IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLORADO

Civil Action No. 04-cv-02340-REB-BNB

UNITED STATES OF AMERICA, and
the STATE OF COLORADO,

Plaintiffs,

v.

HEALTH CARE MANAGEMENT PARTNERS, LTD, (HCMP), d/b/a
O'HARA REGIONAL CENTER FOR REHABILITATION, a limited partnership;
ORCR, INC. d/b/a O'HARA REGIONAL CENTER FOR REHABILITATION, INC.;
a corporation;
SOLOMON HEALTH MANAGEMENT, LLC. (Solomon), d/b/a
SOLOMON HEALTH SERVICES, LLC.
limited liability companies;
and HERSCH "ARI" KRAUSZ;
DAVID SEBBAG; and
V. ROBERT "ROB" SALAZAR,
Individuals,

Defendants.

FIRST AMENDED COMPLAINT

The United States, by William J. Leone, United States Attorney for the District of Colorado, and the State of Colorado, by John W. Suthers, its Attorney General, bring this action for statutory damages under the False Claims Act, as amended, 31 U.S.C. §§ 3729-3733, and to recover all available damages and other monetary relief under the common law or equitable theories of fraud, unjust enrichment, payment by mistake of fact, restitution and disgorgement, and recoupment of overpayments.

JURISDICTION AND VENUE

1. This Court has jurisdiction over this action pursuant to 28 U.S.C. §§ 1331, 1345, 1355, and 2461(a), and 31 U.S.C. § 3732(a) and (b).

2. Venue is proper in this district under 28 U.S.C. §§ 1391(b) and 1395, and 31 U.S.C. § 3732(a) and (b) because the acts alleged in this complaint occurred in the District of Colorado.

PARTIES

3. The United States brings this action to recover losses incurred by its agency, the Department of Health and Human Services (HHS), and its operating division, the Centers for Medicare & Medicaid Services (CMS), formerly the Health Care Financing Administration. HHS provides funding for, and regulates participation of long term care nursing facilities in the Medicare and Medicaid programs.

4. The State of Colorado brings this action on behalf of its agency, the Colorado Department of Health Care Policy and Financing (HCPF), the single state agency in Colorado that administers the Medicaid Program.

5. In 1993, Defendants Hersch "Ari" Krausz (Krausz) and David Sebbag (Sebbag) acquired the Heritage Rehabilitation Facility which was licensed by the State of Colorado as a Class V rehabilitation nursing facility. In 1996, Krausz and Sebbag changed the facility's name to Health Care Management Partners, Ltd. (HCMP), which was a limited partnership that conducted business as the O'Hara Regional Center for Rehabilitation, Ltd. (O'Hara), at 1500 Hooker St., Denver, from approximately August 27, 1996 until approximately June, 1998.

Defendants Krausz and Sebbag owned and operated the facility as partners in Defendant HCMP. Documents show that when the facility's name was changed from Heritage to the O'Hara Regional Center for Rehabilitation, Ltd., HCMP was the owner doing business as O'Hara.

6. Defendant ORCR, Inc. was incorporated on or about May 5, 1998, by Defendant Krausz. ORCR, Inc. conducted business as the O'Hara Regional Center for Rehabilitation, Inc. (O'Hara), at 1500 Hooker St., Denver, from approximately June 2, 1998 until approximately, December 31, 2000, when it closed.

7. Defendant Solomon Health Management, LLC (Solomon), was incorporated on or about December 29, 1995. In April 1996, Solomon began conducting business as a management company for long-term care nursing facilities in the Denver metropolitan area under the name Solomon Health Services, LLC. From January 1, 1996 until approximately June 2000, Solomon had agreements to manage O'Hara. This agreement provided that Solomon would "supervise, direct and control the daily management and operations" of the facility, including coordinating nursing and other services.

8. Defendant Krausz is an individual residing within the District of Colorado. Krausz served as President/owner of Benton Financial Services, which was a general partner of HCMP, and which initially owned the building at 1500 Hooker St. He was also President and Treasurer of ORCR, Inc., which he incorporated and for which he was initially the registered agent. He served as a director on Solomon's Board of Directors. At all times relevant to this complaint, Krausz had ownership interests in HCMP, its general partner, Benton Financial Services, ORCR, Inc. and Solomon, all of the entities involved in the ownership and operations

of O'Hara. From June, 2000, until December 31, 2000 Krausz directly managed O'Hara.

9. Defendant Sebbag is an individual residing in the District of Colorado. Sebbag initially served as a registered agent for HCMP and was also an owner/officer of Benton Financial Services, HCMP's general partner. Sebbag was Vice-President and Secretary of ORCR, Inc. He also served as Executive Vice-President for Solomon and was a director of its board of directors. At all times relevant to this complaint, Sebbag had ownership interests in HCMP, its general partner, Benton Financial Services, ORCR, Inc. and Solomon, all of the entities involved in the ownership and operations of O'Hara. From June 2000 until December 31, 2000 Sebbag directly managed O'Hara.

10. Defendant V. Robert Salazar (Salazar) is an individual residing in the District of Colorado. Salazar was the initial registered agent and manager of Solomon, which was incorporated on approximately December 29, 1995. At all times relevant to this Complaint, Salazar was an owner and President and Chief Executive Officer (CEO) of Solomon, which was responsible for operating O'Hara pursuant to a management agreement until approximately June, 2000.

GENERAL ALLEGATIONS

11. Between September 1, 1997 through December 31, 2000, Defendants systematically and routinely understaffed O'Hara to the point that it was unable to provide sufficient nursing staff to meet the needs of O'Hara's patients or, in some instances, to provide even basic nursing care required to maintain the health and well-being of its residents.

12. As a result, Defendants knowingly presented or caused to be presented claims for

payment to the Medicare and Medicaid programs, for care, goods or services not rendered, that were inadequate or worthless, or that were rendered in violation of applicable statutes, regulations, and guidelines with a nexus to payment.

13. Defendants Krausz and Sebbag through control of financial expenditures, directly or indirectly controlled operations at O'Hara from 1996 until the facility closed on approximately December 31, 2000.

14. Defendant Salazar as president and CEO of Solomon, the company managing O'Hara, participated in the direct control of O'Hara from January 1996 until June 2000, when Solomon withdrew as the management company for O'Hara.

15. Defendant Salazar, who also was licensed as a Nursing Home Administrator, was provided and/or had available to him, detailed information concerning the number of residents in O'Hara, nursing staff costs, use of temporary nursing services, the problems O'Hara had attracting a permanent nursing staff, legal claims of malpractice at the facility, and state survey results which included claims of understaffing at O'Hara.

16. During the time period relevant to this complaint, Defendants also engaged in a pattern of practices intended to mislead, among others, the Colorado Department of Public Health and Environment (the State Survey Agency) and CMS into believing that conditions at O'Hara were either better than they actually were or that O'Hara was taking active and effective steps to address and improve any problems and/or deficiencies.

STATEMENT OF FACTS

The O'Hara Regional Center for Rehabilitation and Operation of the Medicare And Medicaid Programs

17. Medicare is a federal health insurance program for individuals sixty-five (65) years of age and older, certain disabled individuals, and people who have permanent kidney failure. The Medicare statute is codified at 42 U.S.C. §§1395 *et seq*. (Title XVIII of the Social Security Act).

18. Medicaid is a joint federal-state program funded under Title XIX of the Social Security Act. Under Medicaid, the state directly pays health care providers for services rendered to Medicaid recipients, with the state obtaining the federal share of the payment from accounts which draw on funds of the United States Treasury.

19. O'Hara was licensed by the State of Colorado as a 96-bed Class V rehabilitation nursing facility. At all times relevant to this complaint, O'Hara was the only Class V rehabilitation nursing facility in the state of Colorado.

20. The "Class V" designation meant that O'Hara was certified by the State of Colorado to provide care to residents who required a substantially greater quantity and quality of skilled nursing care than ordinary nursing homes were capable of providing. *See* former regulation at 10 C.C.R. 2505-10, at section 8.401.50D.

21. As a Class V facility, O'Hara admitted adults of any age with conditions including traumatic brain and spinal cord injuries, disabling strokes, and complex orthopedic disabilities, as well as ventilator dependent and tracheostomy patients.

22. To submit claims to Medicare and Medicaid, O'Hara was required to adhere to applicable statutes and regulations.

23. At all times relevant to this action, O'Hara had "provider" agreements with Medicare and Medicaid. In the Medicare Provider Agreement and Provider Billing System Agreement, as a prerequisite to enrolling in and receiving payment from the Medicare Program, O'Hara agreed that it

a. was familiar with and agreed to abide by the Medicare laws and regulations;

b. would be responsible for all Medicare claims submitted to CMS on behalf of O'Hara, its employees, or its agents and would submit claims for services that were accurate, truthful and complete; and,

c. acknowledged that all claims will be paid from federal funds, that the submission of such claims is a claim for payment under the Medicare program, and that anyone who misrepresents or falsifies or causes to be misrepresented or falsified any record or other information relating to that claim may, upon conviction, be subject to a fine and/or imprisonment under federal law.

24. O'Hara also entered into a Medicaid provider agreement and agreed to the following provisions as a prerequisite to enrolling in and receiving payment from the Medicaid program, among other provisions:

a. To comply with all Federal and State statutes and rules relating to the delivery of benefits to individuals and to the submission of claims for such benefits.

b. To assume full responsibility for claims submitted to the Department of Health

Care Policy and Financing.

25. Health care providers cannot submit claims for services that are "of a quality which fails to meet professionally recognized standards of health care." 42 U.S.C. § 1320c-5(a)(2).

26. Federal regulations governing skilled nursing facilities required O'Hara, among other things, to:

a. provide each resident with the amount and type of nursing care and services necessary to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being, in accordance with a comprehensive assessment and plan of care. 42 C.F.R. § 483.25(a)(3); 42 U.S.C. §§ 1395i-3(b)(2), 1396r(b)(2).

b. have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. 42 C.F.R § 483.30.

c. provide services in compliance with all applicable federal, state, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. 42 C.F.R. § 483.75 (b).

27. In addition, state regulations governing skilled nursing facilities required O'Hara to:

a. have at least one registered professional nurse (RN), other than the Director of Nursing, and one licensed practical nurse (LPN) on each shift to supervise resident care. 6 C.C.R. 1011-1, Chapter XVII.

b. have a full-time Director of Nursing (DON), licensed as a registered professional nurse with experience in rehabilitative nursing care. 6 C.C.R. 1011-1, Chapter XVII.

c. provide sufficient numbers of staff with sufficient skill to be capable of meeting the individual needs of the residents but in no case less than 3.5 hours of nursing care per resident per 24 hour period exclusive of the hours of the DON, and exclusive of staff training or orientation. 6 C.C.R. 1011-1, Chapter XVII.

28. Many of the O'Hara residents required two or more types of therapy on a regular basis, as well as extensive or clinically complex nursing care such as wound care, urinary catheter care, tube feedings, complex medication management, and other skilled nursing care. A large percentage of O'Hara's residents needed constant tracheostomy care and were ventilator dependent. As a result, O'Hara's residents required a higher proportion of RNs and LPNs, than ordinary nursing homes, which use a greater portion of certified nurse aides (CNA).

29. In addition, most of O'Hara's residents were completely or partially dependent on O'Hara nursing staff for their activities of daily living such as transferring from bed to a wheelchair, turning in bed to prevent pressure sores, toileting, eating, brushing their teeth, dressing, and bathing.

30. To meet these needs, O'Hara represented in facility brochures that it would provide the following high level of services: a) individual care plans developed by a multi-disciplinary team including a physiatrist, pulmonologist, nurse, physical therapist, occupational therapist, speech therapist, dietitian, and social services and activities staff; b) aggressive respiratory treatments and ventilator and tracheostomy weaning programs; c) respiratory escorts for out-of-building activities; d) expanded psychological support services, including group and individual counseling provided by a psychologist or psychiatric nurse specialist; e) individualized plans of care for the transitional and/or recovery phases; f) aqua-therapy program; g) extensive therapeutic recreation program; and, h) patient/family training and support by professional team members.

31. To provide these services, O'Hara represented in facility brochures that it was "committed to recruiting, training and developing the skills of the individuals who make up its team of health care professionals, and providing them with a working environment which enables each to succeed and grow according to his or her personal career goals."

32. Because of the greater costs associated with providing care to O'Hara's high needs, high acuity, dependant residents, Medicaid paid almost twice the reimbursement rate it paid for Medicaid residents residing in other long-term care nursing facilities in the State, i.e., skilled nursing facilities. The Medicare payments varied for each resident.

33. In addition, during the time period relevant to this complaint, Defendants solicited and admitted residents to O'Hara under the Colorado Medicaid Hospital Back Up (HBU) program which paid increased Medicaid *per diem* rates for residents who required hospital-level services in a long-term care setting.

Defendants Failed to Employ Enough Nurses to Provide All Services Required to Care for and Treat O'Hara's Vulnerable Residents

34. Due to the intensive needs, high acuity level and complex medical conditions of O'Hara's residents, a high number of RNs and LPNs were needed to supervise and manage residents' care such as medication management, including medications given intravenously; enteral tube feedings; nursing rehabilitation services and the ongoing assessment of residents' conditions and their needs.

35. O'Hara's brochures disseminated to the public, including the beneficiaries of the Medicare and Medicaid programs, stated that it provided increased services, including a minimum of 6 hours of nursing per day and an average of 3 hours of therapy services per day. O'Hara utilized this brochure to attract new residents until as late as November 1999 knowing that it was entirely false.

36. From at least September, 1997 through November, 1998, O'Hara's internal nurse staffing policy recognized that its residents required an average of 6.00 to 6.6 hours of direct nursing care per patient per day (PPD).

37. On January 1, 1997, O'Hara's direct nursing budget, set by Defendants, provided for approximately 6.32 hours of direct nurse staffing each day for each resident.

38. By May 1998, contrary to its own staffing policy, Defendants had reduced O'Hara's nursing budget to approximately 4.53 nursing hours PPD. This was a reduction of almost 35 per cent for nursing hours per patient per day from January 1997. This reduction in nurse staffing was a cost saving measure approved by Defendants.

39. At no time from September 1997 until December 2000 was there any decrease in the acuity level or nursing needs of the residents to justify reductions in nurse staffing.

40. Actual nurse staffing at O'Hara frequently fell below the 4.53 PPD level of staffing provided for in the May 1998 budget.

41. At various times from September 1997 through December 2000, Defendants failed to provide 24-hour RN nursing coverage at O'Hara.

42. In fact, the majority of O'Hara's nursing staff during this time period consisted of CNAs who are certified after an eight week training course and were not qualified to provide many of the complex medical services needed by O'Hara's residents.

43. Failure to have an RN on duty evaluating the condition and needs of residents violated federal and state regulations and posed a serious and obvious hazard to the residents' health.

44. The nurse staffing problems were at their greatest at nights and on weekends due to Defendants' continuing failure to provide an adequate permanent nursing staff.

45. At various times from January 1997 through December 2000, the Defendants failed to provide adequate therapy services to O'Hara's residents both in terms of quality and quantity of care. Failure to provide adequate respiratory therapy, range of motion therapy, occupational therapy, speech therapy and any other needed therapies affected the health and acuity levels of the O'Hara residents and placed additional burdens on the direct nursing staff, making it more difficult to care for the residents.

46. At various times from January 1997 through December 2000, the Defendants failed to have on hand needed medical supplies and equipment, further limiting the nursing staff's ability to provide necessary care to the O'Hara residents. For example, on numerous occasions, medications prescribed to residents were not given due to failure to have the particular

drug available in the facility. On other occasions, management failed to have new and/or emergency replacement tracheostomy tubes available for residents.

47. Defendants Krausz, Sebbag and Salazar (the "Individual Defendants") collectively had ownership and management control over the corporate defendants. As such, the Individual Defendants controlled staffing budget, compensation, and hiring and firing decisions at O'Hara.

48. The Individual Defendants all have substantial experience in the health care industry. Each has either owned or managed multiple skilled nursing facilities.

49. The Individual Defendants routinely received and reviewed nurse staffing reports from O'Hara showing how many direct care staff, RNs, LPNs and CNAs, worked during a 24-hour period.

50. These staffing reports make it clear that the nurse staffing at O'Hara was chronically low and that on specific days, the staffing slipped to clearly unacceptable levels. From these records, the Individual Defendants knew that O'Hara was significantly short staffed, that it was staffing under budget, and that there were days where O'Hara failed to provide 24 hour RN coverage as required.

51. On repeated occasions, O'Hara management and staff informed the Individual Defendants that O'Hara was failing to attract and retain an adequately skilled permanent nursing staff.

52. To increase O'Hara's profitability, on or about August 6, 1998, Defendant Salazar directed Solomon and O'Hara to terminate use of temporary nurse services by the end of August, 1998.

53. As a result, O'Hara did not have an adequate nursing staff to care for the

residents.

54. Defendant Salazar's directive predictably resulted in severe under-staffing at O'Hara. As an example, on Labor Day weekend, September 1998, O'Hara's DON had only two nurses and one CNA to care for approximately 47 high needs residents.

55. When the DON called a temporary nursing service to seek emergency help, she was informed that upper level Solomon management had directed the temporary nursing service not to respond to calls from O'Hara.

56. Defendants Krausz and Sebbag, with the knowledge of Defendant Salazar, refused to authorize any effective measures to enable O'Hara to attract and retain an adequate permanent nursing staff.

57. O'Hara's staff wages were tied to the wage scale at numerous other ordinary nursing homes controlled, owned and/or operated by Defendants. These "ordinary" nursing homes did not admit patients with acuity levels or needs as high as O'Hara's residents. Many nursing recruits would terminate their applications upon being informed of the O'Hara pay scale.

58. Defendants Krausz and Sebbag retained authority for approving any increases in nurse staffing and any changes in pay scales to ensure that they were consistent with their approved annual operating budget.

59. That the understaffing problems at O'Hara were the result of the deliberate management practices of the Individual Defendants is evidenced by similar problems in the Bergen Regional Care Center in New Jersey ("Bergen"). Bergen suffered from similar quality of care problems related to inadequate staffing after Solomon assumed management of that facility in 1998 under the personal supervision of Defendant Salazar.

60. Because O'Hara was systematically and routinely understaffed, it did not provide the services for which Defendants submitted claims to the Medicare and Medicaid programs. In numerous instances, the shortage of nurses meant that O'Hara failed to, among other things, feed patients, provide their medications, clean and change their wounds, change incontinent patients, who often were left for hours lying in urine and feces, and provide respiratory, physical and occupational therapy.

61. As a result of these failures, many O'Hara residents suffered the following:

a. Skin breakdowns and pressure sores (decubitus ulcers);

b. Dehydration;

c. Preventable contractures of limbs resulting in permanent loss of range of motion;

d. Pain, indignity and depression resulting from lying in feces and urine for prolonged periods of time;

e. Improper use of restraining devices;

f. Pain and depression resulting from being forced to stay in bed for prolonged periods;

g. Discomfort and depression from not being bathed regularly;

h. Inadequate oral hygiene;

i. Preventable infections and incidents of sepsis;

j. Complications and discomfort resulting from failure to properly administer medications;

k. Head and other injuries from falls;

l. Starvation; and

m. Death.

62. The neglect and inadequate care suffered by the residents was in violation of the standards that Defendants were required to meet, and was particularly extreme on the days when the nurse staffing fell below 5 hours PPD and/or on which O'Hara failed to have even one direct staff RN on duty at all times during a 24 hour period.

63. During 1997 and 1998, O'Hara's nursing staff, residents and their family members complained frequently to Defendants and to the Colorado Office of the Ombudsman about the lack of nursing care and the insufficient numbers of nursing staff to provide care at O'Hara.

64. In March, 1998, the Office of the Ombudsman conducted a review of care provided to O'Hara residents. The Office of Ombudsman advised O'Hara and Solomon staff in March 1998 that its review had confirmed complaints that residents were left for hours or large parts of the day and night to lie in their own feces and urine, that they were infrequently bathed, that they failed to receive regular oral care, that residents were forced to be inactive due to the lack of staff and resources, that residents at high risk of skin breakdowns were not turned to prevent the development of pressure sores, that numerous residents with ventilators and/or tracheostomy tubes did not have them cleaned, suctioned and changed as frequently as needed or as prescribed by their physicians, and that there was little or no infection control, resulting in multiple, preventable infections to residents.

65. Defendants' representatives met with the Ombudsman's Office in March 1998, and admitted that O'Hara had failed to provide adequate care. Defendant Solomon

acknowledged that "[p]rior to March 6, 1998, O'Hara was being staffed by the facility administrator and Director of Nursing at dangerously low levels . . . ." However, Defendants' employees represented to the office of the Ombudsman that Defendants would take action to remedy the short staffing and the quality of care problems caused by short staffing.

66. Following the meeting with the Ombudsman's Office, and despite Defendants' representations to the contrary, Defendants did not increase nurse staffing at O'Hara or attempt to meet the nursing needs of its residents. Instead, with the Individual Defendants' knowledge, staffing levels at O'Hara in late April 1998, were further reduced by eliminating 2 LPN and 3 CNA positions. In May, 1998, O'Hara reduced its staffing budget to 4.53 hours PPD.

67. By September 1998, the Colorado Office of the Ombudsman was receiving as many as 12 complaints per day from O'Hara residents and their families. The Ombudsman filed a complaint against O'Hara with the State Survey Agency, regarding the lack of nursing and other services provided to O'Hara residents.

68. The State Survey Agency conducts federally mandated on-site investigations and surveys of long-term care facilities to determine whether they are providing adequate care to residents and to determine whether a facility should continue to be certified to receive government funding.

69. In addition to the complaint from the Office of the Ombudsman, a registered nurse who worked at O'Hara submitted a complaint to the State Survey Agency in early November, 1998, stating that O'Hara was so under-staffed that is was not providing basic nursing services needed by the residents.

70. In November 1998, the State Survey Agency started a survey into the conditions at

O'Hara.

71. The Defendants' deceptive and misleading practices before and during the survey, prevented the State from discovering the full extent and causes for the deficient care at O'Hara.

Defendants Engaged in a Pattern and Practice of Falsification to Obscure the Problems at O'Hara

72. During the time period relevant to this complaint, the Defendants engaged in deceptive practices which included falsifying documents, acts intended to mislead the State Surveyors as to the true nature of O'Hara's operation, misrepresenting facts in plans of correction, and falsifying an insurance application for O'Hara [because insurance was a condition of licensure] so that O'Hara could continue to bill the Medicare and Medicaid programs.

73. Although Defendants authorized a budget for only 4.53 nursing hours PPD at the time of the November 1998 survey, O'Hara falsely represented in its nursing policy provided to the State Surveyors in November 1998 that it provided 24-hour RN coverage and that it provided a direct care nursing staff of over 6.0 PPD.

74. Immediately prior to and during the November 23, 1998 survey and subsequent surveys, the Defendants temporarily increased the nurse staffing at O'Hara and even had Defendant Solomon's corporate nurses, who were not part of O'Hara's nursing staff, perform and direct basic nursing services such as changing residents' diapers and incontinence pads and turning and repositioning residents to create the appearance that O'Hara was fully staffed.

75. The Individual Defendants knew that O'Hara consistently added substantial nursing staff when the Office of the Ombudsman or the State Agency Surveyors came on-site to conduct inspections or surveys. This was done to create a false impression of the level of nursing care at O'Hara. For example, residents received a dangerously low average of only 2.5 hours of

nursing care on Sunday March 8, 1998. On Monday through Friday, residents received an average of only 4.7 hours of nursing care per patient per day. However, on the following Saturday, when a visit from the Office of the Ombudsman was expected, the staffing dramatically increased to 5.85 hours of nursing care per patient. This is the equivalent of adding more than two additional nurses to each shift or an approximate staffing increase of 20% from the weekdays and a 60% increase in staffing from the previous weekend.

76. The November 1998 survey identified substandard care caused, in part, by insufficient nursing staff to provide necessary services. As a result of the survey findings, CMS determined that O'Hara was putting the health and safety of its residents in "immediate jeopardy" (the most severe level of harm) in four different areas, including (a) failure to provide sufficient numbers of nursing staff to provide necessary nursing services to its residents, (b) substandard infection control, (c) substandard incontinence care, including catheter care, and (d) substandard care of residents with ventilators and tracheostomies.

77. Even with the additional temporary staff, the State Surveyors personally witnessed numerous instances of resident neglect and inadequate nursing care. In several cases, the substandard care witnessed by the surveyors was so extreme that O'Hara was found to jeopardize the lives of several of its residents.

78. As permitted by the regulations, to avoid being cut off from Medicaid and Medicare payments, Defendants responded to the State Survey findings by submitting a Plan of Correction, in December 1998.

79. In the December 1998, Plan of Correction, O'Hara disputed many of the State Survey Agency findings. However, it also specified concrete steps that it would take to correct

the problems afflicting the residents. The Plan of Correction specifically provided for more nursing at higher skill levels. Subsequently, in their budget for O'Hara, Defendants budgeted for approximately 5.83 hours of nursing care PPD to meet the needs of the high acuity residents of O'Hara. 5.83 PPD is less that the 6 to 6.6 PPD O'Hara represented was needed in its internal staffing policy and less than the 6.32 PPD O'Hara had budgeted in its January 1997 budget.

80. Defendants represented in their December 1998 Plan of Correction that, to provide a higher nursing skill level in an effort to meet the needs of the patients, O'Hara would replace one LPN with an RN on each shift on the 2nd floor, where the most highest-need residents were housed. Defendants also represented that they would add one CNA to each shift on the 2nd floor.

81. Following the State Survey Agency's acceptance of O'Hara's Plan of Correction, and despite the representations Defendants made in the Plan of Correction, Defendants failed to hire additional RNs making it impossible for O'Hara to add an RN on each shift on the 2nd floor at O'Hara.

82. Defendants knew that O'Hara's December 1998 Plan of Correction falsely asserted that it had an RN on duty 24 hours a day when, in fact, prior to December 1998 there were hundreds of days when there was a substantial gap in RN coverage.

83. Even in the months following the November 23, 1998 survey, O'Hara frequently had no RN on the premises. Defendants failed to staff O'Hara with 24-hour RN coverage on over 85 days after the November 23, 1998 survey until it closed in December 2000. This staffing failure occurred despite Defendants' representation in the Plan of Correction to increase RN staffing to 3 RNs per shift.

84. Defendants knew that O'Hara's Plan of Correction falsely asserted, contrary to the findings of the State Surveyors, that it was adequately staffed on night shifts. The staffing documents supplied in support of this claim were falsified to support O'Hara's claim. This was done to mislead the State Survey Agency into believing there were more nurses on duty for night shifts than there actually were.

85. O'Hara falsely represented in the December 1998 Plan of Correction that "on an average daily basis from September 1998 through November 15, 1998, there were 11 nursing staff on the day shift, 9 nursing staff on the evening shift and 6.5 nursing staff on the night shift or the equivalent of 212 nursing hours per day." Defendants' staffing data for the period of time for September 1, 1998 to November 10, 1998 shows the actual average number of nursing hours to be approximately 183 hours. The difference is 29 nursing hours, which means that O'Hara falsely claimed more than 3.5 additional nurses as working each day.

86. The State accepted the December 1998 Plan of Correction, allowing O'Hara to continue billing the Medicare and Medicaid programs for care, goods and services it represented it had provided.

87. Despite the clear findings of harm to O'Hara residents in the November 1998 survey, Defendants, contrary to their own judgment that a minimum of 5.83 hours PPD was necessary to care for O'Hara's residents, staffed O'Hara at under 5 hours PPD on over 280 days between January 1, 1999 and December 18, 2000.

88. O'Hara submitted false quarterly staffing reports to the State Survey Agency for the weeks of January 16-22 and June 18-24, 2000. These reports grossly inflated the number of nurses on duty to give the appearance of a large nursing staff to care for the residents.

89. In November 2000, O'Hara was again found by the State Survey Agency to be providing inadequate nursing care which put its residents at risk for, among other things, pressure sores, contractures and loss of mobility (range of motion), infections, and failing to provide ordinary activities of daily living such as incontinence care, bathing, dental hygiene and assistance getting out of bed.

90. CMS terminated O'Hara's participation in the Medicare program effective December 11, 2000.

Defendants Knowingly Submitted or Caused to be Submitted False Claims to Medicare and Medicaid

91. Every two weeks Solomon collected data concerning the residents in O'Hara and then prepared electronic "UB-92" claims for each resident.

92. The claims for payment for each day of service for each resident were transmitted by Solomon on behalf of O'Hara to the State's Fiscal Agent for residents covered by the State Medicaid Program, and to the Contract Fiscal Intermediary for HHS for residents covered by the Medicare Program.

93. The claims were processed for payment, and then payment was made to O'Hara usually within one to two weeks for the claimed services.

94. Payments for Medicare residents were paid entirely from federal funds.

95. Payments for Medicaid residents and the Hospital Back Up resident came from both federal and State funds, each sharing approximately half of the costs.

96. Each of the Defendants knew that claims for services to each O'Hara resident were routinely submitted to Medicare and Medicaid every two weeks.

97. Defendants, from September 1, 1997 until late June, 2000, submitted electronic

UB-92 claims for payment and caused such claims for payment to be submitted to the federal and state governments for each Medicare and Medicaid resident at O'Hara for care, goods or services that were not provided, were inadequate or worthless, or which were provided at a time when Defendants' actions had forfeited their right to claim payment. Defendants O'Hara, ORCR, Krausz and Sebbag were also responsible for claims submitted after June, 2000, until O'Hara closed in December, 2000.

98. The Corporate Defendants had knowledge through their employees that these claims were fraudulent due to the failure to care for the residents.

99. The Individual Defendants, as managers and/or owners of the Corporate Defendants, knew that O'Hara was severely under-staffed.

100. The Individual Defendants knew that O'Hara's residents required high levels of nursing care.

101. The Individual Defendants, as managers and/or owners of the Corporate Defendants, knew of and were responsible for the financial and management decisions which caused the severe under-staffing at O'Hara.

102. Despite being instrumental in knowingly creating an environment at O'Hara which institutionalized gross failures of care to the residents leading to grievous harm, suffering and, in some cases, deaths of residents, and/or putting all the residents at risk of harm, the Individual Defendants knew that the Corporate Defendants they managed and/or owned continued to submit claims for payment to the Medicare and Medicaid Programs falsely claiming that appropriate care was being provided to the residents on each day of service claimed.

DEFENDANTS CAUSED FALSE CLAIMS TO BE SUBMITTED FOR A MEDICAID HOSPITAL BACK UP PATIENT

103. Despite O'Hara's inability to care for its residents, Defendant Krausz participated in a negotiated bid with the HCPF to provide HBU services for even higher acuity level Medicaid residents.

104. To secure a Medicaid daily payment rate of $525.51 (over two times the rate for a non-HBU resident, and over four times the amount generally paid for an ordinary nursing home resident) for one resident (identified as DR), Defendant Krausz falsely represented that O'Hara could provide hospital level, long term care services including 15.5 nursing hours per day. O'Hara's bid to provide HBU services included itemized costs of 2 RN hours at a cost of $46.80, 6.5 LPN hours at $105.62 and 7 CNA hours at $63.70 for a total cost of $216.12 for direct nursing staff for a single resident. O'Hara was paid a daily rate of $525.51 to provide services to this resident from July 1, 1993 through May 31, 1998.

105. Defendants neither budgeted for nor made any provision to ensure that the HBU resident actually received the 15.5 nursing hours PPD (2 RN hours, 6.50 LPN hours and 7 CNA hours) during the time period relevant to this complaint. Because of this, the HBU resident received the same substandard level of nursing care that the other residents received.

106. Defendant Salazar knew and approved a revised bid for HBU services for this resident on October 20, 1997, for a daily per diem rate of $507.65. The revised bid itemized daily nursing costs at $114.35, including 1 RN hour, 2.5 LPN hours and 4 CNA hours or a daily PPD of 7.5 nursing hours.

107. Defendant Salazar knew that O'Hara did not have sufficient nursing staff to provide 7.5 nursing hours PPD because Defendants did not separately budget for, or add

additional staff to provide these HBU nursing hours. No steps were ever taken to ensure the HBU resident received these services and, in fact, he did not at any time receive these extra services.

108. During the time period relevant to this complaint, when Defendants knew that O'Hara was consistently understaffing nursing services, Defendants submitted or caused UB-92 claims forms to be submitted twice-a-month for payment by the State Medicaid HBU program for hospital level services that were not provided to the HBU resident.

109. Based on information and belief, Defendants Solomon and Salazar terminated their management relationship with O'Hara in approximately June, 2000. For this reason Defendant Solomon's and Salazar's liability for the claims listed below is limited to the claims submitted to Medicare and Medicaid prior to the termination of their participation in O'Hara as managers in approximately June, 2000.

FIRST CLAIM FOR RELIEF
False Claims Act - 31 U.S.C. § 3729(a)(1)
(Presentation of False Claims to Medicare and Medicaid)
(As To All Defendants)

110. The United States re-alleges and incorporates by reference the allegations of paragraphs 1 through 109.

111. Defendants knowingly presented, or caused to be presented false or fraudulent UB-92 claim forms for reimbursement to the Medicaid and Medicare programs in violation of the False Claims Act for goods and services that they claimed to have provided but that they either did not provide, were worthless or substandard, or were provided in violation of statutory and regulatory requirements that have a nexus to payment under the Medicare and Medicaid programs on the days set forth in Exhibit A hereto.

112. Although some nursing care and/or nursing services were provided at O'Hara on the days listed in Exhibit A, such nursing care and/or nursing services were inadequate and/or worthless and/or failed to comply with Medicaid requirements for a Class V Nursing rehabilitation facility and Medicare requirements for a long-term care facility.

113. In response to Defendants' claims for payment, the Medicare and Medicaid programs made payments in excess of $5,000,000 to O'Hara for the days listed in Exhibit A.

114. All this was done in violation of 31 U.S.C. 3729(a)(1).

SECOND CLAIM FOR RELIEF
False Claims Act - 31 U.S.C. § 3729(a)(2)
(Use of a False Record for Payment)
(As To All Defendants)

115. The United States re-alleges and incorporates by reference the allegations of paragraphs 1 through 109.

116. Defendants knowingly made, used, or caused to be made or used, false records or statements to get the false or fraudulent claims for services for the days listed in Exhibit A paid or approved by the Medicare and Medicaid programs. Defendants or employees and/or agents of Defendants engaged in a practice of deception to hide the true state of care services at O'Hara from the State Survey Agency and the Medicaid and Medicare programs. Defendants' deception included providing false information concerning staffing levels at O'Hara, submission of false statements concerning staffing levels, and false statements in the plans of correction. Had the State Survey Agency been informed of O'Hara's true staffing levels as well as its inability to hire and retain a permanent staff, it could have acted to protect the residents from suffering further harm and to protect Medicaid and Medicare from paying sums not owed.

117. Defendants' knowing submission of claims resulted in the payment from

Medicare and Medicaid for the days listed in Exhibit A.

118. All this was done in violation of 31 U.S.C. § 3729(a)(2).

THIRD CLAIM FOR RELIEF
False Claims Act - 31 U.S.C. § 3729(a)(1)
(Presentation of False Claims to Medicaid for the Hospital Back-Up Program)
(As To All Defendants)

119. The United States re-alleges and incorporate by reference the allegations of paragraphs 1 through 109.

120. Between September 1, 1997 and June, 1999, Defendants knowingly presented, or caused to be presented false or fraudulent UB-92 claims for reimbursement to the State Medicaid program in violation of the False Claims Act for each day of substandard services which they provided to the Hospital Back-Up resident.

121. The State Medicaid program made payments in excess of $330,000 between September 1, 1997 and June, 1999, for services Defendants falsely claimed to provide to the Hospital Back-Up resident.

122. All this was done in violation of 31 U.S.C. 3729(a)(1).

FOURTH CLAIM FOR RELIEF
Payment By Mistake of Fact
(As To All Defendants)

123. The United States and the State of Colorado re-allege and incorporate by reference the allegations of paragraphs 1 through 109.

124. This is a claim for the recovery of monies paid to Defendants under mistake of fact.

125. The United States and Colorado paid for services for the O'Hara residents for the days listed in Exhibit A, and for all dates of services for the Hospital Back-Up resident, based on

the claims submitted by Defendants under the erroneous belief that the Defendants' claims for payments were based upon representations that were factually accurate and that represented reimbursable services.

126. This erroneous belief was material to the payments made by the United States and the State of Colorado to Defendants.

127. Because of these mistakes of fact, Defendants received monies to which they are not entitled.

128. By reason of the overpayments described above, the United States and the State of Colorado are entitled to damages in an amount to be determined at trial exclusive of interest and costs.

FIFTH CLAIM FOR RELIEF
Unjust Enrichment
(As To All Defendants)

129. The United States and the State of Colorado re-allege and incorporate by reference the allegations of paragraphs 1 through 109.

130. Defendants' conduct with respect to the services for the days listed in Exhibit A and for the services claimed for the Hospital Back-Up resident has unjustly enriched them with monies which in good conscience they should not be allowed to retain.

131. Defendants have been unjustly enriched to the detriment of the United States and the State of Colorado.

132. By reason of the overpayments described above, the United States and the State of Colorado are entitled to damages in an amount to be determined at trial exclusive of interest and costs.

SIXTH CLAIM FOR RELIEF
Common Law Fraud
(As To All Defendants)

133. The United States and the State of Colorado re-allege and incorporate by reference the allegations of paragraphs 1 through 109.

134. Between September 1, 1997 and December 31, 2000, Defendants prepared, certified, and submitted, or assisted in, caused, or permitted the submission of the false or fraudulent claims for the days listed in Exhibit A and for services to the Hospital Back-Up resident to the Medicare and Medicaid programs, which they knew were materially false, and submitted these false claims intending to induce Medicare and Medicaid to rely on them to pay for these claimed services.

135. The United States and the State of Colorado paid these false or fraudulent Medicare and Medicaid claims in reliance upon Defendants' representations and without knowledge of material facts which had been concealed by the Defendants.

136. By reason of these payments, the United States and the State of Colorado have been damaged in an amount to be established at trial, exclusive of interest and costs.

SEVENTH CLAIM FOR RELIEF
Restitution and Disgorgement of Illegal Profits,
For Imposition of a Constructive Trust and an Accounting
(As To All Defendants)

137. The United States and the State of Colorado re-allege and incorporate by reference the allegations of paragraphs 1 through 109.

138. This is a claim for restitution and disgorgement of profits earned by Defendants because of false or fraudulent claims for payment submitted or caused to be submitted by Defendants or their agents to the Medicare and Medicaid programs for services and goods which

were not rendered or that were inadequate or worthless or that were rendered in violation of applicable statutes, regulations, and guidelines with a nexus to payment.

139. The United States and the State of Colorado did not detect Defendants' conduct because of actions taken by the Defendants to conceal the true facts concerning the services provided to residents at O'Hara.

140. This Court has the equitable power to, among other things, order Defendants to disgorge the entire profits that each obtained from O'Hara generated as a result of their violations of the False Claims Act and common law.

EIGHTH CLAIM FOR RELIEF
Recoupment of Overpayments
(As to All Corporate Defendants)

141. The United States and the State of Colorado re-allege and incorporate by reference the allegations of paragraphs 1 through 109.

142. This is a claim for recoupment, for the recovery of monies unlawfully paid by the United States and the State of Colorado to O'Hara contrary to statute or regulation.

143. The United States and the State of Colorado paid O'Hara certain sums of money to which it was not entitled, and the corporate Defendants are thus liable under the law of recoupment to account for and to return such amounts, which are to be determined at trial.

NINTH CLAIM FOR RELIEF
Negligent Misrepresentation
(As to All Defendants)

144. The United States and the State of Colorado re-allege and incorporate by reference the allegations of paragraphs 1 through 109.

145. The Defendants negligently gave false information to the United States and to the

State of Colorado in the course of Defendants' business for their use in paying Medicare and Medicaid claims submitted by Defendants and with the intent and/or knowing that the United States and the State of Colorado would rely on the information. The United States' and the State of Colorado's reliance on the information supplied by the Defendants caused each of them damage.

WHEREFORE, the United States and the State of Colorado pray for relief as follows:

a. On the First, Second and Third claims for relief (False Claims Act), judgment against Defendants, jointly and severally, for statutory damages sustained by the United States in an amount to be determined at trial, plus civil penalties assessed against Defendants as are allowed by law, and post-judgment interest, costs, and other proper relief.

b. On the Fourth Claim for Relief (Payment by Mistake of Fact), Fifth Claim for Relief (Unjust Enrichment), Sixth Claim for Relief (Common Law Fraud), Seventh Claim for Relief (Restitution and Disgorgement of Illegal Profits, For Imposition of a Constructive Trust and an Accounting), Eighth Claim for Relief (Recoupment of Overpayments), and Ninth Claim for Relief (Negligent Misrepresentation) judgment against Defendants, jointly and severally, for the damages sustained by the United States and the State of Colorado in an amount to be determined at trial, plus pre-judgment and post-judgment interest, costs and other proper relief (including punitive damages under the Sixth Claim for Relief (Common Law Fraud)).

c. All other legal and equitable relief which the Court finds to be just and proper.

PLAINTIFFS DEMAND A TRIAL BY JURY.

Dated: October 4, 2005.

WILLIAM J. LEONE
United States Attorney

s/ Edwin Winstead
By: EDWIN G. WINSTEAD
Assistant United States Attorney

KEVIN TRASKOS
Assistant United States Attorney
1225 Seventeenth Street
Suite 700
Denver, Colorado 80202
Phone: (303) 454-0265
Fax: (303) 454-0407
Email: edwin.winstead@usdoj.gov
kevin.traskos@usdoj.gov

Attorneys for the United States

JOHN W. SUTHERS
Colorado Attorney General

s/ Robert Douglas

By: ROBERT DOUGLAS
First Assistant Attorney General
State Services Section
1525 Sherman Street, 5th Floor
Denver, Colorado 80203
Phone: (303) 866-5447
Fax: (303) 866-5671
Email: robert.douglas@state.co.us

Attorneys for the Department of Health Care Policy and Financing