

Medicaid, entered into an “Agreement For Participation in the Illinois Medical Assistance Program” (“Agreement”), under which the Hospital was to participate and receive reimbursement from Medicaid. The Agreement requires that, as an express condition for payment from IDHFS, the Hospital was required to be licensed by the Illinois Department of Public Health (“IDPH”),² which inspects and oversees Medicaid providers to ensure that they are in compliance with the required laws and regulations. In the course of operating its NICU, the Hospital falsely stated to IDHFS for Medicaid payment that it was providing NICU services in compliance with such laws and regulations.³ Plaintiffs allege that between 1997 and July 2005, the Hospital certified in both billing certification and annual cost reports that it provided the services, for which IDHFS made payments, in compliance with applicable state laws and regulations under the Agreement, while the Hospital was violating such laws and regulations.

Plaintiffs’ allegations are predicated on the three regulatory violations: (1) the Hospital’s policy and practice of double-bunking infants in the NICU (“double-bunking”);⁴ (2) the Hospital’s policy and practice of operating above its licensed capacity in the NICU (“licensed capacity violation”); and (3) the Hospital’s practice of violating infection control regulations in the NICU (“infection control violation”). That is, between 1997 and July 2005, the Hospital billed IDHFS by “double-bunking” infants in its NICU, so that it could get paid twice for each double-bunked bed space. The Hospital also regularly crowded its NICU beyond the licensed capacity and failed to follow the required infection control procedure under state licensing regulations. The Hospital double-bunked infants even when bed spaces in the NICU were available to admit referrals of infants from other hospitals beyond its licensed capacity. The overcrowding triggered infection outbreaks in the NICU, and the Hospital failed to isolate the infected infants as required under the infection control procedure. Relators, former nurses at the Hospital’s NICU, personally witnessed the double-bunking, overcrowding, and lack of infection control. In September 2003, based on Relators’ disclosure, IDPH conducted an inspection of the Hospital’s NICU and confirmed Relators’ allegations. Subsequently, IDPH recommended termination of the Hospital’s participation in Medicaid, which was postponed on condition upon the Hospital’s promises to discontinue double-bunking, not to exceed its licensed capacity, and to follow infection control requirements. The Hospital failed to keep said promises until the Hospital announced its new policy regarding the operation of the NICU on July 7, 2005.

Based on the foregoing allegations, PJC sets forth the following claims: (1) the Hospital violated the Illinois Whistleblower Reward and Protection Act (“TWRPA”), 740 ILCS 175/1, *et seq.* (Counts I, II and III); (2) the Hospital violated the Illinois Public Assistance Fraud Act (“TPAFA”), 305 ILCS 5/8A-7(b), *et seq.* (Count IV); (3) the Hospital committed common law fraud (Count V); and (4) as a result of false certification of compliance, the Hospital received

² Illinois claims that to be licensed by IDPH, Medicaid providers must certify their compliance with all applicable laws and regulations.

³ Illinois claims that to receive payment from IDHFS, Medicaid providers must submit (1) invoices with billing certification, certifying that the billed services were provided in compliance with applicable laws and regulations, and (2) annual cost reports of the services provided and expenses incurred during that year with certification that the services identified in the cost report were provided in compliance with applicable laws and regulations.

⁴ “Double-bunking” refers to placing two or more radiant warmers, isolettes, or open cribs containing premature and sick infants in a bed space licensed for the care of a single infant.

payments from IDHFS by mistake of fact (Count VI).

Prior to coming to this Court, Plaintiffs initially filed this action in the U.S. District Court, Northern District of Illinois, United States ex rel. _____ v. The University of Chicago Hospitals et al., 2006 WL 516577 (N.D. Ill. Feb. 28, 2006), under the federal False Claims Act ("FCA") and the IWRPA. The Hospital moved to dismiss the complaint pursuant to Fed. R. Civ. P. 9(b) and 12(b). On February 28, 2006, the Northern District Court (1) dismissed Relators' False Claims Act claims pursuant to Fed. R. Civ. P. 9(b) on the ground that the complaint did not allege with sufficient particularity the facts establishing fraud; (2) denied the Hospital's Rule 9(b) motion to dismiss Relators' state law claims and Illinois's complaint as moot; (3) declined to exercise supplemental jurisdiction over both Relators' and Illinois's state law claims; and (4) dismissed the remainder of the Hospital's motions as moot. 2006 WL 516577, at *12.

On March 14th, 2006, Illinois and Relators brought this action against the Hospital in the Circuit Court of Cook County. The Hospital now moves this Court to dismiss Plaintiffs' Joint Complaint pursuant to 735 ILCS 5/2-615.

ANALYSIS

I. Legal Standard under 735 ILCS 5/2-715

A section 2-615 motion to dismiss challenges the legal sufficiency of a complaint based on defects apparent on its face. 735 ILCS 5/2-615 (West 2005); City of Chicago v. Beretta U.S.A. Corp., 213 Ill. 2d 351, 364 (Ill. 2004). In reviewing the sufficiency of a complaint, we accept as true all well-pleaded facts and all reasonable inferences that may be drawn from those facts. Ferguson v. City of Chicago, 213 Ill. 2d 94, 96-97 (Ill. 2004). We also construe the allegations in the complaint in the light most favorable to the plaintiff. King v. First Capital Financial Services Corp., 215 Ill. 2d 1, 11-12 (Ill. 2005). Thus, a cause of action should not be dismissed pursuant to section 2-615 unless it is clearly apparent that no set of facts can be proved that would entitle the plaintiff to recovery. Canel v. Topinka, 212 Ill. 2d 311, 318 (Ill. 2004). It is well settled that Illinois is a fact-pleading jurisdiction. See, e.g., Weiss v. Waterhouse Securities, Inc., 208 Ill. 2d 439, 451 (Ill. 2004). While the plaintiff is not required to set forth evidence in the complaint (Chandler v. Illinois Central R.R. Co., 207 Ill. 2d 331, 348 (Ill. 2003)), the plaintiff must allege facts sufficient to bring a claim within a legally recognized cause of action (Vernon v. Schuster, 179 Ill. 2d 338, 344 (Ill. 1997)), not simply conclusions (Anderson v. Vanden Dorpel, 172 Ill. 2d 399, 408 (Ill. 1996)).

II. Arguments

A. The Hospital's Arguments

The Hospital contends that "violations of State licensing regulations are not actionable under the IWRPA even where a healthcare provider certifies compliance with all laws because Medicaid reimbursement is not conditioned on compliance with such regulations." (Def. Repl. at 2). In support of its assertion, the Hospital argues that "courts have uniformly rejected as a

matter of law false claims certification complaints predicated on violations of state quality-of-care regulations . . .” (Def. Repl. at 2); citing United States ex rel. Rocha and Dickey v. American Transitional Hosps, Inc., 2005 U.S. Dist. LEXIS 38892, *11-13 (S.D. Tex. Dec. 14, 2005); United States ex rel. Sweeney v. Manorcare health Servs., Inc., 2006 WL 4030950, *6-7 (W.D. Wash. March 4, 2005); United States ex rel. Mikes v. Straus, 274 F. 3d 687, 697 (2d Cir. 2001); Luckey v. Baxter Healthcare Corp., 183 F. 3d 730, 733 (7th Cir. 1999); United States ex rel. Joslin v. Community Home Health, 984 F. Supp. 374, 385 (D. Md. 1997).

The Hospital also contends that “there cannot be an IWRPA claim or an IPAFA claim unless compliance with the law allegedly violated is a condition of the government’s payment of the claim.” (Def. Mot. at 8); citing Rocha, 2005 U.S. Dist. LEXIS 38892, at *11-13; Sweeney, 2006 WL 4030950, at *6-7; United States ex rel. Karvelas v. Melrose-Wakefield Hosp., 360 F. 3d 220, 234-35 (1st Cir. 2004); Mikes, 274 F. 3d at 697; Luckey, 183 F. 3d at 733; United States ex rel. Hopper v. Anton, 91 F. 3d 1261, 1266-67 (9th Cir. 1996); United States ex rel. Thompson v. Columbia/HCA Health Care Corp., 125 F. 3d 899, 902 (5th Cir. 1987). The Hospital argues that “[r]egardless whether the certification is express or implied, courts have repeatedly found that state regulatory deficiencies like those here do not support a false claim action, because compliance with such regulations is not material to payment of the claim.” (Def. Repl. at 2-3); citing United States ex rel. Lamers v. City of Green Bay, 168 F. 3d 1013, 1020 (7th Cir. 1999); United States ex rel. Willard v. Human Health Plan of Texas, Inc., 336 F. 3d 375, 382 (5th Cir. 2003).

The Hospital finally contends that even if quality-of-care violations could form the basis for a false claim action, Count II should be dismissed because Plaintiffs failed to allege that any licensed capacity regulations were violated. Count III also should be dismissed because Plaintiffs did not meet the heightened pleading requirements for a fraud claim. Additionally, the IWRPA and IPAFA claims are insufficient to establish a cause of action because the relevant state regulations must be interpreted in the light of overlapping federal law, i.e., the Emergency Medical Treatment and Active Labor Act (“EMTALA”), 42 U.S.C. § 1395.

B. Plaintiffs’ Arguments

Plaintiffs contend in response that the basis of their IWRPA claims is not that the Hospital violated health care or regulatory requirements, but that the Hospital falsely certified that the services rendered to Medicaid NICU patients were provided in compliance with state licensing regulations to receive payments for those services when the Hospital knew that it was violating the required state laws and regulations. (Pl. Resp. at 5). In support of their assertion, Plaintiffs claim that the Hospital’s certification of compliance were “prerequisites for, or conditions of, reimbursement from” Medicaid. (Pl. Resp. at 5). As an express condition of payment, the Hospital was required to enter (and re-enter) into the Agreement to receive reimbursement from Medicaid and to “agree on a continuing basis to comply with applicable licensing standards as contained in State laws and regulations.” (PCJ at ¶ 16). Upon receiving reimbursement for billed services, the Hospital was required to sign and maintain a billing certification, which incorporates the condition that reimbursement is based on the Hospital’s “full compliance with such laws and regulations.” (Pl. Resp. at 24). In addition, to receive reimbursement, the Hospital was required to submit annual cost reports, certifying that the billed

services “were provided in compliance with such laws and regulations.” (Pl. Resp. at 24). Plaintiffs claim that state regulatory violations can be the basis of a false claim under IWRPA when compliance is required as a condition of payment. (Pl. Resp. at 6); citing United States ex rel. Sanders v. East Alabama Healthcare Auth., 953 F. Supp. 1404, 1410-11 (M.D. Ala. 1996); Willard, 336 F. 3d at 382; Mikes, 274 F. 3d at 697; Luckey, 183 F. 3d at 732-33; Sweeney, 2006 WL 4030950, at *4; Rocha, 2005 U.S. Dist. LEXIS 38892, at *8, 16. Plaintiffs contend that they have sufficiently alleged that the Hospital’s certification of compliance was a condition of Medicaid reimbursement under Rocha. 2005 U.S. Dist. LEXIS 38892, at *12.

Plaintiffs also contend that they have sufficiently alleged the Hospital’s false claims under the IWRPA regarding its exceeding the licensed capacity for Medicaid NICU services. Plaintiffs further contend that they have alleged with sufficient particularity the “who, what, when, and how” of the Hospital’s false claims regarding infection control violations. Additionally, Plaintiffs contend that the Hospital’s assertion that it was required under the federal EMTALA to admit and treat infants in its NICU beyond its licensed capacity has no legal ground.

III. The Basis of a False Claims Act under the IWRPA (Counts I, II & III)

The IWRPA imposes civil liability upon “any person” who, *inter alia*, “knowingly presents, or causes to be presented, to an officer or employee of the State . . . a false or fraudulent claim for payment or approval.” 740 ILCS 175/3(a)(1). A person who violates the IWRPA is liable to the state for a civil penalty of not less than \$ 5,000 and not more than \$ 10,000, plus treble damages.⁵ 740 ILCS 175/3(a). The Illinois Supreme Court in Scachitti v. UBS Fin. Servs. held that since the IWRPA closely tracks the False Claims Act (“FCA”), 31 U.S.C. §§ 3729-3733, originally enacted in 1863, FCA case law is generally held to be applicable to IWRPA cases.⁶ 215 Ill. 2d 484, 506 (Ill. 2005). Also, the parties in the instant case agree that case law interpreting the FCA provisions also applies to the IWRPA since the IWRPA is nearly identical to the FCA. (See Def. Mot. at 8, n.4; Pl. Resp. at 3, n.2). As such, we will apply FCA case laws to our interpretation of the IWRPA.

A. Regulatory violation alone is insufficient to constitute an IWRPA action.

Courts have uniformly held that a violation of the underlying statute or regulation *alone*

⁵ The *qui tam* plaintiff is entitled to receive 15% to 25% of the proceeds of the action if the Attorney General intervenes. 740 ILCS 175/4(d)(1). If the Attorney General elects not to intervene, the *qui tam* plaintiff is entitled to receive 25% to 30% of the proceeds, plus reasonable attorney fees and costs. 740 ILCS 175/4(d)(2); see Scachitti v. UBS Fin. Servs., 215 Ill. 2d 484, 506 (Ill. 2005).

⁶ The False Claims Act (“FCA”), 31 U.S.C. §§ 3729-3733, prohibits the submission of false or fraudulent claims to the federal government. The FCA permits private persons to file a *qui tam* action against, and recover damages on behalf of the United States from, any person who:

(1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government . . . a false or fraudulent claim for payment or approval; [or]

(2) 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.

31 U.S.C. § 3729(a).

does not create a false certification cause of action under the FCA.⁷ See United States ex rel. Graves v. ITT Educ. Servs., Inc., 284 F. Supp. 2d 487, 501 (S.D. Tex. 2003) (“A general statement of adherence to all regulations or statutes governing participation in a program through which federal funds are received is insufficient as a basis of False Claims Act liability”); Rocha, 2005 U.S. Dist. LEXIS 38892, at *16 (“the FCA does not create liability for every alleged regulatory violation”).

Citing Luckey, the Hospital contends that, as in the instant case, “technical violations of a federal regulation on which a claim is based does not make the claim ‘false.’” 183 F.3d at 733. In response, Plaintiffs cite Sweeny to contend that false certification of compliance establishes FCA liability. 2005 WL 4030950, at *5. Plaintiffs also cite Sanders to contend that “the knowing submission of a claim that falsely represented attainment of state licensing requirements is enough to constitute a false claim.” 953 F. Supp at 1411.

We disagree with the positions of both parties. As to Luckey, as Plaintiffs point out, the Hospital neglects to include the language immediately following, stating “in this case we do not even have an established violation.” 183 F.3d at 733. Concerning Sweeny, Plaintiffs fail to look at the court’s statement that “[a]bsent actionable false certifications upon which funding is conditioned, the FCA does not provide a remedy for regulatory violations.” 2005 WL 4030950, at *5. As the Hospital points out, Sanders is distinguishable from the instant case in that rather than just contemplating regulatory violations of an otherwise appropriately licensed hospital, Sanders deals with a defendant that was not properly licensed to begin with. 953 F. Supp at 1411.

Thus, the mere fact that the Hospital violated state licensing regulations *alone*, such as double-bunking, exceeding its licensed capacity or failing to follow the required infection control procedure, does not create a false certification cause of action under the IWRPA.

B. Certification of compliance with licensing regulations must be a prerequisite to or condition of payment.

Rather, “[i]t is the false certification of compliance which creates liability when certification is a prerequisite to obtaining a government benefit.” United States ex rel. Lee v. SmithKline Beechman, Inc., 245 F. 3d 1048, 1053 n. 4 (9th Cir. 2001) (internal citations omitted); see also United States ex rel. Gross v. AIDS Research Alliance-Chicago, 415 F. 3d 601, 604 (7th Cir. 2005) (“An FCA claim premised upon an alleged false certification of

⁷ The Hospital contends that under Rocha, “hospital licensing regulations are not conditions of payment and that the alleged violations of those regulations do not give rise to a viable FCA claim.” 2005 U.S. Dist. LEXIS 38892, at *16. Plaintiffs contend in response that the Rocha court held that it is not the regulatory violation, but rather the false certification of compliance that gives rise to the claim. Id. We find that both positions present only a part of the Rocha ruling. What Rocha stands for is that a FCA claim “requires that (1) a defendant makes a knowingly false certification of compliance with a statute or regulation; and (2) the certification is a prerequisite to payment.” (emphasis added). Id. Accordingly, under Rocha, a false certification that was not a prerequisite to government payment would not give rise to an FCA claim, even if regulations are violated.

compliance with statutory or regulatory requirements also requires that the certification of compliance be a condition of or prerequisite to government payment”); Graves, 284 F. Supp. 2d at 497 (“liability arises only if the defendant has made a false certification of compliance with the statute or regulation, when payment is conditioned on that certification”); Hopper, 91 F. 3d at 1266 (“violations of laws, rules, or regulations alone do not create a cause of action under the FCA. It is the false certification of compliance which creates liability when certification is a prerequisite to obtaining a government benefit”); United States ex rel. Russell v. Epic Healthcare Mgmt. Group, 193 F. 3d 304, 308 (5th Cir. 1999) (“The conduct to which liability attaches in a False Claims Act suit consists in part of false statements or claims for payment presented to the government”). It is well settled that the FCA requires that both (1) a defendant makes a knowingly false certification of compliance with a statute or regulation; and (2) the certification is a prerequisite to payment.⁸ Rocha, 2005 U.S. Dist. LEXIS 38892, at *16; see also Graves, 284 F. Supp. 2d at 498 (“when the government has conditioned payment of a claim upon a claimant’s certification of compliance with a provision of a contract entered into pursuant to a regulation, a claimant submits a false claim as a matter of law when he or she falsely certifies compliance with that provision”).

Thus, if the Hospital’s certification of compliance was a condition of *payment* and the Hospital made false certification to receive payment, Plaintiffs have actionable IWRPA claims against the Hospital. On the other hand, if such payment is not conditioned on the Hospital’s certification of compliance, then Plaintiffs have no actionable IWRPA claims against the Hospital, even if the Hospital regularly double-bunked infants in the NICU, admitted NICU patients beyond its licensed capacity, and violated infection control regulations.

C. Court’s Findings

We find that United States ex rel. Mary Hendow v. University of Phoenix provides analytic framework with which to decide the instant case. No. 04-16247, 2006 U.S. App. LEXIS 22568, *1 (September 5, 2006, 9th Cir. 2006) (where relators brought FCA claims against the University of Phoenix, alleging that the University knowingly made false promises to comply with the incentive compensation ban to become eligible to receive Title IV funds). The Ninth Circuit in Hendow held that to state a cause of action under the FCA, a plaintiff must show that “(1) a false statement or fraudulent course of conduct, (2) made with scienter, (3) that was material, causing (4) the government to pay out money . . .” 2006 U.S. App. LEXIS 22568, at *19. In examining each element of the Hendow requirements for the Hospital’s 2-615 motion, we accept as true all well-pleaded facts and all reasonable inferences that may be drawn from those facts (Ferguson, 213 Ill. 2d at 96-97) and also construe the allegations in the complaint in the light most favorable to the plaintiff (King, 215 Ill. 2d at 11-12).

(a) Falsity

Affirming that “[m]ere regulatory violations do not give rise to a viable FCA action” but

⁸ Both Luckey and Sweeny support the Rocha requirements for FCA claims. Luckey, 183 F. 3d at 733; Sweeny, 2005 WL 4030950, at *5.

that the false certification of compliance creates liability only when certification is a prerequisite to obtaining a government benefit, the Hendow court emphasized “the necessity of a false claim, rather than a mere unintentional violation.” 2006 U.S. App. LEXIS 22568, at *11, citing Hopper, 91 F. 3d at 1266-67.

In the instant case, Plaintiffs allege that the “Agreement for Participation in the Illinois Medical Assistance Program” requires that the Hospital agrees “to comply with all current and future program policy provisions as set forth in the applicable Department of Public Aid Medical Assistance Program handbooks.” (See Ex. A of PJC). Plaintiffs also allege that for Medicaid reimbursement payments, the Hospital was required to “sign and maintain a billing certification certifying that the billed services were provided in compliance with applicable laws and regulations.” (PJC at ¶¶23, 24). The billing certification states that the signor is “familiar with pertinent Illinois Department of Public Aid Policies and Procedures as set forth in the Illinois Medical Assistance Handbook.” (See Ex. B of PJC; PJC at ¶23). The referenced Illinois Medical Assistance Handbook states that covered services must be performed in “full compliance with applicable federal and state laws, [and] Department Administrative Rules.” (See Ex. C of PJC; PJC at ¶24). Plaintiffs further allege that Michael Volante, Reimbursement Manger, and John Mordach, Vice President of Finance, certified in annual cost reports, dated July 1, 1999 through June 30, 2000, November 29, 2000, July 1, 2001 through June 30, 2002, and December 13, 2002, that the billed services were rendered in compliance with healthcare services and regulations. (See Ex. D of PJC).

Relying on Joslin, the Hospital contends that the fact that it submitted certification of compliance in billing statements and annual reports does not create liability under the IWRPA. In Joslin, relator argued that annual cost reports submitted by the defendants to the government should have triggered FCA liability because the cost reports contained certifications of compliance with state laws, stating: “I HEREBY CERTIFY that . . . I am familiar with the laws and regulations regarding provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.” (emphasis supplied). 984 F. Supp. at 385. The Joslin court determined that the factual record did not demonstrate the certification of compliance with state laws as contained in the annual cost reports was a prerequisite to obtaining Government payments. Id. The court found that relator failed to prove otherwise, as was required in response to the defendants’ summary judgment motion and at trial. Id. Unlike in Joslin, the facts as currently alleged in PJC show that payment is conditioned on certification of compliance and Plaintiffs have introduced invoices and annual cost reports in which certification of compliance is contained.

Accepting as true all well-pleaded facts with all reasonable inferences that may be drawn from those facts in the light most favorable to Plaintiffs, we find that Plaintiffs’ claims are based on the Hospital’s false certification of compliance, not mere violations of the licensing laws and regulations.

(b) Scierter

The Hendow court stated that the central importance of scierter element to liability under the FCA is that “false claims must be in fact ‘false when made.’” Hendow 2006 U.S. App.

LEXIS 22568, at *12, quoting Hagood v. Sonoma County Water Agency, 81 F. 3d 1465, 1578 (9th Cir. 1996) (“For a certified statement to be ‘false’ under the Act, it must be an intentional, palpable lie”). The Hendow court held that “a palpably false statement, known to be a lie when it is made, is required for a party to be found liable under the [FCA].” Id. at *13. The Hendow court also held that “[s]o long as the statement in question is knowingly false when made, it matters not whether it is a certification, assertion, or secret handshake; False Claims liability can attach.” Id. at *14.

In the instant case, Plaintiffs allege that the Hospital made false certification of compliance knowingly and intentionally as follows. The nursing staffs in the NICU, including Relators, complained to the Hospital management repeatedly about the double-bunking practice, but the Hospital management refused to discontinue the practice of double-bunking infants in the NICU. (PJC at ¶ 46). Specific names and dates of their service in the NICU, who were responsible for such conduct, are provided. (PJC at ¶ 49). The Hospital management “actively concealed” the double-bunking practice from regulatory authorities by decompressing⁹ the NICU whenever they came out to inspect the NICU. (See Ex. L of PJC; PJC at ¶¶ 64-66). During the September 2003 onsite inspection, the inspector observed instances of double-bunking, overcrowding of the NICU, and lack of infection control, and subsequently recommended termination of the Hospital’s participation in Medicaid. (See Ex. M of PJC; PJC at ¶¶ 66-68). When the termination was postponed on condition upon the Hospital’s promise to follow “an approved plan of correction,” the Hospital failed to fulfill that promise. (PJC at ¶ 68). Then the policy and practice of double-bunking continued until the Hospital announced a new policy expressly prohibiting double-bunking and exceeding licensed capacity on July 7, 2005 by Dean of the University of Chicago Medical School and the Hospital’s CEO, when the Hospital learned about the State of Illinois’ investigation. (See Ex. P of PJC; PJC at ¶ 71). Plaintiffs claim that while the Hospital was clearly in violation of the required laws and regulations, it continued to certify compliance in billing statements and annual cost reports.

We find that the facts alleged *supra* establish that: (1) the Hospital was aware of the practice of double-bunking in the NICU exceeding its licensed capacity; (2) the Hospital management concealed the practice of double-bunking from state regulatory authorities; (3) the Hospital was specifically told that it was in violation of the licensing regulations as a result of the September 2003 inspection, but did not discontinue the practice of double-bunking; (4) even after the September 2003 incident, the Hospital continued to submit bills to IDHFS for Medicaid payment with certification of compliance. As such, Plaintiffs have pleaded with specific facts establishing that the Hospital made false certification of compliance knowingly and intentionally.

(c) Materiality

The Hendow court held that “the relevant certification of compliance must be both a ‘prerequisite to obtaining a government benefit’ [] and a ‘*sine qua non* of receipt of [government] funding,’” which is to say, “the false statement [] must be material to the government’s decision to pay out moneys to the claimant.” 2006 U.S. App. LEXIS 22568, at

⁹ “Decompression” was allegedly conducted by moving some double-bunked infants in the NICU to other units, by discharging them, or by moving them into already available individual bed spaces. (PJC at ¶ 64).

*14 (“the government funding must be ‘conditioned’ upon certifications of compliance”); see also Thompson, 125 F.3d at 902 (false certifications of compliance create liability under the FCA where “a claimant submits a false or fraudulent claim when he or she falsely certifies compliance with that statute or regulation”).

First, relying on United States ex rel. Conner v. Salina Regional Health Center, Inc., the Hospital contends that “the Conner plaintiffs alleged that the hospital’s claims for Medicare reimbursement were rendered false due to the hospital’s certifications of compliance with all laws and regulations [as in the instant case] in its provider application and annual Medicare cost reports, and violations of certain quality of care regulations.” (Def.’s September 5, 2006 Letter); citing Conner, 2006 WL 1232859, *2 (D. Kan. May 8, 2006). The Hospital claims that, in Conner, after examining “the quality of care regulations allegedly violated by the defendant,” the court concluded that “none expressly conditioned payment upon certification of compliance.” 2006 WL 1232859, at *5. The Hospital argues that “in the instant case, none of the bed spacing, capacity, or infection control violations plaintiffs allege [the Hospital] to have violated expressly condition payment upon certification of compliance, and plaintiffs’ allegations that the State would not have paid [the Hospital] had it known of the violations are contrary to the regulations and the facts as alleged in their complaint.” (Def.’s September 5, 2006 Letter).

We disagree with the Hospital’s position. The Conner court, as stated in the Hospital’s said letter, held that “[a] legally false certification of compliance with a statute or regulation cannot form a viable FCA cause of action unless payment is expressly conditioned on that certification.” 2006 WL 1232859, at *4. The Conner court granted the defendant’s motion to dismiss because “payment was not expressly conditioned on defendant’s certification” (*id.*), whereas Plaintiffs in the case at bar allege that the Hospital’s certification of compliance is a prerequisite to, or condition of, payment and have introduced documents, indicating that false certifications contained in billing statements and annual cost reports were presented to IDHFS to receive Medicaid payments (PJC at ¶ 76). In addition, the Hospital was not able to point to any regulation that would suggest that the Hospital would still be reimbursed even when it was in violation of state licensing regulations. Furthermore, the Hospital expressly promised to comply with state licensing regulations after it was found in violation of such regulation as a result of the September 2003 inspection and, consequently was recommended to be terminated in the participation in Medicaid. Even if we accept that the Hospital was not aware that Medicaid payment was conditioned on compliance with bed spacing, capacity limit, and infection control requirements, it is evident that the Hospital knew after the September 2003 inspection that it must comply with the required bed spacing, capacity limit and infection control regulations to continue to participate in Medicaid and thus to be reimbursed for Medicaid NICU services. As such, Conner is distinguishable from the case at bar, at least, to the extent that the Hospital knew that certification of compliance with the required regulations was a prerequisite to Medicaid payment.

Second, relying on United States ex. rel. Mikes v. Straus, the Hospital contends that unlike in Mikes where the forms the defendants submitted contained specific terms to comply with, there is no *specific* provision under the Agreement, which the Hospital specifically agreed to comply with, but only *general* provisions universally required for Medicaid providers. We disagree with the Hospital’s contention. In Mikes, the plaintiff alleged that defendants submitted

false claims for Medicare reimbursement for spirometry services. 274 F. 3d 687, 693 (2d Cir. 2001). The Mikes court analyzed the plaintiff's false claims act under both "express" and "implied" false certification theories.¹⁰ Id. at 697-702. Form HCFA-1500, submitted to the federal government for Medicaid reimbursement, expressly stated, in part: "I certify that services shown on this form were *medically indicated and necessary* for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision." (emphasis added). Id. at 698. The Form also contained a provision, stating: "No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations." Id. The Second Circuit found that, based on the form and the Medicare Regulations, "defendants certified they would comply with the terms on the form" and "such compliance was a precondition of governmental payment." Id. The court held that there was no FCA claim because the allegation was predicated on the violation of "quality of care" requirement. Id. The court reasoned that "[t]he term 'medical necessity' does not impart a qualitative element mandating a particular standard of medical care" and the plaintiff did not produce any evidence to support her contention that the tests for which the defendants submitted claims for Medicaid reimbursement were not "medically necessary." Id. at 698, 699. Accordingly, the court concluded that the plaintiff's claim based on express false certification failed. Id. at 699.

Under "implied" false certification theory, the Mikes plaintiff contended that defendants' submission of the form to the government for payment was "impliedly false certifications." Id. The Second Circuit in Mikes declined to follow a Court of Federal Claims opinion in Ab-Tech Construction, Inc. v. United States, which adopted a broader implied false certification approach. Ab-Tech Construction, Inc., 31 Fed. Cl. 429 (Ct. Cl. 1994). The Ab-Tech court held that the defendants' submission of payment vouchers, although containing no express representation, implicitly certified their continued compliance with the eligibility requirements of a federal small business statutory program. 31 Fed. Cl. at 434. The Mikes court significantly limited the Ab-Tech court's approach, holding that the FCA is designed to enforce compliance with only those regulations that expressly state that compliance is a precondition to payment or retention of payments. 274 F. 3d at 700. "Implied false certification is appropriately applied only when the underlying statute or regulation upon which the plaintiff relies expressly states the provider must comply in order to be paid." Id. The court held that there was no FCA claim under an implied false certification claim because, as was under an express false certification claim, the plaintiff's allegation that defendants' performance was not medically reasonable and necessary pertains to the selection of the particular medical procedure, which is not premised on compliance with the particular statute or regulation. Id. at 701.

We find that Mikes is distinguishable from the instant case in that whereas the allegation in Mikes was predicated on defendants' alleged failure of complying with a "quality of care" provision (i.e., providing Medicare services, "medically indicated and necessary for the health of the patient"), not based on compliance with the required licensing regulations as in the case at

¹⁰ An "express false certification" claim is predicated on false certification of compliance with "a particular statute, regulations or contractual term, where compliance is a prerequisite to payment," whereas "[a]n implied false certification claim is based on the notion that the act of submitting a claim for reimbursement itself implies compliance with [the required regulations] that are a precondition to payment." Id. at 698, 699.

bar. The issue in Mikes was not whether the required provision in the form submitted for payment was “specific” or “general,” but whether the term “medical necessity” was predicated on a particular standard of care under Medicare agreement. 274 F. 3d at 698. Under both express and implied false certification theories, the Mikes court found no legal authority. Id. The court specifically noted that “the courts are not the best forum to resolve medical issues concerning levels of care. State, local or private medical agencies, boards and societies are better suited to monitor quality of care issues.” Id. at 700. In the instant case, the allegation is not based on a violation of a quality of care as in Mikes, but specific violations of state licensing requirements, namely, double-bunking, overcrowding and lack of infection control. It is also alleged that compliance with said requirements are contained in the Agreement (for Medicaid participation) and Medicaid payment is conditioned on compliance with said requirements. Furthermore, by submitting certification of compliance in billing statements and annual reports, the Hospital certified its compliance. Accordingly, we find that the Hospital’s contention that it never agreed to any specific provision when it entered into the Agreement as a Medicaid provider and when it certified compliance with state licensing regulations fails.

Third, the Hospital contends that certification of compliance with state licensing regulations is not a “condition of payment” but a “condition of participation in the Illinois Medical Assistance Program,” which is insufficient to establish an IWRPA claim. (Def. Mot. at 14). The same argument was raised by the Hendow defendant where the University of Phoenix entered into an agreement to comply with the incentive compensation ban to become eligible for receiving federal funds, but later falsely certified each year that it was in compliance with the incentive compensation ban while intentionally and knowingly violating that requirement.¹¹ 2006 U.S. App. LEXIS 22568, at *4, 27. The Ninth Circuit stated that “if we held that conditions of participation were not conditions of payment, there would be no conditions of payment at all.” Id. at *25, 26. The court also held that the defendant’s promise to comply with the required laws and regulations under the “Program Participation Agreement” is “conditions of payment” and also “prerequisites” of federal funding. Id. at *27, 28. As in Hendow, the Hospital entered into an “Agreement For Participation in the Illinois Medical Assistance Program,” whereby the Hospital signed and agreed to “comply with all current and future program policy provisions as set forth in the applicable Department of Public Aid Medical Assistance Program handbooks” and also with “applicable licensing standards as contained in State laws or regulations.” (See Ex. A of PJC). Under Hendow, it is evident that the Hospital’s Agreement to comply with all applicable state laws and regulations and licensing requirements (e.g., 89 Ill. Admin. Code 148.50(a)) is a condition of *payment*, not merely a condition of participation.

Finally, the Hospital contends that even after Illinois became aware of the alleged

¹¹ The defendant University of Phoenix entered into the Program Participation Agreement, stating that “the University of Phoenix certifies that it has complied with the incentive compensation ban.” The court explained that the Program Participation Agreement . . . is the condition of payment that the federal government requires—a promise that the University shall not break the law, not merely an assertion that it has not broken the law yet. If such promises were not conditions of payment, the University would be virtually unfettered in its ability to receive funds from the government while flouting the law. This cannot be what Congress and the DOE intend when they ask institutions to sign Program Participation Agreement.” Id. at *27, 28.

violations, following the September 26, 2003 inspection, Illinois continued to pay the Hospital. (Def. Mot. at 26). The Hospital argues that continuing payments indicate that Illinois did not rely on the Hospital's certification of compliance for reimbursement and, thus, the alleged false certification of compliance is not material. (Def. Mot. at 26). Plaintiffs argue in response that the reason why IDHFS did not terminate the Hospital's participation in the Medicaid was because of the Hospital's promise to follow through an approved plan of correction.

We find that the Hospital's failure of compliance even after the September 2003 report indicates that it knowingly and intentionally disregarded the required licensing regulations and yet continued to submit claims to IDHFS for Medicaid payment with false certification of compliance. We also find that the fact that termination of the Hospital's participation in Medicaid was postponed on its promise to comply with such regulations supports that its certification of compliance was "integral to a causal chain leading to payment." United States ex rel. Main v. Oakland City Univ., 426 F. 3d 914, 916 (7th Cir. 2005) (where the University accepted federal funds that were contingent on refraining from paying recruiters contingent fees for enrolling students). In Main, the University submitted an application to establish its eligibility for receiving federal subsidies under the Higher Education Act, which is called a "phase one" application. Id. at 916. Then, the University submitted "phase two" applications for specific grants, loans or scholarships. Id. The Seventh Circuit held that "[i]f a false statement is integral to a causal chain leading to payment, it is irrelevant how the federal bureaucracy has apportioned the statements among layers of paperwork." Id. The court rejected the University's contention that the causal-link approach "would treat any violation of federal regulations in a funding program as actionable fraud. Id. The court held that "if the University knew about the rule [when it submitted the phase-one application] and told the Department [of Education] that it would comply, while planning to do otherwise, it is exposed to penalties under the [FCA]." Id. Even if we grant that the Hospital did not know that it was required to comply with bed-spacing, capacity limit and infection control requirements when it first agreed to the Agreement, it is evident that when it agreed to follow an "approved plan of correction" following the September 2003 inspection as an express condition of not being terminated, the Hospital knew that it was required to comply with state licensing regulations. Accordingly, the Hospital's continuing failure of compliance until July 2005 exposes to false claims act under the IWRPA.

Thus, based on the foregoing reasons, we find that Plaintiffs have pleaded with specific facts establishing that the Hospital's certification of compliance was material to Illinois' decision to pay.

(d) Claim

The Hendow court held that "it is necessary [to] involve an actual claim, which is to say, a call on the government fisc." 2006 U.S. App. LEXIS 22568, at *16. "[F]or there to exist a 'claim' for purposes of [the FCA] liability, it must involve merely some sort of request for the government to pay out money . . ." Id. at *21. "The Supreme Court has cautioned that the False Claims Act was not designed to punish every type of fraud committed upon the government. See United States v. McNinch, 356 U.S. 595, 599 (1958). "The statute attaches liability, not to the underlying fraudulent activity or to the government's wrongful payment, but to the claim for payment." (internal citations omitted). Graves, 284 F. Supp. 2d at 495.

In Hendow, the court found that the statutory language, requiring a “claim paid or approved by the Government,” was “self-evident” that the government was asked to pay out money. 2006 U.S. App. LEXIS 22568, at *16. As in Hendow, the language of the IWRPA requires that an IWRPA claim arises when a “claim for payment or approval” is “knowingly presented . . . to an officer or employee of the State . . .” 740 ILCS 175/3(a)(1). Plaintiffs allege that the Hospital submitted claims for Medicaid reimbursement, including: double-bunked babies (1999) for \$829,156 (Ex. F of PJC); double-bunked babies (2000) for \$1,185,548 (Ex. G of PJC); double-bunked babies (2001) for \$857,861 (Ex. H of PJC); double-bunked babies (2002) for \$1,225,406 (Ex. I of PJC); double-bunked babies (2003) for \$1,787,2000 (Ex. J of PJC); IDHFS’s reimbursement to the Hospital in violation of infection control regulations (Ex. R of PJC; PJC at ¶ 32).

The Hospital cites United States ex rel. Denise Crews & State of Illinois ex rel. Denise Crews v. NCS Healthcare of Illinois, Inc., et al. to argue that “a claim for Medicaid reimbursement is not rendered false for purposes of the [FCA] or [IWRPA] simply because the provider violated applicable federal regulations.” (Def.’s August 21, 2006 Letter); 2006 WL 2371457 (7th Cir. 2006). Plaintiffs contend in response that “the [Crews] court found there was no certification that could form the basis of false claims,” which is to say, plaintiffs failed to “plead certification as a condition of payment” and to introduce “actual relevant evidence” of certification being a condition of payment. (Pl. Resp. to Supplemental Authority at 2).

We agree with Plaintiffs’ interpretation of Crews. The Seventh Circuit in Crews is consistent with the Ninth Circuit in Hendow, holding that the FCA requires three essential elements: “(1) the defendant made a statement in order to receive money from the government, (2) the statement was false, and (3) the defendant knew it was false.” 2006 WL 2371457, at *2, citing United States ex rel. Gross v. AIDS Research Alliance-Chicago, 415 F. 3d 601, 604 (7th Cir. 2005). Accordingly, the Crews case held that if a provider for Medicaid knowingly makes false statements (i.e., certifying its compliance with state laws and regulations under the Medicaid) to obtain reimbursement or payments from the government, that provider is liable.¹² Since the Crews plaintiff failed to introduce any relevant false claim that was actually submitted for payment, the court affirmed summary judgment for defendants. 2006 WL 2371457, at *3. In the instant case, however, Plaintiffs have introduced supporting documents, attached to PJC as Exhibits F, G, H, I, J, and R, to establish a causal link between those actual claims submitted for the purposes of receiving Medicaid reimbursement and its false certification of compliance attached to those claims.

In sum, having examined the case at bar under the Hendow elements, we find that Plaintiffs have pleaded with specific facts establishing that: (1) the Hospital’s certification of compliance is a prerequisite to payment; (2) the Hospital knowingly and intentionally made false certification of compliance while violating the required laws and regulations; (3) the Hospital’s

¹² In Crews, the Seventh Circuit held that without proof of an actual claim submitted to Medicaid, there is no false claim. 2006 WL 2371457, at *3; see also United States ex rel. Quinn v. Omnicare, Inc., 382 F. 3d 432 (3d Cir. 2004); United States ex rel. Clausen v. Lab Corp. of Am., Inc., 290 F. 3d 1301 (11th Cir. 2002); United States ex rel. Alfatooni v. Kitsap Physicians Serv., 314 F. 3d 995 (9th Cir. 2002). In Quinn, Clausen, and Alfatooni, the respective relators’ claims were insufficient because each relator failed to provide a single false claim that was actually submitted to Medicaid.

certification of compliance is material to its Medicaid reimbursement; and (4) IDHFS made payments to the Hospital in reliance on the alleged false certification of compliance. Accordingly, we deny Defendant's motion to dismiss Counts I, II and III that are brought under the IWRPA pursuant to 735 ILCS 5/2-615.

IV. Sufficiency of Licensed Capacity Violation Allegations (Count II)

The Hospital contends that even if Plaintiffs did allege that certification of compliance was a prerequisite to Medicaid reimbursement and the Hospital issued a false certification of compliance, they failed to sufficiently allege the underlying regulatory violation. In support of its position, the Hospital contends that Plaintiffs failed to show that the Hospital violated capacity requirements because Plaintiffs did not allege which capacity regulations were violated.

We disagree. Here, Plaintiffs allege that the total number of NICU beds allowable, as determined by the Department of Public Health, were 53 to 58 at Wyler, and 65 at Comer, but the Hospital submitted bills to IDHFS in violation of its licensed capacity. (PJC at ¶ 100) (see also Exs. E (NICU staff/shift report sheet dated 1/22/2003); F (double-bunked babies in 1999); G (double-bunked babies in 2000); H (double-bunked babies in 2000); I (double-bunked babies in 2001); J (double-bunked babies in 2003) of PJC). In addition, to support their claim, Plaintiffs refer to two regulations, 77 Ill. Admin. Code 250.120(g)(2)¹³ and 77 Ill. Admin. Code 250.230(a) and (b),¹⁴ whereby specific capacity limits are respectively authorized and mandated. (PJC at ¶¶ 28, 29). We find that the foregoing exhibits, supported by statutory regulations, provide specific

¹³ 77 Ill. Admin. Code 250.120 sets forth, in part, "Hospital Licensing Requirements" as follows:

The license shall apply only to the number of beds and the clinical services operating at the time the license is issued. If a new clinical service is to be initiated, or an existing service expanded or discontinued, the approval of the Department must first be obtained. If a change in clinical service results in change of license category, then a new application for license shall be submitted and the provisions of Section 250.110 and this Section shall apply."

77 Ill. Adm. Code 250.120 (g)(2).

¹⁴ 77 Ill. Admin. Code 250.230 also sets forth, in part, "Hospital Licensing Requirements" as follows:

a) Occupancy Control

1) Every hospital shall develop occupancy control measures and participate in inter-hospital and community planning to meet medical and hospital needs. Such planning shall include a continuing evaluation of the hospital's facilities and services to make effective use of existing hospital, nursing home and public health facilities and services, including community home care services, and of developing new and/or additional services.

2) Every hospital shall enforce its occupancy control measures in an effort to avoid over utilization of its facilities and services. Hospitals experiencing a high level occupancy should, if other measures are inadequate, develop hospital expansion plans in conjunction with recognized health facility planning organizations within its area or region. Expansion programs must also comply with Public Act 78-1156, the Illinois Health Facilities Planning Act, as administered by the Health Facilities Planning Board. (Refer to Section 250.310 (a)(14))

b) Admission—Discharge. The hospital shall control its admission and discharge of patients so that occupancy does not at any time exceed capacity, except in the event of unusual emergency and then only as a temporary measure.

77 Ill. Adm. Code 250.230(a), (b).

facts establishing that the Hospital exceeded its licensed capacity in the NICU.¹⁵

The Hospital also contends that Plaintiffs have not clearly shown that any capacity violation occurred because there is no cap on Level II beds. We find that this argument is not persuasive. Here is why. The allegation of the Hospital's licensed capacity violation need not delineate between Level II and III beds when the allegation is based on the assertion that the total number of allowable beds, including both Level II and III beds, was exceeded. If two categories of beds (i.e., Level II and Level III) are allowable, one subcategory that is without any defined limit (i.e., Level II) may not exceed the total number of beds allowed between both categories. A limit on the total number of both Level II and III beds implicitly assumes some limit on each individual category. Accordingly, we find that Plaintiffs have sufficiently alleged that the Hospital's total number of beds in the NICU violated the regulatory limit. Thus, we deny Defendant's motion to dismiss Count II pursuant to 735 ILCS 5/2-615.¹⁶

V. Particularity of Pleading for Fraud (Count III)

The Hospital contends that Plaintiffs failed to plead Count III with "specificity and particularity." (Def. Mot. at 17). The Hospital argues that Plaintiffs have failed to "identify a single Medicaid patient as to whom the Hospital violated the [infection control] isolation regulations." (Def. Mot. at 19-20). Plaintiffs contend in response that they have alleged those patients, who are "pseudonymously identified in Exhibits R-U." (PJC at ¶113). The Hospital also argues that these exhibits only refer to "infection outbreaks," which are not, in and of

¹⁵ We note that the Northern District Court found that "Relators have not pled with particularity as to who in the Hospital authorized or mandated any of the alleged practices of double-bunking infants, overcrowding the NICU, and tolerating serious infection outbreaks among NICU infants. — 2006 WL 516577, at *6. In the instant case, we find that Plaintiffs have pled with particularity specific facts to support their allegations.

¹⁶ The Hospital also contends that its increase in the NICU bed capacity is justifiable on the basis of regulations authorizing a health care facility to increase its bed capacity by 10 beds every two years without seeking permission from the appropriate State agency. The relevant regulation reads:

A permit shall be obtained prior to the establishment, construction or modification of a health care facility unless an exemption has been issued . . . A transaction that is not exempt from review is subject to review and requires a permit if the transaction . . . 4) changes the bed capacity of a health care facility by increasing the total number of beds or by distributing beds among various categories of service or by relocating beds from one physical facility or site to another by more than ten beds or more than ten percent of total bed capacity as defined by the State Board, whichever is less, over a two year period (pursuant to Section 1130.140).

77 Ill. Adm. Code 1130.310(a)(4) (as of February 21, 2003) (as of September 1, 2006, the language of this regulation has changed).

Plaintiffs allege that exceeding capacity occurred "as a matter of course, not as part of the 'establishment, construction or modification' of its NICU." (Pl. Resp. at 11; PJC at ¶¶ 79, 80, 84-89, 92). For this regulation to apply, the Hospital would have to allege a new fact: that the increase in the number of beds was pursuant to some project requiring "establishment, construction, or modification" of the Hospital's facilities. Plaintiffs also argue that such an allegation is inappropriate for a 2-615 motion because it alleges new facts. We agree with Plaintiffs' position. Since the Hospital's claim asserts a new fact, we find that it is inappropriate for consideration under a 2-615 motion.

themselves, violative of any regulation. (Def. Mot. at 20). We disagree. PJC alleges that IDPH determined that the September 2003 outbreak was conclusive evidence of the Hospital's violation of infection control regulations. (See Ex. S of PJC; PJC at ¶113).

The Hospital also contends that Plaintiffs failed to show any nexus between specific infection control regulatory violations, even if true, and the conclusion that such violations in fact caused the infection of specific babies for which the Hospital submitted Medicaid reimbursement requests. (Def. Mot. at 21). Again, the allegation is based on the Hospital's false certification of compliance. Specifying which babies were in fact infected as a result of the Hospital's violation of infection regulations is a question of fact yet to be determined and Plaintiffs are not required to set forth evidence in the complaint. So long as we can draw reasonable inferences from all well-pleaded facts that those patients could have been infected as a result of the Hospital's infection control violation, the pleading can withstand a section 2-615 motion to dismiss.

We find that Plaintiffs have pleaded with specific facts establishing that some infants were infected as a result of the Hospital's violation of infection control regulation, which was resulted from overcrowding its NICU beyond its licensed capacity. Plaintiffs have also sufficiently alleged that the Hospital certified compliance with infection control regulations to receive Medicaid reimbursement payments for services rendered for those NICU patients. (See PJC at ¶ 110; Exs. R and S of PJC). The Hospital's assertion that the identified infants were not in fact injured by the specific regulatory violation the Hospital certified compliance with is not an issue to be considered for a section 2-615 motion. Accordingly, we find that Plaintiffs have pleaded with specific facts establishing a claim of fraud as to Count III of PJC within a legally recognized cause of action.

VI. Federal Law: Emergency Capacity Provisions (Count IV)

The Hospital contends that Plaintiffs' claim under IPAFA, 305 ILCS 5/8A-7(b), is insufficient to establish a cause of action because the federal EMTALA (Emergency Medical Treatment and Active Labor Act) requires that regardless of capacity, a hospital must provide treatment to potential patients with emergency medical conditions, or anyone whose condition is unstable and would deteriorate without treatment.¹⁷ The Hospital argues that the Plaintiffs' application of state laws and regulations impermissibly conflicts with the federal requirements.

However, thus far, facts show that the Hospital's conduct does not indicate that exceeding its licensed capacity was in fact in response to emergency situations. If that is true, the Hospital may want to set forth such situations as affirmative defenses in its Answer to PJC. On the other hand, Plaintiffs allege that the Hospital "decompressed" the NICU to meet capacity

¹⁷ Under IPAFA, 305 ILCS 5/8A-7(b), in part, provides civil remedies when: "Any person, firm, corporation, association, agency, institution or other legal entity, other than an individual recipient, [] willfully, by means of a false statement or representation, or by concealment of any material fact or by other fraudulent scheme or device on behalf of himself or others, obtains or attempts to obtain benefits or payments under this Code to which he or it is not entitled, or in a greater amount than that to which he or it is entitled, . . ." 305 ILCS 5/8A-7(b).

regulations whenever the State made an announced inspection. (PJC at ¶18). When IDPH made a surprise inspection on September 26, 2003, the Hospital was found in violation of the required capacity regulations. (PJC at ¶66). If the Hospital was exceeding capacity in compliance with the federal EMTALA, we do not see the reason for recommendation by IDHS of termination of the Hospital's participation in Medicaid.¹⁸ Rather, based on the allegations set forth in PJC, we find that the Hospital's conduct indicates their regulatory violations as a matter of course, not required by or in compliance with the federal EMTALA.

VII. Common Law Fraud (Count V)

In order to state a claim for common law fraud, Plaintiffs must sufficiently allege facts establishing the following: "(1) a false statement of material fact; (2) the defendant's knowledge that the statement was false; (3) the defendant's intent that the statement induce the plaintiff to act; (4) the plaintiff's reliance on the statement; and (5) the plaintiff's damages resulting from reliance on the statement." Suburban 1, Inc. v. GHS Mortgage, LLC, 358 Ill. App. 3d 769, 722 (2d Dist. 2005).

The Hospital contends that Plaintiffs did not allege that it knowingly made any materially false statement. We find that each certification of compliance constitutes a statement to IDHFS that the Hospital was in compliance with the relevant regulations. PJC sets forth that "[the Hospital] knowingly and intentionally submitted false claims for payment when it was operating the NICU above licensed capacity" and setting forth who were aware of said violations and who were involved in concealment and making false certification of compliance. (See PJC at ¶¶ 80, 83, 104). As such, we find that Plaintiffs sufficiently alleged that the Hospital knowingly made a materially false statement.

The Hospital also contends that Plaintiffs failed to show that it had any intent to deceive. However, Plaintiffs have pled with specificity and particularity that the Hospital "decompressed" the NICU to regulatory compliance prior to the announced inspections, and resumed violation of capacity regulations after the inspections. (PJC at ¶ 64). We find that said allegations are sufficient to show that the Hospital intended to deceive Illinois regarding their compliance with capacity regulations.

The Hospital finally contends that Plaintiffs fail to allege that Illinois' reliance on the Hospital's false statement was the proximate cause of its damages. We find that Plaintiffs have pleaded with specificity and particularity that to receive reimbursement, the Hospital was required to sign a billing certification and submit annual cost reports with certification of compliance. (PJC at ¶23). Plaintiffs also claim that Illinois was unaware of the falsity of such claims and, accordingly, made payment to the Hospital. (PJC at ¶76). Based on Plaintiffs' allegations, it seems logical to infer that Illinois would not have made such payments to the Hospital had it not submitted certification of compliance in billing certification and annual cost reports because such certification is found to be a prerequisite to or condition of payment. Since Illinois made such payments in reliance on the Hospital's certification of compliance, it seems reasonable that damages Illinois sustained were proximately caused by the Hospital's false

¹⁸ If the Hospital was in fact required to admit NICU patients exceeding its state licensed capacity in order to fully comply with EMTALA, it may assert it as an affirmative defense in its answer to PJC.

certification.

Thus, having found that Plaintiffs have satisfied the required elements for common law fraud, we deny Defendant's motion to dismiss Count V pursuant to 735 ILCS 5/2-615.

VIII. Payment by Mistake of Fact (Count VI)

“[W]here money is paid under a mistake of fact, and payment would not have been made had the facts been known to the payor, such money may be recovered. The fact that the person to whom the money was paid under a mistake of fact was not guilty of deceit or unfairness, and acted in good faith, does not prevent recovery of the sum paid, nor does the negligence of the payor preclude recovery.” Bank of Naperville v. Catalano, 86 Ill. App. 3d 1005, 1008 (2d Dist. 1980); see also King v. First Capital Fin. Servs. Corp., 215 Ill. 2d 1, 27-28 (Ill. 2005) (absent fraud, duress, or mistake of fact, money voluntarily paid on a claim of right to the payment cannot be recovered on the ground that the claim was illegal).

The Hospital contends that the mistake of fact claim must be dismissed on the assertion that Illinois was aware of the regulatory violations at least subsequent to the September 26, 2003 inspection, and yet continued to make payments. In response, Plaintiffs first argue that said inspection did not fully reveal the extent of the Hospital's policies ignoring the regulations, and that after promising to remedy the violations, they still failed to do so. Even though the Hospital was reimbursed after violating the regulations, Plaintiffs claim that payment was conditioned on the Hospital's express promise to follow an “agreed plan of correction” in efforts to remedy the alleged violations. (PJC at ¶115). Plaintiffs also claim that despite such promises, the Hospital continued to violate the regulations and Illinois was led to believe any regulatory violations had been remedied, while the violations in fact continued. (PJC at ¶ 116).

We agree with Plaintiffs' position. We find that the fact that even after the September 2003 inspection, the Hospital continued to submit bills for Medicaid services with certification of compliance and to obtain Medicaid payments while still violating the licensing regulations, contrary to its express promise to IDHFS, establishes that the Hospital received Medicaid reimburse under a mistake of fact. Accordingly, we find that Plaintiffs have pleaded with specific facts establishing a claim for payment by mistake of fact within a legally recognized cause of action. Thus, we deny Defendant's motion to dismiss Count VI pursuant to 735 ILCS 5/2-615.

In sum, we find that: (1) the Hospital's “Agreement For Participation in the Illinois Medical Assistance Program” is not merely a condition of participation but a condition of payment; (2) pursuant to said Agreement, the Hospital's certification of compliance with all applicable state laws and regulation for the Illinois Medical Assistance Program in billing certification and annual cost reports is a prerequisite to or condition of payment; (3) pursuant to the IWRPA, Plaintiffs have pleaded specific facts to show that the Hospital made false certification of compliance while violating the required laws and regulation with respect to double-bunking, overcrowding, and infection control violation, to withstand a section 2-615 motion to dismiss; (4) Plaintiffs have pleaded with specificity and particularity that the Hospital violated the IPFA, to withstand a section 2-615 motion to dismiss; (5) Plaintiffs have pleaded

with specificity and particularity that the Hospital committed common law fraud, to withstand a section 2-615 motion to dismiss; and (6) Plaintiffs have alleged enough specific facts to show that, as a result of false certification of compliance, the Hospital received payments from IDHFS under a mistake of fact.

Based on the foregoing findings, we deny Defendant's motion to dismiss Plaintiffs' Joint Complaint pursuant to 735 ILCS 5/2-615. Defendant has 28 days to answer.

ORDER

WHEREFORE, for all the reasons stated,

It is hereby ordered that:

- (1) Defendant's motion to dismiss the Plaintiffs' Joint Complaint pursuant to 735 ILCS 5/2-615 is denied; and
- (2) Defendant has 28 days to answer.

Hon. Allen S. Goldberg

