UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

UNITED STATES OF AMERICA

CRIMINAL COMPLAINT

v.

CASE NUMBER:

SETH GILLMAN

I, the undersigned complainant, being duly sworn on oath, state that the following is true and correct to the best of my knowledge and belief:

Count One

Beginning no later than August 2008 and continuing until January 2012, at Lisle, in the Northern District of Illinois, Eastern Division, and elsewhere, SETH GILLMAN, defendant herein:

> did knowingly and willfully participate in a scheme to defraud a health care benefit program, namely, Medicare, and to obtain money owned by and under the custody and control of Medicare by means of false and fraudulent pretenses, representations, and promises, in connection with the delivery of and payment for health care benefits, items, and services, and, on or about October 14, 2009, did execute the scheme by knowingly and willfully submitting and causing to be submitted a false claim, specifically, that services provided to Patient DB beginning on October 1, 2008 through October 15, 2008 qualified for reimbursement at an elevated level of hospice care,

in violation of Title 18, United States Code, Section 1347.

Count Two

On or about September 8, 2009, at Lisle, in the Northern District of Illinois, Eastern Division, and elsewhere, SETH GILLMAN, defendant herein:

> did endeavor to influence, obstruct, and impede a Federal auditor in the performance of official duties relating to a program receiving in excess of $100,000, directly or indirectly from the United States in any 1 year period, by submitting and causing to be submitted to a federal auditor, namely, TrustSolutions, a file for Patient DB that had been altered so that it would appear that Passages' claim for an elevated level of hospice care regarding Patient DB was justified,

in violation of Title 18, United States Code, Section 1516.

I further state that I am a Special Agent with the Department of Health and Human Services, and that this complaint is based on the facts contained in the Affidavit which is attached hereto and incorporated herein.

Signature of Complainant
WILLIAM LUCZAK
Special Agent, Department of Health and Human Services

Sworn to before me and subscribed in my presence,

January 24, 2014
Date

At Chicago, Illinois
City and State

YOUNG B. KIM, U.S. Magistrate Judge
Name & Title of Judicial Officer

Signature of Judicial Officer

UNITED STATES DISTRICT COURT)
) ss
NORTHERN DISTRICT OF ILLINOIS)

AFFIDAVIT

I, William Luczak, being duly sworn, state as follows:

1. I am a Special Agent with the Department of Health and Human Services, Office of Inspector General, specifically in the Inspector General's Office of Investigations. I have been so employed since 2001.

2. As part of my duties as a Special Agent, I investigate criminal violations relating to Medicare and Medicaid, including health care fraud. Through my training and experience, I have become familiar with the methods by which individuals and entities conduct health care fraud and the tools used in the investigation of such violations, including consensual monitoring, surveillance, data analysis, and conducting interviews of witnesses, informants, and others who have knowledge of fraud perpetrated against Medicare and Medicaid. I have participated in the execution of multiple federal search warrants. Along with other federal agents, I am responsible for the investigation of Passages Hospice.

3. The statements in this affidavit are based on my personal knowledge, and on information I have received from other law enforcement personnel and from persons with knowledge regarding relevant facts. Because this affidavit is being submitted for the limited purpose of supporting a criminal complaint, I have not included each and every fact known to me concerning this investigation.

I. BASIS AND PURPOSE OF AFFIDAVIT

4. As explained in greater detail herein, there is probable cause to believe that beginning no later than August 2008 and continuing to January 2012, SETH GILLMAN did

knowingly and willfully participate in a scheme to defraud a health care benefit program, namely, Medicare, and to obtain money owned by and under the custody and control of Medicare by means of false and fraudulent pretenses, representations, and promises, in connection with the delivery of and payment for health care benefits, items, and services, and, on or about October 14, 2009, did execute the scheme by knowingly and willfully submitting and causing to be submitted a false claim, specifically, that services provided to Patient DB beginning on October 1, 2008 through October 15, 2008 qualified for reimbursement at an elevated level of hospice care, in violation of Title 18, United States Code, Section 1347.

5. In addition, on or about September 8, 2009, with intent to deceive and defraud the United States, GILLMAN did endeavor to influence, obstruct, and impede a Federal auditor in the performance of official duties relating to a program receiving in excess of $100,000, directly or indirectly from the United States in any 1 year period, by submitting and causing to be submitted to a federal auditor, namely, TrustSolutions, a file for Patient DB that had been altered so that it would appear that Passages' claim for an elevated level of hospice care regarding Patient DB was justified, in violation of Title 18, United States Code, Section 1516.

6. The statements in this affidavit are based on my personal knowledge, and on information I have received from other law enforcement personnel and from persons with knowledge regarding relevant facts. Because this affidavit is being submitted for the limited purpose of establishing probable cause to support a criminal complaint, I have not included each and every fact known to me concerning this investigation.

II. SUMMARY OF INVESTIGATION

7. The Federal Bureau of Investigation and the Department of Health and Human Services are investigating SETH GILLMAN, Individual A, and other individuals associated with

Passages Hospice, a company that deployed nurses to provide hospice care at nursing homes and other facilities throughout Illinois. As described in detail below, the investigation has revealed that GILLMAN, Individual A and others have been and are engaged in a scheme to defraud Medicare and Medicaid by submitting and causing to be submitted false claims for hospice care, namely, claims indicating that the visits were justified.

8. Among other things, and as described more below, agents and law enforcement officials have interviewed more than 30 former and current employees of Passages, including several who reported Passages' billing and marketing practices to Medicare and/or law enforcement prior to being contacted by law enforcement. Several former employees, including Individual B, Individual C, and Individual D, may have a financial interest in the government's investigation. Based on checks of criminal-history databases, none of the individuals who have been interviewed and whose statements are described below have any felony convictions or any convictions involving false statements or dishonesty.

9. Agents and law enforcement officials have also reviewed emails and documents that were provided by Passages in 2011 in response to a civil investigative demand, as well as emails and documents that were obtained by law enforcement in executing a search warrant in January 2012.

10. Agents and law enforcement officials have also reviewed patient files that were provided by Passages in response to audit requests, patient files that were obtained during the January 2012 search, and patient files that were provided by Passages in response to subpoenas in 2013 and 2014. Agents also have interviewed patients, family members, and former medical directors.

11. Agents and law enforcement officials have also reviewed and analyzed claims data provided by TrustSolutions and Cahaba, which are both contractors which work to protect the integrity of the Medicare program, and by the Illinois Department of Healthcare and Family Services Office of Inspector General regarding claims submitted by Passages to Medicaid.

III. MEDICARE BACKGROUND INFORMATION

12. Medicare is a health care benefit program within the meaning of 18 U.S.C. § 24(b). Medicare provides free or below-cost healthcare benefits to certain eligible beneficiaries, primarily persons sixty-five years of age or older. Individuals who receive Medicare benefits are often referred to as Medicare beneficiaries.

13. Medicare consists of four distinct parts: Part A provides hospital insurance coverage for inpatient hospital services, skilled nursing care, and home health and hospice care; Part B provides supplementary medical insurance for physician services, outpatient services, and certain home health and preventive services; Part C is a private plan option for beneficiaries that covers all Part A and B services, except hospice; and Part D covers prescription drug benefits.

14. Part A coverage, including hospice care, is paid for by the Federal Hospital Insurance Trust Fund. According to the 2010 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, the Federal Hospital Insurance Trust Fund had approximately $225 billion in revenue in calendar year 2009, including approximately $191 billion from payroll taxes, approximately $15 billion from interest credited from investments in government securities held by the fund, and approximately $1.9 billion in transfers from the general fund of the Treasury.

15. The Centers for Medicare and Medicaid Services, a federal agency within the United States Department of Health and Human Services, administers the Medicare program.

CMS contracts with public and private organizations, usually health insurance carriers, to process Medicare claims and perform administrative functions. In order to promote the integrity of the Medicare program, in 2009, CMS contracted with TrustSolutions, a program safeguard contractor that concentrated on, among other things, fraud and abuse detection and deterrence, and conducted an audit referenced below.

16. The Medicaid program is a federally-assisted grant program that enables states to provide medical assistance and related services to needy individuals. At the federal level, the Center for Medicare and Medicaid Services administers the Medicaid program. However, within broad federal guidelines, participating states determine who is eligible for Medicaid, the services covered, reimbursement levels for services, and administrative procedures. The State of Illinois, acting through the Department of Healthcare and Family Services, administers the Grants to States for Medical Assistance Programs pursuant to Title 42, United States Code, Section 1396. The Illinois Department of Healthcare and Family Services, which receives 50 percent of its funding from the federal government, reimburses medical institutions, including hospices, for reimbursable costs.

17. According to the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services website and Section 1861 of the Social Security Act, codified at 42 U.S.C. § 1395x, "hospice care" is defined as the provision of specified items or services—such as doctor and nursing care, certain medical equipment and supplies, certain drugs for pain or symptoms, home health aide services, therapy, social work and counseling, and short-term inpatient stays—to a patient who is "terminally ill." According to the Medicare Benefit Policy Manual, to be considered "terminally ill," a beneficiary must be certified by the Medical Director of the hospice provider—who must be a registered nurse or physician—as well

as the patient's attending physician as having a terminal prognosis with a life expectancy of six months or less if the disease runs its normal course.

18. According to the Medicare Benefit Policy Manual, once a patient elects to receive hospice care and is certified as terminally ill, the individual may receive hospice care for 90 days before being recertified for an additional 90 day period of hospice care, and after the initial 180 days must be recertified as terminally ill every 60 days. Upon a beneficiary's election of hospice care, the hospice agency assumes the responsibility for medical care related to the beneficiary's terminal illness; the care is palliative rather than curative, and the patient must waive all rights to Medicare payments for treatment of the terminal illness.

19. According to the Medicare Claims Processing Manual, Medicare pays hospice providers a set daily rate based on the geographic location of the patient and level of care provided to the patient. There are four levels of care at which Medicare reimburses hospice providers. The two levels that are particularly relevant to this investigation are routine care and general inpatient care (sometimes known as GIP); the two others are continuous home care and inpatient respite care. According to the Medicare Claims Processing Manual, the hospice provider is paid the routine care rate for each day the patient is under the care of the hospice and not receiving one of the other categories of hospice care, and is billed at the lowest rate.

20. According to the Medicare Benefit Policy Manual, general inpatient care is intended for "pain control" or "acute or chronic symptom management that cannot feasibly be provided in other settings." According to the manual, examples of appropriate general inpatient care include a patient who elects hospice at the end of a hospital stay and needs "pain control" or "symptom management" while preparing to receive hospice care, and "a patient in need of medication adjustment, observation, or other stabilizing treatment."

21. According to Medicare hospice Conditions of Participation 418.108 and 418.110, Title 42, Code of Federal Regulations, Sections 418.108 and 418.110, for inpatient care to be provided in a nursing facility, the nursing facility must provide 24-hour nursing services that meet the nursing needs of its patients. Moreover, if a patient is receiving general inpatient care, then each shift at the nursing facility must have a registered nurse who provides direct patient care.

22. According to a compliance tip sheet by the National Hospice and Palliative Care Organization (last accessed online on January 18, 2014 at http://www.nhpco.org/sites/default/files/public/regulatory/GIP_Tip_GIP_Sheet.pdf), GIP is a "valuable tool that allows hospice staff to provide clinical services to a degree that cannot typically be provided in a patient's home. It is intended for specific circumstances and for a short duration of time and thus must be carefully managed from start to finish." The tipsheet identifies some examples of patient conditions that may warrant providing GIP to a patient:

- ✓ Pain or symptom crisis not managed by changes in treatment in the current setting or that requires frequent medication adjustments and monitoring
- ✓ Intractable nausea/vomiting
- ✓ Advanced open wounds requiring changes in treatment and close monitoring
- ✓ Unmanageable respiratory distress
- ✓ Delirium with behavior issues
- ✓ Sudden decline necessitating intensive nursing intervention
- ✓ Imminent death – **only** if skilled nursing needs are present

23. Common Procedural Terminology codes, also known as CPT codes, are written by the American Medical Association and published yearly. The AMA codes book is a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians. The purpose of the terminology is to provide a uniform language that accurately describes medical, surgical, and diagnostic service. CPT codes are widely accepted by insurance carriers and Medicare as effective means for reporting the performance of medical, surgical, and diagnostic services. In 2000, the CPT code set was designated by the Department of Health and Human Services as the national coding standard for physician and other health care professional services and procedures under the Health Insurance Portability and Accountability Act.

24. According to the Medicare Claims Processing Manual, Chapter 11: Processing Hospice Claims, the various levels of hospice care are billed under the following CPT codes: 0651 (Routine Home Care); 0652 (Continuous Home Care), 0655 (Inpatient Respite Care), and 0656 (General Inpatient Care).

25. According to the Medicare Claims Processing Manual, the daily reimbursement rate for general inpatient care is significantly more than for routine home care—*e.g.* from October 1, 2004, through September 30, 2005, general inpatient care paid a daily rate of $542.61 compared to $121.98 for routine care; those rates rose to $671.84 and $151.23, respectively, for the 2012 fiscal year.[1]

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[1] According to the Medicare Claims Processing Manual, the number of days of inpatient care (both General Inpatient and Inpatient Respite) furnished by a hospice provider is capped at 20% of the total number of days of hospice care provided to all Medicare beneficiaries during the cap period (calculated from November 1 through October 31).

IV. PASSAGES OVERVIEW

26. According to provider enrollment records obtained from Medicare, Passages Hospice, LLC, provides hospice care to patients in Illinois and elsewhere and is an authorized Medicare provider. According to Passages promotional materials, GILLMAN started Passages in 2005 "to address the needs of the patients in the nursing homes."

27. According to organizational charts and his signature line on emails, GILLMAN was the "Administrator" of Passages. According to Illinois Secretary of State records, GILLMAN is the agent for Passages and is also the agent for Asta Care Center of Bloomington, Asta Care Center of Colfax, Asta Care Center of Ford County, Asta Care Center of Pontiac, Asta Care Center of Rockford, and Asta Care Center of Toluca, each of which is a nursing home managed by Asta Healthcare Company, Inc. According to Illinois Secretary of State records, GILLMAN is the agent and secretary of Asta Healthcare Company, and GILLMAN's father is the president. As noted below, many Passages hospice patients were at Asta facilities when referred to Passages.

28. According to a 2009 operating agreement, GILLMAN and his father were two of the four members of Passages Hospice, LLC, with each member having a 25 percent ownership share. According to their signatures in emails with GILLMAN, the other two members were vice presidents at Asta Healthcare Company as of 2010.

29. In a July 8, 2010 email, GILLMAN described himself as a "masters level health care attorney in practice since 1993." According to the Attorney Registration and Disciplinary Commission of the Supreme Court of Illinois's website, GILLMAN was admitted as a lawyer by the Illinois Supreme Court in 1993 and whose registered business address is the office of Passages.

30. Passages had offices in Lisle, Illinois. As the company grew, it divided its operations into several geographic-based regions, with different nurses, nursing directors, and medical directors for each region. According to documents and interviews, Region B covered Chicago and the western suburbs, Region C covered Rockford, Region D covered Bloomington, and Region F covered Belleville, Illinois.

31. Passages did not have its own facility for its hospice patients, but instead deployed nurses to visit patients, typically in the nursing home where they had already been residing, as well as at patients' homes. By contrast, according to statistics from the National Hospice and Palliative Care Organization, in 2009, approximately 40 percent of hospice patients received care in their home and 21 percent in a hospice facility, with only 18.9 percent receiving care in a nursing home.

32. According to interviews, as well as a review of emails and documents, Passages received referrals from physicians and nursing homes for patients who allegedly wanted hospice services. When a patient was referred to Passages, a Passages nurse evaluated the patient for admission to hospice care. If the nurse believed that the patient qualified, then one of Passages' medical directors was asked to certify the patient for admission. However, as discussed below, medical directors sometimes were not consulted about an admission prior to the patient being admitted, and were asked to sign paperwork indicating that the director had approved the admission only afterwards. In addition, GILLMAN caused some patients to be admitted to hospice care even when a medical director did not believe that the patient was eligible for hospice care or when the patient was unaware that Passages provided hospice services.

33. According to interviews, as well as a review of emails and documents, once the patient was admitted, Passages nurses regularly visited patients, who often were at nursing home

facilities. Nurses typically visited patients twice a week if the patient was on the routine level of care and were supposed to visit patients every day if the patient was on general inpatient care. Pursuant to Medicare regulations, Passages employees met to discuss their patients in meetings which were referred to as "interdisciplinary team" or "interdisciplinary group" meetings, often referred to as IDT or IDG meetings. Passages medical directors often attended these meetings and were asked to certify admissions and changes in level of care, as well as to recertify patients for continued hospice care. Passages medical directors typically did not see patients themselves and relied on nurses for information about patients' conditions.

34. Beginning in or around late 2008, according to interviews, as well as a review of documents, and emails, GILLMAN trained and caused to be trained Passages nurses to look for signs that allegedly would qualify a patient for GIP, and thus higher payments per day (see paragraphs 53-56). GILLMAN knew that many of Passages' patients were improperly being placed on GIP, in part as a result of an August 2009 review of patient files, a September 2009 report by an outside consultant, and a September 2010 internal audit (see, e.g., paragraphs 53-56, 83-87, 113-20, 128, 170-71, 183). GILLMAN also knew that patients had been put on GIP without a medical director's approval at the time (see paragraphs 93-96, 168).

35. Individual A was the administrator of Passages along with GILLMAN as of 2011, and shared a joint email address with him in 2011. Individual J was the nursing director of the Passages region covering Chicago and the west suburbs in 2009 and 2010, and then became the director of clinical services beginning in 2010.

V. PASSAGES' PATIENT POPULATION

36. Based on a review of claims data, emails, and interviews with patients and family members, as well as a review done by a consultant retained by the government, Passages' patient

population included many patients who received hospice care from Passages for long stays, many patients who did not have illnesses that are typically considered terminal, and many patients who were placed on general inpatient care for long periods and without justification.

37. According to Medicare claims data, Passages had many patients who received hospice care from Passages for an extended period of time, inconsistent with the certifications that the patients had a life expectancy of six months or less at the time of admission. According to claims data, approximately 22 percent of Passages' patients between January 2006 and October 2011 had more than 180 days of hospice care, with approximately 28 patients receiving more than 1,000 days of hospice care in that period. By contrast, 11.8 percent of hospice patients in 2009 were on hospice for longer than 180 days for the members of the National Hospice and Palliative Care Organization, according to that organization's Facts and Figures: Hospice Care in America edition for 2010.

38. For example, according to claims data, Passages billed for more than 2,000 days of hospice services for Patient JW. According to Patient JW's daughter, Patient JW had a major stroke in 2003 and was on "life support" for some time. He went to a rehabilitation center to recover. Patient JW was then admitted to one of the Asta nursing homes in 2003 when he did not respond to rehabilitation. According to Patient JW's daughter, she got a call from someone at either Passages or Asta recommending hospice care so that Passages could give "more care" than the nursing home could provide.

39. According to Patient JW's daughter, at the time of Patient JW's admission to Passages, his condition was chronic and stable, with no imminence of death. When told that hospice patients needed to be certified as having a life expectancy of six months or less, Patient

JW's daughter said that no one ever told her that this was Patient JW's prognosis. Patient JW said that she recalled wondering why her father was being put in hospice.

40. Another long-term patient was Patient LJ. According to claims data, Passages submitted bills for approximately 1,443 days of hospice services for Patient LJ. According to Patient LJ's son, Patient LJ was admitted to Asta Care nursing home in or around May 2001. According to Patient LJ's son, after Patient LJ was admitted to Asta, the staff at Asta suggested to him that Patient LJ see a doctor who visited Asta Care. Patient LJ's son said that Asta referred Patient LJ to hospice, and that no one explained the Medicare hospice benefit to him.

41. When told that Passages had billed approximately 1,443 days of hospice care for Patient LJ, Patient LJ's son said that the he thought that hospice was intended to make people "comfortable" as they were on the "verge of passing." Patient LJ's son said that Patient LJ had dementia but was "not in bad shape" and had "no imminent danger of dying" until the last month of her life, and added that "if [Medicare] got billed for anything more than 50 to a hundred days, [Medicare] got stiffed."

42. Based on a review of claims data, Passages' patient population changed over time, with many new admissions based on dementia, "unspecified debility," and "adult failure to thrive," rather than diagnoses involving cancer. Based on claims data, cancer-related diagnoses comprised about 24 percent of the admissions in 2006, falling to 10 to 12 percent in 2009 through 2011, while dementia went from 3 percent of admissions in 2006 to 50.1 percent in 2011.[2] By contrast, cancer-related diagnoses made up 40.1 percent of hospice admissions in

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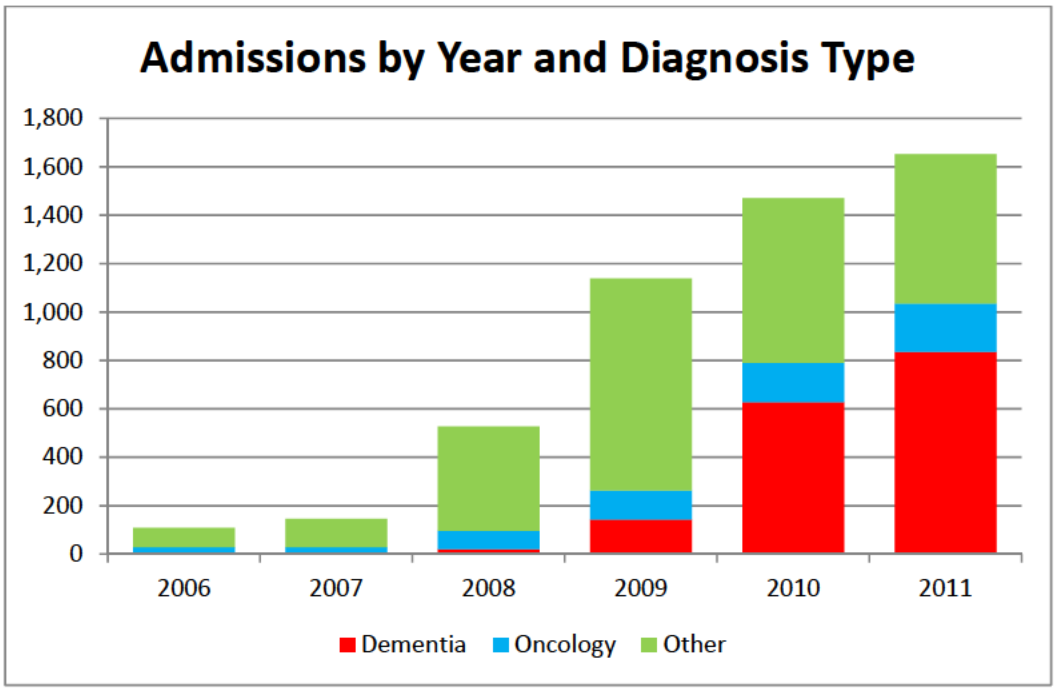
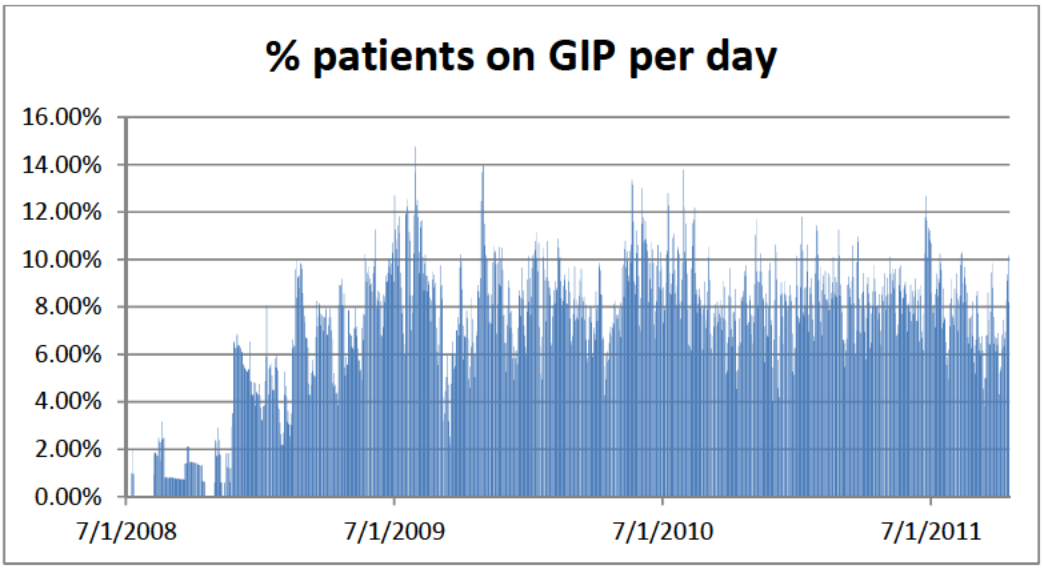
[2] This review was done based on the separate admissions shown in the claims data. In some instances, a patient was discharged and then re-admitted, and would thus show up as having two or more separate admissions. According to claims data, from 2006 through October

2009 for the members of the National Hospice and Palliative Care Organization, according to that organization's Facts and Figures: Hospice Care in America edition for 2010.



43. Based on claims data, the amount of GIP that Passages billed in its claims to Medicare grew significantly beginning in 2008. According to claims data, and as shown in the graph below, Passages had an average of approximately 7.1 percent of its patient population on GIP per day from July 2008 through September 2011, with a high of 14.75 percent on one day in July 2009. By contrast, the percentage of patient care days for general inpatient care in 2009 was 2.9 percent for members of the National Hospice and Palliative Care Organization, according to that organization's Facts and Figures: Hospice Care in America edition for 2010.

2011, approximately 583 patients were admitted more than once, with one patient admitted to hospice care six times, initially with diagnoses of "unspecified" congestive heart failure and then was admitted three later times with dementia, "unspecified debility," and "senility without mention psychosis."

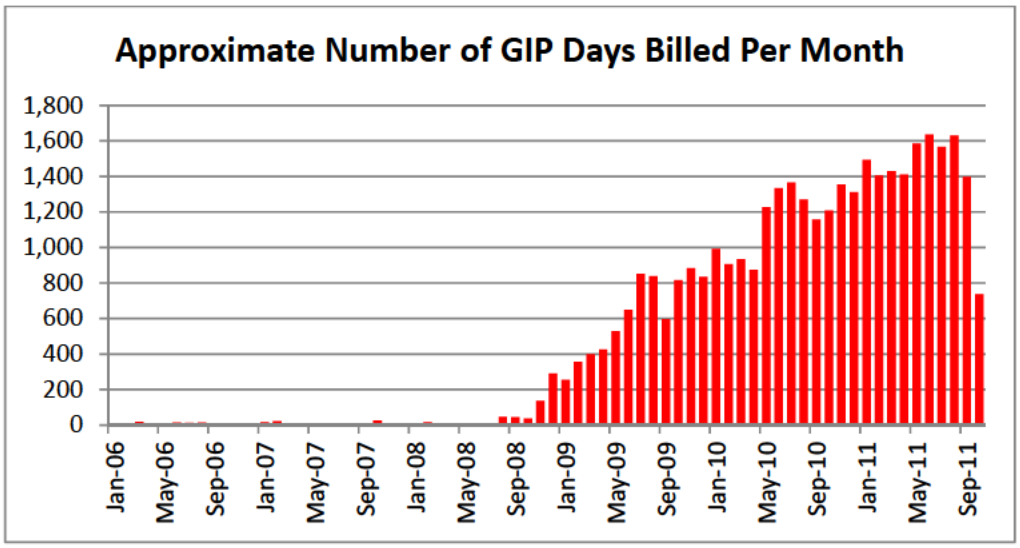


44. According to a review of Medicare claims data, Passages billed Medicare an average of approximately 7 GIP patient days per month between January 2006 and June 2008, with a high of approximately 26 GIP patient days in one month. Beginning in July 2008, Passages billed significantly more GIP patient days per month. Passages billed approximately 1,161 GIP patient days to Medicare a month in 2010, and billed approximately 1,430 GIP patient days a month from January 2011 through September 2011.[3]

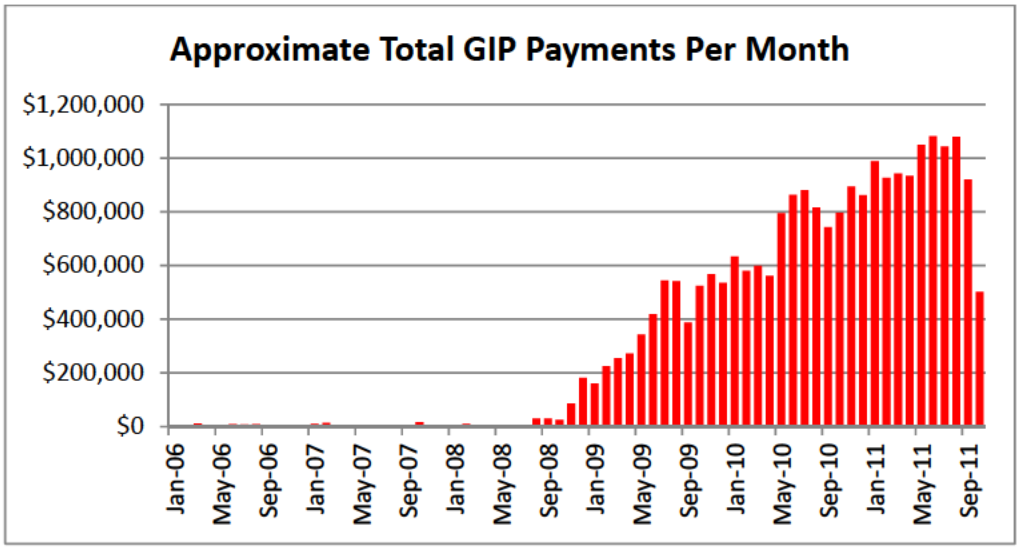
	June 2006 – June 2008	July 2008 – Dec. 2008	2009	2010	2011
Average # GIP patient days per month	7	94	619.3	1,161	1,430
Average total GIP payments per month	$4,437	$59,331	$397,997	$751,917	$946,743

[3] Claims data includes the date that GIP service began and the approximate number of days that the GIP period continued, which was 4 days or less approximately 83 percent of the time. For purposes of the review of claims data, GIP was measured by the month that the GIP service began. For example, if a GIP period began on September 30, 2010 and continued for five days, it is counted for purposes of this analysis as beginning in September 2010 rather than in October 2010.

45. The graph below shows the approximate number of GIP patient days per month, based on a review of claims data:



46. The graph below shows the approximate total amount of GIP payments that Passages received for the GIP it billed in a given month, based on a review of claims data:



47. The government retained a hospice physician who is an expert in the areas of Medicare hospice eligibility and GIP medical necessity to perform a comprehensive review of Passages' patient files, and is paying the expert based on an hourly rate. The government

physician expert specifically evaluated whether the documentation in the patient's medical record supported the patient's hospice eligibility with a six month or less prognosis (the Medicare hospice benefit requirement) and whether the GIP ordered for the patient was medically necessary and actually rendered. Of the 13 patients listed below, the government physician expert found that nine patients were not eligible for the Medicare hospice benefit for part or all of their service on hospice and that all the 503 days of GIP submitted for those patients were improper and excessive.

	Patient	Diagnosis	Length of Service	Approximate Total Medicare Payments to Passages as of November 2011	Hospice Physician Expert Opinion re Hospice Eligibility	Hospice Physician Expert Opinion re GIP	¶s with Additional Info
1	ED	Debility w/ comorbidities of dementia, chronic heart failure	1,598 days over two periods, including 3 GIP days (January 2006 to April 2010, November to December 2010)	$201,104	Not eligible for Medicare hospice benefit with indicated diagnosis for over 4 years for initial admission. .	All GIP days were medically unnecessary and there is little to no documentation that GIP care was even rendered.	See ¶ 58, 61-63
2	LJ	Failure to thrive, dementia	1,443 days over two periods, including 3 GIP days (May 2006 to May 2010, and January 2011)	$191,753	Not eligible for Medicare hospice benefit with indicated diagnosis for entire 4 years of initial admission.	All GIP days were medically unnecessary.	See ¶ 40-41, 58
3	GB	Liver cancer, chronic heart failure	1,384 days over two periods (January 2006 to August 2009, and March 2010 to May 2010)	$191,334	Not eligible for Medicare hospice benefit with liver cancer for entire 32 months on service or with CHF for approximately 2 months on service.	No GIP days billed	See ¶ 58, 91

	Patient	Diagnosis	Length of Service	Approximate Total Medicare Payments to Passages as of November 2011	Hospice Physician Expert Opinion re Hospice Eligibility	Hospice Physician Expert Opinion re GIP	¶s with Additional Info
4	RT	Debility unspecified	667 days, including 160 GIP days (July 2008 to May 2010) Discharged in May 2010 because patient no longer met hospice criteria, according to progress note	$158,855	Not eligible for Medicare hospice benefit with indicated diagnosis for entire 22 months on service.	All GIP days were medically unnecessary and there is little to no documentation that GIP care was even rendered.	See ¶ 112
5	JR	Emphysema, dementia	518 days, including 80 GIP days (March 2010 to June 2011, and June 2011 to September 2011)	$113,013	Appears to have been eligible for hospice.	All GIP days were medically unnecessary and little to no documentation that services were rendered.	
6	EP	Cerebro-vascular accident, dementia	419 days, including 10 GIP days (December 2009 to January 2011) Discharged in January 2011 because patient showed no significant decline in past months, according to order	$70,168	Not eligible for Medicare hospice benefit with indicated diagnosis for entire 14 months on service.	All GIP days were medically unnecessary.	
7	SK	Failure to thrive/debility	263 days, including 36 GIP days (December 2010 to August 2011)	$59,628	Not eligible for Medicare hospice benefit with indicated diagnosis for approximately 5 months on service.	All GIP days were medically unnecessary	

	Patient	Diagnosis	Length of Service	Approximate Total Medicare Payments to Passages as of November 2011	Hospice Physician Expert Opinion re Hospice Eligibility	Hospice Physician Expert Opinion re GIP	¶s with Additional Info
8	MM1	Chronic heart failure	167 days, including 78 GIP days (October 2008 to March 2009)	$56,592	Not eligible for Medicare hospice benefit with indicated diagnosis for over 5 months on service.	All GIP days were medically unnecessary and there is little to no documentation that GIP care was even rendered.	See ¶ 112
9	DB	Chronic heart failure	114 days, including 70 GIP days (August to November 2008)	$53,137	Appears to have been eligible for hospice.	All GIP days were medically unnecessary.	See ¶ 56, 112, 130, 133-40
10	HC	Cardiomegaly	272 days, including 21 GIP days (October 2008 to June 2009) Patient revoked hospice benefit in June 2009, according to patient file	$49,716	Not eligible for Medicare hospice benefit with indicated diagnosis for 8 months on service.	All GIP days were medically unnecessary and there is little to no documentation that GIP care was even rendered.	See ¶ 112
11	VB	Dementia	289 days, including 8 GIP days (October 2009 to July 2010)	$43,824	Not eligible for Medicare hospice benefit for indicated diagnosis for initial 6 months on service.	All GIP days were medically unnecessary.	See ¶ 191-98
12	WA	Dementia	175 days, including 28 GIP days (August 2010 to February 2011)	$43,739	Appears to have been eligible for hospice.	All GIP days were medically unnecessary.	
13	LC	Chronic heart failure	212 days, including 6 GIP days (March to July 2011)	$33,175	Appears to have been eligible for hospice.	All GIP days were medically unnecessary.	See ¶ 202-07

48. According to a review of Passages documents and Medicaid claims data, Passages also submitted claims to Illinois Medicaid seeking payment for patients' room and board. Under Section 1903(o)(3) of the Social Security Act, Medicaid provides payment to a hospice agency for nursing home room and board charges for long-term care facility residents receiving hospice care, which the hospice is then responsible for paying to the nursing home facility.

49. According to a review of Medicaid claims data, Passages also submitted claims to Illinois Medicaid seeking payment for hospice services provided to some patients. According to a review of emails, if a patient was not eligible for hospice services from Medicare, Passages tried to submit the claims for hospice services to Medicaid. For example, Passages submitted its claims for hospice services for Patient MM2, discussed below in paragraphs 163-67, to Medicaid, rather than Medicare, after determining that Passages could not bill Medicare for Patient MM2.

50. According to a review of claims data, from January 2006 to late 2011, Passages submitted claims for approximately 4,769 patients to Medicare and/or Medicaid and was paid approximately $95 million from Medicare and approximately $30 million from Medicaid.

51. According to a review of claims data, from July 2008 through late 2011, Passages was paid approximately $23 million by Medicare based on claims of GIP services. In addition, Passages was also paid by Medicaid on GIP claims submitted on approximately 212 patients.

VI. GILLMAN DIRECTED FRAUDULENT BILLING REGARDING GENERAL INPATIENT CARE

A. GILLMAN Implements Use of GIP in 2008 Over Nursing Director's Objections

52. According to Individual E, she helped GILLMAN and his father start Passages. According to Individual E, she was working for the Asta company, which owned six nursing

homes at the time, when GILLMAN's father and GILLMAN asked her to help them develop Passages. She then served as Passages' clinical director for several years. According to Individual E, many of Passages' initial hospice patients came from the Asta nursing homes.

53. According to Individual E, in the summer of 2008, GILLMAN called her into a meeting with Individual A, who helped GILLMAN manage the company and who held the position of "Administrator" along with GILLMAN. According to Individual E, GILLMAN said that he had learned from Individual A that Individual E had cost him millions of dollars because Passages had not been using general inpatient care. According to Individual E, she explained to GILLMAN the criteria for general inpatient care and brought him regulations about the proper qualifications for general inpatient care. According to Individual E, GILLMAN said that if a patient was under Passages' care, they were sick enough to warrant general inpatient care.

54. According to Individual E, Individual A and GILLMAN began training supervisors for Passages' nurses about general inpatient care at sessions that Individual E attended. According to Individual E, Individual A said that if a patient had a skin tear or a change in medication, that condition would qualify the patient for general inpatient care. According to Individual E, she spoke up at the meetings and said that Individual A was wrong.

55. According to Individual E, nursing directors sent forms to GILLMAN indicating which patients were on general inpatient care for specific days. Individual E provided law enforcement with several forms for November 2008 through January 2009. None of the forms for November 2008 gave a reason for why the patients were on general inpatient care. Some of the forms from December 2008 and January 2009 gave reasons for GIP, but many were blank.

56. In particular, Individual E said that Patient DB was the first patient who caused conflict between her and GILLMAN concerning GIP. According to Individual E, GILLMAN

told her to admit Patient DB into hospice, even though Individual E believed that Patient DB was ineligible because he was still getting treatment for the same condition that was being used to justify admission to hospice. According to Individual E, she saw from Passages' systems that Patient DB was on GIP even though it was inappropriate, and she argued with GILLMAN about having Patient DB on GIP. According to Individual E, GILLMAN told her to "mind" her "own business" because he needed the money.

57. According to Individual E, she also raised concerns in 2008 with GILLMAN multiple times about patients who had been on hospice for long periods. Individual E said that she personally saw some of these patients, specifically, the ones who were at Asta facilities where she had access. Individual E recalled seeing Patient JW, and said that he appeared to be near death when admitted. According to Individual E, Patient JW then recovered, and she believed that Patient JW should be discharged from hospice. According to Individual E, she recommended to GILLMAN that Patient JW be discharged, and GILLMAN refused.

58. Individual E provided law enforcement with a list that she said that she prepared at interdisciplinary meetings of patients whom she believed were chronically ill, rather than terminal. She said that she showed the lists to GILLMAN and recalled discussing a few particular patients with GILLMAN. One list that she said that she prepared in November 2008 included approximately 12 patients with admission dates in 2005 and 2006, including Patients JW, ED, LJ, and GB, each with the note: "Chronically ill – is [he or she] still terminal? Please have [Individual F, a nurse practitioner] see her." According to Individual E, GILLMAN ignored the lists. According to claims data and patient files, out of the 12 patients on the November 2008 list, seven remained on hospice with Passages for more than a year before either being discharged for having an extended prognosis, rather than a terminal one, or for revoking

hospice services, and one (Patient GB) was discharged in August 2009 when Passages nurses determined that the patient did not actually have liver cancer as they had believed.

59. According to Individual E, in late 2008, GILLMAN asked Individual E to provide a training session at Passages' holiday party and asked her to tell attendees that Passages was using GIP properly. Individual E said that she printed out materials about health-care fraud from a seminar that she had recently attended, handed the materials out, and gave a training session based on those materials. According to Individual E, there was no reaction to her training. According to Individual E, GILLMAN's father terminated her the next day.

B. GILLMAN Terminates Individual B

60. According to Individual B, she was hired as Passages' director of clinical services in early 2009, which was soon after Individual E was terminated. According to Individual B, when she began working at Passages, she was surprised at what she observed regarding Passages' patient population. According to her, she found that Passages admitted patients who were not eligible for hospice, such as patients who had psychiatric problems like dementia but were not facing the end of their life. In particular, in the course of an audit that she performed soon after being hired, Individual B found that 70-90% of the patient files did not have a diagnosis or proper documentation to make the patient eligible for the Medicare hospice benefit. She said that she did not see a decline in patients' conditions consistent with clinical tools that showed that the patients were expected to die within six months if their conditions ran their normal course. Individual B said that she saw patients diagnosed with disorders such as Alzheimer's, aphasia or "failure to thrive" that, despite not having a terminal diagnosis, were approved by Passages for hospice care.

61. According to Individual B, she said that she specifically told GILLMAN and Individual A about one patient, Patient ED. Individual B said that she visited Patient ED personally and observed that Patient ED had many psychiatric issues, including some schizophrenia, but was conversant, in no pain, was able to feed herself, and was not underweight. Individual B said that she told Individual A that Patient ED did not qualify for hospice services and should be discharged. Individual A replied that Patient ED did qualify and should remain on hospice. Individual B then spoke with GILLMAN about Patient ED. According to Individual B, GILLMAN replied, "We'll wait and see." According to Individual B, GILLMAN also told Individual B, "Keep your mouth shut and do what I tell you."

62. According to claims data, Patient ED was admitted to Passages on January 16, 2006, and Passages billed for hospice services on Patient ED for more than four years from that date. During that time, Passages changed the lead diagnosis three times. Initially, the diagnosis reported to Medicare in Passages' claims was "unspecified psychosis." Beginning in October 2009, the diagnosis reported to Medicare was "secondary diabetes mellitus with ketoacidosis uncontrolled," which is generally not a terminal illness. Beginning in February 2010, the diagnosis reported to Medicare was "dementia with behavioral disturbances." According to claims data, Passages discharged Patient ED on April 26, 2010. Passages then re-admitted Patient ED in November 2010, and Patient ED then died in December 2010.

63. Patient ED's husband told agents that someone at Asta had told him about Passages and introduced him to a woman who represented Passages. When told that Passages had billed approximately 1,500 days of hospice services for Patient ED, Patient ED's husband said that Patient ED was "definitely" not in hospice for such a long time and that this period was excessive.

64. Individual B said that she was allowed to attend only one interdisciplinary team meeting while working at Passages. She said that she attended the meeting and saw that there was no discussion about patients, no updates to patients' plans of care, and that the medical director, Medical Director A, signed papers that were put before him without reviewing them. Individual B said that she told GILLMAN afterwards that the IDT interdisciplinary team meetings were not being conducted properly. According to Individual B, GILLMAN said that she did not have to attend the interdisciplinary team meetings anymore. According to Individual B, GILLMAN said, "Do what I say and sign what I tell you."

65. Individual B provided hard copies of emails between her, GILLMAN and Individual A in March 2009, leading up to her termination that month. In an email that she sent GILLMAN and Individual A on March 6, 2009, Individual B wrote:

> I will look at the recert [list of patients who had to be recertified to continue on hospice services] [and] make my recommendation as to who should and should not be recerted according to the hospice criteria – as well as the supportive documentation in the CPC – who do you want this sent to? Last time I did this – there were a couple of patients that I felt should not have been recerted; they were anyway, so, let me know how you would like for me to proceed.

66. GILLMAN replied by email: "For one, don't say what you just did."

67. Two days later, on March 8, 2009, Individual B sent another email to GILLMAN and Individual A. In this email, she wrote that she wanted to meet with Gillman about whether he was going to fire her, referring to an online job posting that she had seen about her current position. "If you are planning to fire me, I think it would be only fair that I know about it, and if that is the case, the reason for it," Individual B wrote. Individual A then replied to Individual B's email with an email that I believe was intended for GILLMAN but sent to Individual B

instead. In Individual A's reply, the subject line was changed to "busted," and the text read, "Hum … r u [GILLMAN] going to meet with her [Individual B] Monday?"

68. On March 18, 2009, Individual B sent another email to GILLMAN and Individual A. In this email, she wrote that they should discuss her concerns relating to three topics, including, "recertification of patients for hospice care with little or no documentation" and "improper IDT meetings." Individual B continued:

> These items are improper and may violate the False Claims Act. My understanding is that one of the reasons you hired me was to establish a compliance program as well as to oversee the nursing and clinical portions of Passages. I have certainly tried to move Passages forward but again, I am frustrated with the instructions that I have been receiving. For example, how am I supposed to direct the nursing staff when I am not allowed to talk to them, attend IDT meetings, or make on-site visits to the nursing homes?

69. According to Individual B, she was terminated the next day. According to Individual B, GILLMAN asked if Individual B wanted a different position at Passages rather than the director of nursing, and said that maybe she was "on the right bus, but sitting in the wrong seat."

70. In response to a civil investigative demand in 2011, Passages did not produce any of the emails with Individual B referenced above, but did produce some emails that reflect the discussions between GILLMAN and Individual B around the time that she was terminated.

71. In an email that GILLMAN sent Individual B on March 19, 2009, GILLMAN wrote that he had terminated Individual B because of his "dissatisfaction with the progress and the evidence of your assigned work." According to GILLMAN:

> We met today and I again relayed to you my dissatisfaction with your work and the disappointment I felt with respect to the results I was shown. I told you that I was not confident that you were the right choice for the

> job and that I wanted you to step down. I offered you the regional manager position instead. You declined. … I do not regret asking you to step down from your position and I question your decision as to leave the Company.

72. Individual B replied that GILLMAN's characterization of what had happened was inaccurate, and discussed restrictions that GILLMAN and Individual A had placed on her ability to her job:

> As you know during the last month, you and [Individual A] have unreasonably restricted my ability to perform my position. For example, I was instructed not to talk to nurses that I was supposed to be managing, but rather talk with [Individual F, a nurse practitioner] and then have her talk to the nurses (I called you and Gwen and sent you several e-mails, as well as talked with [Individual F] a couple times); [Individual F] was as avoidant as the both of you. I was not allowed to attend the IDT meetings; your reasons for all of this was that you wanted me to focus on compliance and you wanted me to avoid having to deal with the little things related to my position and rather, delegate those things to [Individual F]. I told you several times that the nursing staff was not getting all the information that I was sending [Individual F]. I knew that since I received phone calls from them asking me questions that they should have already had answers for, but they could not have the answers, since they were not given the information. In essence, I was prevented from doing my job.

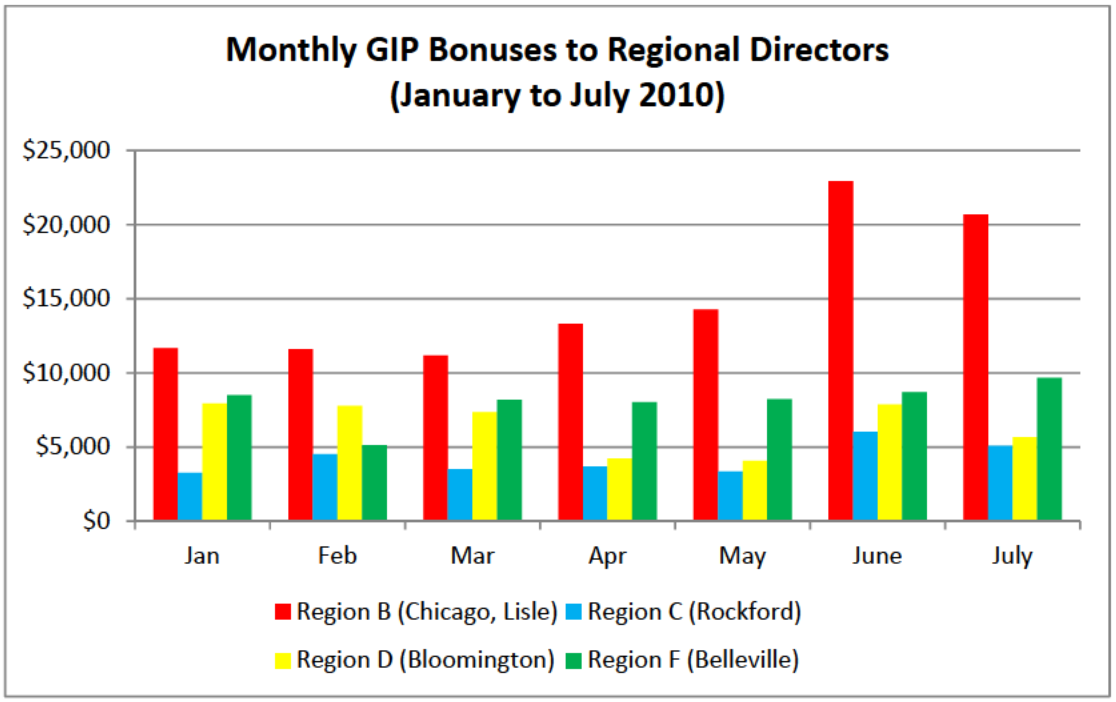
C. GILLMAN Paid Bonuses to Directors to Increase GIP

73. According to interviews, payroll documents and emails, beginning around the fall of 2008, GILLMAN began paying its directors overseeing nurses and certified nursing assistants bonuses based on the amount of GIP under their supervision. This continued up to the time of the January 2012 search by law enforcement, according to the former director of certified nursing assistants for the Rockford region, Individual G.

74. According to Individual G, in the fall of 2008, GILLMAN told her about the bonuses for patients being on GIP or continuous care. According to Individual G, GILLMAN said that if there were four or more patients on GIP or continuous care per month, then both the

regional nursing director and the regional CNA director would get a $25 bonus per patient per day.

75. The chart below shows the total bonuses that the regional directors in Passages' four regions from January 2010 through July 2010, based on a review of payroll summaries for 2010 and bonus request forms kept with payroll documents, which were obtained via the search. As shown in those documents, Region B, which covered Chicago and the western suburbs, had so many patients on GIP and for so long that its director of certified nursing assistants, Individual H, received bonuses that ranged from three to five times her salary for the same periods.



76. According to Individual I, who was the nursing director for the Rockford region in 2010, she got pressure from the director for certified nursing assistants for her region (Individual G) and others to put more people on GIP and thus to get higher bonuses. According to Individual I, Individual G was on the "hunt" for more GIP and sent her many messages trying to get more patients on GIP even though Individual I did not believe that they qualified.

Individual I also provided law enforcement with hard copies of texts that she said were sent by Individual G, showing the effect of the bonus on that director's work. For example, on January 13, 2011, Individual G wrote in a text to Individual I:

> Let's go 'balls out' with GIPS 2morrow. I need a lot of xtra $ - need 2 pay my moms house for next few months to get them back on track. I'm gonna find 2 a day – don't care if I go out til 10pm.

77. According to Individual C, a nurse who worked in the region covering Belleville, Illinois (Region F), she was told by the regional directors in her region to falsify patient notes to make patients appear eligible for GIP. According to Individual C, the directors explained that GIP was "how we get paid," and one told Individual C to "stop the Mary Poppins charting" and to learn how to "bullshit" her charting. As a result, Individual C changed the charts for several patients, including falsely claiming that two patients had been injured as a result of falls and falsely claiming that a patient had no weight gain when the patient had, in fact, gained weight.

78. One such patient that Individual C said that she was told to alter the file of was Patient RR. According to billing data and patient charts, he was on GIP for 89 days, approximately a quarter of the time that he was a patient of Passages. According to one order in the patient file, which was signed by Medical Director F, there was a telephone order by Medical Director F placing Patient RR on GIP on January 19, 2010 because of an "open lesion" and because of a "drastic noted decline in sensory function." According to Individual C, there was no such telephone order, and the information stated about Patient RR was not true.

79. According to interviews and emails, GILLMAN concealed the bonuses from others in the company, including the nurses who actually were required to see patients more frequently once a patient was put on GIP. In a December 2009 email string with GILLMAN and Individual A about hiring Individual K as a new regional nursing director, Individual J, who was

at the time the director of clinical services, confirmed her discussions that the new nursing director, who had already been working at Passages, did not know about the GIP bonus. In one email, Individual J wrote that the new director "has no clue bout Gip." According to Individual J's email, she and Individual A had "discussed waiting to tell her [the new nursing director] about the GIP bonus until after the probation period, just to make sure she can handle it first." In an email later that day, Individual J confirmed a discussion with GILLMAN, "Like we were saying we don't want to tell her about GIP til we know she can handle it."

80. Individual K, who was discussed in the December 2009 email string, recalled being told about the bonus by Individual J, which Individual K recalled being described as a bonus that Individual A "didn't want written down." Individual K said that she had concerns about patients being put on GIP in her region, and said that the director of certified nursing assistants in her region, Individual H, put patients on GIP even when Individual K did not believe it was appropriate. Individual K said that she talked with Individual J, then the director of clinical services, about her concerns about GIP, and that Individual J replied, "This is how we do it." Individual K said that she stepped down as regional director around April 2010 and then left the company a few months later because of concern about her nursing license being in jeopardy by working there. As discussed below in paragraphs 158-59, Individual K sent an anonymous email to GILLMAN in May 2010 reporting her concerns about GIP and the bonus.

81. GILLMAN and Individual A continued to authorize bonus payments to regional directors and other Passages employees through at least April 2011. According to emails, Individual A approved an $11,300 bonus to each of the directors of Region B for the January 29, 2011 paydate and another $8,825 bonus to the same directors for the April 22, 2011 paydate.

82. In addition, based on a review of documents, Passages began paying Individual J a biweekly bonus based largely on the amount of GIP in the relevant period after she stopped being a regional director and instead oversaw all of the regions as the director of clinical services. For example, according to a payroll adjustment form, Individual J received a bonus of $6,987.50, which was broken down in the "explanation" line as follows: "Average GIP total = $4987.5. No Nursing on lists total without follow up: $2000." Based on such forms, Individual J alone received approximately $112,556 in bonuses from March 2010 through December 2010, approximately 70 percent of which was based on the GIP totals. In 2011, Individual A approved by emails a bonus of approximately $7,434 to Individual J for the January 29, 2011 paydate and a bonus of approximately $6,743 to her for the April 22, 2011 paydate.

D. GILLMAN Knew that GIP was Unwarranted

83. On May 25, 2009, Individual H, who was the director of nursing assistants for Region B, sent a GIP tracking sheet to Individual A by email. According to the tracking sheet, Region B had 5 to 9 patients on GIP each day, and thus were to be paid a bonus ranging from $125 to $225 per day, corresponding to a rate of $25 per GIP patient day. According to the tracking sheet, there were 14 patients who were on GIP or continuous care on at least one day, and there were three patients who were on GIP every single day from May 1 to May 25, 2009. Accordingly, Individual H and Individual J were each paid a bonus of $4,450 for the period from May 1 to May 25, 2009.

84. Individual A then forwarded the email to a billing person with a reminder that Individual J was to receive the bonus since Individual J had recently replaced Individual L as the regional nursing director.

85. Approximately 15 minutes later, GILLMAN emailed Individual A, asking, "Who tipped her [Individual J] to it [the bonus]?"

86. Approximately six minutes later, Individual A replied, "[Individual H] did – come on, u know that if it wasn't for the bonus u wouldn't have any of these people on – so it is not like u r out anything – besides, *half these people shouldn't be on most of the time anyways*" (emphasis added).

87. Approximately 30 minutes later, GILLMAN replied, "Why do you write this?"

E. GILLMAN Knew that Nurses Were Placing Patients on GIP Without Physicians' Approval

88. According to the two clinical directors from late 2008 and early 2009, Individual E and Individual B, the interdisciplinary team meetings that they attended in late 2008 and early 2009 were brief and did not involve the detailed discussion of each patient that each believed such a meeting should entail. Each described Medical Director A as simply signing the papers that were put before him without reviewing them.

89. Their description of the interdisciplinary team meetings is corroborated in part by an incident that came to light in the summer of 2009, as well as by changes that Medical Director A attempted to make in the summer and fall of 2009.

90. On July 23, 2009, Passages' medical director at the time, Medical Director A, raised a concern at a corporate meeting about patients with long stays, according to the corporate meeting minutes. According to the minutes, GILLMAN and Individual A attended this conference. According to the meeting minutes, Medical Director A discussed that "there are some patients that have been on hospice for a few yrs that we need to make sure that they still qualify for hospice." According to the meeting minutes, Medical Director A "will let regional director go out and check with patients to see if they are still qualified for hospice on current

state and to document it very well." According to the meeting minutes, a physician liaison was to "follow-up with doctors after IDTs to see which patients were discussed and everything was complete."

91. Following this meeting, at least one long-term patient was discharged from Passages. According to the patient file, Passages nurses discovered by August 2009 that Patient GB had received hospice services for more than three years based on a diagnosis of liver cancer that he did not have. Passages discharged Patient GB on August 27, 2009, but continued to submit claims for hospice services for Patient GB for services through August 26, 2009 even after confirming that he did not have the diagnosis listed in the claims submitted to Medicare.[4]

92. In July or early August 2009, Medical Director A attended a hospice conference and returned with ideas on how to improve Passages' procedures, according to an email by Individual A to GILLMAN, as well as the corporate meeting minutes.

93. On the evening of August 7, 2009, Individual A sent an email to GILLMAN with the subject line "Issues with [Medical Director A]," in which she acknowledged that physicians had not been approving GIP beforehand:

> [Medical Director A] tried to call me twice tonight but I did not take the calls. We need to talk about him before I take the call. From what I

[4] Less than a year later, in March 2010, Passages admitted Patient GB for the second time, this time over the objections of two nurses who had seen Patient GB themselves. In one email, a nurse wrote that she and another nurse had seen Patient GB and believed that he "would not meet requirements." In another email, the nurse wrote that the patient was "better now than 6 months ago and [is] having no s/s [symptoms]." Medical Director A agreed with the nurse and wrote in an email that the patient was not eligible for hospice. Another nurse then wrote to Medical Director A that a nurse practitioner, Individual F, wanted a reassessment for Patient GB, even though the nurse believed that Patient GB would not qualify. Medical Director A admitted the patient. Two months later, Medical Director A discharged Patient GB for the second time. According to patient files and claims data, in December 2012, Patient GB was admitted for the third time by Passages. He continued to be a patient of Passages as of January 2014.

> understand he wants to approve all GIP before they put them on and he does not agree with some of the reasons. I have all those handouts u gave me and we can go over them with him. There was other issues he had….I believe from the conference he attended, I am sure they put fear into part of the presentation….

94. GILLMAN then replied, "What is [Passages' physician liaison] doing to calm him?"

95. A few weeks later, Medical Director A made several recommendations at the next corporate meeting for changes regarding admissions, how Passages ran its interdisciplinary meetings, and how it handled level-of-care changes. According to the minutes of the August 23, 2009 meeting, Medical Director A made the following points:

> We need proper documentation, and get paperwork in order for admission and change in level of care.
>
> Task of IDG is assessing is eligibility, manage pain and symptoms, prepare family and patient and guide family and patient to a "good death". It's more about communicating, not reading the POC [plan of care]. All team members should be prepared and contribute in meeting.
>
> On admission, the assessing nurse must contact the regional medical director with admission criteria and review medications before patient is admitted. SW opinion of mental status unrelated to terminal illness is very important in the assessment process.

96. In addition, the minutes for a September 24, 2009 corporate meeting indicate that Medical Director A discussed at that meeting the importance of getting authorization from a medical director for a level of care change. According to the minutes, Medical Director A suggested, "if they [nurses] don't get verbal authorization we need to find a consequence such as getting written up."

97. Based on interviews with employees in Medical Director A's region, and a review of emails, these procedures appear to have been implemented in Medical Director A's region,

which was based in Rockford. According to Individual I, who was the nursing director in the Rockford region from fall 2009 to early 2011, the procedure for GIP orders in Medical Director A's region was that Passages nurses were supposed to write an email for every potential level of care change. According to Individual I, nurses wrote emails with information about the patient's condition, including the patient's vital signs, weight and co-morbidities. Individual I transmitted the emails to Medical Director A for his approval. If Medical Director A approved, he replied by email and signed an order at the next interdisciplinary team meeting.

98. Medical Director A's procedures appear to have reduced the amount of improper GIP in the geographic region he covered, Region B. According to Individual I, she was berated by Individual A and Individual J for having lower levels of GIP than other regions, as reflected in the bonus information discussed above. In addition, a review of Medical Director A's emails as well as emails provided by Individual I shows that Medical Director A was asked many times about whether a patient should be put on GIP and that he did reject some requests.

99. However, Medical Director A and other Passages' medical directors did not see many of the patients that they certified for hospice care and that they approved for GIP, and relied on nurses for such information. According to interviews and documents, nurses sometimes provided inaccurate or incomplete information to physicians in their requests.

100. For example, Individual I said that Individual G, who was the director of certified nursing assistants in the Rockford region, provided incomplete information to Medical Director A in a February 23, 2011 email about one patient, Patient HM. According to Individual I, Individual G composed an email which Individual I sent to Medical Director A, describing a patient's condition and requesting GIP. Medical Director A approved the change in status to

Individual I, and Individual I reported this to the nurse who was regularly seeing Patient HM. That nurse complained about the change:

> [M]y only problem with that is that is and don't get me wrong she is 104 and really could pass at any time mary and I talk about this daily, but pt has been about the same for a month (I did talk to nurse about poss pain today because PCP [primary care physician] was going to be there later in the day), but it drives me crazy when someone comes down once every 3-6 months that is not a nurse and wants to diagnose all of my patients. This is the third time [Individual G] or [a certified nursing assistant] have come down and made a big deal about one of my pts and they have been put on GIP and 2 or three times it has been normal for that pt and they have had no further problems. I see my pts 5 days a week and feel I know them better than someone who see's them for 5 min and I feel like they walk in an [undermine] everything I have done durign the day.

101. Moreover, according to emails and interviews, Medical Director A's procedures were not implemented in other regions. A review of emails for other regions shows that GIP requests were described as "approved" by nurses, nursing directors, and assistants to nursing directors, without any indication that a medical director had approved the GIP at the time.

102. Individual D, who was the nursing director for the region covering Belleville, Illinois (Region F) from late 2010 to early 2011, said that nurses regularly put patients on GIP without consulting a medical director.

103. Medical Director C, who was one of several medical directors for the region covering Belleville, Illinois (Region F), was asked about some specific GIP changes. For example, Medical Director C was one of several recipients of an August 12, 2011 email in which a nurse wrote that a patient in the Belleville region was being put on GIP because another doctor had ordered Lotrimin to be applied to the patient's toes and feet because the patient was getting a fungal growth. According to the nurse, the patient was being put on GIP so that the nurses could

"monitor for side effects" and "assess for effectiveness and monitor for pain." A few minute later, another nurse replied, "Approved."

104. Medical Director C, who was copied on this email along with another medical director, told agents that he did not believe that he was being asked to approve the GIP request and that he believed that he received this email only to be kept informed about the patient's condition. Medical Director C said that if he had been asked to approve GIP for this patient, he would have denied it based on the information presented.

105. Medical Director C was also asked about a change-in-level-of-care order that he had signed. According to the order, which is dated September 7, 2011, Medical Director C had given a verbal order on August 31, 2011 putting a patient on GIP because the patient had been put on Ambien to improve her sleep, and had ordered GIP so that a nurse would "monitor for increase sleep" and to avoid side effects "such as rash and other severe allergic reactions." Medical Director C said that he did get calls from nurses about significant changes in patients' conditions, but did not believe that he would have received such a call as this. When asked if he would have approved putting this patient on GIP, Medical Director C said that he would have denied it based on the information presented in the order. Medical Director C also said that when he signed papers at the IDG meetings, he did not review every order specifically when signing because he assumed that he was only being given orders that he had already approved in the time since the last meeting.

106. Medical Director B, who was the medical director for the region covering Chicago and the western suburbs (Region B) in 2009 through 2010, said that she occasionally learned at interdisciplinary team meetings about patients who had been put on GIP without her approval. She also saw that some patients had been put on GIP when there was no medical

necessity. For example, she recalled one patient who had been certified for GIP for a skin tear, which Medical Director B said was not appropriate. According to Medical Director B, when she asked nurses at an interdisciplinary team meeting about this patient, the nurses said that the patient's GIP status had been "administratively" approved.

107. According to Medical Director B, she also learned at some interdisciplinary team meetings that patients had been placed on GIP and then returned to routine care without any contemporaneous orders from a doctor. Nurses then presented orders for her to sign at the interdisciplinary team meetings. Medical Director B said that this put her in a "difficult" situation, whereby she was authorizing care that had already been received by the patient. Medical Director B said that she did sign such orders.

108. In addition, when shown some orders that allegedly were signed by her, Medical Director B said that some signatures were not hers.

109. Individual K, who was the director of nursing in the Chicago region in early 2010 and who was discussed above in the December 2009 email string about the GIP bonus (see paragraphs 79-80), said that she attended some of the interdisciplinary team meetings with Medical Director B, first as the assistant to the region's nursing director and then as the region's nursing director herself, also recalled that Medical Director B sometimes was "caught by surprise" at the meetings when finding out that a patient had been put on GIP. According to Individual K, Medical Director B sometimes asked, "Why was I not notified?"

110. In addition, a review of emails involving the region covered by Medical Director B has identified emails in which nurses discuss patients being put on GIP for conditions such as skin tears without a reference to Medical Director B having been consulted. For example, on August 10, 2010, a nurse reported by email that a patient was put on "GIP for a skin tear which is

healing well, scabbing over and open to air." Notably, the email does not refer to Medical Director B having been consulted, and Medical Director B was not copied on the email.

F. GILLMAN Oversees Alteration of Patient Files To Obstruct Medicare Audit of GIP

111. In and around August and September 2009, GILLMAN, Individual A and Individual L, who was the company's chief compliance officer at the time, oversaw and conducted an effort to alter patient files that had been requested by TrustSolutions, a program safeguard contractor that contracted at the time with the Centers for Medicare and Medicaid Services to, among other things, fraud and abuse detection and deterrence.

112. In early August 2009, Passages received a request from TrustSolutions for 30 files pertaining to specific time periods for 27 different patients (some had multiple periods requested), including Patients DB, HC, MM1, and RT. Around the same time, Passages received a separate request from Illinois Medicaid to audit approximately 217 patient files.

113. According to emails sent by Individual L to GILLMAN and Individual A, on August 3, 2009, nursing directors began altering some of the files that had been requested by TrustSolutions. According to an email sent by Individual L on the morning of August 5, 2009, regional directors "are assuming all of the pt. were on GIP and going in to 'fix it' to reflect that." Individual L warned that some nursing directors could create new problems this way since if "we labor under assumption that this is just all about gip and it is NOT, [we] have opened a entirely new can of worms." Individual L advised GILLMAN that there should be a clear leader for the project and that people in the billing department "get the info on the EXACT billing for the DATES IN QUESTION as to exact Level of CARE --- and VERIFY that the level of care for the dates in question truly were billed as GIP."

114. GILLMAN replied in another August 5, 2009 email in which he directed Individual L to "spearhead the project." GILLMAN continued, "I will confirm that these patients are GIP." GILLMAN also wrote, "[P]lease make sure that all of these patients meet the qualifications for GIP including the RN requirement….and the facility requirements for it." GILLMAN also wrote, "I also demand that this is down [done] with cool heads. It could mean a big money overpayment so I need this done right and complete."

115. Individual A, who was the administrator along with GILLMAN, replied with an email providing her own update on the work done thus far. "All the regionals worked very hard yesterday on this and they have a plan and r executing it," Individual A wrote. "[T]hey r hoping to have all completed by tues next week. I like the idea of double checking what we billed for and can pull a report to verify. Call when u get a chance… u might also call all of the reg rn dir [regional nursing directors] to get a better picture of there progress so far."

116. Individual L, who was the chief compliance officer, replied in another August 5, 2009 email that she got her information about the status of the project from Individual J, who was then a regional nursing director and who Individual L wrote was present on August 3 and August 4. In addition, regarding GILLMAN's comment about "cool heads," Individual L reported that Individual M and Individual N, two of the regional directors involved in the project, had been "discussing looking good in prison orange," and said that she had asked Individual A to "call them to diffuse that crazy talk."

117. In her email, Individual L also raised the problem of missing orders elevating patients to GIP:

> if this is GIP - we will need orders signed by MD for change in level of care, is [Medical Director A] going to be willing to go there and write

> back dated orders? some of the pt. clearly do NOT have orders for the level of care change if this is GIP

118. On August 6, 2009, the next day, a billing person at Passages sent by email a list of the audit patients to GILLMAN, Individual A and Individual L. Individual L then sent an email to GILLMAN, Individual A and a billing person, in which she commented that some of the days in the requested period were billed at the routine level, not GIP. Individual L wrote:

> Please let me know when we can get a report or how to get an actual report of the exact billing that was sent to Medicare for the pt. days that are under scrutiny. Again, it would be better to have had this report prior to the regionals starting thier 'work' on the charts. If the regional directors or those they turned this project over to are under working under the assumption that the days they were given to 'work' on are all GIP and working towards reflecting that, we have to turn it around. Now.

119. A few days later, on August 11, 2009, Individual A sent an email to GILLMAN updating him regarding the audit, reporting that she had created a "checkoff list" for each patient file, that regional directors were working "until all info is corrected and printed out," and that there were only a "few items that were not fixable":

> Very busy day! Things r progressing with the medicare audit. [Individual H] and [Individual J] r now in Bloomington and all is well. Everyone promised me that they would all play well tomorrow and work as a team. I have set up folders for every patients and attached a checkoff list for each patient. They all r spending the night again and will not leave tomorrow until all info is corrected and printed out. I have [an employee] working in Elgin copying all the items that we need for the 30 patients from the signed dr. Forms part. She will over night them to Bloomington. [Individual H] and [Individual O] are finishing up any missing ss and chaplain items and all should be complete by end of day tomorrow (the items they were missing were on discharged patients before May). End result, all patients will have an organized file with every piece of needed paperwork by Thursday and ready to be double checked on Friday. I will talk with [Individual L] about this and see if she can do it over the weekend, otherwise I will pull a nurse and have them do it with me.

> There were a few items that were not fixable. Two were in our favor, we billed for GIP but they were on CC. Either way the charting is there, but I am sure they won't point out they owe us money!

120. That same day, Individual H wrote an email to another nurse about what was happening and about GILLMAN's involvement:

> The regional nurses are in Bloomington reviewing 30 charts that Medicare has requested to review charges… Seth [GILLMAN] is really worried about paying back money and having a larger audit because of billing errors that may be found. I think a lot of this is because of the general inpatient level of care. You must be having a smile on your face by now and feel some vindication… The regional nurses are on the hot seat because the nursing documentation is not there.

121. Despite the work done thus far, on August 16, 2009, Individual L reported to Individual A by email that there were still problems with many files and that Passages should ask for more time to respond to the audit request:

> Still in Bloomington and will have to stop with the review now. It is clear we have some issues.
>
> I have review 15 charts of the 30.
>
> Of these items are missing, some were "found" however, some must still be printed or obtained.
>
> SUGGEST WE REQUEST A GRANT OF ADDITIONAL TIME TO PRODUCE THESE 30 FILES.

122. GILLMAN replied, "Can we get an extension? … See what our options are." Individual L replied that the auditor had said "to call them if we have any issues w production of documents. All I can say is that I was very disappointed w what I found knowing people have supposedly been getting this in order for a review. What I was doing was way past that, glad I brought down 2 laptops and my printer." Individual A replied, "In their eyes they r only asking us to make copies and to tell them that we cannot get copies made in 30 days seems a little odd

to me. If u feel that asking for an extension is necessary that is fine, but I will still work with the staff to get this done by the end of the month." GILLMAN then replied, "I'm asking for more time."

123. Two days later, GILLMAN reported that the deadline had been extended until September 15, 2009. According to TrustSolutions' notes, GILLMAN called on August 17, 2009 and requested additional time to provide the medical records, which was granted. According to the notes, GILLMAN's explanation for the request was that Passages was also being audited by Medicaid.

124. On August 18, 2009, Individual L forwarded to GILLMAN by email handwritten notes about her review of the patient files as modified by the regional nursing directors. In the email, Individual L wrote, "Yes, I stay up at nite and worry how we will get this done, and not have to pay them big $$$ back."

125. In an August 19, 2009 email, Individual A reported to GILLMAN by email about missing chaplain assessments. "For the Medicare audit, there r 12 missing Initial Chaplain assessments. I spoke with [a social service director] on this today, she said that she will 'Find' them and get them to me tomorrow." GILLMAN replied, "That's my [first name of the social service director]."

126. In an August 24, 2009 email, Individual A approved bonuses to several regional nursing directors, including Individual J and Individual H. GILLMAN replied, "Holy shit that's a lot of money. Do they understand that if Medicare takes back the inpatient dollars from any of their patients I will dock their bonus pay?"

127. On August 27, 2009, Individual L emailed GILLMAN and Individual A with more notes about the patient files. "Issues continue to plague this process," she wrote. GILLMAN replied, "Can we discuss tomorrow. I saw this and made notes."

128. Based on a review of emails, after Passages employees had spent several weeks altering the files requested by TrustSolutions, Passages retained an outside consultant, Pathway Health Services, to review the altered patient files. On September 8, 2009, Pathway Health Services provided its report to Passages. The report found many problems even with the altered files, and found that almost half of the patient files "had levels of care that were not supported as needed," that Passages was using GIP improperly for patients who had infections or were being given antibiotics, and that two patients "failed to meet the requirements for hospice coverage." The report's findings were as follows:

- 14 of 30 records had levels of care that were not supported as needed.
  - Patients with infections and/or antibiotic use did not meet the criteria for infection, were asymptomatic, and did not require inpatient status.
  - Patients with certain diagnoses failed to have documentation to support need for additional assistance or observation and assessment.
  - Two patients failed to meet the requirements for hospice coverage.
  - Six patients were kept on inpatient status too long.
  - Two patients failed to have inpatient status initiated when there was an identified need.
  - One patient had conflicting diagnoses for hospice coverage.
- 4 of 30 records failed to have physician orders for the change of level of care.
  - One record had conflicting admission orders from 2 physicians.
- 9 of 30 records lacked documentation of visits to meet the planned schedule.

- Most were missing visits but several showed visits in excess of planned numbers.

- 17 of 30 records had bills that showed discrepancies in numbers and types of levels of care provided versus record documentation of delivery of said services.

  - Most discrepancies showed GIP days billed in excess of days provided.
  - Some bills were reflective of under billing services.

129. According to a September 2, 2009 email by Individual A, Passages employees planned to use Pathways' findings to try making further alterations to the patient files. In an email to several regional directors, which was also sent to GILLMAN, Individual A wrote that the "auditor we hired to review the charts [Pathway]" had provided comments to and that they should make the "corrections" identified by the Pathways consultant:

> The auditor we hired to review the charts is finished. I have all of her comments and I will be faxing them to [you] tomorrow. I would like all named [here] to plan on being in the Bloomington Office Next Tuesday and Wednesday to get all of this ready to go and proofed one more time. [Individual L] will be there to [be] head of this final leg. We will start promptly at 9:30. Please arrive by 9 so that u r ready to start at 9:30. If you will need a room for Monday or Tuesday night please let [an employee] know and she will set that up for u. Please bring your computers and printers and extension cords. I would suggest making the corrections that she has stated and then all that will be left to do is review that they were made correctly and that we have all items needed. These will be long days, plan on working at least until 5 or 6 the first night and then be back at the office by 8:30 the next morning. I know it will be long days, but we cannot rush through this part. This needs to go in the mail on Thursday.

130. On September 8, 2009, GILLMAN signed multiple cover letters for the patient files provided to TrustSolutions. For example, in the letter enclosing Patient DB's file, GILLMAN wrote that the "documentation enclosed herein supports the Hospice's claims for

services provided to [Patient DB] from 9/1/08 to 9/15/08 and reflects that all requirements for Medicare coverage were met."

131. Several former employees have admitted to law enforcement their involvement in the altering of patient files in the summer of 2009 as well as in another session in 2010. According to Individual P, who was a former case manager in the Rockford region (Region C), he attended a meeting at a synagogue in Bloomington, Illinois with Individual A, Individual L, and others. According to Individual P, Individual A told the people at the meeting that patient files were missing significant documentation and needed to be "fixed." Individual P said that he understood Individual A's instructions to mean that patient files needed to be altered and that documents had to be created in order to support Passages' fraudulent billing to Medicare. According to Individual P, he and the other participants changed doctors' orders and created or altered notes for patient visits using Passages' charting software. Individual P recalled Individual L bragging about how good she was getting at forging Medical Director A's signature.

132. According to Individual Q, who was the nursing director of the region covering Chicago and the western suburbs (Region B) in 2010, he participated in a session in early 2010 in Elgin. According to Individual Q, he was told to come to Elgin for a project and found that the group was working to alter files. According to Individual Q, he was told that if the forms were not fixed, then Passages would not get paid. Individual Q said that he forged signatures for "all kinds of people," including physicians and chaplains. Individual Q said that Individual A checked all documents and returned them if she found them to be incomplete.

133. One of the files that Passages provided to TrustSolutions was for Patient DB, whom Individual E (the clinical director who was terminated in late 2008, see paragraphs 52-59)

said was the first patient who caused conflict between her and GILLMAN regarding GIP. According to claims data, Patient DB was on GIP from August 8 through October 16, 2008, and then was on routine care from October 17, 2008 through his death on November 29, 2008. In total, he was on GIP for approximately 70 days out of approximately 114 days total, approximately 61.4 percent of the time.

134. Law enforcement has received three versions of the patient file for Patient DB, one which GILLMAN sent to a Medicare auditor in September 2009, one which the company provided in 2013 in response to a subpoena, and one which Individual E printed out prior to losing access to Passages' systems and provided to agents.

135. The patient file for Patient DB, as provided by the company in 2013 in response to a subpoena, does not include a specific order putting Patient DB on GIP. Instead, the initial plan of care stated that he was placed on GIP relating to "frequent upper respiratory infections with frequent hospitalizations," and that he "no longer qualifies for assisting living [related to] skilled needs" and that he was "just discharged from [a] hospital with [a diagnosis of] pneumonia." According to the plan of care, Patient DB was to be seen daily by a nurse, consistent with his being placed on GIP. By contrast, the version provided by Individual E had an initial plan of care that listed Patient DB's level of care as routine and that required a nursing visit only once or twice a week.

136. Despite Passages billing Medicare for GIP services continuously from August 8 through October 16, 2008, the patient file for Patient DB does not reflect daily nurse visits, even in the version produced in 2013. The patient file produced in 2013 includes only five nurse visits in the period from August 8 through August 31, 2008, and only eight nurse visits in the period from September 16 through October 16, 2008, or approximately a visit every other day or less

frequently. Moreover, the summary or progress notes in the patient file for all but one of these visits indicates that the nurse observed no symptoms of acute distress and no symptoms of decline seen, and that Patient DB was stable each time. For the one exception, the nurse noted some confusion by Patient DB as to his name being called and some disorientation as to time and place.

137. The patient file produced in 2013 shows daily nursing visits only for the period of September 2, 2008 through September 15, 2008. According to the notes, during this period, Patient DB was confused, pushed the staff at the nursing facility, yelled at the staff, and needed total assistance with all activities of daily living. As discussed below, that was the period specifically requested by a Medicare auditor in the summer of 2009, and emails and interviews indicate that Passages employees altered Patient DB's file and other files prior to the submission by GILLMAN of such files to the auditor.

138. By contrast, the version provided by Individual E shows only four visits during the September 1 through September 15, 2008 period. Moreover, a review of the nursing notes from Patient DB's nursing home does not include any references to Patient DB pushing staff or yelling at staff in that period.

139. According to claims data, Passages submitted claims for the services allegedly rendered to Patient DB from August 8, 2008 to September 30, 2008 in the fall of 2008. Passages then submitted claims for the services allegedly rendered to Patient DB from October 1, 2008 through November 29, 2008 approximately one year later, all on or about October 14, 2009.

140. More specifically, on October 14, 2009, Passages submitted a claim seeking payment from Medicare for hospice services provided to Patient DB from October 1, 2008 through October 15, 2008 in which it claimed that it provided services at the general inpatient

level to Patient DB throughout that entire period. In fact, Passages' own file shows that a nurse visited Patient DB only four times during that period, and that the nurse saw no symptoms or signs of acute distress during each of these visits. According to claims data, on December 17, 2009, Passages was paid approximately $10,191.82 on the claim for October 1 through October 15, 2008, reflecting approximately a payment of approximately $672.36 per day.

G. GILLMAN Used GIP to Get Referrals from Nursing Homes

141. According to a review of documents and emails, Passages had arrangements with several nursing homes in 2009 and 2010 in which Passages agreed to pay the nursing homes $250 for every patient who was on GIP per day. As of September 2010, Passages had such arrangements with approximately eight nursing homes, according to an email exchange between Individual A, GILLMAN and the chief financial officer at the time, in which the chief financial officer confirmed the nursing-home GIP tracking sheets he had received that month.

142. In at least one instance, Individual A, who was the administrator of Passages along with GILLMAN, agreed in emails with the manager of some nursing homes, Individual R, to make payments to a nursing home if the nursing home had a certain number of residents on hospice with Passages, and receiving GIP care, per month. In her emails, as described below, Individual A also stated that she expected that the nursing home would not refer patients to any other hospice.

143. On October 15, 2009, Individual R sent an email to Individual A. "You will be at 10 residents at [a nursing home in Westmont] by next Friday. [The Westmont nursing home's administrator] is on board When will I start collecting my 250 per day?"

144. Individual A replied:

> Remember I told u that it had to be an average of 10 for the month and then all of your gip days will be at $250…Okay, let's see if u r a man of ur word…if r u really have 10 by next Friday I will start the $250 a day for the gip days this month. I think u have only had one person on this month so far but I will talk with the Regionals about trying to pick a few more up…Besides it will be fun to see if [the nursing home's administrator] is really on board.

145. Individual R replied:

> That is great. You told me 250 per day for each resident. How do we get more on GIP. I got [the nursing home's administrator] on board by telling him I was getting 250 per day for all 10 residents. How do we make it happen?

146. Individual A replied:

> Oh relax, let me put some numbers together and we can chat next week….and to think I just thought u were actually "telling" [the nursing home's administrator] how it was going to be….my guess.....there was a deal with the extra $22,000 a month….I think we can work something out…but if we do I would hope that we don't see any other hospice in there….and I did not tell u $250 per day it was $250 per day for GIP patients.

147. Individual A then forwarded the email string to GILLMAN, who replied, "This guy [Individual R] has dollar signs in his eyes. No way am I gonna lose money on this.only gip. He's already making dough in belleville and he's not exploiting that. I need the extra $ for blackjack."

148. In another instance, on December 14, 2009, Individual A sent GILLMAN an email about her plan to offer GIP payments to another nursing home in Chicago:

> Here is my pitch….20 patients would be monthly cash flow of $85,000 and would be willing to pay for GIP days at 250 so if [he had] 100 days of GIP then that would be an extra 10K. So basically looking at $100,000 a month cash flow and extra staff from passages plus dr. lounge…..
>
> That leads me to this…lets put together some numbers to show [the Chicago nursing home administrator] about monthly cash flow with

> number of patients on…..if he was just to give us 15 patients at each of 9 buildings he would get $513,000 a month cash flow.

149. Emails and recordings also indicate that GILLMAN, Individual A and Passages marketers viewed GIP as a way to fund other kinds of payments to nursing homes. For example, on April 13, 2010, Passages' head of marketing, Individual S, sent an email to GILLMAN and Individual A reporting that a hospital wanted Passages to pay extra for certain patients. GILLMAN replied, "Ill do it if the nurses play ball with GIP. No problem."

150. On September 27, 2010, Individual S, who was Passages' head of marketing, reported to GILLMAN and Individual A that he had gotten a nursing home representative to agree that Passages would not revoke a patient who had just returned from the hospital by agreeing to pay the nursing home the "GIP rate." Individual S also wrote that he had spoken with a nursing director to ensure that the patient, Patient EO, was placed on GIP:

> I met with [a nursing home employee] at [a nursing home in Cicero] and agreed to pay them the Gip rate for the patient [Patient EO] that came back from the hospital. [The nursing home employee] wanted us to revoke the patient so they could use the medicare days. I spoke with [Individual X, the nursing director for the region] to make sure that they would GIP the patient.

151. According to billing data, Passages submitted claims for GIP services for Patient EO beginning on September 27, 2010 and continuing through October 19, 2010. Passages' file for Patient EO, which Passages provided in 2013, included an order signed by a medical director placing the patient on GIP beginning on September 27, 2010. According to the order, as well as a subsequent order, the patient was placed on GIP because of a concern about low oxygen readings.

152. However, to the extent that GIP was allegedly justified beginning on September 27, 2010 by a concern that Patient EO's oxygen readings were below 90 percent, that problem

had already been resolved two days earlier. Orders and patient notes in the file showed that Patient EO had maintained oxygen readings greater than 94 percent after being discharged from the hospital and thus had been returned to the routine level of care on September 25, 2010, two days before Individual S's email and Medical Director D's order.

153. According to payroll documents and emails, GILLMAN and Individual A authorized bonuses to Passages' marketing people based on the number of admissions per period. Individual Z, who worked as an admissions coordinator for Passages from 2009 to 2011, said that she was paid a $50 bonus for every patient enrolled at Passages. Documents entitled "Passages Hospice Bonus Request" had lines for the number of admissions for a given month and the total bonus requested. According to Individual S's bonus request for September 2010, the month in which Patient EO was admitted, Individual S requested a bonus of $30,200 and reported 129 admissions. According to a payroll summary, Individual S was paid that amount.

H. GILLMAN Ignores Continuing Complaints in 2010

154. Throughout 2010, one medical director, a former nursing director, a nurse, and the nurse's boyfriend raised concerns relating to GIP directly to GILLMAN.

1. Passages Fires Nurse Whose Boyfriend Called GILLMAN About Problems

155. According to Individual C, the nurse who was told to falsify patient notes in the Belleville region (see paragraphs 77-78), she discussed her concerns about Passages with her boyfriend, Individual T. Individual C also prepared a grievance that she planned to give GILLMAN and Individual A when they came to the region for a meeting in January 2010.

156. Individual C's boyfriend at the time, Individual T, said that he had overheard some of Individual C's discussions with the regional nursing director, Individual U. He said that he had overheard Individual U tell Individual C to stop the "Mary Poppins charting," and

Individual U's instructions that Individual C place false information in patient charts. He said that he called GILLMAN to report Individual C's conduct, believing at the time that GILLMAN was not aware of the conduct. According to Individual T, GILLMAN seemed to not know about Individual U's conduct, and Individual T believed that GILLMAN would take action based on the call.

157. A few days later, the regional directors terminated Individual C's employment. According to Individual C, the regional directors said that GILLMAN had been upset that Individual T had contacted him. According to Individual C, she tried to read her grievance to the directors, but one snatched it from her hand, yelled "Got it," and ran out. According to Individual C, local police officers then arrived to take Individual C off the premises, and explained that they had received a call that Individual C had a firearm, which she did not have.[5]

2. GILLMAN Ignores Complaint by Former Nursing Director

158. On May 13, 2010, Individual K, a regional nursing director who was discussed in the December 2009 email string about the GIP bonus and who had stepped down as director by this time, sent an anonymous email to GILLMAN asking him to "explain why manager receive extra money for GIPs and the rest of the staff does not. It's the nurses that have to do all the extra care." Individual K continued:

> Mr. Seth Gillman, This is a great company to work for if the right people were placed in management. It is made very clear that Passages is all about how much money it can make and how high the census is. At the last meeting it was stated that we are not a family anymore, which is very true. How can we be a 'family' if we are continued to be overwhelmed

[5] According to a police dispatch report, someone from Passages called local police on February 2, 2010 with a request to "keep the peace" while Passages terminated Individual C, and reported that Individual C "carries a gun." According to the dispatch report, police arrived and resolved the incident without any arrest.

> with work, not be able to voice our concerns without feeling our job is threatened, constantly disrespected and degraded, and constantly reminded that we don't have enough people on GIP?

159. GILLMAN forwarded the email to Individual J (then Passages' director of clinical services), asking for her thoughts. Individual J guessed, correctly, that the email was sent by Individual K. GILLMAN replied, "I too suspected [Individual K]. Is she a cancer in [Region] B?"

3. GILLMAN Ignores Concerns Raised by Medical Director B

160. On April 7, 2010, GILLMAN and Individual A received an email reporting that Medical Director B, who oversaw the region covering Chicago and the western suburbs, had discharged a patient because her condition had stabilized and showed "stable vital signs," and thus no longer qualified for hospice.

161. Within minutes, GILLMAN sent an email to Individual A, stating: "Wtf." Individual A replied, "She [Medical Director B] has to go."

162. The next day, Individual J (the director of clinical services) sent an email to GILLMAN and Individual A explaining that she and others had met with Medical Director B about "recent revocations and denials on admits." According to Individual J, Medical Director B was "doing a great job" but "wasn't very confident with the information that was being presented to her," and that Medical Director B was basing her opinions on the information being presented by the nurses. Individual J commented that the region had many new nurses who "perhaps may not understand exactly how to fish through charts for appropriate diagnosis." In her email, Individual J recommended that GILLMAN keep Medical Director B for a few months, though she recognized that "[u]ltimately in the end it will be your decision."

163. On May 28, 2010, Medical Director B sent an email to a nurse raising a concern about whether a patient who had been admitted the previous day, Patient MM2, was properly eligible for hospice under a diagnosis of "failure to thrive." In her email, Medical Director B wrote:

> The albumin of 6.9 is a red flag. If a patient truly is ftt [failure to thrive] they cannot have such a high albumin. Something is being missed. I am not feeling comfortable with pts being oked [admitted] without having a depth of knowledge that comes from experience. Just my take. My job is to look out for the company in clinical matters. Again I am raising concern. Perhaps we should have a meeting [with a nurse].
>
> I think there are some system issues to work out. Hiring another director is not the immediate solution when the trouble is in the field.

164. Medical Director B forwarded her email to GILLMAN with the message: "We need to talk soon." GILLMAN replied, "I invite it."

165. On his reply to Medical Director B, GILLMAN also copied Individual J, Passages' director of clinical services. Individual J sent GILLMAN an email asking him how to respond to Medical Director B since Individual J believed that the patient qualified for admission. GILLMAN replied: "We make the decisions in our company."

166. According to the patient file for Patient MM2, Medical Director B did sign a form certifying Patient MM2 as eligible for hospice on June 2, 2010. Passages then provided hospice services to Patient MM2 from May 27, 2010 through September 20, 2010, when she was discharged, and billed such services to Medicaid. According to a September 20, 2010 email sent by a regional nursing director to GILLMAN and others, Patient MM2 "no longer qualifies for hospice services" because there was no evidence of weight loss, no signs of significant decline in her cognitive or physical functioning, and because she required only minimal assistance with the activities of daily living.

167. I interviewed Patient MM2 in person on January 21, 2014. Patient MM2 said that she was not dying and said that she had never been told by anyone that she was dying. When asked about hospice care, she initially was not familiar with that concept, but said that she never had received such care. When asked specifically about Passages Hospice, she did not recall the name and did not recall ever being on hospice.

168. According to Medical Director B, she told GILLMAN that some patients were being admitted to hospice and elevated to GIP without her approval. Medical Director B said that GILLMAN replied that if the patients did not qualify, they would not be on hospice. According to Medical Director B, GILLMAN said that he would look into what she had raised, though Medical Director B said that she was not sure if GILLMAN understood her concern. Medical Director B said that she saw no changes in Passages' practices over the following months, and then decided to leave Passages.

4. GILLMAN Ignores Internal Findings About GIP Problems

169. According to Individual V, who was Passages' Medical Compliance Officer in 2010, she began conducting a review of GIP problems at Passages in the summer of 2010. According to Individual V, she did this after setting up a 1-800 number for Passages employees to call with complaints. According to Individual V, the 800 number received numerous complaints, including nurses who reported that GILLMAN had directed them to maintain at least ten percent of their patients in General Inpatient Care, which Individual V learned was more than three times the national average. Through these phone calls, Individual V also learned that regional directors and marketing personnel were receiving monetary rewards, sometimes equal or greater than their salary, for certifying a high percentage of their patients for GIP.

170. In August 2010, Individual W conducted an audit of three patients. On August 16, Individual W sent a report with her findings to GILLMAN, Individual A, Individual V, and Individual T, who was Passages' counsel at the time.[6] In the report, Individual W concluded that there were problems with each of the three patients that she reviewed, with one patient not meeting the criteria for GIP at all and with the two other patients being placed on GIP excessively:

> As requested by [Individual V], please find attached my brief audit of the GIP's of 3 patients in region B, for which [Medical Director B] is the medical director for these 3 patients.
>
> One patient clearly does not meet GIP criteria ([Patient PK]).
>
> While the two others meet initial GIP status, they probably were enrolled for an excessive length of GIP duration, however, the documentation is not clear as to how extensive the disease process is that prompted the status change. If there was very extensive documentation, then that may justify their extended GIP status (For example on [Patient BK]: How bad is the rash? Amount of body involvement? Open wounds? Drainage? Size of vesicles? etc... But nothing like this can be found in the documentation).

171. According to Individual W's report, the following periods of GIP were problematic:

Patient	Beginning Date	Length	Reason	Individual W's finding
PK	7/28/10	4 days	GIP was for "+1 edema," though "documentation states pt. denies pain with no objective s/s of pain/discomfort. Patient's vital signs were all within normal limits."	GIP was improper

[6] Passages provided this email to law enforcement in response to a civil investigative demand and did not claim a privilege regarding this email.

Patient	Beginning Date	Length	Reason	Individual W's finding
FW	7/26/10	4 days	GIP was for "neurological changes," though "vital signs were within normal limits, and no further intervention was required by the nursing facility."	GIP was initially proper, but "length of time on GIP was excessive"
BK	5/6/10	2 days	GIP was for "Eucerin lotion use to help keep skin moisturized"	"Use of over the counter body lotion to help keep skin moisturized clearly does not constitute a change to GIP services"
BK	5/24/10	[Not stated in report, but billing data shows 8 continuous days of GIP beginning on 5/24/10]	GIP was for "monitoring for CVA" after a certified nursing assistant "noted a change in the patient's speech pattern (became slurred) and having difficulty swallowing."	GIP was initially proper but length of time was excessive
BK	6/29/10	4 days	GIP for a "rash that required a prescription for Clobetasol cream."	GIP was initially proper but length of time "seems excessive since she was having no reactions to the medicated lotion."

172. Individual A replied to Individual W's email, "I think those are all good learning points." However, a review of emails and interviews indicates that little was done to educate Passages nurses or medical directors about Individual W's findings.

173. According to Individual W, she tried to teach Passages nurses about how to do GIP properly, but she did not observe any changes as a result of her efforts. Based on a review of emails, GILLMAN was aware of an effort to limit Individual W's training efforts.

174. On September 9, 2010, Individual X, who had become a regional nursing director a few weeks before, sent an email to Individual A and Individual J, then the director of clinical

services, complaining about the training session that Individual W had done that day. According to Individual X, Individual W explained to the nurses that a patient should not be put on GIP because the patient was receiving antibiotic therapy or for a skin tear unless it "looks red after a few days." Individual X wrote that she believed GIP was warranted in situations where a patient "requires more extensive monitoring," such as whenever a patient receives antibiotic therapy or has a skin tear, and complained that it was "inappropriate for [Individual W] to contradict everything we put forth" regarding Passages' nursing procedures.

175. The following day, a Passages attorney sent an email to Individual A and Individual J, summarizing a discussion which they had had. According to the attorney, Individual W would send any information that she planned to use to Individual A, Individual J and to regional directors prior to presenting to nurses. Individual A forwarded the email to GILLMAN.[7]

I. October 2010 Conference Call with Consultant

176. In the fall of 2010, as employees raised questions about GIP, Passages arranged for an outside consultant to conduct a telephonic training session for the regional directors of nurses and certified nursing assistants.

177. On October 24, 2010, Individual J, who was the director of clinical services, sent advance materials from the consultant to the directors of nurses and certified nursing assistants, as well as to GILLMAN and Individual A. In her email, Individual J wrote:

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[7] Passages provided this email to law enforcement in response to a civil investigative demand and did not claim a privilege regarding this email.

> There may be some new info that we will learn on this call, there is no need to express how we are doing things or how we have done things on the call.
>
> If you have specific questions on how we have done things in relation to what she is going to be teaching us please wait til after the call and we can discuss as a team.

178. The materials forwarded by Individual J correctly stated that GIP was to be used only in specific situations. Among other things, the materials included the National Hospice and Palliative Care Organization's compliance tip sheet, which was described and quoted above in paragraph 22.

179. According to Individual I, who was the nursing director for the Rockford region in 2010 and who participated in the training, the teleconference was a turning point for her because she then understood that Passages had been using incorrect criteria for GIP. According to Individual I, the consultant said in the call that hospice nurses should try to manage a patient's condition at a lower level of care before elevating the level of care, and that GIP was only appropriate when a patient's condition could not be managed at the lower level of care. Individual I said that she was alarmed at what she heard because Passages nurses made no efforts to manage patients' conditions at the routine level of care before putting patients on GIP.

180. According to Individual I, she expected that new guidelines about GIP would be promulgated after the October 24, 2010 teleconference. However, no new guidelines or criteria were promulgated, and she did not notice any changes in how GIP was used. By early 2011, Individual I believed that no new guidance would be provided, so she decided to step down as nursing director for her region. Individual I said that she met with Individual J about her concerns, including the pressure that she was getting about GIP from the director of certified nursing assistants in her region. According to Individual I, Individual J said that Individual I had

to learn how to "play the game," which Individual I understood to be an instruction to go along with Passages' practices. According to Individual I, Individual J said that she also received pressure about GIP from GILLMAN and Individual A.

181. Individual D, who started as regional nursing director of the region covering Belleville in the fall of 2010, recalled the conference call. According to Individual D, she believed that the training was being done by a representative of Medicare. According to Individual D, Individual J said before the call that the participants were not to ask questions, and Individual D said that she believed that the call was a formality since Passages did not do GIP the way that the speaker discussed. According to Individual D, in early 2011, she began asking questions about several Passages practices, including GIP. Individual D said that she was terminated soon afterwards.

182. Individual W, who did the internal audit in the summer of 2009 about GIP, said that she was surprised that no one asked questions during the conference call, and that it sounded as if the participants were not paying attention or were dropping off of the call. She said that she did not believe that any changes were made to how Passages did GIP following the call, based on the files that she reviewed as part of audits.

183. According to Individual W, she talked with GILLMAN about GIP when they were visiting an office space together in Schaumburg. According to Individual W, she told GILLMAN that they had a big problem with GIP. According to Individual W, GILLMAN replied words to the effect of, "I know, I know," which she understood as his brushing her off.

184. When asked by law enforcement, several employees have said that they did not hear anything about an outside consultant talking about GIP, or receiving any information indicating that Passages had done GIP improperly prior to law enforcement's search. Medical

Director C, who was one of the regional directors for Passages from 2010 through mid-2011, said that he was never told about a training session.

J. GILLMAN Paid Himself Bonuses Based on GIP

185. According to emails and financial documents obtained during law enforcement's search of Passages' offices, GILLMAN authorized large bonuses to himself and to Individual A based on the number of patients per day at certain nursing home facilities in the Belleville region. In addition, based on payment information found in the search of Passages' offices, from March 2009 through April 2011, GILLMAN authorized at least $833,375 in bonuses to himself based on the number of patients per day.

186. For example, on June 1, 2009, Individual A sent an email to a billing person and to GILLMAN, writing: "Attached is bonus for Seth [GILLMAN] and [Individual A] for May, it is $3900 each. This is calculated by $20 per patient per day on routine care and $75 per day per patient for GIP or CC. This month they were all Routine. This bonus should go on the 15th check." On August 6, 2009, Individual A sent an email to two billing people and to GILLMAN, with the subject line: "Bonus for Seth [GILLMAN] and [Individual A] for Belleville area for July $9,605." According to the backup, this bonus was based on the number of GIP patient days at two nursing homes, Atrium and Lincoln Home, and a rate of $75 per day for certain patients and $20 a day for others.

187. The bonuses increased as the number of patients on GIP increased and as the number of facilities counted for the bonuses increased. The following table shows the bonuses that GILLMAN and Individual A each received for several months between March 2009 through April 2011, based on documents and emails found in the search:

Month	Bonus	Routine Days	GIP Days	CC Days
March 2009	$5,600			
May 2009	$3,900			
July 2009	$9,605			
August 2009	$17,020			
December 2009	$34,885	833	237	6
January 2010	$42,665	989	305	0
February 2010	$38,860	1,013	248	0
May 2010	$46,665	1,197	297	6
July 2010	$67,380	1,929	375	9
August 2010	$72,665	2,122	392	11
September 2010	$74,095	2,276	371	10
October 2010	$78,100	2,405	389	11
November 2010	$78,100	2,405	389	11
December 2010	$88,980	2,611	479	11
February 2011	$84,155			
April 2011	$90,700			
TOTAL	$833,375			

188. In addition, according to financial documents found in the search, from August 2009 through at least November 2010, GILLMAN received an additional bonus based on Passages' total patient population. According to a January 21, 2010 email that GILLMAN sent to the chief financial officer at the time: "Just a reminder. Each month I am to get, in addition to my salary, an extra amount equal to [Individual A's] Belleville bonus and an amount equal to the months average census over 150 times 100, payable on the 15th of the month subsequent."

189. Based on wire transfer forms for payments covering August 2009 through November 2010, bonuses were paid by wire to at least five different accounts, for a total Belleville bonus of at least $395,500 and a total census bonus of at least $364,016.

VII. GILLMAN WAS INVOLVED IN IMPROPER ADMISSIONS

190. Based on a review of emails, GILLMAN caused Passages to admit a patient over a medical director's objection on at least one occasion. Based on a review of emails, GILLMAN

also knew of other improper admissions involving patients who did not know that they were being admitted to hospice care.

1. Patient VB

191. On October 2, 2009, a regional nursing director, Individual N, sent an email to Individual A describing the refusal of Medical Director A, the medical director, to admit Patient VB. Individual N wrote: "Spoke with [Medical Director A], he stated that pt has not shown any decline. Therefore, he does not feel that she has a terminal illness of 6 months or less. Pt is at Belwood and her name is [Patient VB]. We were trying to pick her up for Dementia and she also has Parkinsons."

192. Individual A asked for more details as to why Patient VB may qualify under Passages' hospice guidelines. Individual N replied:

> [Patient VB is] total assist with all adls [activities of daily living], she has dysphagia with a feeding tube, she is demented with agitation and anxiety issues, she is [wheelchair] bound. However, these are all deficiencies that she has had for awhile and has shown no further decline. Her wt is stable since March. She has also recently been dropped by another hospice for "no decline in condition". I can see both sides but as [an employee] said- she has all deficiencies for dementia that their other pts in the facility on our hospice have. Oh, she is also nonverbal which is a qualifier for dementia.

193. Individual A then forwarded the email string to GILLMAN, writing, "Not happy with [Medical Director A] about this … read from bottom of email first."

194. GILLMAN replied, "So fuck him [Medical Director A] and run it [the admission] by [Medical Director B, another medical director]."

195. According to claims data, Passages submitted claims to Medicare for hospice services for Patient VB beginning on October 8, 2009 through Patient VB's death on July 24, 2010.

196. According to the admission order included in the patient file, Medical Director B, whom GILLMAN had referenced in the email above, did not admit the patient either. Instead, it was Medical Director D who certified Patient VB as eligible for hospice. According to a review of emails, Medical Director D was one of three medical directors for Passages at the time, though he was not the medical director for the geographic region covering Patient VB. There is no indication in the patient file that Medical Director D was told that Medical Director A did not believe the patient to be eligible for hospice and that another hospice had discharged that patient.

197. According to Patient VB's daughter, she was approached by a man who worked for Passages and asked the daughter to have Patient VB admitted to Passages. Patient VB's daughter said that she believed hospice was only used when the patient was dying, which she did not believe her mother was at the time. According to Patient VB's daughter, the Passages representative replied that hospice was "not like that anymore."

198. According to claims data, on or about October 19, 2009, Passages submitted its first claim to Medicare for hospice services for Patient VB. According to a review of claims data, Passages was paid approximately $43,824 in total based on claims submitted to Medicare. As noted above in paragraph 47, the government's expert reviewed the patient file for Patient VB and determined that the patient was not eligible for hospice with the diagnosis of dementia for the initial six months of service.

2. Patients Admitted for "Extra Care"

199. In addition, on several occasions, GILLMAN was informed that Passages marketers were improperly describing Passages' services and were telling patients that Passages provided "extra care," rather than services for patients who wanted to suspend curative treatment and were facing the end of their lives.

200. For example, on October 13, 2010, a social service director forwarded GILLMAN an email about a director of nursing at a nursing home who believed that Passages was improperly marketing its services to patients as "extra care" and thus admitting patients who still wanted aggressive treatment for their medical problems and were thus considered "full code."

> She expressed a major concern about the patients here that are on hospice. The concern is that all the patients are full code, receiving aggressive treatment, and go in and out of the hospital from time to time. The patients are revoked, re-admitted, and revoked again. She feels this is a huge disservice to the patients, their families, and the facility. She has spoke to several families of patients on hospice and realize that they are not being educated on the seriousness of hospice, and simply think we are a "extra care" company. She feels in order for the patient to benefit from hospice the families and PCP needs to be fully aware of hospice services, advanced directives, etc. She said she feels it looks bad for the company to misinform families about the services we provide for their loved one, and then take the "extra care" away when they go to the hospital, when we are fully aware from the beginning this is a possibility dealing with sick pts in the nursing home. She feels this adds an extra stressor to the family and an already stressful situation. She has also been receiving calls from doctors and nurses at local hospitals regarding the conflict of interest it is to have a patient there from her facility that they are doing everything in their power to save and someone comes in and says the patient is a hospice patient. It doesn't make sense to her. She feels someone is dropping the ball. She also expressed she has been the DON at other facilities (West Surburban) that Passages staff comes in, but this is the only one that she's having a problem with as far as patients being on our service that may not be appropriate or ready for hospice care.

201. Approximately three months later, on January 26, 2011, a physician's liaison reported in an email to the other physician liaisons and to GILLMAN and Individual A that a medical director refused to recertify some Passages patients because they had not been properly informed as to what hospice was. According to the physician liaison:

> [Medical Director E] denied a few re certs due do the pt either being full code and declining rapidly or it doesn't seem that the family is fully aware of what Hospice really is.
>
> [Medical Director E] mentioned that this could become a problem towards FFE regulations [Medicare regulations implemented in 2011 that required that a hospice physician or nurse practitioner must have a face-to-face encounter with a hospice patient prior to the beginning of the patient's third benefit period and each subsequent benefit period] because if the patient is not hospice appropriate then they will not qualify for a re certification. He feels the marketer is not correctly wording hospice care to the family instead they are telling the families that it is extra care or extra help. Therefore during IDG's alot of these bogus patients that do not understand hospice philosophy are not going to get approved for re-cert.
>
> In [Medical Director E]'s words "Instead of marketing extra care they should be making sure the pt and the family understand "Hospice" and its philosophy, then they can talk about extra care, DNR, etc.. its not like selling a car".

3. <u>Admission without Patient Consent</u>

202. According to an email dated March 21, 2011, which was sent to the email address used by GILLMAN and Individual A as well as marketing people, a nurse reported that Patient LC "will not be admitted at this time. He does not see the need for it. He is against anything that constitutes change."

203. Either GILLMAN or Individual A, using the joint email address for "administrators," replied by sending an email to a marketer, Individual Y: "Wtf?"

204. Individual Y replied:

> I will take care of this tomorrow. I guess [Patient LC] said in front of [a Passages nurse] and [a Passages employee] he thought he was already on hospice and he did not want to be. Patient is confused and told [a Passages employee] he was ready then by the afternoon he was even more confused and did not want anything to do with it. [The Passages nurse] did look at his chart and was not sure if he would even qualify. I will go there myself after the luncheon and sign him on and get it worked out.

205. Billing data does reflect that this patient was admitted to hospice that same day. According to Individual I, she received a call from Individual Y, who said that GILLMAN had basically told her to admit the patient anyway. Individual I asked how Passages could admit someone who did not want to be admitted. According to Individual I, Individual Y said that she put a pen in Patient LC's hand when he was sleeping and had him "sign." According to Individual I, Individual Y said, "Not like we haven't done that before."

206. According to claims data submitted by Passages to Medicare, Passages provided hospice services to Patient LC for two separate time periods, first from March 2009 through June 2009, and then again from March 22, 2011 through July 2011.

207. According to Patient LC's sister, who said that she had power of attorney for Patient LC, she was not familiar with Passages and did not know that Patient LC had been under hospice care. According to Patient LC's sister, Patient LC was essentially bed-ridden, but was not dying until the final month or two of his life.

CONCLUSION

208. Based on the above information, I respectfully submit that there is probable cause to believe that beginning no later than August 2008 and continuing to January 2012, SETH GILLMAN did knowingly and willfully participate in a scheme to defraud a health care benefit program, namely, Medicare, and to obtain money owned by and under the custody and control of Medicare by means of false and fraudulent pretenses, representations, and promises, in connection with the delivery of and payment for health care benefits, items, and services, and, on or about October 14, 2009, did execute the scheme by knowingly and willfully submitting and causing to be submitted a false claim, specifically, that services provided to Patient DB

beginning on October 1, 2008 through October 15, 2008 qualified for reimbursement at an elevated level of hospice care, in violation of Title 18, United States Code, Section 1347.

209. Based on the above information, I further respectfully submit that there is probable cause to believe that on or about September 8, 2009, with intent to deceive and defraud the United States, GILLMAN did endeavor to influence, obstruct, and impede a Federal auditor in the performance of official duties relating to a program receiving in excess of $100,000, directly or indirectly from the United States in any 1 year period, by submitting and causing to be submitted to a federal auditor, namely, TrustSolutions, a file for Patient DB that had been altered so that it would appear that Passages' claim for an elevated level of hospice care regarding Patient DB was justified, in violation of Title 18, United States Code, Section 1516.

FURTHER AFFIANT SAYETH NOT.

_____

WILLIAM LUCZAK
Special Agent
Department of Health and Human Services

Subscribed and sworn
before me this 24th day of January, 2014

Honorable YOUNG B. KIM
United States Magistrate Judge