both the Part A facility fee and the Part B professional fee to Medicare for the cardiology procedures including the cardiology nuclear readings performed by its employee cardiology physicians at the various MHP hospital facilities.

143. As a further inducement to forfeit medical director fees and ensure MRI's loyalty to MHP, MHP and Kowalski allowed MRI to participate in a shared panel with the cardiologists to read and bill for the cardiology nuclear tests performed at Mercy/Mt. Airy. MHP allowed MRI to read all the cardiology nuclear tests at Mercy/Western Hills, and read half of the cardiology nuclear tests at Mercy/Mt. Airy.

144. MRI performed these readings notwithstanding the fact that the nuclear readings are excluded as a part of the 2011 Agreement between MRI and MHP. (See, Exhibit 14 at p. 23, "Exclusions for Sections 1.01 and 2.01 Scope of Exclusivity, Echocardiology and Nuclear Medicine - Cardiology Procedures").

145. From 2011 to the present, MRI continues to bill the Part B professional fees for the medical patients who have the cardiology nuclear medicine tests performed at MHP. By this arrangement MHP forfeits the Part B fee that is available to it for the readings performed by its cardiology employed physicians.

146. One reason for Kowalski's actions in rewarding MRI with access to procedures that are not part of the exclusivity provisions in the 2011 Agreement is that the number and amount of administrative duties Welton is required to perform as the medical director on Mercy's behalf had increased tremendously. A copy of Scott Welton's deposition excerpts, pp. 119/1-

120/4, is attached hereto as Exhibit "16" and incorporated herein. The duties in the 2011 Agreement are duties that are well beyond what will be required for a radiology director. (Exhibit 14 at pp. 21-22; Exhibit 16 at p. 118/17-25). In fact, according to Zipperer-Davis, the medical director duties take a significant amount of time such that they are "on all the time." (Exhibit 6 at pp. 160/6-9, 162/1-15). Thus, access to MHP's patients who require cardiology nuclear testing procedures including MHP's Medicare patients is a reward to MRI for being a good partner and forfeiting the fees associated with the medical director and other administrative duties.

147. When asked why MHP has not paid any medical director compensation to MRI for the services it has provided to MHP, Aukerman stated that "you'd have to ask Mercy." (Exhibit 7 at p. 86/1-6).

148. Mercy has never performed any analysis of the value of the assets it has provided to MRI as a result of its status of a "hospital-based" physician group to justify the nonpayment of the medical director fees in the 2006, 2007 and 2011 Agreements over the last seven years. Nor has it followed its own internal policies which mandate that a fair market value analysis relating to the value of MRI medical director services be analyzed. The reasons for its conduct is that MHP is trading patients in exchange for receiving free medical director and other administrative services performed by MRI, so as to allow MHP to maintain its certification for its radiology departments and bill insurance companies including Medicare for the patients treated at its facilities.

D. Because MHP Has Refused To Pay MRI Any Compensation For Its Medical Director Activities, MRI Has Been Forced To Pay The Mercy Medical Directors Compensation From Payments It Receives From Billings Related To Patient Treatment.

149. To compensate its physicians for the extensive additional services required as the medical directors at the Western Hills, Mt. Airy, and freestanding facilities, MRI paid Drs. Kleimeyer and Welton for those medical director services from patient revenue received by MRI. However, they are not paid on a hourly rate based upon the time they spend performing the medical director duties.

150. Instead, as the medical directors for MHP, Drs. Kleimeyer and Welton are paid by MRI based upon the number of patient referrals MHP directs to MRI under the various agreements for which MRI bills federal health care programs and ultimately collects payment. (Exhibit 6 at pp. 149/1-150/6).

151. Drs. Kleimeyer and Welton are paid by MRI for their medical director duties at the rate of one percent of the proceeds collected from insurance companies for patient treatment at the MHP facilities rendered by MRI physicians. (Exhibit 16 at pp. 37/12-40/15). These payments include proceeds received from federal health care programs for the patients directed to MRI by MHP. The more patients MRI treats, the more medical director fees Kleimeyer and Welton are paid. (Exhibit 16 at p. 40/12-15).

152. Between 2007 and 2011 MRI paid Welton $112,747 for the medical director duties he performed at MHP Mt. Airy, and MRI paid Kleimeyer $122,022 for the medical director duties he performed at MHP Western Hills. A copy of MRI's financial ledgers in which these payments for 2007, 2008, 2009, 2010 and 2011 are identified are attached hereto as

Exhibits "17", "18", "19", "20" and "21" and incorporated herein.[1]

153. MHP did not reimburse MRI for the sums that MRI paid its physicians for the medical director services MRI provided to MHP. These amounts paid to Drs. Kleimeyer and Welton by MRI are in addition to the compensation, salary and bonuses they received as employees and shareholders of MRI.

E. In Addition To Waiving Any Medical Director Fees To Which MRI Is Entitled For The Services They Perform On MHP's Behalf, MRI Has Engaged In A Significant Marketing Campaign On Behalf Of MHP Free of Charge In Order To Ensure Its Status As The Exclusive Provider To MHP For Radiology Services At Its Various Hospitals And Free Standing Facilities And To Recoup The Medical Director Fees MHP Has Refused To Pay.

154. Since 2006, MRI has agreed to forfeit the fair market value of the medical director fees to which it is entitled from MHP in order to maintain in MHP's "good graces." (Exhibit 15 at p. 44/6-14). According to Welton, MRI has forfeited these fees in order to maintain and obtain the exclusive radiology contract with Mercy. (Exhibit 16 at pp. 44/22-46/3).

155. MRI is engaged in significant marketing efforts on MHP's behalf (the offer and payment of remuneration) in order to obtain and maintain the exclusive radiology contract with MHP. These efforts have been undertaken by MRI on MHP's behalf free of charge. In sworn testimony Welton was asked several questions which related to MRI's ongoing marketing efforts and the waiver of the medical director fees by MRI in order to maintain the exclusive contract for radiology with Mercy.

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[1] MRI has continued to pay Welton and Kleimeyer from its patient receipts for the medical director duties it has performed on MHP's behalf during the years 2012 and 2013. Once discovery is undertaken copies of these documents will be presented to the court.

> "Question: In terms of indicating to the hospital that you are the group (Mercy wants to work with) that would include doing the marketing with the oncology, following up with the primary care physicians with Mercy and waiving the medical director fees, would you agree?
>
> Answer: That would be part of it, yes."

(Exhibit 16 at p. 243/3-8).

> "Question: Okay. Because it is important to have the opportunity to go ahead and treat those patients who are being referred by Mercy in order to maintain the viability of Millennium at this time?
>
> Answer: Sure."

(Exhibit 16 at p. 243/9-14).

156. The uncompensated marketing efforts undertaken by MRI on MHP's behalf include the actual physical solicitation of third party physicians by MRI doctors.

157. Beginning in November of 2008, Zipperer-Davis forwarded a memorandum to Jason Wessel, the Director of Imaging Services for Mercy, memorializing an October 27, 2008 meeting between Zipperer-Davis and Kevin Cook that the two parties had agreed "Mercy and the radiologists would aggressively work on additional, outpatient business." (Exhibit 13).

158. On February 13 and 14, 2009, MRI conducted its Board of Directors retreat with Hiltz and Kowalski in attendance. The parties recognized that improving outpatient opportunities was crucial to establishing an increased radiology market share for Mercy. They agreed the hospital needed to do more outpatient business to be profitable. Paul Hiltz told MRI "we are in this together. We can make each other successful." The minutes for the MRI board meeting are attached hereto as Exhibit "22" at p. 6 and incorporated herein. At the board meeting MRI recognized that the key to being profitable was to avoid the Mercy Legal

Department because "[t]hey are slow to the table and bog down progress with their legalese. They are our biggest obstacle for doing business and expanding." (Exhibit 21 at p. 4 of 14).

159. In 2010 and beyond, the parties have engaged in an unlawful joint effort to increase outpatient referrals to Mercy Hospital from third party physicians in three ways. Direct solicitation of third party referring physicians by MRI on behalf of MHP, indirect solicitation by MRI by using MHP personnel to solicit third party physicians, and with in-house marketing presentations by MRI physicians at the Mercy facilities to third party referring physicians invited by MHP. All of these activities were performed without payment and while negotiations for a the 2011 Professional Services Agreement were ongoing between MRI and MHP. Moreover, they are not identified as duties MRI is required to perform under the various professional services agreements with MHP. They are extra services (remuneration) provided free of charge in order to gain access to MHP's federally insured patients.

160. The marketing efforts of MRI were directed at promoting the most expensive outpatient radiology procedures. These included interventional procedures which are described as vetebroplasties, kyphoplasties, RFAs, and cancer treatments using the PET and CT scans.

161. At the March 7, 2010 MRI Board of Directors retreat Hiltz and Kowalski were present. During the retreat MRI indicated to Hiltz and Kowalski that the hospital should provide educational programs and marketing around the procedures offered by MRI. MRI asked the hospital to promote the group with oncology, cardiology and GI (gastrointestinal) groups to increase outpatient business. The March 7, 2010 minutes are attached hereto as Exhibit "23" and incorporated herein.

162. MRI followed up the retreat by proposing and agreeing to a marketing

arrangement with MHP where MRI would actively solicit third party physicians to send their business and patients to MHP. In return for their efforts these patients would be referred to MRI for radiology treatment and ultimately MRI would be awarded the radiology contract for all of MHP's western Cincinnati facilities.

163. High level members of MRI and MHP met in March 2010 to discuss that the solicitation efforts would center on the more lucrative interventional radiology and oncology procedures.

164. On April 13, 2010, Mr. Rob Brown and Joe Kappa, the Directors of Imaging for Mercy, attended a MRI Board of Directors meeting and discussed the organization of an interventional radiology work group between Mercy and MRI. One of the purposes of the work group was to increase the amount of referrals coming into the department for interventional radiology. A copy of the meeting minutes are attached hereto as Exhibit "24" and incorporated herein.

165. As part of the argument between the parties for the pursuit of the third party physicians, Roland Cruickshank, the Chief Operating Officer for Mercy, scheduled a marketing meeting between MHP and MRI in the summer of 2010.

166. Zipperer-Davis met with Cruickshank to finalize MRI's and MHP's business arrangement to generate new business for MHP through the uncompensated efforts of MRI physicians.

167. On July 13, 2010, Cruickshank and Brown attended the MRI board of directors meeting. Cruickshank stated that he intended to draft a list of physicians so that MRI could contact those physicians on MHP's behalf. A copy of these minutes are attached hereto as

Exhibit "25" and incorporated herein. Cruickshank asked MRI to assist MHP in marketing MHP's imaging business in the community. Aukerman and Cruickshank discussed one method of marketing as being the direct solicitation of third party physicians by MRI on MHP's behalf.

168. Subsequently, Robert Brown, the Manager of Imaging Services for Mercy/Mt. Airy, provided Mr. Cruickshank a list of physicians on a document identified as an "outpatient modality list" that listed the physicians who referred patients to Mercy for imaging services based upon volume of referrals. A copy of Robert Brown's deposition excerpts, pp. 61-63, is attached hereto as Exhibit "26" and incorporated herein.

169. In July 2010, Cruickshank produced that outpatient modality list of physicians for MRI to contact and gave the list to Zipperer-Davis.

170. Aukerman and the other MRI doctors received a copy of the outpatient modality list and reviewed it. Aukerman, thereafter, visited third party physicians' offices to solicit them to send their patients to MHP for the expensive interventional procedures being performed at Mercy.

171. In addition to the third party physician visits undertaken by Aukerman, Drs. Welton, Getachew and Gilliam have visited third party physicians' offices over the last three years, and given presentations as to the radiology and imaging services provided at Mercy in order to obtain these third party physicians' referrals for MHP. The third party physicians who have been targeted by MRI are those who have patients that need interventional radiology procedures and oncology treatments.

172. The marketing of the Mercy radiology department by MRI continued through the years as evidenced by a March 10, 2011 email from Kevin Aukerman. A copy of this email is

attached hereto as Exhibit "27" and incorporated herein.

173. Mercy and MRI have also jointly engaged in other marketing activities in order to increase radiology market share for MHP.

174. For example, MRI and Mercy have authored marketing brochures identifying the interventional procedures and oncology treatments being offered at Mercy and being performed by MRI with the purpose of having these marketing materials delivered to third party physician offices.

175. These third party physician visits on behalf of Mercy and MRI are being undertaken by a Mercy employee named Tina Ashley at the direction of Pat Kowalski and Joe Kappa, the Manager of Radiology Services at Western Hills. This has been ongoing since 2010.

176. According to Kappa, these third party physician visits were undertaken by Ashley on both Mercy's and MRI's behalf in order to generate business for both. A copy of Joe Kappa's deposition excerpts are attached hereto as Exhibit "28", pp. 30-53, and incorporated herein.

177. MRI has also engaged in in-house hospital marketing presentations in order to induce MHP to award the exclusive 2011 Agreement. On May 24, 2011, Mercy and MRI engaged in a seminar at the Mt. Airy hospital identifying the interventional radiology services offered at Mercy Hospital. The MRI presenters were Aukerman and Gilliam. The attendees were third party physicians who were invited to the seminar by Tina Ashley and Mercy.

178. This was one month before MRI and MHP signed the June 14, 2011 Agreement.

179. As testified to by Welton, MRI engaged in these joint marketing efforts with MHP, waived medical fees, engaged in promotional activities and traveled to physicians' offices to generate additional business for MHP and in order to ensure that MRI obtained the Mercy

2011 Agreement to perform radiology services at all of MHP's western Cincinnati locations. (Exhibit 16 at p. 270/9-21). MRI provided these free services to MHP in order to induce MHP to award MRI the aforesaid financial agreement thereby providing access to MHP's patients receiving radiology services.

F. The Opportunity Of MRI To Earn Money As The Exclusive Provider Of Radiology Services At MHP Is Substantial To MRI.

180. The value to MRI of being the exclusive provider of radiology services to MHP is substantial.

181. Between 2007 and June 2011, MRI had total gross revenues of $23,000,000 total, or approximately $5,000,000 per year. This same ratio has continued through 2013.

182. The percentage of MRI's gross revenues attributable to patients treated by MRI physicians at MHP facilities was $22,500,000 which is almost 98 percent of MRI's overall revenue.

183. Since 2002 MRI has grown from 2 physicians to 10 physicians as a result of the revenues generated from MHP hospital referrals to MRI.

184. Without the ability to treat patients at MHP, MRI would be financially unable to survive.

VI. BOTH MHP AND MRI HAVE VIOLATED THE AKS

A. Significant Remuneration In The Form Of Free Medical Director Services Was Solicited By MHP And Paid By MRI.

185. In order to retain the exclusive opportunity to provide physician billable Part B services at MHP, the MRI physicians were required to provide significant Medicare Part A supervision, and management services to MHP in the form of medical directorships and direct

physician solicitation for no payment from MHP. These uncompensated services are of significant value to MHP and constitute remuneration under the AKS.

186. The amount of illegal remuneration flowing from MRI to MHP between the date the 2006 Agreement was executed through August 1, 2013 is in excess of $1,000,000.

187. By their 2002 Professional Services Agreement, MRI and Mercy/Mt. Airy admit that at a minimum the value of the medical director services to be performed by MRI is $40,000 per year. The number of hours required from MRI to perform the medical director duties is 7.5 hours per week or 390 hours per year.

188. On February 1, 2007 Mercy and MRI executed an addendum to the 2002 Agreement which reduced the yearly fee to $12,000 per year for the same amount of work as previously performed by MRI at MHP for $40,000.

189. On June 1, 2008, Mercy/Mt. Airy unilaterally discontinued payment to MRI of any amounts for any medical director duties.

190. The August 2006 Agreement between MRI and Mercy/Western Hills required MRI to devote the same amount of time to perform the medical director duties at Mercy/Western Hills which was required of MRI for the medical director duties at Mercy/Mt. Airy. No payments were made from MHP to MRI.

191. The June 14, 2011 Agreement between Mercy and MRI required MRI to perform medical director duties at both of the Mercy/Mt. Airy and Western Hills hospital facilities in addition to the clinical and administrative management of Mercy's three freestanding facilities. No payments were made from MHP to MRI.

192. Zipperer-Davis testified under oath that the minimal reasonable value of the

medical director services performed by MRI for Mercy in 2006 is $60,000 per year per physician at both Mercy/Mt. Airy and Mercy/Western Hills. (Exhibit 6 at p. 161/3-23).

193. Using the $60,000 per year figure, between August 1, 2006 through August 1, 2013, MRI has performed medical director duties with a fair market value of $820,000. By subtracting the payments made by Mercy to MRI in 2007 and 2008 the net fair market value of the free services to MHP is $804,000.

194. In 2010 Zipperer-Davis claimed in the negotiations with Mercy for a new professional services agreement that the fair market value of the medical director services provided by MRI had risen to $200 per hour, or a total of $150,000 per year for both the Western Hills and Mt. Airy hospitals, along with the freestanding facilities associated with these hospitals. This evaluation is memorialized in the draft of the 2011 Agreement and the opinion testimony given by Zipperer-Davis. (Exhibit 6 at pp. 339/10-340/9; Exhibit 14 at p. 12).

195. Using the $150,000 per year figure, between August 1, 2006 through August 1, 2013, MRI has performed free medical director duties for MHP with a fair market value of at least $1,025,000. Subtracting the payments made by Mercy to MRI, the fair market value of the free services (remuneration) from MRI to MHP is $1,009,000.

B. Additional Significant Remuneration Exists In The Form Of Free Marketing Activities, Including The Personal Solicitation By MRI Of Third Party Physicians To Refer Their Patients To The Mercy Hospital Facilities For Radiology Services.

196. Under the AKS it is a violation to offer or accept remuneration for purposes of arranging for or recommending purchasing, leasing or ordering of any item or service payable under Medicare. Marketing and advertising activities fall within the category of AKS violations that are subject to the statute.

197. Because Mercy refused to pay to MRI the fair market value for the medical director services and other services it was providing to Mercy, the parties devised a marketing and solicitation referral scheme by which the MRI doctors would receive additional patient compensation for those services performed at Mercy which would also result in additional revenue to MHP for the patients referred to MHP by MRI's marketing activities. These uncompensated marketing and solicitation activities were of value to MHP and constitute remuneration under the AKS.

198. Beginning in 2009 through the present, MHP and MRI jointly engaged in marketing and personal solicitation activities which were far greater than the designated medical director duties required of MRI which were contained in the 2002 Agreement, 2006 Agreement, 2007 Addendum, and the 2011 Agreement between the parties. These marketing and personal solicitation activities were undertaken by MRI and MHP for the sole purpose of increasing patient referrals to Mercy, thereby increasing the amount of compensation personally received by Welton and Kleimeyer on a per patient basis as the Mercy medical directors.

199. MHP did not pay or compensate MRI for any of these additional marketing or solicitation activities, the value of which is significant. Instead, for each additional patient procedure Welton and Kleimeyer were and continue to be paid the rate of one percent of the monies received for the patients treated by MRI due to the referrals from MHP. This includes patients insured under a federal health program.

C. Mercy Knowingly And Willfully Solicited Free Medical Director And Marketing Services (Remuneration) From MRI In Exchange For Providing MRI Access To Mercy's Patients Which Are Covered By A Federal Health Care Program In Violation Of The AKS.

200. MHP knowingly and willfully violated the AKS by soliciting and accepting remuneration in the form of free medical director and marketing services in exchange for providing MRI access to MHP's federal health care patients. Substantial evidence exists that MHP intentionally violated the AKS. This evidence consists of, but is not limited to, the following:

a. MHP's complete disregard of the applicable federal law that has existed since 1991 as it relates to evaluating the financial arrangements between MPH and MRI.

b. Ignoring its own fair market value policies that were required to be followed when it entered into the professional services agreements where medical director duties were mandated by MRI.

c. MHP's acknowledgment by its high level managers that MHP's fair market value policies require an analysis to be undertaken in its financial arrangements with MRI and their subsequent inability to explain why they ignored these policies.

d. Admissions by MHP's high level management personnel that hospital-based radiologists are not compensated for their medical director services by MHP because they receive a book of business in the form of patient access at MHP which includes federal insured patients.

e. Notification by MRI to MHP that MRI's lawyer believed MHP's continued solicitation and acceptance of free medical services from MRI may be illegal.

f. MHP's failure to conduct any investigation relating to MRI's position that its actions in requiring free medical director services under the proposed 2011 Agreement was illegal. Instead, MHP required MRI to continue their joint conspiracy in violating federal law by requiring MRI to provide free medical director duties under the 2011 Agreement.

g. Offering MRI access to the excluded nuclear cardiology readings at Mercy/Mt. Airy and Mercy/Western Hills in 2011, 2012 and 2013 in order to induce MRI to withdraw its request to be compensated for the medical director services of its employees in the 2011 Agreement.

h. Further, it is anticipated that the evidence obtained in the course of discovery in this case will also demonstrate that the same type of kickback arrangement exists between MHP and its hospital-based radiologists who are located at MHP's other greater Cincinnati facilities. Accordingly, once Relator receives the professional services agreements entered into between MHP and the hospital-based radiologists who are identified as the exclusive providers for radiology services at the other greater Cincinnati MHP facilities Relator intends to amend the complaint to add a claim under the AKS and the FCA for the illegal kickbacks that are ongoing between MHP and those hospital-based radiologists. Those facilities include, but are not limited to, MHP's other hospitals located at Clermont, Anderson, Fairfield, Jewish, and Cincinnati West, and the numerous freestanding facilities located in Southwest Ohio.

D. Compelling Evidence Exists That MRI Knowingly And Willfully Offered And Paid Remuneration In The Form Of Free Medical Director And Marketing Services In Order To Induce Mercy To Award MRI The Various Professional Services Agreements In Exchange For Access To Mercy's Patients In Violation Of The AKS.

201. Scott Welton, a MRI officer and the Mercy/Mt. Airy Medical Director,

specifically testified that free medical director and marketing services were knowingly offered by MRI to Mercy in order to induce Mercy to award the exclusive professional services agreements for its Mt. Airy and Western Hills facilities and thereby gaining access to Mercy's patients, including those covered under a federal health care program. Other evidence, in addition to Welton's testimony, which is consistent with MRI's illegal activities is:

a. Since 2002 the medical director duties performed by MRI on MHP's behalf have substantially increased without any increase in compensation for these services from MHP even though the written financial arrangement between the two required such an increase. MRI has waived those fees in order to maintain access to MHP's patient base.

b. Over time the duties associated with the radiology medical directors became so extensive that the medical directors at Mercy/Mt. Airy and Mercy/Western Hills are "on all the time" (Exhibit 6 at p. 162/13-15), and the duties they perform are well beyond what would normally be required of a radiology medical director at a hospital. MRI has waived the compensation it is entitled for no legitimate reason.

c. MRI was informed by its lawyer that MHP's requirement that MRI forfeit its medical director fees in entering into the financial transaction with MHP may be illegal. Nevertheless, MRI continued to provide free medical director services in order to stay in Mercy's good graces, and to be a "good partner."

d. MRI's intentional forfeiture of the medical director fees and the purposeful solicitation of third party physicians in order to be awarded the MHP 2006 and 2011 Agreements thereby gaining access for MRI to MHP's federally insured-based/patient-based and the opportunity to make money for the treatment of these patients.

e. The promotion of a business arrangement with MHP in which MRI and its medical directors are rewarded for their solicitation efforts of third party doctors by an increase in the medical director compensation proportionate with the increase in billings for the new patients sent by MHP to MRI as a result of MRI's door-to-door sales. The foregoing arrangement has promoted the risk of additional unnecessary procedures by MRI so that additional billings can be submitted to third party insurance companies including Medicare to make up for the lost revenue MRI has sustained as a result of the forfeiture of the medical director fees owed by MHP.

VII. MERCY'S AND MRI'S UNLAWFUL ACTIVITIES UNDER THE AKS SERVE AS A BASIS FOR LIABILITY UNDER THE FCA.

A. Since August 2006 To The Present, Both MRI And MHP Have Submitted False Claims To The United States For Payment Relating To Medical Services They Have Provided To Patients Insured Under A Federal Health Care Program.

202. Relator realleges the allegations in paragraphs 1 through 201 as if fully rewritten herein.

203. Since August 2006, both Mercy and MRI executed various paper and electronic agreements with CMS and the United States. These agreements are identified as Forms 855A and 855I.

204. These documents require as a condition of payment for the claims submitted by Mercy and MRI that they certify there is no violation of the AKS or Stark.

205. Compliance with the AKS and/or Stark is material to the decision by CMS to pay the claims submitted by MRI and MHP as a matter of law. The materiality of compliance with the AKS as a condition of payment has been recognized in the cases of *United States ex rel Fry v. The Health Alliance*, 2002 U.S. Dist. LEXIS 702411 at para. 33 (S.D. Ohio Dec. 18, 2008); and

United States ex rel Daughtery v. Bostwick Laboratories, 2012 U.S. Dist. LEXIS 178641 at para. 31-32 (S.D. Ohio Dec. 14, 2012).

206. Beginning in March 2010 a violation of the AKS is also a *per se* FCA violation.

207. Since August of 2006 to the present, Mercy and MRI have submitted requests for payment for medical services performed for patients insured by a federal health care program while impliedly certifying that they did not engage in any violation of the AKS. These certifications were false thereby making every request for payment claim submitted by Mercy and MRI subject to the FCA.

B. Mercy And MRI Had Actual And Constructive Knowledge Of Their Illegal Activities Which Resulted In The Presentation Of False Claims In Violation Of The FCA.

208. Both MRI and MHP knew that at the time they submitted the claims for payment to the United States for the radiology procedures performed at MHP between August 2006 to the present that these claims were false.

209. MHP's knowledge of its unlawful conduct in violation of the AKS is identified in paragraph 204.

210. In addition, at the same time as it was negotiating the 2011 Agreement with MRI, MHP was entering into exclusive professional services agreements with other third party physicians which required MHP to provide equipment, personnel and office space to those third party physicians for the performance of their medical director duties on behalf of MHP. Under these agreements MHP paid those other physicians significant and substantial compensation in the hundreds of thousands of dollars for the clinical and medical director duties they were performing on behalf of MHP. The amount of these payments were calculated by utilizing the

same fair market value policies that existed at MHP which were being ignored by MHP in the negotiation of the agreements with MRI.

211. MRI's knowledge of its unlawful conduct in violation of the AKS is identified in paragraph 205.

212. MHP and MRI not only possessed actual knowledge of their illegal conduct, but they also acted in reckless disregard and in deliberate ignorance that their actions in submitting claims for patient treatment were false and illegal. To avoid a finding of reckless disregard, a medical provider must make such inquiry as would be reasonable and prudent to conduct under the circumstances. The provision is meant to target defendants such as MHP and MRI who have buried their collective heads in the sand as to the illegality of their conduct. *United States of America Ex Rel. Williams v. Renal Care Group, et al.*, 696 F.3d 518, 530 (6th Cir. 2012).

213. Additionally, pursuant to *United States Ex Rel. Compton v. Midwest Specialties Inc.*, 142 F.3d 296 (6th. Cir. 1998), MHP's and MRI's knowledge of the applicable law, and their failure to insure that their claims for payment to the government for the medical services they provided to federally insured health care patients was consistent with that knowledge is sufficient to constitute reckless disregard under the FCA.

C. MRI And MHP Presented False Claims To The United States.

214. In this case, MRI and MHP entered into professional service contracts in 2006, 2007 and 2011, each of which violated the AKS. Therefore, every claim presented for payment by MRI and MHP since August of 2006 to the present pursuant to those contracts is tainted by the illegality of their conduct arising from their performance of these three illegal financial arrangements.

MRI Submitted False Claims To The United States

215. The unlawful financial kickback arrangements between MHP and MRI violated the AKS and resulted in the knowing presentation by MRI of requests for payment of Part B false claims to the United States for the patients that were referred to MRI by MHP.

216. All of the claims presented by MRI to the United States from August 4, 2006 to the present cannot be specifically identified because MRI has in its exclusive possession the data by which each false claim may be identified.

217. Relator, however, has attached documents he has in his possession for a nine month period in 2010 and 2011 which do identify, as a representative sample, the number of claims submitted by MRI to Medicare and Medicaid for its services generated at MHP. Copies of these reports are attached hereto as Exhibits "29", "30", "31", "32", "33", "34", "35", "36" and "37" and incorporated herein. These are the aging reports generated by MRI which identify each insurance company for which a claim for payment was made for services rendered by MRI pursuant to the referrals received from MHP. MRI has similar aging reports in its possession for each month from August 2006 to the present.

218. The claims submitted to federal health care programs by month pursuant to the aging reports attached hereto are as follows:

Date of Aging Report	Federal Health Care Claims Or Charges Submitted for Champus, Medicaid and Medicare	Exhibit No.
05/31/10	Total = 2710	29
06/30/10	Total = 3561	30
09/30/10	Total = 2792	31
10/31/10	Total = 3002	32

11/30/10	Total = 2956	33
12/31/10	Total = 2568	34
01/31/11	Total = 2714	35
02/28/11	Total = 2503	36
03/31/11	Total = 2899	37
Total	Total = 25,705	

219. Based upon the reports referred to in paragraph 218 above, the total number of tainted claims presented to the United States by MRI for payment from a federal health care program from August 2006 through the present is approximately 2,778 claims per month for 72 months which is approximately 200,016 false claims.

220. Although Relator is not able to specifically identify the patients for whom the claims were submitted in all 200,016 false claims, the Realtor does have specific representative samples of the claims that have been presented to Medicare during August and September of 2010. These claims include the following:[2]

REPRESENTATIVE SAMPLES OF MRI PROCEDURES PERFORMED AT MHP BY MRI AND THEREAFTER BILLED TO MEDICARE BY MRI AND MHP					
Date	**Medical Record No.**	**Patient**	**Birth Date**	**Procedure**	**Physician**
08/10/10	0003502242	C.R.	07/08/29	Vertebroplasty	Gilliam
08/24/10	0002196120	C.E.	12/14/32	Lung aspiration & BX	Aukerman
08/25/10	7000367004	M.M.	04/09/33	Liver BX	Gilliam
08/26/10	0600393717	M.R.	01/16/24	Iliac bone BX	Gilliam
08/26/10	7000084149	S.?	06/10/36	Paracentesis	Welton

[2] Relator has identified the patient by the initials of their first and last name in order to preserve their privacy.

Date	Medical Record No.	Patient	Birth Date	Procedure	Physician
08/27/10	5000441113	A.?	04/18/25	Lung CA	Gilliam
09/01/10	7000373858	W.R.	11/06/35	Vertebroplasty	Gilliam
09/02/10	7000033857	M.H.	11/25/30	Vertebroplasty	Gilliam
09/03/10	7000104823	L.K.	09/21/18	Catheter insert	Gilliam
09/09/10	800140022	P.T.	09/06/35	Nephostomy tube exchange	Wagner
Admission 09/14/10	5001398155	J.B.	08/06/30	Sacralplasty	Gilliam
09/15/10	800140022	P.T.	09/06/35	Percutanous placement of tube	Kleimeyer
Admission 09/16/10	5001667210	M.M.	03/25/31	Liver BX	Merhar
Admission 09/16/10	5000142091	W.H.	04/29/24	Right renal RFA	Gilliam
Admission 09/19/10	0600360544	G.H.	01/03/22	Drg catheter placement	Welton
09/23/10	8000050292	N.S.	07/01/26	Vertebroplasty	Gilliam
Admission 09/24/10	5000609586	B.R.	10/19/32	Liver BX	Gilliam
09/27/10	7000377440	M.N.	07/04/27	Abscess drg catheter	Aukerman
09/29/10	7000301415	P.K.	02/04/28	Vertebroplasty	Aukerman

221. Courts have recognized that it is not necessary to specifically identify the date, time and amount of each claim in a case brought under the FCA where, as here, the allegation concerns a far reaching and fraudulent scheme which stretches over a substantial period of time. See, *Fulton Bank, N.A. v. UBS Sec., LL*, 2011 U.S. Dist. LEXIS 128820 at ¶ 19 (E.D. Pa. Nov. 7, 2011); *United States of America, ex rel. Mark Elliott v. Brickman Group Ltd., LLC*, Case No.

1:11cv392, Opinion and Order at page 19 (S.D. Ohio, Aug. 25, 2011), Barrett, J.; *United States of America, ex rel. v. Center for Diagnostic Imaging, Inc., et al.*, 2011 U.S. Dist. LEXIS 40459 at ¶ 18 (W.D. Wash., April 4, 2011); *United States of America, ex rel. Fry v. The Health Alliance of Greater Cincinnati, et al.*, 2009 U.S. Dist. LEXIS 14963 at ¶ 18 (S.D. Ohio, Feb. 26, 2009); *United States of America, ex rel. Fry v. The Health Alliance of Greater Cincinnati, et al.*, 2008 U.S. Dist. Lexis 102411 at ¶ 33 (S.D. Ohio, Dec. 18, 2008); *Singh v. Bradford Regional Med. Center*, 2006 U.S. Dist. LEXIS 65268 (W.D. Pa., Sept. 13, 2006). Accordingly, every claim MRI submitted to the United States for payment from August 4, 2006 to the present is false because it is the product of Defendants' illegal scheme identified herein and in violation of the FCA and AKS.

222. The total amount of revenue received by MRI as payment from the United States resulting from the submission for these false claims is approximately 2.5 million dollars per year, for a total of 17.5 million dollars.

MHP Submitted False Claims To The United States

223. This illegal financial kickback scheme between MHP and MRI also resulted in MHP's knowing submission of an identical number of Part A inpatient and outpatient false claims to the United States for payment from a federal health care program for patients that were treated at MHP in connection with radiology services provided by MRI physicians.

224. Relator does not have documents that identify the date MHP submitted all these claims to the United States for payment under a federal health care program as these documents are exclusively in MHP's possession. However, the medical claims identified in Exhibits 29, 30, 31, 32, 33, 34, 35, 36 and 37 and performed by MRI physicians were performed at an MHP

facility. MHP submitted Part A claims for payment to the United States and its Medicare Program for the patient claims and charges identified in Exhibits 29 through 37.

225. Additionally, the specific patients listed in paragraph 220 are patients who had radiology procedures performed at a MHP facility by MRI physicians which were billed to Medicare by MHP for the Part A facility fees. These patients and the procedures performed on them by MRI physicians at the MHP facilities are representative of the false claims submitted by MHP to the United States.

226. MHP has kept a record of the claims it submitted to the United States for payment under a federal health care program. It is anticipated that the number of claims, the date of submission, and the identity of the payor is almost identical to the number of claims presented by MRI to the United States, i.e. approximately 200,016 false claims. Each Part A claim for payment is approximately three times the amount of the corresponding Part B claim associated with each radiology procedure. The approximate amount of revenue received by MHP from the United States for these radiology false claims is approximately 52 million dollars.

VIII. IDENTIFICATION OF SPECIFIC STATUTORY VIOLATIONS

A. The Actions Of MRI And MHP Are A Violation Of 31 U.S.C. § 3729(a)(1) (Pre 2009) and 3729(a)(1)(A).

227. Relator realleges the allegations contained in paragraphs 1 through 226 as if fully rewritten herein.

228. From August 4, 2006 to the present, both MRI and MHP have knowingly, or in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, presented or caused to be presented, false or fraudulent claims to the United States Government

for payment by federally funded health insurance programs based upon the illegal referrals in violation of 31 U.S.C. §§ 3729(a)(1) and 3729(a)(1)(A).

229. Both MRI and MHP have falsely certified that, before presenting a claim for payment from a federally funded health insurance program, they had complied with the AKS which was untrue.

230. The false representations referred to in paragraphs 228 and 229 above were material to the United States' decision to pay the claims presented by MRI and MHP. By presenting claims that were in violation of the AKS, both MRI and MHP are in violation of the FCA for which the United States seeks reimbursement from both MRI and MHP for three times the amount of money paid by the United States, plus civil penalties.

B. The Actions Of MRI And MHP Are A Violation Of 31 U.S.C. § 3729(a)(2) (Pre 2009) and 31 U.S.C. § 3729(a)(1)(B).

231. Relator realleges the allegations contained in paragraphs 1 through 230 as if fully rewritten herein.

232. From August 4, 2006 to the present, MRI and MHP knowingly or in reckless disregard or in deliberate ignorance of the truth or falsity of the information involved, made, used, or caused to be used, false or fraudulent records or statements or statements material to a false statement to the United States for the purpose of having a false or fraudulent claim paid or approved in violation of 31 U.S.C. §§ 3729(a)(2) and 3729(a)(1)(B).

233. The representations referred to in paragraph 232 above were material to the United States' decision to pay the claims presented by MRI and MHP.

234. The United States was unaware of the falsity of the claims or statements made, or

caused to be made by MRI and MHP, and in reliance of the accuracy of these claims and/or statements, paid for procedures provided to individuals by MRI and MHP insured by federally funded health insurance programs.

235. By presenting claims that were in violation of the FCA, the United States seeks reimbursement from both MRI and MHP for three times of the amount of the money paid, plus civil penalties.

C. The Actions Of MRI And MHP Are A Violation Of 31 U.S.C. § 3729(a)(3) (Pre 2009) and 31 U.S.C. § 3729(a)(1)(C).

236. Relator realleges the allegations contained in paragraphs 1 through 235 as if fully rewritten herein.

237. MRI and MHP violated 31 U.S.C. §§ 3729(a)(3) and 3729(a)(1)(C) by conspiring to present or causing to present, false or fraudulent claims for payment by federally funded health insurance programs.

238. MRI's and MHPs actions caused the United States to pay false claims that they otherwise would not have paid for if the United States was aware of MRI's and MHP's conspiracy to present such illegal claims.

239. By presenting claims that are in violation of the FCA, the United States seeks reimbursement from both MRI and MHP for three times the amount of money paid, plus civil penalties.

D. The Actions of MRI and MHP Are a Violation of 31 U.S.C. § 3729(a)(1)(G).

240. Relator realleges the allegations contained in paragraphs 1 through 239 as if fully rewritten herein.

241. 31 U.S.C. § 3729(a)(1)(G) provides that any person who knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the United States, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the United States has committed a violation of the FCA.

242. The term obligation means an established duty, whether or not fixed, arising from an express or implied contractual, grantor-grantee, or licensor-licensee relationship, from a fee based or similar relationship, from statute or regulation, or from the retention of any over-payment.

243. MHP has an obligation to submit cost reports under CMS-2552 reconciling payments made to MHP from the United States throughout the calendar year. If an overpayment has been made to MHP, MHP has an obligation to repay the amount to the United States.

244. Due to MHP's illegal conduct, it has been overpaid by the United States an amount equal to the sums presented for all Part A and outpatient radiology services from August 4, 2006 to the present at its Mt. Airy, Western Hills, and freestanding facilities.

245. From 2007 to the present, MHP has failed to identify to the United States that it has been overpaid the Part A facility and outpatient fees for radiology services performed by MHP in violation of the AKS. Specifically during the years 2007, 2008, 2009, 2011 and 2012, MHP submitted a form CMS 2552 to the United States which reconciled the amount paid to MHP with the amount that was due for the procedures performed that fiscal year. MHP never identified the overpayments made by the United States due to the radiology billings associated with the MRI procedures and readings.

246. Pursuant to H.R. 3590, Section 6402, MHP is obligated to report to the United States these overpayments and return the overpayments within 60 days of the date the yearly CMS-2552 reports were due from MHP to its fiscal intermediaries.

247. MHP's retention of these overpayments is a violation of the FCA and subjects MHP to liability under that statute.

248. Similarly, MRI has a duty to report the payments it received to which it is not entitled.

WHEREFORE, Relator requests that judgment to be entered against MRI and MHP jointly and severally as follows:

1. MRI and MHP be enjoined and ordered to cease and desist from submitting or causing the submission of any further false claims;

2. Judgment be entered in the United States' favor against MRI and MHP in the amount of each and every false or fraudulent claim submitted pursuant to the illegal kickback arrangement and multiplied and tripled as provided by 31 U.S.C. § 3729(a), and that a civil penalty of not less than $5,500 nor more than $11,000 per claim submitted since August 4, 2006, as provided by 31 U.S.C. § 3729(a) be imposed. The amount of treble damages is approximately Two Hundred Twenty Million Dollars ($220,000,000). The approximate amount of the civil penalties to which the government is entitled is Four Billion Dollars ($4,000,000,000).

3. Relator be awarded the maximum amount allowed pursuant to 31 U.S.C. § 3730(d), including up to 30 percent of the proceeds of the action or settlement of the claim;

4. That Relator be awarded against MRI and MHP his costs, including but not limited to court costs, expert fees, and all attorneys fees incurred by Relator in the prosecution of

this suit pursuant to 31 U.S.C. § 3730(d); and

5. For such other and further relief as the Court deems just and proper.

RESPECTFULLY SUBMITTED,

/S/ Mark J. Byrne
MARK J. BYRNE (0029243)
KENNETH F. SEIBEL (0025168)
Trial Attorneys for Relator
JACOBS, KLEINMAN, SEIBEL & MCNALLY
Cincinnati Club Building
30 Garfield Place, Suite 905
Cincinnati, OH 45202
Tele (513) 381-6600
Fax (513) 381-4150
E-Mail: mbyrne@jksmlaw.com
kseibel@jksmlaw.com

OF COUNSEL:

A. DENNIS MILLER (0018721)
DRODER & MILLER CO., LPA
Attorney for Relator
125 W. Central Parkway
Cincinnati, OH 45202
Tele (513) 721-1504
Fax (513) 721-0310
E-Mail: dmiller@drodermiller.com

BRIAN E. HURLEY (0007827)
CRABBE, BROWN & JAMES, LLP
Attorney for Relator
30 Garfield Place, Suite 740
Cincinnati, OH 45202
Tele (513) 784-1525
Fax (513) 784-1250
E-Mail: bhurley@cbjlawyers.com

DEMAND FOR JURY TRIAL

The Relator demands a jury trial in this case.

/S/ Mark J. Byrne
MARK J. BYRNE (0029243)
Trial Attorney for Relator

CERTIFICATE OF SERVICE

I hereby certify that a copy of the foregoing was forwarded via electronic mail to Andrew M. Malek, Assistant United States Attorney, Southern District of Ohio, 303 Marconi Boulevard, Suite 200, Columbus, Ohio, 43215, at Andrew.Malek@usdoj.gov; and by hand delivery upon Millennium Radiology, Inc. at its original place of business at 4983 Delhi Avenue, Suite 6 , Cincinnati, Ohio, 45238; and to Mercy Health Partners of Southwest Ohio, Mercy Hospitals West, an Ohio Non-Profit Corporation d/b/a Mercy Franciscan Hospital by forwarding the same, by agreement of counsel, by electronic mail to its attorney, Alan E. Reider, Arnold & Porter LLP, 555 Twelfth Street, NW, Washington, DC, 20004-1206, at alan.reider@aporter.com, this ___ day of October, 2013.

/S/ Mark J. Byrne
MARK J. BYRNE (0029243)
Attorney for Relator