

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MISSOURI
EASTERN DIVISION

UNITED STATES OF AMERICA,)
)
 Plaintiff,)
)
 v.) Case No.: 4:03CV01090-HEA
)
 CATHEDRAL ROCK CORPORATION,)
 et al.,)
)
 Defendants.)

**THE UNITED STATES’ MEMORANDUM IN OPPOSITION TO DEFENDANTS’
MOTION TO DISMISS THE COMPLAINT IN INTERVENTION**

Defendants seek to dismiss the United States’ Complaint in Intervention (Complaint), in its entirety and with prejudice, for failure to state claims upon which relief can be granted, lack of subject matter jurisdiction, and failure to plead fraud with particularity. For the reasons set forth below, Defendants’ Motion is without merit and should be denied.

I. Introduction.

After a thorough investigation of the numerous allegations set forth in the relators’ qui tam, the United States filed a detailed Complaint in Intervention (Complaint) reflecting a careful selection of claims and defendants along with a declination to intervene as to certain other claims and defendants. The United States has brought allegations under both the False Claims Act (“FCA”), 31 U.S.C. § 3729, et seq., and federal common law that are neither novel nor conclusory. Rather, the United States has set forth in more than sufficient detail the gross failures of care at the Defendant Nursing Facilities,¹ the resulting submission of false claims to both Medicare and Medicaid, the corporate structure that both allowed the failures of care and

¹ “Defendant Nursing Facilities” refers collectively to Defendants SpringPlace, McLaran, Oak Forest, Cathedral Gardens and Blanchette. Complaint, ¶ 17.

caused the submission of false claims, and the specific role of each Defendant.

First, Defendants assert that the Complaint fails to state a claim under Fed.R.Civ.P. 12(b)(6) on three grounds: (i) there is no FCA liability for submitting claims for “worthless services;” (ii) there is no FCA liability for an intracorporate conspiracy, and; (iii) the United States has “blurred” Defendants and has not alleged facts sufficient to pierce the corporate veil. These arguments fail. It is widely established that FCA liability exists for the submission of claims for deficient products or substandard services. Against this backdrop, after examining the history and purpose of the FCA, numerous courts have upheld a “worthless services” theory in the nursing facility context. Significantly, in the criminal context, in United States v. Wachter, American HealthCare Management, et al., 2006 WL 2460790, Case No. 4:05CR667-SNL (E.D.Mo. 2006), a United States District Judge in this district noted the wide acceptance of the “worthless services” theory under the FCA and used the rationale behind those cases to deny a motion to dismiss an indictment in a context very similar to the case before this Court. When viewing the allegations of the Complaint as true and drawing all reasonable inferences in favor of the United States, all of Defendants’ arguments for dismissal under Rule 12(b)(6) are without merit.

Second, in support of their argument for dismissal for lack of subject matter jurisdiction, Defendants ignore well-settled Eighth Circuit precedent regarding the joint federal and state nature of Medicaid, misread the plain language of the FCA, and present an overlying expansive reading of United States ex rel. Totten v. Bombardier, 380 F.3d 488 (D.C. Cir. 2004). At the outset, Defendants’ argument for lack of subject matter jurisdiction is fatally flawed because it is premised on the faulty assertion that Medicaid is a state, rather than joint federal and state, program. Lankford v. Sherman, 451 F.3d 496, 504 (8th Cir. 2006). Further, Defendants have

presented an overly narrow construction of the FCA by claiming that the FCA contains a requirement for a direct presentment of a claim to the United States from a defendant. In doing so, Defendants have overlooked that the FCA also expressly imposes liability not only on those who submit false claims to the United States, but also upon those who more broadly “cause” such claims to be submitted. 31 U.S.C. §§ 3729(a)(1) & (2). Similarly, the FCA explicitly defines “claim” to include, in specified circumstances, requests for payment made to a contractor, grantee, or other recipient of federal funds. 31 U.S.C. § 3729(c). Defendants’ reliance on the absence of a direct presentment of a claim from Defendants to the United States is irreconcilable with the FCA’s plain language.

Defendants rely heavily on the D.C. Circuit’s holding in Totten. An examination of the holding in Totten does not support its application here where claims for payment of federal funds were ultimately presented to the federal government for payment. Thus, this Court need not reach the issue of whether the Totten decision is correct. Nevertheless, Totten is in direct conflict with a more persuasive and recent decision from the United States Court of Appeals for the Sixth Circuit, Sanders v. Allison, 471 F.3d 610 (6th Cir. 2006) (petition for cert. filed Aug. 17, 2007) (No. 07-214) (holding that presentment to the federal government is not necessary under (a)(2) or (a)(3) and that whether presentment is directly to the government’s employees or through an intermediary, liability under (a)(1) may attach). The well-reasoned opinion in Sanders, which is supported by a plain reading of the FCA and numerous other cases, demonstrates that jurisdiction in this case is proper under the FCA.

Third, Defendants assert that the Complaint fails to satisfy the particularity requirement of Fed.R.Civ.P. 9(b). A straightforward reading of the United States’ allegations demonstrates that Defendants’ Rule 9(b) arguments are without merit. Defendants’ conclusory assertions that

the Complaint contains no information about how each claim was false and that it gives no facts about what claims were submitted suggest a “boilerplate” motion that ignores the Complaint’s detailed allegations.

Defendants’ Motion to Dismiss fails on all points and should be denied.

II. The Complaint Satisfies Fed.R.Civ.P. 12(b)(6) Because It States Numerous Claims Upon Which Relief Can Be Granted Against Each Defendant.

A. Standard When Ruling On A Motion To Dismiss.

The Supreme Court recently articulated the standard for a court to follow in ruling on a Motion to Dismiss. In Bell Atlantic Corp. v. Twombly, ___ U.S. ___, 127 S.Ct. 1555, 1569 (May 21, 2007), the Court found that a plaintiff must plead enough facts to state a claim for relief that is plausible. Id. at 1574. When considering a motion to dismiss, however, courts are required to accept the complaint’s factual allegations as true. Id. at 1565. All reasonable inferences from the complaint must be drawn in favor of the nonmoving party. Crumpley-Patterson v. Trinity Lutheran Hosp., 388 F.3d 588, 590 (8th Cir. 2004).

While claiming to seek dismissal under Rule 12, Defendants repeatedly and consistently ignore these standards. For example, in the first paragraph of their Memorandum (“Mem.”), Defendants immediately dispute the United States’ allegations and make their own assertions regarding improvement of care at the Defendant Nursing Facilities. Mem. at 1. Moreover, rather than drawing reasonable inferences from the allegations that favor the United States, Defendants ask the Court to do precisely the opposite by giving allegations labels such as “irrelevant factoids,” and drawing inferences in Defendants’ favor, e.g., claiming that certain allegations “show nothing more than that Mr. Harrington was trying to run a business.” Mem. at 11. While Defendants can raise these fact-based arguments at trial, the pending Motion to

Dismiss is the wrong vehicle with which to dispute facts.

Applying the correct legal standards, the Complaint states a claim upon which relief can be granted and Defendants' Motion to Dismiss on this basis should be denied.

B. The Complaint States Claims For “Worthless Services” Under the FCA.

The Complaint states a claim under the FCA because the provision of substandard goods or services to the United States can form the basis for FCA liability. Contractors who provided substandard or worthless products were the reason Congress enacted the FCA. United States ex rel. Newsham v. Lockheed Missiles and Space Co., 722 F. Supp. 607, 609 (N.D. Ca. 1989).

Courts consistently have upheld FCA liability for billing for deficient products. United States v. McNinch, 356 U.S. 595, 599 (1958); United States ex rel. Hopper v. Anton, 91 F.3d 1261, 1266 (9th Cir. 1996) (FCA “actions have also been sustained under theories of supplying substandard products or services”); United States v. Advance Tool, 902 F.Supp. 1011 (W.D.Mo. 1995) (finding FCA liability when substitute goods were delivered, even if the substitute goods were as good as those required because the claims requested payment for the brand name goods requested).

When the lower threshold of substandard goods or services can form the basis of FCA liability, it is axiomatic that billing the government for a product or service that is of no value, if done with the requisite scienter, violates the FCA. U.S. v. Bornstein, 423 U.S. 303 (1976). The government may not be billed for services that are so deficient that they have no value. United States ex rel. Lee v. SmithKline Beecham, Inc., 245 F.3d 1048, 1053 (9th Cir. 2001). Thus, “[k]nowingly submitting claims against the United States for Medicare and Medicaid services not actually performed clearly violates the FCA.” United States v. NHC Healthcare Corp., 115 F.Supp.2d 1149, 1155-56 (W.D.Mo. 2000) (noting Government argues that it paid the defendant

for complete care of elderly patients). If the United States pays for nursing services, it can and should expect that its Medicaid and Medicare beneficiaries actually receive them. “The statement that certain services were rendered is clearly an essential part of a claim submitted to the government ... and such a statement would obviously tend to induce government action ...” United States v. Adler, 623 F.2d 1287, 1289 (8th Cir. 1980) (submitting health care claims for services not rendered a material misstatement that can support criminal liability); United States v. Gordon, 548 F.2d 743 (8th Cir. 1977) (affirming a criminal conviction for submitting claims to Medicare for services not provided).

In line with this well-settled authority, the Complaint alleges that the failure to provide the nursing services at the Defendant Nursing Facilities was so substantial that it rendered the services medically worthless. The determination of what constitutes worthless services is fact-specific and certainly cannot be resolved on a motion to dismiss. This is particularly true of services billed by the providers of skilled nursing services. Although skilled nursing care is at the heart of the bargain with the providers of nursing services, Medicare and Medicaid pay a bundled per diem rate that includes the provision of other ancillary services based on its recognition that such services are integral to the provision of skilled nursing care. These ancillary services include room, board, and routine care such as feeding and hydration. For example, if a resident who needs help with eating is not fed, other nursing care will be of little value to this resident who may ultimately die due to malnutrition. Under these circumstances, even if some services are provided, the services offered by the provider as a whole are properly considered worthless, and the provider’s claim for payment is no less fraudulent, and no less actionable under the FCA, than if it had simply failed to provide any services at all. See, supra, Newsham, McNinch, Hopper, Advance Tool.

In United States v. NHC Healthcare, 163 F. Supp. 2d 1051, 1055-56 (W.D. Mo. 2001), the complaint alleged that patients were given grossly inadequate care and developed pressure sores, incurred weight loss, and suffered unnecessary pain because the defendant knowingly maintained inadequate staffing and supplies at its facility to provide the requisite care, but knowingly billed for care nonetheless. The court denied the defendant's motion to dismiss for failure to state a claim and subsequently denied its motion for summary judgment stating:

NHC agreed to provide "the quality of care which promotes the maintenance and enhancement of the quality of life." At some blurry point, a provider of care can cease to maintain this standard by failing to perform the minimum necessary care activities required to promote the patient's quality of life. When the provider reaches that point, and still presents claims for reimbursement to Medicare, the provider has simply committed fraud against the United States.

Id. See also United States v. Momence Meadows Nursing Center, 2007 WL 685693 (C.D. Ill. March 2, 2007); Fischer v. United States, 529 U.S. 667, 679 (2000) (noting that Medicare payments are made "not simply to reimburse for treatment" but to "maintain a certain level of quality medical care...").

Recently, two judges in this district have acknowledged that a worthless services theory can be the basis for FCA liability as well as the basis for criminal health care fraud. In United States v. Wachter, American HealthCare Management, et al., 2006 WL 2460790, Case No. 4:05CR667-SNL (E.D.Mo. 2006), the Honorable Stephen N. Limbaugh accepted Magistrate Judge Noce's Report and Recommendation and denied the defendants' motion to dismiss the indictment alleging health care fraud based, in part, on a theory of submitting claims to Medicare and Medicaid for worthless services in nursing facilities. In denying the defendants' motion to dismiss the indictment, the court acknowledged the "worthless services" doctrine found in numerous civil cases and held that it was sufficient, in the criminal context, to withstand a

motion to dismiss on the grounds that the theory would render a criminal statute void for vagueness. Id. at *11 (citing to numerous cases that have applied the “worthless services” doctrine in civil cases and noting that the doctrine has been recognized as a basis for relief under the FCA).

Defendants claim that two district court decisions, United States ex rel. Swan v. Covenant Care, Inc., 279 F. Supp. 2d 1212 (E.D. Ca.) and United States ex rel. Sweeney v. ManorCare Health Services, Inc., 2005 WL 4030950 (W.D. Wash. March 4, 2005), “mandate dismissal” of the Complaint. Mem. at 16. In Sweeney, the United States declined to intervene in a qui tam where the relator alleged FCA violations because the defendant nursing facility was not administering certain dietary supplements and snacks. Id. at *1. The unpublished decision in Sweeney that Defendants rely upon was modified after the filing of a second amended complaint. In the modified order, the district court stated as follows:

the Court takes no position on the viability of “quality of care” or “worthless services” as theories of recovery under the FCA in a nursing home setting under different facts. Clearly, each case should be decided on a case to case basis.

United States ex rel. Sweeney v. ManorCare Health Services, Inc., Case No. C03-5320RJB (W.D. Wash. Feb. 27, 2006 Order, p.9) (attached as Exhibit 1). Sweeney is clearly distinguishable on its facts and in no way mandates dismissal of the Complaint.

To the extent that Swan stands for the proposition that in order for regulatory violations to give rise to FCA liability, certification of regulatory compliance must be a prerequisite to payment, Swan has no applicability to the Complaint before the Court. Swan, at 1221-22. To the extent that the court in Swan declined to recognize that the provision of substandard goods and services, or worthless services, can violate the FCA, Swan was wrongly decided and its rationale has been rejected by this district and others. See argument supra; United States v.

Wachter, et al.

Based on the above, Defendants' argument that a "worthless services" theory cannot be the basis for FCA liability must be rejected. Similarly, Defendants' argument that the Complaint has not adequately pled such a claim must be rejected because the Complaint is replete with specific and detailed allegations of the failures. E.g., staffing problems (¶¶ 79-90); failure to pay vendors (¶¶ 91-102); focus on census over patient care (¶¶ 105-113); focus on profits over patients (¶¶ 116-125); lack of control over controlled substances (¶¶ 126-131); falsification of records at SpringPlace (¶¶ 132-140); and lack of wound care at Blanchette and SpringPlace (¶¶141-143). The Complaint is similarly detailed as to the Defendants' knowledge (¶¶ 144-168) and the specific residents that are representative of the scheme involving the submission of claims for failure of care (¶¶ 175-280).

Defendants further argue, as a matter of public policy, that the United States should not be involved in setting health care standards and that failure to follow statutory, regulatory or professional standards should not and does not result in FCA liability. As set forth above, the United States' is not simply asserting claims for regulatory violations or violations of professional standards. Rather, the applicable regulatory and professional standards play a role in the fact-specific inquiry as to whether the claims that were submitted to Medicare and Medicaid were false in that they were for "worthless services." Regulatory and professional standards in no way supplant the FCA and common law claims that the United States has alleged.

Because the Complaint states claims under a "worthless services" theory, Defendants' Motion to Dismiss under Rule 12 should be denied.

C. The Complaint States An FCA Conspiracy.

Defendants assert that there cannot be a conspiracy “amongst corporations, their affiliates, and their employees.” Mem. at 19. However, “the question of whether a person was a participant in a conspiracy is a question of fact.” United States v. Murphy, 937 F.2d 1032, 1039 (6th Cir. 1991) citing United States v. August, 745 F.2d 400, 405 (6th Cir. 1984) and Ghandi v. Police Dept. of Detroit, 747 F.2d 338, 345 (6th Cir. 1984) (recognizing that cases involving conspiracy allegations are not well suited to summary judgment). Certainly, fact questions abound as to whether the law upon which Defendants rely is applicable to the conspiracy allegations in Count III of the Complaint.

The United States alleges that certain Defendant corporations are “holding companies” for one another. Complaint, ¶ 6 (Cathedral Rock Corporation is a holding company for Cathedral Rock of Missouri, Inc.), ¶ 7 (Cathedral Rock of Missouri is a holding company for the Defendant Nursing Facilities). The United States alleges that Cathedral Rock Management LP is a limited partnership, and two of the remaining Defendants are the limited partners in that partnership. Complaint, ¶¶ 8-9 (Cathedral Rock Investment, Inc. is the limited partner of Cathedral Rock Management); and ¶ 10 (Cathedral Rock Management I, Inc. is the general partner of Cathedral Rock Management). The United States makes numerous allegations regarding Defendant Harrington’s ownership and control, however, the United States has alleged an employment relationship only with Defendant Cathedral Rock Corporation. Complaint ¶ 18. Based upon these allegations, and others, there are numerous disputes of fact and unresolved facts regarding the exact relationship between and among Defendants.

As to Defendant Harrington, Count III alleges a conspiracy far beyond he and his employer. It alleges a conspiracy with other corporate entities and with a partnership, Cathedral Rock Management LP, with whom the United States has not alleged an employment

relationship. Moreover, Defendants have conceded that an officer can conspire with his corporation when the officer is acting outside of the scope of his employment or official capacity. Mem. at 19 (arguing that a corporation cannot conspire with its own officers while the officers are “acting in their official capacity”). Based upon the numerous allegations against Defendant Harrington, see page 26 below, it is certainly disputed whether Defendant Harrington was, at all times, acting within the scope of his employment or official role.

As to the partnership of Cathedral Rock Management LP, the United States has made numerous allegations regarding its role in the control of the Defendant Nursing Facilities that are factually sufficient to show that it was a member of the conspiracy. “Unlike fraud and mistake, it is unnecessary to plead conspiracy claims with any greater specificity than other legal claims.” Alfaro v. E.F. Hutton & Co., 606 F. Supp. 1100, 1117 (E.D. Pa. 1985). At the motion to dismiss stage of these proceedings, there is not sufficient undisputed evidence before this Court regarding the relationship of the parties to make a determination as to whether this partnership, based upon its relationship with the other Defendant corporations and Defendants Harrington, was legally incapable of participating in the alleged conspiracy. These same factual issues arise between and among all of the Defendants set forth in Count III.

For these reasons, and in accordance with the standards governing dismissal under Rule 12, Defendants’ Motion should be denied.

D. The Complaint States Claims For Equitable Theories.

In asking the Court to dismiss the Complaint in its entirety, and with prejudice, Defendants have virtually ignored the United States’ claim of common law fraud and its equitable claims for unjust enrichment and disgorgement of profits. Regardless of any ruling on Counts I - III under the FCA, Counts IV - VI state claims and are properly before the Court.

Defendants have not set forth any persuasive legal argument as to why Counts IV (common law fraud), V (unjust enrichment), and VI (disgorgement of profits) fail to state a claim other than simply stating that Count IV must be dismissed because it relies on the “same theory” as Counts I - III, and that Counts V and VI are simply remedies. Mem. at 19.² On the contrary, each of these Counts stands alone as a claim to recover improperly paid Medicare and Medicaid funds. Stone v. U.S., 286 F.2d 56, 61 (8th Cir. 1961) (“Where monies are erroneously paid by agents of the United States, whether the error be one of fact or of law, the Government may always recover the money improperly paid.”)

III. Defendants’ Motion To Dismiss Under Fed.R.Civ.P. 12(b)(1) Should Be Denied Because Subject Matter Jurisdiction Under the False Claims Act Is Proper.

A. Medicaid Is a Joint Federal and State Program.

Defendants argue that this Court lacks subject matter jurisdiction under the FCA over any false Medicaid claims because “Missouri Medicaid is a program of the government of the state of Missouri.” Mem. at 3. In making this assertion, Defendants (1) misquote the averment in the United States’ Complaint; (2) ignore well-settled Supreme Court and Eighth Circuit law; and (3) inexplicably rely on the district court decision of United States ex rel. Atkins v. McInteer, 345 F. Supp. 2d 1302 (N.D. Ala. 2004), when the United States Court of Appeals for the Eleventh Circuit reversed the district court on the issue of lack of subject matter jurisdiction and specifically stated that the Alabama Medicaid Agency was a “jointly run state and federal program.” United States ex rel. Atkins v. McInteer, 470 F.3d 1350, 1352 n.1 (11th Cir. 2006).

² To the extent that Defendants seek dismissal under Rule 9 as well as Rule 12, Rule 9 is not applicable to equitable claims such as unjust enrichment and disgorgement. American Cleaners and Laundry v. Textile Processors, 482 F. Supp. 2d 1103 (E.D.Mo. 2007) (federal common law unjust enrichment count would not be dismissed for failure to plead fraud with particularity).

First, Defendants cite to ¶ 34 of the Complaint and assert that Missouri Medicaid is a state program. In reality, ¶ 34 of the Complaint states quite the contrary -- that “Medicaid is a joint federal-state program funded under Title XIX of the Social Security Act.” (emphasis added). In addition to this allegation, the Eighth Circuit has recognized that Medicaid is a joint federal and state program, financially subsidized by federal dollars.

The Medicaid Act is a federal aid program designed to help the states provide medical assistance to financially-needy individuals, with the assistance of federal funding. See Schwiker v. Hogan, 457 U.S. 569, 572, 102 S.Ct. 2597, 73 L.Ed.2d 227 (1982). Hodgson v. Bd. of County Comm’rs, 614 F.2d 601, 606 (8th Cir. 1980). Participation is voluntary, but if a state decides to participate, it must comply with all federal statutory and regulatory requirements. See Schweiker v. Gray Panthers, 453 U.S. 34, 37, 101 S.Ct. 2633, 69 L.Ed.2d 460 (1981); Bowlin v. Montanex, 446 F.3d 817, 818 (8th Cir. 2006), citing Kai v. Ross, 336 F.3d 650, 651 (8th Cir. 2003). To participate, a state submits a plan to the Secretary of the Department of Health and Human Services that meets the requirements of 42 U.S.C. § 1396a(a) (citations omitted). Once the plan is approved, the federal government subsidizes the state’s medical assistance services. See 42 U.S.C. § 1396; Alexander v. Choate, 469 U.S. 287, 289 n. 1, 105 S.Ct. 12, 83 L.Ed.2d 661 (1985).

Lankford v. Sherman, 451 F.3d 496, 504 (8th Cir. 2006).

Defendants rely heavily on Atkins v. McInteer, 345 F. Supp. 2d 1302 (N.D. Ala. 2004), and assert that it stands for the proposition that Medicaid is “an organ of state government” and, as such, Medicaid claims cannot form the basis for jurisdiction under the FCA. Defendants’ reliance on this district court decision is wholly misplaced. On appeal, the United States Court of Appeals for the Eleventh Circuit disagreed with the district court’s dismissal for lack of subject matter jurisdiction on the very same argument that Defendants present here and stated “Medicaid is a jointly run state and federal program.” United States ex rel. Atkins v. McInteer, 470 F.3d 1350, 1352 at n.1 (11th Cir. 2006).³

³The district court’s dismissal was affirmed on the alternative basis of failure to comply with Fed.R.Civ.P. 9(b).

To the extent that Defendants' argument for lack of subject matter jurisdiction under the FCA is premised on their assertion that Medicaid is a state program, the Motion should be denied.

B. Defendants Have Misconstrued the Presentment Requirement Under The FCA.

Defendants further argue that allegations of Medicare and Medicaid fraud do not fall within the scope of the FCA absent the Defendants' direct submission of false claims to a federal officer or employee. This argument is also without merit. The FCA imposes liability for civil penalties and treble damages upon any person who "knowingly presents, or caused to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment for approval." 31 U.S.C. § 3729(a)(1). Significantly, FCA liability exists not only with respect to any person who submits a false claim, but also with respect to any person who "causes" a false claim to be submitted. *Id.*; 31 U.S.C. § 3729(a)(2) (imposing liability upon any person who "knowingly, makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government.")

The FCA also contains a broad definition of "claim." § 3729(c). Under the FCA, a "claim" is defined as not only those claims submitted directly to the Government, but also claims submitted to a federal "contractor, grantee, or other recipient if the United States Government provides any portion of the money or property which is requested or demanded, or if the Government will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded." 31 U.S.C. § 3729(c).

The Complaint alleges exactly what is required to state a claim under the FCA – that Medicare and Medicaid are federally funded and that the Defendants submitted or caused the submission of false claims to Medicare and Medicaid. Complaint ¶ 23 (the submitting and causing the submission of false claims); ¶ 28 (the United States pays through Medicare, and the United States and the State jointly pay through Medicaid); ¶ 34 (Medicaid is a joint federal-state program); ¶¶ 175-176, 184, 191, 198, 205, 213, 220, 228, 235, 241, 244, 251, 258, 264, 270, 274, 280 (submission of claims to Medicare, Medicaid, or both); ¶ 282 (submitting and causing the submission of false claims to Medicare, Medicaid, or both); ¶ 286 (making or using, or causing to be made or used, false records in support of getting false claims paid by Medicare, Medicaid, or both); ¶ 291 (conspiring to get false claims paid by Medicare, Medicaid, or both).

Moreover, 42 U.S.C. § 1396b(a) makes it clear as a matter of law that Medicaid claims are, albeit indirectly, presented to the federal government for payment. Defendants have set forth an incorrect interpretation of how the Medicaid program is administered by claiming that “[s]tates are paid a lump sum called the Federal Medical Assistance Percentage (‘FMAP’), the amount of which is determined on a year-by-year basis by the federal Department of Health and Human Services.” Mem. at 5. Under Medicaid the FMAP is, as indicated by its name, not a lump sum, but rather a percentage. That percentage, which is established for each state, is used to determine the amount of federal matching funds that each particular state will receive for its Medicaid expenditures. For example, in fiscal year 2006, the FMAP for Missouri was set at 61.93%. See 69 F.R. 68370-01, 2004 WL 2671369 (2004); 42 U.S.C. § 1396d(b). By statute, payments are based upon Medicaid expenditures, consistent with the particular State’s Medicaid plan. See 42 U.S.C. § 1396b(a) (“Computation of amount”) (setting forth that the Secretary “shall pay to each State” with an approved plan, for each quarter, an amount equal to the FMAP

“of the total amount expended during such quarter as medical assistance under the State plan,” subject to numerous other conditions set forth in the statute). This statutory scheme reflects ultimately presentment of Medicaid claims to the federal government for payment.

Because the FCA does not require a direct presentment of a claim to the federal government by a defendant, Defendants’ Motion for lack of subject matter jurisdiction fails.

C. United States ex rel. Totten v. Bombardier Is Not Applicable Or Controlling And, Alternatively, Does Not Require Dismissal of The Complaint.

The crux of Defendants’ argument for lack of subject matter jurisdiction is what they describe as the “seminal” case of United States ex rel. Totten v. Bombardier, 380 F.3d 488 (D.C. Cir. 2004). In Totten, in the context of allegedly false claims submitted to Amtrak by Amtrak contractors, a divided D.C. Circuit panel held that a false claim presented to a recipient of federal funds is not actionable under the FCA absent evidence that the federal-funds recipient in turn resubmitted the claim to a Government officer or employee, even where it is alleged and the record shows that it is the United States Treasury that bears the losses resulting from the alleged fraud. A comprehensive dissenting opinion in Totten set forth why the majority’s statutory construction was inconsistent with the FCA’s plain language set forth above and underlying Congressional intent. Totten, 380 F.3d at 502-16 (Garland, J. dissenting). For numerous reasons, Defendants’ reliance on Totten to dismiss the FCA portion of this case is misplaced.

i. This Court Should Reject Defendants’ Invitation To Greatly Expand The Court’s Holding In Totten.

This Court should reject Defendants’ interpretation and expansive reading of Totten. Defendants argue that under Totten, a fraud perpetrated upon a non-federal agency cannot form the basis for an FCA claim, even if the non-federal agency presents a claim for payment to the federal government. As a preliminary matter, and as set forth above, the premise of Defendants’

argument is fatally flawed because unlike Amtrak, Medicare is a federal program and Medicaid is a jointly run federal-state program. See discussion supra; see also Totten, 380 F.3d 488 at 492 (noting at the outset of its opinion that Amtrak “is not a department, agency, or instrumentality of the United States Government”); 49 U.S.C. § 24301(a)(3).

Further, Defendants have misconstrued the court’s holding in Totten. Totten turned on the fact that there was no allegation that there was any presentation by the defendant of any false claims to the government. Even under Totten, the FCA would encompass cases, such as this, in which a defendant submits a false claim to an intermediary who in turn seeks payment from the federal government. Totten requires presentment of a false claim to the Government, but it in no way precludes presentment via a third-party intermediary. See Totten, 380 F.3d at 492-502. Several courts have rejected the argument that Totten precludes liability unless *the defendant* presented the claim to the United States. See United States v. Sequel Contractors, Inc., 402 F. Supp.2d 1142, 1149-50 (C.D.Ca. 2005); US ex rel. Tyson v. Amerigroup, 2005 WL 2667207 (N.D. Ill., Oct. 17, 2005); United States ex rel. Murphy v. Baptist Medicare, Inc., No. 4:02-CV-440 (E.D. Ark. Oct. 27, 2005) (attached as Exhibit 2) (“Without commenting if Totten was decided correctly, the Court finds the facts of the present case to be distinguishable. The funding mechanism for Medicare and Medicaid is substantially different than the funding mechanism for Amtrak.”). These cases correctly recognize that Totten only requires presentment by “someone,” and that the defendant can therefore be liable for causing a third party (such as a Medicare fiscal intermediary or a state Medicaid agency) to present a false claim to the United States.

If followed, Defendants’ misreading of Totten threatens to exempt Medicare and Medicaid fraud from the ambit of the FCA. As set forth above, the precise details regarding how reimbursement is effectuated under Medicare and Medicaid are technical and complex and, with

respect to Medicaid, vary from state to state. Under Medicare and Medicaid, requests for payment are generally made by providers to third-party contractors, which in turn seek and obtain payment from the federal government. Even if this Court agreed with Totten's presentment requirement, Medicare and Medicaid claims that are indirectly submitted could give rise to FCA liability.

ii. Sanders v. Allison, not Totten, Accurately Construes The FCA.

As set forth above, because Totten does not require direct presentment to the federal government, this Court need not reach the issue of whether it was decided correctly. However, even if this Court found Totten's holding applicable in this case, which it is not, Totten is far from the "seminal" law of the land. After Totten, in Sanders v. Allison, 471 F.3d 610 (6th Cir. 2006) (petition for cert. filed 8/17/2007, No. 07-214), the Sixth Circuit appears to have created a split in the circuits on the issue of presentment of claims to a non-federal agency under the FCA. In Sanders, the plaintiffs alleged fraud in the negotiation and execution of subcontracts to build generator sets for United States Navy missile destroyers. The plaintiffs, employees of the subcontractors, brought qui tam actions against their employers and other subcontractors involved in the generator set project. One of the claims was that the defendants knew that the generator sets were defective, and still submitted invoices for payment to the shipyards, which were the primary contractors with the Navy. After a jury trial, the defendants sought to dismiss the case as a matter of law, relying on Totten and arguing that their invoices were presented to the general contractors rather than the government itself. Thus, they asserted that even if the invoices were false, they could not have violated the FCA. The district court granted the motion to dismiss as a matter of law.

In reversing the district court, the Court of Appeals for the Sixth Circuit stated that it

disagreed with the Totten Court’s interpretation of the FCA for several reasons. Sanders, 471 F.3d at 616. First, the court noted that the plain language of §§ 3729(a)(2) and (3) simply does not require that a claim be presented to the government to be actionable. Moreover, §3729(a)(1) punishes an individual who “presents or causes to be presented” a false or fraudulent claim. “[W]hether a party actually presents a false claim to the government or causes the presentation of that false claim through an intermediary, liability under section (a)(1) may attach.” Sanders, 471 F.3d at 617 n. 4. In Sanders, the court also found that the Totten majority did not comport with the weight of authority interpreting the FCA as a remedial statute that must be broadly construed. Id. at 618 (citations omitted).

As set forth in Sanders and in the Totten dissent, Totten was wrongly decided. The majority in Totten misconstrued the language and purposes of the FCA in concluding that it does not encompass false claims, records and statements submitted to recipients of federal funds absent “resubmission” to a United States officer or employee. The FCA imposes no such requirement. The FCA should be construed broadly “to reach all types of fraud without qualification that might result in financial loss to the government,” and should not be read in a restrictive or rigid manner. United States v. Neifert-White, Co., 390 U.S. 228, 232-33 (1968) (reversing district court’s dismissal of FCA complaint).

The decision in Sanders, unlike that in Totten, is consistent with both the plain language and the statutory intent of the FCA. The legislative history of the 1986 amendments to the FCA expressly state that, under the amended definition of “claim,” “a false claim is actionable although the claims or false statements were made to a party other than the Government, if the payment thereon would ultimately result in a loss to the United States.” S. Rep. No. 99-345, 99th Cong., 2d Sess. 10, reprinted in 1986 U.S.C.C.A.N. 5266, 5275. “For example, a false

claim to the recipient of a grant from the United States or to a State under a program financed in part by the United States, is a false claim to the United States.” Id.

The legislative history of the FCA’s 1986 amendments expressly discusses fraud with respect to Medicare and Medicaid, and confirms that the false claims submitted to third-party intermediaries under these programs are covered under the FCA. As the legislative history explains, “The question has arisen whether claims under the Medicare and Medicaid Programs” fall within the FCA’s scope. S. Rep. No. 99-345, at 21, reprinted in 1986 U.S.C.C.A.N. at 5286. “Under the Medicare program, claims are not submitted directly to the Federal agency, but rather to private intermediaries - usually insurance companies - which are subsequently reimbursed by the United States. However, the false Medicare claims have been uniformly held to be within the False Claims Act, though the claims were actually filed with, and paid by insurance companies.” Id. Similarly, “[a]lthough the Federal involvement in the Medicaid program is less direct, claims submitted to State agencies under this program have also been held to be claims to the United States under the False Claims Act.” S.Rep. No. 99-345, at 22, reprinted in 1986 U.S.C.C.A.N. at 5287. Consistent with this legislative history, many courts have applied the FCA to fraud committed against the Medicaid program. United States ex rel. Fahner v. Alaska, 591 F. Supp. 794, 798 (N.D. Ill. 1984) (collecting cases and stating that “many courts have recognized the applicability of the False Claims Act to Medicaid programs”).

For all of these reasons, jurisdiction is proper under the FCA and Defendants’ Motion to Dismiss for Lack of Subject Matter Jurisdiction should be denied.

IV. The Complaint Satisfies Fed.R.Civ.P. 9(b) Because the United States’ Claims Are Each Pled With Detailed Particularity As To Each Defendant and Claim Of Fraud.

A. Rule 9(b) Must Be Construed In Accordance With Notice Pleading.

Although Rule 9(b) requires that a Complaint must plead such facts as the time, place, and content of the defendant's false representations, as well as the details of the defendant's fraudulent acts, the Eighth Circuit has cautioned that Rule 9(b) is to be interpreted “in harmony with the principles of notice pleading.” Schaller Tel. Co. v. Golden Sky Sys., 298 F.3d 736, 746 (8th Cir.2002) quoting Abels v. Farmers Commodities Corp., 259 F.3d 910, 920 (8th Cir. 2001).

The United States’ Complaint readily satisfies the requirements of Fed.R.Civ.P. 9(b) because it more than adequately gives each Defendant notice of the fraud claims and identifies the “who, what, where, when and how.” United States v. Costner v. URS Consultants, Inc., 317 F.3d 883, 888 (8th Cir. 2003). The sixty-two page Complaint sets forth in particular detail the basis upon which the United States claims that certain Defendants violated the FCA and how they are responsible for their conduct under common law. The United States identifies:

(1) who: the named Defendants in each Count and throughout the Complaint; (2) what: the false claims identified by resident and exactly why these claims, and others, were false in that they were worthless; (3) where: the facilities in question are identified by name and address; the claims are identified by resident and dates of service and whether they were submitted to Medicare, Medicaid or both; (4) when: the precise dates of service for which the false claims were submitted; and (5) how: through the submission of claims for reimbursement to Medicare and Medicaid and a complex corporate structure through which money was intended to be diverted away from the Defendant Nursing Facilities and to Defendant Harrington and the other Defendants. Defendants are fully advised of what actions the United States alleges were fraudulent.

Defendants’ arguments to the contrary appear disingenuous when examined in the context of what is set forth in the Complaint.

- Defendants complain that “[n]o information is given about when the claim or claims were submitted.” Mem. at 8. On the contrary, in addition to pleading overall failure, the Complaint alleges the exact dates of service at issue for seventeen residents and alleges that claims for Medicare, Medicaid, or both were submitted for those dates of service. The actual date of the submission of the electronic claim is not necessary to put the Defendant on notice of what claims are at issue. Complaint, ¶¶ 178-280.
- Defendants complain that “[n]o information is given about”... “by whom [the claims] were submitted.” Mem. at 8. On the contrary, in addition to identifying the Defendant Nursing Facilities generally, the Complaint states, for each of the seventeen identified residents, the identity of the Defendant (and its Medicare or Medicaid provider number) that submitted the claim.
- Defendants complain that “[n]o information is given about” ... “what was contained in the claim, [o]r the amount of the claims.” Mem. at 8. On the contrary, the Complaint clearly asserts that claims were submitted by resident for the per diem rate or Medicare RUG rate, and the Complaint further identifies whether the actual payment of the claims was made at the per diem amount or was reduced by payment from any other source (such as a resident co-pay). The actual dollar amount of each claim is not required to put Defendants on notice of the claims against them or to satisfy Rule 9(b).
- Defendants complain that “[n]o information is given about” ... “who precisely received the claims.” Mem. at 8. On the contrary, the Complaint alleges that the claims were electronically submitted to Medicare, Medicaid, or both. In the era of electronic claim submission, the idea that Defendants are seeking the actual name of an individual who received or viewed the electronic claim is simply absurd, and is not required by Rule 9.
- Defendants complain that they “are not informed how many supposedly false claims were made...which makes it impossible to determine how much the government is seeking in penalties.” Mem. at 9. Neither Rule 9(b) nor the FCA requires the government to plead the amounts of penalties it seeks.

Defendants assert that the Complaint in this case must be dismissed because it is “closely akin” to the faulty pleadings in two qui tams in which the United States declined to intervene: United States ex rel. Karvelas v. Melrose-Wakefield Hosp., 360 F.3d 220, 234 (1st Cir. 2004) and United States ex rel. Phillips v. Permian Residential Care Center, 386 F. Supp.2d 879 (W.D. Tex. 2005). Mem. at 7. The Complaint before this Court bears virtually no similarity to the

complaints the courts dismissed in Karvelas and Phillips. In Karvelas, the district court partially described the shortcoming in the relator's complaint as follows:

Karvelas alleges repeatedly that the defendants submitted false claims to the United States. Karvelas asserts that these claims included "cost reports," which the defendants certified falsely were complete, true, and correct. He also refers to false "confirming orders of physicians," and "progress notes." It is not clear whether he is alleging that those documents were false claims. He argues that the defendants "wrongfully bill Medicare and/or Medicaid," but does not provide specifics about the nature of the bills.

United States ex rel. Karvelas v. Melrose-Wakefield Hosp., 2003 WL 21228801 at * 5, No.

Civ.A. 01-10583-DPW (May 21, 2003) (internal citations omitted). Here, in contrast to

Karvelas, the Complaint contains all of the necessary specifics. Similarly, in Phillips, the court

found that the relators provided "no factual basis" for their belief that the defendants had

submitted claims for medically unnecessary services other than "conclusory statements that the

services were performed only to obtain money from healthcare financial institutions." Id. at

883. Here, the Complaint gives a wealth of factual information. The complaints in Karvelas and

Phillips bear little resemblance to the Complaint here.⁴

The sufficiency of the pleadings under 9(b) may depend "upon the nature of the case, the complexity or simplicity of the transaction or occurrence, the relationship of the parties and the determination of how much circumstantial detail is necessary to give notice to the adverse party

⁴Notably, neither Phillips nor Karvelas supports Defendants' request for immediate dismissal with prejudice under Rule 9. In Phillips, the defendants' first motion to dismiss under 9(b) was denied and the relators were ordered to amend their complaint. Only after filing an amended complaint that continued to fail to comply with 9(b) did the court dismiss the complaint. 386 F. Supp. at 880. In Karvelas, the relator alleged sixteen separate schemes in a second lawsuit against the defendants. Karvelas, 2003 WL 21228801 at *1; Karvelas, 360 F.3d at 232. In affirming the dismissal under 9(b) without giving the relator sua sponte leave to amend, the Court of Appeals noted that at no time did plaintiff seek leave to amend, and that the relator had already had a "generous opportunity to sharpen his pleadings when it did not dismiss with prejudice the plaintiff's first FCA retaliation complaint against the defendants." Karvelas, 360 F.3d at 242.

and enable him to prepare a responsive pleading.” Payne v. U.S., 247 F.2d 481, 486 (8th Cir. 1957). Here, Defendants are sophisticated parties who have been involved in Medicare, Medicaid, and the skilled nursing field since at least mid-2001. As set forth in the Complaint, during the relevant times, for the care purportedly provided, the Defendant Nursing Facilities have received over \$19 million from Medicare and \$57 million from Missouri Medicaid.⁵ Complaint ¶ 104. These facts evidence that Defendants are well-versed in Medicare and Medicaid claims and payment,⁶ and certainly militates in favor of the conclusion that the Complaint has given Defendants ample notice to enable them to prepare a responsive pleading.

B. The Alleged “Blurring” Of Defendants Does Not Violate Rule 9(b).

In a certain and limited number of paragraphs, the United States makes allegations against the Defendants collectively. E.g., Complaint ¶ 102 (alleging Defendants’ failure to pay vendors); ¶155 (alleging Defendants’ knowledge of the failures of care based on numerous lawsuits); ¶ 159 (alleging Defendants’ knowledge of the conditions based upon frequent and numerous citations in surveys). In the instances where Defendants are identified collectively, the United States intends its allegations to be against each Defendant.

Defendants argue that each of the Defendants’ activities must be separately described, Mem. at 8-9, however, Rule 9(b) has no such requirement and furthermore does not require unnecessarily duplicative or formalistic pleading. Moreover, it was Defendants’ intentional “blurring” of the various corporate entities and their respective financial roles in the alleged FCA

⁵As set forth above, the federal government paid approximately 61% of Missouri Medicaid expenditures in fiscal year 2006.

⁶For example, Defendants are well aware that the Defendant Nursing Facilities in this case traditionally submitted electronic claims for Medicaid payment twice a month, on the 15th of the month and the last day of the month, through a fiscal contractor. Certainly, information such as this is not necessary for Defendants to respond to the Complaint or to satisfy Rule 9.

conspiracy that has, in some instances, caused the United States to make an allegation against them collectively. In the instances where the United States alleges that “Defendants” took certain actions, each Defendant is being notified that the United States is alleging this action as to each of them. Defendants, therefore, have ample notice regarding the particular allegations and there is no Rule 9(b) violation.

C. Neither “Piercing The Corporate Veil” Nor Vicarious Liability Are Necessary To State A Claim Against Defendant Harrington Or The Various Entities.

Defendants assert that a corporate owner cannot be liable under the FCA “simply because they owned the company that is alleged to have committed fraud,” and that a “corporate officer cannot be held vicariously liable for fraudulent acts performed in the corporation’s name by another person.” Mem. at 9. Defendants assert, therefore, that the Complaint has not sufficiently alleged piercing the corporate veil.

The Complaint need not allege either “piercing the corporate veil” or vicarious liability for the United States to state a claim under the FCA or common law. As to each Defendant identified in each Count, the United States has alleged direct FCA liability (Counts I and III), liability under common law fraud (Count IV) as well as equitable claims of unjust enrichment and disgorgement of profits (Counts V-VI). As to Defendant Harrington, he has not been named as a Defendant simply because he is a corporate officer, nor must the United States plead and prove that he is vicariously responsible⁷ for the acts of others or the acts of any of the

⁷Although Defendants argue to the contrary, under the FCA a principal may be held vicariously liable when her agent violates the FCA. Grand Union Co. v. United States, 696 F.2d 888, 891 (11th Cir. 1983) (“We have held in cases brought under the False Claims Act that the knowledge of an employee is imputed to the corporation when the employee acts for the benefit of the corporation and within the scope of employment.”); United States v. Hangar One, Inc., 563 F.2d 1155, 1158 (5th Cir. 1977) (stating that False Claims Act liability will attach to a

corporations he owns and controls. On the contrary, the United States has made numerous direct allegations against Harrington, all of which must be taken as true and construed in the United States' favor. See Complaint at ¶ 11 (Harrington as owner); ¶ 18 (Harrington as President and CEO); ¶ 19 (Harrington as majority stockholder); ¶ 20 (Harrington as President); ¶ 22 (Harrington exercising control); ¶¶ 23-25 (summarizing Harrington's role in the allegations); ¶ 41 (Harrington as a manager of the Defendant Nursing Facilities); ¶ 58 (Harrington personally signing Medicare agreements); ¶ 96 (e-mails showing that Harrington was personally on notice and involved in the non-payment of facility vendors); ¶ 105 (Harrington exerting pressure to increase census); ¶ 106 (Harrington was focused on profits over patient care); ¶ 109 (Harrington rewarded those who increased census); ¶ 111 (Harrington received census updates); ¶ 114 (Harrington's role in putting marketing rather than clinical personnel in charge of facility admissions); ¶ 115 (Harrington's role in termination of a medical director for failure to refer residents to Cathedral Rock facilities); ¶ 116 (Harrington's focus on profits); ¶ 171 (Harrington's personal knowledge of facility conditions because of site visits and e-mails); ¶ 173 (Harrington's personal knowledge of events at SpringPlace); ¶ 175-176 (Harrington's personal knowledge of the survey outcomes at SpringPlace); ¶ 178 (Harrington's e-mail acknowledging "clinical performance" issues at SpringPlace); ¶ 182 (Harrington's ownership); ¶ 183-184 (Harrington's salary); and Counts I, III, V and VI (specifically identifying Harrington as a Defendant in these Counts).

Based upon the allegations above, and the several additional allegations wherein

corporation if an employee acts within scope of authority and for benefit of corporation). Thus, although the United States brings its allegations directly against each defendant, vicarious liability could also make the corporate defendants liable for Defendant Harrington's actions.

Defendant Harrington is included with allegations made against all Defendants, the United States has alleged that Defendant Harrington is directly liable under the FCA for his personal and immediate role in “causing” the submission of the false claims and conspiring to submit those claims. See Counts I and III. Similarly, the United States has alleged that Defendant Harrington is directly and personally liable for the equitable claims asserted against him. See Counts V and VI. There is no need to address the issue of vicarious liability or piercing the corporate veil as to Defendant Harrington. Defendants have recognized and conceded this legal point by stating that the United States “must plead specifically what each defendant did to violate the FCA or it must plead specifically why the corporate veil between the defendants can and should be pierced.” Mem. at 9.

Defendants’ argument for dismissal of the “subsidiary” corporations on the same grounds of failure to pierce the corporate veil similarly fails. The United States is not trying to hold one corporation or individual responsible for the actions of fraud of another – the reason why a party might allege piercing the corporate veil. 18 Am. Jur. 2d Corporation § 47 (2007) (piercing the corporate veil is a theory “typically employed by a third party seeking to go behind the corporate existence in order to circumvent the limited liability of the owners and to hold them liable for some underlying corporate obligation”). The FCA includes a broad class of potential defendants by stating that liability exists for “any person” who, with the requisite scienter, presents or causes a claim to be presented, makes, uses or causes to be made or used a false record to get a false claim paid or approved, or conspires to defraud the government to get a false claim allowed or paid. § 3729(a)(1)(2) & (3). As set forth in the Complaint, the United States alleges that each of the corporate Defendants and the Defendant limited partnership bear

individual responsibility for their respective role in the fraud scheme under both the FCA and the United States' equitable claims as set forth in each respective Count.

For example, in Count I (knowingly submitting or causing the submission of false claims), Defendants appear to have conceded that the Complaint contains sufficient factual allegations to support the claims against the individual Defendant Nursing Facilities. Mem. at 10 (“The Complaint is bereft of factual allegations that any defendant other than the individual facilities were involved in or caused the actual submission of Medicaid or Medicare claims.”) (emphasis added). Defendants argue, however, that Count I violates Rule 9 through its inclusion of Defendants Cathedral Rock Corporation, Cathedral Rock Management, and Defendant Harrington. As set forth above, there are ample factual allegations to support inclusion of Defendant Harrington based upon the allegations that he “caused” of the submission of false claims. Similarly, there are ample factual allegations regarding Cathedral Rock Corporation and Cathedral Rock Management’s total and absolute control over the Defendant Nursing Facilities to support the United States’ allegations that they “caused” the submission of false claims. While not an exhaustive list, see e.g., Complaint, ¶¶ 76-81 (Cathedral Rock and Cathedral Rock Management controlled staffing, set budgets that were not adequate, including improper personnel in the nursing budget); Complaint ¶¶ 91-102 (Cathedral Rock Management had the responsibility for and failed to pay vendors), these factual allegations were part and parcel of the failure of care and these Defendants, through their own acts, “caused” the submission of the false claims.

Similarly, Defendants make general arguments asserting that Rule 9(b) is not satisfied through the inclusion of the particular Defendants in Counts II and III under the FCA, relying on

the same arguments of “piercing the corporate veil.” For the reasons set forth above as to Count I, this argument also fails as to Counts II and III.

The Complaint pleads the FCA claims against each of the Defendants with sufficient particularity to withstand Defendants’ challenge under Rule 9. While Defendants may dispute these and other allegations made against Cathedral Rock, Cathedral Rock Management, and the other entities, those disputes of fact cannot be resolved on a Motion to Dismiss.

D. If This Court Finds That Rule 9(b) Is Not Satisfied, The United States Seeks Leave To Amend The Complaint.

If this Court determines that the Complaint is lacking in some aspect of the particularity required by Rule 9(b), as to any Defendant, the United States respectfully seeks leave to amend. Certainly, leave to amend for failure to comply with Rule 9(b) should be freely granted. Hart v. Bayer Corp., 199 F.3d 239, 248, n. 5 (5th Cir. 2000) (failure to meet specific pleading requirements should not automatically result in dismissal of the complaint with prejudice and a case should not be dismissed without granting leave to amend unless the defect is simply incurable or the plaintiff has failed to plead with particularity after being afforded repeated opportunities to do so) (citations omitted).

V. Conclusion

The United States respectfully requests that Defendants’ Motion to Dismiss be denied.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I certify that a copy of the foregoing Memorandum in Opposition to Defendants' Motion to Dismiss Complaint In Intervention was filed and electronically served on this 6th day of September, 2007 to the following:

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