

UNITED STATES DISTRICT COURT  
SOUTHERN DISTRICT OF FLORIDA

Case No.

09-21736

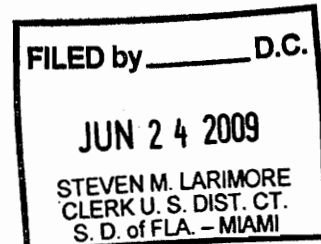
UNITED STATES OF AMERICA,

Plaintiff,

CIV-MORENO / TORRES

vs.

ABC HOME HEALTH CARE, INC.;  
FLORIDA HOME HEALTH CARE  
PROVIDERS, INC.; GLADYS ZAMBRANA;  
ENRIQUE PEREZ; JAVIER ZAMBRANA;  
CARLOS CASTANEDA;  
ALEJANDRO HERNANDEZ QUIROS  
a/k/a ALEX HERNANDEZ; and  
VICENTA TELLECHEA,



FILED UNDER SEAL

Defendants.

**DECLARATION OF SPECIAL AGENT LYNNETTE ALVAREZ-KARNES, IN  
SUPPORT OF UNITED STATES' EMERGENCY EX PARTE MOTION FOR  
TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION**

I, Lynnette Alvarez-Karnes, having being duly sworn, hereby depose and state:

1. I am an investigative and law enforcement officer of the United States who is empowered by law to conduct investigations of and to make arrests for offenses enumerated in Title 18 of the United States Code.

2. I have been employed as a Special Agent with the Federal Bureau of Investigation for approximately eight years. I am currently assigned to the Miami Field Office, where I am assigned to a health care squad that investigates violations of federal law, including conspiracies to commit health care fraud, false claims to Medicare, false statements and related bank fraud. I have participated in health care fraud investigations and have received training in investigating financial crimes.

3. The facts and information contained in this Declaration are based upon my knowledge and observations, including a review of relevant evidence and interviews with relevant persons; information received from other agents of the Federal Bureau of Investigation working on this investigation; and information gained from my training and experience. This Declaration is being submitted for the limited purpose of supporting the temporary restraining order (“TRO”) and preliminary injunction sought by the United States in this action, and I have not included each and every fact known to me concerning this investigation. I have only set forth the facts and circumstances that I believe are necessary to support the entering of the TRO and preliminary injunction.

#### **THE DEFENDANTS**

4. Defendant ABC HOME HEALTH CARE, INC. (“ABC”) is a company organized and existing under the laws of the State of Florida. On February 10, 2004, ABC filed its Articles of Incorporation with the Florida Secretary of State indicating that it was incorporated effective February 10, 2004. ABC identified its principal place of business as 15715 S. Dixie Highway #304, Miami, Florida 33157.

5. On February 6, 2006, ABC filed with the Florida Secretary of State an Articles of Amendment to Articles of Incorporation that deleted all prior officers and registered agents, and identified Defendant JAVIER A. ZAMBRANA as ABC’s sole officer, director, and registered agent, effective January 31, 2006. On February 9, 2006, ABC filed with the Florida Secretary of State an Articles of Amendment to Articles of Incorporation that changed its principal place of business and mailing address to 5600 SW 135 Avenue #202A, Miami, Florida 33183.

6. On August 15, 2006, ABC filed with the Florida Secretary of State an Articles of Amendment to Articles of Incorporation that added Defendant ENRIQUE PEREZ (“PEREZ”) as

ABC's vice president; changed ABC's principal place of business to 8360 W. Flagler Street Suite 210, Miami, Florida; and noted the issuance of 45 shares of stock to PEREZ. On February 27, 2007, ABC filed with the Florida Secretary of State an Amended Annual Report that added Defendant GLADYS ZAMBRANA as ABC's treasurer.

7. On June 28, 2007, ABC filed with the Florida Secretary of State an Amended Annual Report that deleted Defendant GLADYS ZAMBRANA as ABC's treasurer and replaced JAVIER ZAMBRANA with PEREZ as ABC's registered agent. That Amended Annual Report also identified PEREZ as ABC's president, secretary, and sole director (but failed to delete Defendant JAVIER ZAMBRANA). On June 5, 2008, ABC filed with the Florida Secretary of State an Articles of Amendment to Articles of Incorporation that deleted JAVIER ZAMBRANA as ABC's president and transferred 100% of ABC's stock shares to PEREZ. According to this filing, these changes had become effective July 1, 2007, nearly one year earlier.

8. While they still owned and operated ABC, several of the Defendants took over ownership and control of Defendant FLORIDA HOME HEALTH CARE PROVIDERS, INC. ("FHH").

9. Defendant FHH is a company organized and existing under the laws of the State of Florida. On August 26, 2004, FHH filed its Articles of Incorporation with the Florida Secretary of State indicating that it was incorporated effective August 25, 2004. FHH identified its principal place of business as 1779 W 37<sup>th</sup> Street, unit 15, Hialeah, Florida 33012.

10. On October 2, 2007, FHH filed with the Florida Secretary of State an Articles of Amendment to Articles of Incorporation that, among other things, added Defendant VINCENTA TELLECHEA ("TELLECHEA") as FHH's president and registered agent, effective September 28, 2007. On November 30, 2007, FHH filed with the Florida Secretary of State an Amended

Annual Report that added Defendant GLADYS ZAMBRANA as FHH's secretary, and reflected a new business and mailing address for FHH of 4150 NW 7<sup>th</sup> Street, Suite 204, Miami, Florida 33126. On June 30, 2008, FHH filed with the Florida Secretary of State an Annual Report that added Defendant GLADYS ZAMBRANA as FHH's vice-president and secretary. This change left Defendants TELLECHEA and GLADYS ZAMBRANA as FHH's sole officers. On April 5, 2009, FHH filed with the Florida Secretary of State an Annual Report that re-stated its prior filings, confirming that Defendants TELLECHEA and GLADYS ZAMBRANA were FHH's sole officers and registered agent.

11. Defendant GLADYS ZAMBRANA is a resident of the Southern District of Florida, in Miami-Dade County, Florida. As identified above, GLADYS ZAMBRANA was an officer and one of the true owners of ABC, is an officer and owner of FHH, and exercised control over ABC and FHH.

12. Defendant PEREZ is a resident of the Southern District of Florida, in Miami-Dade County, Florida. As identified above, Defendant PEREZ is the named owner, and sole officer, director, and registered agent, of ABC, although PEREZ exercised control over ABC and FHH. PEREZ is the husband of Defendant GLADYS ZAMBRANA.

13. Defendant JAVIER ZAMBRANA is a resident of the Southern District of Florida, in Miami-Dade County, Florida. As identified above, Defendant JAVIER ZAMBRANA was an officer and owner of ABC, and exercised control over ABC. Defendant JAVIER ZAMBRANA is the son of Defendant GLADYS ZAMBRANA.

14. Defendant CARLOS CASTANEDA ("CASTANEDA") is a resident of the Southern District of Florida, in Miami-Dade County, Florida, and one of the true owners of

FHH, and exercises control over FHH. CASTANEDA is the son of TELLECHEA, the president and registered agent of FHH.

15. Defendant ALEJANDRO HERNANDEZ QUIROS a/k/a ALEX HERNANDEZ (“HERNANDEZ”), is a resident of the Southern District of Florida, in Miami-Dade County, Florida, and was one of the true owners of and exercised control over ABC.

16. Defendant TELLECHEA is a resident of the Southern District of Florida, in Miami-Dade County, Florida, and was the president and exercised control over FHH.

17. Defendants GLADYS ZAMBRANA, JAVIER ZAMBRANA, PEREZ, CASTANEDA, HERNANDEZ, and TELLECHEA are collectively referred to as the “Individual Defendants.”

#### **THE MEDICARE PROGRAM**

18. Except as otherwise specifically noted, the statements below describe aspects of the Medicare program (“Medicare”) and other facts during the entire period relevant to this action, *i.e.*, from January 2006, through the present.

19. Medicare is a federal health insurance program that provides coverage for people age 65 or older and for certain disabled people. Individuals who receive benefits under Medicare are commonly referred to as “beneficiaries.” Medicare is financed by federal funds including funds from payroll taxes and premiums paid by beneficiaries. Benefits available under Medicare are prescribed by statute and by federal regulations administered by HHS, through its agency, CMS.

20. The Medicare program is divided into different “parts.” “Part A” of the Medicare program covers certain health services provided by hospitals, skilled nursing facilities, hospices,

and – at issue in this case – home health agencies (“HHAs”). Defendants ABC and FHH were both HHAs participating in Medicare.

21. Payments under the Medicare program are often made directly to a provider of the services, such as an HHA, rather than to the beneficiary. This occurs when the HHA provider accepts assignment of the right to payment from the beneficiary. In that case, the HHA provider submits the claim to Medicare for payment, either directly or through a billing company.

22. Claims for payment are not submitted directly to CMS. Instead, various entities are under contract to provide services to CMS. These services include processing and paying Medicare claims and safeguarding the integrity of the Medicare program. In the Southern District of Florida, Palmetto Government Benefits Administrators (“Palmetto”) is responsible for processing and paying claims related to home health services provided by HHAs.

23. In order to be eligible to file a claim for payment with Medicare, an HHA must submit an enrollment application to obtain a provider number. In the application, the HHA agrees to abide by all Medicare laws, regulations, and program instructions applicable to HHAs. Further, the HHA certifies that it understands that payment of a claim by Medicare is conditioned upon the claims and the underlying transaction complying with such laws, regulations, and applicable program instructions and on the HHA’s compliance with all applicable conditions of participation in Medicare.

24. After obtaining a provider number, the HHA would then submit or cause the submission of claims to an entity that processed those claims for CMS, such as Palmetto. When a claim was submitted, the HHA would certify that the contents of the claim were true, correct, and complete, and that the claim was prepared in compliance with all Medicare laws and regulations.

25. An HHA, such as Defendants ABC and FHH, seeking reimbursement from Medicare had to meet certain obligations. Among other things, these obligations were to:

- a. bill Medicare only for reasonable and necessary medical services;
- b. not make false statements or misrepresentations of material facts concerning requests for payment under Medicare;
- c. assure that such services were not substantially in excess of the needs of such patients; and
- d. not submit or cause to be submitted bills or requests for payment substantially in excess of the provider's costs.

26. In order to bill Medicare for services purportedly rendered, Defendants ABC and FHH submitted a claim form (Form 1450) to Palmetto. When a Form 1450 was submitted, usually in electronic form, the provider HHA certified that the contents of the claim form were true, correct, complete, and that the form was prepared in compliance with all Medicare laws and regulations. The information in the claim form, including the beneficiary's name, the specific services provided, the dates of service, and the prescribing or referring physician, was the basis for the payment to the HHA provider.

#### **HOME HEALTH BILLING AND PAYMENT UNDER MEDICARE**

27. Medicare paid for specified home health services provided by or under arrangement with an HHA only when certain requirements were met. Specifically, Medicare paid for such services only when the beneficiary was:

- a. confined to the home;
- b. under the care of a physician who established and periodically reviewed a Plan Of Care ("POC"); and

- c. in need of skilled services, which included skilled nursing care, physical and speech therapy, and, if one of these skilled services was required, occupational therapy. 42 U.S.C. § 1395n(a)(2)(A); 42 C.F.R. § 409.42.

In addition, Medicare would only pay for home health services if those services were medically necessary. 42 U.S.C. § 1395f(a)(2); 42 U.S.C. § 1395n(a)(2)(A).

28. As relevant to this case, assuming the above criteria were met, Medicare would pay for skilled nursing visits to administer insulin injections to eligible beneficiaries if they were insulin-dependent diabetics who were confined to their home, unable to inject their own insulin and had no care-giver available able or willing to inject the insulin, and had an appropriate POC. (However, such reimbursement would not include the actual insulin, syringes, needles, and other supplies needed to inject the insulin, or durable medical equipment supplies needed to test and monitor a beneficiary's blood glucose level. The insulin and other supplies had to be provided by the beneficiary, and was reimbursed under Medicare Part D and Part B.)

29. The POC was required to identify the medical treatments to be furnished, the type of home health discipline that would furnish those services (*i.e.*, skilled nursing for insulin injections or physical therapy), and the frequency the services would be provided. Specifically, the POC had to include: the medical necessity of the home health services; all pertinent diagnoses, including mental status; types of services and equipment required; frequency of visits; prognosis; rehabilitation potential; functional limitations; activities permitted; nutritional requirements; medications and treatments; any safety measures to protect against injury; instructions for timely discharge or referral; and any other appropriate items. POCs that included an order for rehabilitation therapy services had to include the specific procedures and modalities to be used and the amount, frequency, and duration. 42 C.F.R. § 409.43.

30. The physician who established the POC had to sign and date the POC. The physician certified that the beneficiary was confined to the home, needed skilled nursing services or rehabilitation therapy, and was under an established POC that was regularly reviewed by a physician. 42 U.S.C. § 1395n(a)(2)(A); 42 U.S.C. § 1395f(a)(2)(C); 42 C.F.R. § 424.22. The POC had to be reviewed by a physician, in consultation with the HHA personnel, at least every 60 days. 42 C.F.R. § 409.43(e). Each 60-day period was referred to as an “episode.” *Id.*

31. Payment for covered home health services was calculated and provided to HHAs based on each 60-day episode. 42 C.F.R. § 484.205. Medicare payments to HHAs for each 60-day episode were based on fixed, predetermined amounts that could be adjusted downward based on low utilization or to reflect an episode lasting less than 60 days. 42 C.F.R. § 484.205(b). This fixed amount was geographically adjusted, based on the beneficiary’s location. It was also adjusted to reflect the characteristics and corresponding home health care needs of the individual beneficiary. This patient-specific adjustment (known as a “case-mix adjustment”) was calculated based on the Outcome and Assessment Information Set (“OASIS”) that had to be submitted to Medicare by the HHA at the start of the beneficiary’s first episode of care. A registered nurse had to conduct and complete the OASIS, and that OASIS evaluation had to be conducted at least once every 60-day episode. 42 C.F.R. § 484.55. The nurse could be an employee of the HHA, or could be providing those services under arrangement with the HHA.

32. In addition to the case-mix adjustment, the fixed per-episode payments could be increased if the beneficiary’s 60-day episode qualified as an outlier. 42 C.F.R. § 484.205(b). Outliers were beneficiaries whose home health care needs, as determined by and recorded on the OASIS and the POC, exceeded the average, and thus the costs of providing home health services to those beneficiaries would be far higher than the normal threshold dollar amount. Medicare

therefore paid an HHA additional amounts for each beneficiary who was categorized as an outlier. 42 C.F.R. § 484.240; 42 C.F.R. § 484.205(e).

33. Unlike traditional Medicare reimbursements, HHAs did not have to wait until after the services were provided in order to bill Medicare. Instead, they could submit a claim for payment in anticipation of providing services. Such a claim was called a Request for Anticipated Payments (“RAP”). 42 C.F.R. § 409.43(c)(2). For a beneficiary’s first 60-day episode of care, when an HHA submitted a RAP, Medicare would pay the HHA 60% of the total expected payment for that patient’s episode, including payments for case-mix, geographic, and outlier adjustments. 42 C.F.R. § 484.205(b).

34. Upon completion of the beneficiary’s first 60-day episode, the HHA would then submit its final claim to Medicare. Medicare would then pay the HHA the remaining 40% of the total payment for that episode. 42 C.F.R. § 484.205(b). A physician had to certify the POC, as detailed above, before the final claim was submitted to Medicare. 42 C.F.R. § 409.43(c)(3).

35. The HHA would then submit to Medicare a RAP at the beginning of each subsequent 60-day episode, and a final claim at the end of each episode, but the reimbursement was split 50%-50% for these subsequent episodes, rather than the 60%-40% split in the first episode. 42 C.F.R. § 484.205(b). Therefore, for each beneficiary, an HHA would submit two claims to Medicare for each 60-day episode of providing home health services.

36. The RAP is a “claim” for purposes of Federal criminal, civil, and administrative law enforcement authorities, including but not limited to the False Claims Act. 42 C.F.R. § 409.43(c)(2). The Health Care Fraud Statute, 18 U.S.C. § 1347, prohibits the knowing and intentional submission of false or fraudulent claims for payment to any health care benefit program. Medicare is a health care benefit program, as defined in 18 U.S.C. § 24(b).

### **ABC'S FRAUDULENT BILLING SCHEME**

37. On or about March 3, 2005, ABC signed and submitted a Medicare enrollment application (CMS form 855A), in which, among other things, ABC agreed to abide by all Medicare laws and regulations. ABC subsequently received a Medicare provider number (10-8147) from Medicare, effective March 22, 2005. Once it received a Medicare provider number, ABC was able to bill and be paid by Medicare for covered and eligible home health services.

38. On or about March 30, 2006, ABC submitted to Medicare an updated form 855A advising Medicare that Defendant JAVIER ZAMBRANA had become the new owner of ABC, effective January 11, 2006. In signing that form, JAVIER ZAMBRANA certified, individually and on behalf of ABC, that: "I agree to abide by all Medicare laws, regulations, and program instructions. . . . I understand that payment of a claim by Medicare is contingent 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) . . . ."

39. In or around August 2007, ABC submitted another updated form 855A, stating to Medicare that, effective July 1, 2007, Defendant ENRIQUE PEREZ replaced JAVIER ZAMBRANA as ABC's owner. The August 2007 submission was signed and certified by Defendant PEREZ. In that same submission, ABC informed Medicare that its business office address had changed to 8360 West Flagler Street, Suite 210, Miami, Florida 33144, also purportedly effective July 1, 2007.

40. From on or about January 12, 2006, through December 4, 2008, ABC submitted approximately 2,580 claims to Medicare, totaling approximately \$17,026,543.00. These home health services claims were principally for skilled nursing services (the administration of injectable insulin to purported insulin-dependent beneficiaries who were allegedly confined to

their homes), home health aides, and physical therapy that ABC claimed to have provided to eligible Medicare beneficiaries. Based on those submitted claims, Medicare, through Palmetto, ultimately paid ABC approximately \$11,293,852.39.

41. However, through investigative efforts, it was determined that many if not all of these claims were for services not rendered, not medically necessary, or otherwise tainted by fraud.

42. Among other claims, from on or about June 11, 2006, through on or about July 11, 2008, ABC submitted to Medicare 82 claims totaling \$662,200.00 for home health services allegedly provided to six beneficiaries. According to the claims ABC submitted to Medicare, Jorge Valido, M.D., was the physician who signed the POC for each of those beneficiaries and who certified the need for the home health services.

43. Federal agents interviewed Dr. Valido, and he stated that he never treated those beneficiaries and never wrote or certified any POCs. In fact, Dr. Valido was already cooperating with federal authorities when ABC claimed he wrote and certified some of the POCs. All 82 claims submitted by ABC to Medicare that identified Dr. Valido as the certifying physician are completely false claims. Medicare paid ABC \$427,717.59 for those 82 false claims.

44. Among other claims, from on or about March 9, 2006, through December 4, 2008, ABC submitted to Medicare 226 claims totaling \$1,623,354.00 for home health services allegedly provided to 21 beneficiaries.

45. According to the claims submitted by ABC to Medicare, all of these beneficiaries were insulin-dependent diabetics confined to the home and in need of skilled nursing care to administer the insulin. ABC thus billed Medicare for providing two or more skilled nursing visits a day to each beneficiary, as well as home health aides and physical therapy services.

46. Analysis of Medicare records and billing data establish that these beneficiaries failed to order sufficient insulin, needles, and/or syringes necessary to receive the numerous daily insulin injections ABC claimed to have provided. Indeed, some beneficiaries failed to order any insulin at all, and many were already taking oral hyperglycemic agents to manage or control their diabetes, and had no medical need for insulin injections. Many other beneficiaries never purchased the lancets, test strips, and controls that are absolutely indispensable to conduct the multiple-times-a-day testing of their blood glucose levels that had to be done before receiving any insulin injections. As part of the scheme to defraud Medicare, ABC also falsified the OASIS reports for their beneficiaries, claiming they had medical conditions and needs that did not exist so the beneficiaries would be categorized as outliers, thus significantly increasing Medicare's payments to ABC. Medicare paid ABC \$1,063,037.40 for the false claims relating to just those 21 beneficiaries.

47. For example, from approximately December 21, 2006, through May 8, 2008, ABC submitted to Medicare 18 claims totaling \$144,200.00 for home health services allegedly provided to beneficiary A.J. ABC claimed to have provided two skilled nursing visits every single day to administer insulin injections, plus visits by a home health aide and some physical therapy. These services were allegedly provided between December 21, 2006, and April 25, 2008.

48. During that time, however, A.J. failed to order insulin and syringes for nearly half of the months in which ABC billed Medicare for allegedly sending a nurse to A.J.'s home to inject the insulin. (A.J. failed to order insulin from January through March 2007, September through November 2007, and January and February 2008.) A.J.'s Medicare claims data after April 2008, when she left ABC and switched to FHH, displays similar gaps in obtaining insulin.

Without insulin and syringes, ABC's nurse could not have injected any insulin. According to claims submitted by ABC, A.J.'s diagnosis – the reason she needed skilled nursing care in the home – also switched back and forth between diabetes with ophthalmic complications to “physical therapy” and back to diabetes. ABC also falsified the OASIS reports for A.J., so A.J. would be categorized as an outlier, thus significantly increasing Medicare's payments to ABC. Medicare paid ABC \$90,715.75 for these false claims relating to A.J.

49. From approximately March 24, 2007, through July 11, 2008, ABC submitted to Medicare 14 claims totaling \$121,200.00 for home health services allegedly provided to beneficiary J.S. ABC claimed to have provided two skilled nursing visits every single day to administer insulin injections, plus visits by a home health aide and some physical therapy. These services were allegedly provided between March 24, 2007, and May 7, 2008.

50. During that time, however, J.S. failed to order insulin and syringes for nearly half of the months in which ABC billed Medicare for allegedly sending a nurse to J.S.' home to inject the insulin. (J.S. failed to order insulin from October 2007 through February 2008, and again in April 2008.) J.S. also failed to order any syringes – needed to inject the insulin – during the entire time ABC was allegedly injecting her twice a day with insulin. J.S.' Medicare claims data after April 2008, when she left ABC and switched to FHH, displays similar gaps in obtaining insulin and syringes. Without insulin and syringes, ABC's nurse could not have injected any insulin. According to claims submitted by ABC, J.S.' diagnosis – the reason she needed skilled nursing care in the home – also switched back and forth from diabetes without complication, to “physical therapy,” back to diabetes without complication, then to diabetes with neurological manifestations. ABC also falsified the OASIS reports for J.S., so J.S. would be categorized as an

outlier, thus significantly increasing Medicare's payments to ABC. Medicare paid ABC \$78,495.66 for these false claims relating to J.S.

51. From approximately March 12, 2007, through October 22, 2008, ABC submitted to Medicare 20 claims totaling \$161,607.20 for home health services allegedly provided to beneficiary R.U. ABC claimed to have provided several skilled nursing visits every single day to administer insulin injections, plus a near-daily visit by a home health aide and some physical therapy. These services were allegedly provided between March 12, 2007, and October 14, 2008.

52. During that time, however, R.U. failed to order syringes and needles needed to administer the insulin for all but three months of the year and a half in which ABC billed Medicare for allegedly sending a nurse to R.U.'s home to inject the insulin, and R.U. rarely ordered the lancets or glucose test strips necessary to determine her blood glucose level prior to administering insulin. R.U. also skipped weeks and went more than one month where she failed to obtain the insulin necessary for the alleged injections. Moreover, from January 2006 until March 2007, when ABC began billing for her nurse visits and insulin injections, R.U. ordered insulin only twice, in January and March of 2006, and was instead apparently managing her diabetes by oral hyperglycemic agents. R.U.'s Medicare claims data after October 2008, when she left ABC and switched to FHH, displays similar gaps in obtaining syringes and testing supplies. Without insulin, syringes, and supplies, ABC's nurse could not have injected any insulin. All of ABC's claims to Medicare for home health services allegedly provided to R.U. are false, fabricated claims. ABC also falsified the OASIS reports for R.U., so R.U. would be categorized as an outlier, thus significantly increasing Medicare's payments to ABC. Medicare paid ABC \$107,528.69 for these false claims relating to R.U.

53. In addition, many of ABC's claims submitted to Medicare are fraudulent because they were obtained through the payment of kickbacks to beneficiaries and others.

54. For example, among other claims, from on or about March 9, 2006, through on or about September 5, 2008, ABC submitted to Medicare 70 claims totaling \$532,892.40 for home health services allegedly provided to beneficiaries C.C., F.C., and G.C. However, ABC was only able to obtain beneficiary information and submit claims to Medicare for services allegedly provided to C.C., F.C., and G.C., because ABC, through Defendants GLADYS ZAMBRANA, PEREZ, HERNANDEZ, and others, paid cash kickbacks to those and other beneficiaries, in violation of Medicare rules and regulations and the federal anti-kickback statute, 42 U.S.C. § 1320a-7b(b)(2). Defendant HERNANDEZ, among others, acted as a patient recruiter, paying kickbacks to beneficiaries so that ABC could use those beneficiaries' information to bill Medicare.

55. In addition, according to analysis of Medicare data, beneficiaries C.C., F.C., and G.C. would each go months without ordering insulin or the supplies needed to administer insulin, all while ABC was billing Medicare for having a nurse administer insulin to each of these beneficiaries several times a day. ABC also falsified the OASIS reports for C.C., F.C., and G.C., so they each would be categorized as an outlier, thus significantly increasing Medicare's payments to ABC. Medicare paid ABC \$359,355.05 for those false claims.

56. Lastly, many of ABC's claims to Medicare were fraudulent because ABC would create and use altered blood samples to try to justify the skilled nursing, diabetic home health services. Specifically, at the direction of GLADYS ZAMBRANA, PEREZ, HERNANDEZ, and others, and in exchange for receiving kickbacks, MODESTO HIDALGO, a laboratory medical assistant who drew blood and performed medical tests, would falsify blood tests and medical

records of ABC beneficiaries to make it appear that legitimate home health care services were being provided to those ABC beneficiaries, when in fact, legitimate blood tests would have established that no such services were necessary.

57. All the fraudulent billings identified above were submitted to Medicare by ABC when Defendants GLADYS ZAMBRANA, JAVIER ZAMBRANA, PEREZ, and HERNANDEZ were in control of ABC, and those Defendants knew the claims were for services not rendered, not medically necessary, and obtained and tainted by their payment of kickbacks.

#### **FHH'S FRAUDULENT BILLING SCHEME**

58. On or about August 22, 2005, FHH signed and submitted a Medicare enrollment application (CMS form 855A), in which, among other things, FHH agreed to abide by all Medicare laws and regulations. FHH subsequently received a Medicare provider number (10-8298) from Medicare, effective May 9, 2006. Once it received a Medicare provider number, Defendant FHH was able to bill and be paid by Medicare for covered and eligible home health services.

59. On or about January 18, 2008, FHH submitted to Medicare an updated form 855A advising Medicare that Defendant TELLECHEA had been added as an owner, managing employee, and officer of FHH, effective September 28, 2007. On or about December 19, 2007, FHH submitted to Medicare an updated form 855A advising Medicare that Defendant GLADYS ZAMBRANA had become an owner of FHH, effective November 30, 2007.

60. From on or about September 28, 2007, when Defendant GLADYS ZAMBRANA and her co-conspirators took control and ownership of FHH, continuing through the present, FHH submitted more than 1,022 claims to Medicare, totaling at least \$5,475,723.18.<sup>1</sup> At least

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<sup>1</sup> Although FHH's unlawful activities and Medicare billings continue to the present day, the data herein only includes claims submitted by FHH through March 2009.

\$5,153,953.87 of that amount were home health services claims for skilled nursing services – specifically, the administration of injectable insulin to purported insulin-dependent beneficiaries who were allegedly confined to their homes – along with home health aides and physical therapy that FHH claimed to have provided to such Medicare beneficiaries. However, through investigative efforts, it was determined that many if not all of these claims were for services not rendered, not medically necessary, or otherwise tainted by fraud. Indeed, home health services for 43 of the beneficiaries had previously been fraudulently billed to Medicare by ABC, and, after the Defendants took control of FHH, they simply transferred those fraudulent billings to FHH. Medicare paid FHH at least \$4,007,003.57 for these false claims.

61. Among other claims, from on or about September 28, 2007, to February 27, 2009, FHH submitted to Medicare 18 claims totaling \$122,025.88 for home health services allegedly provide to beneficiary M.L. These services were allegedly provided to M.L. from September 28, 2007, to February 6, 2009, and consisted mostly of skilled nursing visits for the injection of insulin.

62. However, M.L.’s actual treating physician was interviewed by federal agents and advised that M.L. has controlled diabetes and takes Glibizide, an oral hyperglycemic agent, and *does not take* nor need injectable insulin. All of FHH’s claims for home health services to M.L. are false, fabricated claims.

63. Medicare paid FHH at least \$85,786.82 for these false claims relating to M.L.

64. Similarly, among other claims, from on or about April 11, 2008, through January 14, 2009, FHH submitted to Medicare six claims for \$47,455.00 for home health services allegedly provided to beneficiary B.R. These claims were principally for skilled nursing services to inject insulin to B.R. from April 11, 2008, through January 1, 2009.

65. However, B.R.'s actual treating physician was interviewed by federal agents and advised that B.R. has controlled diabetes and takes Glucophage, an oral hyperglycemic agent, and *does not take* nor need injectable insulin. All of FHH's claims for home health services to B.R. are false, fabricated claims.

66. Medicare paid FHH \$34,674.69 for these false claims relating to B.R.

67. Among other claims, from on or about September 28, 2007, through March 19, 2009, FHH submitted to Medicare at least 470 claims totaling \$2,774,419.60 for home health services allegedly provided to 61 beneficiaries. According to the claims submitted by FHH to Medicare, all of these beneficiaries were insulin-dependent diabetics confined to the home and in need of skilled nursing care to administer the insulin. FHH thus billed Medicare for providing two or more skilled nursing visits a day to each beneficiary, as well as home health aides and physical therapy services.

68. Analysis of Medicare records and billing data establish that these beneficiaries failed to order sufficient insulin, needles, and/or syringes necessary to receive the numerous daily insulin injections FHH claimed to have provided. Indeed, some beneficiaries failed to order any insulin at all, and many were already taking oral hyperglycemic agents to manage or control their diabetes, and had no medical need for insulin injections. Many other beneficiaries never purchased the lancets, test strips, and controls that are absolutely indispensable to conduct the multiple-times-a-day testing of their blood glucose levels that had to be done before receiving any insulin injections. As part of the scheme to defraud Medicare, just as ABC had done, FHH also falsified the OASIS reports for their beneficiaries, claiming they had medical conditions and needs that did not exist, so the beneficiaries would be categorized as outliers, thus significantly increasing Medicare's payments to FHH.

69. All these claims submitted by FHH were false, fraudulent claims for services that were not medically necessary and never actually rendered. Medicare paid FHH at least \$2,026,314.94 for the false claims relating to those 61 beneficiaries.

70. For example, from on or about February 12, 2008, through February 13, 2009, FHH submitted to Medicare 18 claims totaling \$145,153.14 for home health services allegedly provided to beneficiary O.F. FHH claimed to have provided numerous skilled nursing visits every single day to administer insulin injections, plus visits by a home health aide and some physical therapy. These services were allegedly provided between February 12, 2008, and February 5, 2009.

71. During that time, however, O.F. failed to obtain insulin and syringes for nearly half of the months in which FHH billed Medicare for allegedly sending a nurse to O.F.'s home to inject the insulin. (O.F. failed to order insulin or syringes from February through June 2008.) O.F.'s Medicare claims data prior to February 2008, when FHH first started billing for him, establishes that O.F. had not obtained nor needed insulin since March 2007, and hadn't obtained syringes since November 2006. Without insulin and syringes, FHH's nurse could not have injected any insulin. FHH also falsified the OASIS reports for O.F., so O.F. would be categorized as an outlier, thus significantly increasing Medicare's payments to FHH. Medicare paid FHH \$103,855.04 for those false claims relating to O.F.

72. In addition, among other claims, from on or about September 28, 2007, through February 6, 2009, FHH submitted to Medicare 18 claims totaling \$94,470.88 for home health services allegedly provided to beneficiary M.G. FHH claimed to have provided two skilled nursing visits every single day to administer insulin injections, plus visits by a home health aide. These services were allegedly provided between September 28, 2007, and January 30, 2009.

73. During that time, however, M.G. failed to obtain insulin and syringes for several of the months in which FHH billed Medicare for allegedly sending a nurse to M.G.'s home to inject the insulin. (M.G. failed to obtain insulin in February and April 2008, and failed to obtain syringes in January, February, April, and September 2008.) Without insulin and syringes, FHH's nurse could not have injected any insulin. M.G. also rarely ordered the lancets and test strips that would have been absolutely indispensable to conduct the multiple-times-a-day testing of his blood glucose levels that had to be done before receiving any insulin injections. Further, M.G. was also regularly filling prescriptions for Glipizide ER, an oral hyperglycemic agent used to treat type II diabetes. However, FHH stated on its billings to Medicare that M.G. suffered from Type I, or juvenile, diabetes. Persons with Type I diabetes do not need and do not take oral hyperglycemic agents.

74. Prior to FHH's fraudulent billings to Medicare for home health services allegedly provided to M.G., ABC had similarly billed Medicare for home health services allegedly provided to M.G., principally a skilled nurse to inject insulin. From on or about May 19, 2006, through September 25, 2007, ABC submitted 16 claims to Medicare totaling \$136,600.00 for such home health services, allegedly provided by ABC to M.G. from May 19, 2006, to August 29, 2007. However, M.G. obtained no insulin or syringes from June to September 2006, and again failed to obtain insulin or syringes in November and December 2006. In addition, from August 30, 2007, after ABC stopped billing for providing a nurse to administer insulin to M.G., through September 28, 2007, when FHH began such billing, M.G. had no home health nurse to administer insulin. FHH and ABC also falsified the OASIS reports for M.G., so M.G. would be categorized as an outlier, thus significantly increasing Medicare's payments to FHH. Medicare

paid FHH \$69,992.14 for those false claims, and Medicare paid ABC \$84,707.28 for those false claims related to M.G.

75. In addition, among other claims, from on or about October 24, 2007, through October 23, 2008, FHH submitted to Medicare 12 claims totaling \$72,060.00 for home health services allegedly provided to beneficiary R.A. FHH claimed to have provided two skilled nursing visits every single day to administer insulin injections, plus some physical therapy. These services were allegedly provided between October 24, 2007, and October 11, 2008.

76. During that time, however, R.A. failed to obtain insulin for nearly half of the months in which FHH billed Medicare for allegedly sending a nurse to R.A.'s home to inject the insulin. (R.A. failed to obtain insulin in February 2008, and obtained no insulin from April through July 2008. He also only ordered syringes for four of the 12 months he allegedly received insulin injections, and failed to obtain syringes October and November 2007, and January through July 2008.) Without insulin and syringes, FHH's nurse could not have injected any insulin. R.A. never ordered the test strips and controls, and only ordered lancets in one month out of 12, that would have been absolutely indispensable to conduct the multiple-times-a-day testing of his blood glucose levels that had to be done before receiving any insulin injections. FHH also falsified the OASIS reports for R.A., so R.A. would be categorized as an outlier, thus significantly increasing Medicare's payments to FHH. Medicare paid FHH \$53,316.66 for these false claims relating to R.A.

77. In addition, just like the Defendants had done with ABC, many of FHH's claims submitted to Medicare are fraudulent because they were obtained through the payment of kickbacks to beneficiaries and others. The Defendants transferred many of the beneficiaries to whom they were paying kickbacks from ABC to FHH, and continued to defraud Medicare.

78. For example, among other claims, from on or about July 16, 2008, through on or about February 23, 2009, FHH submitted to Medicare 14 claims totaling \$82,720.00 for home health services allegedly provided to beneficiaries C.C. and F.C. (the same beneficiaries discussed *supra*, under ABC). FHH claimed to have provided two skilled nursing visits every single day to administer insulin injections, plus some physical therapy and home health aides. These services were allegedly provided from July 16, 2008, through January 13, 2009.

79. ABC stopped “providing” an alleged skilled nurse for insulin injections to C.C. on June 10, 2008. However, FHH did not begin providing that alleged service until July 16, 2008. For one month, therefore, C.C. did not have any skilled nursing visits, and thus did not need the insulin injections or a nurse to administer them, indicating all billings for C.C. were fraudulent.

80. However, just like the Defendants had done with ABC, FHH was only able to obtain beneficiary information and submit claims to Medicare for services allegedly provided to C.C. and F.C. because FHH, through Defendants GLADYS ZAMBRANA, TELLECHEA, CASTANEDA, and others paid cash kickbacks to those and other beneficiaries, in violation of Medicare rules and regulations and the federal anti-kickback statute, 42 U.S.C. § 1320a-7b(b)(2). Defendant CASTANEDA, among others, acted as a patient recruiter, paying kickbacks to beneficiaries so that FHH could use those beneficiaries’ information to bill Medicare. FHH also falsified the OASIS reports for C.C. and F.C., so each would be categorized as an outlier, thus significantly increasing Medicare’s payments to FHH. Medicare paid FHH \$59,612.61 for these claims.

81. All the fraudulent billings identified above were submitted to Medicare by FHH when Defendants GLADYS ZAMBRANA, PEREZ, CASTANEDA, and TELLECHEA were in

control of FHH, and those Defendants knew the claims were for services not rendered, not medically necessary, and obtained and tainted by their payment of kickbacks.

**ABC'S DISSIPATION AND FRAUDULENT TRANSFERS OF ASSETS**

82. On or about December 5, 2005, ABC opened a corporate bank account with Washington Mutual Bank, account number xxxxxxxxxxx9253. From January 2006 through April 2006, Medicare paid ABC's claims by depositing funds into ABC's account at Washington Mutual Bank.

83. In February 2006, ABC opened a corporate bank account with Regions Bank, account number xxxxxx9519. From April 2006 through August 2007, Medicare paid ABC's claims by depositing funds into ABC's account at Regions Bank. This account was emptied by Defendants and closed on August 29, 2007.

84. In August 2007, ABC opened a corporate bank account with Wachovia Bank, account number xxxxxxxxxxx5521. From August 2007 through August 2008, Medicare paid ABC's claims by electronically depositing funds into ABC's account at Wachovia Bank.

85. In January 2008, ABC opened a corporate bank account at Bank of America, account number xxxxxxxx8106. From September 2008 through November 2008, Medicare paid ABC's claims by electronically depositing funds into ABC's account at Bank of America.

86. From in or around January 2006, through in or around November 2008, Medicare deposited at least **\$11,293,852.39** into ABC's various bank accounts, first through checks and then through Electronic Funds Transfers.

87. These deposits by Medicare to ABC were in payment for the false claims submitted by ABC. ABC and the Individual Defendants concocted schemes to transfer these

Medicare monies to themselves both directly and by using a number of shell companies. These shell companies were owned and controlled by the Individual Defendants.

**Transfers to Defendant Castaneda**

88. From on or about September 5, 2006, through on or about August 6, 2007, Defendants dissipated proceeds of their Medicare fraud by transferring at least \$98,870 to Defendant CASTANEDA from ABC's account at Regions Bank.

89. From on or about September 4, 2007, through on or about November 2, 2007, Defendants dissipated proceeds of their Medicare fraud by transferring at least \$23,685.00 to Defendant CASTANEDA from ABC's account at Wachovia Bank.

**Transfers to Defendant Hernandez**

90. From on or about May 8, 2006, through on or about May 21, 2007, Defendants dissipated proceeds of their Medicare fraud by transferring at least \$277,888 to Defendant HERNANDEZ from ABC's account at Regions Bank.

91. From on or about August 12, 2007, through on or about August 28, 2008, Defendants dissipated proceeds of their Medicare fraud by transferring at least \$349,213.04 to Defendant HERNANDEZ from ABC's account at Wachovia Bank.

92. From on or about February 22, 2008, through on or about September 25, 2008, Defendants dissipated proceeds of their Medicare fraud by transferring at least \$32,335.98 to Defendant HERNANDEZ from ABC's account at Bank of America.

**Transfers to Defendant Perez**

93. From on or about July 14, 2006, through on or about August 14, 2007, Defendants dissipated proceeds of their Medicare fraud by transferring at least \$338,555 to Defendant PEREZ from ABC's account at Regions Bank.

94. From on or about August 20, 2007, through on or about August 28, 2008, Defendants dissipated proceeds of their Medicare fraud by transferring at least \$417,006.44 to Defendant PEREZ from ABC's account at Wachovia Bank.

95. From on or about February 4, 2008, through on or about November 18, 2008, Defendants dissipated proceeds of their Medicare fraud by transferring at least \$48,100 to Defendant PEREZ from ABC's account at Bank of America.

**Transfers to Defendant Gladys Zambrana**

96. From on or about July 23, 2006, through on or about August 3, 2007, Defendants dissipated proceeds of their Medicare fraud by transferring at least \$206,743 to Defendant GLADYS ZAMBRANA from ABC's account at Regions Bank.

97. From on or about February 4, 2008, through on or about November 14, 2008, Defendants dissipated proceeds of their Medicare fraud by transferring at least \$51,625.00 to Defendant GLADYS ZAMBRANA from ABC's account at Bank of America.

98. From on or about August 24, 2007, through on or about August 26, 2008, Defendants dissipated proceeds of their Medicare fraud by transferring at least \$284,984.02 to Defendant GLADYS ZAMBRANA from ABC's account at Wachovia Bank.

99. From on or about March 21, 2008, through on or about January 14, 2009, Defendants dissipated proceeds of their Medicare fraud by transferring at least \$43,900 to Defendant GLADYS ZAMBRANA; \$9,300 to Defendant PEREZ; and \$5,000 to Defendant TELLECHEA, from Defendant GLADYS ZAMBRANA's account at Wachovia Bank, account number xxxxxxxxx5779.

**Transfers to Defendants' Shell Companies – G.E. Investment Services**

100. G.E. Investment Services, Corp. ("G.E.") is a Florida company incorporated by Defendant GLADYS ZAMBRANA on May 11, 2006. Defendants PEREZ and GLADYS ZAMBRANA are the sole owners, officers, and registered agent of G.E.

101. From on or about August 12, 2006, through on or about August 20, 2007, Defendants dissipated proceeds of their Medicare fraud by transferring at least \$24,258 to G.E. from ABC's account at Regions Bank.

102. From on or about August 20, 2007, through on or about August 7, 2008, Defendants dissipated proceeds of their Medicare fraud by transferring at least \$312,052.00 to G.E. from ABC's account at Wachovia Bank.

103. On or about July 1, 2008, Defendants dissipated proceeds of their Medicare fraud by transferring at least \$7,500.00 to G.E. from ABC's account at Bank of America.

104. G.E. maintains a corporate bank account at Bank of America, account number xxxxxxxx8086.

105. From on or about July 6, 2006, through on or about August 5, 2008, Defendants dissipated proceeds of their Medicare fraud by transferring at least \$87,080.00 from G.E.'s account at Bank of America to Defendant GLADYS ZAMBRANA.

106. From on or about December 10, 2007, through on or about August 5, 2008, Defendants dissipated proceeds of their Medicare fraud by transferring at least \$18,000.00 from G.E.'s account at Bank of America to Defendant PEREZ.

107. From on or about February 5, 2008, through on or about March 17, 2008, Defendants dissipated proceeds of their Medicare fraud by transferring at least \$5,715.00 from G.E.'s account at Bank of America to Defendant CASTANEDA.

108. On or about April 16, 2008, Defendants dissipated proceeds of their Medicare fraud by transferring at least \$9,500.00 from G.E.'s account at Bank of America to Defendant TELLECHEA.

**Transfers to Defendants' Shell Companies – G.E.A. Florida Services**

109. G.E.A. Florida Services, Inc. ("G.E.A.") is a Florida company incorporated by Defendant PEREZ on March 20, 2006. Until March 5, 2008, Defendants PEREZ, GLADYS ZAMBRANA, and HERNANDEZ, were the sole owners and officers of G.E.A. According to public records filed with the Florida Secretary of State, as of August 25, 2008, Defendant GLADYS ZAMBRANA is G.E.A.'s sole officer and registered agent.

110. From on or about May 10, 2006, through on or about February 16, 2007, Defendants dissipated proceeds of their Medicare fraud by transferring at least \$46,200 to G.E.A. from ABC's account at Regions Bank.

111. From on or about August 20, 2007, through on or about April 1, 2008, Defendants dissipated proceeds of their Medicare fraud by transferring at least \$155,600.00 to G.E.A. from ABC's account at Wachovia Bank.

**Transfers to Defendants' Shell Companies – Seamar Home Care**

112. Seamar Home Care, Inc. ("Seamar") is a Florida company incorporated on September 19, 2005. According to corporate records filed with the Florida Secretary of State, Defendant HERNANDEZ is the administrator of Seamar, and L. Hernandez, with the same address as Defendant HERNANDEZ, is its president and registered agent.

113. From on or about December 11, 2007, through on or about August 28, 2008, Defendants dissipated proceeds of their Medicare fraud by transferring at least \$283,075.00 to Seamar from ABC's account at Wachovia Bank.

114. On or about September 17, 2008, Defendants dissipated proceeds of their Medicare fraud by transferring at least \$4,600 to Seamar from ABC's account at Bank of America.

**Transfers to Defendants' Shell Companies – Consultant Billing**

115. Consultant Billing, Inc. ("Consultant Billing") is a Florida company incorporated by Defendant GLADYS ZAMBRANA on or about May 19, 2008. Defendant GLADYS ZAMBRANA is the owner and sole officer of Consultant Billing.

116. From on or about September 17, 2008, through on or about October 2, 2008, Defendants dissipated proceeds of their Medicare fraud by transferring at least \$10,500 to Consultant Billing from ABC's account at Bank of America.

117. The transfers and asset dissipations described herein occurred at the direction of or with the knowledge of the Individual Defendants.

118. Currently, approximately \$4,900 remains in ABC's known bank accounts. Defendants have now dissipated more than **\$11 million** in Medicare funds paid to ABC.

**FHH'S DISSIPATION AND FRAUDULENT TRANSFERS OF ASSETS**

119. On or about June 2006, FHH opened a corporate bank account with Bank Atlantic, account number xxxxxx5679. From July 2006 through June 2007, Medicare paid FHH's claims by depositing funds into FHH's account at Bank Atlantic.

120. In June 2007, FHH opened a corporate bank account with Wachovia Bank, account number xxxxxxxxx7819. From June 2007 through January 2008, Medicare paid FHH's claims by electronically depositing funds into FHH's account at Wachovia Bank. Defendants TELLECHEA and GLADYS ZAMBRANA are authorized signatories on FHH's account at Wachovia Bank.

121. In November 2007, FHH opened a corporate bank account with Bank of America, account number xxxxxxxx3954. Defendants TELLECHEA and GLADYS ZAMBRANA are authorized signatories on FHH's account at Bank of America.

122. From in or around October 2007, continuing through the present, Medicare deposited at least **\$4,007,003.57** into FHH's various bank accounts using Electronic Funds Transfers.

123. These deposits by Medicare to FHH were in payment for the false claims submitted by FHH. FHH and Defendants GLADYS ZAMBRANA, PEREZ, CASTANEDA, and TELLECHEA, among others, concocted elaborate schemes to transfer these Medicare monies to themselves both directly and by using a number of shell companies. These shell companies were owned and controlled by these Defendants.

**Transfers to Defendants Tellechea and Gladys Zambrana**

124. On or about January 10, 2008, Defendants dissipated proceeds of their Medicare fraud by transferring at least \$9,500.00 to Defendant TELLECHEA from FHH's account at Wachovia Bank.

125. On or about January 14, 2008, Defendants dissipated proceeds of their Medicare fraud by transferring at least \$1,600.00 to Defendant GLADYS ZAMBRANA from FHH's account at Wachovia Bank.

126. From on or about January 15, 2008, through on or about February 5, 2008, Defendants dissipated proceeds of their Medicare fraud by transferring at least \$143,396.74 to Defendant FHH's account at Bank of America from FHH's account at Wachovia Bank.

127. From on or about October 15, 2008, through on or about March 2, 2009, Defendants dissipated proceeds of their Medicare fraud by transferring at least \$16,925.00 to Defendant GLADYS ZAMBRANA from FHH's account at Bank of America.

**Transfers to Defendants' Shell Companies**

128. St. Mary's Home Health Agency, Inc. ("St. Mary's") is a Florida company incorporated by I. Castaneda, a relative of Defendant CASTANEDA, on or about May 1, 2006. From July 2006 to March 2008, Defendant CASTANEDA was St. Mary's vice-president and treasurer, and Defendant TELLECHEA was St. Mary's president and secretary. On March 6, 2008, Defendant CASTANEDA became the sole officer and owner of St. Mary's.

129. From on or about October 9, 2008, through on or about January 30, 2009, Defendants dissipated proceeds of their Medicare fraud by transferring at least \$220,469.67 to St. Mary's from FHH's account at Bank of America.

130. From on or about October 15, 2008, through on or about March 5, 2009, Defendants dissipated proceeds of their Medicare fraud by transferring at least \$155,860.00 to Consultant Billing, Inc., from FHH's account at Bank of America.

131. These transfers and asset dissipations all occurred at the direction of or with the knowledge of Defendants GLADYS ZAMBRANA, PEREZ, CASTANEDA, and TELLECHEA.

132. Currently, approximately \$181,000 remains in FHH's known bank accounts. Defendants have now dissipated more than **\$3.7 million** in Medicare funds paid to FHH.

133. Defendants' dissipation of their assets and the proceeds of their Medicare fraud continues to this day.

134. Based upon my experience and training, as well as the information described in this Declaration and otherwise learned in this investigation, I believe that the claims submitted to

Medicare by ABC and the defendants from January 12, 2006, to December 5, 2008, were false, fraudulent claims, in that ABC and the defendants failed to provide home health services they billed for, failed to obtain proper POCs, paid kickbacks to obtain POCs and beneficiaries, and claimed to have provided home health services to Medicare beneficiaries who were not eligible to receive such services, and have resulted in ABC and the defendants obtaining money of a health care benefit program through the means of a scheme and artifice to defraud, in the sum of more than **\$11.2 million**. In addition, the claims submitted to Medicare by FHH and the defendants from September 28, 2007, through the present, were false, fraudulent claims, in that FHH and the defendants failed to provide home health services they billed for, failed to obtain proper POCs, paid kickbacks to obtain POCs and beneficiaries, and claimed to have provided home health services to Medicare beneficiaries who were not eligible to receive such services and have resulted in FHH and the defendants obtaining money of a health care benefit program through the means of a scheme and artifice to defraud, in the sum of at least **\$4 million**.

FURTHER DECLARANT SAYETH NAUGHT.

Pursuant to Title 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct and is based upon my personal knowledge this 24<sup>th</sup> day of June, 2009, in Miami, Florida.

A handwritten signature in black ink, appearing to read "Lynnette Alvarez-Karnes", written over a horizontal line.

SPECIAL AGENT LYNNETTE ALVAREZ-KARNES  
FEDERAL BUREAU OF INVESTIGATION