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UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA ex. rel. [UNDER SEAL], Relator, v. [UNDER SEAL], Defendants.	Case No. SACV16-01824 CAS(GJSx) **COMPLAINT** **FILED IN CAMERA AND UNDER SEAL** **Pursuant to** **31 U.S.C. § 3730(b)(2)**

DOCUMENT TO BE KEPT UNDER SEAL

DO NOT ENTER ON PACER

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UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA ex. rel. HOWARD BECK, M.D.,

Relator,

v.

ST. JOSEPH HEALTH SYSTEM, COVENANT HEALTH SYSTEM, COVENANT MEDICAL CENTER, COVENANT MEDICAL GROUP,

Defendants.

Case No.

COMPLAINT

FILED IN CAMERA AND UNDER SEAL
Pursuant to
31 U.S.C. § 3730(b)(2)

1 **COMPLAINT**

2 Relator Howard Beck, M.D., by and through the undersigned counsel, brings
3 this Qui Tam Complaint on behalf of the United States of America, against
4 Defendants St. Joseph Health System, Covenant Health System ("CHS"), Covenant
5 Medical Center ("CMC"), and Covenant Medical Group ("CMG"). This action is
6 brought by Relator to recover civil penalties and treble damages under the False
7 Claims Act ("FCA"), 31 U.S.C. §§ 3729-33, the Anti-Kickback Statute ("AKS"),
8 42 U.S.C. § 1320a-7b(b), and the Stark Statute, 42 U.S.C. § 1395nn. Relator
9 further seeks relief for violations of state law under California Business and
10 Professions Code § 17200 *et seq.*, Texas Human Resources Code § 32.039, and
11 Texas Human Resources Code § 36.001 *et seq.*
12
13 **INTRODUCTION**

14 1. This is an action to recover treble damages and civil penalties, on
15 behalf of the United States of America (the "United States" or the "Government"),
16 arising from false and/or fraudulent statements, records and claims made and
17 caused to be made by the Defendants and/or their agents and employees in violation
18 of the federal False Claims Act, 31 U.S.C. § 3729 *et seq.*, as amended ("the FCA"),
19 the California Unfair Competition Act, Bus. & Prof. Code § 17200 *et seq.*, the
20 Texas Medicaid Fraud Prevention Act, Tex. Hum. Res. Code § 36.001 *et seq.*, and
21 Texas's anti-kickback law, Tex. Hum. Res. Code § 32.039.

22 2. This *qui tam* case is brought against Defendants for knowingly
23 defrauding the federal Government and the state of Texas by submitting and/or
24 causing the submission of false claims for reimbursement to Medicare, 42 U.S.C. §
25 1395 *et seq*., and Medicaid, 42 U.S.C § 1396 *et seq*., in violation of the anti-
26 kickback statute ("AKS"), the Stark statute, the FCA, and California and Texas
27 state laws. As alleged below, for at least the past six years, Defendants have
28 engaged in a scheme to pay improper compensation to CMG physicians to induce

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1 them to refer patients, including Medicare and Medicaid patients, to CMC for
2 inpatient and ancillary services.

3 3. The compensation offered to physicians as an inducement for referrals
4 includes overall compensation above fair market value, as evidenced by
5 Defendants' substantial and consistent losses on their medical group CMG.
6 Defendants tolerate such losses only because Defendants are able to recover such
7 losses, plus substantial additional sums, by ensuring the same physicians refer their
8 patients to CMC for inpatient and ancillary services. Compensation to these
9 referring physicians came in many forms including annual salaries well above fair
10 market value, transcription services, IT services, insurance and questionable real
11 estate transactions. The financial relationships between the Defendants and the
12 CMG physicians trigger the application of the stark Statute, the AKS, and various
13 state laws.

14 4. The CMG physicians have entered into illegal financial relationships
15 with Defendants that include unlawful kickbacks. The CMG physicians refer large
16 volumes of patients, including Medicare and Medicaid patients, to CMC in
17 violation of federal and state law. Defendants have, and continue to submit, false or
18 fraudulent claims based on these referrals to the United States to obtain millions of
19 dollars in Medicare and Medicaid reimbursement that they are not legally entitled
20 to obtain. Under the FCA, such claims are false and/or fraudulent because the
21 Defendants are not entitled to payment for such unlawfully obtained referrals.

22 5. Further, despite knowing that millions of dollars in payments from
23 federal and state governments have been received in violation of the Stark statute's
24 prohibition on receipt of payment for services rendered pursuant to an improper
25 financial arrangement, Defendants have failed to refund these payments as required
26 by the statute. Under the FCA, this constitutes a knowing and improper avoidance
27 of an obligation to transmit money to the Government.
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JURISDICTION AND VENUE

6. This action arises under the False Claims Act, as amended, 31 U.S.C. §§ 3729-33. This Court has subject matter jurisdiction over this action pursuant to 28 U.S.C. § 1331, and subject matter jurisdiction under the Federal False Claims Act, 31 U.S.C. § 3732. The Court has supplemental subject matter jurisdiction over the state law claims pursuant to 28 U.S.C. § 1367(a), as the state law claims arise from the same facts as the federal claims, such that they form part of the same case or controversy.

7. This court has personal jurisdiction over Defendants pursuant to 31 U.S.C. § 3732(a) because that section authorizes nationwide service of process, because Defendants are related corporate entities and co-conspirators that have engaged in concerted misconduct as alleged herein, and because all Defendants have minimum contacts with the United States. Moreover, one or more Defendants can be found in and transact substantial business in the Central District of California, including business related to Defendants' concerted misconduct.

8. Venue lies in this District under 28 U.S.C. § 1391(b)(2), 1391(c), 1395(a) and 31 U.S.C. § 3732(a) because this is an action under § 3730 for violations of § 3729, Defendant St. Joseph Health System may be found, resides and transacts substantial business in this district and all other Defendants are related St. Joseph entities and co-conspirators that have engaged in concerted misconduct as alleged herein. Venue is also proper in this District because one or more Defendants can be found in and transacts substantial business in this District, including business related to Defendants' concerted misconduct.

THE PARTIES

9. Relator Howard Beck, M.D., is a citizen and resident of the State of Texas. Relator has practiced medicine in Lubbock, Texas since 1991. Relator has been a staff member/held privileges at Defendant CMC since Defendant CHS was

formed in 1998 through a merger of Methodist Hospital and Saint Mary of the Plains Hospital (which was owned by St. Joseph Health System). Dr. Beck was the Chief of Staff at St. Mary's at the time of the merger. Dr. Beck was on the committee to establish Medical Staff Bylaws for the new Covenant hospital. In addition to his privileges at CMC, Dr. Beck is on the medical staff of three other hospitals in the geographic area. Dr. Beck is also employed to provide on call coverage for CMC but is compensated by its ultimate parent company St. Joseph's for those services. He is also a participating provider in Medicare and Medicaid.

10. Defendant St. Joseph Health System is a non-profit health care system that includes CHS, and its associated hospitals including CMC. St. Joseph's corporate office and principal place of business is located at 3345 Michelson Drive, Suite 100, Irvine, California 92612. St. Joseph is the sole or corporate member of 14 acute care hospital affiliates located throughout the country, largely in the southwestern United States. St. Joseph does business under a multitude of names across several states. St. Joseph and Lubbock Methodist Hospital System are the corporate members of Defendant CHS.

11. Defendant CHS is a non-profit entity owned and controlled by its parent company, St. Joseph. CHS's corporate office and principal place of business is located 2107 Oxford Avenue, Suite 112, Lubbock, Texas 79410. CHS's Chief Executive Officer is paid by its parent, St. Joseph. The reserved rights in CHS's tiered governance structure contemplate approval by its ultimate parent, St. Joseph, for financing, budgets, unbudgeted expenditures of defined amounts, strategic plan, appointment of auditors, creation or investment in a legally recognized entity, joint venture purposes, sales or disposition of real property, merger or sale of substantially all assets, appointment and removal of trustees, and adoption or amendment of articles or bylaws.

12. Defendant CMC is CHS's Covenant Health System's flagship hospital, located at 3615 19th Street, Lubbock, Texas 79410. CMC is wholly owned by

CHS and, therefore, is indirectly owned by St. Joseph. In fact, Dr. Beck is informed and believes that physician services at CMC are compensated by its ultimate parent, St. Joseph.

13. CMG is a non-profit, tax-exempt medical foundation which is certified by Texas law to employ physicians and practice medicine. CMG is owned by CHS and, therefore, indirectly owned by St. Joseph. CMG advertises itself as the largest physician group in the Lubbock area, employing over 250 physicians in various specialties. CMG's principal place of business is 3420 22nd Place, Lubbock, Texas 79410.

14. CMG is controlled by CHS and its ultimate parent, St. Joseph. More specifically, the Principal Officer of CMG Steve McCamy is compensated by CHS. CMG's Chief Executive Officer is also compensated by CHS. CMG has no independent board members because all board members are required to be active physicians with loyalties to its parent CHS. CHS is the sole corporate member of CMG. Similar to CHS, CMG has a tiered governance in which the corporate members reserve the right to appoint trustees to the CMG Board. All trustee appointments that come from the CMG as nominations must be approved by CHS, as the corporate member, and its ultimate parent, St. Joseph. The reserved rights in the CMG's tiered governance structure contemplate approval by the CHS Member of financing, budgets, unbudgeted expenditures of defined amounts, strategic plan, appointment of auditors, creation or investment in a legally recognized entity, joint venture purposes, sale or disposition of real property, merger or sale of substantially all assets, appointment and removal of trustees, and adoption or amendment of articles or bylaws.

15. Pursuant to 31 U.S.C. § 3730(b)(2), a copy of this complaint and written disclosure of substantially all material evidence and information Dr. Beck possesses has been or is being served on the Government in accordance with Fed. R. Civ. P. 4(i). As required by 31 U.S.C. § 3730, Dr. Beck made a disclosure

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statement of material evidence and information in his possession to the Government and the United States Attorney General for the Central District of California demonstrating the actions that serve as the basis for this action. This action is not based on any public disclosure of information within the meaning of 31 U.S.C. § 3730(e)(4)(A). Dr. Beck has direct and independent knowledge, within the meaning of 31 U.S.C. § 3730(e)(4)(B), of the information on which the allegations in this complaint are based. To the extent any of these allegations may have been publicly disclosed within the meaning of 31 U.S.C. § 3730, Dr. Beck voluntarily provided this information to the Government before any such disclosure.

STATUTORY AND REGULATORY FRAMEWORK

The Federal False Claims Act

16. The False Claims Act provides that any person who knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval, or who knowingly makes, uses or causes to be made or used, a false record or statement material to a false or fraudulent claim to the United States is liable for damages in the amount of three (3) times the amount of loss the government sustained, and penalties which range between $5,500 and $11,000 per claim. 31 U.S.C. § 3729(a); 28 C.F.R. § 85.3. For purposes of the FCA, "the terms 'knowing' and 'knowingly' mean that a person . . . (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information." 31 U.S.C. § 3729(b). Proof of specific intent to defraud is <u>not</u> required under the FCA. *Id.*

Federal Healthcare Programs- Medicare

17. Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395 *et seq.*, establishes the Health Insurance for the Aged and Disabled program, known as Medicare. Medicare is a federally operated and funded program administered by

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the Secretary of Health and Human Services ("HHS") through the Centers for Medicare and Medicaid Services ("CMS"), a department of HHS.

18. Under the Medicare program, CMS makes payments retrospectively (after services are rendered) to hospitals, physicians, and other providers for inpatient and outpatient services. Medicare enters into provider agreements to establish the provider's eligibility to participate in the Medicare program. Medicare Part A authorizes payment for institutional care, including hospitals. Part B covers payments for physician and laboratory services. 42 U.S.C. §§ 1395c-1395i-4; § 1395k.

19. Providers who participate in Medicare Part A or Part B must periodically sign an application for participation, Form 855A for inpatient care and Form 855B for outpatient care, and submit it to the United States. Form 855A contains a "Certification Statement" that provides, *inter alia*:

> I agree to abide by the Medicare laws, regulations and program instructions that apply to this provider. . . I understand that payment of a claim by Medicare is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, the Federal anti-kickback statute and the Stark law), and on the provider's compliance with all applicable conditions of participation in Medicare. . .
>
> I will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare, and I will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity.

CMC participates in the Medicare program. At all relevant times, CMC's Chief Financial Officer signed the Form 855A application for CMC, and caused it to be submitted to the United States. Form 855 B contains a similar certification. At all

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relevant times, CMG's Chief Financial Officer signed the Form 855B application for services rendered by CMG physicians, and caused it to be submitted to the United States.

20. As a prerequisite to payment pursuant to Medicare Part A, CMS requires hospitals to submit annually form CMS-2552, known as the hospital cost report. Cost reports are the final claim that a provider submits for items and services rendered to Medicare beneficiaries.

21. At the end of each provider's fiscal year, the provider files its cost report, stating the amount of Part A reimbursement the provider believes it is due for the year. *See* 42 U.S.C. § 1359g(a); 42 C.F.R. § 413.20. Medicare relies on the provider's cost report to determine whether the provider is entitled to additional reimbursement than it has already received through interim payments, or has been overpaid and must reimburse Medicare. 42 C.F.R. §§405.1803, 413.60 and 413.64(f)(1).

22. At all relevant times, CMC was required to and did submit annually a hospital cost report. The cost report contains another "Certification" that must be signed by the chief administrator of the provider, or a responsible designee. This certification includes a statement that the services identified in the cost report were provided in compliance with federal laws and regulations. At all relevant times, CMC submitted a signed hospital cost report, certifying that the services it had provided that year were provided in compliance with federal laws and regulations, including those identified in this lawsuit.

Federal Healthcare Programs- Medicaid

23. Medicaid is a joint federal-state program that provides health care benefits for certain groups—primarily the poor and disabled. Each state administers its own Medicaid program, under federal regulations that generally govern what services should be provided, under what conditions. CMS monitors the state-run programs and establishes requirements for service delivery, quality,

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funding and eligibility standards. The federal government provides a portion of each state's Medicaid funding.

24. To submit claims to and receive reimbursement under Medicaid, providers must apply to and enroll in their state's Medicaid program, agree to a provider agreement, and submit periodic reports and recertification documents, all of which contain attestations to the providers' compliance with federal laws.

The Anti-Kickback Statute

25. The federal Anti-Kickback Statute ("AKS"), 42 U.S.C. § 1320a-7b, prohibits the payment, in any form, whether direct or indirect, made in part or in whole to induce or reward the referral or generation of federal health care business. The AKS prohibits the offer or payment of "any remuneration" in return for referrals. 42 U.S.C. § 1320a-7b (b). The AKS extends equally to the solicitation or acceptance of payments and to offers to pay for referrals. The AKS was enacted because of Congressional concerns that payments made in return for referrals would lead to overutilization, affect medical judgment, and restrict competition.

26. In addition to prohibiting payments designed to induce referrals, the AKS prohibits the entity receiving a prohibited referral from presenting or causing to be presented to Medicare any claim for referrals that are induced by kickbacks. In 2010, the AKS was amended to provide that a claim that includes items or services resulting from kickback violations are deemed "false" under the FCA. 42 U.S.C. § 1320a-7b(g).

The Stark Statute

27. The Stark statute, 42 U.S.C. § 1395nn prohibits a hospital (or other entity) from submitting Medicare claims for designated health services based on referrals from physicians who have a "financial relationship" with the hospital, and prohibits Medicare from paying for such claims. "Financial relationship" includes a "compensation arrangement" which means any arrangement involving any

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remuneration paid directly or indirectly to a referring physician. 42 U.S.C. § 1395nn(h)(1)(A)-(B).

28. The Stark statute and regulations contain exceptions for certain compensation arrangements, which include "bona fide employment relationships" and "personal services arrangements." To qualify for these exceptions, the compensation or remuneration, among other things, must not exceed fair market value, and must not be based on or determined in any manner that accounts for the value or volume of referrals. 42 U.S.C. § 1395nn(e)(2)(B) and (C); 42 U.S.C. § 1395nn(e)(3)(A)(v).

29. The Stark statute also applies for claims for payment under Medicaid, and federal funds may not be used to pay for designated health services through a state Medicaid program. 42 U.S.C. § 1396b(s).

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ALLEGATIONS REGARDING DEFENDANTS' WRONGDOING

Basic Framework of Illegal Scheme

30. Defendants have been involved in a scheme designed to induce individual physicians to refer admissions, lab work, radiology services, and all ancillary services exclusively to CMC, rather than any number of other hospitals in the geographic region. A large portion of the services provided at CMC through these referrals include services provided to Medicare and Medicaid patients, and for which CMC has made claims through Medicare and Medicaid.

31. In summary, this is a closed-loop system, pursuant to which excessive compensation is used to induce CMG physicians to refer exclusively to CMC, and the revenues generated by those referrals comprise a significant revenue stream for CHS, which in turns transfers millions of dollars to CMG to sustain the inflated salaries. To insure continuity in this system, CMG's Chief Medical Officer and Chief Executive Officer are actually paid by CHS. In turn, CHS's Chief Executive

Officer is paid by St. Joseph. This allows St. Joseph, through CHS, to maintain control over CMG and its physicians.

32. As a foundation of this scheme, St. Joseph, CHS and CMC formed CMG, for the purposes of controlling patient referrals for both inpatient and outpatient services, including those covered by federally-funded healthcare programs as well as the designated health services listed in the Stark statute. Subsequently, these CMG physicians increased the number of patients, including Medicare, Medicaid, and other federally-insured patients they referred to CMC for outpatient and inpatient hospital services.

33. The Defendants, via their wholly owned and controlled subsidiary CMG, employed greater number of physicians and physician specialty practices. Despite being disguised as CMG physicians, these physicians were truly CHS/CMC physicians who are required to refer patients to CMC for inpatient and ancillary services. To make employment at CMG more attractive to the physicians than maintaining their own private practices, Defendants have provided and continue to provide what they know to be excessive compensation, perks, and benefits to the CMG physicians.

Exorbitant Compensation to CMG Physicians

34. CMG incentivizes physician referrals to CHS by providing compensation to a number of physicians that far exceeds fair market value of the services provided. Of the 23 physicians listed on CMG's 2013 IRS Form 990, 15 physicians exceeded the 90th percentile of compensation reported in the MGMA Physician Compensation and Production Survey, 2014 Report Based on 2013 Data ("MGMA"). Eighteen physicians exceeded the 90th percentile of compensation reported in the AMGA Medical Group Compensation and Financial Survey, 2014 Report Based on 2013 Data ("AMGA").[1] Similar results were found for 2012. Of

[1] The 2014 Surveys were utilized as they contain 2013 data, which are considered the most comparable to CMG's 2013 compensation data.

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1 the 25 physicians listed in CMG's 2012 IRS Form 990, 15 physicians exceeded the
2 90th percentile of compensation reported in the MGMA Physician Compensation
3 and Production Survey, 2013 Report Based on 2012 Data. Eighteen physicians
4 exceeded the 90th percentile of compensation reported in the AMGA Medical
5 Group Compensation and Financial Survey, 2013 Report Based on 2012 Data.[2]

6 35. For example, the highest paid physician reported on the 2013 Form
7 990, interventional cardiologist Dr. Kurdi, received compensation of $2,028,112 in
8 2013. By comparison, the median reported by AMGA for interventional cardiology
9 is $544,733 and the median reported by MGMA is $560,000. The 90th percentile
10 for Interventional Cardiology reported by AMGA is $757,294 and the 90th
11 percentile reported by MGMA is $854,651. **This indicates the compensation**
12 **received by Dr. Kurdi is over $1.2 million higher than the 90th percentile**
13 **indications reported in the AMGA and MGMA surveys, which is not**
14 **commercially reasonable.**

15 36. As shown in the table below, there were at least 11 CMG physicians
16 (listed by specialty) in 2013 that were paid in excess of $100,000 over the 90th
17 percentile of the AMGA survey (and 9 physicians for the MGMA survey).
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Specialty	Total 2013 Compensation	90 %ile		Excess over 90 %ile	
		AMGA	MGMA	AMGA	MGMA
Interventional Cardiology	$ 2,028,112	$ 757,294	$ 854,651	$ 1,270,818	$ 1,173,461
Maternal Fetal Medicine	1,058,555	610,044	731,394	448,511	327,161
Interventional Cardiology	1,187,538	757,294	854,651	430,244	332,887
Pediatric Cardiology	823,908	413,580	457,514	410,328	366,394
Pediatric Surgery	1,078,229	727,681	791,696	350,548	286,533
Internal Medicine	619,577	355,058	378,143	264,519	241,434
Hospitalist	613,326	360,116	363,099	253,210	250,227
Hematology/Oncology	766,187	570,081	805,271	196,106	(39,084)
Family Medicine	474,549	336,162	345,540	138,387	129,009
Orthopedic Surgery	946,192	837,553	954,677	108,639	(8,485)
Obstetrics/Gynecology	638,486	531,455	539,218	107,031	99,268

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28 [2] The 2013 Surveys were utilized as they contain 2012 data, which are considered the most comparable to CMG's 2012 compensation data.

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1 37. In addition to those CMG physicians receiving in excess of $100,000
2 over the survey participants set forth above, there are a further six physicians
3 receiving an amount in excess of the 90th percentile of the indications reported in
4 the AMGA survey and MGMA survey:
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Specialty	Total 2013 Compensation	90 %ile		Excess over 90 %ile	
		AMGA	MGMA	AMGA	MGMA
General Surgery	$ 683,588	$ 590,053	$ 610,505	$ 93,535	$ 73,083
Internal Medicine	435,009	355,058	378,143	79,951	56,866
Family Medicine	401,114	336,162	345,540	64,952	55,574
CV Surgery	1,018,400	976,016	947,362	42,384	71,038
Pediatrics	379,117	358,831	379,023	20,286	94
General Cardiology	660,067	645,156	636,982	14,911	23,085
Interventional Cardiology	770,154	757,294	854,651	12,860	(84,497)

12 38. Similar results were found for 2012. As shown in the table below,
13 there were at least 11 CMG physicians (listed by specialty) in 2012 that were paid
14 in excess of $100,000 over the 90th percentile of the 2013 AMGA survey (and 9
15 physicians for the MGMA survey).
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Specialty	Total 2012 Compensation	90 %ile		Excess over 90 %ile	
		AMGA	MGMA	AMGA	MGMA
Interventional Cardiology	$ 1,894,648	$ 756,710	$ 833,769	$ 1,137,938	$ 1,060,879
Pediatric Cardiology	870,092	405,208	495,530	464,884	374,562
Interventional Cardiology	1,141,484	756,710	833,769	384,774	307,715
Pediatric Surgery	1,081,586	750,519	828,577	331,067	253,009
Hospitalist	614,430	348,406	333,281	266,024	281,149
Internal Medicine	584,650	344,191	364,485	240,459	220,165
Orthopedic Surgery	1,077,038	844,019	975,673	233,019	101,365
General Surgery	793,632	571,391	606,703	222,241	186,929
Orthopedic Surgery	1,028,525	844,019	975,673	184,506	52,852
Maternal Fetal Medicine	796,504	642,263	785,527	154,241	10,977
Obstetrics/Gynecology	646,864	506,160	515,866	140,704	130,998

25 39. In addition to those CMG physicians receiving in excess of $100,000
26 over the survey participants set forth above in 2012, there are a further four
27 physicians receiving an amount in excess of the 90th percentile of the indications
28 reported in both the AMGA survey and MGMA survey:

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Specialty	Total Compensation	90 %ile		Excess over 90 %ile	
		AMGA	MGMA	AMGA	MGMA
Family Medicine	$ 424,013	$ 326,977	$ 337,869	$ 97,036	$ 86,144
Family Medicine	414,868	326,977	337,869	87,891	76,999
Internal Medicine	423,307	344,191	364,485	79,116	58,822
Hematology/Oncology	655,622	586,101	809,197	69,521	(153,575)
Pediatrics	363,791	346,380	359,467	17,411	4,324
Emergency Medicine	427,323	416,543	447,073	10,780	(19,750)
Emergency Medicine	423,486	416,543	447,073	6,943	(23,587)

40. As additional inducement for steering cardiac-related referrals to CMC (including Medicare and Medicaid patients), the CMG cardiologists are provided with a range of other services, which they would otherwise have to pay for, including transcription services, IT services, and insurance. The CMG physicians' steady stream of referrals to CMC is induced by these additional perks.

In exchange for the exorbitant compensation, referrals

41. In exchange for the exorbitant salaries CMG pays them, the CMG physicians refer to CMC for admissions, lab work, and other ancillary services. For example, CMG pays exorbitant salaries to its cardiologists, as more specifically described above. In exchange, these cardiologists refer all cardiac-related lab work, diagnostic work, and admissions (including but not limited to pacemaker placement, angioplasty, stents, and coronary artery bypass grafting). The services provided at CMC as a result of these referrals from CMG physicians include costly procedures reimbursed by insurers (including Medicare and Medicaid) at desirable rates, and thus provide a key source of revenue for CHS and St. Joseph.

42. An analysis of top 10 designated health service ("DHS") related CPT codes[3] performed in the hospital setting by the highest compensated CMG physician (an interventional cardiologist) indicates three of the CPT codes (93306, 93970 and 75630) had volumes in excess of the 90th percentile of all cardiology

[3] CPT Codes 93306, 78452, 93880, 93970, 93971, 93925, 75630, 75710, 93320 and 93325.

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specialty physicians in the United States performing those procedures in the facility setting, as reported in the CMS Medicare Provider Utilization and Payment Data for 2013[4]. A further three (93880, 93971 and 75710) had volumes in excess of the 75th percentile of all cardiology specialty physicians in the facility setting.

43. At all times relevant to this action, Defendants have all realized and intended that the referrals Defendants have gained as a result of such arrangements with the CMG physicians would include referrals of Medicaid, Medicare and other federally-insured patients.

The Scheme Forces CMG To Lose Millions Every Year

44. Defendants' scheme to control referral revenue through overcompensating CMG physicians is apparent from the following pattern of economic trade-offs: Defendants endure persistent losses in operating CMG, but realize substantial gains from hospital admissions and ancillary service referrals from the CMG physicians.

45. Consistently, year after year, Defendants lose large sums of money on their subsidiary CMG. As demonstrated by the chart below, CMG's excessive salaries have resulted in substantial losses each year for CMG, including from years 2009 through 2013.

Tax year	Revenue Less Expenses
2009	$-22,318,239
2010	$-20,621,653
2011	$-25,204,356
2012	$-23,996,881
2013	$-23,241,248

46. For example, in 2013, CMG reported a loss of $23,241,248 on net revenues of $111,952,418 on its IRS Form 990 (Return of Organization Exempt From Income Tax). It also reported a loss of $23,996,881 on net revenues of

[4] Medicare Provider Utilization and Payment Data, 2013 Detail.

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$105,219,320 in 2012. In contrast, CHS reported net income of $62,070,236 on net revenues of $570,446,474 in 2013 on its 2013 IRS Form 990. CHS also reported net income of $35,748,437 on net revenues of $552,925,902 in 2012.

47. Such losses exist because the revenue generated by the CMG physicians' practices is insufficient to sustain both (a) the substantially above market salaries, bonuses, and other extravagant perks and benefits Defendants provide the CMG physicians and (b) the other, normal operating expenses required to run the practice.

48. Defendants are thus compensating the CMG physicians whose practices they have purchased at levels that not only exceed what Defendants can rationally afford while maintaining physician practices that could be economically viable on their own merits, but that even more dramatically exceed what Defendant CMG physicians could reasonably expect to earn if they had continued to own and operate the business themselves.

49. Accordingly, as a stand-alone venture, CMG is not economically viable. In most significant part, this is so because the total package of compensation and benefits Defendants pay the CMG physicians is <u>not</u> rationally related to the income produced by those physicians.

50. The only conclusion which explains why Defendants would excessively compensate CMG physicians while tolerating the substantial losses is because Defendants value the referrals obtained from these same physicians and know that they can more than make up for those losses through marginal gains in income that Defendants realize by using such arrangements to maximize the referrals to CMC from these CMG physicians for inpatient and ancillary services.

51. CHS regularly contributes millions to CMG. For at least the past 6 years specifically, CHS has contributed between $20,000,000 and $25,000,000 a year to CMG. Moreover, as stated above, CMG's Chief Medical Officer is actually paid by CHS, allowing CHS to maintain control over CMG.

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1 **The Scheme Violates Federal and State Law**

2 52. Defendants' compensation scheme is not commercially reasonable
3 because CMG incurs substantial financial losses as direct result of the
4 compensation paid to the physicians. At the same time, CHS generates a net
5 income that is partially attributable to referrals made to CMC by CMG physicians.
6 As such, all CMG physician referrals to CMC for services are the product of an
7 illegal kickback scheme in violation of the AKS. Kickbacks are *malem in se.*
8 Compliance with the AKS is also a material condition for participation in federal
9 health insurance programs.

10 53. Defendants' payments to the CMG physicians also constitute improper
11 financial relationships under the Stark statute that are not subject to any safe harbor.

12 54. Defendants knowingly submitted (and continue to submit) to
13 Medicare, Medicaid and other federal health care programs claims for
14 reimbursement and interim payment on the annual hospital cost reports, which
15 cover at least the past 10 years, for the medical services provided as a result of these
16 referrals. The entire time, Defendants have known that the claims were not
17 properly payable and should not have been submitted under the applicable laws and
18 regulations.

19 55. On each annual hospital cost report Defendants have filed over the past
20 10 years, the Defendants have falsely certified that the medical services identified
21 therein were provided in compliance with all applicable laws and regulations.

22 56. Defendants expressly certified their understanding that AKS
23 compliance is of material importance when they enrolled to participate in Medicare.
24 See CMS Provider/Supplier Enrollment Application, Forms 855-A and 855-B.

25 57. Submitting a claim under false pretense of entitlement is a false claim
26 under the FCA. Defendants violated the FCA by knowingly presenting claims for
27 payment to federal health insurance programs that are materially false on account of
28 Defendants' AKS violations.

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58. In addition, notwithstanding their clear obligation under federal law and the terms of federal insurance programs, Defendants have billed and continue to bill the Government for self-interested referrals from its extensive network of approximately 250 physicians.

59. Finally, St. Joseph and CHS are operated under common management and control. St. Joseph's Corporate Responsibility Handbook provides in relevant part:

> As a nonprofit organization, SJHS and its nonprofit ministries have a legal and ethical obligation to comply with applicable laws, to engage in activities to further its charitable purpose, and to ensure that its resources are used to further our charitable mission rather than the private or personal interest of any private individual. The requirements for organizations exempt under Section 501(c)(3) of the Internal Revenue Code and similar provisions of state law must be followed.
>
> . . .
>
> Transactions must be in the best interest of SJHS and negotiated at "arm's length" for fair market value. SJHS employees must avoid compensation arrangements in excess of fair market value. Employees unsure of how to proceed with sensitive situations should consult with management for guidance.

60. Despite the express knowledge of its impropriety and admonishment against overcompensation, Defendants have engaged in such activities.

61. This action seeks damages, civil penalties, and disgorgement arising from the fraudulent claims paid pursuant to this scheme.

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COUNT 1

FEDERAL FALSE CLAIMS ACT VIOLATIONS

31 USC § 3729(a)(1)(A) & (B)2

Presenting or Causing Presentment of a False Claim as a Result of Violations of the AKS

62. Relator realleges and incorporates by reference the allegations in the foregoing paragraphs.

63. To the extent wrongdoing occurred prior to May 20, 2009, this Complaint also alleges violations of the Federal False Claims Act prior to its recent amendments e.g., 31 U.S.C. §3729(a)(1).

64. At all times relevant to this action, Defendants were legally obligated to only seek reimbursement for services provided to federally insured patients if Defendants complied with applicable federal law.

65. At all times relevant to this action, Defendants were also legally obligated to take corrective action upon discovering that they received payment for services not provided or provided in derogation of Defendants' obligations under federal law.

66. Instead, Defendants violated federal law and the terms and conditions of participation in federal health insurance programs by:

a. Entering into physician employment agreements that compensate physicians in a commercially unreasonable manner and/or in excess of fair market value in violation of the employment exception to the referral prohibition imposed by the Stark Law, 42 U.S.C. § 1395nn;

b. Compensating employee physicians based on the volume or value of services referred to the hospital in violation of the Stark Law;

c. Accepting self-interested referrals prohibited by 42 U.S.C. §1395nn(a)(1)(A);

d. Paying remuneration to employee physicians in exchange for referrals

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in violation of the AKS, 42 U.S.C. § 1320a-7b; and

e. In other such ways as discovered during the litigation of this action.

67. Defendants knowingly presented, or caused to be presented, false and fraudulent claims for payment or approval to the United States, including those claims for reimbursement for services provided in violation of the Anti-Kickback Statute, which prohibits any form of remuneration to induce referrals.

68. Defendants presented these claims with actual knowledge of the information, or acted in deliberate ignorance of the truth or falsity of the information, or acted in reckless disregard of the truth or falsity of the information. 31 U.S.C. § 3729(b)(1).

69. Defendants knowingly, willfully and falsely certified their compliance with federal law when they submitted claims for payment that violated the Stark Law and the AKS in the manner described above.

70. These violations are material to Defendants' participation as a provider in federal health insurance programs such that Defendants' fraudulent certification of compliance with federal law renders these claims false for the purpose of the FCA.

71. Defendants knowingly and willfully presented these claims to obtain payment from federal health insurance programs including Medicare, TRICARE/CHAMPUS, and Medicaid.

72. Defendants knew that the Medicare, TRICARE/CHAMPUS, and Medicaid programs relied on, and continues to rely on, Defendants' false certification that their claims complied with federal law.

73. Defendants' fraudulent claims have been and continue to be paid by federal health insurance programs at great cost to United States taxpayers.

74. Defendants' conduct is a violation of 31 U.S.C. § 3729(a)(1)(A) & (B), as amended.

75. As a result of the false or fraudulent claims Defendants made, the United States has suffered damages and therefore is entitled to recovery as provided by the FCA in an amount to be determined at trial, plus a civil penalty for each violation.

COUNT 2

FEDERAL FALSE CLAIMS ACT

Presenting Claims to Medicare and Medicaid for Designated Health Services Rendered as a Result of Violations of the Stark Statute

76. Plaintiff realleges and incorporates by reference the allegations in the foregoing paragraphs.

77. Defendants knowingly presented, or caused to be presented, false and fraudulent claims for payment or approval for designated health services rendered to patients who were referred by physicians who had a prohibited financial relationship, indirectly, through CMG and CHS.

78. These claims were presented with actual knowledge of their falsity, or with reckless disregard or deliberate ignorance of whether they were false.

79. By virtue of the false or fraudulent claims made by Defendants, the United States has suffered damages and therefore is entitled to recovery as provided by the FCA of an amount to be determined at trial, plus a civil penalty for each violation.

COUNT 3

FEDERAL FALSE CLAIMS ACT, 31 USC 3729(a)(1)(B)

Use of False Statements

80. Relator realleges and incorporates by reference the allegations in the foregoing paragraphs.

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81. Defendants made, used and caused to be made or used, false records or statements material to a false or fraudulent claim—i.e., the false certifications and representations made and caused to be made by Defendants when initially submitting the false claims for interim payments and the false certifications Defendants made when submitting the cost reports.

82. Defendants made the false records or statements with actual knowledge of their falsity, or with reckless disregard or deliberate ignorance of whether or not they were false.

83. As a result of Defendants' false records or statements material to a false or fraudulent claim, the United States has suffered damages and therefore is entitled to recovery as provided by the FCA in an amount to be determined at trial, plus a civil penalty for each violation.

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COUNT 4

FEDERAL FALSE CLAIMS ACT, 31 USC 3729(a)(1)(C)

Conspiracy to commit a violation

84. Relator realleges and incorporates by reference the allegations in the foregoing paragraphs.

85. Defendants entered into a conspiracy or conspiracies among themselves and others, to violate 31 U.S.C. § 3729(a)(1)(A) or 31 U.S.C. § 3729(a)(1)(B), and committed one or more overt acts in furtherance of said conspiracy or conspiracies, in violation of 31 USC § 3729(a)(1)(C).

86. As a result of Defendants' acts, the United States has suffered damages and therefore is entitled to recovery as provided by the False Claims Act in an amount to be determined at trial, plus a civil penalty for each violation.

COUNT 5

CALIFORNIA UNFAIR COMPETITION ACT VIOLATIONS

Cal. Bus. & Prof. Code §§ 17200 *et seq.*

87. Relator realleges and incorporates by reference the allegations in the foregoing paragraphs.

88. Defendants' conduct set forth herein has had a substantial effect on commerce, and constitutes unlawful, unfair, and fraudulent business practices in violation of §§ 17200, *et seq.*, of the California Business and Professions Code.

89. Defendants willfully intended to benefit from the illegal referrals to CMC and to compensate referring physicians at CMG well above the fair market value of their services in violation of, *inter alia*, Texas Human Resources Code § 32.039(b), which prohibits any form of remuneration to induce referrals, and in violation of the Texas Medicaid Fraud Prevention Act, Tex. Hum. Res. Code § 36.002(1), (2), & (13).

90. Defendants' illegal activities were unfair harmful to the public because they induced physicians to refer patients to extra or more expensive services, and the referrals were based on considerations other than the best interests of the patient, including the Defendants' profit motive.

91. As a direct and proximate result of Defendants' unlawful acts, Relator has suffered and will continue to suffer injury to his business and goodwill.

92. Unless Defendants are preliminarily and permanently enjoined from committing the unlawful acts described herein, Relator will continue to suffer irreparable harm. Relator is thus entitled, pursuant to California Business and Professions Code §§ 17203 and 17535, to an injunction restraining Defendants, their officers, agents and employees, and all persons acting in concert with them, from engaging in any further such acts of unfair competition, as well as to restitution and disgorgement of Defendants' profits.

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COUNT 6

TEXAS MEDICAID FRAUD PREVENTION ACT VIOLATIONS

Tex. Hum. Res. Code § 36.002(1), (2), (9), & (13)

93. Relator realleges and incorporates by reference the allegations in the foregoing paragraphs.

94. At all times relevant to this action, Defendants were legally obligated to only seek reimbursement for services provided to Medicaid patients if Defendants complied with applicable federal and Texas law.

95. Instead, Defendants violated federal and Texas law and the terms and conditions of participation in Medicaid programs by paying remuneration to employee physicians in exchange for referrals in violation of, *inter alia*, Texas Human Resources Code § 32.039(b).

96. Defendants knowingly presented, or caused to be presented, false and fraudulent claims for payment or approval to the state of Texas, including those claims for reimbursement for services provided in violation of, *inter alia*, Texas Human Resources Code § 32.039(b), which prohibits any form of remuneration to induce referrals, and in violation of the Texas Medicaid Fraud Prevention Act, Tex. Hum. Res. Code § 36.002(1), (2), & (13).

97. Defendants presented these claims with actual knowledge of the information, or acted in deliberate ignorance of the truth or falsity of the information, or acted in reckless disregard of the truth or falsity of the information.

98. Defendants entered into a conspiracy or conspiracies among themselves and others, to violate applicable Texas law, and committed one or more overt acts in furtherance of said conspiracy or conspiracies, in violation of the Tex. Hum. Res. Code § 36.002(9).

99. As a result of the false or fraudulent claims Defendants made, the state of Texas has suffered damages and therefore is entitled to recovery as provided by

1 the Texas Medicaid Fraud Prevention Act in an amount to be determined at trial,
2 plus a civil penalty for each violation.
3
4 **PRAYER**

5 **WHEREFORE,** Relator Howard Beck, M.D. prays for judgment against
6 Defendants as follows:

7 1. That Defendants cease and desist from violating 31 U.S.C. § 3729 et seq.;
8 2. That this Court enter judgment against Defendants in an amount equal to
9 three times the amount of damages the United States has sustained because of
10 Defendants' actions, plus a civil penalty of not less than $5,500 and not more
11 than $11,000 for each violation of 31 U.S.C. § 3729;
12 3. That this Court enter judgment against Defendants in an amount equal to
13 three times the amount of damages the state of Texas has sustained because
14 of Defendants' actions, plus a civil penalty of not less than $5,500 and not
15 more than $11,000 for each violation of the Texas Medicaid Fraud
16 Prevention Act;
17 4. That Plaintiff/Relator be awarded the maximum amount allowed pursuant to
18 § 3730(d) of the False Claims Act;
19 5. That Plaintiff/Relator be awarded the maximum amount allowed pursuant to
20 Texas Human Resources Code § 36.110(a) and/or any other applicable
21 provision of law;
22 6. That the Court grant preliminary and permanent injunctions enjoining
23 Defendants, their officers, agents and employees, and all persons acting in
24 concert with them, from engaging in any further such acts of unfair
25 competition, as alleged herein;
26 7. That Defendants be required to account for and pay Plaintiff/Relator the
27 maximum amount allowed pursuant to § 17200 of the California Business
28 and Professions Code;

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8. That Plaintiff/Relator be awarded all costs of this action, including attorneys' fees and expenses;
9. That the United States, the state of Texas, and Plaintiff/Relator be granted pre-judgment and post-judgment interest on the damages caused by Defendants; and
10. That the United States, the state of Texas and Plaintiff/Relator recover such other and further relief as the Court deems just and proper.

JURY DEMAND

Pursuant to Federal Rule of Civil Procedure 38, Relator demands a trial by jury on all issue so triable.

Dated: September 30, 2016

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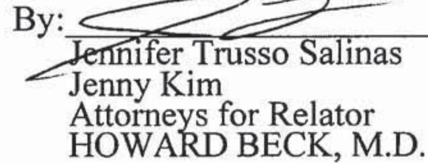
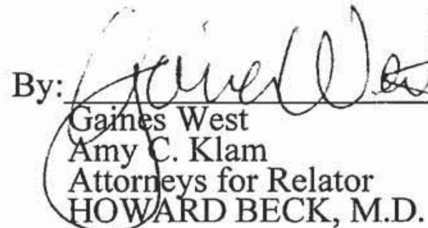


By: ______________________
Jennifer Trusso Salinas
Jenny Kim
Attorneys for Relator
HOWARD BECK, M.D.

Dated: September 30, 2016

WEST, WEBB, ALLBRITTON & GENTRY



By: ______________________
Gaines West
Amy C. Klam
Attorneys for Relator
HOWARD BECK, M.D.

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UNITED STATES DISTRICT COURT, CENTRAL DISTRICT OF CALIFORNIA
CIVIL COVER SHEET

I. (a) PLAINTIFFS (Check box if you are representing yourself [ ])

UNITED STATES OF AMERICA. ex. rel. HOWARD BECK, M.D.

DEFENDANTS (Check box if you are representing yourself [ ])

ST. JOSEPH HEALTH SYSTEM, COVENANT HEALTH SYSTEM, COVENANT MEDICAL CENTER, COVENANT MEDICAL GROUP

(b) County of Residence of First Listed Plaintiff ____________
(EXCEPT IN U.S. PLAINTIFF CASES)

County of Residence of First Listed Defendant ____________
(IN U.S. PLAINTIFF CASES ONLY)

(c) Attorneys (*Firm Name, Address and Telephone Number*) If you are representing yourself, provide the same information.

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5 PARK PLAZA, SUITE 1400
IRVINE, CALIFORNIA 92614 TELEPHONE: 949-622-2700

Attorneys (*Firm Name, Address and Telephone Number*) If you are representing yourself, provide the same information.

II. BASIS OF JURISDICTION (Place an X in one box only.)

- [x] 1. U.S. Government Plaintiff
- [ ] 3. Federal Question (U.S. Government Not a Party)
- [ ] 2. U.S. Government Defendant
- [ ] 4. Diversity (Indicate Citizenship of Parties in Item III)

III. CITIZENSHIP OF PRINCIPAL PARTIES-For Diversity Cases Only
(Place an X in one box for plaintiff and one for defendant)

	PTF	DEF		PTF	DEF
Citizen of This State	[ ] 1	[ ] 1	Incorporated or Principal Place of Business in this State	[ ] 4	[ ] 4
Citizen of Another State	[ ] 2	[ ] 2	Incorporated and Principal Place of Business in Another State	[ ] 5	[ ] 5
Citizen or Subject of a Foreign Country	[ ] 3	[ ] 3	Foreign Nation	[ ] 6	[ ] 6

IV. ORIGIN (Place an X in one box only.)

- [x] 1. Original Proceeding
- [ ] 2. Removed from State Court
- [ ] 3. Remanded from Appellate Court
- [ ] 4. Reinstated or Reopened
- [ ] 5. Transferred from Another District (Specify) ____________
- [ ] 6. Multidistrict Litigation - Transfer
- [ ] 8. Multidistrict Litigation - Direct File

V. REQUESTED IN COMPLAINT: JURY DEMAND: [x] Yes [ ] No (Check "Yes" only if demanded in complaint.)

CLASS ACTION under F.R.Cv.P. 23: [ ] Yes [x] No [ ] **MONEY DEMANDED IN COMPLAINT:** $ ____________

VI. CAUSE OF ACTION (Cite the U.S. Civil Statute under which you are filing and write a brief statement of cause. Do not cite jurisdictional statutes unless diversity.)

31 U.S.C. SECTION 3729 ET SEQ.; 42 U.S.C. SECTION 1395 ET SEQ.; 42 U.S.C. SECTION 1396 ET SEQ.

VII. NATURE OF SUIT (Place an X in one box only).

OTHER STATUTES
- [x] 375 False Claims Act
- [ ] 376 Qui Tam (31 USC 3729(a))
- [ ] 400 State Reapportionment
- [ ] 410 Antitrust
- [ ] 430 Banks and Banking
- [ ] 450 Commerce/ICC Rates/Etc.
- [ ] 460 Deportation
- [ ] 470 Racketeer Influenced & Corrupt Org.
- [ ] 480 Consumer Credit
- [ ] 490 Cable/Sat TV
- [ ] 850 Securities/Commodities/Exchange
- [ ] 890 Other Statutory Actions
- [ ] 891 Agricultural Acts
- [ ] 893 Environmental Matters
- [ ] 895 Freedom of Info. Act
- [ ] 896 Arbitration
- [ ] 899 Admin. Procedures Act/Review of Appeal of Agency Decision
- [ ] 950 Constitutionality of State Statutes

CONTRACT
- [ ] 110 Insurance
- [ ] 120 Marine
- [ ] 130 Miller Act
- [ ] 140 Negotiable Instrument
- [ ] 150 Recovery of Overpayment & Enforcement of Judgment
- [ ] 151 Medicare Act
- [ ] 152 Recovery of Defaulted Student Loan (Excl. Vet.)
- [ ] 153 Recovery of Overpayment of Vet. Benefits
- [ ] 160 Stockholders' Suits
- [ ] 190 Other Contract
- [ ] 195 Contract Product Liability
- [ ] 196 Franchise

REAL PROPERTY
- [ ] 210 Land Condemnation
- [ ] 220 Foreclosure
- [ ] 230 Rent Lease & Ejectment

REAL PROPERTY CONT.
- [ ] 240 Torts to Land
- [ ] 245 Tort Product Liability
- [ ] 290 All Other Real Property

TORTS
PERSONAL INJURY
- [ ] 310 Airplane
- [ ] 315 Airplane Product Liability
- [ ] 320 Assault, Libel & Slander
- [ ] 330 Fed. Employers' Liability
- [ ] 340 Marine
- [ ] 345 Marine Product Liability
- [ ] 350 Motor Vehicle
- [ ] 355 Motor Vehicle Product Liability
- [ ] 360 Other Personal Injury
- [ ] 362 Personal Injury-Med Malpratice
- [ ] 365 Personal Injury-Product Liability
- [ ] 367 Health Care/Pharmaceutical Personal Injury Product Liability
- [ ] 368 Asbestos Personal Injury Product Liability

IMMIGRATION
- [ ] 462 Naturalization Application
- [ ] 465 Other Immigration Actions

TORTS
PERSONAL PROPERTY
- [ ] 370 Other Fraud
- [ ] 371 Truth in Lending
- [ ] 380 Other Personal Property Damage
- [ ] 385 Property Damage Product Liability

BANKRUPTCY
- [ ] 422 Appeal 28 USC 158
- [ ] 423 Withdrawal 28 USC 157

CIVIL RIGHTS
- [ ] 440 Other Civil Rights
- [ ] 441 Voting
- [ ] 442 Employment
- [ ] 443 Housing/Accommodations
- [ ] 445 American with Disabilities-Employment
- [ ] 446 American with Disabilities-Other
- [ ] 448 Education

PRISONER PETITIONS
Habeas Corpus:
- [ ] 463 Alien Detainee
- [ ] 510 Motions to Vacate Sentence
- [ ] 530 General
- [ ] 535 Death Penalty

Other:
- [ ] 540 Mandamus/Other
- [ ] 550 Civil Rights
- [ ] 555 Prison Condition
- [ ] 560 Civil Detainee Conditions of Confinement

FORFEITURE/PENALTY
- [ ] 625 Drug Related Seizure of Property 21 USC 881
- [ ] 690 Other

LABOR
- [ ] 710 Fair Labor Standards Act
- [ ] 720 Labor/Mgmt. Relations
- [ ] 740 Railway Labor Act
- [ ] 751 Family and Medical Leave Act
- [ ] 790 Other Labor Litigation
- [ ] 791 Employee Ret. Inc. Security Act

PROPERTY RIGHTS
- [ ] 820 Copyrights
- [ ] 830 Patent
- [ ] 840 Trademark

SOCIAL SECURITY
- [ ] 861 HIA (1395ff)
- [ ] 862 Black Lung (923)
- [ ] 863 DIWC/DIWW (405 (g))
- [ ] 864 SSID Title XVI
- [ ] 865 RSI (405 (g))

FEDERAL TAX SUITS
- [ ] 870 Taxes (U.S. Plaintiff or Defendant)
- [ ] 871 IRS-Third Party 26 USC 7609

FOR OFFICE USE ONLY: Case Number: SACV16-01824 CAS(GJSx)

UNITED ST... ES DISTRICT COURT, CENTRAL DISTRICT OF C..LIFORNIA
CIVIL COVER SHEET

VIII. VENUE: Your answers to the questions below will determine the division of the Court to which this case will be initially assigned. This initial assignment is subject to change, in accordance with the Court's General Orders, upon review by the Court of your Complaint or Notice of Removal.

QUESTION A: Was this case removed from state court? ☐ Yes ☒ No	STATE CASE WAS PENDING IN THE COUNTY OF:	INITIAL DIVISION IN CACD IS:
If "no," skip to Question B. If "yes," check the box to the right that applies, enter the corresponding division in response to Question E, below, and continue from there.	☐ Los Angeles, Ventura, Santa Barbara, or San Luis Obispo	Western
	☐ Orange	Southern
	☐ Riverside or San Bernardino	Eastern

QUESTION B: Is the United States, or one of its agencies or employees, a PLAINTIFF in this action? ☒ Yes ☐ No	**B.1.** Do 50% or more of the defendants who reside in the district reside in Orange Co.? *check one of the boxes to the right* →	☒ YES. Your case will initially be assigned to the Southern Division. Enter "Southern" in response to Question E, below, and continue from there.
		☐ NO. Continue to Question B.2.
If "no," skip to Question C. If "yes," answer Question B.1, at right.	**B.2.** Do 50% or more of the defendants who reside in the district reside in Riverside and/or San Bernardino Counties? (Consider the two counties together.) *check one of the boxes to the right* →	☐ YES. Your case will initially be assigned to the Eastern Division. Enter "Eastern" in response to Question E, below, and continue from there.
		☐ NO. Your case will initially be assigned to the Western Division. Enter "Western" in response to Question E, below, and continue from there.

QUESTION C: Is the United States, or one of its agencies or employees, a DEFENDANT in this action? ☐ Yes ☒ No	**C.1.** Do 50% or more of the plaintiffs who reside in the district reside in Orange Co.? *check one of the boxes to the right* →	☐ YES. Your case will initially be assigned to the Southern Division. Enter "Southern" in response to Question E, below, and continue from there.
		☐ NO. Continue to Question C.2.
If "no," skip to Question D. If "yes," answer Question C.1, at right.	**C.2.** Do 50% or more of the plaintiffs who reside in the district reside in Riverside and/or San Bernardino Counties? (Consider the two counties together.) *check one of the boxes to the right* →	☐ YES. Your case will initially be assigned to the Eastern Division. Enter "Eastern" in response to Question E, below, and continue from there.
		☐ NO. Your case will initially be assigned to the Western Division. Enter "Western" in response to Question E, below, and continue from there.

QUESTION D: Location of plaintiffs and defendants?	**A.** Orange County	**B.** Riverside or San Bernardino County	**C.** Los Angeles, Ventura, Santa Barbara, or San Luis Obispo County
Indicate the location(s) in which 50% or more of *plaintiffs who reside in this district* reside. (Check up to two boxes, or leave blank if none of these choices apply.)	☐	☐	☐
Indicate the location(s) in which 50% or more of *defendants who reside in this district* reside. (Check up to two boxes, or leave blank if none of these choices apply.)	☒	☐	☐

D.1. Is there at least one answer in Column A?	**D.2. Is there at least one answer in Column B?**
☒ Yes ☐ No	☐ Yes ☒ No
If "yes," your case will initially be assigned to the SOUTHERN DIVISION. Enter "Southern" in response to Question E, below, and continue from there. If "no," go to question D2 to the right. →	If "yes," your case will initially be assigned to the EASTERN DIVISION. Enter "Eastern" in response to Question E, below. If "no," your case will be assigned to the WESTERN DIVISION. Enter "Western" in response to Question E, below. ↓

QUESTION E: Initial Division?	INITIAL DIVISION IN CACD
Enter the initial division determined by Question A, B, C, or D above: →	SOUTHERN

QUESTION F: Northern Counties?

Do 50% or more of plaintiffs or defendants in this district reside in Ventura, Santa Barbara, or San Luis Obispo counties? ☐ Yes ☒ No

UNITED ST...ES DISTRICT COURT, CENTRAL DISTRICT OF C...LIFORNIA
CIVIL COVER SHEET

IX(a). IDENTICAL CASES: Has this action been previously filed **in this court**? [x] NO [ ] YES

If yes, list case number(s): ______

IX(b). RELATED CASES: Is this case related (as defined below) to any civil or criminal case(s) previously filed **in this court**? [x] NO [ ] YES

If yes, list case number(s): ______

Civil cases are related when they (check all that apply):

- [ ] A. Arise from the same or a closely related transaction, happening, or event;
- [ ] B. Call for determination of the same or substantially related or similar questions of law and fact; or
- [ ] C. For other reasons would entail substantial duplication of labor if heard by different judges.

Note: That cases may involve the same patent, trademark, or copyright is not, in itself, sufficient to deem cases related.

A civil forfeiture case and a criminal case are related when they (check all that apply):

- [ ] A. Arise from the same or a closely related transaction, happening, or event;
- [ ] B. Call for determination of the same or substantially related or similar questions of law and fact; or
- [ ] C. Involve one or more defendants from the criminal case in common and would entail substantial duplication of labor if heard by different judges.

X. SIGNATURE OF ATTORNEY (OR SELF-REPRESENTED LITIGANT):

DATE: 9/30/16

Notice to Counsel/Parties: The submission of this Civil Cover Sheet is required by Local Rule 3-1. This Form CV-71 and the information contained herein neither replaces nor supplements the filing and service of pleadings or other papers as required by law, except as provided by local rules of court. For more detailed instructions, see separate instruction sheet (CV-071A).

Key to Statistical codes relating to Social Security Cases:

Nature of Suit Code	Abbreviation	Substantive Statement of Cause of Action
861	HIA	All claims for health insurance benefits (Medicare) under Title 18, Part A, of the Social Security Act, as amended. Also, include claims by hospitals, skilled nursing facilities, etc., for certification as providers of services under the program. (42 U.S.C. 1935FF(b))
862	BL	All claims for "Black Lung" benefits under Title 4, Part B, of the Federal Coal Mine Health and Safety Act of 1969. (30 U.S.C. 923)
863	DIWC	All claims filed by insured workers for disability insurance benefits under Title 2 of the Social Security Act, as amended; plus all claims filed for child's insurance benefits based on disability. (42 U.S.C. 405 (g))
863	DIWW	All claims filed for widows or widowers insurance benefits based on disability under Title 2 of the Social Security Act, as amended. (42 U.S.C. 405 (g))
864	SSID	All claims for supplemental security income payments based upon disability filed under Title 16 of the Social Security Act, as amended.
865	RSI	All claims for retirement (old age) and survivors benefits under Title 2 of the Social Security Act, as amended. (42 U.S.C. 405 (g))