UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA

CASE NO. 0:14-cv-61301-KMW

UNITED STATES OF AMERICA and
THE STATE OF FLORIDA *ex rel.*
JACK CARREL, MAURICIO FERRER
and SHAWN LOFTIS,

Plaintiffs,

vs.

AIDS HEALTHCARE FOUNDATION, INC.,

Defendant.
_____//

SECOND AMENDED COMPLAINT FOR VIOLATIONS OF THE FEDERAL FALSE CLAIMS ACT [31 U.S.C. §§ 3729 *et. seq.*] AND FLORIDA FALSE CLAIMS ACT [§§ 68.081 *et. seq.*, Fla. Stat.]

Plaintiff-Relators Jack Carrel, Mauricio Ferrer, and Shawn Loftis (collectively "Relators"), through their attorneys of record, on behalf of the United States of America and the State of Florida, file their Second Amended Complaint against Defendant AIDS Healthcare Foundation, Inc. ("AHF"), and allege as follows:

I. NATURE OF THE ACTION

1. This False Claims Act lawsuit arises from a multi-state kickback scheme engineered by AHF to enhance its revenues derived from Federal health care programs, including Medicare, Medicaid and HIV/AIDS grant programs sponsored by the Health Resources and Services Administration ("HRSA") and the Centers for Disease Control and Prevention ("CDC"), two agencies located within the U.S. Department of Health & Human Services ("HHS"). AHF's kickback scheme, in direct violation of the federal Anti-Kickback Statute, 42 U.S.C. § 1320a-7b(b), involves funds entrusted to AHF for the purpose of assisting a

vulnerable patient population consisting of individuals living with HIV/AIDS, more than 1.1 million of whom reside in the United States.

2. Specifically, AHF enhances funding from federal health care programs in violation of the Anti-Kickback Statute by paying unlawful financial inducements to employees and patients in order to generate referrals to AHF's various service centers, including clinical services, insurance services, pharmacy services, and testing services. The resulting illegal referrals have led and continue to lead to the provision of medical services, treatment, and medications to thousands of patients, for which AHF has submitted and continues to submit "false and fraudulent" claims under the Federal Civil False Claims Act ("FCA"), 31 U.S.C. §§ 3729, *et seq*., and Florida False Claims Act, §§ 68.081 *et seq.*, Fla. Stat., resulting in its recovery of at least tens of millions of dollars in fraudulent payments by federal health care programs, including Medicare and Medicaid, as well as HIV/AIDS assistance programs funded by HRSA and CDC. Therefore, Relators Jack Carrel, Mauricio Ferrer, and Shawn Loftis seek to recover all available damages, civil penalties, and other relief for violations alleged herein.

II. PARTIES

3. Relator Jack Carrel resides in Louisiana and was the Director of Public Health, Southern Bureau for AHF, from August 9, 2012 to August 1, 2013. In that position, Relator Carrel was responsible for program implementation, coordination, and evaluation of the prevention division, as well as for providing guidance to program staff on budget management, supervision of personnel and volunteers, patient/client relations, community relations and the oversight and management of prevention program administration in the Southern Bureau.

4. Relator Mauricio Ferrer resides in Florida and was a Senior Program Manager in the Southern Bureau of AHF from May 17, 2011 to in or about August 2012. In that position, Relator Ferrer was responsible for supervising the daily functions and administrative operations of prevention and testing programs in Florida, including launching and growing Prevention Program Services throughout the Bureau and supervising Program Managers for the Out of the Closet Thrift Store-based HIV test site programs, and two Mobile Testing Units (MTUs).

5. Relator Shawn Loftis resides in New York and was the Grants Manager, Southern Bureau for AHF, from January 2, 2013 to August 16, 2013. In that position, Relator Loftis was responsible for day-to-day fiscal management of sponsored projects.

6. AHF is a California corporation headquartered in Los Angeles, California. AHF conducts business operations within the State of Florida from offices, care centers and pharmacy outlets located throughout the state, including Ft. Lauderdale, Miami, Pensacola, Ft. Myers, Orlando, Tampa, Delray Beach, and Jacksonville. In addition to Florida and California, AHF conducts operations in at least ten other states, including Georgia, Louisiana, Maryland, Mississippi, New York, Ohio, South Carolina, Texas, Nevada, and Washington, D.C. AHF describes itself as a global organization providing cutting-edge medicine and advocacy to more than 200,000 patients in 28 countries. AHF boasts that it is the largest provider of HIV/AIDS medical care in the United States.

III. JURISDICTION AND VENUE

7. This Court has jurisdiction over the subject matter of this action pursuant to 28 U.S.C. § 1331, 28 U.S.C. § 1367, and 31 U.S.C. § 3732, the latter of which specifically confers jurisdiction on this Court for actions brought pursuant to 31 U.S.C. §§ 3729 and 3730. Under 31

U.S.C. § 3730(e), there has been no statutorily relevant public disclosure of the "allegations or transactions" in this Complaint. Relators are the original sources of the facts and information alleged in this Complaint.

8. This Court has personal jurisdiction over the Defendant pursuant to 31 U.S.C. § 3732(a) because that section authorizes nationwide service of process and because the Defendant has minimum contacts with the United States. Moreover, the Defendant can be found in this District and transacts business in this District.

9. Venue is proper in this District pursuant to 28 U.S.C. §§ 1391(b) and 1395(a) and 31 U.S.C. § 3732(a) because the Defendant can be found in and transacts business in this District. At all times relevant to this Complaint, Defendant regularly conducted substantial business within this District, maintained employees in this District, and/or made significant sales within this District. In addition, statutory violations, as alleged herein, occurred in this District.

IV. FACTS

A. The Scheme to Induce Patient Referrals Through Illegal Incentive Payments

10. Starting no later than in or about 2010 and continuing through the present, AHF instituted a fraudulent scheme to generate consumer demand and increase revenue for its programs by implementing a system of illegal payments that incentivized patients to utilize AHF services and that rewarded employees, via payments wholly distinct from compensation for the provision of services, solely for referring patients to AHF's testing, clinical, pharmacy, and insurance service centers. These payments were made in violation of the federal anti-kickback statute, 42 U.S.C. § 1320a-7b(b), which prohibits knowingly and willfully offering, receiving, soliciting or paying anything of value, whether directly or indirectly, overtly or covertly, in cash

or in kind, in return for the referral of an individual for services reimbursable by a Federal health care program or for the purchase or ordering of items or services reimbursable by a Federal health care program. A "Federal health care program" includes Medicare, Medicaid and any other "plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government." 42 U.S.C. § 1320a-7b(f). AHF's kickback scheme began in California and spread eastward across the country through standardized financial incentive policies governing the entire organization.

11. Once AHF provided medical services, treatment, or medications to the patients referred illegally, AHF submitted "false and fraudulent" claims for payment with government funds. The FCA prohibits knowingly presenting or causing to be presented to the federal government a false or fraudulent claim for payment or approval. 31 U.S.C. § 3729(a)(1)(A).[1] Additionally, it prohibits knowingly making or using a false or fraudulent record or statement "material to a false or fraudulent claim" paid or approved by the federal government, or "material to an obligation to pay" money to the government and further prohibits knowingly concealing and improperly avoiding or decreasing "an obligation to pay" money to the government. 31 U.S.C. § 3729(a)(1)(B) and (G). The FCA defines a "claim" to include any request or demand, whether under contract or otherwise, for money or property which is made to a contractor, grantee, or other recipient if the United States government provides any portion of the money or property which is requested or demanded, or if the government will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is

[1] Citations are to the renumbered liability provisions of the FCA, as effected by the Fraud Enforcement and Recovery Act of 2009 (Publ. L. No. 111-21, May 20, 2009).

requested. A "false claim" is defined by statute to include any claim that incorporates items or services resulting from a violation of the federal anti-kickback statute:

> In addition to the penalties provided for in this section [i.e., 42 U.S.C. § 1320a-7b] . . . a claim that includes items or services resulting from a violation of this section constitutes a false or fraudulent claim for purposes of [31 U.S.C. §§ 3729 et seq.]

42 U.S.C. § 1320a-7b(g).

12. Although formed as a non-profit entity, AHF exhibited a for-profit corporate mindset and a voracious appetite for any and all revenues associated with HIV-patient referrals. AHF's scheme involving illegal incentives for referrals was designed to channel employee and patient referrals to all corners of AHF's operations, from testing services to clinical services to pharmacy services to insurance services.

Testing Services

13. AHF was contracted by various government agencies, including the State of Florida, to conduct HIV testing. Payments to AHF under these testing contracts were either allocated as lump sum amounts paid in equal installments or paid on a per test cost reimbursement basis periodically throughout the year. Many of AHF's HIV testing contracts required, as a condition of the contract, that AHF perform a certain volume of testing and further demonstrate "linkage" between HIV positive test results and clinical care for the individuals who tested positive. Failure to meet these goals resulted in payment reductions under the contracts. For example, one contract with Florida Department of Health provided as follows:

> The Provider must *link* at least 95% of clients with a positive test result to medical care. The provider will have a chart for each positive client that will include . . . proof of medical linkage. . . . (Emphasis added).

The contract further provided, in relevant part, that:

> Failure to conduct a minimum of 950 HIV tests quarterly in the target population shall result in a reduction in payment in the amount of $24.86 per HIV test not performed. (Emphasis added).
>
> Failure to screen, test or treat a minimum of 750 individuals per quarter shall result in a reduction in payment in the amount of $52.50 per individual not screened, tested or treated. (Emphasis added).

14. In order to ensure compliance with these and other similar contractual requirements, and to avoid losing funding under the testing contracts, AHF unlawfully incentivized its employees to increase the volume of HIV test referrals to AHF's testing locations and, despite its freedom under the contracts to refer HIV-positive patients to other medical care providers, to refer such patients to AHF's own clinical service centers and pharmacies and not to any other providers.

15. AHF paid its HIV testing personnel under a "commission based" formula that combined a base salary amount and an additional "commission" amount solely predicated on the volume of tests performed. Additional incentive compensation was paid to testing staff managers, who received financial bonuses if their staff exceeded numerical testing goals, as reflected in the AHF commission-based testing cost analysis chart attached as Exhibit 1 and incorporated below. Such incentive compensation paid to the testing managers was not based on any services furnished or provided by the managers themselves, but rather was paid to encourage the managers to increase the volume of testing performed by the testing staff under their supervision, in direct violation of the anti-kickback statute. This chart was taken from AHF's internal records and is shown below with emphasis added:

PG 2

Commission Based Testing - Cost Analysis

LOCATIONS	Monthly Base Goal	15% Increase	CBT $	30% Increase	CBT $	45% Increase	CBT $
LA - MTU	1400	1610	$ 2,100.00	1820	$ 4,200.00	2030	$ 6,300.00
LA - OTC	990	1139	$ 1,485.00	1287	$ 2,970.00	1436	$ 4,455.00
FL - MTU	1027	1181	$ 1,540.50	1335	$ 3,081.00	1489	$ 4,621.50
FL - OTC	1202	1382	$ 1,803.00	1563	$ 3,606.00	1743	$ 5,409.00
Total	4619	5312	$ 6,928.50	6005	$ 13,857.00	6698	$ 20,785.50
		increase in tests	693	increase in tests	1386	increase in tests	2079

LOCATIONS	Jan-13	JAN Vs Base goals	% of tests Jan vs Base Goal
LA - MTU	1660	260	12%
LA - OTC	1201	211	12%
FL - MTU	1099	72	11%
FL - OTC	1641	439	14%
Total	5601	982	

Program Manager CBT	
0 to 15%	$ -
16% to 20%	$ 300.00
21% to 30%	$ 400.00
31% to 40%	$ 500.00
41% to 50%	$ 650.00
51% to 60%	$ 800.00
61% to 75%	$ 950.00
76% to 85%	$ 1,000.00
86% to 95%	$ 1,200.00
95% and up	$ 1,400.00

Clinical Services

16. The referral of HIV-positive patients into AHF's constellation of services, known as "linkage," was key to AHF's business model. As reflected below, AHF's internal records are replete with references to the importance of linking HIV-positive patients into AHF's care and the financial rewards that would flow not only to employees who were responsible for "linkage" but also to patients who were induced through remuneration to refer themselves ("self-referred") to AHF for clinical services.

17. At all times relevant to this action, AHF has employed people with the title "Care Coordinators" or "Linkage Coordinators" whose job it is to ensure that HIV-positive patients are connected to the full menu of AHF healthcare services, including testing, clinical, pharmacy, and insurance services. An "AHF Linkage to Care Training Manual" (attached as Exhibit 2) emphasizes the role of the Care Coordinator to "cooperate with PHD-SB Management and HIV Testing Counselors to ensure the referral of 100% of preliminary positive clients into AHF

Healthcare Centers . . . and AHF Pharmacies or other remote healthcare referral locations within 72 hours." The training manual provides step-by-step instructions on how to link patients into AHF care and specifies that HIV-positive patients will be connected on both their first and second visits at an AHF Healthcare Center with a "benefits counselor," a "phlebotomist," a "medical doctor," and the "pharmacy."

18. AHF's linkage system has been under the direction of the "Linkage Director" in AHF's California headquarters, a position held by Mena Gorre for part of the time period relevant to this action. "Linkage Managers" at each local AHF Bureau throughout the country have overseen and supervised the Linkage Coordinators working in that Bureau. Under AHF policy, whenever a patient tests positive for HIV at an AHF testing center, an AHF employee places the patient on the phone with a linkage coordinator whose job it is to get the patient to: 1) visit an AHF clinic within 72 hours to undergo a confirmatory HIV test; and 2) return to the clinic a second time for the test results. Once the patient makes this second visit to an AHF clinic and it is confirmed the patient is HIV positive, AHF considers the patient "linked." Under AHF's illegal kickback scheme involving compensation not for services rendered but for referrals, this linkage entitles the Linkage Coordinator to a $100 commission. Furthermore, bonus compensation of up to $100 is paid to the employee who linked the patient with a positive test result to the AHF Linkage Coordinator for referral to the clinical services. This compensation is not predicated on any services furnished or provided by the AHF employee who linked the patient, but rather is paid in return for the employee's referral of the patient for items and services furnished by others at AHF. The below description was taken from AHF's internal records (attached as Exhibit 3):

Commission Based Testing Formula

- Set a realistic monthly goal for all testers to meet per department
- Keep everyone at their current salary and anyone testing above the monthly goal will get a monthly commission
- Testers who successfully link a positive client to linkage (client speaks to linkage and provides correct phone number) will get a bonus – ($50 to $100)

(Emphasis added).

19. AHF has paid its employees these commissions on a monthly basis in checks issued at the same time as, but separate from, their regular payroll checks. To initiate payment to Linkage Coordinators, the Coordinator or the Coordinator's Linkage Manager inputs in a national AHF database the dates for each qualifying patient's first and second clinic visit. This information is verified by, or at the direction of, the Linkage Director at AHF's California headquarters before the payroll department, also at the California headquarters, issues payment for the linkage commissions. Exhibit 4, which is a redacted, printed hard copy of this national database as it existed in or about May 2013, shows which patients were "linked," identifies the Linkage Coordinator responsible for their linkage, and further identifies when AHF acknowledged and processed each Coordinator's commission payment for the linkage. Exhibit 4 identifies in the "fldEIPCoordinato" column the Linkage Coordinators for hundreds of patients; notes whether each patient attended his or her initial and follow-up clinic visits in the "fldInitialVisit" and "fldFollowUp" columns; states the specific date that the Linkage Coordinator's commission was sent to accounts payable for processing in the "fldSentAP" column; and identifies the individuals that created and modified the database with regard to each patient, and when they did so, in the "fldCreated," "fldCreatedBy," "fldModified," and "fldModifiedBy" columns. The database also identifies, for claims reimbursement purposes, what type of insurance each patient has in the "fldInsurance" and "fldNotes" fields, and, for

numerous illegally referred patients, reflects federal sources of funding for medical care, including Medicare, Medicaid, and Ryan White funding. This database further demonstrates that while it was often the local Linkage Manager that created and modified the database, the individual Linkage Coordinators and the Linkage Director at AHF's California headquarters did so as well. For instance, on page 1 of Exhibit 4, the name Jason Handy, who was the Linkage Manager in the Southern Bureau of AHF, appears dozens of times. But, as shown below, the names Elveth Bentley and Shireathia, both Linkage Coordinators, appear as creating or modifying information for their assigned patients. (Ex. 4, p. 1 at rows 13, 57-80). And, as also shown below and in the attached Exhibit 4, Mena Gorre, the AHF Linkage Director, is shown to have created or modified information with regard to numerous patients. (Ex. 4, p. 1 at rows 63, 65, 81-88).

	fldEIPCoordinato	fldIntake	fldInitialVisit	fldFollowUp	fldPayrollCounte	fldSentAP	fldInsurance	fldCreated	fldCreatedBy	fldModified	fldModifiedBy
13	Elveth	013 8:30:00 AM	013 9:00:00 AM	013 8:30:00 AM	3995	3/15/2013		013 5:23:22 PM	jason.handy	13 11:49:00 AM	elveth.bentley
57	Shireathia	013 9:00:00 AM	013 9:00:00 AM		3910		Ryan White	013 3:11:54 PM	shireathiar	013 4:20:03 PM	shireathiar
58	Shireathia	013 9:00:00 AM	013 3:30:00 PM	013 4:00:00 PM	3911	4/26/2013	Medical	013 3:34:18 PM	shireathiar	013 4:18:07 PM	shireathiar
59	Shireathia	013 8:45:00 AM	013 9:00:00 AM	13 11:00:00 AM	3912	3/1/2013	Medical	013 4:21:31 PM	shireathiar	013 4:28:22 PM	shireathiar
60	Shireathia	013 9:00:00 AM	013 2:30:00 PM		3913		Military	013 4:31:42 PM	shireathiar	013 4:44:45 PM	shireathiar
61								13 11:24:47 AM	shireathiar		
62	Shireathia	013 2:00:00 PM	013 3:00:00 PM	013 1:15:00 PM	4060	3/15/2013	Ryan White	013 9:53:03 AM	shireathiar	013 1:11:56 PM	shireathiar
63	Shireathia	013 9:00:00 AM	013 9:00:00 AM	013 9:45:00 AM	4061	4/26/2013	Medical	13 12:53:01 PM	shireathiar	013 8:50:09 AM	mena.gorre
64	Shireathia	013 8:45:00 AM	13 10:00:00 AM	013 9:45:00 AM	4062	3/29/2013		13 12:58:31 PM	shireathiar	013 1:04:38 PM	shireathiar
65	Shireathia	13 10:30:00 AM	013 2:30:00 PM	013 1:45:00 PM	4063	3/29/2013	Ryan White	013 1:16:09 PM	shireathiar	013 8:49:26 AM	mena.gorre

(Excerpt from Ex. 4).

20. To ensure they satisfied AHF's expectations with regard to patient linkage, Linkage Coordinators were required to attend two weekly meetings. The first was a local meeting with the Linkage Manager and the other local Linkage Coordinators. The second meeting was a national conference call run by AHF's Linkage Director and attended by the Linkage Managers and Linkage Coordinators from each AHF's location.

21. In order to induce patients to attend their appointments at the AHF clinics as scheduled by the Linkage Coordinators, the Coordinators were authorized to pay for patient meals at local fast food restaurants and even pay the transportation costs for those patients to travel to AHF clinical service centers. Patients received gift cards for an AHF Thrift Store called "Out of the Closet" after attending two clinic visits, and they were also incentivized to frequent AHF clinical service centers for treatment and testing of sexually transmitted diseases ("STD"), for returning to AHF service centers every few months for ongoing medical care, and for remaining STD negative.

Pharmaceutical & Insurance Services

22. AHF owns and operates pharmacies near, and sometimes connected to, the locations where it has clinics, and it markets its own managed care insurance products for Medicare and Medicaid patients known as "Positive Healthcare."

23. Just as AHF seeks to link each HIV positive patient to services at an AHF Clinic, it seeks to link each HIV positive patient to services at an AHF Pharmacy and enrollment in an AHF insurance plan.

24. To induce this linkage, AHF pays remuneration in the form of gift certificates and cash payments valued at up to $50 or more to any AHF Public Health Division ("PHD") employee -- including but not limited to the AHF Linkage Coordinators -- responsible for referring a patient to an AHF Pharmacy or to Positive Healthcare. And, just as with linkage to clinical services, AHF paid bonus compensation of up to $100 to the employee who linked the patient with a positive test result to the AHF Linkage Coordinator for referral to the pharmaceutical services. This compensation was not predicated on any services furnished or

provided by the AHF employee who linked the patient, but rather was paid in return for the employee's referral of the patient for items and services furnished by others at AHF.

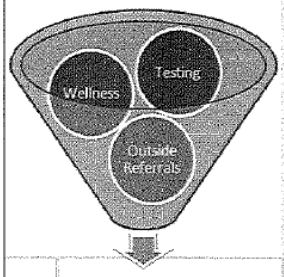
25. AHF gives GNC gift cards to patients who enroll in a Positive Healthcare plan. And it gives Ensure to patients who use its pharmacies.

26. Additionally, AHF provides remuneration directly to patients who both enroll in a Positive Healthcare plan and use an AHF Pharmacy, including a monthly allotment of multivitamins and nutrition shakes worth more than $50, which AHF has shipped directly to such patients.

27. AHF directed its PHD physicians to get patients enrolled in Positive Healthcare and linked with an AHF Pharmacy. To induce its physicians to comply, AHF tied their annual bonuses to the number of Positive Healthcare patients being treated. Thus, PHD physicians were paid bonus compensation based, not on services furnished or provided to patients, but rather on the number of patient referrals made to AHF's Positive Healthcare insurance program.

28. In addition to AHF's conduct set forth above, the chart below (attached as Exhibit 5), excerpted from an internal AHF financial presentation given on or about March 28, 2013, evidences AHF's intense interest in tracking its success in channeling patient referrals to all corners of AHF's operations:

All AHF

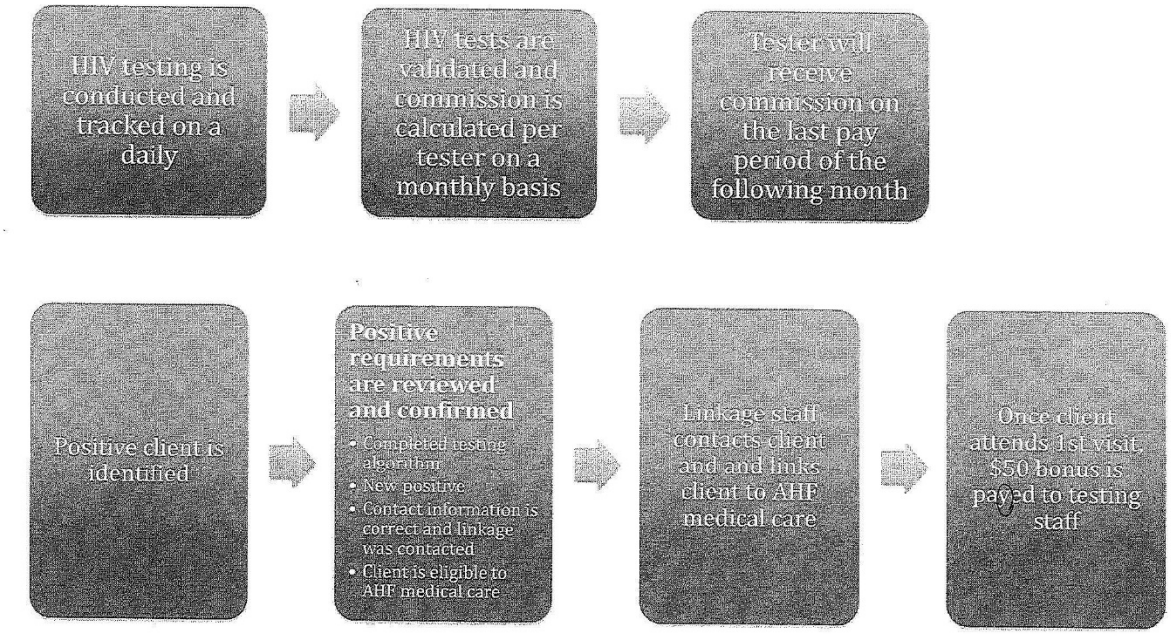


			Full Year2011			Full Year2012		
		Number of Tests	72,982			98,283		
		Positives	890	1.20%		1,113	1.13%	
		Referrals	633			823		
		Number of Positives from tests and referrals	1,523			1,936		
				% of Positives			% of Positives	
Linkage	HCC	Become an AHF HCC Patient	814	53%		1,123	58%	
	MC	Enroll in one of our Managed Care Plans	39	3%	37 also HCC Patients	38	2%	33 also HCC Patients
	Rx	Fill your Rx at an AHF Pharmacy	672	44%	615 (76%) from HCC 57 Pharmacy Only	822	42%	780 (69%) from HCC 42 Pharmacy Only

29. The importance and financial rewards associated with linking patients into AHF's care are referenced throughout the business records of the organization. At a May 2013 Leadership Summit ("Leadership Summit") held in Cleveland, Ohio, AHF defined "success" for the PHD in 2013 as the ability to "link 60% of those we identify as [HIV] positive into our care." Financial incentives were paid to AHF testers, testing managers and linkage personnel (i.e., Care Coordinators) for linking patients into AHF services and products. The chart below (attached as Exhibit 6), taken from AHF's records, describes financial incentives paid to AHF's HIV testers if they were able to successfully "link" such patients "to AHF medical care":

PG 1

Commission Based Testing Flow Chart

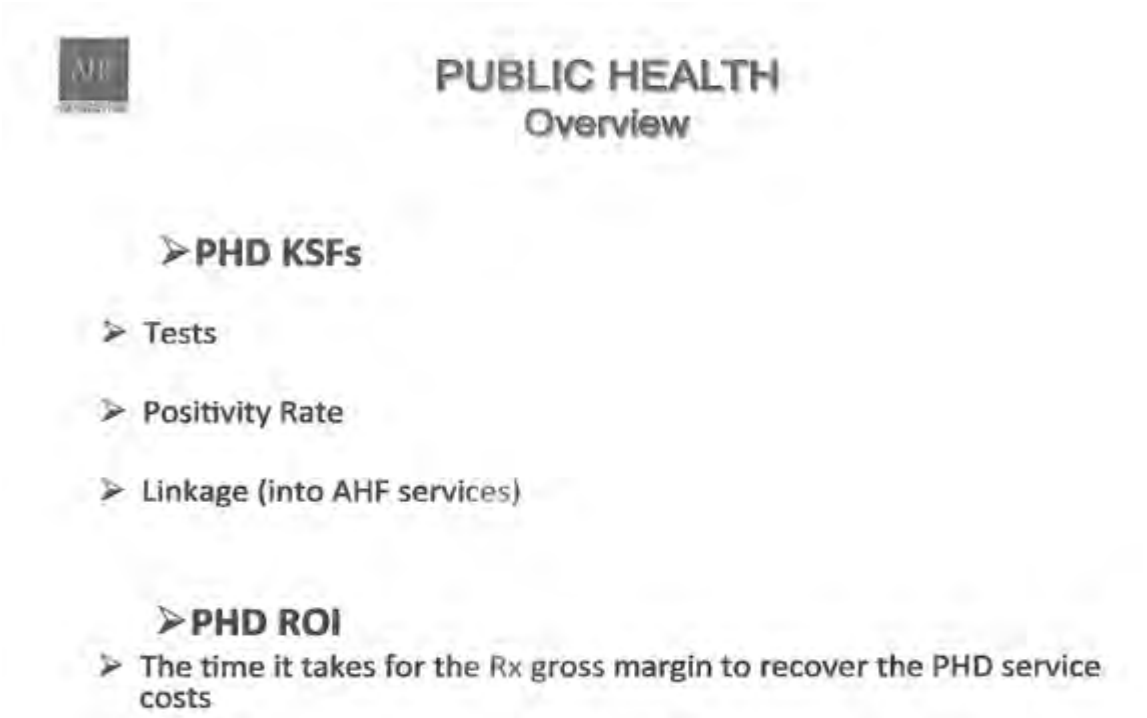


30. AHF's President, Michael Weinstein, attended the May 2013 Leadership Summit and personally advocated for: (1) increased testing to raise HIV "positivity" rates; (2) improved "linkage" of patients to and retention in AHF medical care; and (3) the payment of financial incentives to patients for the purpose of inducing self-referrals to AHF medical care. Weinstein specifically directed staff to raise the patient financial incentive to $50 immediately and to implement the incentive program nationally throughout the AHF organization. Weinstein also directed a patient financial incentive of $50 to those falling out of care to induce them to return to AHF medical care and also a financial incentive of up to $50 every few months to remain in AHF care, as well as an additional financial "bonus" at the end of one year of such care. Explicit discussions were held concerning the importance of "find[ing] more positives" and "gain[ing]

more referrals." Also discussed was the relationship between referrals of HIV-positive patients into AHF medical care and the start of medication regimens through AHF Pharmacy outlets. AHF allocated substantial and increasing financial resources to its patient self-referral incentive program. Specifically, AHF spent the following amounts for "Patient Incentives Program Service Expenses" between 2011 and 2013 according to tax returns filed by the organization:

2011	2012	2013
$141,921	$222,585	$242,230

31. The financial rewards paid by AHF to patients and employees were paid only for referrals to AHF, not for care rendered by any other providers. AHF, moreover, measured the financial success and "return on investment" in its PHD in terms of how effectively the PHD was able to link patients into other AHF services so that AHF could generate sufficient revenue to recoup the costs incurred in rendering care to HIV-positive patients. That strategy is well-illustrated by the AHF record below (attached as Exhibit 7), excerpted from an internal PHD financial presentation given on or about March 28, 2013, which describes how AHF sought to recover the costs of care incurred by the PHD through revenues earned in its Pharmacy Division:



32. AHF's strategy is further reflected in its business records, which carefully track numbers and percentages of HIV-positive patients who were linked into AHF Healthcare Centers and AHF Pharmacies and their associated revenue streams. AHF maintained weekly "Linkage to Care" reports that tracked HIV-positive patients who were linked to AHF care (an example of which is attached as Exhibit 8). AHF financial records tracked the numbers of patient referrals into AHF Healthcare Centers and Pharmacies and their associated revenue impact (an example of which is attached as Exhibit 9). Those records also disclose that AHF's Pharmacy Division was an enormous revenue generator, being responsible in 2012 alone for more than $300 million in total revenue.

B. AHF's Admissions Concerning Its Payment For Referrals

33. Since the initial filing of this lawsuit, AHF, through its President Michael Weinstein, has made numerous admissions acknowledging that AHF pays incentives to patients and employees for the purpose of linking such patients to AHF services.

34. In a message to "Partners and Friends" issued on April 13, 2015, AHF President Michael Weinstein defended the practice of paying financial incentives to patients, stating: "The provision of small incentives to patients in order to help link them to care is appropriate, legal and necessary [to] keep them in care and healthy." In fact, the practice described, which involved payment of cash and in-kind remuneration worth a minimum of $50 and was implemented by AHF for the express purpose of generating referrals to AHF's various health services, is patently an unlawful and direct violation of the Anti-Kickback Statute.

35. In an interview with Frontiers Media published the same day, Weinstein defended AHF's practice of "giving incentives up to the level of $50 per patient in order to make sure that they come in for their first two appointments." Karen Ocamb, *AHF's Weinstein on Florida Lawsuit: 'We Did Nothing Wrong' (Special Report),* Frontiers Media, Apr. 13, 2015, available at https://www.frontiersmedia.com/frontiers-blog/2015/04/13/ahfs-weinstein-on-florida-lawsuit-we-did-nothing-wrong-special-report/. Weinstein continued:

> We employee (sic) linkage coordinators to ensure that people get into care. That's their job. Do we pay incentives to employees whose job it is to get people into care when they successfully link? Yes. Do we pay commissions to testers based on doing more tests that (sic) what the quota is? Yes. And do we give small incentives to make sure patients come in? Yes….

Id.

36. The admissions referenced above, when combined with all of the other evidence already discussed, leave no room for doubt that AHF has implemented an organization-wide

kickback scheme utilizing financial incentives to induce patient referrals to AHF health services. AHF and Weinstein freely acknowledge doing so and attempt to justify the practice with an "ends justifies the means" rationale of ensuring that HIV-positive individuals receive needed care for their medical conditions. The public policies animating the Anti-Kickback Statute, however, do not permit such a cavalier approach.

37. As expressly recognized by the Office of Inspector General, Department of Health and Human Services, on its website, those public policies do not depend on whether services were rendered, or even on whether services were medically necessary, but rather on the corrupting effect of kickbacks in healthcare and the resulting risks of "overutilization, increased program costs, corruption of medical decisionmaking, patient steering and unfair competition." *See* http://oig.hhs.gov/compliance/physician-education/01laws.asp. The prohibition against kickbacks, moreover, "applies to all sources of referrals, even patients." *Id.* AHF was not entitled to game the healthcare system by implementing a system of financial incentives designed to manipulate the HIV patient referral stream to AHF's singular advantage, thereby offending all of the public policy imperatives underlying the Anti-Kickback Statute.

C. AHF Submitted Claims To And Received Reimbursement From Federal Health Care Programs Based On Illegal Patient Referrals

38. Through the scheme described above, AHF generated many millions of additional dollars for: (1) clinical services provided by AHF to illegally referred patients and reimbursed by the Federal Health Care Programs, including Medicare and Medicaid; (2) medications distributed by AHF to illegally referred patients through its pharmacy locations and reimbursed by the Federal Health Care Programs, including Medicare and Medicaid; (3) HIV testing services paid for with federal or state funds and provided to illegally referred patients; and (4) payments

received by AHF through its Positive Healthcare managed care insurance product for illegally referred Medicare and Medicaid patients living with HIV.

39. A major source of AHF's revenues is derived from Federal Health Care Programs. In its 2005 Annual Report, AHF stated:

> AHF has many contracts, subcontracts, and grants with government agencies. AHF's business development staff bid for these contracts and they are managed by our Contracts Department. Government contracts account for almost 50 percent of AHF's revenues. Sources of funds include the RyanWhite CARE Act, Centers for Disease Control and Prevention, Medicare, and state Medicaid.

More recently, AHF's Consolidated Financial Statements for 2013 disclosed that Medicare and Medicaid dollars comprised approximately 45% of its patient service revenue. Medicare revenues were listed at approximately $46 million on AHF's 2013 tax return; revenues from government grants were listed at approximately $18 million.

40. AHF submitted claims for clinical services rendered to illegally referred patients under the general authority and direction of Whitney Engeran-Cordova, AHF's National Senior Director of Public Health, and it submitted claims for pharmacy services under the general authority and direction of Kenneth Scott Carruthers, AHF's Chief of Pharmacy. The clinical services themselves were rendered by AHF physicians, whose actual or electronic signatures appeared on AHF's claims for reimbursement from Federal Health Care Programs. Physicians employed by AHF who rendered care to patients illegally incentivized by AHF, and whose signatures accompanied AHF's claims for reimbursement, included at least the following individuals between 2010 and 2013: Lisha Wilson; Gerald Hamwi; Rebecca L. Colon; Susan G. Sanchez; Catherine Chien; Robert J. Catalla; Joseph Piperato; Deborah Holmes; and Clifford Kinder.

41. The precise number of illegally referred HIV-positive patients cannot be known with certainty at this time, but a spreadsheet generated by AHF and attached as Exhibit 5 lists more than 840 "linked" (and de-identified) patients who represent at least a portion of the illegal referrals generated by AHF and who received services paid for by Federal Health Care Programs, as described above. Using an average annual cost of HIV care of approximately $23,000 (which is the estimated 2010 average annual cost according to the CDC government website) would mean that for this group of patients alone, AHF's fraudulent kickback scheme caused Federal Health Care Programs to pay AHF in the range of $20 million in HIV care costs in just a single year. The total amount that AHF improperly received from the government over the entire life of the illegal scheme, of course, will be much higher.

Ryan White Funding

42. HRSA and CDC provide federal funding to community-based organizations like AHF, either directly or indirectly through State or local agencies, for programs designed to expand medical care for people living with HIV/AIDS and to increase awareness of HIV status.

43. HRSA provides much of its funding through the Ryan White HIV/AIDS Program ("Ryan White"), which is the largest Federal program focused exclusively on HIV/AIDS care. According to the HRSA website, Ryan White is for individuals living with HIV/AIDS who have no health insurance, have insufficient health care coverage, or lack financial resources to get the care they need. The majority of Ryan White funds support primary medical care and essential support services, and a smaller portion also supports technical assistance, clinical training, and research on innovative models of care.

44. The legislation that created Ryan White specifies a number of Parts to meet the needs of different communities and populations. Part A provides emergency assistance to certain

metropolitan and other areas that are most severely affected by the HIV/AIDS epidemic. Part B provides grants to the States, the District of Columbia and certain U.S. territories. Part C provides comprehensive primary health care in an outpatient setting for people living with HIV disease. Part D provides family-centered care involving outpatient or ambulatory care for women, infants, children, and youth with HIV/AIDS. Part F provides funding for other programs, including training programs for providers treating people with HIV/AIDS.

45. Ryan White works with cities, states, and local community-based organizations to provide HIV-related services to more than half a million people each year. AHF received a portion of its Ryan White funding in direct HRSA grants and another portion through various Florida state and county agencies, including the Florida Department of Health HIV/AIDS Program. AHF was a recipient of Ryan White grant funds over a period of years.

46. Of the more than 1.1 million people living with HIV/AIDS, an estimated 240,000 are unaware of their HIV-positive status. According to the CDC, increasing the number of people who are aware of their HIV status is a key strategy in preventing infections. In order to achieve this goal, the CDC provides funding for expanded HIV testing programs aimed, in part, at significantly increasing the number of persons who are tested in jurisdictions having a high rate of HIV among disproportionately affected populations. AHF participated in some of these CDC-funded HIV testing programs and received CDC grant funds over a period of years.

47. AHF's entitlement to HRSA and CDC grant funds was contingent upon its compliance with standard terms and conditions that attached to all HHS grants. In applying for and accepting HHS grant funds, AHF certified its compliance with these terms and conditions. In general, the requirements that apply to the recipient of grant funds, including public policy requirements, also apply to sub-recipients and contractors under grants. As will be explained

further below, AHF knowingly and repeatedly violated an essential grant term and condition – compliance with the federal Anti-Kickback Statute -- which rendered its acceptance and use of grant proceeds fraudulent and a violation of the False Claims Act.

48. Standard terms and conditions of HHS grants are set forth in federal regulations and further explained by the HHS Grants Policy Statement, *available at* http://www.hhs.gov/asfr/ogapa/aboutog/hhsgps107.pdf, which states, at I-6:

> HHS grant awards generally are made to organizations. The organization is legally accountable for the performance of the award and the expenditure of funds. . . In signing a grant application, [the organization's authorized representative] agrees that the organization will assume the obligations imposed by applicable Federal statutes and regulations and other terms and conditions of the award, including any assurances, if a grant is awarded. These responsibilities include accountability both for the appropriate use of funds awarded and the performance of the grant-supported project or activities as specified in the approved application.

49. The Notice of Award is the legal document indicating an award has been made and that funds may be requested from HHS. According to the HHS Grant Policy Statement, "until an awarding office has issued a [Notice of Award] for the initial budget period, any costs incurred by the applicant for the project are incurred at its own risk." (HHS Grant Policy Statement at I-34). The Notice of Award sets forth relevant information about the award, including "the amount of Federal funds authorized" and "[a]pplicable terms and conditions of award, either by reference or inclusion." *Id*. at I-34 and 35. A grant recipient "indicates acceptance of an award and its associated terms and conditions by drawing or requesting funds from the designated HHS payment system or office" and "[i]f a recipient cannot accept the award, including the legal obligation to perform in accordance with award terms and conditions, the organization" is expected to notify HHS immediately. *Id*. at I-35. If the award is accepted, "the contents of the [Notice of Award] are binding on the recipient unless and until modified by

a revised [Notice of Award] signed by the [Grants Management Officer]." *Id*. HHS "may administratively recover funds paid to a recipient in excess of the amount to which the recipient is . . . entitled under the terms and conditions of the award, including misspent funds or unallowable costs incurred." *Id*. at II-96. "If a recipient has failed to materially comply with the terms and conditions of award, [HHS] may suspend the grant, pending corrective action, or may terminate the grant for cause." *Id*. at II-93; see 45 CFR §§74.61, 74.62, 92.43.

50. Among the standard terms contained in the Notice of Award is a requirement that the award recipient comply with the requirements of the federal Anti-Kickback Statute:

> Recipients and sub-recipients of Federal funds are subject to the strictures of the Medicare and Medicaid anti-kickback statute (42 U.S.C. 1320a-7b(b)) and should be cognizant of the risk of criminal and administrative liability under this statute, specifically under 42 U.S.C. 1320 7b(b) illegal remunerations which states, in part, that whoever knowingly and willfully: (A) Solicits or receives (or offers or pays) any remuneration (including kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind, in return for referring (or to induce such person to refer) an individual to a person for the furnishing or arranging for the furnishing of any item or service, OR (B) In return for purchasing, leasing, ordering, or recommending purchasing, leasing, or ordering, or to purchase, lease, or order, any goods, facility, services, or item .... For which payment may be made in whole or in part under subchapter XIII of this chapter or a State 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. (Emphasis added).

See Exhibit 10, Sample Notice of Award at p. 3, ¶ 3.

51. The HHS Grant Policy Statement also states that "[a]nyone who becomes aware of the existence (or apparent existence) of fraud, waste, or abuse related to HHS grants or use of grant funds should report this information to HHS." [Grants Policy Statement at I-7.] HHS defines "fraud, waste, or abuse" to include "embezzlement, misuse, or misappropriation of grant funds or property, and false statements, whether by organizations or individuals." *Id*. at I-7. The HHS Grant Policy Statement further puts all grant recipients on notice that the "Federal

government may pursue administrative, civil, or criminal action under a variety of statutes that relate to fraud and false statements or claims," including the False Claims Act. *Id*. at I-8.

52. AHF submitted claims for all Ryan White-eligible patients, including those who received AHF services as a result of AHF's illegal kickback scheme described above. AHF submitted those claims for services rendered as a result of illegal referrals despite knowing that those claims were ineligible for payment.

53. The manner in which AHF submitted such claims depended on the rules and regulations established by each county authorized to distribute Ryan White funds. For patients residing in Miami-Dade County, AHF electronically logged services rendered to Ryan White-eligible patients in a computer program/system called SDIS. At the end of each month, an AHF Grants Manager printed the billing information for the electronic entries for that month, certified they were a true and accurate accounting of services rendered and the payments AHF was entitled to, and mailed the documents to the Ryan White Grants Coordination Office for Miami-Dade County. The County then paid AHF for reimbursable services by electronically depositing the funds into a bank account controlled by AHF's California headquarters. By contrast, Broward County has delegated the distribution of Ryan White funds to the Broward County Health Services Planning Council. Every quarter, AHF files claims with the Planning Council for services rendered to Ryan White-eligible patients residing in Broward County, and the Council directs electronic payments be made to a bank account controlled by AHF's California headquarters. But regardless of how a particular county decides to accept claims for or distribute its Ryan White funds, each county, as required by the Ryan White program, makes compliance with federal health care laws, including the Anti-Kickback Statute, a condition of payment.

54. As a result of submitting ineligible claims for payment with Ryan White funds, AHF obtained federal funds for treatment and services performed as a result of referrals made in violation of the Anti-Kickback Statute that, upon information and belief, amount to millions of dollars.

Medicare Reimbursements

55. The Medicare Program, Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395, *et seq.*, is a health insurance program administered by the United States that is funded by taxpayer revenue. Entitlement to Medicare is based on age, disability or affliction with certain diseases. The program is overseen by HHS through the Centers for Medicare and Medicaid Services ("CMS"). Medicare provides for payment of hospital services, medical services, durable medical equipment and prescription drugs on behalf of Medicare-eligible beneficiaries.

56. Compliance with federal health care laws, including the Anti-Kickback Statute, is a condition of payment by the Medicare program. Violators of the Anti-Kickback Statute are prohibited from receiving payment as part of the Medicare program. When providers enroll in the Medicare Program, they must acknowledge "that payment of a claim by Medicare is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, the Federal Anti-Kickback Statute and the Stark law), and on the supplier's compliance with all applicable conditions of participation in Medicare. *Medicare Enrollment Application*, at p. 31.

57. In order to receive payment from Medicare, a claim must be submitted electronically or on paper, and every claim contains a certification by the provider that the claim complies with all applicable laws, regulations and program instructions required for payment, including but not limited to the federal Anti-Kickback Statute. It was AHF's corporate practice

to have billing personnel in its testing centers, clinics, and pharmacies submit claims to Medicare electronically for each Medicare-eligible patient, regardless of the type of services rendered, soon after treatment or services were provided to that patient. Medicare paid the claims electronically to an account controlled by AHF's corporate headquarters in California.

58. AHF submitted such claims for all Medicare-eligible patients, including those who received AHF services as a result of AHF's illegal referral scheme described above. Upon information and belief, AHF submitted those claims for services rendered after illegal referrals to Medicare despite knowing that those claims were ineligible for payment.

59. As a result of submitting these ineligible claims to Medicare, AHF obtained federal funds for treatment and services performed as a result of referrals made in violation of the Anti-Kickback Statute that, upon information and belief, amount to millions of dollars.

60. AHF was required by law or Medicare rules or regulations to repay to the federal government the payments it received for the ineligible claims, but it did not do so.

Medicaid Reimbursements

61. The Medicaid Program, Title XIX of the Social Security Act, 42 U.S.C. §§ 1396-1396v, is a health insurance program administered by the United States and individual states and is funded by federal, state and local taxpayer revenue. The Medicaid Program is overseen by HHS through CMS. Medicaid was designed to assist participating states in providing medical services, durable medical equipment and prescription drugs to financially needy individuals that qualify for Medicaid. The Medicaid program pays for services pursuant to plans developed by the States and approved by HHS through CMS. 42 U.S.C. §§ 1396a(a)-(b). States pay doctors, hospitals, pharmacies, and other providers and suppliers of medical items and services according

to established rates. 42 U.S.C. §§1396b(a)(1), 1903(a)(1). The federal government then pays each state a statutorily established share of "the total amount expended ... as medical assistance under the State plan." See 42 U.S.C. §1396b(a)(1). This federal-to-state payment is known as Federal Financial Participation.

62. Florida maintains a federally-approved Medicaid program to reimburse health care charges made by physicians and other health care providers for the treatment of many low-income Florida citizens not covered by Medicare or private insurance. Claims submitted to the Florida Medicaid Program cause payments to be made by both the United States and Florida. The United States and Florida each contribute approximately half the cost of each claim submitted to the Florida Medicaid Program. Providers apply to participate in the Florida Medicaid Program and agree as a condition of both participation and payment to comply with all the policies and procedures of the Florida Agency for Health Care Administration ("AHCA"), which administers the Medicaid Program in Florida. Medicaid providers must sign a provider agreement promising that the provider will comply with all laws and rules governing the delivery and reimbursement of services or goods to Medicaid recipients. *Florida Medicaid, Provider General Handbook*, at 2-12. Each claim submitted to the Medicaid Program, whether electronically or on a paper claim form, carries a certification that the claim complies with all federal and state laws and regulations; that the services for which reimbursement is claimed "were medically indicated and necessary to the health" of the patient; that the information contained in the claim "is true, accurate and complete," and that the provider understands "that payment and satisfaction of [the] claim will be from Federal and State funds and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under

applicable Federal or State laws." *Florida Medicaid, Provider Reimbursement Handbook*, CMS-1500.

63. AHCA policies and procedures bar Medicaid payments for services resulting from fraud or abuse. "Abuse" includes practices that result in unnecessary cost to the Medicaid program and may include "a violation of state or federal law, rule or regulation." *Florida Medicaid, Provider General Handbook*, at 5-3. "Fraud" is defined as "an intentional deception or misrepresentation made by a person with the knowledge that the deception results in unauthorized benefit to herself or himself or another person" and also includes "any act that constitutes fraud under federal or state law." *Id*. "Overpayment" is defined as "any amount that is not authorized to be paid by the Medicaid program whether paid as a result of inaccurate or improper cost reporting, improper claims, unacceptable practices, fraud, abuse or mistake." *Id*.

64. AHF submitted claims for all Medicaid-eligible patients, including those who received AHF services as a result of AHF's illegal kickback scheme described above. AHF submitted those claims for services rendered after illegal referrals to Medicaid despite knowing that those claims were ineligible for payment.

65. As a result of submitting these ineligible claims to Medicaid, AHF obtained federal and state funds for treatment and services performed as a result of referrals made in violation of the Anti-Kickback Statute.

66. AHCA requires "repayment for inappropriate, medically unnecessary, or excessive goods or services from the person furnishing them, the person under whose supervision they were furnished, or the person causing them to be furnished." *Id*. AHF was, therefore, required to repay to the federal government the payments it received for the ineligible claims.

V. CAUSES OF ACTION

COUNT ONE
Federal False Claims Act
31 U.S.C. § 3729(a)(1)(A)

67. Relators repeat and re-allege each and every allegation contained in paragraphs 1 through 66 above as though fully set forth herein.

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

69. By virtue of the acts described above, Defendant knowingly presented or caused to be presented, false or fraudulent claims to officers, employees or agents of the United States government for payment or approval. 31 U.S.C. § 3729(a)(1)(A).

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

71. By reason of the Defendant's acts, the United States has been damaged, and continues to be damaged, in a substantial amount to be determined at trial.

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

COUNT TWO
Federal False Claims Act
31 U.S.C. § 3729(a)(1)(B)

73. Relators repeat and re-allege each and every allegation contained in paragraphs 1 through 66 above as though fully set forth herein.

74. By virtue of the acts described above, Defendant knowingly made, used, or caused to be made or used false or fraudulent records and statements, and omitted material facts, to get false or fraudulent claims paid or approved by the United States government, within the meaning of 31 U.S.C. § 3729(a)(1)(B).

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

76. By reason of the Defendant's acts, the United States has been damaged, and continues to be damaged, in a substantial amount to be determined at trial.

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

COUNT THREE
Federal False Claims Act
31 U.S.C. § 3729(a)(1)(G)

78. Relators repeat and re-allege each and every allegation contained in paragraphs 1 through 66 above as though fully set forth herein.

79. By virtue of the acts described above, Defendant knowingly made, used, or caused to be made or used, a false record or statement material to an obligation to pay or transmit

money or property to the Government, or knowingly concealed or knowingly and improperly avoided or decreased an obligation to pay or transmit money or property to the Government, within the meaning of 31 U.S.C. § 3729(a)(1)(G).

80. The United States, unaware of the falsity of the records and statements and of the Defendant's concealment and unlawful conduct, was denied an opportunity to claim and demand return of the money and property to which it was legally entitled.

81. By reason of the Defendant's acts, the United States has been damaged, and continues to be damaged, in a substantial amount to be determined at trial.

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

COUNT FOUR
(Florida False Claims Act)
§ 68.082(2)(a), Fla. Stat.

83. Relators repeat and reallege each and every allegation contained in paragraphs 1 through 66 above as though fully set forth herein.

84. This is a claim for treble damages and penalties under the Florida False Claims Act, §§ 68.081 *et seq.*, Fla. Stat., as amended.

85. By virtue of the acts described above, Defendant knowingly presented or caused to be presented, false or fraudulent claims to Florida for payment or approval, within the meaning of § 68.082(2)(a), Fla. Stat.

86. Florida, unaware of the falsity of the claims made or caused to be made by the Defendant, paid and continues to pay the claims that would not be paid but for Defendant's unlawful conduct.

87. By reason of the Defendant's acts, Florida been damaged, and continues to be damaged, in a substantial amount to be determined at trial.

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

COUNT FIVE
(Florida False Claims Act)
§ 68.082(2)(b), Fla. Stat.

89. Relators repeat and reallege each and every allegation contained in paragraphs 1 through 66 above as though fully set forth herein.

90. This is a claim for treble damages and penalties under the Florida False Claims Act, §§ 68.081 *et seq*., Fla. Stat., as amended.

91. By virtue of the acts described above, Defendant knowingly made, used, or caused to be made or used false or fraudulent records and statements, and omitted facts, material to false or fraudulent claims, within the meaning of § 68.082(2)(b).

92. Florida, unaware of the falsity of the records, statements and material omissions made or caused to be made by the Defendant, paid and continues to pay the claims that would not be paid but for Defendant's unlawful conduct.

93. By reason of the Defendant's acts, Florida has been damaged, and continues to be damaged, in a substantial amount to be determined at trial.

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

COUNT SIX
(Florida False Claims Act)
§ 68.082(2)(g), Fla. Stat.

95. Relators repeat and reallege each and every allegation contained in paragraphs 1 through 66 above as though fully set forth herein.

96. This is a claim for treble damages and penalties under the Florida False Claims Act, §§ 68.081 *et seq.*, Fla. Stat., as amended.

97. By virtue of the acts described above, Defendant knowingly made, used, or caused to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly concealed or knowingly and improperly avoided or decreased an obligation to pay or transmit money or property to the Government, within the meaning of § 68.082(2)(g), Fla. Stat.

98. Florida, unaware of the falsity of the records and statements and of the Defendant's concealment and unlawful conduct, was denied an opportunity to claim and demand return of the money and property to which it was legally entitled.

99. By reason of the Defendant's acts, Florida has been damaged, and continues to be damaged, in a substantial amount to be determined at trial.

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

PRAYER FOR RELIEF

WHEREFORE, Relators, acting on behalf and in the name of the United States of America and the State of Florida, demand and pray that judgment be entered against Defendant under the Federal False Claims Act and Florida False Claims Act as follows:

(1) That Defendant cease and desist from violating 31 U.S.C. §§ 3729 *et seq*. and §§ 68.081 *et seq*., Fla. Stat., as set forth above;

(2) That this Court enter judgment against Defendant in an amount equal to three times the amount of damages the United States has sustained because of Defendants' actions, plus a civil penalty of not less than $5,000 and not more than $11,000 for each violation of 31 U.S.C. § 3729;

(3) That this Court enter judgment against Defendant in an amount equal to three times the amount of damages the State of Florida has sustained because of Defendant's actions, plus a civil penalty of not less than $5,500 and not more than $11,000 for each violation of § 68.082(2), Fla. Stat.;

(4) That Relators be awarded the maximum amount allowed pursuant to 31 U.S.C. § 3730(d) and § 68.085, Fla. Stat.;

(5) That Relators be awarded all costs of this action, including attorneys' fees and expenses; and

(6) That Relators recover such other relief as the Court deems just and proper.

DEMAND FOR JURY TRIAL

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

Dated: May 26, 2015

By: */s/Theodore J. Leopold*

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CERTIFICATE OF SERVICE

I hereby certify that on May 26, 2015, I electronically filed the foregoing document with the Clerk of the Court using CM/ECF. I also certify that the foregoing document is being served this day on all counsel of record or pro se parties identified on the attached Service List in the manner specified, either via transmission of Notices of Electronic Filing generated by CM/ECF or in some other authorized manner for those counsel or parties who are not authorized to receive electronically.

By: */s/Theodore J. Leopold*
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