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### **FOURTEEN AREA DEFENDANTS CHARGED IN EIGHT SEPARATE FEDERAL HEALTH CARE FRAUD CASES**

CHICAGO – One Chicago area physician, two chiropractors, three nurses, a pharmacist, and several home health industry administrators and recruiters are among fourteen defendants charged this week in eight separate, unrelated federal health care fraud cases, federal law enforcement officials announced today. Federal arrest warrants were executed this morning for ten of the defendants. Nine defendants allegedly work in the home health care industry, of which seven were charged with conspiring to violate the criminal anti-kickback statute, which makes it illegal to offer or solicit kickbacks in exchange for referrals of Medicare patients.

Several of today's enforcement activities in the Chicago area are being conducted as part of a nationwide takedown by Medicare Fraud Strike Force operations that led to charges against 111 defendants for their alleged participation in numerous Medicare fraud schemes. The Medicare Fraud Strike Force is a multi-agency team of federal, state and local investigators designed to combat Medicare fraud through the use of Medicare data analysis techniques and an increased focus on community policing. The Departments of Justice and Health and Human Services today announced that the Medicare Fraud Strike Force, previously operating in seven locations across the country,

has expanded operations to Chicago and Dallas. Five of the eight cases announced today were brought as a part of strike force operations.

“With this takedown, we have identified and shut down large-scale fraud schemes operating throughout the country. We have safeguarded precious taxpayer dollars. And we have helped to protect our nation's most essential health care programs, Medicare and Medicaid,” said Attorney General Holder. “As today's arrest prove, we are waging an aggressive fight against health care fraud.”

Patrick J. Fitzgerald, United States Attorney for the Northern District of Illinois, announced the formation of the HEAT Strike Force in the Northern District of Illinois. “Health care fraud has become an increasingly important priority of federal law enforcement in the Chicago area. We are organizing to deploy all of our resources to ensure that dishonest medical providers do not profit from cheating Medicare, Medicaid, and private insurers,” said Mr. Fitzgerald. Speaking particularly of the kickback violations alleged against several defendants in the home health care industry, Mr. Fitzgerald explained, “Paying for Medicare and Medicaid patients is a crime. We are focusing our resources on making sure that those who offer or solicit kickbacks are held accountable by the criminal justice system.”

Also announcing the charges was Robert D. Grant, Special Agent-in-Charge of the Chicago office of the Federal Bureau of Investigation. “Healthcare fraud will not be tolerated,” said Mr. Grant. “It affects every citizen through increases in insurance premiums and rising costs for both Medicare and Medicaid. As consumers of healthcare services, we should all be cognizant of possible fraud and promptly report suspicious charges to our insurance carriers or law enforcement.”

“Health care fraud is a crime committed against vulnerable patients, U.S. taxpayers, and the government programs funding vitally-needed health services,” said Lamont Pugh III, the Chicago Region's Special Agent in Charge for the Office of Inspector General of the Department of Health & Human Services. “The actions we have taken today are part of a coordinated, nationwide crackdown in our continuing battle against criminals who enrich themselves at our great expense.”

James Vanderberg, Special Agent-in-Charge for the Chicago Regional Office of the United States Department of Labor, Office of Inspector General said: “Today's charges represent the OIGs firm commitment to actively investigate health care fraud schemes in which union sponsored health and welfare funds are defrauded. We will continue to work vigorously with the U.S. Attorney's Office and our law enforcement partners to investigate crimes that undermine the financial well-being of union affiliated benefit funds.”

Mr. Fitzgerald announced the cases, all eight of which were charged this week in U.S. District Court, with Robert D. Grant, Special Agent-in-Charge of the Chicago Office of Federal Bureau of Investigation; Lamont Pugh, Special Agent-in-Charge of the U.S. Department of Health and Human Services Office of Inspector General in Chicago; and James Vanderberg, Special Agent-in-Charge of the U.S. Department of Labor Office of Inspector General in Chicago. The Office of Criminal Investigations of the Food and Drug Administration, the Office of the Inspector General of the U.S. Railroad Retirement Board, the City of Chicago Office of Inspector General, and the U.S. Department of Labor Employee Benefits Security Administration also participated in the investigations.

The defendants were each charged with one or more counts of health care fraud, mail fraud, false statements relating to health care matters, and/or conspiracy. If convicted of health care fraud,

each count carries a maximum penalty of 10 years in prison and a \$250,000 fine. If convicted of mail fraud, each count carries a maximum penalty of 20 years in prison and a \$250,000 fine. If convicted of false statements relating to health care matters, each count carries a maximum penalty of 5 years in prison and a \$250,000 fine. If convicted of conspiracy, each count carries a maximum penalty of 5 years in prison and a \$250,000 fine. The Court, however, would determine the appropriate sentence to be imposed under the advisory United States Sentencing Guidelines.

In each case, the public is reminded that charges are not evidence of guilt. The defendants are presumed innocent and are entitled to a fair trial at which the government has the burden of proving guilt beyond a reasonable doubt. The details of each case follow:

**United States v. Virgilio Orillo and Merigrace ("Grace") Orillo**

Virgilio Orillo and Merigrace ("Grace") Orillo, who co-own and operate Chalice Home Healthcare Services, Inc. ("Chalice"), with offices in Chicago, Freeport, and Morris, Illinois, were charged with three counts of health care fraud in a criminal indictment filed on Tuesday. According to the charges, Chalice nurses, nurse aides, physical therapists, and occupational therapists provide services to patients at their homes. The indictment alleges that the Orillos falsified documents in order to increase the payments Chalice received from Medicare. These falsifications were allegedly made on documents known as OASIS forms and made Chalice's patients appear to be sicker than they actually were and in need of greater care than they actually required. The indictment alleges that the Orillos' fraud scheme cause a loss of more than \$500,000 to the Medicare program.

Virgilio Orillo, 68, and Merigrace ("Grace") Orillo, 44, both of Elmhurst, will be arraigned on February 22, 2011, at 10:30 a.m. at U.S. District Court in Rockford, Illinois, before Magistrate Judge P. Michael Mahoney.

The government is being represented by Assistant U.S. Attorney Scott Verseman. The case was investigated by the FBI and the Inspector General's offices of the U.S. Department of Health and Human Services and the U.S. Department of Labor.

**United States v. Marilyn Maravilla, Junjee Arroya, Ferdinand Echavia,  
Kennedy Lomillo, and Baltazar Alberto**

Five individuals associated with Goodwill Home Healthcare, Inc. ("Goodwill"), were charged by criminal complaint with conspiracy to violate the federal anti-kickback statute by agreeing to offer or pay or to solicit or receive kickbacks for the referral of Medicare patients for home health care services. According to the charges, Marilyn Maravilla, a nurse who became the controlling owner of Goodwill in approximately August 2008, began causing kickbacks to be paid for the referral of Medicare patients to Goodwill. Goodwill's Medicare billings, which were

approximately \$679,596 in 2008, increased to approximately \$2,133,391 in 2009 and approximately \$2,700,000 in 2010. According to records seized during a search of Goodwill headquarters, approximately \$410,998 in kickbacks were paid to approximately 28 persons for the referral of approximately 912 patients. In addition to Marilyn Maravilla, the complaint charges Junjee Arroyo, director of nursing; Ferdinand Echavia, a nurse; Kennedy Lomillo, an accountant and bookkeeper; and Baltazar Alberto, a nurse. The investigation is ongoing.

The government is being represented by Assistant U.S. Attorney John Kness. The case was investigated by the FBI and Inspector General's offices of the U.S. Department of Health and Human Services and the U.S. Department of Labor.

Marilyn Maravilla, 54, of Chicago; Junjee Arroyo, 42, of Elmurst; Ferdinand Echavia, 37, of Chicago; Kennedy Lomillo, 43, of Mundelein; and Baltazar Alberto, 47, of Morton Grove, were arrested earlier today and will appear before the Honorable Jeffrey Cole, U.S. Magistrate Judge, for an initial appearance today at 3:30 p.m.

#### **United States v. Alona Dizon Bugayong and Han Woo**

Han Woo and Alona Dizon Bugayong were charged by a criminal complaint unsealed today with one count of conspiring to pay kickbacks for the referral of patients to home health care agencies run by Han Woo. According to the charges, Woo operates New Covenant Home Health Agency LLC and Healthquest Homecare LLC. The complaint alleges that Bugayong and Woo conspired to pay kickbacks in exchange for physician referrals of home health care patients. Bugayong and Woo devised a scheme in which they would provide an initial kickback to a physician in exchange for a patient referral and would continue to pay smaller fees for subsequent recertifications for subsequent cycles of care. The investigation is ongoing.

Alona Dizon Bugayong, 35, of Lincolnwood, and Han Woo, 35, of Hoffman Estates, were both arrested this morning and will appear before the Honorable Jeffrey Cole, U.S. Magistrate Judge, for an initial appearance today at 1:30 p.m.

AUSA Jasmin Best represents the government. The case was investigated by the FBI and the Office of the Inspector General of the U.S. Department of Health and Human Services.

#### **United States v. Jaswinder Rai Chhibber**

Dr. Jaswinder Rai Chhibber, president and owner of the Cottage Grove Community Medical Clinic in Chicago, was charged by a criminal complaint unsealed today with one count of health care fraud. The complaint alleges that Chhibber devised and participated in a scheme to defraud health care insurance providers including Medicare, Medicaid, and Blue Cross Blue Shield of Illinois, which administers medical claims for several union health and welfare funds in the Chicago area. According to the charges, Chhibber submitted medical services reimbursement claims for procedures never rendered, or if performed, carried out despite not being medically necessary. In particular, Chhibber is charged with performing complicated diagnostic tests on patients, such as

echocardiograms, electrocardiograms (“EKGs”), non-invasive vascular studies, nerve conduction studies and carotid doppler ultrasounds, without a medical need for those tests. The complaint further alleges that Chhibber billed insurance providers for diagnostic tests never actually performed on patients. To justify the charges submitted to insurance providers, the complaint alleges that Chhibber submitted false patient diagnoses in the reimbursement claims he submitted to insurers. The investigation is ongoing.

Jaswinder Rai Chhibber, 48, of Schaumburg, was arrested this morning and will appear before the Honorable Jeffrey Cole, U.S. Magistrate Judge, for an initial appearance later today.

AUSAs Joel Hammerman and Samuel Cole represent the government. The case was investigated by the FBI and Inspector General’s offices of the U.S. Department of Health and Human Services, the U.S. Department of Labor, and the U.S. Railroad Retirement Board.

### **United States v. Jay Hammerman**

Jay Hammerman, a pharmacist and the owner of Jay's Save Rite Thorndale Pharmacy, was charged earlier today by criminal information with two counts of health care fraud. According to the charges, Hammerman devised and participated in a scheme to defraud health care insurance providers, including Medicare, Medicaid, Blue Cross Blue Shield of Illinois, Blue Cross Blue Shield of Minnesota, Health Net, Humana, and Caremark, by submitting fraudulent reimbursement claims for prescription medications that were never actually dispensed. The criminal information alleges that Hammerman was able to obtain more than \$200,000 in reimbursement claims for prescription medications never ordered, dispensed or purchased by the pharmacy's customers.

Hammerman, 62, of Chicago, will be arraigned at a later date in U.S. District Court.

The government is being represented by Assistant U.S. Attorney Joel Hammerman, who is not related to the defendant. The case was investigated by the FBI, the Inspector General’s offices of the U.S. Department of Health and Human Services and the U.S. Department of Labor, and the Office of Criminal Investigations of the Food and Drug Administration.

In addition to the foregoing cases, which address allegations of fraud against Medicare or Medicaid as part of the HEAT partnership between the U.S. Department of Justice and the U.S. Department of Health and Human Services, the following cases announced today involve allegations of fraud against private insurers and/or the City of Chicago.

### **United States v. Brandy Howard**

Brandy Howard, a licensed chiropractor, was charged with two counts of health care fraud, three counts of mail fraud, and two counts of false statements relating to health care matters, in a criminal indictment filed Tuesday in U.S. District Court and unsealed today. Howard allegedly submitted false claims to Blue Cross Blue Shield for orthotics. According to the charges, Howard participated in health fairs at school districts and a police department, where she advertised that she could provide Blue Cross PPO subscribers with free shoes. She then prepared and submitted to Blue Cross fraudulent letters of medical necessity stating that the subscribers required orthotics because they had reported chronic pain, when in fact Howard knew that they had not made such statements. The indictment alleges that Howard submitted claims to Blue Cross in excess of \$20,000.

Howard, 35, of Naperville, was arrested upon surrendering to authorities today and will appear today before the Honorable Young B. Kim, U.S. Magistrate Judge, for an initial appearance at 1:00 p.m.

The government is being represented by Assistant U.S. Attorney Shoshana L. Gillers. The case was investigated by the FBI and the Inspector General's office of the U.S. Department of Labor.

### **United States v. Andrew Carr**

Dr. Andrew Carr, a licensed chiropractor, was charged with one count of health care fraud. According to the charges, Carr operated numerous chiropractic businesses in the Chicago suburbs over the past six years. The complaint alleges that Carr submitted claims to Blue Cross Blue Shield of Illinois (which administers several union health and welfare funds in the Chicago area), Aetna, Inc., and Professional Benefits Administrators for chiropractic services that were never rendered. The investigation is ongoing.

Andrew Carr, 41, of Lake in the Hills, was arrested this morning and will appear before the Honorable Jeffrey Cole, U.S. Magistrate Judge, for an initial appearance today at 1:15 p.m.

AUSAs Steven Grimes and Shoba Pillay represent the government. The case was investigated by the FBI, the Office of the Inspector General of the U.S. Department of Labor, and the U.S. Department of Labor Employee Benefits Security Administration.

### **United States v. U.S. Occupational Health**

U.S. Occupational Health, a medical services company that performed physical examinations and medical testing for employees of private and governmental entities, was charged by criminal information yesterday today with one count of mail fraud. According to the charges, the City of Chicago ("the City") used USOH to perform physical examinations and medical testing on applicants and employees of various City departments, including the Chicago Police Department ("CPD") and the Chicago Fire Department ("CFD"). USOH's contract with the City required, among other things, that the results of certain medical tests performed for the CPD and CFD -- specifically, pulmonary function studies, EKGs, and x-rays -- be reviewed and interpreted by board-certified specialists in pulmonology, cardiology, and radiology. The criminal information alleges that between 1999 and 2005, USOH defrauded the City by falsely representing that the results of tests performed at USOH had been reviewed by board-certified specialists in pulmonology, cardiology, and radiology when, in fact, such board-certified specialists had not reviewed or interpreted the results of these tests. USOH accomplished this, in part, by using signature stamps of actual board-certified specialists to sign letters indicating that the specialists had reviewed and interpreted the results of tests performed at USOH. Overall, USOH examined in excess of 10,000 applicants for the CPD and CFD, and USOH caused the City to overpay USOH approximately \$600,000 as a result of the fraud.

U.S. Occupational Health, an Illinois corporation, will be arraigned at a later in U.S. District Court.

The government is being represented by Assistant U.S. Attorney Rick Young. The case was investigated by the FBI and the City of Chicago Inspector General's Office.

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