UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF ILLINOIS
URBANA DIVISION

UNITED STATES OF AMERICA and the STATE OF ILLINOIS, *ex rel.* VANESSA ABSHER and LYNDA MITCHELL, Plaintiffs,	)	
v.	)	No. 2-04 C 2289
MOMENCE MEADOWS NURSING CENTER, INC., and JACOB GRAFF, individually, Defendants.	)	Hon. Harold A. Baker United States District Judge

UNITED STATES' STATEMENT OF INTEREST IN RESPONSE TO DEFENDANTS' MOTION FOR SUMMARY JUDGMENT

The United States of America (United States) respectfully submits this Statement of Interest, pursuant to 28 U.S.C. § 517, in response to Defendants' Motion and Memorandum for Summary Judgment (Defs. Mem. Summ. J.), filed June 1, 2012 (d/e 344). Defendants urge the Court to adopt mistaken interpretations of the False Claims Act (FCA), 31 U.S.C. §§ 3729 *et seq*., contrary to the statute and case law. The United States takes no position on the merits of these particular relators' claims or on whether they have demonstrated a genuine issue of material fact sufficient to survive summary judgment. However, we urge the Court not to adopt Defendants' erroneous interpretations of the law if it does grant their summary judgment motion.

The United States has a significant interest in FCA case law, even when generated in a *qui tam* case such as this, where the government has declined to intervene. The United States brings most of the successful cases under the Act. FCA case law, whether generated in a declined or intervened case, has an impact on matters initiated by the United States and *qui tam*

cases in which the United States intervenes. Moreover, even in cases it declines, the United States remains a real party in interest. 31 U.S.C. § 3730 (c) (2) (D) (3). In the event Relators prevail in this case, the United States is entitled to receive up to 75% of the judgment against the Defendants. 31 U.S.C. § 3730(d) (2).

BACKGROUND

This *qui tam* action against Momence Meadows Nursing Center, Inc., and Jacob Graff (collectively, Momence) was initiated by Vanessa Absher and Lynda Mitchell (Relators), former employees at Momence, pursuant to section 3730 of the FCA. On May 10, 2006, the United States and the State of Illinois declined to intervene in the case.[1] On May 22, 2006, this Court lifted the seal on the Complaint and directed Relators to serve their Complaint upon Defendants. In their Sixth Amended Complaint, Relators allege that Momence failed to provide residents with necessary medical care (Sixth Am. Compl. ¶ 2, d/e 145), billed the government for worthless services (Sixth Am. Compl. ¶¶ 4, 17, 19, d/e 145), and billed for services that did not meet those statutory and regulatory standards that are conditions material to payment (Sixth Am. Compl. ¶ 63, d/e 145).

Defendants have raised the following arguments in their Memorandum of Law in Support of Summary Judgment (Defs. Mem. Summ. J.):

1. Relators' worthless services claims fail as a matter of law and fact.
2. Relators' false certification claims fail as a matter of law and fact.
3. Section 3730(e) (3) of the FCA precludes Relators from bringing claims based on facts that were the subject of civil monetary penalties previously imposed on Momence.

[1] A decision to decline intervention should not be construed as a statement about the merits of the case. Indeed, the Government retains the right to intervene at a later date upon a showing of good cause. 31 U.S.C. § 3730(c) (3).

4. Relators' disclosures were not voluntary within the meaning of Section 3730(e) (4) (B) of the FCA.

5. Relators cannot satisfy the elements of their state and federal retaliatory discharge claims.

Defs. Mem. Summ. J. (d/e 344).

The United States primarily addresses Defendants' overreaching and troubling arguments that Relators' worthless services and false certification claims fail as a matter of law.[2] Relators allege that Defendants knowingly billed for worthless services and that they falsely certified compliance with the statutes and regulations that are conditions material to government payment. Billing for worthless services is one of several ways a claim can be false within the meaning of the FCA. Worthless services cases stand for the proposition that one may not knowingly bill the government for goods and services where *"the service is so substandard as to be tantamount to no service at all*." *In re: Genesis Health* Ventures, 112 F. App'x 140, 143 (3rd Cir. 2004) (emphasis added). Ignoring this precedent, Defendants attempt to undermine the soundness of the long line of cases that have upheld the validity of the worthless services theory in precisely the context alleged by Relators. *See* discussion *infra,* Part A.

A claim may also be false simply because it demands payment, and in so doing "certifies" compliance with conditions material to payment with which it does not comply.[3] Defendants try to attach significance to distinctions between express and implied certifications,

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[2] The United States also addresses Defendants' argument that Relators' disclosures were not voluntary within the meaning of Section 3730(e) (4) (B) of the FCA. *See* Part E *infra.*

[3] The certification may be express, on the face of the claim form itself, or implied by the act of submitting the claim. *See United States ex rel. Augustine v. Century Health*, 289 F.3d 409, 414-15 (6th Cir. 2002); *United States ex rel. Shaw v. AAA Eng'g & Drafting, Inc.*, 213 F.3d 519, 531-33 (10th Cir. 2000); *United States ex rel. Quinn v. Omnicare Inc.*, 382 F.3d 432, 442 (3d Cir. 2004); *United States ex rel. Mikes v. Strauss*, 274 F.3d 687, 697 (2d Cir. 2001); *United States ex rel. Siewick v. Jamieson Science & Eng'g*, 214 F.3d 1372, 1376 (D.C. Cir. 2000); *Ab-Tech Construction, Inc. v. United States*, 57 F.3d 1084 (Fed. Cir. 1995).

attacking the language of the express certifications at issue and challenging the validity of the implied certification theory. In so doing, Defendants obscure the real issue at stake. Whether a claim is false does not depend on what category a certification may fall in or how it is worded. *United States ex rel. Hutcheson v. Blackstone Medical, Inc.,* 647 F.3d 377, 385-86 (1st Cir. 2011). A claim is false if a defendant seeks money it is not entitled to because it has violated a condition material to payment. If the defendant falsely certifies compliance with that condition, the false statement makes the defendant's conduct all the worse; however, the existence of a "properly worded" false certification is not a prerequisite to FCA liability.

In attempting to support their attacks on Relators' FCA claims, Defendants have made several arguments that have no relevance or validity with respect to the essential elements needed to establish FCA liability. With respect to those erroneous arguments, the United States will establish the following:

1. The worthless services theory has been upheld by every court that has addressed the issue, including this Court in its Order denying Defendants' Motion to Dismiss, slip op. at 3, n. 3 (d/e 195). *See* Part A *infra.*

2. The provision of materially substandard services can form the basis for a worthless services claim. *See* Part A *infra.*

3. Proof of a worthless services claim does not require proof that no services at all were provided; the essence of a worthless services claim is that some services were provided but at so substandard a level as to be essentially worthless. *See* Part A *infra.*

4. With or without any certification of compliance, express or implied, if Relators can establish that Defendants, in providing the services at issue, violated conditions material to payment within the meaning of the FCA, statutory, regulatory, or otherwise, the claims are false.

See Part B *infra.*

5. While not all the conditions of participation in the Medicare and Medicaid programs are material to payment, the essential parts of what the government bargained for in agreeing to reimburse nursing facilities can constitute conditions material to payment for purposes of establishing FCA liability. *See* Part B.1 *infra.*

6. The language of the certifications in the Medicare application forms and annual cost reports relied upon by Relators can provide the basis for FCA liability. *See* Part B.2.a *infra.*

7. These certifications of compliance did not need to be knowingly false when signed since they imposed a continuing duty to comply. *See* Part B.2.b *infra.*

8. Defendants cannot avoid FCA liability on public policy grounds. *See* Part C *infra.*

9. The existence of the nursing facility survey process administered by the Centers for Medicare and Medicaid Services (CMS) and its administrative findings do not preclude FCA liability. *See* Part D *infra.*

10. Relators' disclosures can still be "voluntary" within the meaning of Section 3730(e) (4) (B) of the FCA, regardless of any state law duty to report resident abuse to the state. *See* Part E *infra.*

ARGUMENT

A. Defendants' Arguments Regarding the Legal Standards Applicable to Worthless Services Claims Are Wrong.

Defendants make several erroneous arguments in their attempt to challenge Relators' worthless services claims. They wrongly argue that the provision of substandard services cannot give rise to FCA liability under the worthless services theory. They wrongly argue that proof of a worthless services claim requires proof that no services at all were provided. And they ignore

or wrongly interpret the long line of court decisions that have held to the contrary.

It is well-settled that billing the United States for a product or service that is of no value, if done with the requisite *scienter*, violates the FCA. *See United States v. Bornstein*, 423 U.S. 303 (1976); *United States ex rel. Lee v. Smithkline Beecham, Inc*., 245 F.3d 1048, 1053 (9th Cir. 2001). Courts consistently have upheld FCA liability for billing for deficient products and services in many contexts. *See United States v. McNinch*, 356 U.S. 595, 599 (1958); *United States ex rel. Hopper v. Anton*, 91 F.3d 1261, 1266 (9th Cir. 1996).

There is no question that health care providers, including nursing facilities, that knowingly[4] make claims for payment for worthless services may be liable to the United States under the FCA. *See, e.g., United States ex rel. Mikes v. Strauss*, 274 F.3d 687, 703 (2d Cir. 2001) ("[a] worthless services claim asserts that the knowing request for federal reimbursement for a procedure with no medical value violates the Act irrespective of any certification."); *United States v. Cathedral Rock Corp*., No. 03-1090, 2007 WL 4270784, at *6 (E.D. Mo. Nov. 30, 2007) ("In a worthless services claim, the performance of the service is so deficient that for all practical purposes it is the equivalent of no performance at all."); *United States v. Villaspring Health Care Center*, 2011 WL 6337455, at *4 (E.D. Ky. Dec. 19, 2011) (agreeing with C*athedral Rock*).

The determination of what constitutes worthless services often is highly fact-specific and must be made on a case-by-case basis. *Villaspring*, 2011 WL 6337455, at *5. In assessing whether the government received any value for the services for which it paid, a court should examine, among other factors, the purpose of the service, how the service was performed, and

[4] The definition of "knowing" under the FCA is not limited to actual knowledge; it also encompasses recklessness or deliberate indifference. *Lee*, 245 F.3d at 1053 ("In an appropriate case, knowingly billing for worthless services or recklessly doing so with deliberate ignorance may be actionable under § 3729. . . .").

how it was billed (whether as a stand-alone service or as part of a larger bundle of services). *Id.* The fact-specific nature of the inquiry often makes it difficult to rule on the merits of a worthless services case as a matter of law. *See United States v. NHC Healthcare Corp.*, 163 F. Supp. 2d 1051, 1056-1057 (W.D. Mo. 2001).

As this Court and others have recognized, the provision of materially substandard services can form the basis for FCA liability. *See* Order denying Defendants' Motion to Dismiss, slip op. at 4 (d/e 195). In *In re: Genesis Health Ventures,* the Third Circuit held that "[c]ase law in the area of 'worthless services' under the FCA addresses instances where *either* services literally are not provided *or the service is so substandard as to be tantamount to no service at all*." 112 F. App'x at 143 (emphasis added). Similarly, in *United States v. Houser*, Crim. Case 4:10-cr-00012-HLM-WEJ (N.D. Ga. April 2, 2012), slip op. attached as Exhibit A, the court recently applied the worthless services theory to find the defendant nursing home operator guilty of criminal health care fraud. In so ruling, the court made the following conclusion of law:

> A worthless services claim stands for the unexceptional proposition that an entity may not bill the Government for products or services that are not rendered, or that are so deficient that they have no value to the resident, or are totally undesirable. Worthless services are services that are so inadequate, deficient, and *substandard*, or so completely lacking in value or of no utility to the resident, that a reasonable person would understand that any services provided were worthless.

Houser, Exhibit A, slip op. at 429- 430 (emphasis added).

Courts also have readily recognized that worthless services claims under the FCA are not, as a legal matter, limited to instances where no services were provided. A service can be worthless because of its deficient nature even if the service was provided. In *Mikes*, the Second

Circuit explained that "[i]n a worthless services claim, *the performance of the service* is so deficient that for all practical purposes it is the equivalent of no performance at all." 274 F.3d at 703 (emphasis added). *See also In re: Genesis Health Ventures,* 112 F. App'x at 143.

Defendants cite *United States ex rel. Swan v. Covenant Care*, 279 F. Supp. 2d 1212 (E.D. Cal. 2002), in an apparent attempt to argue that FCA liability under the worthless services theory requires proof of no services at all. Defs. Mem. S.J. at 4-5 (d/e 344). In *Swan*, a declined *qui tam* in which the court granted the defendant's motion for summary judgment, the relator alleged the defendant billed for worthless services and violated applicable regulations.[5] 279 F. Supp. 2d at 1215. The court held that it lacked subject matter jurisdiction because the allegations had been publicly disclosed and the relator was not the original source. *See id.* at 1220. The court then stated, in *dicta,* that the relator had failed to state a claim under Fed. R. Civ. P. 12(b)(6) because she did not allege that the defendant's neglect of the resident was so severe as to be the equivalent of providing no services at all. *See id.* at 1221.

Swan did not hold that there can never be a worthless services case so long as a nursing facility provides some incidental service, such as a roof over the resident's head; indeed such a rule would be absurd. The Medicare program reimburses nursing facilities to provide skilled nursing services and therapy. These services must be provided on an in-patient basis; thus the government also pays for the other charges incidental to the nursing and therapy services, including room and board. *See* 42 U.S.C. § 1395x(h). The notion that a nursing facility can fail to provide the skilled services it is being paid for, and escape FCA liability as long as it provides incidental room and board, turns the very purpose of the Medicare benefit on its head. When

[5] Notably, the relator in *Swan* did not allege any nexus at all between the statutes and regulations violated by the defendants and government payment. *See Swan*, 279 F. Supp. 2d at 1215.

measuring the value of the services provided in the Medicare program, a court must look to the essential services at the heart of the bundle: the skilled nursing services and therapy. If those services are not provided, or provided so poorly as to be worthless, the provider is not entitled to payment, even for incidental services.[6]

The court in *Houser* applied this same reasoning to hold as follows:

> Defendant's contention that he is not guilty because the nursing homes may have provided some care or some portion of the bundle of services paid by Medicare and Georgia Medicaid is without merit. Even though the services were paid per diem, reasonable persons would know that supplying limited, or no, basic services fails to comport with the very essence of the provider and benefit agreements, and that seeking reimbursement for such deficient services constitutes fraud.

Exhibit A, slip op. at 433-434.

B. Defendants' False Certification Arguments Are Wrong and Serve Only to Obscure the Real Issue with Respect to Falsity.

Separate and distinct from their worthless services claim, Relators allege FCA liability based upon Defendants' submission of false certifications falsely certifying compliance with specific regulatory "requirements for long term care facilities" set forth in 42 C.F.R. §§ 483.1 *et seq.* *See* Sixth Am. Compl., pp. 14-15 (d/e 145).

Defendants rely on distinctions between express and implied certifications in an attempt to challenge Relators' false certification claims; they attack the language of the express certifications at issue, and they question the validity of the implied certification theory. In so doing, Defendants obscure the real issue at stake. Whether a claim is false does not depend on

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[6] Of course, if the facility fails to provide certain incidental services, the skilled nursing services may be worthless. For example, to take a seemingly extreme but all too frequent occurrence, if a facility fails to help feed a resident who needs help with eating, skilled nursing care will be of little value to this resident, who may ultimately get sick or die due to weight loss, malnutrition, or starvation.

what category a certification may fall in or how it is worded. *Blackstone,* 647 F.3d at 385-86. The real issue in determining the falsity of a claim is whether the defendant seeks money to which it is not entitled.

In *Blackstone*, the First Circuit refused to employ such "judicially created formal categories," noting that they can "create artificial barriers that obscure and distort" the analysis of "how different behaviors can give rise to a false or fraudulent claim." 347 F.3d at 385. The Court of Appeals emphasized that "[t]he text of the FCA does not refer to … 'express certification' or 'implied certification.' Indeed, it does not refer to 'certification' at all." 347 F. 3d at 385-386, *citing United States ex rel. Hendow v. Univ. of Phoenix*, 461 F.3d 1166, 1172 (9th Cir. 2006) (refusing to give the term "certification" a "paramount and talismanic significance" in part because it does not appear in the text of the FCA). The Court of Appeals in *Blackstone* recognized that any concern about overextending FCA liability "does not call for 'adopting a circumscribed view of what it means for a claim to be false or fraudulent,' but rather calls for 'strict enforcement of the Act's materiality and *scienter* requirements.'" 647 F.3d at 387 – 388, *citing United States v. Sci. Applications Int'l Corp. (SAIC)*, 626 F. 3d 1252, 1269 (D.C. Cir. 2010).

When payment is conditioned upon certain requirements, and the defendant fails to meet those requirements, the government does not get what it bargained for, and claims for payment are false even where the defendant makes no certifications of compliance with applicable requirements. *See, e.g., Scolnick v. United States*, 331 F.2d 598, 599 (1st Cir. 1964); *United States v. McLeod*, 721 F.2d 282, 284 (9th Cir. 1983). If the defendant makes such false certifications, they provide further evidence of the defendant's wrongful conduct. However, the absence of a "properly worded" certification does not preclude FCA liability. *Mikes,* 274 F.2d at

703. Accordingly, if Relators can establish that Defendants, in providing the services at issue, violated statutes, regulations, or contractual provisions that were material to payment, the claims for those services are false even in the absence of and regardless of the language in any certification of compliance.

Thus, the Court should not adopt Defendants' faulty premise that their FCA liability depends on whether their actions can be shoe-horned into an express or implied certification theory of liability. Nevertheless, Defendants make significant errors in their attempt to deny liability under the false certification theory, and the United States seeks to correct those errors to ensure the proper application of the law.

1. The Applicable Regulations Create Conditions Material to Payment that Can Form the Basis for FCA Liability.

In arguing that Relators' false certification claims fail, Defendants begin by making certain erroneous statements about the statute and regulations at issue. One such error lies in Defendants' contention that "while hospitals and other types of long-term care facilities have conditions of participation, there are none for *skilled nursing facilities* such as Momence." Defs. Mem. Summ. J. at 14 (emphasis in original) (d/e 344). Yet the very regulations cited by Defendants to support their contention state precisely the contrary. Those regulations, found in 42 C.F.R. Part 483, repeatedly refer to their provisions as "requirements" for "participating" in Medicare and Medicaid. Section 483 Subpart B, entitled "Requirements for Long Term Care Facilities," states, in relevant part, as follows:

> § 483.1 Basis and scope.
> (a) *Statutory basis.* (1) Sections 1819 (a), (b), (c), and (d) of the Act provide that—
> (i) Skilled nursing facilities participating in Medicare must meet certain specified requirements; and . . .
> (3) Sections 1919 (a), (b), (c), and (d) of the Act provide that *nursing facilities participating in Medicaid must meet certain specific requirements*.

> (b) *Scope*. The provisions of this part contain the *requirements that an institution must meet in order to qualify to participate as a SNF in the Medicare program and as a nursing facility in the Medicaid program*. They serve as the basis for survey activities for the purpose of determining whether a facility meets the requirements for participation in Medicare and Medicaid.

42 C.F.R. § 483 Subpart B (emphasis added). The regulations at issue in the present case are among Part 483's "requirements that an institution must meet in order to qualify to participate" in the Medicare and Medicaid programs. *See* 42 C.F.R. §§ 483.13 - 483.70. Whether these are properly labeled conditions of participation is not significant however. *See Hendow*, 461 F.3d 1166, 1176 (rejecting the defendant's argument that a term in a program participation agreement "is merely a condition of *participation*, not a condition of *payment*," reasoning that "in this case, that is a distinction without a difference") (emphasis in original).

Far more troubling is Defendants' contention that nursing facilities have carte blanche to violate these regulations without fear of FCA liability. The regulations relied on by Relators set forth requirements with respect to such essential matters as abuse, restraint, care, nursing and physician services, rehabilitative services, infection control, nutrition, and medication. *See* 42 C.F.R. §§ 483.13 - 483.70. Regardless of whether they are labeled conditions of participation or statutory and regulatory requirements, these provisions are material to payment and their violation can therefore give rise to FCA liability.

Defendants are correct that not all regulatory infractions give rise to FCA liability. However, sections (b), (c), and (d) of the Nursing Home Reform Act (NHRA) and their regulations contain essential provisions that lie at the heart of the bargain between the government and nursing facilities. *See* 42 U.S.C. § 1395i-3(b), (c), and (d); 42 C.F.R. §§ 483.13 - 483.70. It cannot be true, as Defendants suggest, that nursing facilities can pay no need whatsoever to these regulations and still be immune from FCA liability. For example, section

483.25 of the regulations demands that nursing facilities provide basic treatment to prevent bedsores (§ 483.25 (c) (2)); to prevent falls and other accidents (§ 483.25 (h) (2)); to maintain proper nutrition and hydration (§ 483.25 (j)); and to prevent medication errors and over-medication of residents (§ 483.25 (l) (1) and (m) (2)).

Clearly these are the types of requirements that go to the essence of what the government expects a nursing facility to provide in return for reimbursement under the Medicare and Medicaid programs; a provider's failure to meet those requirements violates conditions material to payment that could subject the provider to FCA liability. *See United States ex rel. Aranda v. Comm. Psych. Ctrs. of Okla., Inc.*, 945 F. Supp. at 1488; *Villaspring*, 2011 WL 6337455, at *7-8.[7]

The NHRA explicitly recognizes that violation of these requirements could affect the government's decision to pay a nursing facility. If a facility fails to comply with these particular requirements, the statute expressly authorizes the Secretary of Health and Human Services (HHS) to deny further payments to the facility:

> The Secretary may take the following actions with respect to a finding that a facility has not met an applicable requirement:
>
> (i) Denial of payment -
> The Secretary *may deny any further payments* under this subchapter with respect to all individuals entitled to benefits under this subchapter in the facility or with respect to such individuals admitted to the facility after the effective date of the finding. [8]

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[7] The court in *Villaspring*, while noting that not all conditions of participation are conditions material to payment, also made clear that FCA liability can be based only on those violations that "had they been disclosed, would have been material to CMS's decision to pay". *Id.,* slip op. at 6.

[8] The fact that this provision does not require the Secretary to deny payment does not prevent the relevant statutory and regulatory provisions from being conditions material to payment for FCA liability purposes. It is sufficient if violation of the condition would materially affect the decision to pay the provider. The definition of "material" under the FCA is "having a natural tendency to influence, or be capable of influencing, the payment or receipt of

42 U.S.C. § 1395i-3(h) (2) (B) (I) (emphasis added).

The statute further provides that if a facility remains out of compliance with any of these conditions of participation within three months after having been found to be out of compliance, the Secretary *must* deny payment for new patients. *See* 42 U.S.C. § 1395i-3(h) (2) (D) (emphasis added). Therefore, sections 1395i-3(b), (c), and (d) of the statute and their corresponding regulations are unquestionably conditions material to payment that may render a claim false, and therefore support an FCA claim, assuming the other elements of the FCA are established. The United States does not contend that every violation of one of these essential provisions of the NHRA would *per se* render it false for FCA purposes. Nor does the United States take a position on whether Relators have proven that false claims were submitted here. Rather, we urge the Court not adopt Defendants' extraordinary argument that, no matter the nature, scope or frequency of a facility's disregard of these provisions, such conduct can never give rise to a violation of the FCA.

2. Certifications in Annual Cost Reports and Medicare Application Forms Further Support an FCA Claim.

Defendants erroneously contend that Relators' express certification claims fail because the language of the certifications contained in the Medicare application forms and annual cost

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money or property." 31 U.S.C. § 3729 (b) (4). In *United States v. Rogan*, 517 F.3d 449, 452 (7th Cir. 2008), the Seventh Circuit flatly rejected a defendant's argument that he was not liable under the FCA for submitting false statements in a cost report because the United States did not offer evidence from "a federal employee in a position to make a decision … that the government was sure to enforce the statute. That's not a component of materiality." 517 F.3d at 452. Momence makes this same faulty argument. *See* Defs. Mem. Summ. J. at 2, 9. (d/e 344).

Quoting the FCA definition of "material" falsity, the Court of Appeals in *Rogan* explained that "a statement or omission is 'capable of influencing' a decision even if those who make the decision are negligent and fail to appreciate the statement's significance." *Id. See also United States ex rel. Bahrani v. Conagra, Inc.,* 465 F.3d 1189, 1204 (10th Cir. 2006) ("[I]n determining whether a false statement is material under § 3729 (a) (7), the inquiry focuses on the potential effect of the false statement when it is made, not on the actual effect of the false statement when discovered." (*quoting, United States ex rel. A+ Homecare, Inc. v. Medshares Mgmt. Group, Inc.*, 400 F.3d 428, 442 (6th Cir. 2004)). *Accord United States v. Bourseau*, 531 F.3d 1159, 1171 (9th Cir. 2008).

reports at issue "do not provide a valid basis for FCA claims." Defs. Mem. Summ. J. at 10, 12 (d/e 344). As discussed above, the real issue in determining FCA liability is not the particular format or language or specificity of a certification, but whether the defendants were in compliance with Medicare conditions material to payment when in fact they were not. Where, as Relators allege, a defendant submits claims in contravention of a condition material to payment, its express certifications of compliance provide an added basis for liability. Section 3729 (a) (1) (B) of the FCA specifically imposes separate liability on one who knowingly makes false statements material to a false claim. 31 U.S.C. § 3729 (a) (1) (B). Certifications such as those at issue in this case provide additional support for the argument that compliance with a statute or regulation was material to payment and additional evidence that the defendant acted with the requisite *scienter*. The Seventh Circuit has recognized that FCA liability can be based on some of the very same certifications at issue in this case. *See, e.g., Rogan*, 517 F.3d 449 (affirming a health care provider's FCA liability for making false statements in a cost report).

a. The Language of the Certifications Provide a Valid Basis for Relators' FCA Claim.

Ignoring the legal framework within which the validity of a false certification claim must be assessed, Defendants instead question the language of each certification form at issue. The language of the certifications in these forms does indeed support Relators' FCA claims. The three certifications are Momence's Health Insurance Benefit Agreement Form, its Provider Agreement, and its annual cost reports. All three forms use similar certification language to make clear that continuing compliance with the specific nursing facility statutes and regulations at issue in this case is a pre-requisite to payment. Form CMS-855A is the Provider Agreement signed by all nursing facilities in order to establish eligibility to receive reimbursement from

Medicare. Form CMS-855A contains the following certification:

> I understand that *payment of a claim by Medicare* is conditioned upon the claim and the underlying transaction *complying with such laws, regulations, and program instructions* (including, but not limited to, the Federal anti-kickback statute and the Stark law), and on the provider's *compliance with all applicable conditions of participation* in Medicare.

CMS-855A at 37, ¶ 3 (emphasis added).

In order to receive Medicare and Medicaid payments, a nursing facility must also sign a Health Insurance Benefit Agreement, Form CMS-1561. 42 U.S.C. § 1395cc. The Agreement contains the following certification:

> *In order to receive payment* under title XVIII of the Social Security Act [42 U.S.C. § 1395cc], [Name of the nursing home inserted here], as the provider of services, agrees to conform to the provisions of section of [sic] 1866 of the Social Security Act *and applicable provisions in 42 C.F.R.*

Form CMS-1561 (emphasis added).

All Medicare providers also must submit cost reports annually. Cost reports contain the following certification provision:

> I further certify that I am familiar with *the laws and regulations regarding the provision of health care services,* and that the *services identified in this cost report were provided in compliance with such laws and regulations*.

(emphasis added).

Thus the certifications in all three forms condition Medicare or Medicaid payment upon compliance with the specific laws and regulations applicable to nursing facilities. These are the very provisions at issue in this case. As discussed *supra*, several of these conditions of participation – those governing abuse, restraint, comprehensive assessments, quality of care, nursing services, physician services, rehabilitative services, infection control, dietary services,

and pharmacy services– are such essential elements of what the Government bargained for that they can also constitute conditions material to payment within the meaning of the FCA. *See* 42 U.S.C. §§ 1395i-3(b), (c), and (d), and 42 C.F.R. §§ 483.13 - 483.70.

In *Houser,* the court examined the same certifications at issue in this case and reached the following conclusion of law:

> The agreements that Defendant and Washington entered into with the Government to participate in the Medicare and Georgia Medicaid programs explicitly conditioned payment on Defendant's compliance with all applicable laws and regulations.

Houser, Exhibit A, slip op. at 432.

Defendants argue that the certification accompanying cost reports cannot provide a basis for FCA liability "because there is no basis by which to link annual cost reports with a particular request for payment and because the certification does not require regulatory perfection." Defs. Mem. Summ. J. at 11 (d/e 344). To the contrary, the Seventh Circuit and numerous other courts have held that a cost report can provide the basis for FCA liability if the certification on the cost report was executed, and the claims submitted were not correct in accordance with the certification language. *See, e.g., Rogan*, 517 F.3d 449; *Mason v. Medline Industries, Inc.*, 731 F. Supp.2d 730, 739 (N.D. Ill. 2010); *United States ex rel. Thompson v. Columbia/HCA Healthcare Corp.*, 20 F. Supp.2d 1017, 1049 (S.D. Tex. 1998). *Compare United States ex rel. Augustine v. Century Health Services Inc*., 289 F.3d 409, 415 (6th Cir. 2002) (upholding district court's finding that cost reports can establish falsity for purposes of a FCA claim because defendants did not file amended cost reports after failing to comply with Medicare regulations governing reimbursement).

Defendants rely heavily on *United States ex rel. Connor v. Salina Reg'l Health Ctr., Inc.,* 543 F.3d 1211, 1217 (10th Cir. 2008), to support their cost report certification contentions. In

Connor, a declined *qui tam*, a relator sued a hospital under the FCA, alleging various violations of the Medicare statutes and regulations. The relator further alleged that the hospital had submitted an annual cost report certifying compliance with the laws and regulations regarding the provision of health care services. *Id*. at 1219. The relator alleged that "this certification, standing alone, explicitly conditions Medicare payments on compliance with *all* applicable Medicare statutes and regulations." *Id*. at 1218. (emphasis in original). Hence, according to the relator, all claims for reimbursement were false because the hospital had failed to comply with all Medicare statutes and regulations. *Id.* The court rejected the relator's argument, stating that "the FCA cannot support such expansive liability in the absence of an underlying statute or regulation that conditions payment on compliance with the certification." *Id*. at 1219. In *Connor*, it was the relator's attempt to "condition the government's payment on perfect compliance with all underlying statutes and regulations" that offended the court. 543 F.3d at 1222. However, the court made clear that FCA liability can attach if the statutory or regulatory violation is material to the government's decision to pay. As the Tenth Circuit explained, "some regulations or statutes may be so integral to the government's payment decision as to make any divide between conditions of participation and conditions of payment a 'distinction without a difference.'" *Connor*, 543 F.3d at 1222 (*quoting Hendow*, 461 F.3d at 1177). The court in *Connor* noted that the relator was unable to point to any such regulations or statutes and instead tried to "condition the government's payment on perfect compliance with all underlying statues and regulations." *Connor*, 543 F.3d at 1219.

In contrast to *Connor*, Relators in the present case can point to several specific regulations set forth in 42 C.F.R. § 483.1 *et seq.* that are so fundamental as to constitute conditions material to payment with the meaning of the FCA. *See, e.g.*, Sixth Am. Compl., ¶ 44

(d/e 145). *See also* discussion *supra* at 13 - 15. Thus, unlike *Connor*, FCA liability in the present case is based on specific regulations whose "violations, had they been disclosed, would have been material to CMS's decision to pay. Therefore perfect compliance is not required" or sought in the present case. *Villaspring,* 2011 WL 6337455, *at 8 (citation omitted).

b. The Certifications at Issue Need Not be Knowingly False at the Time They were Made because Defendants had a Continuing Duty to Comply.

Defendants contend that the provider agreement, Form CMS-855A, cannot form the basis for an FCA claim unless the relator alleges that the defendants signed it knowing they would later commit violations. To the contrary, the claim need not "be expressly false at the time it was submitted" in order for liability to attach under the False Claims Act. *Augustine,* 289 F. 3d at 415. FCA "liability can attach if the claimant violates its continuing duty to comply with the regulations on which payment is conditioned." *Id.*

CMS regulations and guidelines make clear that nursing facilities must remain in continual compliance with the applicable provisions of Title 42 of the Code of Federal Regulations. *See* 42 C.F.R. §§ 483.1 *et seq.,* and §§ 488.300 *et seq.* The *CMS State Operations Manual Chapter 7 - Survey and Enforcement Process for Skilled Nursing Facilities and Nursing Facilities* states:

> The regulation emphasizes the need for continued, rather than cyclical compliance. The enforcement process mandates that policies and procedures be established to remedy deficient practices and to ensure that correction is lasting; specifically, that facilities take the initiative and responsibility for *continuously* monitoring their own performance to sustain compliance.

Id., § 7000, http://www.cms.gov/manuals/downloads/som107c07.pdf (emphasis added).

Thus, compliance with the regulations, including those in Part 483 Subpart B, is required beyond the date the nursing facility signed Forms CMS-855A and CMS-1561. Each time a

provider submits a bill for payment to the Medicare program, it is recertifying compliance with all laws and regulations, including the provisions of Part 483 Subpart B at issue in this case. Therefore FCA liability can attach after the signing of Forms CMS-1561 and CMS-855A, if the nursing facility violates its continuing duty to comply.[9]

C. Public Policy Arguments Cannot Shield Defendants From FCA Liability That Would Neither Usurp CMS Regulatory Discretion Nor Undermine Public Policy.

Defendants incorrectly contend that imposing FCA liability would "usurp the discretion afforded the regulatory agencies" and "violate public policy." Defs. Mem. Summ. J. at 15-18 (d/e 344). Defendants ignore the public policy codified in the FCA, where Congress sought to safeguard public funds by providing remedies for false claims to the government and vesting private citizens with the power to seek those remedies on behalf of the United States, even where the United States declines to pursue the suit. They ignore the public policy evidenced in the NHRA and numerous certification forms, where Congress and the Executive Branch rightfully attempted to tell would-be Medicare providers what kind of care the United States would pay for and what kind of care it would not.

Defendants' arguments are based on the false characterization of this FCA action as a "vehicle for ensuring regulatory compliance" that "proposes to supplant the government's assessment with their own." Defs. Mem. Summ. J. at 16-17 (d/e 344). Here, Relators do not argue that Defendants merely failed to follow certain regulations. This is not a regulatory compliance case; nor, as Defendants would have the Court believe, is it an attempt to federalize

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[9] To support their contention, Defendants rely solely on *United States ex rel. Blundell v. Dialysis Clinic, Inc.*, 2011 WL 167246, at *15 (N.D. N.Y. Jan. 19, 2011) (finding that the "plaintiff failed to allege that defendants knew, when they signed the form, that they would be accepting payment in violation of the anti-kickback statute."). The Sixth Circuit in *Augustine* specifically rejected this reasoning. 289 F.3d at 415. *See also Rogan*, 517 F.3d at 45. Moreover, *Blundell* is not binding precedent on this Court because it is an unreported case from the Northern District of New York.

malpractice. Defs. Mem. Summ. J. at 17 (d/e 344). This is a fraud case, where Relators allege not only that the services billed fell so far below accepted standards of care that they were essentially worthless, but also that they knowingly violated conditions material to payment that go to the heart of the bargain between Defendants and the United States, causing financial harm to the government.

All that is relevant here is whether material facts are in dispute regarding the elements of Relators' FCA claims. There is nothing contrary to public policy about holding a defendant liable for an FCA violation simply because of the existence of the NHRA administrative remedies. Indeed, Congress explicitly declined to make those administrative consequences an exclusive remedy. Section 1395i-3(h) (5) of the NHRA states, in relevant part, as follows:

> The remedies provided under this subsection are *in addition* to those otherwise available under state or *federal law* and *shall not be construed as limiting such other remedies* **. . .** (emphasis added).

42 U.S.C. § 1395i-3(h) (5).

Consistent with the NHRA's statutory mandate, courts in FCA cases have resoundingly rejected the argument that administrative remedies are "prerequisites [or] substitutes" to an FCA action. *United States ex rel. Aranda v. Comm. Psychiatric Ctrs. of Oklahoma*, 945 F. Supp. 1485, 1488-89 (W.D. Okla. 1996) (declining "to hold that the existence of a comprehensive regulatory scheme for monitoring quality of care issues under the Medicaid program precludes [an] FCA suit"). *See also United States ex rel. Onnen v. Sioux Falls Ind. Sch. Dist. # 49-5,* 2012 WL 3206223, at *5 (8th Cir. 2012) (explicitly rejecting a district court's ruling that FCA actions based upon violations of an underlying statute are "precluded by the comprehensive administrative remedies and sanctions available to the government under that Act … We agree

with the government that ‘Congress intended to allow the government to choose among a variety of remedies, both statutory and administrative, to combat fraud.”); *United States v. Tenet Healthcare Corp.*, 343 F. Supp.2d 922, 926 (C.D. Cal. 2004) (holding that where the United States decides to pursue a judicial remedy, the exhaustion of remedies doctrine is inapplicable in an FCA case); *United States ex rel. Sanders v. E. Alabama Healthcare Auth.*, 953 F. Supp. 1404, 1412 (M.D. Ala. 1996) (same).

The court in *United States v. NHC Healthcare Corp.,* 115 F. Supp. 2d 1149 (W.D. Mo. 2000), rejected many of the same public policy arguments raised by Defendants here:

> [T]here may be broad negative implications for the health care industry by the continued prosecution of providers under the FCA. But it is not the place of this Court to exempt an entire industry from FCA liability simply because it may be hurt by such suits. If the claims submitted by the Government comport with the requirements of claims submitted under the FCA, then the suit is proper. If this outcome is unsavory to the Defendant or its industry as a whole then the change is to made in the political arena via Congress or the Executive Branch. This Court will interpret the plain meaning and logical interpretation of the FCA as it applies to this case, and not entertain wide speculation as to the effect of any particular decision.

115 F. Supp. 2d at 1152.

D. The CMS Regulatory Survey Process and Momence’s Survey History Do Not Preclude a Finding of FCA Liability.

Defendants ask the Court to rule, as a matter of law, that the existence of an administrative process to regulate the quality of care provided by nursing facilities and Momence’s performance under that process preclude a finding of FCA liability. Defs. Mem. Summ. J. at 5, 9 (d/e 344). Defendants' argument ignores applicable statutory language and draws inappropriate inferences as to the meaning of the administrative process without considering the significant differences between the purpose of administrative enforcement under

the NHRA and FCA enforcement. The NHRA's survey process is the means by which CMS regulates nursing facilities whereas the FCA provides a vehicle for the government to recover money fraudulently obtained.

As part of the NHRA, Congress created the survey process to monitor nursing facilities' compliance with the NHRA and to impose administrative consequences, including civil monetary penalties, plans of correction, and limitations on new admissions, for facilities that fail to comply with the statute and regulations. *See* NHRA, 42 U.S.C. § 1395i-3(h) (2) (B) (i)–(iii).

Contrary to Defendants' contention, the fact that State surveyors found Momence to be in substantial compliance with the regulatory requirements for nursing facilities at the time of the survey inspections is fully compatible with a claim of FCA liability. Defs. Mem. Summ. J. at 5 d/e 344). The purpose of the CMS survey process is to determine whether nursing facilities meet the conditions for participation in the Medicare and Medicaid programs and to take administrative action if they fail to do so. *See* 488 C.F.R. § 300. State surveyors inspect nursing facilities only approximately once every 15 months, and may also conduct "complaint surveys." 42 C.F.R. § 488.308. Federal surveyors conduct "look behind" surveys in approximately five percent of cases. *See* 488 C.F.R. § 330. The survey report therefore provides only a snapshot of what the surveyors saw in the limited time they were in a facility. Thus, the fact that surveyors may inspect a nursing facility periodically is far from dispositive about the quality of care provided in that facility. This is especially true where, as in this case, there are allegations that Defendants lied and presented false records to the surveyors. *See* Sixth Am. Compl. ¶ 55, (d/e 145).

In the FCA context, the survey report is simply another piece of factual evidence that can support or refute allegations of FCA liability. It describes the snapshot of time seen by the

surveyors and how the provider responded. It should be examined along with the medical records, interviews, expert reports, and various other types of evidence, from many sources, that provide a far more detailed picture not limited to the period when the surveyors were in the facility.

The defendants in the recently decided *Houser* criminal case raised similar arguments, all of which the court flatly rejected. Citing evidence about the snapshot nature of the survey process and its limitations in the FCA context, "[t]he Court concludes that Defendant may be criminally prosecuted for health care fraud whether or not such conduct additionally violates administrative policies or civil regulations." *Houser,* Exhibit A, slip op. at 450. In *Villaspring*, the court rejected a similar attempt by a nursing facility to rely on survey findings to negate a FCA claim: "The fact that CMS did not 'declare the services to be worthless' does not constitute a representation from the government that the claims submitted by Villaspring were not false." 2011 WL 6337455, at *3.

Moreover, the fact that surveyors may have found that some of the residents in the facility received care in compliance with the regulatory standards does not preclude an FCA action. It is not necessary to prove that "all care" to "all residents" during the relevant time period was worthless in order to set forth a FCA violation. If Defendants provided a mere three weeks of worthless services to thirty patients, or five patients, or even one patient, and knowingly billed the government for that care, then the United States is entitled to recover all damages resulting from those particular false claims. *See, e.g., NHC Health Care Corp.*, 163 F. Supp. 2d at 1051 (alleging FCA violations for worthless services provided to two nursing facility residents during summer and fall of 1998).

Nor is FCA liability precluded by the fact that government surveyors may have

investigated some of the same allegations at issue in a FCA case, but did not seek repayment.

The court in *Houser* rejected a similar argument:

> [T]he Court also rejects Defendant's suggestion throughout this case that, simply by paying claims, the Government has somehow endorsed Defendant's fraudulent conduct … Whether or not a nursing home was allowed to continue operating is irrelevant to the issue of whether a provider was submitting false claims to Medicare and Georgia Medicaid for reimbursement. Under Defendant's theory, a provider may continue to submit fraudulent claims so long as it has not been terminated from the Medicare program or denied payment for regulatory non-compliance. This case demonstrates why reliance on the survey system in this way is illogical and unreasonable. The fact that, prior to paying Defendant, the Government may not have detected the entirety of Defendant's fraud through its state survey regulatory process, a process that clearly is not designed to investigate criminal health care fraud cases, has no bearing at all on whether Defendant knowingly submitted false claims. In a similar fashion, the fact that, prior to the IRS paying a tax refund based on a phony tax return, an IRS Revenue Agent failed to detect fraud during several civil audits of the taxpayer's tax records, does not mean the taxpayer did not willfully commit tax fraud, or that the taxpayer can continue submitting tax returns that the taxpayer knows to be "fraudulent.

Exhibit A, slip op. at 451-452, n. 3.

In sum, Defendants exaggerate and distort the significance of the surveys conducted at their facility. Relators' FCA claim is not precluded by the existence of the regulatory scheme or its results.

E. Defendants Have Not Shown that Relators' Complaint is Jurisdictionally Barred by Section 3730(e) (4) of the FCA.

Under the FCA there is a jurisdictional bar for *qui tam* actions based upon information that has been publicly disclosed, unless the relator qualifies as an "original source." 31 U.S.C. § 3730(e) (4) (1988). The Seventh Circuit has adopted a three-step approach for district courts to use when applying Section 3730(e) (4):

> First it examines whether the relator's allegations have been "publicly disclosed." If so, it next asks whether the lawsuit is "based upon" those publicly disclosed allegations. If it is, the court determines whether the relator is an "original source" of the information upon which the lawsuit is based.

Glaser v. Wound Care Consultants, Inc., 570 F.3d 907, 913 (7th Cir. 2009). Momence argues that the Relators do not qualify as original sources, skipping over the first two steps. Defs. Mem. Sum. J. at 17-18 (d/e 344). Before reaching the question of whether the relators qualify as an "original source," a court must first determine that the relators' allegations have been publicly disclosed and that the lawsuit is based upon those publicly disclosed allegations. If the court answers either of the first two inquires in the negative, then it never needs to reach the "original source" issue and there is no jurisdictional bar.

Here, it appears as though Momence has assumed that the existence of state survey reports amounts to this action being "based upon" a "public disclosure." While there may have been a "public disclosure" of some of the Momence's violations of the Medicaid requirements in the state survey reports, Defendants have not explained how this *qui tam* action is "based upon" those publicly disclosed allegations. According to Seventh Circuit precedent, a "relator's complaint is 'based upon' publicly disclosed allegations or transactions when the allegations in the relator's complaint are substantially similar to allegations already in the public domain." *Id.* at 910. The state survey agency, the Illinois Department of Public Health, did not investigate a fraudulent scheme. During the surveys the state agency assessed whether the nursing facility was providing care in compliance with the applicable Medicare and Medicaid regulations with respect to specific residents during a specific limited point in time. *Id.* By contrast, Relators' allegations allege widespread patterns and practices of fraud, including the failure to provide basic care to the residents of Momence from approximately December 1997 through June 2006. Defendants have not shown that the relators' complaint is based upon publicly disclosed allegations, and therefore the Court need not examine whether the relators qualify as original

sources.

Even if the relator's allegations have been previously disclosed, they may still proceed with the *qui tam* if they qualify as an "original source" within the meaning of the FCA. 31 U.S.C. § 3730(e) (4) (A). To qualify as an "original source", the relator must "voluntarily" provide the information to the government before filing suit. 31 U.S.C. § 3730(e) (4) (B); *United States v. Northrop Corp.*, 5 F.3d 407, 411 (9th Cir. 1993), *cert. denied*, 511 U.S. 1033 (1994). A disclosure is not voluntary if it is compelled by a duty to report *fraud* against the *federal* government. *United States ex rel. Fine v. Chevron, U.S.A., Inc.*, 72 F.3d 740, 744 (9th Cir. 1995), *cert. denied* 517 U.S. 1233 (1996); *United States ex rel. Paranich v. Sorgnard*, 396 F.3d 326, 340 (3rd Cir. 2005).

Defendants contend that Relators' disclosures to the federal government in this *qui tam* were not voluntary because, as nursing facility employees, Relators had an obligation to report suspected abuse or neglect to the Illinois Department of Public Health under 210 Ill. Comp. Stat. § 30/4. Defs. Mem. Sum. J. at 17-18 (d/e 344). A state law duty to report abuse or neglect to a state agency does not fall within the meaning of Section 3730(e) (4) (B) of the FCA. Indeed, finding otherwise would discourage *qui tam* suits by facility administrators, agents, and employees in Illinois and the many other states with abuse reporting requirements, creating an unintended windfall for those who would defraud the United States.

A relator's disclosure is voluntary if the relator had no obligation or legal duty to report fraud to the federal government. *See United States Dep't of Transp. ex rel. Arnold v. CMC Eng'g*, 745 F. Supp. 2d 637, 645-46 (W.D. Pa. 2010) (holding that because a state government auditor whose job duties required him to report fraud to the state government had no obligation

to report fraud to the federal government, the "[r]elator voluntarily provided his findings of fraud to the federal government, therefore, he is an original source under section 3730(e) (4) (B).") *See also United States ex rel. Wison v. Maxxam Inc.*, 2007 WL 2781169, *6 (N.D. Cal. 2007) (finding that a state employee who was paid to report fraud to state officials did "voluntarily" disclose to the federal government for purposes of the FCA).

The Illinois state statute relied on by Defendants does not require facility employees to report suspected fraud against the government, either federal or state. 210 Ill. Comp. Stat. § 30/4. Nor does it require them to report anything at all to the federal government. *Id.* The reporting duties required by this state statute therefore do not bar Relators' disclosures from being voluntary within the meaning of Section 3730(e) (4) (B).

Ignoring the overwhelming body of case law on this issue, Defendants rely solely on *United States ex rel. Fine v. Chevron, U.S.A., Inc.*, 72 F.3d 740 (9th Cir. 1995). *See* Defs. Mem. Sum. J. at 17-18 (d/e 344). *Fine* is readily distinguishable. In *Fine,* the relator was a retired auditor for the Office of Inspector General at the United States Department of Energy who brought two *qui tam* actions under the FCA based on his work as an auditor. *Id.* at 741. As a manager in the audit office, the "'paramount responsibility of his position' [was] the duty to disclose fraud to his supervisors". *Id.* at 742-43. The relator in *Fine* provided the information underlying his claims to the government prior to filing suit, but he did so while still employed, as his job responsibilities required. *Id.* at 741. The court held that when a relator is a federal government employee, employed specifically to disclose fraud, the relator's disclosures cannot be considered voluntary. *Id.* at 742-44. *See also United States ex rel. Biddle v. Bd. of Tr. of the Leland Stanford, Jr. Univ.*, 161 F.3d 533, 542-43 (9th Cir. 1998) (finding that the relator did not "voluntarily" disclose information to the federal government because he had a duty as an

Administrative Contracting Officer for the Office of Naval Research to disclose fraud).

Unlike the relator in *Fine*, Relators in the present case were not employees of the federal government. Their primary job responsibilities as nurses involved caring for Momence Meadow's patients, and not disclosing fraud to the federal government. *See* Sixth Am. Compl. ¶ 8, (d/e 145). Their disclosures were clearly voluntary within the meaning of the FCA.

CONCLUSION

For the foregoing reasons, the United States respectfully requests that, in ruling on Defendants' Motions for Summary Judgment, the Court decline to adopt the mistakes of law addressed above.

Respectfully submitted,

STUART F. DELERY
Acting Assistant Attorney General

JAMES A. LEWIS
United States Attorney

Dated: August 24, 2012

____
ERIC LONG
Assistant United States Attorney
318 South 6th Street
Springfield, Illinois 62701
217-492-4450

DANIEL R. ANDERSON
SARA MCLEAN
ANDY MAO
ANDREW PENN
JESSICA J. WEBER
Attorneys, Civil Division
United States Department of Justice
P.O. Box 261, Ben Franklin Station
Washington, D.C. 20044
Phone: (202) 616-0291
Fax: (202) 514-0280