UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

UNITED STATES OF AMERICA, ex rel. JESSE ALLEN, Plaintiff, v. JAY JOHNSON; AUSTIN WHILES; SARAH HASLOCK; GENUS3, LLC; WHY NOT PRODUCTIONS LLC; and WHITSON MEDICAL, INC., Defendants.	No. 1:19-CV-5598-SEG

THE UNITED STATES OF AMERICA'S COMPLAINT IN INTERVENTION

The United States of America (the "United States") asserts claims against Defendants Jay Johnson, Austin Whiles, and Genus3, LLC ("Genus3") under the False Claims Act, 31 U.S.C. §§ 3729, *et al.*, to recover treble damages and civil penalties arising from their knowing submission, and causing the submission of, false claims to Medicare. The United States also brings common law claims for unjust enrichment and payment by mistake of fact against Defendants Johnson, Whiles, Sarah Haslock, Genus3, Why Not Productions LLC ("Why Not Productions"), and Whitson Medical, Inc. to recover Medicare funds improperly obtained through, or derived from, the submission of those false claims.

PRELIMINARY STATEMENT

This case arises from Jay Johnson and Austin Whiles' exploitation of faith-based communities and vulnerable seniors to generate laboratory claims that Medicare never should have paid. Johnson and Whiles used church conferences and senior living communities to generate testing volume through kickbacks, sales pressure, sham orders, and copied provider signatures, bypassing the treating providers whose individualized medical judgment was required to establish medical necessity. The result was millions of dollars in Medicare claims for tests that were not medically necessary and not eligible for payment.

The schemes unfolded in two stages. First, Mr. Johnson and Mr. Whiles used church-sponsored health fairs and religious conferences to generate expensive genetic testing. Then, when COVID-19 disrupted that model, they shifted to senior living communities, where they used legitimate demand for COVID testing to generate higher-reimbursing respiratory pathogen panel testing.

The common thread was laboratory claims driven by sales opportunity, not individualized physician judgment. In the church fairs scheme, kickbacks were paid to faith-based organizations for access to attendees who were swabbed

for genetic testing, unsupported by treating provider orders, and not tied to individualized clinical need. In the senior living RPP scheme, residents received broad respiratory testing through account-level paperwork, standing orders, copied signatures, standardized diagnosis codes, and sales-team order entry—not resident-specific treating provider decisions.

Mr. Johnson and Mr. Whiles knew Medicare does not pay for laboratory tests unless they are ordered by providers exercising individualized medical judgment and are medically necessary for the patients tested, yet they submitted and caused the submission of claims for tests that were neither. Moreover, Mr. Whiles received commissions through Whitson Medical and used those proceeds for his and his wife's personal benefit.

Mr. Johnson and Mr. Whiles ignored warnings and complaints regarding the schemes. Providers, employees, billing personnel, communities, and seniors repeatedly raised the same concern: the billed tests lacked individualized provider judgment required to establish medical necessity. Tests had not been ordered, had not been requested, had not been used for patient care, or had been billed under providers who had not authorized them. After the government began investigating, Mr. Whiles sought retroactive paperwork to make the testing and commission payments appear legitimate.

In all, Mr. Johnson, Mr. Whiles, and Genus3 caused Medicare to pay approximately $13.7 million for laboratory tests generated through kickbacks, sham orders, copied signatures, uniform diagnosis codes, and deceptive billing practices. The United States brings this action to recover those funds, treble damages, and statutory penalties.

JURISDICTION AND VENUE

1. This Court has original subject matter jurisdiction over this action pursuant to 28 U.S.C. §§ 1331 & 1345, and supplemental jurisdiction over the common law and equitable causes of action under 28 U.S.C. § 1367(a).

2. This Court may exercise personal jurisdiction over Defendants and venue is appropriate in this Court under 31 U.S.C. § 3732(a) because Defendants can be found in, reside in, and/or transact business in the Northern District of Georgia.

PARTIES

3. The United States brings this action on behalf of the Department of Health and Human Services ("HHS"), including HHS's component, the Centers for Medicare and Medicaid Services ("CMS"), which administers the Medicare Program.

4. Defendant Jay Johnson is an individual who currently resides in Florida. During the relevant period, he resided in the Northern District of

Georgia. At all relevant times, Mr. Johnson served as the Chief Operating Officer and later Chief Executive Officer of ISPM Labs, LLC d/b/a Capstone Diagnostics, LLC ("Capstone"). During the relevant period, he owned and served as Chief Executive Officer of Genus3 and Chief Executive Officer of Sparrow Healthcare, LLC ("Sparrow"). Mr. Johnson directed, participated in, and caused the conduct alleged in this complaint. On December 10, 2025, a federal grand jury in the Northern District of Georgia indicted Mr. Johnson on criminal charges arising from alleged conduct related to the church fair genetic-testing scheme described in this complaint. That prosecution remains pending.

5. Defendant Austin Whiles is an individual who resided in Kansas during the relevant period. During the relevant period, Mr. Whiles served as Capstone's Chief Sales Officer and later Vice President of Business Development, and he performed sales, business development, or management functions at Genus3 and Sparrow. Mr. Whiles owned and controlled Whitson Medical, Inc. Mr. Whiles directed, participated in, and caused the conduct alleged in this Complaint. During the relevant time period, he transacted business in the Northern District of Georgia.

6. Defendant Sarah Haslock is an individual who resides in the Northern District of Georgia. Ms. Haslock is the former spouse of Mr. Johnson.

7. Defendant Genus3 LLC is a limited liability company organized

under the laws of Texas with its principal place of business in Texas. During the relevant period, Genus3 operated as a clinical laboratory.

8. Defendant Why Not Productions LLC is a limited liability company organized under the laws of Georgia with its principal place of business in Georgia. During the relevant period, Mr. Johnson owned and controlled Why Not Productions.

9. Defendant Whitson Medical, Inc. was a Kansas domestic for-profit corporation with its principal place of business in Kansas. During the relevant period, Mr. Whiles owned and controlled Whitson Medical. Whitson Medical dissolved in 2025.

BACKGROUND

I. The False Claims Act

10. The False Claims Act provides, in pertinent part, that any person who: (a)(1)(A) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval; (a)(1)(B) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim; [or] (a)(1)(C) conspires to commit a violation of subparagraph (A) [and] (B); is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C. 2461 note; Public Law 104-

410), plus 3 times the amount of damages which the Government sustains[.] 31 U.S.C. § 3729.

11. For purposes of the False Claims Act, the term "knowing" and "knowingly" mean that a person, with respect to information (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; and require no proof of specific intent to defraud.
31 U.S.C. § 3729(b).

12. The False Claims Act defines "material" to mean "having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property." 31 U.S.C. § 3729(b)(4).

II. The Anti-Kickback Statute

13. The Anti-Kickback Statute ("AKS") arose out of Congressional concern that providing things of value to those who can influence health care decisions may corrupt their professional judgment and result in federal funds being diverted to pay for goods and services that are medically unnecessary, of poor quality, or even harmful to a vulnerable patient population. The AKS prohibits the payment of kickbacks to protect the integrity of Medicare, TRICARE, and other federal healthcare programs. *See* Social Security Amendments of 1972, Pub. L. No. 92-603, §§ 242(b) and (c); 42 U.S.C. § 1320a-7b,

Medicare-Medicaid Antifraud and Abuse Amendments, Pub. L. No. 95-142; Medicare and Medicaid Patient and Program Protection Act of 1987, Pub. L. No. 100-93.

14. The AKS prohibits any person or entity from soliciting, receiving, offering, or paying any remuneration to induce a person to, or reward a person for referring, recommending, or arranging for the purchase of any item for which payment may be made in whole or in part by a federal health care program. In pertinent part, the statute provides:

> b. Illegal remunerations
> (1) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind—
> (A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, or
> (B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program, shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.
> (2) Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person–
> (A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for

> which payment may be made in whole or in part under a Federal health care program, or
> (B) to purchase, lease, order or arrange for or recommend purchasing, leasing or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program, shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

42 U.S.C. § 1320a-7b(b).

15. The AKS not only prohibits outright payments to a provider for referrals but also prohibits offering or paying for any remuneration to any person in exchange for arranging for or recommending ordering any service or item paid for by federal health care programs. Claims that include items or services resulting from a violation of the AKS are false or fraudulent under the FCA. 42 U.S.C. §1320a-7b(g).

16. Moreover, by submitting claims to Medicare, a supplier implicitly certifies compliance with the AKS, and their failure to do so renders each claim legally false under the FCA notwithstanding the absence of any express certification.

17. The Office of Inspector General for the United States Department of Health and Human Services ("HHS-OIG") published safe harbor regulations that define arrangements that do not violate the AKS because the practice would be unlikely to result in fraud or abuse. Safe harbor protection is afforded only to

those arrangements that precisely meet all conditions set forth in the safe harbor.

18. One such regulatory safe harbor protects some arrangements between an entity and an independent contractor, but only if the arrangement meets all seven standards. Specifically, the arrangement must (1) be in writing and signed by the parties; (2) cover all services provided by the independent contractor, and specify those services; (3) for part-time work, set forth the schedule, length, and exact charge for the intervals of work; (4) span at least one year; (5) specify the methodology for determining the compensation in advance, which must be fair market value and not be determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties[1]; (6) not involve services that involve the counseling or promotion of a business arrangement or other activity that violates any State or Federal law; and (7) cover aggregate services that do not exceed those reasonably necessary to accomplish the commercially reasonable purpose

[1]In 2020, HHS revised the safe harbor under 42 CFR § 1001.952(d). Before those revisions, the safe harbor condition at 42 CFR § 1001.952(d)(1)(iv) required that the compensation paid to an agent be set in advance. As relevant here, the amendments clarify that to receive protection under that safe harbor, the methodology for determining compensation is set in advance, rather than requiring the aggregate compensation itself to be fixed at the outset. Under both the original and revised framework, to receive protection under this safe harbor, compensation must still reflect fair market value and must not be determined in a manner that takes into account the volume or value of referrals or other business generated between the parties.

of the services. 42 C.F.R. § 1001.952(d)(1).

19. Another safe harbor to the AKS protects payments by an employer to its *bona fide* employees. 42 U.S.C. § 1320a-7b(b)(3)(B); 42 C.F.R. § 1001.952(i). The term "employee," as used in the AKS safe harbor, "has the same meaning" as the Internal Revenue Code's definition of "employee," found in 26 U.S.C. § 3121(d)(2). 42 C.F.R. § 1001.952(i). The Internal Revenue Code provides, in relevant part, that an "employee" is "any individual who, under the usual common law rules applicable in determining the employer-employee relationship, has the status of an employee." 26 U.S.C. § 3121(d)(2).

20. HHS-OIG specifically did not extend protection under the *bona fide* employee safe harbor to arrangements with independent contractors because of the "existence of widespread abusive practices by salespersons who are independent contractors and, therefore, who are not under appropriate supervision and control." Medicare and State Health Care Programs; Fraud and Abuse; OIG Anti-Kickback Provisions, 56 Fed. Reg. 35952, 35981 (July 29, 1991).

III. HHS-OIG Fraud Alerts and Opinions

21. Pursuant to 42 U.S.C. § 1320a-7d(b), the Secretary of the HHS, in consultation with the Attorney General, is authorized to issue advisory opinions on specific topics, including what constitutes prohibited remuneration under 42 U.S.C. § 1320a-7b(b), and whether any activity or proposed activity could result

in the imposition of sanctions or exclusion from participation in federal health care programs. 42 U.S.C. § 1320a-7d(b)(2).

22. HHS-OIG has issued unfavorable advisory opinions where compensation to independent contractors was based on commission-based sales agreements. *See e.g.*, HHS-OIG Advisory Opinion No. 99-3 (Issued March 1999), *available at* https://oig.hhs.gov/fraud/docs/advisoryopinions/1999/ao99_3.htm; HHS-OIG Advisory No. Opinion 10-23 (Issued October 2010), *available at* https://oig.hhs.gov/fraud/docs/advisoryopinions/2010/AdvOpn10_23.pdf.

23. In HHS-OIG Advisory Opinion No. 99-3, HHS-OIG noted that "any compensation arrangement between a seller and an independent sales agent for the purpose of selling health care items or services that are directly or indirectly reimbursable by a Federal health care program potentially implicates the anti-kickback statute." HHS- OIG Advisory Opinion No. 99-3 (Issued March 1999), *available at* https://oig.hhs.gov/fraud/docs/advisoryopinions/1999/ao99_3.htm.

24. Similarly, HHS-OIG Advisory Opinion No. 98-10 stated that "percentage compensation arrangements are potentially abusive, however, because they provide financial incentives that may encourage overutilization of items and services and may increase program costs." HHS-OIG Advisory

Opinion No. 98-10 (Issued March 1998), *available at* https://oig.hhs.gov/fraud/docs/advisoryopinions/1998/ao98_10.htm. The opinion also noted that arrangements that are "based on a percentage of the volume or value of business generated between the parties" and that involve "active marketing, including direct contacts" are particularly problematic. *Id*.

25. In 2010, HHS-OIG issued another unfavorable opinion regarding a similar arrangement. HHS-OIG stated:

> Marketing fees paid on the basis of successful orders for items or services are inherently subject to abuse because they are linked to business generated by the marketer. Because the Requestor receives a fee each time its marketing efforts are successful, the Requestor's financial incentive to arrange for or recommend the Hospital's sleep testing facility is heightened. The more test orders the Requestor's marketing efforts generate, the more fees the Requestor receives.

HHS OIG Advisory Op. No. 10-23 (Issued Nov. 4, 2010), *available at* https://oig.hhs.gov/fraud/docs/advisoryopinions/2010/AdvOpn10-23.pdf.

IV. The Medicare Program

26. In 1965, Congress enacted Title XVIII of the Social Security Act ("Medicare") to pay for the costs of certain health care services. 42 U.S.C. § 1395, *et seq*. Entitlement to Medicare is based on age, disability, or affliction with end-stage renal disease. *See* 42 U.S.C. §§ 426 to 426-1.

27. HHS is responsible for the administration and supervision of the

Medicare program. CMS is a component of HHS and is directly responsible for the administration of the Medicare program.

28. Part B of the Medicare program is a federally subsidized, voluntary insurance program that pays for various medical and other health services and supplies, including laboratory testing, hospital outpatient services, physician services and physical, occupational, and speech therapy services. *See* 42 U.S.C. §§ 1395j to 1395w-6.

29. Medicare regulations require suppliers to certify that they meet, and will continue to meet, the requirements of the Medicare statute and regulations. 42 C.F.R. § 424.516(a)(1).

30. To enroll in the Medicare program, suppliers of laboratory services must submit a Medicare Enrollment Application, Form CMS-855B. Enrolled suppliers must also complete Form CMS-855B to change information or to reactivate, revalidate, and/or terminate Medicare enrollment.

31. Form CMS-855B requires, among other things, signatories to certify:

> I agree to abide by the Medicare laws, regulations and program instructions that apply to me or to the organization listed in section 2A1 of this application. The Medicare laws, regulations, and program instructions are available through the Medicare Administrative Contractor. 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, 42 U.S.C. section 1320a-7b(b)) (section 1128B(b) of the Social Security Act . . . .).

> * * *
> 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.

See Form CMS-855B at §15A, *available at* www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/cms855b.pdf.

32. The signing authorized official must represent to CMS that their signature "legally and financially binds this supplier to the laws, regulations, and program instructions of the Medicare program." Form CMS-855B at §15B.

33. Medicare only reimburses services that are "reasonable and necessary for the diagnosis or treatment of illness or injury." 42 U.S.C. § 1395y(a)(1)(A). Compliance with applicable statutory, regulatory, and sub-regulatory requirements governing coverage, medical necessity, documentation, and coding is a condition of payment under Medicare Part B. *See* 42 U.S.C. §§ 1395l(e), 1395y(a)(1)(A); 42 C.F.R. §§ 410.32, 424.516.

34. CMS is responsible for specifying services covered under the "reasonable and necessary" standard and has discretion in selecting the means for doing so. *See* 42 U.S.C. § 1395ff(a). The Secretary acts through formal regulations, and CMS periodically issues guidance.

35. CMS provides guidance to eligible providers and suppliers pursuant to a series of Manuals, published by CMS, which are available to the public via

the Internet. *See generally* CMS Internet-Only Manuals, available at www.cms.gov/medicare/regulations-guidance/manuals/internet-only-manuals-ioms.

36. Medicare payment is conditioned upon compliance with applicable coverage, documentation, and medical necessity requirements. 42 U.S.C. §§ 1395l(e), 1395y(a)(1)(A).

37. Medicare Part B is funded by insurance premiums paid by enrolled Medicare beneficiaries and by contributions from the Federal Treasury. Eligible individuals who are 65 or older or disabled may enroll in Medicare Part B to obtain benefits in return for payments of monthly premiums. Payments under Medicare Part B can be made directly under assignment to service suppliers, such as clinical labs, rather than to the beneficiary. In that case, the clinical laboratory bills the Medicare program directly.

38. CMS provides reimbursement for Medicare Part B claims from the Medicare Trust Fund.

39. CMS contracts with private contractors, known as Medicare Administrative Contractors (MACs), to perform various Medicare Part B administrative functions on its behalf, including reviewing and paying Medicare Part B claims submitted by health care suppliers. 42 U.S.C. § 42 U.S.C. § 1395kk-1; 42 C.F.R. §§ 421.401 and 421.404. MACs generally act on behalf of CMS to

process and pay Medicare Part B claims and perform administrative functions in their jurisdiction. From time to time, MACs issue Local Coverage Determinations ("LCD") regarding whether a particular item or service is covered. 42 U.S.C. § 1395ff(f)(2). At all times relevant to this Complaint, Palmetto GBA was the MAC covering the State of Georgia and Novitas Solutions was the MAC covering the States of Texas and New Jersey. An LCD is a determination by a MAC respecting whether or not a particular item or service is covered on a contractor-wide basis. 42 U.S.C. § 1395ff(f)(2)(B).

40. To obtain Medicare reimbursement for certain outpatient items or services, health care suppliers submit a claim form known as the CMS-1500 form or its electronic equivalent, known as the 837P format.

41. To submit electronic claims via the 837P format, a supplier must complete and submit an Electronic Data Interchange Enrollment Form ("EDI") to CMS. The EDI may be completed by the supplier or an authorized individual who has the legal authority to "commit the provider to abide by the laws, regulations, and the program instructions of Medicare." On the EDI, the supplier agrees to "submit claims that are accurate, complete, and truthful" and certifies the provider's legal electronic signature and an assurance that services were performed as billed." The supplier's EDI certification then serves as the signature for every electronic the supplier submits thereafter.

42. For a claim to be paid by Medicare Part B, it must identify each service rendered to the beneficiary by the provider or supplier. The Healthcare Common Procedure Coding System ("HCPCS") is a collection of standardized codes that represent medical procedures, supplies, products, and services. Level I of the HCPCS is comprised of codes defined by the American Medical Association ("AMA") and contained in the AMA publication called the Current Procedural Terminology ("CPT") Manual. These codes are referred to as "CPT codes." Level II codes of the HCPCS are defined by CMS and are updated throughout the year as necessary. Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes. Each procedure or service is identified by either a five-digit CPT code or by Level II HCPCS code consisting of a single alphabetical letter followed by four numeric digits.

43. Medicare uses CPT and HCPCS codes to determine both coverage (if it will pay for the billed procedure) and reimbursement (how much it will pay for the billed medical service). Medicare has made clear that it is inappropriate for a laboratory to unbundle component services of a single laboratory panel into multiple separately billable CPT codes unless permitted by governing coding guidance. *See, e.g.*, Medicare Claims Processing Manual ("MCPM"), Pub. 100-04, Ch. 15, § 90.3.

44. In addition to the CPT Manual, the AMA publishes the International Classification of Diseases ("ICD") Manual, which assigns a unique numeric identifier to each medical condition. To be payable by Medicare, the claim must identify both the CPT code that the provider or supplier is billing for and the corresponding ICD version 10 ("ICD-10") code(s) for the beneficiary's medical condition that supports the medical necessity of the provider's or supplier's service.

45. Health care suppliers are prohibited from knowingly presenting or causing to be presented claims for items or services that the person knew or should have known were not medically necessary or knew or should have known were false or fraudulent. *See, e.g.*, 42 U.S.C. § 1395y(a)(1)(A); 42 U.S.C. § 1320a-7(b)(7) (OIG may exclude health care entities for fraud, kickbacks, and other prohibited activities).

46. A supplier has a duty to familiarize itself with the statutes, regulations, and guidelines regarding coverage for the Medicare services it provides. *Heckler v. Cmty. Health Servs. of Crawford Cty., Inc.*, 467 U.S. 51, 64 (1984).

47. Because it is not administratively feasible for MACs to conduct prepayment reviews of the underlying medical records for each of the billions of Medicare claims, the program relies on providers and suppliers to comply with

Medicare requirements and to submit truthful and accurate certifications and claims.

48. Generally, once a supplier submits a claim to the Medicare program, the claim is paid directly to the supplier, relying on the foregoing certifications, without any review of supporting documentation, including underlying medical records.

49. Medicare requires suppliers to report and return a self-identified overpayment to the MAC within 60 days of identifying the overpayment. 42 U.S.C. § 1320a-7k(d).

V. Clinical Laboratory Testing

A. Overview

50. A clinical laboratory is defined as a facility for the ". . . . examination of materials derived from the human body for the diagnosis, prevention, or treatment of a disease or assessment of a medical condition." 42 C.F.R. § 493.2.

51. With respect to medical necessity, pursuant to Medicare regulations, (1) laboratory tests must be ordered by the physician treating the beneficiary for a specific illness or injury; (2) laboratory test orders that are not individualized to patient need, or for which the need is not documented in the medical record, are not covered services; and (3) claims for laboratory services that do not meet these requirements are ineligible for payment. *See* 42 C.F.R. § 410.32.

52. All diagnostic laboratory tests "must be ordered by the physician who is treating the beneficiary, that is, the physician who furnishes a consultation or treats a beneficiary for a specific medical problem and who uses the results in the management of the beneficiary's specific medical problem. Tests not ordered by the physician who is treating the beneficiary are not reasonable and necessary." 42 C.F.R. § 410.32(a). (This law is referred to throughout the complaint as the treating provider order requirement).

53. A laboratory test order is "a communication from the treating physician/practitioner requesting that a diagnostic test be performed for a beneficiary." MBPM, Ch. 15, § 80.6.1. Medicare requires that an ordering provider "must clearly document, in the medical record, his or her intent that the test be performed." *Id*.

54. Laboratories are "discouraged" from accepting standing orders, which are only permitted "in connection with an extended course of treatment" (*i.e.*, for an individual patient based on a particular medical need). 63 Fed. Reg. 45,076, 45,081 (Aug. 24, 1998) (OIG Compliance Program Guidance for Clinical Laboratories). Standing orders that are not patient-specific and not tied to an extended course of treatment do not satisfy Medicare's treating provider order requirement. *See* 42 C.F.R. § 410.32(a).; Novitas LCD L35099 (Nov. 2019) ("A standing order is not acceptable documentation for a covered laboratory

service.").

55. Clinical laboratory services must be used promptly by the provider who is treating the beneficiary as described in 42 C.F.R. § 410.32(a). *See* MBPM, Ch. 15, § 80.1. A laboratory must therefore "promptly" report test results "for the physician to use the result and instruct continuation or modification of patient care." Novitas LCD L35099. A laboratory service that is not timely reported such that it cannot be used by the treating provider in the management of the beneficiary's specific medical problem does not meet Medicare's medical necessity requirement. *See* 42 C.F.R. § 410.32(a); MBPM, Ch. 15, § 80.1; Novitas LCD L35099.

56. A laboratory claim is not payable unless it includes a diagnosis code supporting medical necessity. *See* MCPM, Ch. 16, § 120.1. If a provider fails to provide one, the laboratory must contact the provider directly to obtain the code. *Id.* A laboratory may not independently select or assign ICD-10 diagnosis codes in the absence of documentation from the ordering provider supporting medical necessity. *Id.*

57. Medicare does not cover "tests that are performed in the absence of signs, symptoms, complaints, personal history of disease, or injury." MCPM, Ch. 6, § 1201. It also does not cover tests "performed for a purpose other than treatment or diagnosis of a specific illness, symptoms, complaint, or injury." 42

C.F.R. § 411.15(a)(1). Therefore, diagnostic laboratory tests performed for screening purposes in the absence of signs, symptoms, or a documented clinical need are not covered by Medicare. *See* 42 U.S.C. § 1395y(a)(1)(A); 42 C.F.R. § 411.15(a)(1); MCPM, Ch. 6, § 1201; *see also* 63 Fed. Reg. at 45,079 (Medicare can deny coverage for tests "done for screening purposes.").

58. Medicare requires proper and complete documentation of laboratory services rendered to beneficiaries. In particular, the Medicare statute provides that:

> No payment shall be made to any provider of services or other person under this part unless there has been furnished such information as may be necessary in order to determine the amounts due such provider or other person under this part for the period with respect to which the amounts are being paid or for any prior period.

42 U.S.C. § 1395l(e); *see also* 42 U.S.C. § 1395u(c)(2)(B)(i) ("The term 'clean claim' means a claim that has no defect or impropriety (including any lack of any required substantiating documentation)).")

59. A laboratory's claim for a service is ineligible for payment if there is not sufficient documentation in the medical record to establish that the service was reasonable and necessary. 42 C.F.R. § 410.32(d)(3).

60. Medicare regulations allow labs to request documentation from ordering providers regarding medical necessity. 42 C.F.R. § 410.32(d)(3)(iii).

61. Each laboratory has a "legal duty to ensure that it is not submitting false or incorrect claims to Government." 63 Fed. Reg. at 45,077. It "should take all reasonable steps to ensure that it is not submitting claims for services that are not covered, reasonable and necessary" including by contacting an ordering provider to request "documentation to support the medical necessity of the service the laboratory has provided and billed to" Medicare. *Id.*

B. Genetic Testing (CGx and PGx Tests)

62. Cancer genetic ("CGx") testing used DNA sequencing to detect mutations in genes that could indicate a higher risk of developing certain types of cancers in the future. CGx testing was not used to diagnose whether a beneficiary presently has cancer. If a beneficiary had been diagnosed with cancer, CGx tests could also provide information to the beneficiary's treating provider about the type of cancer the beneficiary had, as well as what treatment options might be available to treat that cancer.

63. Pharmacogenetic ("PGx") testing used DNA sequencing to assess how the body's genetic makeup would affect its response to certain medications. PGx testing could therefore help determine whether certain medications would be effective if used by a particular beneficiary and whether the beneficiary would be at risk of experiencing side effects from a specific medication. Typically, medical providers used PGx testing to prescribe medications that were effective

for their patients, to avoid new medications that may cause side effects, and to determine the most effective dosages for their patients. PGx testing was not used, however, to identify any specific malady or stand-alone condition.

64. To perform CGx and PGx tests (referred to collectively as "genetic testing" or "genetic tests"), a beneficiary provides a saliva sample or cheek (or "buccal") or nasal swab containing DNA material. The DNA sample is then submitted to a diagnostic laboratory, such as Capstone, to conduct CGx or PGx testing. Tests are then run on different "panels" of genes. Genetic testing procedures are then billed to Medicare using certain billing codes, each with its own reimbursement rate.

65. Medicare generally does not cover genetic testing performed solely for predictive or screening purposes. Diagnostic genetic testing may be covered, however, when it is reasonable and necessary for the diagnosis or treatment of a beneficiary's condition and is ordered by a provider who is treating the beneficiary for a specific medical problem and uses the results in managing that problem. *See* 42 C.F.R. § 410.32(a).

66. During the relevant period, Palmetto GBA, LLC ("Palmetto") administered the Molecular Diagnostic Services ("MolDX") program in its jurisdiction. Under Palmetto LCD L35025, molecular diagnostic tests subject to MolDX were required to satisfy applicable coverage requirements, including test

registration and technical assessment where required. MolDX covered and reimbursed only those tests that demonstrated sufficient analytical validity, clinical validity, and clinical utility to satisfy Medicare's reasonable-and-necessary standard. *See* Palmetto GBA, MolDX: "Molecular Diagnostic Tests (MDT)," LCD L35025.

C. Respiratory Pathogen Panel Testing

67. Respiratory Pathogen Panel ("RPP") testing is molecular diagnostic testing used to detect respiratory viruses, bacteria, and other pathogens from a respiratory specimen. Broad RPPs test simultaneously for numerous pathogens, some of which are associated with different clinical presentations, settings, or patient populations. Accordingly, whether testing for the pathogens included in a particular panel is medically appropriate depends on the individual patient's symptoms, clinical circumstances, and the judgment of the treating provider. *See, e.g.*, Palmetto GBA, MolDX: "Multiplex Nucleic Acid Amplified Tests for Respiratory Viral Panels," LCD L37713 (effective until April 17, 2022); 42 C.F.R. § 410.32(a).

68. To perform RPP testing, a respiratory specimen is collected from the beneficiary, typically by nasal or nasopharyngeal swab, and submitted to a diagnostic laboratory for molecular testing. RPPs vary in size according to the number of pathogens included, ranging from limited panels targeting a small

number of pathogens to broad multiplex panels testing for numerous pathogens simultaneously. Medicare reimburses laboratory testing according to the applicable billing code, and during the relevant period the reimbursement available for multi-pathogen respiratory testing could substantially exceed the reimbursement for a single-target COVID-19 test. *See, e.g.*, Palmetto GBA, LCD L37713; CMS, *Medicare Administrative Contractor COVID-19 Test Pricing*; CMS, Clinical Laboratory Fee Schedule.

69. Palmetto, through its MolDX program, limits Medicare coverage for RPPs based on panel size and clinical necessity. Small panels (5 or fewer pathogens) are generally covered for symptomatic or high-risk patients, while larger, expanded panels (more than 5 pathogens) often require specific clinical criteria, specific ICD-10 codes, or specialist orders depending on the place of service. *See, e.g.*, MolDx: "Molecular Syndromic Panels for Infectious Disease Pathogen Identification Testing," L38988.

D. COVID-19 and Testing of Specific Respiratory Pathogens

70. In the early stages of the COVID-19 pandemic, CMS temporarily expanded the Medicare requirement that COVID-19 and certain respiratory pathogen tests (*i.e.*, influenza and respiratory syncytial virus) be ordered by a treating provider or consulting physician. Under the May 8, 2020, interim final rule, CMS amended the ordering requirement of 42 C.F.R. § 410.21 to include

COVID-19, influenza, and respiratory syncytial virus tests when ordered by any health care professional authorized to do so under state law (not just the treating physician), or without an order from an authorized professional if the results were provided directly to the beneficiary. 85 Fed. Reg. 27550, 27558 (May 8, 2020).

71. CMS again temporarily revised the regulation on September 2, 2020, to establish that only one COVID-19 test, one influenza test, and one respiratory syncytial virus test without a practitioner order was medically necessary and required further tests to be ordered by an authorized health care professional. 85 Fed. Reg. 54820 (Sept. 2, 2020), *amending* 42 C.F.R. § 410.32(a)(3). While the revised regulation expanded the ordering and documentation requirements for these specific tests, it did not remove other applicable requirements. 85 Fed. Reg. 54820, 54837 (Sept. 2, 2020).

72. Even under the regulation as amended by the May 8, 2020 and September 2, 2020 interim final rules, COVID-19 tests and the relevant respiratory pathogen tests still had to be reasonable and necessary for the treatment of illness or injury and appropriately documented.

73. In June 2020, HHS-OIG warned laboratories of the program integrity risks associated with add-on testing performed in conjunction with otherwise covered services, including RPPs billed with COVID-19 testing. *See* HHS-OIG

Public Alert, "COVID-19 Pandemic and Program Integrity Risks" (June 2020); 63 Fed. Reg. at 45,076.

74. The Centers for Disease Control (CDC) did not recommend broad RPP testing as routine COVID-19 screening or surveillance. Instead, CDC guidance generally addressed testing for COVID-19 and, where clinically appropriate, consideration of targeted testing for specific respiratory pathogens such as influenza or RSV based on symptoms, clinical presentation, and other patient-specific circumstances.

THE LABORATORY ALLIANCE

I. Jay Johnson Controlled Capstone, Genus3, and Sparrow

75. In April 2018, Defendant Jay Johnson became Chief Operating Officer of Capstone, a clinical laboratory based in Atlanta, Georgia that performed, among other tests, CGx, PGx, and RPPs. In December 2019, Mr. Johnson became Capstone's Chief Executive Officer.

76. In November 2019, Mr. Johnson formed Genus3, LLC ("Genus3"), a clinical laboratory in Milton, Texas, that performed, among other tests, RPPs. Mr. Johnson owned Genus3 and served as its Chief Executive Officer. To launch and operate Genus3, Mr. Johnson hired several Capstone employees on a part-time basis and used Capstone personnel, resources, and infrastructure to support Genus3's business.

77. In approximately 2019, Mr. Johnson became Chief Executive Officer of Sparrow, a clinical laboratory in Spring, Texas, that performed, among other tests, RPPs. Mr. Johnson also used Capstone employees and resources to support Sparrow.

78. Capstone and its owner, Andrew "Drew" Maloney, previously resolved civil False Claims Act allegations arising in part from the submission of false RPP claims alleged in this Complaint. In 2024, Capstone and Maloney agreed to pay approximately $14.3 million to resolve allegations that, among other things, Capstone paid volume-based commissions to independent sales representatives to generate medically unnecessary RPP testing for senior living communities seeking COVID-19 testing. Capstone and Maloney are therefore not named as defendants in this action.

79. Mr. Johnson referred to Capstone, Genus3, and Sparrow collectively as the "Laboratory Alliance." Through the Laboratory Alliance, Mr. Johnson pooled personnel, resources, sales operations, billing support, and laboratory capacity across the three laboratories.

80. Mr. Johnson used the Laboratory Alliance to route specimens and claims based on business and reimbursement considerations, including which laboratory had capacity to perform testing and which Medicare Administrative Contractor would process the claim. The purpose was not to better patient care

but to maximize reimbursement by steering claims toward more favorable coverage and payment pathways and away from reimbursement restrictions.

81. Through the Laboratory Alliance, Mr. Johnson controlled the operations of Capstone, Genus3, and Sparrow, including their sales forces, billing teams, laboratory operations, employee training, financial performance, marketing, and long-term business initiatives. He used that control to direct testing volume, coordinate sales activity, route specimens, and implement billing strategies across the laboratories.

82. Mr. Johnson managed aggressively and personally drove testing volume. He set demanding quotas, dictated marketing messages, directed sales pitches, pressed employees to generate revenue, and disregarded compliance-related complaints and warnings concerning medical necessity, ordering practices, sales conduct, and commission payments.

83. Mr. Johnson made clear that revenue was his overriding objective. In December 2019, he told Capstone staff, "The company's MBO [Manage by Objective] is to drive revenue. . . . The money's the money. Money—the one thing it all has in common is it's green. I don't f[___][2] care where it comes from."

II. Austin Whiles Drove Sales and Testing Volume

84. In July 2017, Defendant Austin Whiles began working at Capstone

[2] Expletive deleted.

as Chief Sales Officer. He later became Vice President of Business Development. Mr. Whiles also performed sales, business-development, or management functions for Genus3 and Sparrow.

85. Mr. Whiles owned and controlled Whitson Medical, a Kansas domestic for-profit corporation that dissolved in 2025. As alleged below, Mr. Whiles used Whitson Medical during the senior living RPP scheme to receive, route, and conceal commission proceeds tied to testing volume generated by independent marketers working under his direction.

86. As a member of Capstone's executive team, Mr. Whiles received a salary and a share of Capstone's profits. His employment contract expressly prohibited his receipt of sales commissions.

87. Mr. Whiles was responsible for driving sales and testing volume at Capstone. He directed sales personnel and independent marketers, demanded regular updates, pressed employees and marketers to increase test volume, and directed sales activity that generated the claims alleged in this Complaint.

88. Like Mr. Johnson, Mr. Whiles emphasized profit and volume. In 2021, for example, he prepared a presentation for Capstone's independent marketers that identified "Driving profits" as a top objective.

III. Mr. Johnson and Mr. Whiles Knew the Rules Governing Medical Necessity, Provider Ordering Requirements, and Kickbacks.

A. Mr. Johnson and Mr. Whiles Knew Laboratory Testing Required

Individualized Medical Necessity and Valid Provider Orders.

89. Mr. Johnson and Mr. Whiles knew the Medicare rules that governed laboratory testing. Capstone's compliance materials, provider notices, code-of-conduct training, marketing materials, and online Medicare-compliance training made clear that laboratory tests had to be medically necessary, ordered by authorized providers, supported by appropriate documentation, and free from kickbacks.

90. Capstone's annual notice to providers, which all sales representatives received, emphasized that laboratory testing had to be based on individualized provider orders. The notice explained that Medicare "will only pay for tests that are deemed medically necessary for the diagnosis and treatment of the individual patient;" that Capstone "will only submit diagnosis information obtained from the ordering practitioner;" and that "'Standing orders [for laboratory tests] generally should be limited to cases of an extended course of treatment."

91. Capstone's code-of-conduct training reinforced the same rules. The training stated that Medicare only pays for tests that are "reasonable and necessary for the diagnosis and treatment [of an] injury." It emphasized that requisition forms were "required," and must include "diagnosis codes that support the tests(s) being ordered," and be "signed by the ordering practitioner."

It also instructed that "[u]nder no circumstances should any Capstone employee, contractor, or vendor . . . [c]reate diagnosis information" or "[m]ake up information for claim submitting purposes." It also warned that "[m]any payors prohibit standing orders," but even where permitted must be "medically necessary," and include patient-specific information such as "[p]atient name, address and date of birth," [d]iagnosis for the test ordered," and "[p]rovider[']s signature." The training also instructed sales personnel to "ensure that ordering physicians comply with the laboratory's medical necessity policies," and prohibited employees from "encouraging practitioners to order tests that are not medically necessary."

92. Mr. Johnson and Mr. Whiles completed and passed Capstone's online Medicare compliance training for clinical laboratories. That training was based on the OIG Compliance Program Guidelines for Clinical Laboratories, and covered seven elements of a successful compliance program, including risk areas, coding, tests and panels, inducements, and billing. By completing and passing that training, Mr. Johnson and Mr. Whiles confirmed their knowledge of the rules that governed the testing generated by Capstone's sales operation.

93. Mr. Johnson also actively reviewed Capstone's compliance guidance for healthcare marketing. In early March 2020, just as Capstone was preparing to expand COVID-related testing, Mr. Johnson reviewed and provided feedback on

Capstone's "Compliance in Healthcare Marketing" slide deck, noting as one "potential problem *[sic]* we might encounter running this business in an ethical manner…A customer asks to get a kickback?". That deck addressed legal limits on health care marketing, including the need to avoid improper remuneration, ensure compliant sales practices, and preserve medical judgment in testing decisions.

94. Mr. Johnson and Mr. Whiles therefore knew that sales personnel could not replace a treating provider's judgment with account-level paperwork, generic standing orders, copied signatures, internally selected diagnosis codes, or testing protocols designed to generate reimbursement.

95. Mr. Johnson and Mr. Whiles also repeatedly received compliance training materials addressing the AKS. One training slide stated that the AKS "prohibits anyone from offering, paying, soliciting, or receiving anything of value to induce or reward referrals from any federal healthcare program." Another stated that the AKS applies to anyone who knowingly and willfully "offers or pays" remuneration "for arranging Medicare or Medicaid services."

B. Mr. Johnson and Mr. Whiles Used Independent Marketers Despite Known AKS Risk.

96. Mr. Johnson and Mr. Whiles also knew that volume-based commissions paid to independent marketers created serious legal risk under the AKS. To generate testing volume, they used both W-2 sales representatives

employed by the laboratories and 1099 independent contractors who marketed laboratory testing services. Capstone paid those independent marketers volume-based commissions tied to the testing business they generated.

97. The commission structure was reimbursement driven. Independent marketers received a specified amount for each test sold to a client, and Capstone paid the commissions only after receiving reimbursement, including reimbursement from Medicare. The more reimbursable testing the marketers generated, the more commissions they earned.

98. Mr. Whiles supervised and controlled a team of independent marketers that included Patrick Howell, Ryan Whiles, and Erich Brandt. Mr. Whiles personally arranged for Capstone to hire them, received their monthly commission reports, forwarded those reports to them, and directed their sales activity. As alleged below, those marketers became central to the senior living RPP scheme.

99. Mr. Johnson and Mr. Whiles also received repeated internal warnings about Capstone's use of volume-based commissions for independent marketers. In December 2018, Capstone's owner sent Mr. Johnson and Mr. Whiles a compliance report warning that "your lab doesn't fall in [the AKS's] employment safe harbor if it pays sales commissions to independent contractors." The report further stated: "That's why our law firm always

recommends that, if labs pay sales people on commission, then those sales people should be employees and not independent contractors."

100. Other similar warnings followed. In August 2018, Capstone's owner told Mr. Johnson that he would "not continue to put the company at risk" and that Mr. Johnson would need to build a full-time employee sales team. In January 2019, the owner forwarded Mr. Johnson a compliance report stating that laboratories were replacing independent marketers with W-2 employees because of compliance concerns.

101. Mr. Johnson also concealed Capstone's commission practices from Capstone's laboratory director. In October 2019, Dr. John Hanson asked Mr. Johnson, "are we paying our sales team commission?" Mr. Johnson called Dr. Hanson and falsely stated that Capstone did not pay commissions. He then followed up with an email stating, "[W]e are and stay committed to a compliant program."

102. In March 2020, Capstone's attorneys prepared a memorandum for Mr. Johnson and Capstone's owner that analyzed commission-based compensation to sales representatives under the AKS and Eliminating Kickbacks in Recovery Act of 2018 ("EKRA"). The memorandum concluded: "We recommend terminating all independent contractor sales arrangements that do not meet the personal services and management contracts safe harbor."

103. These materials, trainings, and warnings gave Mr. Johnson and Mr. Whiles clear notice of the rules that governed laboratory testing and health care marketing. They knew that laboratory tests billed to Medicare had to be medically necessary, ordered by authorized providers exercising individualized clinical judgment, supported by appropriate documentation, and generated without unlawful remuneration.

THE FRAUDULENT SCHEMES

104. Mr. Johnson and Mr. Whiles implemented two related schemes to generate laboratory claims reimbursable by Medicare: the church fairs scheme and the senior living RPP scheme.

105. The schemes operated in different settings and used different tactics, but they shared the same core defects: testing was driven by access, volume, reimbursement, and illegal remuneration—not individualized treating providers' judgment. In the church fairs scheme, Mr. Johnson and Mr. Whiles used faith-based events to generate genetic testing. In the senior living RPP scheme, they used demand for COVID testing to generate higher-reimbursing RPP testing.

106. The claims generated by both schemes were false because the tests lacked medical necessity. The genetic tests generated through the church fairs scheme were not ordered by treating providers exercising individualized clinical judgment and were not used to manage and treat specific medical problems. The

RPPs generated through the senior living RPP scheme likewise were not ordered by treating providers pursuant to individualized medical necessity determinations but instead were performed as screening or surveillance tests.

107. The claims were independently false because both schemes were driven by unlawful remuneration. In the church fairs scheme, Capstone offered or paid remuneration to organizations and intermediaries that provided access to beneficiaries, arranged event logistics, helped secure medical professionals, and generated testing volume. In the senior living RPP scheme, Capstone paid volume-based commissions to independent marketers who generated federally reimbursable RPP testing, and Mr. Whiles secretly captured most of those commissions through Whitson Medical.

I. The Church Fairs Scheme

A. Mr. Johnson Used Faith-Based Organizations to Generate Genetic Testing Specimens.

108. Mr. Johnson built the church fairs scheme to turn faith-based events into genetic testing volume. The scheme was not driven by treating providers identifying patients who needed CGx or PGx testing. Instead, it was driven by access to church-sponsored health fairs, religious conferences, and attendees who could be persuaded by sales personnel to provide specimens for genetic testing.

109. Mr. Johnson first used Church Alive and Viva Iglesia, organizations owned by Kevin Singer that sponsored faith-based health fairs and religious

events throughout the United States. Under the arrangement, Church Alive would provide Capstone access to events, assist with logistics, and help identify medical professionals whose names or signatures could be used to support testing. Capstone would collect specimens, perform or arrange genetic testing, bill insurers, and share the resulting reimbursements with Church Alive.

110. Mr. Johnson promised Church Alive half of the insurance reimbursements generated by tests collected at Church Alive events, including reimbursements from Medicare. The promised revenue share induced Church Alive to provide access, logistical support, and provider connections.

111. Mr. Johnson, Mr. Singer, and Capstone's owner understood the financial upside immediately. Mr. Singer called the arrangement "a home run for all." Capstone's owner wrote: "Could be MASSIVE . . . Are we f[____][3] kidding!!!!! With Church Alive, OH MY GOD (granted I am an atheist but PRAISE JESUS!!!) . . . This is exactly what we needed."

112. They also knew the legal risk. Before the first event, Mr. Singer told Mr. Johnson that Church Alive's health care attorney had warned that the proposed "compensation model" created serious AKS risk because compensation could not be calculated as a percentage of laboratory revenue or based on the volume or value of federally reimbursed testing.

[3] Expletive deleted.

113. But Mr. Johnson did not abandon the arrangement. Instead, the proposed workaround "for the church play" was to characterize Church Alive as a 1099 independent contractor while continuing to "split" the reimbursements generated by the tests. Mr. Johnson avoided committing the arrangement to a final written agreement, telling Mr. Singer shortly before the first event that while they had reached "agree[ment] on[] % split," they would "adjust and finalize agreement post initial event (and may need a couple more)."

114. Church Alive provided Capstone access to events, assisted with logistics, and helped identify medical professionals. Capstone collected specimens, performed or arranged genetic testing, and obtained insurance reimbursements. By November 2019, after Church Alive had performed but not been paid, Mr. Singer asked Mr. Johnson to "push [Capstone's owner] to get the contract done so we can collect money from you."

115. Mr. Johnson later terminated the Church Alive relationship after Capstone's attorneys advised him that the arrangement raised legal concerns, including violations of the AKS. But he still acknowledged the promised compensation, telling Mr. Singer: "We will process your Church Alive payments. The total sum will get paid to you over the next three months." Mr. Johnson ultimately withheld the payments, but the offer had already served its purpose: it induced Church Alive to provide access, assistance, and testing business.

116. After ending the Church Alive relationship, and despite the AKS advice, Mr. Johnson shifted the same basic model to HealthMax, another organization that worked with churches and religious organizations to sponsor health conferences. HealthMax was co-owned by Misha Maynard and her father, Jerry Maynard, who also owned Koinonia Kingdom International Consortium, a ministry organization.

117. Mr. Johnson's arrangement with HealthMax was materially similar to the arrangement with Church Alive. HealthMax would provide Capstone access to events and help arrange providers who could purportedly authorize genetic testing. In return, Capstone would pay HealthMax a share of reimbursements generated by tests collected at the events. Mr. Johnson directed Capstone to enter into a 1099 independent contractor agreement with Mr. Maynard that provided for an annual payment of $60,000 plus commissions.

118. Mr. Johnson also directed Capstone to enter into a separate agreement with Koinonia Kingdom under which Capstone purportedly provided a $100,000 "grant . . . in order to support HealthMax national health and wellness initiatives through COGIC [Church of God in Christ]." In substance, the purported grant was remuneration paid through Mr. Maynard's ministry organization in exchange for HealthMax's efforts to provide access to events and arrange genetic testing. Capstone paid the $100,000 in two $50,000

installments.

119. Between May 2019 and March 2020, Capstone participated in approximately twenty Church Alive events and approximately nine HealthMax-sponsored events. At those events, Capstone employees and sales personnel, including Mr. Whiles, approached attendees, collected insurance information, asked screening questions, including eventually by using a checklist authorized by Mr. Johnson, and obtained cheek or nasal swabs for CGx and PGx testing.

120. Mr. Whiles helped execute the church fairs scheme. He directed and monitored Capstone's event-based sales activity, staffed and coordinated testing events, tracked the number of specimens collected, reported testing volume to Mr. Johnson, and helped administer payments tied to the testing generated at those events. For example, on October 13, 2019, Mr. Whiles reported to Mr. Johnson from a church event: "Closing out on morning services. Additional 30 tests collected from last update. Closed morning out with 70 tests. Will be back to the church at 5pm - 11pm for more testing."

B. Mr. Johnson Routed Church Fair Tests Through a Pass-Through Billing Laboratory to Ensure Reimbursement.

121. Mr. Johnson also confronted a reimbursement problem. Capstone's MAC, Palmetto, imposed heightened coverage requirements that restricted reimbursement for genetic testing. Mr. Johnson acknowledged the problem in a communication to Mr. Singer concerning the "variability of pay out from

surrounding MAC[s] for Medicare pay."

122. Mr. Johnson's solution was to route the tests through a laboratory that appeared as the originating and billing laboratory even though Capstone generated the testing business, arranged the purported orders, collected the specimens, and performed the tests. That laboratory was Sovereign Laboratory ("Sovereign"), a New Jersey laboratory owned by John Hanson and located in a MAC jurisdiction that Mr. Johnson believed was more favorable for Medicare genetic testing reimbursement.

123. Mr. Johnson used Why Not Productions as the contracting vehicle for the Sovereign arrangement. Acting through Why Not Productions, Mr. Johnson entered into an agreement with Sovereign to use Sovereign as the billing conduit for genetic tests generated through the church fairs scheme. Under the arrangement, Capstone generated the testing business. Sovereign then appeared as the originating and billing laboratory, submitted claims through its Medicare jurisdiction, and referred the specimens back to Capstone to perform the testing. In substance, the arrangement allowed Capstone-generated tests to be billed as Sovereign-originated claims while Capstone retained the testing work and received payment from Sovereign.

124. Why Not Productions had no meaningful role in the Sovereign arrangement independent of Mr. Johnson. Mr. Johnson owned and controlled

Why Not Productions, used it as his contracting vehicle, and acted through it to facilitate the Sovereign billing arrangement. The arrangement was not undertaken for any legitimate Why Not Productions business purpose. It was part of Mr. Johnson's effort to route Capstone-generated genetic tests through Sovereign for reimbursement.

125. Sovereign did not perform the genetic testing itself because it lacked the necessary equipment. The arrangement did not improve patient care, expand clinical oversight, or enhance testing quality. Its purpose was reimbursement: to route Capstone-generated genetic tests through a laboratory and MAC jurisdiction that Mr. Johnson believed would pay more favorably than Capstone's MAC. For example, Mr. Johnson wrote in a text message to Mr. Whiles, "Sovereign revenue is dependent on Medicare. We like sov revenue[.]"

126. By November 2019, Sovereign had paid Capstone approximately $686,200 under the parties' arrangement. Those payments were made in exchange for Capstone's role in generating genetic testing business, routing the tests to Sovereign for billing, and performing the tests after Sovereign referred them back to Capstone.

C. Mr. Johnson Generated Genetic Tests Without Treating Provider Orders or Individualized Medical Necessity.

127. The genetic tests generated at Church Alive and HealthMax events were not the result of individualized decisions by treating providers. Instead,

Capstone procured specimens first and then used provider signatures, standing orders, screening forms, and requisition paperwork to make the tests appear ordered, medically necessary, and payable.

128. Mr. Johnson knew before the first Church Alive event in Baltimore that the providers identified for the events would not consistently be present, would not evaluate each attendee, and would not make individualized medical necessity determinations. Before the event, Church Alive told Mr. Johnson that Dr. Deborah Fitzpatrick would not be physically present and would instead "just . . . sign off on the test[s] at day's end." Church Alive raised concerns about the "legalities of someone else doing the consultation and the doctor signing off on the docs afterward."

129. Mr. Johnson proceeded anyway. Before the Baltimore event, he directed a Capstone employee to create a stamp of Dr. Fitzpatrick's signature. When the employee questioned whether Capstone needed permission, Mr. Johnson responded: "Don't need their permission." Church Alive advised that it was "not comfortable with the use of the stamp."

130. The same model continued at other Church Alive and HealthMax events. Capstone used purported standing orders signed by medical professionals to generate orders for attendees whom the signing providers had not met, examined, evaluated, or counseled about genetic testing. Those

standing orders did not establish that CGx or PGx testing was medically necessary for each attendee.

131. Mr. Johnson knew that event-based standing orders could not substitute for individualized medical judgment. The medical professionals associated with the events did not have treating provider relationships with the attendees, were not expected to review their medical histories, were not expected to use the test results to manage their care, and were not expected to follow up with them about the results.

132. In some instances, Capstone and Sovereign listed doctors as ordering providers for days or events when those doctors were not present. In other instances, Capstone used signatures, stamps, or standing order paperwork from medical professionals who had not evaluated the beneficiaries whose tests were billed under their names.

133. Mr. Johnson used Capstone employee Anna Leon to create the appearance of medical judgment at the events. Ms. Leon had attended medical school but was not licensed to practice medicine anywhere in the United States. She was not a treating physician, did not evaluate attendees as a treating provider, and could not supply the individualized clinical judgment required to establish medical necessity. Mr. Johnson nevertheless held her out as a "medical liaison," had her wear a white coat, directed her to interact with attendees, and

relied on her to market genetic testing and answer questions.

134. Mr. Johnson also personally directed employees to add physician signatures to requisition forms. On September 7, 2019, he instructed a Capstone employee: "When you are done at conference that paperwork is mostly done. Just load the signature form of dr at the back end."

135. Thus, the resulting requisitions did not reflect individualized medical judgments made by treating physicians. They were post hoc paperwork used to make specimens collected at mass events appear ordered, medically necessary, and eligible for reimbursement.

D. Representative Church Fair Claims Demonstrate the Pattern.

136. The following representative claims show how that process worked in practice: Capstone and Sovereign billed Medicare for genetic tests under the names of providers who had not supplied the individualized medical judgment required for payment.

137. Dr. Shindana Feagins was identified as the ordering provider for genetic tests collected at two Church Alive events: the TRIAD2019 conference in Nashville, Tennessee, from July 16 to July 19, 2019, and the GCC2019 conference in Memphis, Tennessee, from July 23 to July 24, 2019. But she attended neither event. Instead, she had met Mr. Johnson at her church, where he asked her to sign a form in case she later decided to participate in future health fairs. Because

Dr. Feagins was not present at either event, she did not evaluate the attendees, review their medical histories, determine whether CGx or PGx testing was needed for their diagnosis or treatment, or order the tests. Nevertheless, claims for genetic testing were submitted to Medicare under her name, and Medicare paid Sovereign more than $108,000 for those tests.

138. Dr. Michelle Powell was identified as the ordering physician for genetic tests submitted from eight Church Alive and HealthMax events. However, she attended only portions of four events and did not attend the others at all. Dr. Powell never gave Capstone permission to use her name on documentation through an electronic or physical stamp. When she accessed Capstone's portal, she discovered that Capstone had used her name as the ordering physician for patients in other states. Mr. Johnson attempted to justify that use by claiming that Dr. Powell had given him verbal permission to use her credentials. She had not. Dr. Powell told Mr. Johnson that she never authorized Capstone to use her credentials and that she could not authorize use of her medical license for states in which she was not licensed. Mr. Johnson then made an unannounced visit to Dr. Powell's office, and Dr. Powell stated that she felt Mr. Johnson was trying to "muscle her."

139. Even when Dr. Powell was present for part of an event, she did not have physician-patient relationships with the attendees whose tests were billed

under her name, did not make individualized medical necessity determinations for those attendees, and did not review or discuss the genetic testing results with them. Capstone and Sovereign nevertheless used Dr. Powell's identifying information as the ordering physician for tests collected at events where she was absent or only partially present, including AIM2019 in Tampa, Florida, from July 1 to July 5, 2019, where Dr. Powell attended only portions of two days; Kansas City East Jurisdiction in Kansas City, Missouri, on July 24, 2019; Exploit in Buffalo, New York, from August 8 to August 11, 2019; Sheppards2019 in Kansas City, Missouri, from August 26 to August 29, 2019; and HealthMaxNBC19 in New Orleans, Louisiana, from September 2 to September 6, 2019. Claims for those tests were submitted as Sovereign-originated claims, while Capstone performed the testing. Medicare paid approximately $220,612 for those tests.

140. The claims associated with Nurse Jill Hudnell show the same pattern. Nurse Hudnell was identified as the ordering provider for genetic tests collected at the HealthMax Fellowship of Faith Church conference in Huntsville, Alabama, from February 15 to February 16, 2020. Before the event, HealthMax told Nurse Hudnell that she would collect specimens and speak with attendees about the tests. But when Nurse Hudnell arrived, the specimen collection operation was already underway. Mr. Maynard told her that other people were swabbing attendees, and Nurse Hudnell was not asked to do anything. Nurse

Hudnell provided her NPI and signed standing order paperwork, but she did not have provider-patient relationships with the attendees, did not evaluate them, did not review their medical histories, did not determine whether CGx or PGx testing was medically necessary for any attendee, and did not understand that Medicare claims would be submitted listing her as the ordering provider. Nevertheless, claims for genetic testing were submitted to Medicare under her name, and Medicare paid Sovereign more than $3,793 for those tests.

141. These examples reflect the same core defect that appeared throughout the church fairs scheme. The purported ordering providers did not act as treating providers making individualized patient-specific decisions. They supplied, or were associated with, names, signatures, stamps, NPIs, or standing order paperwork that was used after specimens had already been generated at mass events. The resulting claims falsely presented the tests as medically necessary, provider-ordered genetic testing when, in reality, the testing was generated through event access, sales activity, kickbacks, and post hoc paperwork.

E. Mr. Johnson Continued Despite Warnings, Provider Complaints, and Result Reporting Failures.

142. Mr. Johnson received repeated notice that the providers identified by Church Alive and HealthMax to serve as the ordering providers at the events either were not meaningfully involved in evaluating the attendees who received

genetic testing or were not even present at the events.

143. On August 6, 2019, Kristina Beaman of Church Alive advised Mr. Johnson that a physician scheduled for an event believed Capstone's process "jeopardizes the doctor's license" and therefore would not participate. Mr. Johnson responded that the process was "up to the doctor's discretion" and that "this is why the lab stays out of finding the doctor."

144. Dr. Powell later contacted Capstone after individuals asked why she had been identified as the ordering physician for genetic tests billed to their insurance. She advised Capstone that she did not recognize the patients and had not authorized the tests. In or around November 2019, Dr. Powell met directly with Mr. Johnson and told him she had never authorized Capstone to use her credentials for events or patients outside Florida.

145. Likewise, Dr. Feagins complained after learning that Capstone had used her as an ordering provider without permission. She told Mr. Johnson she wanted to review all tests ordered under her name and did not authorize Capstone to use a signature stamp to order or approve testing. She also stated that Mr. Johnson promised she would receive all test results, but she never received them. On August 15, 2019, she terminated any agreement concerning the use of her name as a referring physician.

146. Capstone employees also warned Mr. Johnson that results were not

reaching patients or providers. On July 16, 2019, Capstone employee TJ Giordano warned Mr. Johnson: "My problem is if we know these people are going to have a hard time getting their reports and we know that some of them will never get their reports, than *[sic]* are we just doing this for money . . . My biggest concern is that someone will contact Medicare after they are billed . . . They will unravel the entire program."

147. By September 2019, Capstone's Chief Financial Officer, Rachel Sheats, warned Mr. Johnson that health fairs attendees were contacting insurers after receiving bills as high as $70,000 for testing they did not remember receiving. Ms. Sheats explained that the patients did not know the purported ordering providers, who were often licensed in states where the patients had never been. Ms. Sheats told Mr. Johnson that "these patients have no idea who these ordering docs are and that they are not their PCP" and concluded that the Church Alive process "doesn't work at all."

148. Those warnings identified the scheme's core defects: the tests were not ordered by treating providers, the providers listed on the requisitions had not evaluated the beneficiaries, the results were not being used to manage patient care, and patients did not understand what testing had been performed.

149. Despite those warnings, Mr. Johnson continued the church fairs scheme. Even after ending Capstone's relationship with Church Alive, he

continued the scheme with HealthMax.

F. The Church Fairs Scheme Generated Kickback-Tainted False Claims.

150. Mr. Johnson and Mr. Whiles participated in calculating, communicating, and directing payments arising from the church fairs testing. In August 2019, Ms. Sheats emailed both, stating that they needed to review "details on the Sovereign and conference payments."

151. The payment records confirmed the kickback structure. Mr. Johnson promised Church Alive 50% of the reimbursements generated by testing collected at Church Alive events. Around October 2019, he provided Mr. Singer with a spreadsheet listing genetic tests generated at Church Alive health fairs, applying the agreed 50% commission rate, and calculating approximately $325,628 owed to Church Alive. Capstone ultimately did not pay that amount, but the promised revenue share had already induced Church Alive to provide event access, logistical support, and provider connections.

152. Mr. Johnson used the same model with HealthMax. In October 2019, he directed Capstone to pay HealthMax $18,750. In December 2019, he directed Capstone to pay Ms. Maynard approximately $58,288 in commissions and Koinonia Kingdom an additional $96,723. Capstone later paid HealthMax approximately $68,000 in January 2020 and another $38,435, representing half of Capstone's share of the revenue generated from genetic testing at HealthMax

conferences. Capstone paid Koinonia Kingdom a total of approximately $217,648.

153. Mr. Whiles helped administer the HealthMax payments. On February 27, 2020, he sent Ms. Maynard and Mr. Maynard a spreadsheet identifying approximately $106,435 in Capstone payments to HealthMax, calculated as a 50% share of revenue. On May 28, 2020, he sent Mr. Maynard and Ms. Maynard, copying Mr. Johnson, another report showing that Sovereign had paid Capstone approximately $102,960 for testing generated through HealthMax events and that HealthMax received a 50% share.

154. These payments were not fixed, fair market value compensation for legitimate services independent of federal health care program business. They rose and fell with the volume and value of reimbursed genetic tests—the more reimbursable testing Church Alive and HealthMax helped arrange, the more money they stood to receive.

155. The remuneration was central to the church fairs scheme. Church Alive and HealthMax provided access to faith-based events, helped arrange event logistics, and helped identify medical professionals whose names, signatures, or standing orders could be used to support genetic-testing claims. Capstone, in turn, offered or paid compensation tied to the reimbursements generated from the testing collected at those events.

156. Mr. Whiles' role was significant enough that Mr. Johnson awarded him a $100,000 bonus based in part on his "specific efforts" involving Church Alive. The supporting justification credited Mr. Whiles with work at ten conferences that generated 963 CGx tests and 1,255 PGx tests, generating approximately $598,080 in revenue. It also credited him with three HealthMax events that generated 90 CGx tests and 125 PGx tests, with seven additional events planned.

157. Mr. Johnson also personally benefited from the scheme. Throughout 2020 and 2021, Mr. Johnson received over $13.2 million in payments from Capstone.

158. Medicare payment for genetic testing depended on the tests being medically necessary for the beneficiary tested, ordered by an authorized provider exercising individualized clinical judgment, and supported by documentation showing why the testing was needed for diagnosis or treatment. Medicare also would not knowingly pay claims generated through illegal remuneration paid to induce or reward federally reimbursable laboratory testing.

159. The claims generated through the church fairs scheme lacked medical necessity. The genetic tests were not ordered by treating providers exercising individualized clinical judgment, were not based on individualized

assessments of the beneficiaries' medical conditions or treatment needs and were not used by the purported ordering providers to manage the beneficiaries' care.

160. The same claims were independently false because they were tainted by illegal remuneration. Mr. Johnson offered Church Alive 50% of the reimbursements generated through its events, even though he ultimately withheld the promised payments. Capstone also paid HealthMax, Ms. Maynard, Mr. Maynard, and Koinonia Kingdom in connection with testing revenue generated through HealthMax events. Those remuneration arrangements were intended to induce or reward access to beneficiaries, event logistics, provider connections, and testing volume.

161. Between May 2019 and February 2020, Mr. Johnson, Mr. Whiles, and Why Not Productions caused Capstone and Sovereign to bill Medicare for approximately 548 genetic tests generated through the church fairs scheme. Medicare paid at least $573,324 for those tests. Those claims were false and ineligible for payment.

162. The following table includes examples of claims that Medicare paid Sovereign for CGx and/or PGx tests that were not medically necessary and were tainted by illegal remuneration.

Beneficiary	Date of Service	Ordering Provider	Who Submitted the Claim	Claim Submission Date	Paid Amount	Date of Medicare Payment
W.A.	5/29/2019	D.F.	Sovereign Laboratory	11/5/2019	$3,049.63	11/22/2019
K.C.	7/17/2019	S.F.	Sovereign Laboratory Service	8/2/2019	$2,912.43	8/21/2019
A.F.	7/3/2019	M.P.	Sovereign Laboratory Service	7/31/2019	$2,912.43	8/8/2019
L.H.	7/25/2019	M.P.	Sovereign Laboratory Service	9/20/2019	$2,912.43	9/27/2019
A.H.	2/16/2020	J.H.	Sovereign Laboratory Service	5/21/2020	$305.57	6/5/2020

II. The Senior Living RPP Scheme

163. In early 2020, the COVID-19 pandemic spread across the United States, ending the large in-person gatherings that had fueled the church fairs scheme. Mr. Johnson and Mr. Whiles identified a new and more profitable source of specimens: senior living communities with large populations of Medicare beneficiaries in need of COVID-19 testing.

164. Mr. Johnson and Mr. Whiles exploited a legitimate need for COVID testing to generate orders for broad RPPs. RPPs generally were not medically necessary for routine COVID screening or surveillance absent individualized symptoms, clinical need, and treating provider judgment; however, Medicare reimbursed RPPs at far higher rates than COVID testing alone.

165. The senior living RPP scheme was not driven by treating providers

identifying residents who needed broad RPPs. It was driven by access to senior living communities, the opportunity to convert specimens collected for COVID testing into higher-reimbursing RPP claims, and volume-based commissions paid to independent marketers.

166. Mr. Johnson and Mr. Whiles used a recurring model. Mr. Johnson drove the RPP strategy, approved and caused Capstone to pay volume-based commissions, and continued the scheme despite internal complaints and warnings. Mr. Whiles implemented the scheme through a small team of Capstone employees and independent marketers.

167. Mr. Whiles' team included Capstone employees Lindsey Clasen and Paige Hart, who worked successively as assistants to Mr. Whiles, and three independent marketers: Mr. Whiles' close friend, Patrick Howell; Mr. Whiles' younger brother, Ryan Whiles; and Mr. Whiles' father-in-law, Mr. Brandt.

168. Mr. Whiles used that team to convert COVID testing volume from senior living communities into high-reimbursing RPP claims. The team primarily did that by controlling account setup and order entry for clients. The team marketed COVID testing to senior living communities, used onboarding paperwork to create purported authorization for resident RPP testing, and entered orders after specimens arrived by selecting RPP testing, inputting standardized diagnosis codes, and applying provider signatures.

169. The commission structure reinforced the scheme. Capstone paid Mr. Howell, Ryan Whiles, and Mr. Brandt a commission for each test they generated, including federally reimbursed RPPs. Mr. Whiles then routed most of those commission payments back to himself through Whitson Medical.

A. Mr. Johnson and Mr. Whiles Launched the Senior Living RPP Scheme as a Pandemic Revenue Opportunity.

170. In early March 2020, as COVID-19 spread across the globe, Mr. Johnson recognized that the pandemic could be used to generate high-reimbursing RPP claims. After Mr. Johnson learned that a single RPP could generate more than $1,000 in Medicare reimbursement, he shared the information with Capstone's owner, who immediately saw the revenue opportunity: "If we did 10 per day (JUST 10 !!) that is 3.7 million in revenue and easily 3 in gross profit. 10 per day!! Let's go . . . . This needs to happen . . . . Corona is here."

171. Meanwhile, Mr. Johnson understood that COVID testing alone generated far less reimbursement. On March 14, 2020, when he learned that reimbursement for a COVID test could be as low as $51.31, Mr. Johnson responded: "If we tag rpp it should be more." In the same period, Mr. Johnson worked with Capstone personnel to confirm that Capstone could combine COVID testing with RPP testing to "get higher reimbursements and guaranteed money." Capstone's owner likewise acknowledged that, given low

reimbursement, standalone COVID testing was "not a test anyone would want to try to make a profit off of."

172. Mr. Johnson was prepared to pursue broad COVID/RPP testing even where individualized clinical need had not been established. On March 21, 2020, during a text exchange with Mr. Giordano about whether a community was waiting until someone was symptomatic before testing, Mr. Johnson wrote that, "selfishly," Capstone should test everyone as a "baseline." He then wrote: "I think we roll the dice . . . Test everyone[;] we can let the system sort it out." Mr. Giordano understood that Mr. Johnson was referring to COVID/RPP testing, responding: "I agree," and asking what insurance would not pay for if Capstone offered "COVID and RPP."

173. Shortly afterward, Mr. Giordano prepared and circulated Capstone's "COVID-19 Battle Strategy" presentation to Capstone personnel, including Mr. Whiles. The presentation reflected the core elements of the emerging COVID/RPP strategy: pairing COVID testing with RPP testing, marketing "the full panel" to long-term-care communities, and helping communities through the testing process.

174. Mr. Johnson and Capstone's owner then identified senior living communities as the target market. On April 2, 2020, Capstone's owner sent Mr. Johnson a list of "Senior Living COVID-19" "[p]ossible leads." The opportunity

was obvious: senior living communities urgently needed COVID testing for vulnerable residents, and those residents were largely Medicare beneficiaries.

175. Within days, Mr. Johnson began promoting a resident-focused COVID/RPP "screening" model for senior living communities. On April 8, 2020, after Mr. Johnson communicated with CHSGa/Ethica, a large Georgia-based senior living chain, they agreed that employees would receive "Covid-19 test only" while residents would receive "Covid-19 plus RPP." After landing that business, Mr. Johnson forwarded the communication to Capstone's owner and wrote: "This is how we get there."

176. That communication captured the financial logic of the scheme. COVID testing opened the door to senior living communities. But the real money was in adding RPPs to resident testing, since most residents were Medicare beneficiaries, whereas employees were not.

177. Mr. Johnson then turned RPP volume into a sales mandate. On July 6, 2020, he told Mr. Giordano: "Need RPP . . . 100 COVID at $75 is $7,500. 11 RPP at $700 is $7,700." Three days later, he directed the sales team: "Get RPP."

178. Mr. Johnson's sales team understood the message. Mr. Giordano testified that Mr. Johnson "wanted more RPP in the lab" and that getting RPPs "was an expectation." Mr. Giordano further testified that, according to Mr. Johnson, "if you weren't bringing RPP in[to] the lab . . . every day . . . [on] every

sales call . . . you're under the microscope." Mr. Johnson "would always want RPP," Mr. Giordano testified, "because it paid better, and that's all he cared about." Capstone employee Andrew Wiseman likewise testified that Mr. Johnson often told the sales team to "Get RPP," and that sales representatives understood they were expected to grow their RPP business.

179. Mr. Johnson also tracked RPP volume closely. On April 9, 2020, he asked for the "rpp split." On April 20, 2020, he again directed that RPP volume be separated from COVID testing volume: "Please divide rpp into covid and rpp appropriately." He regularly requested and received reports showing RPP volume, payer mix, reimbursement, and payment status, including reports showing the number of RPPs billed to Medicare and Medicaid and the amounts paid.

180. Mr. Whiles executed Mr. Johnson's strategy in the field. He marketed COVID/RPP testing to senior living communities, managed the Capstone employees and independent marketers who generated senior living testing volume, and as alleged below, used account-level paperwork, standardized codes, and internal order entry to convert COVID-testing demand into RPP claims.

181. The RPP push was financially driven in another respect as well. On May 26, 2020, Mr. Johnson directed that Capstone would pay independent

marketers $100 for each Medicare or Medicaid RPP. Capstone then paid Mr. Howell, Ryan Whiles, and Mr. Brandt volume-based commissions for the testing business they generated, including federally reimbursed RPPs. As alleged below, Mr. Whiles routed most of those commission payments back to himself through Whitson Medical.

182. Mr. Whiles' team viewed the pandemic as a business opportunity. On June 5, 2020, after Mr. Whiles told Ms. Clasen and Mr. Howell that the team was "gonna be busy for a while," Mr. Howell responded: "[H]opefully people are scared and test more!!!" That statement captured the attitude inside Mr. Whiles' team: fear would drive more testing, more testing would drive more RPP volume, more RPP volume would drive more Medicare reimbursement, and more reimbursement would drive more commissions.

183. Mr. Johnson and Mr. Whiles then used the Laboratory Alliance to turn senior living RPP volume into federal claims. The same sales-driven model generated RPP specimens and order paperwork for Capstone, Genus3, and Sparrow, and Mr. Johnson directed where testing would be performed or billed based on reimbursement considerations and laboratory capacity. As a result, all three laboratories billed Medicare for RPPs generated through the senior living scheme.

184. From March 2020 through September 2021, Mr. Johnson and Mr.

Whiles caused Capstone, Genus3, and Sparrow to submit or cause the submission of claims to Medicare for approximately 25,836 RPPs generated through the senior living scheme, resulting in approximately $13,109,669 in federal payments.

185. Capstone received approximately $10,770,089 for 19,044 RPPs; Genus3 received approximately $1,734,490 for 5,418 RPPs; and Sparrow received approximately $605,090 for 1,374 RPPs.

B. Mr. Johnson and Mr. Whiles Knew COVID Testing Did Not Justify Blanket RPP Testing.

186. But the financial opportunity did not make the claims payable. RPPs were not reimbursable simply because senior living communities urgently needed COVID testing, because residents lived in congregate settings, or because Medicare paid far more for RPPs than for COVID testing alone. Each RPP still required individualized medical necessity, a valid provider order, and documentation showing why that beneficiary needed that test.

187. Mr. Johnson and Mr. Whiles knew that. Before and during the senior living RPP scheme, they received compliance training, billing guidance, reimbursement warnings, and internal communications making this clear.

188. On March 2, 2020, after learning that RPPs "do not meet Medicare's 'reasonable and necessary' criteria," Mr. Johnson acknowledged the need to maintain compliance. He wrote: "We need to ensure that we are maintaining the

compliance on this testing (along with UTI). We can't just do test to do test. We MUST have the medical necessity and ensure the proper documentation from the clinics."

189. Mr. Johnson nevertheless pursued the RPP scheme while repeatedly receiving warnings that RPPs could not be performed or billed as blanket add-ons to COVID testing. On March 23, 2020, after a prospective business partner alerted Mr. Johnson to Palmetto's restrictions on broad RPP reimbursement, Mr. Johnson forwarded the issue to VitalAxis, Capstone's billing vendor, asking: "Am i missing something? It appears this says we would not get $900 on rpp."

190. The next day, VitalAxis told Mr. Johnson: "We can't do full RPP panel on all COVID patients. We have to order COVID screening only on most cases. Order full panel only if needed."

191. Mr. Johnson did not abandon the RPP scheme. He pressed VitalAxis on reimbursement and noted that Novitas appeared to pay more favorably than Palmetto. VitalAxis confirmed: "At this moment Novitas is a better MAC to bill." Mr. Johnson then created a dual-channel billing strategy through the Laboratory Alliance: Capstone would bill Palmetto by "unbundling" the panel into individual CPT codes, while Sparrow and Genus3 would bill Novitas under the full RPP code, CPT 87633.

192. Mr. Johnson also knew that RPPs could not be run on asymptomatic

individuals merely because they were being tested for COVID-19. On April 3, 2020, VitalAxis told Mr. Johnson: "We cannot Run RPP panel for Asymptomatic." That same day, Mr. Johnson circulated a "data coding flow" to Mr. Whiles and others stating that Capstone could not run RPPs for patients with "Exposure/Contact" or "Non-Symptomatic + Covid" because "we need to have sign or symptom for which there is suspicion of respiratory illness."

193. Mr. Johnson reiterated the point in another communication: "Make sure you Have right codes. Asymptomatic patients are not approved for rpp." When a Sparrow employee suggested that RPP was run only when COVID was positive, Mr. Johnson corrected her: "No Rpp only if symptomatic. You cannot reflex asymptomatic positive to rpp. This is an important compliance step."

194. Mr. Johnson also knew that repeated RPP testing on the same beneficiary could not support medical necessity. On May 1, 2020, Genus3 billing personnel advised Mr. Johnson that repeating COVID-only testing could be appropriate, but repeating "respiratory with covid" did "not support medical necessity."

195. Capstone and Genus3's billing manager, Arkadia Johnson, agreed with that assessment, explaining that "the majority of the time they are not sending anything that shows that medical necessity." Mr. Johnson responded: "If there are no icd 10 codes....which is medical necessity....then why did we run

it??"

196. On May 4, 2020, Mr. Johnson forwarded that warning to Mr. Whiles and others, stating: "FYI, Strong recommendations from billing. Essentially: repeated rpp+covid testing frowned upon." Mr. Johnson further explained that if a respiratory panel with COVID "is done and full test is repeated again, it does not support medical necessity."

197. Mr. Whiles therefore received the same core warning that Mr. Johnson had received: RPPs could not be treated as automatic add-ons to COVID testing, and repeated COVID-plus-RPP testing did not support medical necessity absent individualized clinical justification. Mr. Whiles nevertheless continued directing his team to generate RPP volume from senior living communities.

198. At the same time, Mr. Johnson continued to stand up the RPP scheme. On May 8, 2020, Mr. Johnson asked Vital to research whether there was anything that prevented Capstone from "[b]illing COVID with RPP on consecutive days." Vital responded: "Presently, there are no such limitations in billing COVID with RPP on consecutive days." Mr. Johnson forwarded that message to Capstone's owner, calling it a "Key billing update[]" he would "review face to face."

199. Mr. Johnson also knew that community-wide standing orders for RPPs were not compliant. On August 1, 2020, he told the sales team, including

Mr. Whiles: "Rpp is not 'everybody' does it" and "Just doing a blanket everyone is not recommended." Mr. Johnson attached a compliance alert concerning government scrutiny of COVID-19 "add-on tests," including RPPs billed in conjunction with COVID testing.

200. Despite these warnings, Mr. Johnson escalated the pressure on the sales team. On July 9, 2020, he instructed them: "Get RPP." He then directed: "Every single LTC facility should have a standing order to, at a minimum, reflex to rpp for all positive and / or symptomatic."

201. Mr. Johnson did not frame that instruction as a request that treating providers make individualized determinations for each resident. He instructed the sales force to obtain facility-level standing orders that could be used across entire senior communities. He further directed the sales team to "[s]end us that order," emphasizing that their job was to secure paperwork that would allow Capstone to add RPPs to COVID testing.

202. Mr. Johnson invoked CDC guidance to justify the sales push, stating: "CDC even recommends" and "[i]t's not a sales message it literally what they recommend." When another employee sought clarification by noting, "If they are symptomatic," Mr. Johnson responded: "Was that a question?" When the employee explained that he was seeking clarification, Mr. Johnson stated: "Signs or symptoms. A positive covid seems like a good sign."

203. Mr. Johnson then turned the instruction into a performance demand. He told the sales team to "[m]ake a plan," to look at their "percentage of covid to rpp," and to report back. He then threatened the marketers who failed to deliver: if they could not obtain RPP orders from senior communities, "let's bring you into the home office so you label fckn tubes."

204. The message was unmistakable. RPP volume was a sales requirement. Marketers who could not produce would be removed from the field.

205. Mr. Johnson's directive was inconsistent with his own prior recognition that a positive COVID test did not, by itself, authorize an RPP. An RPP still required individualized treating provider judgment, not a facility-level standing order obtained by sales personnel under pressure to improve their "percentage of covid to rpp."

206. Mr. Johnson also knew that Mr. Whiles' team was generating unusually high RPP volume. On September 23, 2020, Capstone's chief compliance officer, Ms. Sheats, raised concerns to Mr. Whiles and Mr. Johnson concerning Mr. Howell. She wrote that Mr. Howell had 2,051 billed RPP samples, of which 998—or 48%—were COVID plus RPP, which "seems unnaturally high."

207. On October 28, 2020, Ms. Sheats again asked Mr. Johnson whether

he was comfortable with the amount of RPP volume that Mr. Howell was generating. She wrote: "Its 2 to 1 on his COVID only samples. Makes me nervous…." Ms. Sheats later said that Mr. Johnson dismissed her concerns with an expletive.

208. Mr. Johnson and Mr. Whiles therefore knew that Mr. Whiles' team was producing RPP volume that Capstone personnel considered abnormal and concerning. Mr. Johnson nevertheless allowed the conduct to continue, and Mr. Whiles continued driving the sales team to generate that volume.

C. Mr. Whiles Drove RPP Volume Through Daily Pressure and Tracking.

209. Mr. Johnson set the expectation that Capstone's sales team would "Get RPP." Mr. Whiles turned that expectation into a daily sales mandate for his team. He tracked RPP volume, demanded frequent reports, monitored account growth, measured projected revenue, and pressured his team to increase the percentage of COVID testing paired with RPPs.

210. Mr. Whiles had a direct financial motive to do so. The more RPP volume his team generated, the more commissions flowed to Mr. Howell, Ryan Whiles, and Mr. Brandt—and then back to Mr. Whiles through Whitson Medical. Mr. Whiles therefore treated low RPP volume as a sales failure, not as evidence that residents lacked individualized medical necessity for broad respiratory testing.

211. Mr. Whiles tracked senior living testing in revenue terms. On May 19, 2020, he told Mr. Howell to compile a spreadsheet identifying accounts, current volumes, projected run rate, and expected revenues, with revenues based on the Medicare fee schedule by tests ordered.

212. Mr. Whiles also imposed a daily management structure around testing volume. On June 30, 2020, he told Ms. Hart and Mr. Howell that his "only requirement" was "protecting and growing" their accounts. That same day, he required daily morning calls, daily review of incoming samples, and end-of-day recaps reporting total incoming tests by account.

213. Mr. Whiles repeatedly demanded RPP numbers. On June 10, June 15, July 13, July 16, July 20, August 10, August 12, August 21, October 16, and October 21, 2020, he asked his team variations of the same question: "How many RPP." On July 20, 2020, he asked for totals, Genus3 volume, and the RPP breakdown. On September 10, 2020, after Ms. Hart reported only two RPPs, Mr. Whiles responded: "only 2 RPP, is that correct?"

214. Mr. Whiles also used RPP volume to create competition and accountability within his team. At his direction, Ms. Hart circulated testing numbers to the team and told them to study their numbers before weekly calls because Mr. Whiles would ask questions about their performance. When Mr. Howell reported "150ish" RPPs in July 2020, Ms. Hart responded, "Dang!!" In

January 2021, Ms. Hart wrote: "Here are your numbers for tomorrow's meeting. Look at it and get to know before the meeting so when Austin asks you questions, you have the answers." In February 2021, Ms. Hart again wrote: "Here are your numbers. Look at them and know them." Ms. Hart later testified that Mr. Whiles directed her to track COVID and RPP orders, circulate those numbers, and include specific directives in those emails.

215. In October 2020, Mr. Whiles created an RPP sales message for his team: "Can't MISS with RPP." He explained that "MISS" stood for "Meaningful, Innovative, Sensitive, Standard." Mr. Whiles directed his team to "start using this when speaking to accounts" as a way to stay "on message during the conversation." He wrote: "RPP matters. Don't MISS."

216. Mr. Whiles used that message to demand more RPP volume. On October 16, 2020, after two days with no RPPs, he texted his team: "RPP? 2 days no RPP. Can't MISS WITH RPP." One week later, he told the team: "We need to get more biz. Our RPP percentage has dropped 38%. Can't MISS with RPP especially now. Protect and grow."

217. Mr. Whiles continued pressuring the team into 2021. On January 15, 2021, after RPP samples were rejected for missing insurance information, Mr. Whiles told Mr. Howell to "[r]un the numbers" and criticized the team because hundreds of RPP samples had been rejected. On January 21, 2021, he told Mr.

Howell and Mr. Whiles, that they were his "veterans" but were "playing like rookies," told them to "fix your s[___]," [4] and warned that if they could not "PROTECT[] AND GROW[]" their accounts, he would "find alternatives."

218. The pressure continued through the spring and summer of 2021. On March 23, 2021, Mr. Whiles told Ms. Hart, Ryan Whiles, and Mr. Howell: "I can't stress enough how important it is that each of you are pushing EVERY SINGLE DAY!" On April 30, 2021, he told Ms. Hart and Mr. Howell: "Covid is still our #1 sales vertical. DO NOT lose sight of that." On May 12, 2021, he repeated the point: "The #1 sales vertical is covid," and directed them to "[p]rotect and grow the business," adding that he hoped "we are seeing more volume come in besides these lower numbers." The next day, he told them: "RPP must get done today, top of the priority." And on June 30, 2021, after Ms. Hart reported 155 total tests and 84 RPPs, Mr. Whiles responded: "Good day on RPP. All those to capstone?"

219. Mr. Whiles' repeated RPP-volume demands were not tied to medical necessity. They were tied to sales performance, revenue, account growth, and commissions. The same communications that tracked RPP volume also tracked accounts, projected revenue, laboratory routing, rejected claims, missing insurance information, and commission-generating volume.

[4] Expletive deleted.

D. Mr. Whiles Used New Account Forms to Turn Physician Signatures into Reusable Ordering Paperwork.

220. Mr. Whiles' daily RPP-volume demands required a paperwork component. He did not build a process to obtain provider-originated and signed lab orders. He built a process to apply reusable provider signatures.

221. The key document was Capstone's new account form, which was onboarding paperwork, not a patient-specific requisition. It did not identify the residents to be tested, their symptoms, their conditions, their treating providers, or why any resident needed a broad respiratory panel.

222. The form nevertheless contained standing order language that Mr. Whiles' team used to convert a provider's signature into a reusable ordering form. The language was not tailored to RPP testing. It stated: "This standing order represents my determination that it is both medically necessary and a matter of prudent practice of medicine to run the selected urine drug screening and confirmation. I authorize Capstone . . . to perform urine drug analysis on my patients from my organization as indicated on the form. In addition, I hereby authorize and instruct Capstone . . . to run selected testing on samples sent to Capstone."

223. Mr. Whiles and his team treated that language as blanket authority to apply a provider's signature to future RPP orders for residents the provider had not treated. The mismatch between the form's urine drug testing language,

and the RPP claims it was used to support, further confirms that the form was not a genuine resident-specific test order. It was a repurposed form used to later make RPP testing appear authorized.

224. That use of the form eliminated the provider from the actual ordering process. Once the provider signed the new account form, Mr. Whiles' team uploaded the signature into VitalAxis and dealt with community administrators—not treating providers—to decide what tests would be ordered, what diagnosis codes would be used, and which residents would be tested.

225. Mr. Whiles and his team showed no interest in whether the signing provider had examined the residents, treated the residents, reviewed their symptoms, needed the RPP results to manage care, or made any individualized medical necessity determination. Nor did they return to the provider for resident-specific orders. Instead, they treated the new account form as authorizing all future testing for that community.

226. Mr. Whiles' own communications reflected that process. On March 25, 2020, Mr. Whiles told Sonata Senior Living ("Sonata") that "for us to be compliant we will need a[n] order for the test" and that Capstone would provide a form "that can be used for you and all your communities." He told other communities, "All I really need is the first page completed and the doctors signature." He told another community, "Please put your community name as

the doctor is signing for tests at the community." Those statements reflected community-level authorization, not patient-specific medical judgment.

227. Ms. Hart, who worked directly for Mr. Whiles and reported to him, confirmed this process under oath. She understood that once a doctor signed the new account form, the doctor's signature would be uploaded into VitalAxis and placed on requisitions whenever Mr. Whiles' team entered orders. She further understood that if the RPP box was selected on the new account form, the physician had supposedly authorized later RPP orders and did not need to authorize each individual test.

228. Ms. Hart also testified that Mr. Whiles told her the new account form needed to be signed "for compliance purposes." As Ms. Hart explained: "Everything I know is usually from Austin." Ms. Hart later told a Windsor Manor community that the doctor's signature did not need to come from a physician directly associated with the community; Capstone needed "a Dr. signature who is willing to sign in order to move forward with testing for compliance reasons."

229. Mr. Howell likewise understood from Mr. Whiles that the new account form, once signed, would authorize all testing going forward. But Mr. Whiles also told Mr. Howell that standing orders were not compliant and that Mr. Howell should not mention "standing orders" in writing.

230. Mr. Whiles therefore knew the process did not establish individualized medical necessity. He knew the new account form was being used as a standing order. The signature was thus treated as a compliance checkbox, not as the product of a treating provider's resident-specific medical judgment.

E. Mr. Whiles Turned COVID-Testing Requests into RPP Paperwork.

231. Once Mr. Whiles had a process for obtaining reusable provider signatures, he needed paperwork that appeared to authorize RPPs. When senior living communities asked how to obtain COVID testing, or when providers objected that the new account form did not include a COVID-only option, Mr. Whiles directed them to select RPP or write COVID next to the RPP selection.

232. For example, on March 24, 2020, Mr. Whiles told Sonata that Capstone was launching its COVID test, which would "include a comprehensive RPP panel," and added: "If you have any symptomatic or asymptomatic residents we can definitely get them tested."

233. The next day, Mr. Whiles told Sonata that they needed to complete the new account form "for us to be compliant." This single form would cover "all your communities." Two days later, when Sonata asked whether the provider should check "respiratory pathogen panel or add covid-19," Mr. Whiles responded: "Respiratory pathogen panel."

234. Sonata then made clear that its doctors were not authorizing blanket RPP testing. On April 1, 2020, Sonata told Mr. Whiles that its doctors were saying "covid only unless there are symptoms." Mr. Whiles responded: "Thank you for the clarification Lorrie. I have looped Jay in so we are all on the same page." Despite that COVID-only instruction, Mr. Whiles and his team continued ordering RPPs for Sonata residents.

235. The next day, after a Sonata representative explained that most residents were not symptomatic, Mr. Whiles said Capstone would run RPPs on residents with any reported symptoms. In another April 2 communication, Mr. Whiles forwarded a list of Sonata residents to Capstone personnel and explained: "These all already have orders for Covid only but will need RPP as well."

236. Mr. Whiles used the same approach with Watercrest. On May 12, 2020, Watercrest told Mr. Whiles that a physician had reviewed the new account form and said there was "no where on the sheet saying we are testing for Covid." The physician was willing to sign only if the form included COVID testing. Mr. Whiles responded that the physician could either check the box next to Respiratory Pathogen Panel or write "Covid-19 Testing" next to the RPP box, "[w]hatever he is most comfortable with."

237. Mr. Whiles gave similar directions to Principal Senior Living communities. On June 8, 2020, a Principal representative told Mr. Whiles: "I do

not see COVID test on the form and don't want the full respiratory panel what should I check?" Mr. Whiles responded: "You can just write COVID next to the Respiratory box." Four days later, another Principal representative asked what test she needed to check on the form. Mr. Whiles responded: "You can check off the respiratory panel."

238. Mr. Whiles repeated the same practice with Kinship Pointe. On August 5, 2020, a Kinship Pointe representative asked what she should mark to ensure COVID testing. Mr. Whiles responded: "On the second page, just make the respiratory and we will know what the means." On October 17, 2020, another Kinship Pointe representative asked for help completing the form for COVID-19 testing and stated that she did not want to do it wrong. Mr. Whiles responded: "You are good! Just mark the respiratory box and I will get you all set up!"

239. These communications show how Mr. Whiles used Capstone's onboarding paperwork to blur the distinction between COVID testing and RPP testing. Senior living communities asked for COVID testing, questioned why the form did not include a COVID-only option, or expressly stated that they did not want a full respiratory panel. Mr. Whiles nevertheless directed them to the RPP box or told them to write COVID next to the RPP box, creating paperwork that Capstone later used to support COVID-plus-RPP claims for residents.

F. When the Signed Paperwork Did Not Authorize RPP, Mr. Whiles' Team Changed It.

240. Mr. Whiles' direction to select RPP converted some COVID-testing requests into RPP paperwork. But when communities or providers signed forms that still did not purportedly authorize RPPs, Mr. Whiles' team sometimes went further: it added RPP selections or attached RPP pages after the provider had already signed.

241. The altered paperwork took several forms. Some signed new account forms did not select RPP. Others lacked the page on which RPP could be selected. Others contained handwritten language showing that the community or provider wanted COVID testing only. In each circumstance, adding RPP after signature changed the substance of the document.

242. If the signing providers had ordered RPPs, Mr. Whiles' team would not have needed to add RPP selections after signature. The post-hoc RPP selection was not a harmless clerical detail; it was the purported authorization for a high-reimbursing respiratory panel.

243. Mr. Howell later confirmed that this was not a paperwork accident. For The Residence at Penniman Hill, Dr. Heather Bryant-McKenney signed a new account form that did not select RPP. Mr. Howell later selected RPP after the physician signed because Mr. Whiles told him they wanted RPPs.

244. Mr. Whiles' team changed signed forms for many other

communities as well. For Market Street Palm Coast, Nurse Practitioner ("NP") Sandy Ratner signed a new account form that did not select RPP and instead selected an "Other Custom Panel" for "COVID19." Mr. Howell later selected RPP, and Capstone billed RPPs under NP Ratner's name. For Benton House of Grayson, Dr. Gary Figiel signed a new account form, and Mr. Howell later added a second page selecting RPP.

245. The Benton House of St. Johns form made the lack of authorization explicit. The signed new account form stated: "COVID 19 TEST" and "We do not approve any other test on this form ONLY COVID TEST." Mr. Howell later selected the RPP box after the physician signed.

246. For SLM communities associated with Dr. Shahzad Khan, the original new account form did not select RPP and referenced COVID-19 in an attached note. Mr. Howell later created separate versions for individual communities with RPP selected.

247. For Grace communities associated with Dr. Kevin O'Neil, multiple new account forms either did not select RPP or lacked a second page selecting RPP. Members of Mr. Whiles' team later added RPP selections or second pages.

248. Other altered forms reflected the same pattern. For Residence at Freeman Lake, NP Paul Pricop signed a new account form that did not select RPP; Mr. Howell later selected RPP after the physician signed. For Hearthside

Senior Living Bartlett, the original new account form did not select RPP; RPP was later selected after the physician signed.

249. These were not isolated incidents. Altered forms appeared across multiple community chains, multiple physicians, multiple laboratories, and multiple members of Mr. Whiles' team. The pattern confirms that Mr. Whiles' team was not obtaining individualized orders. It was creating paperwork to support RPP billing after the fact.

G. Mr. Johnson and Mr. Whiles Used Standardized Diagnosis Codes to Support RPP Claims.

250. Mr. Johnson and Mr. Whiles also used standardized diagnosis codes to support RPP claims. The codes did not come from treating providers. They came from Capstone personnel, Mr. Johnson, Mr. Whiles, and Mr. Whiles' sales team.

251. Mr. Johnson helped create and distribute the coding template. On April 1, 2020, Capstone personnel circulated a "COVID & RPP Codes Cheat Sheet" that "[i]ncluded [the] RPP Codes," for cough and shortness of breath. Mr. Johnson directed that the cheat sheet be shared broadly within Capstone, including with the sales team.

252. The codes were then used in the field. On May 12, 2020, as Mr. Whiles was developing the LCB Senior Living account, LCB stated that Mr. Whiles would provide the "Z and R codes" for COVID/RPP testing. Mr. Whiles

then sent LCB four "applicable/suggested ICD codes for the RPP/Covid test." Those codes matched the standardized codes Mr. Johnson had circulated the prior month.

253. Mr. Whiles used the same process with other major senior living accounts. On June 4, 2020, while establishing testing with Five Star Senior Living, Mr. Whiles wrote: "As discussed the residents will be getting Covid and RPP . . . Here are the ICD codes," followed by four codes, three of which matched the codes Mr. Johnson had circulated.

254. Mr. Whiles also trained his team to use the same codes when entering orders. Ms. Clasen prepared a training document for Mr. Whiles' team that identified the codes to use for COVID/RPP orders, including codes for shortness of breath and acute respiratory infection. Ms. Hart testified that Mr. Whiles approved the use of those codes and that she used them when placing RPP orders.

255. Mr. Whiles' team did not obtain individualized diagnosis codes from treating providers for each resident. Instead, the team repeatedly supplied the same codes to communities and used the same codes when placing orders. In many order entry communications, no diagnosis codes were identified at all because, as Ms. Hart testified, the team used the same standard codes each time.

256. The communications confirm that practice. When Mr. Whiles' team

placed orders, the shorthand was often simply "COVID/RPP for residents" or "RPP Residents," without any patient-specific diagnosis information. On August 19, 2020, Ms. Hart reminded the team which codes to use, including the recurring diagnosis codes Z20.828, J22, and R06.02. Ms. Hart testified that Mr. Whiles instructed her to share those codes.

257. Mr. Whiles and his team occasionally asked communities to confirm use of the same codes previously used, rather than obtain patient-specific diagnosis codes from treating providers. For example, Mr. Whiles asked Zon Beachside whether it wanted COVID/RPP run on residents "with the same ICD codes as previous." He similarly asked Five Star Senior Living whether it wanted COVID/RPP testing run "as before" and stated that, if so, Capstone would "use the same ICD codes as we did previously."

258. The result was standardized diagnosis coding on a massive scale. For 82.3% of the RPP claims paid by Medicare, the laboratories used one or more of six recurring diagnosis codes—and no other diagnosis code. That pattern is consistent with template coding by a sales and order entry team, not individualized diagnosis coding by treating providers.

259. This coding process was central to the scheme. Mr. Johnson and Mr. Whiles knew that RPP claims needed diagnosis codes to appear medically necessary. Rather than obtain patient-specific diagnoses from treating providers,

they supplied standard codes to communities and trained Mr. Whiles' team to use the same codes when entering RPP orders. Those codes made RPP claims appear supported by individualized clinical need when, in reality, the claims were generated through sales activity, account-level paperwork, and standardized order entry.

H. Mr. Whiles' Team Turned Paperwork into RPP Claims Through Internal Order Entry.

260. The standardized coding process depended on a deeper defect: Mr. Whiles' sales team controlled the order entry process. The team did not merely market testing or collect paperwork from communities. Once specimens arrived from senior living communities, Mr. Whiles' team entered orders into Capstone's ordering system by selecting the test panel, adding diagnosis codes, and applying the signature of the provider who purportedly ordered the test. Ms. Hart's testimony confirms these facts.

261. To select the test panel, Mr. Whiles' team used a spreadsheet called the Community Tracker, which identified what test should be ordered for employees and residents of each community. According to Ms. Hart, the team knew what test to order because Mr. Whiles had a conversation with the community at the beginning of the relationship, and the resulting testing protocol was then placed in the Community Tracker.

262. That process did not involve treating providers making resident-specific medical decisions. It involved Mr. Whiles and his team deciding at the account level what testing protocol would be used for residents and employees of a community. The misplaced control over this process correlated to the financial motive of Mr. Whiles and his sales team.

263. That control mattered. Even when the signed paperwork did not select RPP, lacked the page on which RPP could be selected, or indicated that the community or provider wanted COVID testing only, Mr. Whiles' team still entered RPP orders. That occurred because the team followed the Community Tracker, Mr. Whiles' account-level instructions, or prior account practice—not provider orders for each resident.

264. The order entry examples show the point. For Forum at Park Lane, the signed new account form did not select RPP and stated "COVID-19 per discussion with Austin" and "This is for COVID-19 testing of residents and employees." Mr. Howell nevertheless entered the account as COVID/RPP for residents because Mr. Whiles told him to put COVID/RPP. For Forum at the Woodlands, the signed new account form stated "COVID19 only," but the account was later "converted" and "upsold" to RPP for residents.

265. Other communities followed the same pattern. For Benton House of Douglasville, the signed new account form did not select RPP and was sent

shortly after Principal told Mr. Whiles it wanted COVID testing, not the full respiratory panel. Mr. Whiles' team nevertheless ordered RPPs that same day. For Residence at Cedar Dell, the signed new account form crossed out RPP and included an instruction for "COVID testing to all residents at the community." Mr. Whiles' team nevertheless ordered RPPs.

266. These examples confirm the function of the order entry process. The signed new account form did not control whether RPPs were ordered. Mr. Whiles' team did.

267. Mr. Whiles' team also controlled the provider signature attached to each order. Ms. Hart testified that when she entered orders, the provider's name and signature appeared because the provider had signed the new account form. In other words, after a provider signed a new account form, Mr. Whiles' team could apply that provider's signature to later resident orders entered by the team. The provider's signature became a reusable ordering credential, not evidence of individualized medical judgment.

268. Mr. Whiles personally approved that process. On May 26, 2020, Mr. Howell texted Ms. Clasen and Mr. Whiles that he was "going to cutout the Doc's signature from the new account form and upload manually" because it had not been loaded into Capstone's ordering system through the normal process. Ms.

Clasen asked Mr. Whiles for his thoughts. Mr. Whiles responded: "Upload it." The physician signature was then used to place orders.

269. Mr. Whiles' team also controlled the diagnosis codes used to support RPP orders, as alleged above. Ms. Hart testified that she entered diagnosis codes provided by Mr. Whiles, and that those same codes were used by others on his team. Mr. Howell likewise said that the diagnosis codes came from Mr. Whiles, not from communities or treating providers, and that Mr. Whiles told Mr. Howell the codes "worked for billing."

270. The repeated use of the same codes across entire communities was not based on individualized clinical determinations by treating providers. It reflected an internal order entry process controlled by Mr. Whiles and his team.

271. Mr. Whiles' team therefore controlled the three critical components of the claim: the test ordered, the codes used to justify it, and the provider signature attached to it. Community administrators sometimes confirmed testing protocols or codes, but those confirmations did not cure the absence of valid treating provider orders.

272. Mr. Whiles also treated missing requisitions and diagnosis codes as administrative problems that his sales team could fix rather than going back to ordering providers as Medicare requires. On September 23, 2020, after learning that several RPP orders Mr. Howell placed did not include complete requisition

forms with ICD-10 codes, Mr. Whiles told Mr. Howell: "On the missing req and codes, please resolve those ASAP. That['s] all easy fixes." Mr. Howell asked: "Do you want the exceptions for reqs and codes removed?" Mr. Whiles responded: "Yes, Thats stuff you can fix easily."

273. Mr. Whiles' team also scaled order entry through bulk-upload and spot-check processes. On November 30, 2020, after repeated order entry burdens and errors, Mr. Howell and Ms. Hart formulated a plan for VitalAxis to bulk upload orders that included more than 25 seniors. Mr. Whiles asked how the team was checking to ensure the orders were done correctly. Mr. Howell responded that he had spot-checked RPP orders and that the codes were correct. Ms. Hart added that she and Mr. Howell were "pretty good about double checking Dx quick to make sure orders are in and for the right codes." Mr. Whiles responded: "Good to hear! Let's spot check daily, I don't want to have a 250k daily mistake."

274. In short, Mr. Whiles' team controlled the order, the diagnosis codes, and the provider signature. Treating providers did not supply the codes, did not generate the orders, and did not decide resident by resident whether a broad RPP was medically necessary. Mr. Whiles' process converted signatures, trackers, and sales-team order entry into billable RPP claims.

I. Capstone Billing Personnel Warned that Mr. Whiles' Order Entry Process Was Improper.

275. Capstone billing personnel warned Mr. Johnson and Mr. Whiles that the process was improper, inconsistent with Capstone policy, and created compliance risk.

276. Ms. Johnson, Capstone's billing manager, repeatedly raised concerns about Mr. Whiles' order entry process. She testified that Mr. Whiles had his team input orders for communities, and that this raised concerns because the diagnosis codes were not properly documented and were all the same. Ms. Johnson further testified that this practice violated Capstone's policy or practice, which everyone understood.

277. Ms. Johnson raised these concerns with both Mr. Johnson and Mr. Whiles. Mr. Johnson led Friday calls during which he told Mr. Whiles multiple times to stop inputting orders. Ms. Johnson also told Mr. Johnson that Mr. Whiles continued the practice after those warnings. Ms. Johnson testified that Mr. Johnson gave Mr. Whiles only a "slap on the wrist."

278. The warnings continued. On October 3, 2020, after samples from Mr. Whiles' accounts arrived without orders, Ms. Johnson told Mr. Whiles that "the process is broken" and that, as the sales leader, he "should be leading by example." Another Capstone employee added that the problem was consistent and that there was "no resolution in sight."

279. On May 10, 2021, a Capstone employee again warned Mr. Whiles

that Capstone could not enter orders for facilities because that meant "the lab putting in orders for itself" and "could compromise compliance with CMS & OIG."

280. These warnings confirmed the defect in Mr. Whiles' order entry process. Treating providers were not driving the ordering of RPPs, as Medicare requires. Instead, Mr. Whiles' sales team was doing so after specimens arrived, using account-level paperwork, reusable signatures, and standardized codes to generate orders that Capstone, Genus3, and Sparrow could bill to Medicare.

J. Mr. Whiles' Team Used Screening Rationales to Defend and Preserve RPP Volume.

281. After billing personnel warned that sales team order entry was improper, Mr. Whiles' team defended and preserved RPP volume by telling senior living communities that RPPs could identify other respiratory pathogens circulating among residents.

282. The message was directed to communities, not treating providers, and it focused on facility-wide risk, pathogen spread, prevention, and reassurance—not resident-specific diagnosis, treatment, or management.

283. Mr. Whiles' team used that message repeatedly. On June 19, 2020, Mr. Howell told a Five Star community that the COVID/RPP test would test for "COVID and any colonized pathogens that could spread in the community." Mr. Howell later explained that Mr. Whiles directed him to send that confirmation.

On July 15, 2020, Mr. Howell told Forum at the Woodlands that Capstone would "run the respiratory panel to test for any collated *[sic]* pathogens circling your residents at your community." Mr. Howell later testified that Mr. Whiles wanted him to act more like a salesperson and to upsell senior living facilities.

284. The same rationale appeared when communities questioned why residents were receiving RPPs. On October 19, 2020, after an SLM community stated that it "wasn't aware we were testing for anything but covid," Ms. Hart responded that Capstone had confirmed with SLM corporate personnel that residents would receive COVID/RPP "so you can see if they have any other respiratory virus." Ms. Hart later testified that Mr. Whiles told her the RPP was "no extra cost" for the communities.

285. Others on the sales team echoed the same fear-based messaging. On October 18, 2020, one Capstone employee wrote: "Order RPP and MISS the mystery, MISS the risk." Another wrote: "Don't die. Do RPP."

286. Mr. Whiles continued using the same prevention rationale into 2021. In July 2021, he told his team that "RPP/Covid might be a great option for prevention when testing occurs."

287. These statements confirm that Mr. Whiles' team sold RPPs as screening, surveillance, prevention, and reassurance for senior living communities. That rationale did not establish medical necessity for any

individual resident.

K. Representative Senior Living Communities Demonstrate the Pattern

288. The senior living scheme followed the same basic pattern across numerous communities that sought COVID testing, supplied account-level paperwork, and then saw RPPs ordered and billed for residents through Mr. Whiles' team's internal order entry process.

289. The following communities are representative examples that show the same recurring features: COVID-only requests, confusing or altered new account forms, reusable provider signatures, sales team order entry, standardized diagnosis codes, community complaints, physician denials, and federal payments for RPPs that were not based on individualized treating provider judgment.

i. Sonata Senior Living

290. On April 1, 2020, Sonata told Mr. Whiles that its doctors wanted "covid only unless there are symptoms."

291. Mr. Whiles did not limit Sonata testing to COVID-only absent individualized symptoms and provider orders. On April 20, 2020, Mr. Whiles told Capstone personnel that Sonata West residents would be "all Covid and RPP," and confirmed that order entry personnel should enter COVID and RPP with the same repeated diagnosis codes.

292. Sonata later complained about the ordering process. On January 28, 2021, Sonata contacted Mr. Whiles concerning a resident who had received a bill for an RPP run with COVID testing. Sonata explained that the test had been ordered by Dr. GL, "who was not his physician," and that the resident did not believe he should have to pay for the charge. That complaint placed Mr. Whiles on notice that the purported ordering physician was not the resident's treating physician.

293. Mr. Whiles' team ordered approximately 468 RPPs for residents of Sonata communities, causing Medicare to pay approximately $261,376.

ii. Watercrest Senior Living

294. Watercrest Senior Living shows how Mr. Whiles used the RPP box as a substitute for COVID testing. On May 12, 2020, Watercrest told Mr. Whiles that a physician had reviewed the new account form and objected that it did not say COVID testing. The physician was willing to sign only if a COVID option was added. Mr. Whiles responded that the physician could check the RPP box or write "COVID-19 Testing" next to the RPP box.

295. Watercrest communities thereafter submitted new account forms that Mr. Whiles' team used to support RPP testing.

296. Watercrest later questioned the testing. On October 12, 2020, a Watercrest representative informed Ms. Hart, copying Mr. Whiles, that residents

had received Medicare summaries and were asking why they had been tested for chlamydia, mycoplasma, legionella, and staph. Ms. Hart responded that those pathogens were included in the respiratory panel for residents.

297. Watercrest later confirmed that its preferred order was COVID-only and that additional testing would be requested only on a case-by-case basis.

298. Mr. Whiles' team ordered approximately 1,673 RPPs for residents of Watercrest communities, causing Medicare to pay approximately $1.36 million.

iii. Principal Senior Living / Benton House

299. Principal and Benton House show both methods of the scheme: Mr. Whiles directing communities to use the RPP box when they sought COVID testing, and his team later causing RPPs to be ordered even when signed paperwork did not authorize RPPs.

300. On June 8, 2020, a Principal representative told Mr. Whiles that she did not see a COVID-only test option on the new account form and did not want the full respiratory panel. Mr. Whiles told her she could write "COVID" next to the respiratory box. Four days later, another Principal representative asked what test she needed to check on the form, and Mr. Whiles instructed her: "You can check off the respiratory panel."

301. Numerous Benton House forms thereafter reflected COVID-only language or did not select RPP. For Benton House of St. Johns, the signed new

account form stated: "COVID 19 TEST" and "We do not approve any other test on this form ONLY COVID TEST." Mr. Howell later selected the RPP box after the physician signed.

302. Principal later confirmed that COVID-only testing was all that had been authorized absent a specific physician order for additional testing. On July 8, 2021, a Principal representative wrote that if the physician or PCP did not write an order for a respiratory panel instead of a COVID test, "we should only be doing the COVID pcr testing." On August 10, 2021, Principal confirmed that "unless a HCP specifically writes the order for something different, only the COVID test should be done."

303. Mr. Howell later said that when he spoke with Principal around this time, he learned that what Mr. Whiles' team had been doing was "not above board."

304. Mr. Whiles' team ordered approximately 2,093 RPPs for residents of Principal and Benton House communities, causing Medicare to pay approximately $1.2 million.

iv. Senior Living Management

305. Senior Living Management ("SLM") shows that communities and physicians understood Capstone to be providing COVID testing, not blanket RPP testing.

306. On June 24, 2020, an SLM representative wrote concerning the new account form that, once input, the doctor would not need to sign each order "so long as the order is for the standard COVID test." SLM thus understood the process to relate to COVID testing.

307. The next day, new account forms for Savannah Grand of Columbus and Savannah Grand of Bossier City were signed by Dr. Miguel Cossio. Although the RPP box was selected, the forms included "COVID PANEL ONLY" language and were accompanied by a separate letter specifying "COVID-19 testing." Dr. Cossio later denied authorizing RPPs and was not the treating physician for the SLM residents whose tests were billed under his name.

308. SLM also worked with Dr. Shahzad Khan to oversee COVID testing at numerous communities. Dr. Khan did not select RPP on the new account form, and COVID-19 was referenced in an attached note. Mr. Howell later selected RPP when creating separate new account forms for individual SLM communities. Dr. Khan did not authorize RPPs.

309. SLM later questioned the RPP testing. On August 11, 2020, an SLM community responded to Ms. Hart's request to continue COVID/RPP testing by stating: "I'm Not really sure what that means." After Ms. Hart explained that residents had been receiving COVID plus respiratory panel testing, the community responded: "I think all we want is the covid testing."

310. On February 5, 2021, SLM forwarded to Ms. Hart an internal communication stating: "The panel tests for 35 additional pathogens. It is inappropriate to do a respiratory panel on people with no respiratory symptoms. In addition, we have not obtained orders from our physicians to do this testing - only for COVID." Ms. Hart forwarded SLM's questions to Mr. Whiles, placing him on notice that SLM physicians did not authorize RPPs.

311. SLM later raised additional concerns that showed RPPs were not being used for resident care. In July 2021, SLM asked whether RPPs were covered by insurance and noted that the results were not being printed and shared with residents or physicians. Ms. Hart testified that Mr. Whiles told her not to recommend RPP for uninsured residents, further showing that the testing protocol was driven by reimbursement, not medical necessity.

312. On August 26, 2021, after Capstone received the government's CID, SLM wrote to Mr. Whiles that "unless specifically ordered on an individual basis by a resident or employee physician, the only testing that SLM expects to be provided by CapStone is COVID testing."

313. Mr. Whiles' team ordered approximately 4,947 RPPs for residents of SLM communities, causing Medicare to pay approximately $2.96 million.

v. LCB Senior Living

314. LCB Senior Living shows that RPPs were billed even where COVID-

only documentation existed and where communities complained that RPP testing had never been requested.

315. At Residence at Cedar Dell, the signed new account form crossed out RPP and included an instruction stating "COVID testing to all residents at the community." Despite that COVID-only documentation, Capstone billed Medicare for approximately 574 RPPs associated with Residence at Cedar Dell, resulting in approximately $300,000 in Medicare payments.

316. At Residence at Vinnin Square, Dr. Bryant-McKenney signed a new account form on which "COVID" was written beside the RPP selection. Dr. Bryant-McKenney later stated that she ordered only COVID testing and described the additional testing as an abuse of the system.

317. LCB later complained that RPPs had been billed even though the orders were for COVID. On November 25, 2020, LCB asked why residents were receiving RPP results and asked: "How is this being billed as the orders are just for Covid."

318. On March 2, 2021, a Residence at Melrose Station representative wrote that tests had been "done, billed BUT NEVER REQUESTED." Those complaints showed that LCB communities did not understand that RPPs were being ordered or billed as part of COVID testing.

319. Mr. Whiles' team ordered approximately 4,393 RPPs for residents of

LCB communities, causing Medicare to pay approximately $2,653,534.

vi. Five Star Senior Living

320. Five Star Senior Living shows that Mr. Whiles' team entered RPP orders even when the community and providers wanted COVID testing only.

321. On May 29, 2020, a new account form for Forum at Park Lane stated "COVID-19 per discussion with Austin" and "This is for COVID-19 testing of residents and employees." RPP was not selected. Nevertheless, Mr. Howell entered the account as COVID/RPP for residents because Mr. Whiles told him to put COVID/RPP.

322. On June 9, 2020, a new account form for Forum at the Woodlands stated "COVID19 only" and did not select RPP. Mr. Howell later confirmed that it was evident from that communication that the doctor wanted only COVID testing. Yet on July 14, 2020, Mr. Howell reported internally that he had "converted" Forum at the Woodlands to RPP for residents. Mr. Whiles' team never received an updated and signed new account form reflecting that change.

323. Five Star communities later complained about RPPs. On March 3, 2021, Mr. Whiles alerted Mr. Howell that Forum at the Woodlands was telling a patient's wife that RPP tests had not been ordered and should not be charged. Mr. Whiles instructed Mr. Howell to "get with the account and handle."

324. On March 30, 2021, Forum at the Woodlands wrote that residents

and team members had reported that RPP was being run when COVID tests were sent in, that the testing was hitting insurance for more than $1,100, and that the community was "only requesting the Covid test." Mr. Howell, copying Mr. Whiles, responded that Forum at the Woodlands would be COVID-only "for the time being."

325. The effect was immediate. Before that complaint, Capstone had billed approximately 497 RPPs for Forum at the Woodlands. Afterward, only two additional RPPs were billed. The collapse in RPP volume after Five Star insisted on COVID-only testing confirms that the prior RPP volume had been driven by Mr. Whiles' team's ordering practices, not by ordering providers.

326. Mr. Whiles' team ordered approximately 3,523 RPPs for residents of Five Star communities, causing Medicare to pay approximately $2,467,166.

vii. Grace Management

327. Grace Management shows that Mr. Whiles continued the scheme despite both RPP authorization defects and ordering provider enrollment problems.

328. Multiple Grace new account forms associated with Dr. O'Neil did not select RPP or lacked a second page selecting RPP. In numerous instances, Mr. Howell, Mr. Whiles, or others added the RPP selection after the physician signed. Mr. Whiles' team also convinced administrative staff at Grace to get

RPPs by telling them it was "normal testing procedure" and that everyone ran RPPs.

329. Dr. O'Neil later confirmed that he did not authorize RPPs and did not believe they were appropriate to run on everyone who received a COVID test.

330. Capstone also identified problems with Dr. O'Neil's Medicare enrollment. On November 30, 2020, Ms. Johnson forwarded to Mr. Whiles a communication stating that Dr. O'Neil and other providers were not enrolled with Medicare to bill claims. Mr. Whiles responded: "Good info! I will get with them today."

331. The warnings continued. On January 6, 2021, Ms. Hart sent Mr. Whiles a list of physicians and communities that did not have Medicare or Medicaid licenses, including Dr. O'Neil and multiple Grace communities. On February 11, 2021, Mr. Whiles stated that Dr. O'Neil's signature was active because he had "personally ensured it was." On March 31, 2021, Ms. Johnson told Mr. Whiles that Dr. O'Neil's Medicare enrollment "never completed and is still showing inactive."

332. Mr. Whiles therefore knew that Grace-related RPP claims had ordering provider defects. Nevertheless, testing and billing associated with Dr. O'Neil continued.

333. Mr. Whiles' team ordered approximately 1,371 RPPs for residents of Grace communities, causing Medicare to pay approximately $804,820.

viii. Additional Community Complaints

334. Other senior living communities raised the same concerns. In September 2020, The Enclave of Springboro complained that families were upset about "unnecessary test[s]" run with COVID testing. The community explained that residents had been exposed to COVID and needed COVID testing, but that "all of these other respiratory tests were ran that they 'didn't need.'" The community later stated that going forward it wanted testing "solely for COVID."

335. That same month, Morningside Ministries raised concerns about "Possible Medicare Fraud," stating that it "was not aware of any tests other than Covid that could have been done" and that if two people had billing "errors," there were likely more. Rather than stop the RPP process, Mr. Howell responded that Capstone would continue providing COVID-only tests for staff and COVID with RPPs for residents to detect "colonized viruses present in the community." Mr. Howell later explained that Mr. Whiles told him to call the community, explain what RPP was, and show the reports to keep the business.

A. Mr. Johnson and Mr. Whiles Continued Despite Internal Warnings and Client Complaints.

336. The warnings did not stop with billing personnel. By the fall of 2020 and continuing into 2021, Mr. Johnson and Mr. Whiles had repeated notice that

the senior living RPP scheme was generating claims without individualized treating provider orders or medical necessity determinations. As alleged above, billing personnel warned that Mr. Whiles' sales team should not be entering orders. Communities said they had requested COVID testing only. Families questioned charges for respiratory panels. Community personnel and providers denied authorizing RPP testing.

337. Compliance personnel raised the same concern internally. On September 23, 2020, Ms. Sheats emailed Mr. Johnson and Mr. Whiles about "Concerns on [Mr. Howell]," noting that Mr. Howell had 2,051 billed RPP samples for the prior month and that 998 of those samples—48%—were COVID-plus-RPP. Ms. Sheats described that rate as "unnaturally high" and asked whether Mr. Howell was placing client orders himself.

338. Mr. Whiles did not respond by stopping Mr. Howell's RPP volume or requiring treating providers to enter orders. Instead, he defended the process. Mr. Howell later explained that Mr. Whiles showed him Ms. Sheats' email, told him he needed to be compliant because he was "now on their radar," and that Mr. Whiles' statements in response to Ms. Sheats were not true.

339. The external complaints alleged above confirmed the same defect. Communities including Sonata, Watercrest, Principal, SLM, LCB, Five Star, Grace, The Enclave of Springboro, and Morningside Ministries raised concerns

that RPPs had not been authorized, had not been ordered by treating providers, were not appropriate for residents without respiratory symptoms, or had resulted in unexpected charges. Those complaints placed Mr. Johnson and Mr. Whiles on notice that the RPP claims were not being generated through individualized treating provider judgment.

340. Their response was to protect the business, not to fix the lack of medical necessity problems. Mr. Whiles and his team managed complaints, reassured communities, explained RPPs after the fact, shifted individual accounts to COVID-only when pressure became too great, and sought retroactive confirmations after the Department of Justice served a CID on Capstone. However, what they failed to do was implement a process that ensured treating providers made individualized medical necessity determinations before RPPs were ordered and billed.

341. That continued conduct confirms scienter. This was not a good-faith response to pandemic confusion. Mr. Johnson and Mr. Whiles opportunistically continued after billing personnel warned that sales team order entry was improper, after compliance personnel questioned abnormal RPP volume, after communities said they had requested COVID testing only, and after community personnel and providers denied authorizing RPPs. The scheme continued because RPPs generated revenue, commissions, and Medicare claims.

B. Mr. Whiles Routed Volume-Based Commissions to Himself Through Whitson Medical.

342. The reason Mr. Whiles continued pushing RPP volume despite repeated warnings was straightforward: he personally profited from it. Mr. Whiles did not merely execute Mr. Johnson's RPP strategy. He used other sales team members, including Mr. Howell, Ryan Whiles, and Mr. Brandt, to capture volume-based commissions that he could not openly receive himself.

343. Mr. Whiles' employment contract with Capstone prohibited him from receiving volume-based commissions. To get around that limitation, Mr. Whiles directed Capstone to hire Mr. Howell, Ryan Whiles, and Mr. Brandt as independent marketers paid volume-based commissions for laboratory testing business, including federally reimbursed RPPs.

344. Mr. Whiles used Whitson Medical to receive most of those commission proceeds. Although Whitson Medical was nominally a separate entity, Mr. Whiles owned and controlled it, used it to receive payments from Mr. Howell, Ryan Whiles, and Mr. Brandt, and then used those funds for his own benefit. Whitson Medical had no role in the scheme independent of Mr. Whiles.

345. The arrangement was simple. Mr. Whiles managed the marketers and told them what to do. Capstone sent their monthly commission statements to Mr. Whiles, who sent them to the marketers. Mr. Whiles told the marketers how much they could keep. The marketers then paid the rest to Whitson

Medical. Outwardly, Capstone was paying independent marketers. In reality, Mr. Whiles captured the bulk of those commissions for himself.

346. Mr. Howell was Mr. Whiles' close friend and top independent marketer. Mr. Whiles caused Mr. Howell to create Defy Medical so Defy could receive commission payments from Capstone. Mr. Whiles and Mr. Howell had a verbal agreement that Mr. Howell would keep half of the commissions Capstone paid to Defy, but in practice Mr. Whiles told Mr. Howell how much Mr. Howell could keep and how much Mr. Howell needed to pay to Whitson Medical.

347. Month after month, the same pattern played out: Capstone paid Defy, Defy transferred almost all the money to Whitson Medical, and Defy transferred a smaller amount—typically several thousand dollars—to Mr. Howell. The timing and amounts of the payments show that Mr. Howell was passing through Capstone commissions to Mr. Whiles.

348. For example, on June 29, 2020, Capstone paid Defy approximately $27,313. Two days later, Defy paid Whitson Medical $22,300. Three days after that, Defy transferred the remaining $5,000 to Mr. Howell's personal bank account. The next month followed the same pattern: Capstone paid Defy approximately $48,888, Defy paid Whitson Medical approximately $42,888, and Defy transferred the remaining $6,000 to Mr. Howell's personal bank account.

349. Mr. Howell wrote checks to Whitson Medical at Mr. Whiles'

direction. Mr. Whiles directed Mr. Howell to personally deliver checks to him or his wife, including at the hospital where Mr. Whiles' wife worked.

350. The documents confirm that Mr. Howell's payments were commission pass-throughs. In January 2021, Mr. Whiles' wife, Bristol Whiles, sent Mr. Howell an email titled, "Defy payments to Whitson 2020." The attached chart listed payments from Defy to Whitson Medical and was titled, "Comissions *[sic]* Paid to Whitson Medical from Defy Medical." The only commissions reflected in those payments were the commissions Mr. Howell had received from Capstone.

351. The checks told the same story. On 15 of the 16 available checks that Mr. Howell wrote to Whitson Medical, Mr. Howell identified the payment as that month's commission. For example, Defy's check to Whitson Medical dated January 29, 2021, includes "January Commission" on the memo line. Mr. Brandt likewise identified payments to Whitson Medical as commissions.

352. Ryan Whiles served the same pass-through function. Capstone paid Ryan Whiles commissions, and Ryan Whiles then transferred almost all commissions to Whitson Medical while keeping only a small amount for himself. For example, on February 26, 2021, Capstone paid Ryan Whiles approximately $213,486. The next day, Ryan Whiles paid Whitson Medical $206,386, leaving approximately $7,000 for himself. On March 24, 2021, Capstone paid Ryan

Whiles approximately $141,601. Two days later, Ryan Whiles paid Whitson Medical $134,600, again leaving approximately $7,000 for himself.

353. Mr. Brandt served a similar pass-through role. Although Mr. Brandt's payments to Whitson Medical did not always match Capstone's commission payments on the same monthly schedule as Mr. Howell's and Ryan Whiles' payments, the cumulative payments showed the same result: Mr. Brandt transferred substantial commission proceeds to Whitson Medical.

354. Mr. Whiles' control over the arrangement extended beyond the payment instructions. Mr. Whiles and his wife also prepared tax forms for Mr. Howell, further demonstrating Mr. Whiles' control over the commission pass-through.

355. The lopsided economics confirmed Mr. Whiles' control over the commissions. Mr. Howell, Ryan Whiles, and Mr. Brandt transferred nearly all commissions they received from Capstone to Whitson Medical and kept only a small portion for themselves. In substance, Mr. Howell, Ryan Whiles, and Mr. Brandt served as pass-throughs for commissions that Mr. Whiles pocketed.

356. The relationships among the participants further explain how Mr. Whiles was able to route commission proceeds to himself. Mr. Howell was Mr. Whiles' close friend. Ryan Whiles was Mr. Whiles' brother. Mr. Brandt was Mr. Whiles' father-in-law. Mr. Whiles also viewed the accounts serviced by Mr.

Howell, Ryan Whiles, and Mr. Brandt as his own accounts, and the pass-through arrangement allowed him to capture the commissions generated by those accounts without receiving those commissions directly from Capstone.

357. From March 2020 through September 2021, Capstone paid Mr. Howell, Ryan Whiles, and Mr. Brandt more than $5 million in volume-based commissions. Approximately $3.95 million of those commissions were attributable to federal health care program business. Mr. Howell, through Defy Medical, received approximately $3.57 million in commissions, including approximately $2.78 million attributable to federal health care program business. Ryan Whiles received approximately $1.16 million in commissions, including approximately $911,491 attributable to federal health care program business. Mr. Brandt, through Lakeside Promo, received approximately $300,195 in commissions, including approximately $258,801 attributable to federal health care program business.

358. Mr. Whiles ultimately received approximately 95% of the commissions paid to Mr. Howell, Ryan Whiles, and Mr. Brandt—approximately $4,753,864—through payments to Whitson Medical. Whitson Medical then spent more than $4.28 million of those funds for the benefit of Mr. Whiles and his wife, including by transferring approximately $2.47 million into their personal bank account, $600,000 into a Commerce Trust account, $150,000 into an American

Express account, nearly $60,000 into a Merrill Lynch account, nearly $49,000 for a car, and nearly $40,000 to Sallie Mae.

359. Those transfers confirm that Whitson Medical was Mr. Whiles' personal payment vehicle. The pass-through arrangement concealed Mr. Whiles' personal financial stake in the RPP volume generated by his team and gave him a direct incentive to maximize RPP volume, preserve accounts generating RPP claims, and ensure that Mr. Howell, Ryan Whiles, and Mr. Brandt continued receiving commissions that could be routed back to himself via Whitson Medical.

360. Mr. Whiles also received significant W-2 compensation and bonuses from Capstone. Between 2020 and 2021, Mr. Whiles received approximately $2.5 million in compensation from Capstone.

361. Mr. Johnson knew about and approved Capstone's volume-based commission payments to Mr. Howell, Ryan Whiles, and Mr. Brandt. As Capstone's CEO, Mr. Johnson caused Capstone to pay those marketers based on the laboratory testing volume they generated, including federally reimbursed RPP testing. Mr. Whiles also regularly sent Mr. Johnson commission reports showing the marketers' testing volume and commission payments.

362. Those volume-based commission payments were unlawful remuneration because they were paid to induce or reward the ordering, arranging for, or recommending of laboratory testing reimbursable by Medicare.

363. Mr. Whiles' pass-through arrangement further demonstrates his knowledge and intent and Whitson Medical's role in the scheme. Acting through Whitson Medical, Mr. Whiles used third-party marketers to capture commissions he could not receive openly, tied those payments to the RPP volume his team generated, and routed the proceeds through Whitson Medical for his own benefit.

C. After the CID, Mr. Whiles Tried to Paper Over Invalid RPP Orders and Commission Kickbacks.

364. On August 11, 2021, the Department of Justice served a CID on Capstone seeking documents and other materials related to the senior living RPP scheme. Within days, Mr. Whiles tried to create retroactive support for both sides of the scheme: the purported authorization for RPP orders and the commission payments routed to Whitson Medical. His post hoc attempts to fix the process clearly show what the original process lacked—valid, resident-specific RPP orders and legitimate support for the payments he had received through Whitson Medical.

i. Mr. Whiles Sought Retroactive Confirmations for RPP Standing Orders.

365. For the RPP orders, Mr. Whiles and his team sought retroactive confirmations to support the claim that physicians had authorized the standing orders his team had been using to generate RPPs. But those communications

exposed the defect in the original process. If the new account forms and prior communications had established valid, resident-specific treating provider orders for RPPs, Mr. Whiles' team would not have needed retroactive acknowledgments after the government served a CID.

366. The retroactive confirmations also exposed a deeper defect: RPPs could not be justified through community-wide standing orders. Each billed RPP required a treating provider's individualized determination that the test was medically necessary for the particular resident.

367. On August 16, 2021, Mr. Howell emailed the Enclave of Springboro stating that Capstone was "updating its records with current accounts who have conducted COVID Testing with us" and asked the community "to confirm testing protocol…remaining the same as COVID only for staff and COVID+Respiratory Panel for residents" with specified diagnosis codes. According to Mr. Howell, these emails kept Mr. Whiles calm and helped "button things up." Mr. Howell also said that Mr. Whiles was stressed because Capstone was being investigated and RPP testing would come under scrutiny because of the volume.

368. That same day, Mr. Whiles emailed Lake Crossing stating: "We are updating our standing orders with our communities as testing is starting to ramp back up," and asked the community to confirm that it and its medical provider

still wanted the same panels and diagnosis codes as before: COVID-only for employees and COVID/RPP for residents. That communication was particularly significant because Mr. Whiles told Mr. Howell that standing orders were not compliant and should not be mentioned in writing.

369. On August 18, 2021, Ms. Hart told Grace that Capstone was conducting an "internal audit" and asking every community to send an additional form to its signing medical provider. Ms. Hart explained: "We have the new account form, but this gives the lab some more confirmation." That explanation admitted that the new account form itself was not sufficient documentation of valid RPP orders.

370. Mr. Whiles' team sought similar retroactive confirmations from LCB, Principal, and Watercrest. Mr. Howell asked LCB and Principal to sign forms confirming, after the fact, that COVID-plus-RPP testing had been authorized or understood. Watercrest questioned the process, noting that Mr. Whiles had previously said one signature would suffice for all communities.

371. Mr. Howell later said that Mr. Whiles directed him to send the Principal email and came up with the language used. Mr. Howell also said that he and Mr. Whiles had dinner with a Principal representative the night before and tried to convince her to order RPPs, but she still wanted COVID-only testing.

372. These post-CID communications show that Mr. Whiles knew the

original documentation did not establish valid RPP orders. He tried to obtain after-the-fact confirmations to make prior RPP billing appear supported after the government began investigating. But retroactive confirmations from communities could not establish medical necessity, could not substitute for individualized treating provider judgment, and could not convert prior community-level testing protocols into valid resident-specific RPP orders.

ii. Mr. Whiles Tried to Disguise Commission Payments as Consulting Fees.

373. Mr. Whiles also tried to paper over the commission payments routed to Whitson Medical. As alleged above, Mr. Howell, Ryan Whiles, and Mr. Brandt had routed commission proceeds to Whitson Medical. Shortly after Capstone received the CID, Mr. Whiles "frantically" arranged for Mr. Howell to help create invoices describing the large payments to Whitson Medical as pursuant to a "Consulting Agreement." Mr. Whiles told Mr. Howell to come to his home, directed Mr. Howell to create invoices that would explain the large payments, and prepared, printed, and signed the invoices with Mr. Howell.

374. Mr. Whiles told Mr. Howell why he needed the invoices: the payments to Whitson Medical did "not look good." Mr. Whiles then told Mr. Howell to "get aligned with the fact that [he] was receiving consulting" from Whitson Medical.

375. Whitson Medical then used the same consulting story in response to

a CID. Whitson Medical characterized the payments as compensation for "extensive ongoing consulting services including the delivery of in-person and remote strategic and tactical advice, training and tutoring on the development of processes, targeting sales, programming and frequency implementation, messaging, product and process management, and time management, including review and assessment of ongoing performance and accomplishments of benchmarks."

376. However, Whitson Medical did not provide legitimate consulting services in exchange for the payments. Mr. Howell knew that no legitimate consulting services were provided. The services later described as "consulting" were the same sales management functions Mr. Whiles already performed in his capacity as Capstone's Vice President and sales leader.

377. The invoices themselves showed that they were after-the-fact cover documents. In some instances, the purported invoice was dated after the payment had already been made. For example, on April 2, 2021, Whitson Medical issued an invoice to Mr. Whiles for $3,870 for "Sales Consulting." But Mr. Whiles had already written Whitson Medical a check for that exact amount the day before, on April 1, 2021.

378. Mr. Howell's invoices showed the same problem. Defy repeatedly paid Whitson Medical before Mr. Howell supposedly received the corresponding

invoice. On January 29, 2021, Defy paid Whitson Medical $508,000; the corresponding invoice was marked received on January 31, two days after payment. On March 26, 2021, Defy paid Whitson Medical $431,355; the corresponding invoice was marked received on March 27, one day after payment. On May 28, 2021, Defy paid Whitson Medical $209,985; the corresponding invoice was marked received on May 29, one day after payment. On June 25, 2021, Defy paid Whitson Medical $145,562; the corresponding invoice was marked received on June 29, four days after payment.

379. The same irregular timing continued after Capstone received the CID. On August 26, 2021, Defy paid Whitson Medical $114,024. The corresponding invoice was dated August 27 and marked received on August 28—one day after payment and two days after the check. On September 24, 2021, Defy paid Whitson Medical $158,967; the corresponding invoice was marked received on September 25. On October 29, 2021, Defy paid Whitson Medical $156,300; the corresponding invoice was marked received on October 30. Those dates could not be reconciled with a legitimate process in which Whitson Medical invoiced Defy for services and Defy then paid the invoice.

380. The post-CID invoices indicated that no legitimate consulting services were provided. Before the investigation, Mr. Howell, Ryan Whiles, and Mr. Brandt routed commission proceeds to Whitson Medical. After the

investigation began, Mr. Whiles tried to relabel those same payments as consulting fees.

D. The Senior Living RPP Scheme Generated False Claims.

381. Medicare payment for RPP testing depended on the test being medically necessary, ordered by an authorized provider exercising individualized clinical judgment, and supported by accurate documentation, including provider-directed diagnosis codes and requisition information. Medicare also would not knowingly pay claims generated through illegal remuneration to recommend or assist with the ordering of federally reimbursable laboratory testing.

382. Mr. Johnson and Mr. Whiles knew those requirements. They knew that COVID testing did not justify blanket RPP testing, that asymptomatic or exposure-only testing did not support RPPs, and that repeated RPP testing required individualized medical necessity was not payable under Medicare. They also knew that treating providers—not sales personnel, community administrators, account managers, or internal order entry teams—had to determine whether a broad RPP was medically necessary for a particular beneficiary.

383. The senior living RPP claims lacked medical necessity because they were not based on individualized treating provider judgment. Instead, Mr.

Johnson and Mr. Whiles caused those claims to be generated through sales pressure, account-level paperwork, reusable provider signatures, standardized diagnosis codes, and internal order entry by Mr. Whiles' team.

384. That process did not establish that the signing provider treated the resident, identified symptoms warranting a broad respiratory panel, ordered the RPP for that resident, or intended to use the results to manage that resident's care. In many instances, the evidence showed the opposite: communities or providers requested COVID testing only, RPP was not selected, COVID-only language was clearly written on the form, RPP was added after the provider signed, and/or Mr. Whiles' team entered RPP orders despite paperwork that did not authorize RPP.

385. Community confirmations and standing order paperwork did not cure those defects. Community administrators could not make individualized medical necessity determinations, supply resident-specific diagnoses, or substitute for treating providers. Nor could a community-wide standing order establish that each billed RPP was medically necessary.

386. The same claims were independently false because they were tainted by illegal remuneration. Capstone paid volume-based commissions to Mr. Howell, Ryan Whiles, and Mr. Brandt to generate laboratory testing business, including federally reimbursable RPPs. Mr. Johnson approved and caused

Capstone to pay those commissions. Mr. Whiles then routed most of those commissions back to himself through Whitson Medical.

387. By causing Capstone, Genus3, and Sparrow to submit claims for those RPPs, Mr. Johnson and Mr. Whiles caused Medicare to pay claims that were false on two independent grounds. First, the RPPs lacked medical necessity because they were not based on individualized treating provider judgment. Second, the claims were tainted by illegal remuneration because they were generated through volume-based commission arrangements that violated the AKS.

388. From March 2020 through September 2021, Mr. Johnson and Mr. Whiles caused Capstone, Genus3, and Sparrow to submit or cause the submission of claims to Medicare for approximately 25,836 RPPs generated through the senior living scheme, resulting in approximately $13,109,669 in federal payments. Those claims were false and ineligible for payment.

389. The following table includes examples of claims that Medicare paid Capstone, Genus3, and Sparrow for RPPs that were not medically necessary and were tainted by illegal remuneration.

Beneficiary Initials	Date of Service	Ordering Provider	Who Submitted the Claim	Claim Submission Date	Medicare Paid Amount	Date of Medicare Payment
J.B.	6/26/2020	M.C.	ISPM Labs, LLC	7/13/2020	$687.17	7/27/2020
S.B.	8/6/2020	M.C.	ISPM Labs, LLC	8/20/2020	$687.17	9/3/2020
V.P.	8/18/2020	A.Z.	ISPM Labs, LLC	12/12/2020	$722.26	12/28/2020

Beneficiary Initials	Date of Service	Ordering Provider	Who Submitted the Claim	Claim Submission Date	Medicare Paid Amount	Date of Medicare Payment
C.W.	1/4/2021	M.C.	ISPM Labs, LLC	1/19/2021	$698.80	2/2/2021
S.F.	4/14/2021	A.Z.	Genus3, LLC	4/26/2021	$593.53	5/10/2021

SARAH HASLOCK RECEIVED AND RETAINED FUNDS DERIVED FROM THE FRAUDULENT SCHEME

390. Mr. Johnson personally received millions of dollars from Capstone and Genus3 while the fraudulent schemes alleged in this complaint were ongoing.

391. In 2020 alone, Mr. Johnson received approximately $3,015,677 from Capstone; $949,034 from Genus3; $582,000 from Sparrow. Those payments included a series of large bonuses paid while Capstone, Genus3, and others were generating false claims through the church fairs and the senior living RPP schemes.

392. The timing is significant. On August 5, 2020, the U.S. Attorney's Office for the Northern District of Georgia served a CID on Capstone. Two days later, Mr. Johnson received a $92,000 bonus from Capstone.

393. Mr. Johnson continued to receive substantial Capstone bonuses after that CID. Between September 2020 and December 2020, he received additional bonuses of $122,000, $150,000, $172,000, $200,000, $108,000, $1,000,000, and $700,000. During that same period, he received significant payments from Sparrow, including $50,000 on October 28, 2020; $40,000 on October 30, 2020;

$105,000 on November 24, 2020; $66,500 on December 8, 2020; and $40,428 on December 15, 2020. He also received four large payments from Genus3: $300,000 on December 28, 2020; $500,000 and another $81,534 on December 30, 2020; and $67,500 on December 31, 2020.

394. In January 2021, Mr. Johnson used $1,800,000 to purchase a beach house in St. Augustine, Florida.

395. In 2021, Mr. Johnson received approximately $10,257,615 from Capstone; $3,175,583 from Sparrow; and $2,122,830 from Genus3. Those payments included bonuses from Capstone of $500,000, $1,100,000, $500,000, $1,000,000, $2,500,000, $720,000, $2,500,000, $530,000, $330,000, and $280,000. They also included payments from Genus3 of $1,100,000, $500,000, and $400,000.

396. Mr. Johnson did not simply receive those funds and hold them in his own name. During and after the schemes, he transferred millions of dollars to Ms. Haslock, to accounts held for her benefit, or to entities she owned or controlled.

397. On May 28, 2021, Mr. Johnson transferred $3,000,000 to purchase a 10.8-acre equestrian estate in Ms. Haslock's name. Ms. Haslock was the sole registered owner of the property.

398. On August 1, 2021, Mr. Johnson made five transfers from his accounts to accounts jointly held with Ms. Haslock. The net value of those

transfers was approximately $1,926,525.

399. On August 11, 2021, the Department of Justice served another CID on Capstone. Two days later, the Department of Justice served a CID on Genus3.

400. Less than two months later, on October 1, 2021, Mr. Johnson transferred $10,000,000 from a personal account into an investment account called KSJ Investment Holdings. Ms. Haslock was a 50% beneficiary of the account.

401. On December 15, 2022, the Department of Justice conveyed to Mr. Johnson that it believed he had violated the False Claims Act for his role in the church fairs and senior living RPP schemes.

402. Mr. Johnson then made additional transfers to or for the benefit of Ms. Haslock.

403. On May 8, 2023, Mr. Johnson transferred approximately $3,010,934 from the KSJ Investment Holdings account to an investment account in Ms. Haslock's name.

404. On May 11, 2023, Mr. Johnson transferred $450,000 from the KSJ Investment Holdings account to an account held by 3490 Shipwreck LLC, an entity owned by Ms. Haslock.

405. On June 23, 2023, Mr. Johnson transferred another $1,300,000 from the KSJ Investment Holdings account to the same entity owned by Ms. Haslock.

406. In total, since 2021, Mr. Johnson transferred approximately $21,487,459 from accounts he controlled. Of that amount, approximately $14,926,000 was transferred to Ms. Haslock, to accounts jointly held with Ms. Haslock, to accounts for which Ms. Haslock was a beneficiary, or to entities owned or controlled by Ms. Haslock.

407. These transfers were not isolated or incidental. They occurred after Mr. Johnson had received millions of dollars from Capstone during the fraudulent schemes; after the government had served CIDs on Capstone and Genus3; and, in several instances, after the Department of Justice expressly conveyed that it believed Mr. Johnson had violated the False Claims Act.

408. The funds transferred to Ms. Haslock, directly or indirectly, were derived in whole or in part, from funds that Capstone paid to Mr. Johnson during the fraudulent schemes alleged in this complaint.

409. Ms. Haslock received, retained, or benefitted from those funds, even though the funds were derived, in whole or in part, from federal health care program payments for claims that were not medically necessary, were not validly ordered, were tainted by unlawful remuneration, or were otherwise ineligible for payment.

410. The United States seeks recovery from Ms. Haslock under common law theories because she received, retained, or benefitted from funds to which

she was not entitled and that, in equity and good conscience, should be returned to the United States.

COUNT I
False Claims Act, 31 U.S.C. § 3729(a)(1)(A)
Presenting False or Fraudulent Claims for Payment

411. The United States realleges and incorporates by reference all paragraphs of this complaint set out above.

412. From in or around 2019 through September 2021, Defendants Jay Johnson and Austin Whiles knowingly submitted, or caused to be presented, false or fraudulent claims for payment to Medicare, in violation of 31 U.S.C. § 3729(a)(1)(A), through both the church fairs scheme and the senior living RPP scheme.

413. During the period relevant to the senior living RPP scheme, Defendant Genus3 knowingly caused false or fraudulent claims to be presented to Medicare, in violation of 31 U.S.C. § 3729(a)(1)(A), for RPPs generated through that scheme. Genus3 submitted or caused the submission of RPP claims to Medicare.

414. Specifically, with respect to the church fairs scheme, Defendants Johnson and Whiles knowingly submitted or caused to be submitted claims to Medicare for laboratory tests that were not reasonable and necessary for the diagnosis or treatment of an illness or injury. The tests were not ordered by

treating providers for specific medical problems, were not based on individualized determinations of medical necessity, were not used by treating providers to manage beneficiaries' specific medical problems, and were induced by unlawful remuneration.

415. Specifically, with respect to the senior living RPP scheme, Defendants Johnson, Whiles, and Genus3 knowingly submitted, or caused to be submitted, claims to Medicare for RPPs that were not reasonable and necessary for the diagnosis or treatment of an illness or injury. The RPPs were not ordered by treating providers pursuant to individualized medical necessity determinations, were performed as impermissible screening or surveillance tests, were supported by diagnosis codes not selected by treating providers, and were not used by treating providers to manage beneficiaries' specific medical problems.

416. The claims were also false or fraudulent because they resulted from violations of the AKS. Defendants paid, received, offered, solicited, or caused unlawful remuneration to induce or reward the ordering, arranging for, or recommending of laboratory testing reimbursable by Medicare.

417. Had Medicare known these facts, the United States would not have paid these claims.

418. By reason of the foregoing, the United States suffered actual

damages and therefore is entitled to treble damages under the False Claims Act, in an amount to be determined at trial, plus civil penalties for each false or fraudulent claim.

COUNT II
False Claims Act, 31 U.S.C. §3729(a)(1)(B)
Making or Using False Records or Statements

419. The United States realleges and incorporates by reference all paragraphs of this Complaint set out above.

420. From in or around 2019 through September 2021, Defendants Johnson and Whiles knowingly made or used, or caused to be made or used, false records or statements material to false or fraudulent claims submitted to Medicare, in violation of 31 U.S.C. § 3729(a)(1)(B), through both the church fairs scheme and the senior living RPP scheme.

421. During the period relevant to the senior living RPP scheme, Defendant Genus3 knowingly made or used, or caused to be made or used, false records or statements material to false or fraudulent claims submitted to Medicare, in violation of 31 U.S.C. § 3729(a)(1)(B), for RPPs generated through that scheme. Genus3 made or used claim and billing records for RPP testing.

422. Specifically, with respect to the church fairs scheme, Defendants Johnson and Whiles made or used, or caused to be made or used, false records or statements representing that laboratory tests generated through health fairs and

church events were validly ordered, medically necessary, lawfully generated, and eligible for payment by Medicare.

423. Those records and statements were false because the tests were not ordered by treating providers for specific medical problems, were not based on individualized determinations of medical necessity, were not used by treating providers to manage beneficiaries' specific medical problems, and were induced by unlawful remuneration.

424. Specifically, with respect to the senior living RPP scheme, Defendants Johnson, Whiles, and Genus3 made or used, or caused to be made or used, false records or statements representing that RPPs were validly ordered, medically necessary, supported by appropriate diagnosis codes, lawfully generated, and eligible for payment by Medicare. Mr. Whiles, acting through Whitson Medical, made or used, or caused to be made or used, false records and statements that concealed remuneration tied to those RPP claims, including commission records, purported consulting invoices, and other records used to disguise commission pass-through payments as legitimate consulting fees.

425. Those records and statements were false because the RPPs were not ordered by treating providers, were performed as impermissible screening or surveillance tests, were not supported by diagnosis codes selected by treating providers based on individualized patient assessments, were not used by

treating providers to manage beneficiaries' specific medical problems, and were induced by unlawful remuneration.

426. These false records and statements included, among others, false or misleading claim submissions, certifications, requisitions, provider order documentation, diagnosis codes, new account forms, commission records, invoices, and other documents or data used to support claims for payment by Medicare.

427. Defendants made or used, or caused to be made or used, these false records or statements with actual knowledge of their falsity, deliberate ignorance of their truth or falsity, or reckless disregard of their truth or falsity.

428. These false records and statements were material to Medicare's decision to pay the claims.

429. Had Medicare known these facts, the United States would not have paid these claims.

430. By virtue of these false records and statements, the United States was damaged in the full amount of the false claims paid by Medicare, in an amount to be determined at trial, subject to trebling under the False Claims Act. Furthermore, Defendants are liable for civil penalties for each violation, with the number of violations to be determined at trial.

COUNT III
False Claims Act, 31 U.S.C. § 3729(a)(1)(C)

Conspiracy to Submit False Claims

431. The United States realleges and incorporates by reference all paragraphs of this Complaint set out above.

432. From in or around 2019 through September 2021, Defendants Johnson and Whiles knowingly entered into an unlawful agreement with each other and with one or more others to submit, and cause the submission of, false or fraudulent claims to Medicare, in violation of 31 U.S.C. § 3729(a)(1)(C), through both the church fairs scheme and the senior living RPP scheme.

433. During the period relevant to the senior living RPP scheme, Defendant Genus3 knowingly entered into or participated in an unlawful agreement with Johnson, Whiles, and one or more others to submit, and cause the submission of, false or fraudulent claims to Medicare for RPPs generated through that scheme. Genus3 participated by submitting or causing the submission of RPP claims generated through the scheme.

434. Specifically, with respect to the church fairs scheme, Defendants Johnson, Whiles, and their co-conspirators agreed to a plan by which, among other things, they would organize or participate in health fairs and church events; induce testing through unlawful remuneration; collect specimens from beneficiaries; cause laboratory testing to be performed without valid treating-provider orders or individualized medical necessity determinations; route

Capstone-generated genetic tests through Sovereign for billing; cause Medicare to be billed for those tests; and share, route, or retain proceeds from those claims.

435. Defendants Johnson, Whiles, Genus3, and their co-conspirators performed acts in furtherance of the church fairs conspiracy by, among other things, arranging and conducting testing events, recruiting beneficiaries for testing, obtaining or using purported provider-order documentation, causing specimens to be submitted for laboratory testing, using Why Not Productions as the contracting vehicle for the Sovereign arrangement, causing claims to be submitted to Medicare, and receiving or distributing proceeds from those claims.

436. Specifically, with respect to the senior living RPP scheme, Defendants Johnson, Whiles, Genus3, and their co-conspirators agreed to a plan by which, among other things, they would use senior living communities' demand for COVID-19 testing to obtain paperwork for RPP billing; cause RPPs to be performed without individualized treating provider orders or medical necessity determinations; use diagnosis codes not selected by treating providers based on individualized patient assessments; pay, receive, route, or conceal unlawful remuneration tied to testing volume; and cause Medicare to be billed for RPPs that were not medically necessary, were not validly ordered, and were tainted by unlawful remuneration.

437. Mr. Whiles' agreement to and participation in the senior living RPP

conspiracy is further shown by the commission-funneling arrangement. Mr. Whiles directed or caused Capstone to hire Mr. Howell, Mr. Whiles, and Mr. Brandt as independent marketers paid volume-based commissions for laboratory testing business, including federally reimbursed RPPs. Mr. Whiles managed those marketers, directed their sales activity, received and distributed their commission reports, dictated their commission amounts, and caused them to route most of the remaining commission proceeds to Whitson Medical. Through that arrangement, Mr. Whiles received and concealed remuneration tied to the RPP volume his team generated and the Medicare claims that resulted.

438. Defendants Johnson, Whiles, Genus3 and their co-conspirators performed acts in furtherance of the senior living RPP conspiracy by, among other things, directing senior living communities to select RPP when they sought COVID testing; changing paperwork after providers signed; causing RPPs to be ordered and performed without individualized treating provider orders or medical necessity determinations; using repeated diagnosis codes not selected by treating providers; billing Medicare for RPPs; paying or receiving volume-based commissions; routing commission proceeds to Whitson Medical; and creating or using purported consulting records to disguise commission pass-through payments.

439. Defendants Johnson, Whiles, Genus3, and their co-conspirators also

performed acts in furtherance of the conspiracies by retaining, distributing, transferring, concealing, or otherwise using proceeds from false or fraudulent claims for their own benefit.

440. Had Medicare known these facts, the United States would not have paid these claims.

441. By virtue of these false or fraudulent claims, the United States suffered damages and therefore is entitled to treble damages under the False Claims Act, in an amount to be determined at trial, plus civil penalties for each violation.

COUNT IV
Unjust Enrichment

442. The United States realleges and incorporates by reference all paragraphs of this Complaint set out above.

443. By virtue of the wrongful acts described in this Complaint, Defendants Johnson and Whiles obtained, retained, or benefitted from federal health care program funds to which they were not entitled through both the church fairs and the senior living RPP scheme.

444. By virtue of the wrongful acts described in this Complaint, Defendant Why Not Productions, acting through Mr. Johnson and as Mr. Johnson's alter ego, obtained, retained, or benefitted from federal health care program funds to which it was not entitled through the church fairs scheme.

445. By virtue of the wrongful acts described in this Complaint, Defendants Whitson Medical and Genus3 obtained, retained, or benefitted from Medicare funds to which they were not entitled through the senior living RPP scheme. Genus3 obtained or benefitted from Medicare payments for RPP claims generated through that scheme. Whitson Medical obtained or benefitted from commission proceeds routed from marketers whose commissions were tied to Medicare-reimbursable RPP testing and then used those proceeds for the benefit of Mr. Whiles and his wife.

446. By virtue of the wrongful acts described in this Complaint, Defendant Haslock obtained, retained, or benefitted from funds transferred to her, to accounts held for her benefit, or to entities owned or controlled by her, even though those funds were derived, in whole or in part, from Medicare payments for the claims alleged in this complaint.

447. The United States paid Medicare funds for laboratory tests that were not reasonable and necessary, were not validly ordered, were induced by unlawful remuneration, or were otherwise ineligible for payment.

448. The false or misleading representations that the laboratory tests were reasonable and necessary were material to Medicare's decision to provide reimbursement. Had Medicare known the facts described above, the United States would not have provided reimbursement.

449. The false or misleading representations that the laboratory tests were validly ordered by appropriate providers were material to Medicare's decision to provide reimbursement. Had Medicare known the facts described above, the United States would not have provided reimbursement.

450. The false or misleading representations that the laboratory tests were lawfully generated and not tainted by unlawful remuneration were material to Medicare's decision to provide reimbursement. Had Medicare known the facts described above, the United States would not have provided reimbursement.

451. Based on the above, Defendants were unjustly enriched. The circumstances dictate that, in equity and good conscience, the money should be returned to the United States, and it would be inequitable and unconscionable for Defendants to retain the funds they obtained, retained, or benefitted from as a result of the conduct alleged in this Complaint.

COUNT V
Payment by Mistake of Fact

452. The United States realleges and incorporates by reference all paragraphs of this complaint set out above.

453. By virtue of the wrongful acts described in this Complaint, the United States paid federal health care program funds under the mistaken belief that the claims at issue were for laboratory tests that were reasonable and

necessary, validly ordered, lawfully generated, not tainted by unlawful remuneration, and otherwise eligible for payment.

454. With respect to Defendants Johnson and Whiles, the United States paid Medicare funds by mistake of fact for claims generated through both the church fairs scheme and the senior living RPP scheme.

455. With respect to Defendants Genus3 and Whitson Medical, the United States paid Medicare funds by mistake of fact for claims generated through the senior living RPP scheme. Genus3 received or benefitted from Medicare payments for RPP claims that were not medically necessary, not validly ordered, or tainted by unlawful remuneration. Whitson Medical received or benefitted from commission proceeds tied to those mistakenly paid claims.

456. With respect to Defendant Why Not Productions, acting through Mr. Johnson and as Mr. Johnson's alter ego, the United States paid Medicare funds by mistake of fact for claims generated through the church fairs scheme and routed through the Sovereign arrangement.

457. By virtue of the wrongful acts described in this Complaint, Defendant Haslock obtained, retained, or benefitted from funds transferred to her, to accounts held for her benefit, or to entities owned or controlled by her, even though those funds were derived, in whole or in part, from Medicare payments for the claims alleged in this Complaint.

458. With respect to Defendant Haslock, the United States paid Medicare funds by mistake of fact for claims alleged in this Complaint, and Defendant Haslock obtained, retained, or benefitted from funds derived, in whole or in part, from those mistakenly paid claims.

459. The false or misleading representations that the laboratory tests were reasonable and necessary were material to Medicare's decision to provide reimbursement. Had Medicare known the facts described above, the United States would not have provided reimbursement.

460. The false or misleading representations that the laboratory tests were validly ordered by appropriate providers were material to Medicare's decision to provide reimbursement. Had Medicare known the facts described above, the United States would not have provided reimbursement.

461. The false or misleading representations that the laboratory tests were lawfully generated and not tainted by unlawful remuneration were material to Medicare's decision to provide reimbursement. Had Medicare known the facts described above, the United States would not have provided reimbursement.

462. Based on the foregoing, Medicare mistakenly paid funds to Capstone, Genus3, and Sovereign to which they were not entitled. Defendants obtained, retained, or benefitted from those funds, and the circumstances dictate

that, in equity and good conscience, the amount of these payments should be returned to the United States.

PRAYER FOR RELIEF

The United States requests that judgment be entered in its favor against Defendants identified in each Count, jointly and severally as appropriate, as follows:

(a) On Counts I through III (False Claims Act), against Jay Johnson and Austin Whiles for both the church fairs scheme and the senior living RPP scheme; and against Genus3 for the senior living RPP scheme only, for treble the United States' damages under the False Claims Act, together with the such civil penalties allowed by law, together with the costs of this action and such other and further relief as may be just and proper;

(b) On Count IV (Unjust Enrichment), against Jay Johnson and Austin Whiles for both the church fairs scheme and the senior living RPP scheme; against Why Not Productions for the church fairs scheme only; against Whitson Medical and Genus3 for the senior living RPP scheme only; and against Sarah Haslock, for the amounts by which Defendants were unjustly enriched, plus interest, costs, and expenses, and for all such other relief as the Court deems equitable;

(c) On Count V (Payment by Mistake), against Jay Johnson and Austin Whiles for both the church fairs scheme and the senior living RPP scheme; against Why Not Productions for the church fairs scheme only; against Whitson Medical and Genus3 for the senior living RPP scheme only; and against Sarah Haslock, for the amounts by which Defendants were overpaid by Medicare, plus interest, costs, and expenses, and for all such other relief as the Court deems equitable; and

(d) Such other relief as the Court may deem appropriate.

JURY DEMAND

Pursuant to Rule 38 of the Federal Rules of Civil Procedure, the United States requests a trial by jury.

Dated: September 17, 2026.

Respectfully submitted,

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Certificate of Compliance

I hereby certify, pursuant to Local Rules 5.1 and 7.1D, that the foregoing brief has been prepared using Book Antiqua, 13 point font.

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