UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

UNITED STATES OF AMERICA, STATE OF NEW JERSEY, STATE OF NEW YORK, STATE OF ILLINOIS, CITY OF CHICAGO AND CITY OF NEW YORK *ex rel.* JANE DOE,

Plaintiffs,

v.

BALANCE DIAGNOSTICS USA, LLC, MULTI MOBILE IMAGING, INC., and MOUNT SINAI DOCTORS RIVERSIDE MEDICAL GROUP,

Defendants.

UNITED STATES OF AMERICA,

Plaintiff,

v.

BALANCE DIAGNOSTICS USA, LLC.

Defendant.

15 Civ. 2641 (VSB)

JURY TRIAL DEMANDED

COMPLAINT-IN-INTERVENTION

Plaintiff the United States of America (the “United States” or the “Government”), by and through its attorney, Damian Williams, United States Attorney for the Southern District of New York, brings this civil fraud action against Balance Diagnostics USA, LLC (“Balance” or “Defendant”) alleging as follows:

PRELIMINARY STATEMENT

1. This is a civil fraud action brought by the United States against Balance under the False Claims Act, 31 U.S.C. §§ 3729-33 (the "FCA"), to recover treble damages sustained by, and penalties owed to, the United States as a result of the submission of false claims to Medicare and Medicaid. The United States also seeks damages under the common law for unjust enrichment and payment by mistake.

2. Balance is a diagnostic testing facility based in Cedarhurst, New York, which provides on-site mobile diagnostic testing services ("DTS"), such as video steganography (used to diagnose balance disorders) and ultrasound procedures.

3. From January 2009 through December 2019, Balance offered and paid physicians and their practices hundreds of thousands of dollars in kickbacks in the form of sham rent payments to induce them to refer patients to Balance for DTS in violation of the Anti-Kickback Statute (the "AKS"), 42 U.S.C. § 1320a-7b(b). Balance entered into sham office rental arrangements with over 100 physicians in the New York City area (the "Providers"), who referred thousands of patients to Balance for DTS that were reimbursed by Medicare and Medicaid.

4. Balance's scheme worked as follows. Balance representatives reached out to physicians to inquire about "renting" space within their offices on certain days each month, where Balance would perform DTS on patients referred by these providers. Balance typically would seek to use one exam room in the office and would send its staff to perform the tests on the referred patients.

5. Unlike legitimate lease arrangements where rent amounts are based on the fair market value of the leased premises, Balance's so-called rental arrangements with the Providers were based entirely upon the volume of patient referrals Balance received. Specifically, Balance

representatives inquired about the volume of patients the Providers anticipated referring for DTS each month. Balance and the Providers then used these anticipated referral rates to negotiate the amount Balance would pay in rent to the Providers each month. Balance made no effort to determine whether any of these monthly payments were consistent with the fair market value of the leased space. In many instances, the agreed-upon monthly payments were well above fair market value.

6. After reaching an agreement on the monthly rent payments, Balance and the Providers typically entered into purported written lease agreements. Many of these agreements, however, misrepresented key terms, such as the square footage of the rented space and the number of days per month Balance would use the space. In some instances, Balance did not even enter into written lease agreements.

7. Balance closely monitored the referral rates of the Providers to verify that the volume of patient referrals was consistent with what was discussed during negotiation of the rent amount. If the monthly referral rates fell below the levels Balance expected, Balance frequently reduced the rent amount it paid to the Providers. Balance representatives regularly contacted the Providers to pressure them to meet or exceed the expected referral rates. In some instances, where referral rates were consistently below anticipated levels, Balance renegotiated the rent amounts downward or terminated the lease arrangements entirely.

8. Balance characterized the payments to the Providers as rent payments because it knew that it was illegal to make payments in exchange for referrals and wanted to conceal the true purpose of the payments.

9. Balance performed DTS on thousands of Medicare and Medicaid beneficiaries referred by physicians to whom Balance had paid illegal kickbacks in the form of rent payments.

Balance submitted, or caused other providers to submit, reimbursement claims to Medicare and Medicaid for these services. Balance's violations of the AKS rendered these claims false under the FCA. As a result, Medicare and Medicaid and/or their contractors paid substantial amounts for DTS to Balance and other providers that they were not entitled to receive.

JURISDICTION AND VENUE

10. This Court has jurisdiction over the claims brought under the FCA pursuant to 31 U.S.C. § 3730(a) and 28 U.S.C. §§ 1331, and 1345, and over the common law claims pursuant to 28 U.S.C. § 1345.

11. This Court may exercise personal jurisdiction over Balance pursuant to 31 U.S.C. § 3732(a), which provides for nationwide service of process.

12. Venue lies in the Southern District of New York pursuant to 31 U.S.C. § 3732(a) and 28 U.S.C. §§ 1391(b) and 1391(c), because Balance resides in this district, does business in this district, and Balance's misconduct occurred in this district.

PARTIES

13. Plaintiff is the United States of America suing on its own behalf and on behalf of the United States Department of Health and Human Services and its component agency, the Centers for Medicare and Medicaid Services, which administers and oversees the Medicare and Medicaid programs.

14. Defendant Balance Diagnostics USA, LLC, is a domestic limited liability company organized under the laws of the State of New York, with its principal place of business located in Cedarhurst, New York. Balance is a diagnostic testing facility that provides DTS to patients in the New York City area, including in this district.

15. Relator is a resident of New York. On or about April 6, 2015, Relator filed a complaint under the *qui tam* provisions of the FCA and similar state false claims acts. Relator subsequently filed an amended complaint and a second amended complaint.

BACKGROUND

I. Relevant Statutes

A. The False Claims Act

16. The FCA establishes civil penalties and treble damages liability to the United States for an individual who, or entity that, "knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval," or "knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim." 31 U.S.C. § 3729(a)(1).

17. "Knowingly" is defined to include actual knowledge, reckless disregard, and deliberate ignorance. 31 U.S.C. § 3729(b)(1). No proof of specific intent to defraud is required. *Id.*

B. The Anti-Kickback Statute

18. The AKS prohibits any person or entity from knowingly and willfully offering or paying any remuneration, directly or indirectly, overtly or covertly, in cash or in kind, to induce such person to, *inter alia*, "refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program." 42 U.S.C. § 1320a-7b(b)(2).

19. The scienter element of the AKS is established by showing that "one purpose" of the remuneration at issue was to induce purchases or referrals, even if the remuneration also had other purposes that were legitimate. *United States v. Narco Freedom, Inc.*, 95 F. Supp. 3d 747,

759 (S.D.N.Y. 2015). The AKS provides: "With respect to violations of this section, a person need not have actual knowledge of this section or specific intent to commit a violation of this section." 42 U.S.C. § 1320a-7b(h).

20. Pursuant to the AKS, "a claim that includes items or services resulting from a violation of [the AKS] constitutes a false or fraudulent claim for purposes of [the FCA]." 42 U.S.C. § 1320a-7b(g). Accordingly, a person violates the FCA when they knowingly submit or cause to be submitted claims to federal health care programs that result from violations of the AKS.

21. The HHS Office of Inspector General has promulgated "safe harbor" regulations that define practices that are not subject to the AKS because such practices are unlikely to result in fraud or abuse. 42 C.F.R. § 1001.952. The safe harbors set forth specific conditions that, if met, assure persons involved of not being sanctioned for the arrangement qualifying for the safe harbor. However, safe harbor protection is an affirmative defense that is afforded to only those arrangements that meet all requirements of the safe harbor.

22. Under the "space rental" safe harbor, a payment made to lease medical office space is not remuneration for purposes of the AKS only if the rental arrangement satisfies all of the following six requirements:

(1) The lease agreement is set out in writing and signed by the parties.

(2) The lease covers all of the premises leased between the parties for the term of the lease and specifies the premises covered by the lease.

(3) If the lease is intended to provide the lessee with access to the premises for periodic intervals of time, rather than on a full-time basis for the term of the lease, the lease specifies exactly the schedule of such intervals, their precise length, and the exact rent for such intervals.

(4) The term of the lease is for not less than one year.

(5) The aggregate rental charge is set in advance, is consistent with fair market value in arms-length transactions and is not determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties for which payment may be made in whole or in part under Medicare, Medicaid, or other Federal health care programs.

(6) The aggregate space rented does not exceed that which is reasonably necessary to accomplish the commercially reasonable business purpose of the rental.

42. C.F.R. § 1001.952(b).

23. Pursuant to this safe harbor provision, the term "*fair market value* means the value of the rental property for general commercial purposes, but shall not be adjusted to reflect the additional value that one party (either the prospective lessee or lessor) would attribute to the property as a result of its proximity or convenience to sources of referrals or business otherwise generated for which payment may be made in whole or in part under Medicare, Medicaid and all other Federal health care programs." *Id.*

II. Relevant Federal Health Care Programs

24. Medicare is a federal program that provides subsidized health insurance primarily for persons who are 65 years of age or older or disabled. *See* 42 U.S.C. § 1395 *et seq.* Through Part B, Medicare covers reasonable and necessary outpatient medical services and care, including the types of diagnostic services and tests provided by Balance.

25. Medicaid is a joint federal and state program that provides healthcare benefits to certain groups, primarily the poor and those with disabilities. 42 U.S.C. § 1396 *et seq.* Under Medicaid, each state establishes its own eligibility standards, benefit packages, payment rates, and program administration rules in accordance with certain federal statutory and regulatory requirements. The state directly pays the healthcare providers for services rendered to Medicaid recipients, with the state obtaining the federal share of the Medicaid payment from accounts which draw on the United States Treasury. *See* 42 C.F.R. § 430.0 *et seq.*

26. New York's Medicaid program covers reasonable and necessary outpatient medical services and care, including the types of diagnostic services and tests provided by Balance.

27. The federal portion of each state's Medicaid payments, known as the Federal Medical Assistance Percentage, is based on the state's per capita income compared to the national average. 42 U.S.C. § 1396d(b). Federal funding under Medicaid is provided only when there is a corresponding state expenditure for a covered Medicaid service to a Medicaid recipient. The federal government pays to the state the statutorily established share of the "total amount expended . . . as medical assistance under the State plan." 42 U.S.C. § 1396b(a)(1).

DEFENDANT'S FRAUDULENT SCHEME

28. During the period from 2009 through 2019, Balance orchestrated a kickback scheme designed to direct patients to Balance for DTS reimbursable by Medicare and Medicaid. Specifically, Balance paid kickbacks to Providers in the form of sham rent payments to induce them to refer their patients to Balance for diagnostic tests and procedures.

29. Balance routinely sent employees to visit physicians and medical practices—such as primary care—to persuade them to enter into these kickback arrangements. Knowing these arrangements to be wrong, Balance sought to structure the payments as rent payments for office space used by Balance personnel to administer on-site DTS. In actuality, the purpose of these payments was to induce referrals of patients to Balance for DTS.

30. Balance's agreements with the physician practices typically provided for the use of an exam room by Balance personnel, as well as for the use of basic equipment (*e.g.*, a telephone, fax machine, a computer) and administrative staff to assist with patient flow and recordkeeping. In exchange, Balance agreed to make a monthly rent payment, which could range from $1000 to several thousand dollars per month. In many cases, the monthly payments

exceeded the fair market value for Balance's limited use of the rented space, equipment, and services. The sole factor Balance took into account when setting the monthly rent was the expected value of the patient referrals the Provider would generate.

31. To ensure the monthly payments were generating the expected volume and value of patient referrals, Balance closely monitored patient referrals on a daily and monthly basis. If referral rates fell below Balance's expected levels, Balance employees reached out to the Providers and pressured them to increase patient referrals. Balance also sometimes reduced the amount of its monthly payment, or made no monthly payments at all, based on low referral rates. Ultimately, Balance terminated certain lease agreements because of the continued low referral rate.

32. From 2009 to 2019, Balance paid hundreds of thousands of dollars in rent to more than 100 Providers, who, in turn, referred thousands of patients to Balance for DTS. A significant proportion of these referred patients were Medicare or Medicaid beneficiaries, and Balance billed Medicare or Medicaid for DTS administered on these beneficiaries.

A. Balance Negotiated Sham Rent Amounts Based on Patient Referral Volume

33. Balance routinely approached physician practices to solicit their involvement in the kickback scheme and negotiated the so-called rent payment based entirely upon the volume of patients the practice estimated it would be able to refer to Balance for DTS each month. Balance representatives typically asked about the number and type of DTS that the physician practice anticipated referring to Balance per day and/or per month. Balance and the physician practice then negotiated the rent amount based on this information.

34. The agreed-upon payment bore no relationship to the fair market value of the leased premises or factors affecting fair market value, such as the location, size, and quality of

the office space. Indeed, Balance representatives made no effort to determine the fair market value of the leased premises.

35. For example, in February 2015, Balance staff approached a physician practice ("Provider 1") specializing in, among other things, oncology, hematology, and internal medicine, to discuss a patient referral arrangement. Provider 1 had offices in Manhattan and the Bronx. Representatives of Balance and Provider 1 discussed the volume of DTS that Provider 1 anticipated being able to refer to Balance. Specifically, the representative of Provider 1 estimated a patient volume of 10-15 per day. The Balance representative asked, if Provider 1 referred 5-6 patients for DTS on one visit, would Provider 1 be able to refer 11-12 patients on the second visit. The representative of Provider 1 responded affirmatively and stated, "I know how to push it if I have to."

36. In March 2015, Balance representatives likewise reached out to a physician family practice in Purchase, New York ("Provider 2"), to discuss the referring of patients to Balance for DTS. A Balance representative asked a representative of Provider 2 how many diagnostic tests Provider 2 could refer to Balance. The representative of Provider 2 proposed referring 6 – 7 diagnostic tests each day Balance sent staff to the office. The Balance representative responded that he wanted 12-15 tests. Balance and Provider 2 ultimately agreed that Balance staff would go to Provider 2's office twice a month, and the purported monthly rent payment would be $1300 (or $650 per visit).

B. Balance and the Providers Entered Into Sham Lease Agreements

37. After agreeing upon a monthly rent amount based upon the anticipated patient referral rate, Balance and the Providers frequently executed written lease agreements to make it appear as though the parties were entering into legitimate office rental arrangements. In other

instances, Balance and the Provider proceeded without even bothering to execute a written agreement.

38. When written lease agreements were prepared, the terms specified in the leases often did not reflect the actual terms of the arrangement. Balance's written lease agreements with Providers frequently used identical stock language to describe the office space and access to the space, regardless of the actual arrangement or leased premises. For example, many of the written lease agreements state that Balance rented 750 square feet and that Balance would use the office space seven days per week as needed, even though the actual square footage significantly differed from 750 square feet and Balance staff used the space only a handful of days each month.

39. The reason that certain terms of Balance's lease agreements—other than the monthly rent amounts—were largely identical and often did not reflect the actual square footage or frequency of use is that the lease agreements were shams, intended to make it appear as though Balance's monthly kickbacks were legitimate rent payments that complied with the AKS, when that was not the case. In reality, Balance made payments to the Providers based solely on the volume of patients they referred to Balance for DTS. Balance structured and characterized the stream of payments to the Providers as rent payments for the use of office space because it understood that paying physicians for patient referrals was illegal. Because lease terms such as square footage had no bearing on the agreed-upon monthly kickback amounts, it made little difference to Balance whether the written lease agreements stated the terms accurately.

C. Balance Pressured Providers to Meet Anticipated Referral Rates and Reduced or Terminated Monthly Payments for Low Referral Volume

40. Balance prepared Records detailing the number of patients and types of DTS that the Providers referred to Balance each month and closely monitored this data to determine

whether they were consistent with the anticipated referral rates that Balance and the Providers had discussed when agreeing upon the monthly rent amount.

41. If a Provider's referral rate was lower than anticipated, Balance representatives reached out and pressured the Provider to increase the number of patient referrals. In addition, Balance unilaterally reduced the amount of monthly payments to Providers, or made no monthly payments at all, based solely on lower-than-expected referral rates. In some instances, Balance terminated its agreements with Providers due to low referral volume.

42. For example, Balance monitored the number and type of DTS that Provider 1 referred to Balance each month and repeatedly encouraged Provider 1 to increase its referrals when the referral volume was less than Balance had anticipated.

43. In October 2015, when Balance did not receive the expected volume of referrals from Provider 1, a Balance principal told a Balance employee that Provider 1 had to get its numbers up.

44. In March 2016, the Balance principal and employee discussed the referral numbers with a representative of Provider 1. During this discussion, the Balance principal stated that "we can't go up and down" in referrals, that "in almost every one of the offices that we service, we for sure see 10 [referrals]." The Balance principal further stated that "if I keep on seeing a trend, if I see it is working out for us, the relationship will keep on going," but "[i]f I see that it is not worth it to us, I'm just going to tell you." The Balance principal also advised the Provider 1 representative that certain diagnostic tests did not count as referrals because of the low reimbursement rate that Balance would receive from insurance.

45. Balance representatives continued to pressure Provider 1 to meet Balance's expected referral rates. On multiple occasions in 2016, Balance made reduced monthly

payments, or made no monthly payments at all, to Provider 1 because Provider 1 did not refer as many patients as Balance had expected. Balance's pressure to increase referrals continued until Balance terminated the sham rental arrangement with Provider 1 in late 2016.

46. Balance likewise closely monitored Provider 2's patient referral rates. In May 2015, a Balance representative had a discussion with a representative of Provider 2 about the insufficient volume of referrals. The Balance representative noted that Provider 2 had referred only 7 ultrasound tests to Balance when staff were at the office on May 11, 2015. The Balance representative further stated that, in order for the agreed-upon $650/visit rate to work for Balance, Provider 1 would need to make more than 7 referrals per visit. The representative of Provider 2 responded that this was possible.

47. In June 2015, a Balance principal and an employee discussed Balance's upcoming monthly payment to Provider 2. The Balance employee had prepared two checks for Provider 2—one check for the full rent amount of $1,300, and a second check for half of that amount, or $650—and asked which check Balance should provide. The Balance principal reviewed the number of referrals from Provider 2 over the previous months and explained that Balance wanted an average of close to 15 referrals per visit for a $650 per visit rate. Concluding from this review and discussion that the volume of Provider 2's prior referrals had been insufficient, Balance decided to give Provider 2 the check for half the monthly amount. In the following months, Balance's monthly payments to Provider 2 continued to vary in amount depending on the number of patients referrals from Provider 2.

48. Balance varied its monthly payments to dozens of other Providers based solely on patient referral volume. For example, during 2012 through 2016, Balance had a lease agreement with a physician practice located in Yonkers, New York, specializing in, among other things,

primary care and internal medicine ("Provider 3"). Pursuant to its agreement with Provider 3, Balance initially agreed to make monthly payments of $5,000. However, Balance repeatedly changed the amount of the monthly payment paid to Provider 3 based on referral volume despite the rent amount specified in the lease. In 2015, the rent amount was changed to $1,500 per month. Eventually, after several months during which the number of referrals was lower than Balance expected, Balance unilaterally lowered the amount of the monthly payment to $500.

49. Likewise, during 2012, Balance had a lease agreement with a physician practice specializing in internal medicine located in Elmhurst, New York ("Provider 4 "). Under the agreement, Balance agreed to make monthly payments of $1,200 to Provider 4. Balance representatives told a representative of Provider 4 that Balance expected to receive approximately 10 referrals each day Balance staff were at the office to justify the monthly payment amount. After the first month of the arrangement, Balance paid Provider 4 less than the agreed-upon monthly payment amount, or made no monthly payments at all. When an employee of Provider 4 telephoned Balance to inquire about the reduced or absent monthly payments, a Balance representative advised that Balance paid less rent, or no rent at all, when the referral rates for diagnostic tests were lower than Balance expected.

50. Balance made no meaningful attempt to determine whether any of the purported rent payments it made to Providers were consistent with the leased premises' actual fair market value. In many instances, the purported rent payments significantly exceeded fair market value.

* * * * *

51. The AKS provides a safe harbor for legitimate office rental agreements. However, to qualify for the relevant safe harbor, the rental fees must be set in advance, consistent with fair market value, and not be determined in a manner that takes into account the

volume of any referrals, and the lease must be commercially reasonable in the absence of referrals.

52. Here, because Balance's payments to Providers were actually kickbacks structured as rent payments, they failed to meet any of these criteria. As described above, though agreements typically set a monthly rental fee, Balance reduced or skipped monthly payments to a Provider when the value of referrals dipped, without regard to the rent purportedly due. In many cases, Balance's payments were significantly in excess of fair market value. And the lease agreements were not commercially reasonable in the absence of referrals; indeed, when the value of referrals from a Provider continued to fall below Balance's expectations, Balance terminated the arrangement.

53. The Providers referred thousands of Medicare and Medicaid beneficiaries to Balance for DTS. After the DTS were administered, other medical providers (the "Readers") read and interpreted the results. Sometimes the Reader was one of the Providers who had kickback arrangements with Balance. Both Balance and the Readers submitted reimbursement claims to Medicare and Medicaid for the diagnostic test and procedures.

54. Accordingly, Balance submitted, and caused the Readers to submit, claims for payment to Medicare and Medicaid for services resulting from the unlawful payments made to the Providers. Because these claims were tainted by Balance's kickbacks, they constituted false claims under the FCA. Consequently, Balance wrongfully received, and caused the Readers wrongfully to receive funds from Medicare and Medicaid to which they were not entitled.

CLAIMS FOR RELIEF

COUNT ONE: PRESENTING FALSE CLAIMS FOR PAYMENT VIOLATION OF THE FALSE CLAIMS ACT, 31 U.S.C. § 3729(a)(1)(A)

55. The Government incorporates by reference each of the preceding paragraphs as if fully set forth herein.

56. The Government seeks relief against Balance under 31 U.S.C. § 3729(a)(1)(A).

57. Through the acts set forth above, Balance, acting with actual knowledge or with deliberate ignorance or reckless disregard of the truth, presented, or caused to be presented, false or fraudulent claims for payment or approval to the government when requesting reimbursements for services or procedures. Specifically, Balance presented or caused to be presented false claims for payment to the government for DTS that were the result of patient referrals by physicians to whom Defendant had paid kickbacks in violation of the AKS.

58. By reason of the false or fraudulent claims, the United States has sustained damages in a substantial amount to be determined at trial and is entitled to treble damages plus a civil penalty for each violation.

COUNT TWO: USE OF FALSE STATEMENTS VIOLATION OF THE FALSE CLAIMS ACT, 31 U.S.C. § 3729(a)(1)(B)

59. The Government incorporates by reference each of the preceding paragraphs as if fully set forth herein.

60. The Government seeks relief against Balance under 31 U.S.C. § 3729(a)(1)(B).

61. Through the acts set forth above, Balance knowingly made, used, or caused to be made and used, false records and statements material to the payment of false or fraudulent claims for payment for DTS performed on Medicare and Medicaid beneficiaries. These false records and statements included but are not limited to false certifications that the claims complied with

applicable laws, regulations, and program instructions for payment and were true, accurate, and complete.

62. These false records and statements were material to the false or fraudulent claims because Medicare and Medicaid would not have paid the claims absent the records and statements.

63. Balance made, used, or caused to made and used, these false records and statements with actual knowledge of their falsity, or indeliberate ignorance or reckless disregard of whether or not they were false.

64. By reason of these false records and statements, the Government has sustained damages in a substantial amount to be determined at trial and is entitled to treble damages plus a civil penalty for each violation.

COUNT THREE: UNJUST ENRICHMENT

65. The Government incorporates by reference each of the preceding paragraphs as if fully set forth herein.

66. Through the acts set forth above, Balance has received Medicare and Medicaid reimbursements to which it was not entitled and therefore has been unjustly enriched. The circumstances of these payments are such that, in equity and good conscience, Balance should not retain those payments, the amount of which are to be determined at trial.

COUNT FOUR: PAYMENT UNDER MISTAKE OF FACT

67. The Government incorporates by reference each of the preceding paragraphs as if fully set forth herein.

68. The Government seeks relief against Balance to recover monies paid under mistake of fact.

69. The Government paid Balance for claims submitted to Medicare and Medicaid based on the mistaken and erroneous belief that the claims were not the result of patient referrals by physicians to whom Balance had paid kickbacks in violation of the AKS. If the Government had known that the claims were the result of patient referrals by physicians to whom Balance had paid kickbacks in violation of the AKS, it would not have paid the claims. In such circumstances, the payments by Medicare and Medicaid to Balance were by mistake and were not authorized.

70. Because of these payments by mistake, Balance received monies to which it is not entitled.

71. By reason of the foregoing, the Government was damaged in a substantial amount to be determined at trial.

PRAYER FOR RELIEF

72. WHEREFORE, the Government respectfully requests judgment to be entered in its favor as follows:

(i) On Counts One and Two (FCA violations), a judgment against Balance for treble damages and civil penalties to the maximum extent allowed by law;

(ii) On Counts Three and Four (Unjust Enrichment and Payment Under Mistake of Fact), a judgment against Balance for damages to the maximum extent allowed by law; and

(iii) A judgment against Balance for costs and such other relief as the Court may deem appropriate.

Dated: May 10, 2024
New York, New York

DAMIAN WILLIAMS
United States Attorney for the
Southern District of New York

/s/ Pierre G. Armand

PIERRE G. ARMAND
Assistant United States Attorney
86 Chambers Street, Third Floor
New York, New York 10007
Tel.: (212) 637-2724
Email: pierre.armand@usdoj.gov
Counsel for the United States