UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

UNITED STATES OF AMERICA, and the STATE OF INDIANA, ex rel. THOMAS P. FISCHER,

Plaintiffs,

vs.

COMMUNITY HEALTH NETWORK, INC., COMMUNITY HEALTH NETWORK FOUNDATION, INC., COMMUNITY PHYSICIANS OF INDIANA, INC., VISIONARY ENTERPRISES, INC., NORTH CAMPUS SURGERY CENTER, LLC d/b/a COMMUNITY SURGERY CENTER NORTH, SOUTH CAMPUS SURGERY CENTER, LLC d/b/a COMMUNITY SURGERY CENTER-SOUTH, EAST CAMPUS SURGERY CENTER d/b/a COMMUNITY SURGERY CENTER EAST, HAMILTON SURGERY CENTER, LLC d/b/a COMMUNITY SURGERY CENTER HAMILTON, HOWARD COMMUNITY SURGERY CENTER d/b/a COMMUNITY SURGERY CENTER KOKOMO, NORTHWEST SURGERY CENTER, LLC d/b/a COMMUNITY SURGERY CENTER-NORTHWEST, HANCOCK SURGERY CENTER, INDIANAPOLIS ENDOSCOPY CENTER, LLP d/b/a COMMUNITY ENDOSCOPY CENTER, COMMUNITY ENDOSCOPY CENTER, LLC d/b/a COMMUNITY DIGESTIVE CENTER-ANDERSON, NORTH CAMPUS OFFICE ASSOCIATES, L.P.,

Defendants.

Case No. 1:14-cv-1215-RLY-DLP

SECOND AMENDED COMPLAINT FOR VIOLATION OF THE FEDERAL FALSE CLAIMS ACT [31 U.S.C. §§ 3729 *et seq*.]; INDIANA FALSE CLAIMS AND WHISTLEBLOWER PROTECTION ACT [Ind. Code §§ 5-11-5.5-1 *et seq*.]; BREACH OF CONTRACT; BREACH OF ORAL CONTRACT; PROMISSORY ESTOPPEL; QUANTUM MERUIT and BLACKLISTING [Ind. Code § 22-5-3-1]

TABLE OF CONTENTS

SECOND AMENDED COMPLAINT

1. Plaintiff-Relator Thomas P. Fischer brings this qui tam action, by and through undersigned counsel, adopting and incorporating by reference the Government's Complaint in Intervention [Dkt. 96], Relator's Complaint [Dkt. 1] and First Amended Complaint [Dkt.32] to the extent not inconsistent herewith, and files this Second Amended Complaint against Defendants Community Health Network, Inc., Community Health Network Foundation, Inc., Community Physicians of Indiana, Inc., Visionary Enterprises, Inc., North Campus Surgery Center, LLC d/b/a Community Surgery Center North, South Campus Surgery Center, LLC d/b/a Community Surgery Center South, East Campus Surgery Center, LLC d/b/a Community Surgery Center East, Hamilton Surgery Center, LLC d/b/a Community Surgery Center Hamilton, Howard Community Surgery Center, LLC d/b/a Community Surgery Center Kokomo, Northwest Surgery Center, LLC d/b/a Community Surgery Center-Northwest, Hancock Surgery Center, Indianapolis Endoscopy Center, LLP d/b/a Community Endoscopy Center, Community Endoscopy Center, LLC d/b/a Community Digestive Center, and North Campus Office Associates, L.P., for damages and civil penalties arising out of the Defendants' collective violations of the False Claims Act, 31 U.S.C. §§ 3729-3733, as amended, Pub. L. 99-562, 100 Stat. 3153 (1986), the Anti-Kickback Statute, 41 U.S.C. § 1320a-7b, the Stark Law, 42 U.S.C. § 1395nn, and the relevant statutes in the State of Indiana, including the Indiana Anti-Kickback Statute, Burns Ind. Code Ann. § 12-15-24-2, along with claims arising under Indiana common law.

INTRODUCTION

2. This case seeks to recover damages and civil penalties on behalf of the United States of America and the State of Indiana, arising from Defendants' scheme to defraud the federal

and state governments by entering into improper arrangements and deals that resulted in Defendants paying above fair market value physician compensation to illegally induce physicians to refer Medicare, Medicaid and other government insurance patients to Defendants' hospitals and associated medical entities for general healthcare services paid for by government-funded healthcare programs.

3. Defendants effectuated the fraudulent kickback scheme by knowingly and willfully paying incentives to physicians to induce them to become employed or affiliated with Defendants, and to continue and remain so, to ensure that they refer all, or substantially all, of their patients to Defendants' hospitals and associated medical entities rather than to any competitor hospitals or health networks. Such a scheme led Defendants to submit, or cause the submission of, kickback-tainted claims, statements or records related to those illegally referred patients.

4. Defendants improperly incentivized and induced employed physicians and affiliates to gain access to their referrals, thus, by virtue of the various kickback schemes, Defendants violated the Stark Law and the federal and state anti-kickback statutes, in the following ways.

5. First, in violation of anti-kickback statutes, Community paid illegal remuneration to investor physicians by funneling money through equity interests in ambulatory surgical centers ("ASCs") and other joint ventures. Community used these lucrative deals as a means to steer high-margin business to ASCs by inducing investor physicians – and physicians who were interested in becoming a potential investor – to refer patients to Community.

6. In addition to physician investors, Community also paid its hospital investors kickbacks in the form of "management fees" based on ASC profitability. Community knew that these hospital investors would refer Medicare and Medicaid patients to the ASCs.

7. Second, Community paid excessive and above fair market value physician compensation packages to referring physicians, including a combination of high base salaries, generous performance and retention bonuses, and lump sum payments. At all times, Community knew it was violating the Stark Law and paying and intended to pay the integrated practices, such as cardiology, neurology, breast oncology, orthopedics and obstetrics and gynecology, above fair market value.

8. Third, in violation of anti-kickback and Stark laws, Community also paid above fair market value rates to the "CHOP" group of medical oncologists to get them to practice exclusively at Community and to stop treating patients at Methodist Hospital. To do so, Community focused exclusively on securing oncology referrals (outpatient oncology services) by paying kickbacks.

9. Finally, Community also engaged in sham business arrangements with a local nursing home provider, which split revenues and other government funded reimbursements with Community, and paid Community for services not needed or performed, as a quid pro quo for, or in exchange for, directing patients to its nursing homes in violation of anti-kickback laws.

10. Community and CEO Bryan Mills coordinated the widespread culture of corruption surrounding kickback-tainted referrals through ASCs and CHOP, improper physician compensation arrangements, and sham business deals, encompassing nearly all of the employed physicians and hospitals at Community and its affiliated entities.

11. As a result, Defendants submitted or caused to be submitted thousands of false claims to federal and state-funded health care programs for services provided pursuant to kickback-tainted referrals from physicians with whom Defendants had financial relationships that did not

fall within any safe harbors or exceptions. Thus, each submission is a false or fraudulent claim that violates the federal and Indiana False Claims Acts.

JURISDICTION AND VENUE

12. This is an action brought pursuant to the False Claims Act, 31 U.S.C. §§ 3729, *et seq*., and the subject matter is invoked pursuant to 28 U.S.C. § 1331. This case arises from the wrongful conduct of the Defendants incident to obtaining funds from the federal government.

13. This Court has personal jurisdiction over the Defendants under 31 U.S.C. § 3730(a), which authorizes nationwide service of process and because the Defendants have a least minimum contacts with the United States.

14. 31 U.S.C. § 3730(a) provides: "Any action under section 3730 may be brought in any judicial district in which the Defendant or, in the case of multiple Defendants, any one Defendant, can be found, resides, transacts business, or in any proscribed by section 3729 occurred."

15. Venue is proper in the Southern District of Indiana, Indianapolis Division, pursuant to 28 U.S.C. §§ 1391(b) and 1395(a) and 31 U.S.C. § 3732(a) because Defendants can be found in and/or transact or have transacted business in this district and division. At all times relevant to this Second Amended Complaint, Defendants regularly conducted, and continue to conduct, substantial business within this district and division and/or maintain employees and offices in this district and division.

16. Relator has insider knowledge of the information contained herein and is an original source. Relator pre-disclosed the facts giving rise to these claims to the Government before filing suit and before amending the complaint. The government would not have known about this

fraud, its details, and its breadth and scope, without the personal knowledge provided by the Relator.

PARTIES AND ENTITIES

A) Plaintiff - Relator Thomas P. Fischer

17. Plaintiff-Relator Thomas P. Fischer is a resident of Florida and was a resident of Indiana when working for Community. He worked in healthcare finance and operations for decades. In October 2005, Community recruited Relator from his private practice, where he offered investment banking and advisory services to large healthcare organizations. Relator joined Community as the Chief Financial Officer. In December 2012, Community promoted him to serve concurrently as the Chief Operating Officer and Chief Financial Officer. In these roles, Community tasked the Relator with significant responsibility, including leading teams of administrators in overseeing the finances, operations, supply chains, and managed care contracts of the network's eight hospitals. On November 27, 2013, Community discharged Relator.

B) Defendants

18. Defendant Community Health Network, Inc. ("Community") is a 501(c)(3) non-profit integrated health system located in Indianapolis, Indiana. It is incorporated in the State of Indiana with its principal place of business at 1500 N. Ritter Avenue, Indianapolis, Indiana, which is located in Marion County, Indiana. It includes 8 hospitals, several surgery centers, urgent care centers, and outpatient facilities, bringing its total sites of care to over 200. It employs over 350 physicians through subsidiaries and affiliates, primarily wholly-owned subsidiary Community Physician Network ("CPN"). Community derives a substantial portion of its revenues from government payers.

19. Defendant Community Health Network Foundation, Inc. is a 509(a)(3) non-profit organization headquartered in Indianapolis, Indiana. Its mission is to raise money for Community Health Network, Inc.

20. Defendant Community Physicians of Indiana, Inc. d/b/a Community Physician Network (referred to herein as "CPN") is a non-profit subsidiary of Community headquartered in Indianapolis, Indiana. It is a large multi-specialty physician group which employs over 350 primary care and specialty physicians on behalf of the Community network either directly or through subsidiaries and affiliates. Community employs or otherwise contracts with physicians through a variety of subsidiaries, affiliates, and intermediaries. CPN is the primary vehicle through which Community contracts with physicians. However, at times, Community employed certain of the physicians through subsidiaries and affiliated entities such as, *inter alia*, Community Health Network and Community Hospitals of Indiana.

21. Community also has used, and may still use, other subsidiaries such as Indiana Heart Hospital, Inc. d/b/a Community Heart and Vascular Hospital[1] or Central Indiana Pulmonary Consultants, LLC d/b/a Indiana Medical Management to employ or contract with physicians to provide services at Community facilities.

22. Hereinafter, all references to CPN refer to all Community subsidiaries and affiliates through which Community contracts with physicians to provide professional services at Community medical facilities.

23. Visionary Enterprises, Inc. ("VEI") is a for-profit subsidiary of Community. VEI's primary business is the acquisition and management of ambulatory surgical centers

[1] Prior to 2009, Community and a group of independent physicians shared ownership of Indiana Heart Hospital. On January 1, 2009, Community purchased the ownership interests of the physicians and became the sole owner of Indiana Heart Hospital. Community renamed the hospital to Community Heart and Vascular. In October of 2014, the hospital completely merged with Community.

("ASCs") on behalf of Community. VEI, through a variety of partnerships and other corporate forms, co-owns and manages at least 10 ASCs, including two Endoscopy Centers, in Indiana. Ownership of many of the Indiana ASCs is shared with physicians employed by CPN.

24. These include: North Campus Surgery Center, LLC d/b/a Community Surgery Center-North; South Campus Surgery Center, LLC d/b/a Community Surgery Center-South; East Campus Surgery Center, LLC d/b/a Community Surgery Center-East; Hamilton Surgery Center, LLC d/b/a Community Surgery Center – Hamilton (also known as Indiana Surgery Center Noblesville); Howard Community Surgery Center, LLC d/b/a Community Surgery Center-Kokomo; Northwest Surgery Center, LLC d/b/a Community Surgery Center Northwest (also known as the Foot & Ankle Center ("FASC")); Hancock Regional Surgery Center; Indianapolis Endoscopy Center, LLP d/b/a Community Endoscopy Center; Community Endoscopy Center, LLC d/b/a Community Digestive Center-Anderson. Community holds an equity stake in all of the ambulatory surgical centers.

25. North Campus Office Associates, L.P. ("NCOA") owns the building where Community owns the land and the North ASC (owned by Community) leases space in the NCOA-owned building. VEI is the general partner of the North ASC and the physician owners are limited partners. Its principal place of business is at 6626 E 75th Street, Ste. 200, Indianapolis, Indiana, 46250. Mr. Mills was an executive officer in the North ASC as of a 2009 SEC filing.

26. Community and all of its affiliates, including those named here as individual defendants, are collectively referred to as "Community" or "Defendants" in this pleading.

LEGAL BACKGROUND

A) False Claims Act ("FCA")

27. The FCA provides, in pertinent part, that any person who:

> (a)(1)(A) knowingly presents, or causes to be presented, a false or Fraudulent claim for payment or approval;
> (a)(1)(B) knowingly makes, uses, or causes to be made or used, a False record or statement material to a false or fraudulent claim;
> (a)(1)(C) conspires to defraud the Government by getting a false or Fraudulent claim allowed or paid; or
> …
> (a)(1)(G) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government,
> …
> is liable to the United States for any civil penalty, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C. 2461 not; Public Law 104-401), [which is currently not less than $11,463 and not more than $23,331] plus 3 times the amount of damages which the Government sustains because of the act of that person. 31 U.S.C. § 3729.

28. For purposes of the False Claims Act, the terms "knowing" and "knowingly" mean that a person, with respect to information: (i) has actual knowledge of the information; (ii) acts in deliberate ignorance of the truth or falsity of the information; or (iii) acts in reckless disregard of the truth or falsity of the information; and (B) require no proof of specific intent to defraud. 31 U.S.C. § 3729(b).

29. The FCA defines a "claim" to include any request or demand, whether under a contract or otherwise, for money or property which is made to a 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. 31 U.S.C. § 3729(b)(2)(A)(i)-(ii).

30. The term "material" means having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property." 31 U.S.C. § 3729(b)(4).

31. The FCA contains an independent requirement to correct errors that will cause, or have caused, a government overpayment. The Act attaches liability to anyone who knowingly makes, uses, or causes to be made or used, a false statement or record material to an obligation to pay or transmit money to the government, or who knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money to the government. 31 U.S.C. § 3729(a)(1)(G).

32. Pursuant to the Federal Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C. 2461 note; Public Law 104-410), the FCA civil penalties were adjusted to not less than $11,463 and not more than $23,331.

B) The Physician Self-Referral ("Stark") Law and the Anti-Kickback Statute

33. Two separate, but related, federal laws are designed to ensure that physicians and other healthcare providers make decisions based on unbiased medical judgment and patients' best interest, rather than the provider's own financial interests.

34. Congress enacted the Physician Self-Referral Law ("Stark Law") to address concerns regarding improper financial arrangements between physicians and entities to which they refer patients. These arrangements can compromise the physician's professional judgment as to whether an item or service is medically necessary, safe, effective, and of good quality.

35. Similarly, the Medicare and Medicaid Fraud and Abuse Statute ("Anti-Kickback Statute" or "AKS"), arose out of Congressional concern that payoffs to those who can influence health care decisions could result in goods and services being provided that are medically inappropriate, unnecessary, of poor quality, or even harmful to a vulnerable patient population.

36. The two laws have somewhat different scope (the Stark Law covers only referrals of certain "Designated Health Services," while the AKS covers all healthcare services for a wider range of programs), and taken together they establish a clear policy on how patient treatment should be based on sound medical decision making rather than the referring or treating physician's financial interest.

37. The Stark Law prohibits physicians from referring patients for designated health services from entities with which the physician has a financial relationship unless an exception applies. Financial relationships can be ownership or investment interests or compensation arrangements. Congress enacted the Stark Law in two parts, commonly known as Stark I and Stark II.

38. In 1993, Congress amended the Stark Law ("Stark II") to cover referrals for ten additional designated health services. *See* Omnibus Budget Reconciliation Act of 1993, Pub. Law 103-66, § 13562, Social Security Act Amendments of 1994, Pub. Law 103-432, § 152. As of January 1, 1995, Stark II applied to patient referrals by physicians with a prohibited financial relationship for twelve "designated health services" ("DHS"). *See* 42 U.S.C. § 1395nn(h)(6).

39. In pertinent part, the Stark Law prohibits physicians from making referrals to an entity with which he or she has a financial relationship for DHS payable by Medicare or Medicaid. 42 U.S.C. § 1395nn(a)(1).

40. In addition, providers may not bill Medicare or Medicaid for DHS furnished as a result of a prohibited referral.

41. Further, no payment may be made by Medicare or Medicaid for DHS provided in violation of 42 U.S.C. § 1395nn(a)(1). *See* 42 U.S.C. §§ 1395nn(g)(1); 1396b(s).

42. Finally, if a person collects payments billed in violation of 42 U.S.C. § 1395nn(a)(1), that person must refund those payments on a "timely basis," defined by regulation not to exceed 60 days. *See* 42 U.S.C. § 1395nn(g)(2); 42 C.F.R. § 411.353(d); 42 C.F.R. § 1003.101.

43. Violations of the Stark Law may subject the physician and the billing entity to exclusion from participation in federal health care programs and various financial penalties, including: (a) a civil money penalty for each service included in a claim for which the entity knew or should have known that the payment should not be made; and (b) an assessment of three times the amount claimed for a service rendered pursuant to a referral the entity knows or should have known was prohibited. *See* 42 U.S.C. §§ 1395nn(g)(3), 1320a-7a(a).

44. The Stark Law broadly defines prohibited financial relationships to include any "direct or indirect compensation arrangement . . . with an entity that furnishes DHS." 42 C.F.R. § 411.354(a)(1). An entity is defined to "furnish" DHS if it performs or bills for the service. 42 C.F.R. § 411.351.

45. The statute's exceptions then identify specific types of transactions (safe harbors and other similar categories) that will not trigger its referral and billing prohibitions. None of these apply to the allegations here.

46. The Stark Law has exceptions and the AKS has safe harbors that can protect certain conduct from liability under the respective statutes. Although the exceptions and safe harbors often cover similar conduct, they are not completely overlapping. In other words, compliance with a Stark law exception does not immunize an arrangement under the AKS.

47. The AKS prohibits any person or entity from offering or accepting payment to induce or reward any person for referring, recommending, or arranging for the purchase of any

item for which payment may be made under a federally-funded health care program. 42 U.S.C. § 1320a-7b(b).

48. Ascribing liability to both sides of an impermissible kickback relationship, the AKS contains statutory safe harbors that exempt certain transactions from its prohibitions such as contracts for employment or personal services, or for investments in entities like specific types of ambulatory surgical centers. Neither these, nor any other safe harbors apply here.

C) The Medicare Program

49. To administer the Medicare program, private insurance companies act as agents of the HHS, making payments on behalf of the program beneficiaries and providing other administrative services. 42 U.S.C. §§ 1395h and 1395u. These companies are called "carriers." *See* 42 C.F.R. §§421.5(c). Through local carriers, Medicare establishes and publishes the criteria for determining what services are eligible for reimbursement or coverage. This information is available to providers who seek Medicare reimbursement.

1. Medicare Contracts and Claims Submission

50. Medicare reimburses health care providers for the costs of providing covered health services to Medicare beneficiaries. *See* 42 U.S.C. § 1395x(v)(1)(A).

51. To bill Medicare Part A, a provider must submit an electronic or hard copy claim form called the UB-04 (also known as the CMS 1450) to the appropriate Medicare carrier. To bill Medicare Part B, a provider must submit an electronic or hard-copy claim form called the CMS 1500 to the appropriate Medicare carrier. These forms describe, among other things, the provider, the patient, the referring physician, the service(s) provided by procedure code, the related diagnosis code(s), the dates of service, and the amount charged.

52. In addition, each Medicare provider must sign a provider agreement and by so doing must agree to comply with all Medicare requirements including the fraud and abuse provisions. A provider who fails to comply with these statutes and regulations is not entitled to payment for services rendered to Medicare patients.

53. At all times relevant to this action, the local carriers that reviewed and approved the claims at issue in this case based their review upon the enrollment information and claim information provided by the Defendants, and relied on the veracity of that information in determining whether to pay the claims submitted by Defendants.

54. As a prerequisite to payment, Medicare also requires hospitals to submit annually a Form CMS-2552-10, commonly known as the Hospital Cost Report. Cost reports are the final claim that a provider submits to the fiscal intermediary for items and services rendered to Medicare beneficiaries.

55. Every Hospital Cost Report contains a "Certification" that must be signed by the chief administrator of the provider or a responsible designee of the administrator. Through this certification, the provider confirms that the cost report is "a true, correct and complete statement" and that the services identified "were provided in compliance with [the laws and regulations regarding the provision of the health care services]." The certification also states, *inter alia*: "if services identified in this report were provided or procured through the payment directly or indirectly of a kickback or were otherwise illegal, criminal, civil and administrative action, fines and/or imprisonment may result."

56. Thus, a provider must certify that the filed hospital cost report is complete and accurate and that the services provided in the cost report are billed in compliance with applicable laws and regulations, including the Stark Law and AKS.

57. A hospital is required to disclose all known errors and omissions in its claims for Part A reimbursement (including its cost reports) to its MAC.

58. Medicare, through its MACs, has the right to audit a provider hospital's cost reports and financial representations to ensure their accuracy and preserve the integrity of the Medicare Trust Funds. This right includes the right to make retroactive adjustments to hospital cost reports for any overpayments. *See* 42 C.F.R. § 413.64(f).

2. Medicare Payments for Hospital and Physician Services

59. Medicare pays hospitals for providing inpatient and outpatient care. Since 1983, Medicare, Medicaid, and other federally-funded health insurance programs have reimbursed hospitals for inpatient care through a prospective payment system based on classification of patients through Diagnosis Related Groups ("DRGs").

60. DRGs are groups of clinically similar diagnoses and/or procedure codes, which are presumed to have similar resource utilization. Medicare pays a fixed amount per case by DRG.

61. Payments for outpatient hospital services are also based on a bundled, per-case payment system. Hospitals use Ambulatory Payment Classification ("APC") codes to bill for costs associated with outpatient services.

62. Medicare reimburses hospitals for outpatient services through standardized payments determined by the APC to which the claim is assigned. Each claim is assigned one or more APCs based on the procedure codes included on the claim form.

63. Physician services provided to either inpatients or outpatients are billed and reimbursed separately from the hospital's DRG or APC-based payment. Physician services are reimbursed through a payment system based on the Healthcare Common Procedure Coding System ("HCPCS").

3. Medicare Payment for Ambulatory Surgical Centers ("ASCs")

64. ASCs are healthcare facilities that provide single or multi-specialty outpatient surgical care in the same day, which may include diagnostic and preventative procedures. Such outpatient surgical services are provided to patients who need no hospitalization and for whom the expected duration of services is less than 24 hours following admission. An ASC can be independent or operated by a hospital (under the common ownership, licensure, or control of a hospital).

65. ASCs receive a single Medicare payment for covered surgical procedures. To receive Medicare payment, ASCs must meet certification requirements and enter into an agreement with CMS according to 42 C.F.R. § 416 Subpart B.

66. As a general rule, payment is based on a prospectively determined rate. This rate covers the cost of services such as supplies, nursing services, equipment, etc., as specified in 42 C.F.R § 416.61. For a single surgical procedure, payment is based on the prospectively determined rate for that procedure. 42 C.F.R. § 416.120(c)(2)(i). For multiple surgical procedures, payment is based on the full rate for the procedure with the highest prospectively determined rate and one-half of the prospectively determined rate for each of the other procedures. 42 C.F.R. § 416.120(c)(2)(ii)(A-B).

67. In addition, Medicare pays ASCs separately for covered ancillary services integral to a covered surgical procedure, including services furnished immediately before, during, or immediately after the procedure.

4. Medicare Payment for Infusion Services

68. Drug infusion therapy, such as chemotherapy, is an outpatient therapeutic service subject to direct supervision policy.

69. Part B and D covers drugs for infusion therapy. Supplies, equipment and nursing are covered in some circumstances through the Part B DME benefit, the prosthetic benefit, the Medicare home health benefit, or some combination of these benefits.

70. Infusion therapy is covered under the DME benefit separately if: (1) the drug is necessary for the effective use of a covered external or implantable infusion pump; and (2) the drug being used with the pump it itself reasonable and necessary for the patient's treatment.

71. Unlike most drugs covered under Part B, DME infusion drugs are not paid based on average sales prices. Social Security Act § 1842(o)(1)(D)(i) sets payment amounts for these drugs at 95 percent of the average wholesale price, which refer to list prices established by drug manufacturers and reported by publishers.

5. Medicare Payment for Nursing Home Services

72. Nursing facilities and skilled nursing facilities must comply with the requirements in 42 C.F.R § 483(B), to receive payment under Medicare. *See* Medicare Program Integrity Manual, Chapter 6 – Medicare Contractor Medical Review Guidelines for Specific Services, Sec. 6.1.

73. Part A and B covers many of the services provided by nursing facilities and skilled nursing facilities. Reimbursement for Medicare claims are managed through CMS, which contracts with MACs to process reimbursement claims.

74. Medicare pays nursing facilities and skilled nursing facilities through its PPS, which refer to per diem rates based on the patient's condition.

D) The Medicaid Program

75. Medicaid is a public assistance program providing for payment of medical expenses for low-income and disabled patients. Funding for Medicaid is shared between the Federal Government and those states participating in the program.

76. Federal regulations require each state to designate a single state agency responsible for the Medicaid program. The agency must create and implement a "plan for medical assistance" that is consistent with Title XIX and with the regulations of the Secretary of HHS. Although Medicaid is administered on a state-by-state basis, the state programs adhere to federal guidelines.

77. Each provider that participates in the Medicaid program must sign a provider agreement with his or her state. For example, the State of Indiana requires any prospective Medicaid provider to certify that he or she will only submit claims that: 1) can be documented as medically necessary medical assistance services actually provided to the person in whose name the claim is being made; and 2) are for compensation that the provider is legally entitled to receive.

FACTS AND ALLEGATIONS

78. To eliminate repetition and given the Government's intervention on certain claims, the Relator adopts and incorporates by reference the Government's Complaint in Intervention [Dkt. 96] as if fully set forth here again. The following are the additional facts and claims as to the non-intervened claims.

79. Under Mr. Mills' new leadership as Community's CEO in 2009, Community began a systematic, corporate-wide campaign to increase the number of both its employed and affiliated physicians and physician practice groups to increase market share in the Indianapolis region and to gain a market advantage over both competing health networks and health insurance companies contracting with Community.

80. At the time, Community was the smallest of the four large provider networks in the Indianapolis region, which also included IU Health, St. Vincent and St. Francis.

81. Community sought continued growth to mitigate against the risk that it would lose the ability to compete with the other networks, especially in its leverage to secure favorable terms when contracting with private health insurance companies.

82. Corporate growth strategy emerged as early as 2008 through 2012 and continued through the present.

83. Specifically, Community planned to use various compensation structures to recruit and retain a greater number of employed and affiliated physicians, including specialists who could refer a large number of patients to Community's hospitals and other related facilities.

84. Community also planned to execute several key deal arrangements to steer high-margin business to surgical centers owned (or partially owned) by its employed physicians.

85. Of those deals, Community was also involved in negotiations with nursing home providers to send referrals to their facilities in exchange for an exorbitant amount of money.

86. From at least 2012 through the present under Mr. Mills' leadership, Community used a myriad of vehicles to pay and accept illegal kickbacks and inducements to physicians and physician practices in order to receive referrals to Community's hospitals, surgical centers, specialists and other affiliated facilities.

87. Primary kickback mechanisms included the use of:

a. Joint venture arrangements with its physician investors in exchange for referrals between Community and its ambulatory surgery centers;

b. Space rental agreements that were multiples of fair market value between a non-profit ambulatory surgery center and a surgeon-owned real estate company;

c. Employment agreements based on referrals with physicians from various practice areas, including cardiology, neurology, breast oncology, orthopedics, and obstetrics & gynecology, that paid specialists above fair market value salaries;

d. Professional Services Agreements to funnel illegal remuneration to medical oncologists affiliated with Community, for referrals; and

e. A monitoring agreement with a chain of Indianapolis-based nursing homes, which split revenue and other government funded reimbursements with Community and also paid Community for services not needed or performed, in exchange for directing patients to the nursing homes.

88. The schemes alleged in this Second Amended Complaint was coordinated by the Community Compensation Committee, Mr. Mills, and CPN President Dr. Ramarao Yeleti, encompassing nearly all of the practice areas, surgical centers, and employed and affiliated physicians and physician practices, violating both the Stark Law and the federal and Indiana AKS.

89. Community submitted or caused to be submitted false claims to federal health care programs for services provided pursuant to kickback-tainted referrals from physicians and physician practices with whom Community had financial relationships that did not fall within any Stark exception or AKS safe harbor. Thus, each submission is a false or fraudulent claim that violates the federal False Claims Act.

90. Community and its ASCs and affiliated entities all submit Medicare and Medicaid enrollment forms, cost reports and claims to the federal and state authorities respectively that certify compliance with all laws including Stark and the federal and Indiana AKS when they knew, or recklessly disregarded, those certifications to be false.

91. Compliance with the Stark Law and the federal and Indiana AKS laws are conditions of payment under the Medicare and Medicaid programs and that compliance is material to the federal and state healthcare programs' decisions to pay on the claims. *See e.g.*, 42 U.S.C. §§ 1395nn(a)(1), (g)(1).

A) Community Paid Illegal Remuneration to Referring Physicians by Funneling Money Through their Equity Interests in ASCs and Other Joint Ventures.

i) Investing in Community's ASCs Was a Highly Lucrative Proposition for the Physician Investors and for Community and VEI.

92. The federal AKS prohibits any person or entity from offering or accepting payment to induce or reward any person for referring, recommending, or arranging for the purchase of any item for which payment may be made under a federally-funded health care program. 42 U.S.C. § 1320a-7b(b).

93. The Indiana AKS prohibits getting or giving kickbacks in connection with the provision of services to Medicaid recipients. Giving a doctor an opportunity to invest in an ASC in exchange for referrals to the ASC violates the Indiana AKS.

94. Community and VEI engaged in an unlawful kickback scheme that paid remuneration, through an equity interest in various Community ASCs and other joint ventures, to physicians in exchange for referrals and in violation of the federal and Indiana anti-kickback statutes.

95. The following list includes the numerous Community/VEI ASC entities:

- Community co-owns and manages, through VEI, at least nine ASCs, including two Endoscopy Centers, in Indiana. Most, if not all, are owned in part by physicians – both Community-employed physicians and independent physicians. These include:
- North Campus Surgery Center, LLC d/b/a Community Surgery Center North;
- South Campus Surgery Center, LLC d/b/a Community Surgery Center South;
- East Campus Surgery Center, LLC d/b/a Community Surgery Center East;

- Hamilton Surgery Center, LLC d/b/a Community Surgery Center Hamilton (aka Indiana Surgery Center Noblesville);
- Howard Community Surgery Center, LLC d/b/a Community Surgery Center Kokomo;
- Hancock Regional Surgery Center;
- Community Endoscopy Center, LLC d/b/a Community Digestive Center;
- Northwest Surgery Center (aka Foot & Ankle Center or FASC); and
- North Campus Office Associates, L.P.

96. Together, these joint ventures account for approximately $30 million in operative income and more than 50,000 outpatient procedures a year.

97. These ASCs were organized under state law, and at times with VEI as a manager or member of the ASCs and with Mr. Mills' signature on the respective Articles of Organization filed with the state, including for the South Campus Surgery Center, LLC (filed 1997) and North Campus Office Associates, L.P. (filed 1995). Mr. Mills also signed as a non-member organizer for Hancock Regional Surgery Center, LLC's state corporate filing in 2006.

98. Community aggressively and intentionally used the ASCs to provide kickbacks to investor physicians as an incentive to affiliate with Community and to induce them to send all or nearly all of their referrals to Community's hospitals and other facilities, which they did.

99. Community's ASCs typically generate substantial profits – some in the range of 80% or more return on investment per year. As such, the opportunity to invest in these ASCs is highly sought after by physicians.

100. Thus, Community used the opportunity to invest in the ASCs as an incentive to induce investor physicians – and physicians who hope to become investors – to refer their patients to Community.

101. Defendants did this knowingly, as it was a strategic, core building block of the ASCs that the physicians' return on investment would be "substantially higher" than the norm and

therefore enticing to physician investors. A 2005 consultant's report by Navigant Consulting about Community's and its affiliates' expected financial position notes, "The average return on investment to center stakeholders is **substantially higher** than generally published industry data." (emphasis added).

102. Community also had other joint ventures with physicians that served a similar strategic purpose – namely giving the physicians a financial incentive to and reward for referring patients (including patients covered by Medicare, Medicaid and other government-funded healthcare programs) to Community.

103. For example, Community set up a joint venture with two prominent surgical groups to share the profits from referrals for lucrative Magnetic Resonance Imaging tests. This venture was specifically designed to give physicians a share of the fees Community would otherwise have generated from such tests in exchange for the physicians agreeing to refer their commercial patients to that joint venture and their Medicare patients to other Community facilities.

104. The incentive proved to be effective. Investor physicians accounted for a substantial share of the surgeries performed at the ASCs and referred significant other business to Community.

105. For example, in 2010, investor surgeons performed: (a) 7,917 (79%) of the surgeries at Community Surgery Center South; (b) 10,489 (91%) of the surgeries at Community Surgery Center North; (c) 7421 (91%) of the surgeries at Community Surgery Center East; and (d) 2533 (90%) of the surgeries at Hamilton Surgery Center. In addition, the ASC investors performed 16345 surgeries at Community's hospitals.

106. Moreover, Medicare, Medicaid and other government-funded healthcare programs covered a substantial portion of the patients treated at Community's ASCs.

107. An August 2013 analysis showed that 45.4% of the charges at Community Surgery Center East, 24.32% of the charges at Community Surgery Center North and the Hamilton Surgery Center, and 33.78% of the patients at South Campus Surgery Center were for Medicare or Medicaid patients.

108. In fact, as demonstrated in the representative examples below, reports to Relator and public documents confirmed that all or nearly all physician investors perform surgeries on patients covered by Medicare, Medicaid or other government-funded healthcare programs at the ASCs. These investors also sent other government-funded referrals to Community.

109. As examples only, and as of 2013:

- Dr. Kurt Martin, an investor in the South ASC, performed total knee replacement on Medicare patients using ICD-9-CM code 81.54, among other codes, at least 101 times;
- Dr. Kevin Julian, an investor in the South ASC, performed total knee replacement on Medicare patients using ICD-9-CM code 81.54, among others, at least 135 times as of 2013, and performed hip replacement on Medicare patients using ICD-9-CM code 81.51, among others, at least 37 times;
- Dr. Thomas Cittadine, an investor in Noblesville, performed total knee replacement on Medicare patients using ICD-9-CM code 81.54, among others, at least 31 times;
- Dr. Stephen Sexon, an investor in Noblesville, performed total knee replacement on Medicare patients using ICD-9-CM code 81.54, among others, at least 51 times;
- Dr. Ronald Baughman, an investor in the North ASC, performed laparoscopic gall bladder removal surgery on Medicare patients using ICD-9-CM code 51.23, among other;
- Dr. Jon Jansen, an investor in the North ASC, performed laparoscopic gall bladder removal surgery on Medicare patients using ICD-9-CM code 51.23, among others;
- Dr. Joseph Pavlik, an investor in the North ASC, performed laparoscopic gall bladder removal surgery on Medicare patients at least 22 times as of 2013 using ICD-9-CM code 51.23, among others;
- Dr. Chris Magee, an investor in the North ASC, performed prostate removal and prostate resection surgeries on Medicare patients using ICD-9-CM code 60.5 and 60.29, among others;

- Dr. David Scheidler, an investor in the North ASC, performed prostate removal and prostate resection surgeries on Medicare patients at least 77 times as of 2013 using ICD-9-CM code 60.5 and 60.29, among others; and
- Dr. Jill Donaldson, an investor in the North ASC, performed lumbar spinal fusion surgery on Medicare patients at least 26 times using ICD-9-CM code 81.08 among others.

ii) Physician Ownership of ASC Shares Was Explicitly Conditioned on the Physicians Referring Patients to Community.

110. As OIG recognized, ASCs have an inherent risk "that a return on investment in an ASC might be disguised payment for referrals" and "medical decision-making may be corrupted by financial incentives offered to potential referral sources who stand to profit from services provided by another physician." 64 F.R. 63534, 36 (Nov. 19, 1999).

111. Accordingly, the safe harbor for investment specifically provides:

> "ii) The terms on which an investment interest is offered to a passive investor, if any, who is in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for the entity must be no different from the terms offered to other passive investors.
>
> "(iii) The terms on which an investment interest is offered to an investor who is in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for the entity must not be related to the previous or expected volume of referrals, items or services furnished, or the amount of business otherwise generated from that investor to the entity.
>
> "(iv) There is no requirement that a passive investor, if any, make referrals to, be in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for the entity as a condition for remaining as an investor."

42 CFR § 1001.952(b).

112. Similarly, the safe harbor for ASC investments states: "The terms on which an investment interest is offered to an investor must not be related to the previous or expected volume of referrals, services furnished, or the amount of business otherwise generated from that investor to the entity." 42 CFR § 1001.952(r).

113. Notwithstanding this clear requirement that the opportunity to invest in a joint venture or ASC cannot be conditioned on the investor's agreement to refer patients to that facility, Community's ASCs did just that.

114. The various ASC arrangements explicitly provided that physicians may only purchase investment interests if they performed a certain minimum number of cases at the ASC.

115. For example, for the East and North ASCs, the physician investors had to meet a 50 case per year minimum. The specific case minimums varied by ASC, but all or nearly all of Community's ASCs had such a minimum. Community did not allow physicians who did not meet those case minimums to invest.

116. Moreover, once they were investors, if physicians failed to meet case minimums, they were required to sell their shares. Community tracked the number of cases each physician performed at a given ASC on a regular basis during the year. If a physician appeared to be at risk of failing to meet the case minimum, the ASC's medical director or a business executive contacted the physician to warn them of the consequences of failing to meet the case minimum (forced share divestiture) and discussed strategies to increase referrals.

117. This forced divestiture occurred regardless of the reason, including loss of license, retirement and death. In fact, the ability to initially receive, and to continue to maintain, an investment interest in (and yearly distributions from) these ASCs was contingent upon the investor's ability to continually refer volume.

118. These arrangements were intentional and unambiguous – in exchange for the profit share in these ASCs, a certain volume of referrals would flow to the physicians and flow to the hospital investors alike.

119. ASC investor deals also included other features designed to ensure investors referred patients to Community. This includes Defendant-described "rigid no-compete covenants with significant financial penalties and strict enforcement."

120. These non-compete restrictions acted to prohibit physician investment in other ASCs except for those owned by VEI, Community or other ASC hospital investors. In other words, Community barred physician investors from investing in any competitor ASCs (or sending referral or volume to competitor entities).

121. In a presentation about the Foot & Ankle Center (FASC), Community described enforcement efforts related to a non-compete provision as follows:

> Competitors attempts to recruit/employ Podiatrists who are owners and/or users of the Center Steps taken to mitigate risks: VEI has mirrored the Practice Operating Agreement restricted territory of 45 miles and has increased penalties monetarily to reduce risk of surgeons violating partnership relationship…

122. Community and VEI closely monitored, rigidly adhered to and strictly enforced these "core requirements" to drive and maintain referrals.

123. Periodically the various ASCs made new shares available – either purchased by new investors or by existing investors.

124. New investors were allowed to buy shares in order to secure their referrals to the ASC and to Community's other facilities. Community allowed only certain physicians to invest. Community based its decision on the number of referrals the physician sent to the ASC.

125. In at least one case, however, an oncologist who performed few surgeries at the North ASC – few enough that there were often concerns that he would not meet his case minimums – was still allowed to invest. Although that surgeon performed few surgeries, he generated significant other revenue for Community through referrals to its hospitals and other facilities.

126. When existing investors purchased additional shares, there was often conflict about who could invest and how many shares they could purchase. This reflected the fact that the shares were highly coveted given the incredible returns they generate. Community routinely resolved these disputes by giving investment preference to high volume surgeons.

127. Notably, these offerings were not because the ASCs needed the investment capital or due to poor cash position. Instead, the offerings distributed most, if not all, of the new capital to the existing investors upon completion of the offering.

128. Most, if not all, physician investors maintained capital accounts with $0 balance. In other words, they had no capital at risk.

129. In addition, language in documents stating the objectives, risks and terms of the investment stated that physician investor financial risk was limited to the balance in their capital accounts, which again showed that they had no capital at risk yet enjoyed immense returns.

iii) Community and Other ASC-Investor Hospitals' Referrals to the ASCs Provide Additional Illegal Remuneration.

130. Another key feature of the ASCs was that Community and other hospitals were co-investors with the surgeons.

131. OIG, through the safe harbor regulations and otherwise, has recognized that allowing a hospital to invest in an ASC along with high-referring physicians presents a risk that the hospital will send its patients to the ASC as a way of inducing those physicians to or rewarding them for referring patients to the hospital. Accordingly, the ASC safe harbors provide that a hospital investor may not be in a position to make or influence referrals directly or indirectly to any investor or the entity." CFR § 1001.952(r)(4)(viii).

132. Community and the investor hospitals were not only in a position to refer patients to the ASCs and the investor physicians (by directing the hospital's employed and affiliated

physicians to refer their patients there), but actively touted the value of those referrals when discussing the value of ASC investment to target physicians.

133. For each of the ASCs, Community and/or other hospital investors were in a position to refer Medicare and Medicaid patients to these ASCs and their investor surgeons and they did so.

134. Moreover, hospital investors, who were in a position to refer Medicare and Medicaid patients to the ASCs, were paid "management fees" that varied based on ASC profitability. The more referrals, the more profitable the ASC, and the higher the hospital investor's "management fee."

135. Community's take-over of the FASC provides an illustration of the way that Community used the promise of referrals from Community employed and affiliated physicians as an inducement, traded to the ASC investor surgeons in exchange for their referrals.

136. The Northwest Surgery Center, formerly known as the FASC, is a single-specialty (podiatric) center that began in 1995. It began operations on Township Line Road at a 12,000 square foot location in or about May 2007.

137. In January 2012, Community subsidiary VEI purchased a 51% interest in the FASC, which became the Northwest Surgery Center, LLC, a single-specialty podiatric surgery center in the northwest region of Indianapolis. Achilles Podiatry, 11-member podiatry group owned and used the center.

138. One doctor had primary ownership of the center with 94% of the shares. Five other members of Achilles Podiatry owned between .5% and 2% each. The four remaining members of Achilles Podiatry used the center, but did not have an ownership stake.

139. VEI offered several forms of valuable consideration in exchange for its majority (51%) ownership interest. First, VEI paid a purchase price ($1,421,063) based on five times the 2009 profit. Because this purchase price was based, in part, on the value of services previously referred to the ASC by the physician investors, and an expectation that such referrals would continue, this purchase price violated the AKS.

140. The second item of substantial value that Community gave the ASC owners was access to Community's lucrative contracts with commercial insurers. Because Community is a large network, it had substantial leverage in negotiations with commercial insurers than a single podiatry group. Community offered to use this leverage to secure higher commercial reimbursement for the members of Achilles Podiatry in exchange for the podiatrists agreeing to send all or substantially all of their referrals to Community.

141. Finally, Community offered the podiatrists access to referrals from Community's network of employed primary care physicians. In an undated analysis of the Foot and Ankle transaction, Community noted, as justification for the deal: "With employment of primary care physicians by hospitals and national corporations, existing ASCs are looking for ways to limit their loss of access to patients by identifying organizations that are employing physicians and partnering with that organization."

142. In exchange, Community expected to get access to a variety of lucrative referrals from the podiatrists and that is exactly what it got.

143. Specifically, a PowerPoint presentation by Kyle Fisher, VEI CEO, Bret Weitzel, VEI CFO, and Larry Monn, M.D., VEI Chief Medical Officer, explained that, as part of the transaction, Community planned to use non-competition agreements with the Achilles Podiatry

members to "mitigate [the] risk[]" of "[c]ompetitors attempts to recruit/employ Podiatrists who are owners and/or users of the Center."

144. Community also stated, "Our other [Network] Hospitals and Surgery Centers, will also have opportunity to **capture cases** that are going to our competition." (emphasis added). As was common with these ASCs, Defendants' stated intent was to "capture cases," that were otherwise going to its competitors.

145. The presentation quantified the expected "downstream referrals" Community would capture in exchange for the purchase of the surgical center as:

(a) 1,800 imaging services;

(b) 2,500 physical therapy services; and

(c) 150 inpatient surgery cases.

146. When analyzing the financial viability of acquiring 51% of the FASC, VEI noted that it meant to induce, and expected the deal to yield, significant referrals for the hospital and other Community ancillary providers, and it did, including significant Medicare, Medicaid and other government programs in connection with Community-ASC rendered services.

147. In addition, Community projected that, because the ASC would now have access to its lucrative commercial contracts, it would recapture more than 250 cases previously going to Community's competitor, St. Vincent.

148. Also as part of the deal, the center's majority owner, Dr. Anthony Miller, agreed to "make an additional 19% of his [then] owned units available for subsequent purchase [by] other surgeons who VEI identifie[d]." This was a significant concession because it gave VEI the power to offer these lucrative shares to other surgeons to induce them to refer their patients to the ASC and/or other Community facilities.

149. VEI used these shares for just this purpose. In a 2013 PowerPoint presentation analyzing the Foot and Ankle transaction after its first year of operation, Mr. Fisher, Mr. Weitzel and Dr. Monn noted that the ASC had experienced lower than expected volume. As one of their proposed strategies for "increasing volume," they looked to bringing on qualifying physician investors, noting "Four (4) new investors in 2012, two (2) new prospects, one (1) recently toured the center."

150. Further, "management fees" were a significant revenue factor in this ASC. As shown in the slide below, when pitching this acquisition, VEI estimated that it would receive $4,900,000 in distributions over five years, which is revenue that takes into account number of referrals as it is a straight percentage of net revenue based on performance of the ASC, in violation of the federal and Indiana AKS.

	Before	After
• VEI to receive distributions estimated to be $4,900,000 over five years	$2,091,000	$4,900,000
• VEI will provide day-to-day management and receive 5.5% of net revenue, estimated to be $1,142,541 over the first five years Note: Not included in ROI estimate	$826,334	$1,142,541
• Projected ROI of 35.2% (see attached Financial Projections)	25.2% Before Tax 15.2% After Tax	58.8% Before Tax 35.2% After Tax

iv) The North ASC Real Estate Partnership

151. The "North ASC" physician hospital joint venture is structured differently than Community's other ASCs. The North ASC rents space in a building owned by North Campus Office Associates, L.P., not itself an ASC, but instead a real estate partnership co-owned by Community and the investor surgeons. No safe harbor applies to this particular arrangement.

152. The building in which the North ASC is housed is rented half by the North ASC and half by other, unaffiliated doctor's offices.

153. VEI takes a management fee from the North ASC for management functions, including managing the affairs of the North ASC.

154. Physicians can only invest in the real estate partnership if they refer a minimum number of cases (50) to the ASC. This case minimum requirement is more egregious in this situation than with respect to the other ASCs, because here, it is applied not to investment in an ASC but rather to investment in a completely separate entity.

155. The investor surgeons are rewarded for the referrals to the ASC through the rent paid by the ASC to the real estate partnership. The ASC's rent is based on a fixed base amount, plus a share of the profits of the ASC in violation of the federal and Indiana AKS.

156. This is different from the rent the partnership charges to the other tenants of the building – none of which are tied to the tenants' profitability.

157. Because of this feature, the rent paid by the ASC is many multiples higher than the rent that the real estate partnership charges to its other tenants. At times, the ASC's rent was up to approximately nine times the rent paid by the real estate partnership's other tenants on a per square foot basis.

158. When investing in the real estate partnership, physicians were explicitly warned that the profitability of their investment depended on the profitability of the ASC, and thus, that if they referred fewer surgeries to the ASC, they received a lower return on their investment in the real estate partnership.

159. In other words, the distributions to the physician investors directly accounted for the number of cases performed at the ASC and the physician investors' total compensation unlawfully rose and fell with the number of cases performed (*e.g.*, the number of referrals).

160. Investment in the North ASC was offered and provided to referring physicians to induce and/or reward their referrals in violation of the federal and state AKS statutes.

161. The North ASC refers patients enrolled in federal programs like Medicare and Medicaid for services to Community and vice versa.

162. There have been at least two North ASC stock offerings made and reported publicly. As of the 2009 filing, reflecting an offering of $975,062.00, the minimum investment was $20,746.00 and there were 47 investors reported.

163. As of a later, 2018, SEC filing, there were 43 investors reported for a $3,138,660.00 offering. The minimum investment accepted from outside investors for the 2018 offering is reportedly $15,750.00.

164. Community rewarded the investor physicians in the North ASC joint venture (through the real estate partnership) for their referrals. The return on their investment often reaches $500,000 per year, and, in many cases, results in annual returns in excess of 100% on physician investments.

165. This arrangement and structure continue to the present.

v) Community Intentionally Used Investment Opportunities to Secure and Reward Referrals.

166. Community's presentations made it clear that it knowingly violated the AKS by using the ASC profit shares and the opportunity to invest in ASCs as an inducement to get physicians to refer patients to the ASCs and to Community's other facilities. Community routinely described the offering investment interests to physicians as a strategy to increase referral volume.

167. For example, in a presentation given in 2005 or 2006, VEI touted its experience using ASCs and other joint ventures as being "critically important to the Network's physician linkage strategies" and that "VEI is a vital component of Network growth strategies through linkages with physicians."

168. In a 2009 VEI presentation, it explained its ASC "business strategy fundamentals" to "aggressively increase the number of physician/surgeon owners."

169. In a 2005 consultant's report by Navigant Consulting about Community's and its affiliates' expected financial position, "physician linkage" is a "focus" of Community and VEI.

> **VEI - Physician Partnerships**
> One of the core strategies of CHN has been the creation of unique and differentiated partnerships with physicians. CHN has focused on building strong physician relationships and the creation of VEI and its physician joint ventures at the Indiana Surgery Centers provides a forum for **physician involvement and a linkage to the Network that dissuades them from seeking opportunities outside the Network**.

170. Similarly, a 2006 presentation about the Noblesville ASC notes that one "business goal" is to "maximize profitability of its owners." A listed strategy to maximize profitability is to "increase investors."

171. The Noblesville presentation also highlighted how Community offers investment opportunities to hospitals in a position to make referrals.

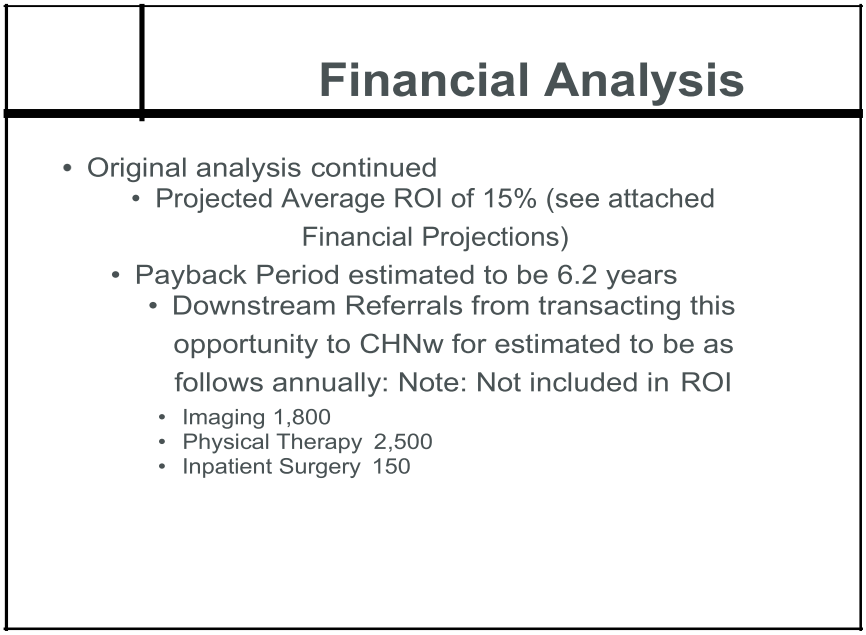
172. A 2012 Community presentation titled "VEI Investment Foot & Ankle Surgery, LLC [(FASC)]," similarly highlights key features of the "linkage" strategy.

173. The presentation noted that Community struck a deal with Westview hospital whereby Westview invested in the ASC, owning 20%, and in return was the "recipient of in-patient cases," or referrals, from the ASC.

174. When discussing the "strategic fit" of this relationship, the presentation noted that an intended consequence was "capturing cases" (e.g. referrals) from the competition. "Due to the

diverse geography of Achilles Podiatry offices our other Community Hospitals and Surgery Centers, will also have opportunity to capture cases that are going to our competition."

175. The Defendants expected, and counted on, referrals to follow the creation of the ASCs as they structured them. The FASC presentation even quantified expected "downstream referrals" as part of expected return on investment "ROI":



B) Community Paid Above Fair Market Value Salaries to its Referring Physicians.

176. Under Mr. Mills' leadership, Community identified various initiatives that proved to be foundational for Community in terms of profitability and long-term growth. One of those initiatives included protecting and expanding key service lines, such as cardiology, neurology, breast oncology, orthopedics, and obstetrics and gynecology.

177. Specifically, Community knowingly created and offered above fair market value physician compensation packages. These payment arrangements were generally comprised of three components: base salary, retention payment and incentive compensation.

178. Payments were neither limited nor inadvertent. Instead, they were systematic and directed by Community executives at the highest levels with knowledge that they were paying physicians at above fair market value rates.

179. In fact, key Community executives and members of Community's Board Compensation Committee regularly held meetings to discuss physician compensation and the integration of the specialties.

180. The Compensation Committee was responsible for all physician compensation decisions that were deemed to represent a risk of violating fair market value guidelines. Key Community executives (most prominently Mr. Mills) and its outside consultant (Sullivan Cotter) advised the committee. The materials provided to the committee, the detail of its review of these materials and the bases for its decisions was highly secretive and were not disclosed to individuals beyond Mr. Mills and other Community executives including Dr. Yeleti (President of CPN) and Jill Parris, VP of Human Resources.

181. Certain financial implications of physician integration arrangements were periodically discussed with the Network Finance Committee members. This committee was not informed of individual physician compensation levels and relied entirely on the Network Compensation Committee opinion that such compensation arrangements satisfied fair market value requirements.

182. Mr. Mills and Compensation Committee members controlled the process for forming, approving and implementing physician compensation packages.

183. Community analyzed not only the expected performance of the physician group itself, but also the expected financial performance level of each physician at its hospitals, surgical centers and other facilities.

184. While the details of Community compensation arrangements with different physicians varied in form, they were similar in two key aspects: 1) Community paid the physicians work Relative Value Units ("wRVU") rates that exceeded fair market value; so much that Relator, as the CFO, noticed that Community lost substantial amounts on the physicians' practices excluding the value of downstream referrals; and 2) Community evaluated the overall financial performance rather than just the value of the physician practice on its own.

185. In fact, from at least 2011 through 2013, up until Relator's termination, there was a pattern of operating loss variances that continued for the third consecutive year in 2013 and Relator's suspicions of potentially illegal physician compensation arose. At the time, Relator could only explain these significant losses if downstream referrals were considered in the financial analysis.

186. Despite Relator's numerous requests for explanations to Mr. Mills, Dr. Yeleti, and other CPN employees about the large practice losses reported by CPN, Community ignored Relator's concerns and queries.

187. Instead, Community retaliated against, and fired Relator, for his inquiries about the losses and his efforts to stop and correct Community's practices.

188. Specifically, Community recruited and employed physicians from the local Indianapolis market, many of whom already practiced at Community or at an affiliated facility.

189. The integration successfully employed hundreds of physicians from several key specialties listed below. The below serve as representative examples of the many unlawful compensation arrangements that Community entered into as part of its campaign to boost its network.

i) The Orthopedic Surgeons Integration

190. Community also targeted orthopedic surgery as an area for expansion and knowingly, or with reckless disregard, violated the Stark Law and the Indiana AKS in setting up and executing these deals.

191. In the summer of 2010, Community targeted orthopedic surgery as an area for potential expansion. To do so, it hired 15 surgeons from two then-independent orthopedic groups: (a) eleven surgeons from Indiana Orthopedic Center; and (b) four surgeons from The Sports Medicine Institute of Indiana. These two practices were consolidated with two practices of physicians who were already employed by Community: (a) one surgeon from North Rivercross Orthopedics; and (b) two surgeons from Orthopedic Surgeons of Central Indiana.

192. In a September 13, 2011 meeting, Jon Fohrer, the CEO of Ambulatory Services for Community, Jane Callahan, Community's Chief Physician Services Executive, and Tony Javorka, COO of CPN, presented the key terms of the deal to the PIC.

193. The compensation for the 18 surgeons increased dramatically and was beyond fair market value. They were each given an unsubstantiated 20% increase in their base salary, plus additional incentives and retention payments. As a result, the total cost of physician compensation for these surgeons was expected to increase almost 49%, from $8,707,710 to $12,937,534, upon consolidation, and 4% per year thereafter.

194. Below is an internal Community chart that itemized the compensation package for the orthopedic integration practice:

Orthopedic Integration Physician Comp. Assumptions 09/08/11	2010	Year 1	Year 2	Year 3	Year 4
Base Compensation	$8,207,710	$10,289,456	$10,751,689	$11,237,088	$11,746,702
Quality Incentive (Includes ED) 50%	500,000	1,407,821	1,407,821	1,407,821	1,407,821
Cost Savings Incentive	0	500,000	500,000	500,000	500,000
Retention Bonus (Paid Yr. 6.5, 7 &10)	0	740,257	740,257	777,270	856,944
Total Compensation	$8,707,710	$12,937,534	$13,399,767	$13,922,179	$14,511,467
Retention Calculation:					
Estimated RVU's	201,431	211,502	222,077	233,182	244,841
Pool # 1 @ $3.50/RVU (Paid in year 6)		$3.50	$3.50	$3.50	$3.50
Total		$740,257	$777,270	$816,137	$856,944
Pool #2 @$3.50/RVU (Paid in year 7.5 &10)					

195. The compensation for the orthopedic surgeons, including, Drs. C. Melton Doxey; Richard W. Eaton; Douglas A. Kuhn; Brett R. Fink; Philip C. Sailer; Ralph H. Kahn; Edward P. Todderud; Jon M. Sieber; Gregory L. Estes; Eric S. Leaming; Herbert M. Biel; Victor Egwu; Mariss Sraders; Steve Sexson; George Feliciano; Louis Angelicchio; Andrew Combs; and Jill Wilson, was based on a methodology involving wRVU-based compensation for productivity, quality incentives, retention pay and call pay. The surgeons also received guaranteed compensation for at least two years.

196. Despite the lack of business or other significant factors to justify the above-market compensation, the physicians received more compensation than Community collected on them. For example, Dr. Angelicchio received at least $400,473, while Community only collected $389,199.

197. Moreover, twelve of the orthopedic surgeons received payment referred to as a "guaranteed supplement" based on the volume of referrals.

198. In setting these physician salaries at the outset, Community improperly factored in the financial performance of the physicians' expected referrals within the Community Network to fund the surgeons' excessive salaries.

199. During the term of these agreements, and through the present, the orthopedic surgeons made designated health service referrals to Community, including referrals for inpatient and outpatient hospital services, for which Community submitted claims to and received payments from Medicare.

200. Community's submission of claims to Medicare for designated health services that were referred by these orthopedic surgeons therefore violated the Stark Law, the Indiana AKS and the FCA.

ii) The OB/GYN Integration

201. Community also targeted obstetrician/gynecologists ("OB/GYNs") as an area for expansion and knowingly, or with reckless disregard, violated the Stark Law and the Indiana AKS in setting up and executing these deals.

202. As with other practices, Community significantly overpaid its OB/GYNs to prevent them from defecting to another health care network and to "capture" and keep the referrals.

203. Between 2007 and 2009 several OB/GYN groups in the Indianapolis market switched their affiliations. To prevent its OB/GYNs from affiliating with other networks, Community responded by employing them at above fair market value rates. For example, in 2013, according to a national survey of physician compensation, an OB/GYN whose salary was at the 90th percentile of all OB/GYN compensation made $522,162 per year. The 25 Community OB/GYNs who are paid salaries tied to their productivity were paid, on average, $116,000 more than that - $638,542.

204. IU then responded by building two hospitals with strong obstetric departments, one on North Meridian Street to directly compete with St. Vincent and another at Exit 10 of I-69 (10 miles north of Community Hospital North) to compete with Community Hospital North.

205. Under the OB/GYN integration plan, Community paid 25 physicians a salary rate of $638,542 per year in 2013, as shown in Community's "Physician Benchmarking Analysis" document below.

206. The average was an exorbitant amount, given that the national average for OB/GYN physician compensation that year under the 90th percentile made $522,162 per year.

207. Moreover, the following Community analysis chart showing its compensation average above the 90th percentile did not even include all of the physician compensation, expressly excluding any "guaranteed compensation."

Community Physician Network
Physician Benchmarking Analysis
Summary of OBGYN

2013 - OBGYN

Benchmark Data

	wRVUs	Charges	Net Collections	Collections / wRVU	Comp / wRVU	Comp
25th	5,064	$ 833,041	$ 487,771	$ 71.35	$ 43.92	$ 241,732
Median	6,297	$ 1,076,336	$ 618,173	$ 82.27	$ 48.57	$ 311,300
75th	7,732	$ 1,394,025	$ 796,553	$ 100.46	$ 56.28	$ 409,349
90th	9,328	$ 1,775,531	$ 999,147	$ 114.85	$ 65.99	$ 522,162
Benchmark Geography	*Midwest*	*National*	*Midwest*	*National*	*Midwest*	*Midwest*

Performance

	wRVUs	Charges	Net Collections	Collections / wRVU	Comp / wRVU	Comp
Benchmark Comparison	*> 90th*	*50th-75th*	*50th-75th*	*< 25th*	*75th-90th*	*> 90th*
Annualized YTD June 30, 2013[1]	10,682	$ 1,342,484	$ 640,391	$ 59.95	$ 59.78	$ 638,542

Annualized June 30, 2013 Performance Against the 90th Percentile[1]

	wRVUs	Charges	Net Collections	Collections / wRVU	Comp / wRVU	Comp
CPN Average per Physician	10,682	$ 1,342,484	$ 640,391	$ 59.95	$ 59.78	$ 638,542
90th Percentile Benchmark	9,328	$ 1,775,531	$ 999,147	$ 114.85	$ 65.99	$ 522,162
Excess (Shortfall) of 90th Percentile	**1,354**	**$ (433,047)**	**$ (358,755)**	**$ (54.90)**	**$ (6.21)**	**$ 116,380**

Conclusion:
(1) Collections percentage is low

(2) Need to review payor contracts and collections procedures

(3) Physician comp is high compared to productivity

Notes:
(1) Collections data is based on annualized July 31, 2013 data (not annualized June 30, 2013 data).

(2) OBGYN physicians included (or excluded) in the analysis are as follows:

Included	Included	Included	Excluded
Larkins, Debra D.O - **COMP**	Adams, Kristin M.D. - **COMP**	Hayes, Amy M.D. - **COMP**	*Carr, Rachel M.D.*
Beckwith, Mary M.D. - **COMP**	Crane, Sarah M.D. - **COMP**	Lane, Indy M.D. - **COMP**	*Hartmann, Christy M.D.*
Bean, Keith M.D. - **COMP**	West, Karen M.D. - **COMP**	Nemunaitis, Jennifer M.D. - **COMP**	*Darroca, Roberto M.D.*
Box, Kristina M.D. - **COMP**	Kerlin, Sarah M.D. - **COMP**	Marshall, Angela M.D. - **COMP**	*Clark, Carol M.D.*
Stuhldreher, Pratima M.D. - **COMP**	Sanders, Anthony M.D. - **COMP**	Linton, David D.O. - **COMP**	*Adair, Regina M.D.*
Voelkel, Sonja M.D. - **COMP**	Fraley, Stuart M.D. - **TERM**	Murphy, Michelle M.D. - **COMP**	*Brown, Gail M.D.*
Wagner, John M.D. - **COMP**	Linn-Bruns, Cady M.D. - **COMP**		*Miser, Margaret M.D.*
Salazar, Charles M. D. - **COMP**	Henderzahs, Kevin M.D. - **COMP**		*Hoffman, April D.O.*
Ertel, Sylvia M.D. - **COMP**	Rasmussen, Chelsey M.D. - **COMP**		*Perry, James M.D.*
Bernenderfer, Kathleen M.D. - **COMP**			*Perry, Nicole M.D.*
			Szentes, David M.D.
			Tisch, Donna M.D.
			Pierce, Sara M.D.
			Ipema, Neal M.D.
			Holt, Melissa M.D.
			Paulsen, Dean M.D.

==> Note, all OBGYN physicians on 'guaranteed' compensation plans have been excluded in addition to physicians with minimal productivity.

208. While other hospitals only paid their top (at the 90th percentile) OB/GYNs an average of 52.3 percent of their collections, Community knowingly and intentionally paid its OB/GYNs 99.7% of its collections.

209. During the term of these agreements, and through the present, the OB/GYN physicians made referrals for designated health services to Community, including inpatient and outpatient hospital services, for which Community submitted claims and received payments from Medicare.

210. Compliance with the Stark law and the Indiana AKS are material to government payers and are conditions of payment under the Medicare program and that compliance is material to the federal healthcare program's decisions to pay on the claims. *See e.g.*, 42 U.S.C. §§ 1395nn(a)(1), (g)(1).

211. Community's submission of claims to Medicare and Medicaid by these OB/GYNs violated the Stark Law, the Indiana AKS and the FCA.

C) Community Knew it Was Paying Above Fair Market Value for the Integrated Practices.

i) Community Knowingly Violated the Stark Law and the Fair Market Value Requirement

212. CMS has specifically cautioned that substantial increases in physician compensation following a hospital's acquisition of a physician practice and/or employment of a physician could be strong evidence that the payments are intended to be remuneration in exchange for physician referrals.

213. At the time(s) Community crafted each deal and set the compensation for the integrated physicians, Community's own valuation expert, Sullivan Cotter, hired to opine as to the fair market value under the Stark Law of proposed compensation to integrated physician groups, advised Community that the standard benchmark to be within fair market value was for compensation to physicians to be at or under the 60th percentile TCC/wRVU.

214. With the majority of its integrated physicians, Community expected the compensation (TCC) to exceed the 60th percentile at the time of the contracts, and it routinely did so in practice.

215. In setting such high physician salaries, Community knew, and intended, that the pay and wRVUs were out of line with industry survey data; excess of fair market value.

216. Furthermore, in setting the terms of the contract, Community did not analyze or quantify the significance of any "other business factors," such as exceptional qualifications of individual physicians, cost of recruiting and out-of-market physician to meet patient need, etc., before negotiating compensation packages.

217. Instead, Community used minimal efforts to justify such compensation on a limited basis.

218. In fact, the fair market value analysis noted that such "other business factors" could potentially justify compensation above the 75th percentile. However, Community refused to base its decision on such factors.

219. The only factors considered and analyzed were the revenue each physician would yield based on the ancillary referrals.

220. Community showed deliberate intent to increase the compensation of orthopedic surgeons based on referrals, for example, as indicated in internal e-mail correspondence. Below are snapshots from an email from Network Chief Accounting Officer Holly Millard to the PIC forwarded to the Relator, indicative of the type of issues that were raised during the integration planning process:

My understanding is that there are 18 physicians that may want to integrate with the Network into one Orthopaedic group to be currently housed under CHI. I understand those physicians to include:

My questions/requests for each group include:

1) For each of the four groups identified above, we need financial statements for the years ended December 31, 2008 and 2009 and if available, for the three months ended March 31, 2010 as compared to 2009. Please let me know if these are prepared on an accrual or cash basis
2) Assuming that these financial statements will include practice revenue only and thus billing under professional fee codes, data will be needed as to what services shows up on the hospital financial results as being linked directly to the physician or shows up as a referral by physician. Is there a way to get revenues and costs?
3) Need downstream contribution margins for the physicians for 2008, 2009 and current in 2010 by physician, by location and by service

221. By reviewing "services […] linked directed to the physician or shows up as a referral by physician" and "downstream contribution margins" for previous years, Community intentionally considered physician referrals that were expected.

222. The stated and obvious intent for the physician integrations was to "capture" or retain referrals.

223. Community's motivation and intent was clear. In internal communications and presentations, Community repeatedly voiced fear of losing referrals to competitors, and on the other hand, securing or "capturing" referrals if certain high-referring doctors could be brought into Community's fold.

224. There was real, economic value to Community from both retaining referrals and securing new ones, and it paid physicians for referrals at above fair market value at the time of the contract.

ii) Community Knew it Was Paying and Intended to Pay the Orthopedic Surgeons Above Fair Market Value

225. For the orthopedic deal, these surgeons on the whole received total cash compensation above the 75% percentile and TCC/wRVU above the 60th percentile.

226. However, it is not necessary to rely on inference to establish that Community employed these physicians to get access to their referrals. The PowerPoint and financial analysis presented during the September 13, 2011, PIC meeting, as well as similar analyses presented before and after the meeting, made it clear that Community knowingly entered into these financial arrangements to "capture" or keep the referrals from these surgeons.

227. For example, the PowerPoint notes as "Key Assumptions" that through this deal, Community would "recapture" approximately $1.5 million in physical therapy rehabilitation services and 1,350 Magnetic Resonance Imaging ("MRI") tests worth $1,000,000 per year.

228. Prior to the acquisition, the orthopedic surgeons at the Indiana Orthopedic Center offered physical therapy services in their offices. After the consolidation of the orthopedic surgery practices, the physical therapy facility became a department of the hospital and, as such,

Community was able to "capture" these referrals and bill for these services at higher hospital outpatient rates.

229. Similarly, prior to the acquisition, several of the orthopedic surgeons owned shares of an imaging center, and referred patients for MRIs to that center. As part of the acquisition, Community purchased the physicians' interests in the center and shut it down, to eliminate any competition with its own imaging centers.

230. Community then monitored physician referrals to other imaging centers and spoke to physicians who did so.

231. The financial analysis presented at the September 2011 meeting considered and used physicians' referrals to set compensation and internally justify the deal. When analyzing the overall financial outcome of the deal, Community netted how much it would have to spend for compensation of the orthopedic surgeons against the expected referrals the surgeons would send to Community's hospitals and affiliated surgical centers.

232. Thus, although Community expected to lose $4.4 million on the orthopedic physician practices, Community expected that the referrals to its hospitals would be worth $4.9 million and Community's share of referrals to its surgical centers would be worth an additional $4 million.

233. In other words, at the time of contract, Community justified the above fair market compensation paid to the surgeonswith its projection that hiring the surgeons would produce a $4.5-million-dollar profit - considering the expected referrals from these surgeons.

234. In fact, the financial analysis specifically noted that the substantial decrease in operating margin for the practices was due to "the increase in physician compensation due to

integration." It also noted that the operating margin for the hospitals included the value of the recaptured physical therapy and imaging referrals.

235. Beyond projections, by 2013, the fundamental problem with these employment contracts was clear. In an analysis of the productivity and compensation of these physicians through June 30, 2013, on average each of them was paid $943,418 per year, exceeding the 75th percentile.

Community Physician Network
Physician Benchmarking Analysis
Summary of Orthopedic Surgery - General

2013 - Orthopedic Surgery - General

Benchmark Data

	wRVUs	Charges	Net Collections	Collections / wRVU	Comp / wRVU	Comp
25th	6,292	$ 1,307,898	$ 740,880	$ 75.74	$ 59.70	$ 438,941
Median	7,727	$ 1,852,961	$ 967,907	$ 88.60	$ 70.46	$ 580,177
75th	10,443	$ 2,517,774	$ 1,317,782	$ 118.87	$ 91.78	$ 802,443
90th	13,252	$ 3,297,539	$ 1,577,087	$ 125.92	$ 108.73	$ 1,030,323
Benchmark Geography	*Midwest*	*National*	*Midwest*	*National*	*Midwest*	*Midwest*

Performance

	wRVUs	Charges	Net Collections	Collections / wRVU	Comp / wRVU	Comp
Benchmark Comparison	*50th-75th*	*50th-75th*	*25th-50th*	*< 25th*	*50th-75th*	*75th-90th*
Annualized YTD June 30, 2013[2]	10,308	$ 2,251,396	$ 755,313	$ 73.28	$ 91.53	$ 943,418

Annualized June 30, 2013 Performance Against the 50th Percentile[1]

	wRVUs	Charges	Net Collections	Collections / wRVU	Comp / wRVU	Comp
CPN Average per Physician	10,308	$ 2,251,396	$ 755,313	$ 73.28	$ 91.53	$ 943,418
50th Percentile Benchmark	7,727	1,852,961	967,907	88.60	70.46	802,443
Excess (Shortfall) of 50th Percentile	**2,581**	**$ 398,435**	**$ (212,593)**	**$ (15.32)**	**$ 21.07**	**$ 140,975**

Notes:
(1) December 31, 2012 data has not been annualized for the physicians joining CPN 3/31/12 - figures are understated for 2012.

(2) Collections data is based on annualized July 31, 2013 data (not annualized June 30, 2013 data).

(3) General orthopedic surgeons included (or excluded) in the analysis are as follows:

Included	Included	Included	*Excluded*
Kerpsack, James M.D. - **GUAR**	Doxey III, C. Melton M.D. - **GUAR**	Kuhn, Douglas M.D. - **GUAR**	*None*
Feliciano, George M.D. - **GUAR**	Eaton, Richard M.D. - **GUAR**	Leaming, Eric M.D. - **GUAR**	
Sexson, Stephen M.D. - **GUAR**	Estes, Gregory M.D. - **GUAR**	Sailer, Philip M.D. - **GUAR**	
Sraders, Mariss (Jiff) M.D. - **GUAR**	Fink, Brett M.D. - **GUAR**	Sieber, Jon M.D. - **GUAR**	
Egwu, Victor MD M.D. - **GUAR**	Kahn, Ralph M.D. - **GUAR**	Todderud, Edward M.D. - **GUAR**	
Biel, Herbert M.D. - **GUAR**			

236. Notably, capturing ancillary services was also a common factor motivating these integrations.

237. As to the orthopedic surgeons, on September 13, 2011, during a PIC meeting that included Jon Fohrer, the CEO of Ambulatory Services for Community, Jane Callahan, Community's Chief Physician Services Executive, and Mr. Javorka, discussing the business justification for orthopedic integration, the executives expressed a strong desire that the integration would result in a "recapture" of at least $1.5 million in physical therapy rehabilitation and 1,350 Magnetic Resonance Imaging (MRI) tests worth $1,000,000 per year.

238. Below is a slide from the PowerPoint presented during the meeting, evidencing that among it "key assumptions" were the expected ancillary referrals and demonstrating Community's goals to generate profit from ancillary services through the orthopedic integration:

KEY ASSUMPTIONS

•MRI Recapture (1,350) - $1,000,000

•Rehab Reimbursement (IOC) (500) - $1,400,000

•Rehab Recapture - $150,000

239. In fact, when calculating Community's "Operating Margin" from the integration, Community knowingly included the expected revenue from "Rehab and MRI" referrals it would "recapture." Footnote 4 from one of the charts presented during the September 11 PIC meeting indicates as such:

Hospitals Only	Volumes- Cases/ Encounters	Net Revenue (4)	Operating Margin $ (4)	Operating Margin %
2009	9,394	$ 37,859,819	$ 977,544	2.6%
2010	9,677	$ 40,829,211	$ 1,053,457	2.6%
2012	12,117	$ 47,972,606	$ 4,967,729	10.4%
2013	13,398	$ 55,497,131	$ 6,650,885	12.0%
2014	15,165	$ 65,880,290	$ 8,773,634	13.3%
2015	17,331	$ 79,018,610	$ 11,499,046	14.6%

(1)- Indiana Surgery Center Operating Income Numbers are pre tax.
(2)- The decrease in operating margin % is due to a projected decrease in reimbursement from government payers.
(3)- The decrease in operating margin % is due to the increase in physician compensation due to integration (estimated 20% in 2012, 4.3% thereafter)
(4)- Numbers include Rehab and MRI recapture business beginning January 1, 2012.
(5)- 2009 was a start up year for Specialty MRI.

iii) Community Knew it Was Paying and Intended to Pay the OB/GYNs Above Fair Market Value

240. The fact that the above fair market value compensation was known, and in fact, intended, to pay for referrals was clear from Community's own internal analysis, explanations and communications about the integration deals, including those for the OB/GYNs.

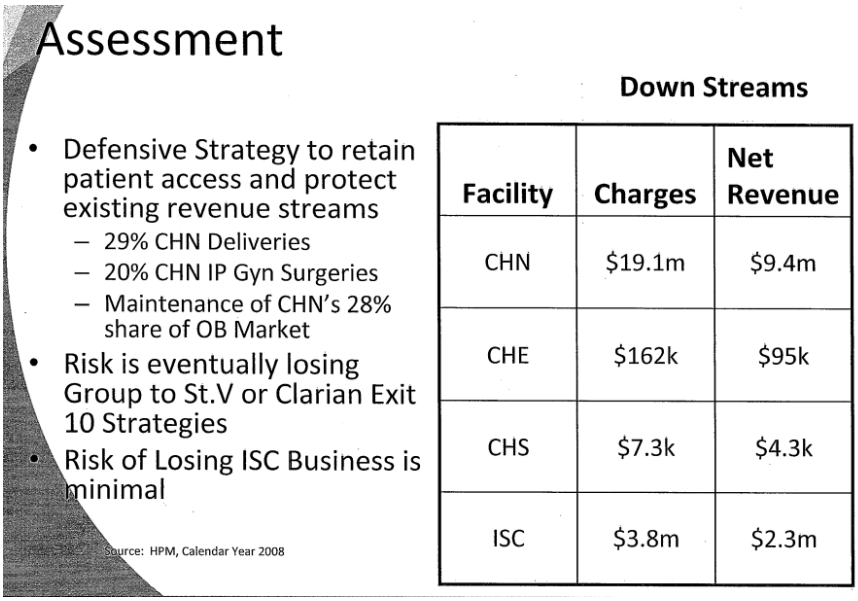
241. That Community paid its OB/GYNs above fair market-value rates to induce and control their referrals was clear in materials created to justify their employment. For example, in September 2009, a presentation attended by the Relator was made to Community's Finance Committee to lay out the business case for acquiring the Clearvista Women's Care OB/GYN practice.

242. The practice consisted of 7 physicians (Dr. Kristina Box; Dr. John Wagner; Dr. Lynn Bemenderfer; Dr. Pratima Sthuldreyer; Dr. Kris Beckwith; Dr. Sonja Voelkel; and Dr. Chemen Tate) with offices near Community Hospital North.

243. Acquisition of the practice was described as a "[d]efensive strategy to retain patient access and *protect existing revenue streams*." "Defense" of the practice was necessary because Community believed it faced a risk of losing the group to St. Vincent or IU.

244. Further, maintaining the group's referrals was crucial, because they were responsible for 29% of Community North's deliveries and 20% of the hospital's inpatient gynecological surgeries, which generated net revenue of about $9.5 million for Community Hospital North and East.

245. Below is a slide from the presentation highlighting the reasons for acquiring the Clearvista group of OB/GYNs as a "defensive" strategy and obtaining the referral source:



246. Typically, when a Community Board member or executive questioned the financial soundness of paying exorbitant compensation for integrating these practices, the answer that consistently came back was the return on investment based on the expected patient referrals.

247. That same response applied to the OB/GYN integrations well. On or about September 2009, Relator was part of an email chain discussing the OB/GYN integration.

248. A Community Board member raised concerns about the compensation arrangements with the OB/GYNs by pointing to the projected 5-year Proforma. As the CFO, he questioned the economic reasoning and soundness of investing in Clearvista when the Proforma showed that Community would lose money on it every year, specifically, with a 5-year total net income loss of $2,692,336. The slide indicative of the loss in net operating income and net income is shown below:

Proforma

		2010	2011	2012	2013	2014	Total Five Years
Revenues:							
Gross revenue		$ 7,438,487	$ 7,806,940	$ 8,193,255	$ 8,596,145	$ 9,031,110	$ 41,065,937
Contractual allowances		2,454,701	2,576,290	2,703,774	2,836,728	2,980,266	$ 13,551,759
Charity		-	-	-	-		-
Net revenue		$ 4,983,787	$ 5,230,650	$ 5,489,481	$ 5,759,417	$ 6,050,843	$ 27,514,178
Operating Expenses:							
Salaries and wages- phy	x	$ 2,357,372	$ 2,357,372	$ 2,404,519	$ 2,452,610	$ 2,501,662	$ 12,073,535
Salaries and wages- emp	x	1,044,553	1,081,112	1,118,951	1,158,115	1,198,649	$ 5,601,380
Employee benefits- phy	x	262,330	275,447	289,219	303,680	318,864	$ 1,449,539
Employee benefits- emp	x	285,163	295,144	305,474	316,165	327,231	$ 1,529,177
Professional fees	x	30,000	10,000	10,000	10,000	10,000	$ 70,000
Billing	x	198,790	204,754	210,896	217,223	223,740	$ 1,055,403
Supplies	x	270,287	282,169	294,598	307,536	321,441	$ 1,476,030
Service	x	325,788	411,179	459,348	492,427	531,655	$ 2,220,398
Dept misc.	x	124,595	130,766	137,237	143,985	151,271	$ 687,854
Facility	x	430,650	431,694	432,760	433,847	434,955	$ 2,163,906
Unallocated	x	36,000	36,000	36,000	36,000	36,000	$ 180,000
Bad debt	x	74,757	78,460	82,342	86,391	90,763	$ 412,713
Pension- phy	x	102,900	104,958	107,057	109,198	111,382	$ 535,496
Pension- emp	x	62,673	64,867	67,137	69,487	71,919	$ 336,083
Interest	x	0	0	0	0		$ -
Depreciation	x	63,000	73,000	83,000	93,000	103,000	$ 415,000
Total Operating Expenses		5,668,857	5,836,921	6,038,539	6,229,664	6,432,532	30,206,513
Net Operating Income		(685,071)	(606,272)	(549,058)	(470,247)	(381,688)	(2,692,336)
Other Income (Expense)							0
Net Income		$ (685,071)	$ (606,272)	$ (549,058)	$ (470,247)	$ (381,688)	$ (2,692,336)
Operating Margin %		-13.75%	-11.59%	-10.00%	-8.16%	-6.31%	-9.79%

Note: There is a 10 yr Retention Compensation Agreement worth potentially $1.8m not reflected in this 5 year proforma

249. The response to the Board member described the acquisition of Clearvista as a "defense strategy" that would capture referrals and keep others from leaving.

250. Community ignored Relator's and others' concerns raised internally about losing money on any particular integration because it knew and intended that downstream revenue would yield it an overall profit. In order to justify Clearvista, it emphasized the downstream revenue as well as its strategy to prevent the OB/GYNs from defecting to other networks.

251. As to the OB/GYNs, when deciding on compensation for this integration, Community also considered what losing these physicians would do to its other practices (ancillary services), including its OB/GYN and NICU business.

252. In sum, Community knew, or had reckless disregard for the fact, that it was paying its integrated physicians above fair market value compensation packages and it did so, in order to

capture or keep downstream and ancillary referrals and for no other reasonable business reason in violation of the Stark Law and the Indiana AKS.

iv) Community Achieved its Financial Goals through Integration

253. The excessive and above fair market value compensation arrangements and deals based on referrals worked to meet Community's ends and yielded lucrative results for the hospital including increased market share and profits.

254. Post-integration, Community's 2013 market share in the central Indiana market rose from 21.5 percent to 23.1 percent, while the market shares of its three competitor hospital systems dropped during the same period.

255. This was the largest annual increase in its market share in over 25 years.

256. Between January and October 2013, Community paid physician salaries totaling approximately $25.1 million on 158 primary care doctors (about $158,000 per physician) and $70.4 million on 178 specialists (about $393,000 per physician) employed by the network. This excludes the amount Community paid to physicians employed through other Community affiliates and subsidiaries.

257. According to a November 2013 analysis of Community's operations, between January and October 2013, the net income Community collected from the professional services provided by physicians prior to integration was only $12.29/wRVU. Post-integration, Community's analysis reported that it lost over $55 per wRVU.

258. At the same time, for those physicians who did not meet the internal referral threshold, Community did not pay incentive compensation, including guaranteed compensation and above fair market value salaries.

259. All of the claims for services referred to Community by the integrated practice physicians and paid for by government-funded healthcare programs are false and or fraudulent claims because and to the extent that Community's contractual relationships with the physicians and payment of illegal remuneration violate the AKS and the Stark Law and claims paid by those government-funded healthcare programs are covered by the AKS and/or the Stark Law.

260. Moreover, Community's submission of claims to Medicare and other government-funded healthcare programs that were referred by physicians therefore violated the Stark Law (only for Medicare claims), the Indiana AKS and the FCA.

261. Compliance with the Stark and/or AKS laws are conditions of payment under the Medicare program and other government-funded healthcare programs and that compliance is material to the federal healthcare program's decisions to pay on the claims. *See e.g.*, 42 U.S.C. §§ 1395nn(a)(1), (g)(1).

D) Community Paid Above Fair Market Value Rates to the "CHOP" Group of Medical Oncologists to Get Them to Practice Exclusively at Community and to Stop Treating Patients at Methodist Hospital

262. In relation to Community's creation of the Community Breast Center, in the late 2000s and early 2010 period, a major part of Community's growth strategy focused on expanding its cancer service line.

263. This was driven both by a fear of losing its exiting oncologists (and their patients and referrals), and by recognition that oncology is a high margin service line that generates substantial revenue through related and downstream services and referrals.

264. Community engaged in multiple detailed analyses of its patients who were diagnosed with cancer, looking for the most profitable strategic approach. It mined its own "tumor

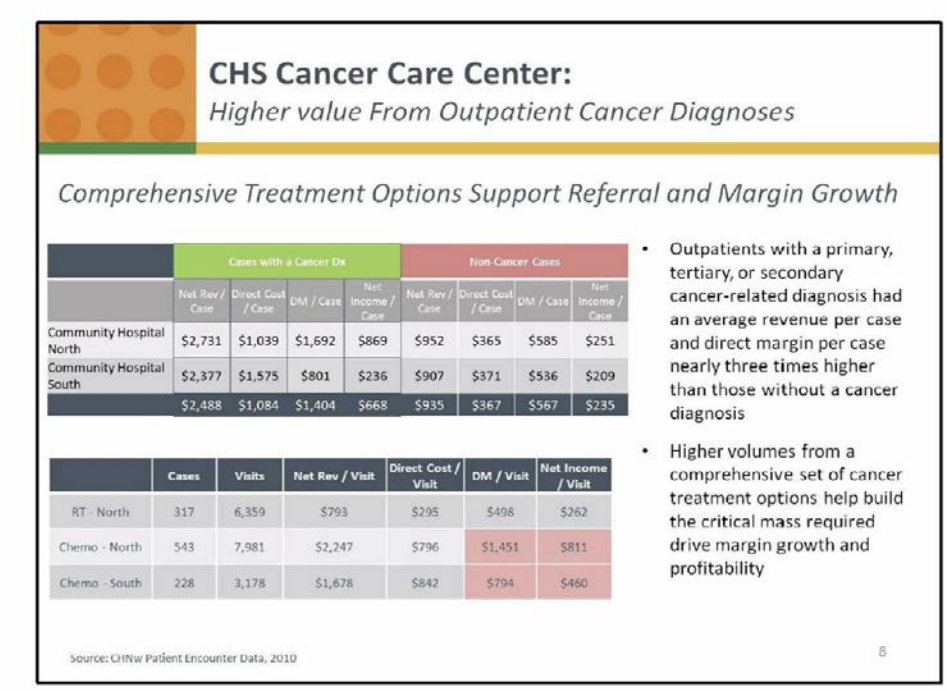
registry" as well as the Indiana State Department of Health cancer incidence estimates and other sources to identify the most profitable way to market to, and bill for treating, patients with cancer.

265. Community's strategic documents analyzed patients facing the devastating prospect of a cancer diagnosis as commodities to be mined for financial gain with such headlines as: "Strong Growth in Prostate Lung Breast and Colorectal" and "… most notably in the North and South markets (2011 -2016 proj.) in a slide from Community's Cancer Care Services Strategic Plan for 2012 to 2014 (begun in August 2011) that analyzed expected cancer cases in Community's targeted market area by tumor site.

266. Another Community strategic document described the challenge of caring for patients faced with cancer as follows: "CHS Cancer Care Center: Growing demand, fleeting opportunity."

267. Notably, these strategic presentations primarily focused their most detailed and data-driven analysis primarily on the network's ability to market to and otherwise attract the patients. Community's clinical ability to treat the patients more effectively than their competitors or other quality justifications for the initiative were given far less focus or granular analysis.

268. For example, a key slide from the presentation analyzes the caner "opportunity" as follows:



CHS Cancer Care Center:

Higher value From Outpatient Cancer Diagnoses

Comprehensive Treatment Options Support Referral and Margin Growth

	Cases with a Cancer Dx				Non-Cancer Cases			
	Net Rev / Case	Direct Cost / Case	DM / Case	Net Income / Case	Net Rev / Case	Direct Cost / Case	DM / Case	Net Income / Case
Community Hospital North	$2,731	$1,039	$1,692	$869	$952	$365	$585	$251
Community Hospital South	$2,377	$1,575	$801	$236	$907	$371	$536	$209
	$2,488	$1,084	$1,404	$668	$935	$367	$567	$235

	Cases	Visits	Net Rev / Visit	Direct Cost / Visit	DM / Visit	Net Income / Visit
RT - North	317	6,359	$793	$295	$498	$262
Chemo - North	543	7,981	$2,247	$796	$1,451	$811
Chemo - South	228	3,178	$1,678	$842	$794	$460

- Outpatients with a primary, tertiary, or secondary cancer-related diagnosis had an average revenue per case and direct margin per case nearly three times higher than those without a cancer diagnosis
- Higher volumes from a comprehensive set of cancer treatment options help build the critical mass required drive margin growth and profitability

Source: CHNw Patient Encounter Data, 2010

8

269. In fact, presentations such as the 2012 to 2014 strategic plan often acknowledged that there were limitations in Community's ability to treat those patients they might be able to attract through their marketing strategies, such as acknowledgments that Community would:

- "Lack the necessary core cancer care delivery platform in its key markets the greatest deficiency at CH South in Medical Oncology and Radiation Oncology."
- "Will require the delivery of a more uniform patient care and service experience across each campus and care delivery site for each targeted disease states, further investments in facilities and equipment are indicated (South and North)"

270. Even more directly, the 2012 to 2014 strategy presentation observed: "While there is a general sense that no one networks cancer program holds an insurmountable market leading position there's a perception that CHN's competitors offer more comprehensive cancer care options."

271. Although Community's strategic plans proposed investment in enhanced clinical facilities, the core strategy focused on first securing oncology referrals by paying kickbacks rather than winning referrals through superior patient experience and clinical outcomes.

272. As part of this strategy, Community focused on outpatient oncology services. The 2012 to 2014 strategic plan noted that, as of fiscal year 2010, while seven (7) percent of Community's patients had a cancer diagnosis, those patients accounted for 21% of Community's outpatient revenue, representing a 56% growth since 2008.

273. As a general matter, cancer treatment falls into through rough treatment categories: (1) medical oncology, where physicians primarily use chemotherapy and other similar treatments to fight the patients' cancer; (2) radiation oncology, where treatment is primarily based on the use of radiation therapy, often delivered through a linear accelerator; and (3) surgical treatment, where tumors are removed through various surgical techniques.

274. By late 2011 and early 2012, after the Community Breast Center integration had settled into a more stable operational mode, Community began looking for ways to focus on other aspects of the full "cancer picture."

275. Medical oncology is a particularly important in the overall cancer care financial picture both because the drugs used for chemotherapy have a very high margin (especially for a hospital network, such as Community, that can take advantage of the 340(b) discount drug program) and because medical oncologists generate substantial referrals to both radiation oncologists and surgeons. Surgery and radiation therapy are used not only as an alternative to chemotherapy, but also, often, in conjunction with chemotherapy.

276. A key target for Community's cancer strategy was Dr. Sumeet Bhatia and his Community Hospitals Oncology Physicians, LLC ("CHOP") physician practice. At the time CHOP had five oncologists (Dr. Bhatia, Dr. Pablo Bedano, Dr. Radhika Walling, Dr. William Dugan and Dr. Anuj Agarwala).

277. CHOP also employed a number of nurse practitioners who provided medical oncology services (that were billed using the provider numbers of the CHOP physicians). By reliance on the nurse practitioners, the CHOP physicians were often able to generate significantly more wRVUs than national benchmarks (at times multiples higher than those national benchmarks).

278. The CHOP physicians provided services at Community's outpatient clinics and to Community's inpatients. Under that deal, Community generally paid the CHOP physicians on a per wRVU basis for services performed, and then billed Medicare, Medicaid and other payers for the services.

279. The CHOP physicians were not direct employees of Community or any of its affiliates. CHOP was (and still is) an independent practice that contracted with Community.

280. The CHOP physicians did a substantial amount of work at Community, generating between $34 to $36 million per year in net revenue for Community, and correspondingly between $17 and $22 million per year in contribution margin.

281. It was causal, and not coincidental, that the 56% increase in Community's outpatient oncology revenue noted in the 2012 to 2014 strategic plan cited above coincided with Community's execution of a new, substantially more lucrative contract with CHOP in 2008.

282. Dr. Bhatia treated 1,577 Community patients in 2010 and 1,626 in 2011. Dr. Bhatia referred 61 patients in 2010 and 52 patients in 2011 to Community for home care. He also referred 40 patients in 2010 and 51 patients in 2011 to Community for hospice care.

283. Dr. Bedano treated 327 Community patients in 2010 and 327 in 2011. Dr. Bedano referred 19 patients in 2010 and 28 patients in 2011 to Community for hospice care.

284. Dr. Walling treated 680 Community patients in 2010 and 747 in 2011. Dr. Walling referred 22 patients in 2010 and 19 patients in 2011 to Community for hospice care.

285. Dr. Dugan treated 135 Community patients in 2010 and 68 in 2011.

286. Dr. Agarwala treated 32 Community patients in 2010 and 149 in 2011. Dr. Agarwala referred 2 patients in 2010 and 13 patients in 2011 to Community for hospice care.

287. Although the CHOP physicians treated a substantial number of patients at Community, they did not practice exclusively there. Instead, they split their time between Community and Methodist Hospital (now part of IU Health System).

288. As part of its 2012 strategy to increase is medical oncology revenues and referrals, Community wanted to get CHOP to practice exclusively at Community, and correspondingly to switch all of their patients and referrals that were then going to Methodist over to Community.

289. CHOP agreed to do this in exchange for a substantial increase in the value of their contracts with Community.

290. In 2012, Community and CHOP agreed to a new set of contracts that required CHOP physicians to practice exclusively at Community and to refer all of their patients to Community (with a few, very limited possible exceptions).

291. In exchange, Community agreed to pay CHOP productivity-based remuneration (per wRVU) that was substantially above fair market value. Beyond this productivity-based salary, CHOP physicians received numerous additional financial "sweeteners," such as payments for services as medical directors, research directors, clinic co-managers as well as various other "performance," "quality" or other incentives.

292. For example, Dr. Bhatia received approximately $3 million per year through the productivity compensations. At that time, according to numerous national benchmarks,

oncologists earning at the high end of the fair market value scale (those at the 90th percentile) were making in the range of $550,000 to $650,000 per year. Thus, Dr. Bhatia's salary was more than five times the 90th percentile national average standard for fair market value.

293. That Dr. Bhatia was apparently a hard worker does not justify his salary, or bring it within established measures of Fair Market Value. Dr. Bhatia was also paid substantially above fair market value on a per wRVU basis as well – especially considering the fact that as a general rule the per unit rate should go down (in a relative sense) for physicians who are billing at the top end of the wRVU volume scale. In 2012, the 75th percentile for oncologist compensation was in the range of $95 to $99 per wRVU. Dr. Bhatia received approximately $113 per wRVU (not counting the other financial benefits in the CHOP contracts).

294. Accordingly, regardless of the measure, Dr. Bhatia's compensation substantially exceeded fair market value.

295. Payments to CHOP for the other physicians arose from the same formula as used for the payments to Dr. Bhatia. Accordingly, those physicians also received payments above fair market value in violation of the Stark Law and the AKS.

296. Although Dr. Bhatia was (and is) highly regarded clinically in the Indianapolis medical community, neither his reputation nor any other market factors provide a basis to pay him so far above fair market value.

297. Instead, Community paid Dr. Bhatia and CHOP those highly inflated salaries to get access to the patients and referrals that CHOP was otherwise sending to Methodist, and to ensure that CHOP kept all of its existing patients and referrals at Community.

298. Later, Community recruited another local oncologist, Dr. Mary Lou Mayer, who had been practicing both at Community and another competing hospital (St. Vincent's Hospital.)

Community hired Dr. Mayer on similar terms as the 2012 CHOP deal, and eventually joined CHOP. As a result, and as expected, she shifted all or substantially all of her referrals to Community.

299. The 2012 Community / CHOP contract had its desired effect. In 2012, Community's net revenue from CHOP rose to $52 million and in 2013 to between $60 and $75 million.

300. This post-2012 volume (like the pre-2012 volume) included a substantial number of patients covered by Medicare (and other government-funded healthcare programs).

301. For example, in 2014, Dr. Bhatia provided Medicare patients with 89 new patient office visits (Medicare paid $8,262), 538 existing patient office visits (Medicare paid $23,662) and 887 evaluation and management services to inpatients (Medicare paid $63,839).

302. Dr. Bedano provided Medicare patients with 182 new patient office visits (Medicare paid $19,342), 1,134 existing patient office visits (Medicare paid $46,018) and 707 evaluation and management services to inpatients (Medicare paid $51,409).

303. Dr. Walling provided Medicare patients with 62 new patient office visits (Medicare paid $6,942), 614 existing patient office visits (Medicare paid $27,336) and 517 evaluation and management services to inpatients (Medicare paid $35,506).

304. Dr. Agarwala provided Medicare patients with 154 new patient office visits (Medicare paid $17,924), 665 existing patient office visits (Medicare paid $29,565) and 556 evaluation and management services to inpatients (Medicare paid $39,949).

305. All of the services set forth in the four preceding paragraphs were provided in a hospital (inpatient, outpatient or clinic) setting, and thus, because of CHOP exclusivity arrangement with Community all or nearly all of these services were performed at Community.

306. Accordingly, upon information and belief, Relator alleges that Community billed facility fees, technical fees or other amounts (including amounts bundled into per case payments) and received payment from Medicare and other government-funded healthcare programs for these services.

307. Relator also alleges, upon information and belief, given the high volume of referrals for chemotherapy, radiation oncology, surgical oncology and other treatments generally resulting from treatment by medical oncologists such as the CHOP physicians that Community billed and was paid for such services referred by the CHOP physicians.

308. All claims for services referred to Community by the CHOP physicians and paid for by government-funded healthcare programs are false and or fraudulent claims because and to the extent that Community's contractual relationships with CHOP and payment of illegal remuneration violate the AKS and the Stark Law and claims paid by those government-funded healthcare programs are covered by the Federal and Indiana AKS and/or the Stark Law.

309. Moreover, Community's submission of claims to Medicare and other government-funded healthcare programs that were referred by CHOP physicians therefore violated the Stark Law (only for Medicare claims), the AKS (for Medicare and other government-funded healthcare programs) and the FCA.

310. Compliance with the Stark and/or AKS laws are material to government payers and are conditions of payment under the Medicare program and other government-funded healthcare programs and that compliance is material to the federal and state healthcare program's decisions to pay on the claims. *See e.g.*, 42 U.S.C. §§ 1395nn(a)(1), (g)(1).

E) Community Solicited and Received Kickbacks from Johnson Memorial Hospital in Exchange for Patient Referrals to its Nursing Homes.

311. Community involvement with kickbacks was also in the form of a sham payment arrangement (also referred to herein as the "monitoring agreement") that involved Medicaid Upper Payment Limit (UPL) payments.

312. In 2013, Community executed a lucrative deal with local nursing homes purchased by a municipal provider that could participate in the UPL program, which basically reimbursed providers at Medicare rates for Medicaid patients, and thus, took advantage of higher Medicaid rates.

313. Ostensibly, under the deal, Community provided monitoring and consultation services to nursing homes.

314. However, in practice, it was a sham monitoring agreement designed to conceal the underlying financial reality, which was the purchase of Community referrals by a nursing home provider named Johnson Memorial Hospital ("Johnson Memorial."). The agreement was a sham because the nursing homes did not need the services and Community provided only minimal services.

315. However, Johnson Memorial paid Community millions for the services not provided listed on the monitoring agreement.

316. Under the Medicaid program, several states pay providers extra money on top of what they receive from regular Medicaid reimbursements to deliver care. The payments include both disproportionate-share hospital payments to reimburse for uncompensated care and upper payment limit supplemental payments that fill the gap between Medicaid fee-for-service payments and Medicare rates.

317. The supplemental payment, known as the Medicaid UPL, is a federal limit placed on fee-for-service reimbursement of Medicaid providers.

318. Specifically, the UPL is the maximum amount that states can pay for nursing home care covered by Medicaid. In other words, the state cannot claim federal matching dollars for provider payments in excess of the applicable UPL.

319. Indiana has several UPL programs under Medicaid, including a UPL program for "Non-State Governmental Nursing Facilities," which refers to a nursing facility where a non-state governmental entity holds the license and is party to the facility's Medicaid contract.

320. For the providers receiving these supplemental payments, such as nursing homes, which are at issue here, there are separate UPL payments based on facility ownership.

321. Prior to the federal requirement for separate UPL calculations by ownership class, Medicaid could pay large supplemental payments to county nursing homes.

322. However, later, separate UPLs based on facility ownership were required in order to limit states from using Medicaid to pay the state, county, or other government-owned facility substantially more than their costs and more than other facilities.

323. Therefore, in practice, the state portion is paid through an intergovernmental transfer (IGT) of funds from the government facility receiving the enhanced payment to the state.

324. Only a governmental entity, such as a nursing home owned by a county hospital, is qualified to make the IGT payment. Thus, private nursing homes or nursing homes owned by private hospitals, do not qualify for UPL payments.

325. Local nursing homes in Indiana participating in the UPL program are owned and operated by county hospitals.

326. The county hospitals IGTs the non-federal share of the UPL payments to the state, allowing the state to draw down the federal portion of the UPL. The county hospital then receives

supplemental payments in an amount equal to the difference between the Medicaid rate and the approximate Medicare equivalent.

327. Cluing into how substantial UPL payments could be, in 2011, Johnson Memorial, a county-owned hospital system, purchased the licenses of about 35 nursing homes from Miller's Merry Manor ("Miller's Merry"), a private nursing home provider in Indiana.

328. As the municipal provider of the nursing homes, Johnson Memorial and its nursing homes (also referred to as Miller's Merry nursing homes) were eligible for the UPL payments. These supplemental payments were held in nursing facility-specific accounts until the end of the hospital's fiscal year when they could be transferred to the hospital's general account.

329. By 2015, similar county-owned hospitals purchased the licenses of about 350 nursing homes in Indiana to participate in the UPL program. Such purchases similar to the Johnson Memorial-Miller's Merry deal allowed county-owned hospitals and its nursing homes to benefit from UPL payments as it became increasingly challenging for private nursing homes to provide Medicaid services at a reasonable profit margin.

330. However, here, as part of the purchase deal with Community, Johnson Memorial and its nursing homes also secured unlawful referrals from Community to its nursing homes.

331. Mr. Mills personally negotiated the agreement with Johnson Memorial that called for Johnson Memorial and Community to split the windfall profits received by Johnson Memorial under the UPL arrangement, then instructed Relator to negotiate a service agreement to support the large sum of money to be paid by Johnson Memorial to Community.

332. Prior to the purchase deal between Johnson Memorial and Miller's Merry was executed, Johnson Memorial had a partnership with Community through a formal clinical affiliation.

333. In or about May 2011, the two entities entered into a Clinical Collaboration Agreement, which specified among other things, the "Nursing Homes Ownership Model" and the "County Hospital Affiliation Model" under their areas of affiliation.

334. The purpose of their partnership was to foster business with a local private nursing home owner in order to ultimately take advantage of the UPL program.

335. A few months later, on August 8, 2011, Community and Johnson Memorial began discussions with Miller's Merry. Mr. Mills worked closely with Larry Heydon, Johnson Memorial's CEO. Community knew that Miller's Merry was shopping for a UPL deal. Community also knew that Miller's Merry was particularly interested in doing business with Johnson Memorial because of its ongoing affiliations with Community.

336. Miller's Merry liked Johnson Memorial's ties with Community because it had several facilities close to the Community North and East hospitals, which could open up opportunities for direct referrals from Community to Miller's Merry's nursing homes (purchased by Johnson Memorial).

337. Under the purchase deal, Johnson Memorial bought Miller's Merry's nursing homes and Miller's Merry provided operational and administrative services at the facilities.

338. Miller's Merry received a base management fee of 4.5% of revenue and a subordinated management fee of 4.25% of patient revenue, while Johnson Memorial received higher Medicaid rates based on the UPL payment rates.

339. Community's ability to direct patient referrals to Miller's Merry's nursing homes (prior to Johnson Memorial's purchase) was a critical factor in in Miller Merry's choice of Johnson Memorial, since Johnson Memorial was a small hospital with limited ability to refer patients to Miller's Merry facilities and Miller's Merry had no facilities in the vicinity of Johnson Memorial.

340. Mr. Mills controlled the negotiation of terms in the purchase deal between Miller's Merry and Johnson Memorial. In fact, Mr. Mills negotiated such a deal with Miller's Merry, before Johnson Memorial became aware of the terms of the arrangement.

341. Immediately upon execution of the deal, Community solicited kickbacks from Johnson Memorial-owned nursing homes in exchange for directing Community patients to the facilities in violation of the AKS.

342. As a result, Johnson Memorial expected to financially benefit from a higher government reimbursement fee under the UPL program and Community split those revenues with Johnson Memorial in exchange for the referrals.

343. In 2012, Community and Johnson Memorial discussed the terms under a "Management Consulting and Oversight Agreement" (also referred to as the "monitoring agreement") which gave Community a percentage of the net patient revenues.

344. Initially, Johnson Memorial proposed to pay Community 1.34 percent of net patient revenue, which estimated to be about $2 million annually. In exchange, Johnson Memorial asked Community to oversee Miller's Merry's management services and provide strategic consulting, despite the fact that under the Johnson Memorial - Miller's Merry purchase deal, Miller's Merry already agreed to provide similar operational and administrative services at the nursing home facilities.

345. However, Community was dissatisfied with those terms and wanted more out of the deal.

346. By September 2012, Mr. Mills directly negotiated payment terms with Mr. Heydon, CEO to CEO, and successfully struck a deal where Community would receive 50 percent of the

UPL payments Johnson Memorial received on the nursing homes. This amounted to 2 percent of net patient revenue.

347. In November 2012, Mr. Heydon calculated the total benefit to Community for services provided using a "2 percent of revenues" approach. According to the internal revenue analysis, the estimated fees paid to Community under such an arrangement, which purportedly included necessary quality and other operational oversight of the 35 nursing homes that Johnson Memorial would operate, was about $4.2 million.

348. Below is a snapshot of one of the spreadsheets that displayed the estimated costs required to provide the services being considered plus a 35 percent markup amount:

CHN Allocations (Oversight Pmts = 2.0% of NPR):	Annual Net Patient Revenues									
2 Cardon HUD Nursing Homes (3/1/12 Effective)	$ 23,394,694	$ 38,991	$ 116,973	$ 116,973	$ 116,973	$ 116,973	$ 116,973	$ 116,973	$ 116,973	$ 116,973
3 Millers HUD Nursing Homes (7/1/12 Effective)	$ 23,962,888			$ 119,814	$ 119,814	$ 119,814	$ 119,814	$ 119,814	$ 119,814	$ 119,814
3 Community Hospital Anderson Homes (12/1/12 Effect)	No Oversight Pmt - 100% UPL				$ 259,731	$ 779,193	$ 779,193	$ 779,193	$ 779,193	$ 779,193
8 Millers HUD Nursing Homes (4/1/13 Target)	$ 45,845,012						$ 229,225	$ 229,225	$ 229,225	$ 229,225
17 Millers Non-HUD Nursing Homes (4/1/13 Target)	$ 94,192,722						$ 470,964	$ 470,964	$ 470,964	$ 470,964
Total CHN Allocation	2.00%	$ 38,991	$ 116,973	$ 236,788	$ 496,519	$ 1,015,981	$ 1,716,170	$ 1,716,170	$ 1,716,170	$ 1,716,170
JMH Allocations		$ 129,233	$ 387,699	$ 880,307	$ 814,908	$ 814,908	$ 3,212,069	$ 3,212,069	$ 3,212,069	$ 3,212,069

349. The final monitoring agreement, which was signed in 2013 but retroactive to 2012 when Johnson Memorial started receiving increased Medicaid payments for the nursing home purchased from Miller's Merry, gave Community 2.25 percent of the net patient revenue.

350. On February 11, 2013, in an email from Liz Heddon, Chief Operating Officer of Extended Services at Johnson Memorial, and Mr. Heydon to the Relator, Johnson Memorial agreed to Community's proposed fee structure of 2.25 percent of net patient revenue:

To: Thomas P. Fischer[TFischer@ecommunity.com]
Cc: Larry Heydon[LHeydon@johnsonmemorial.org]
From: Liz Heddon
Sent: Mon 2/11/2013 4:41:02 PM (UTC)
Subject: Management Consulting and Oversight Agreemnt
1607_001.pdf

Tom – In follow-up to your meeting with Larry last week, attached is the revised Management Consulting and Oversight Agreement.

The only change to this document from the original draft dated August 30, 2012 is the language in Section 3.1 – Fees. The fee structure has been updated to reflect 2.25% of NPR.

I am sending to you under separate cover two original copies of this Agreement signed by Larry. If you would please return a fully-executed original copy of the Agreement back to me and retain one for your files, I would appreciate it. We can then get the administrative and financial processes in place for the implementation of the various agreement terms.

Please don't hesitate to let me know if you have any additional questions on the attached and/or you need me to loop back with anyone else in the Network.

Thanks, Tom.

Liz Hedden
Chief Operating Officer Extended Services
1125 W. Jefferson Street
Franklin, IN 46131
Office: 317-736-3396
Fax: 317-736-2692

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351. The provision in the final monitoring agreement indicating as such is also provided below:

ARTICLE III
COMPENSATION

Section 3.1. Fees. For the Services provided hereunder, JMH shall pay to CHNw a fee for each calendar month during the term of this Agreement in an amount equal to 2.25%) of the JMH-attributable Net Patient Revenues from all Facilities (the "Fee"). This fee does not include any special governmental payments (e.g., NSGO-UPL distributions) in the calculation of net patient revenues. This fee shall be reviewed annually and adjusted, if appropriate, based upon mutual agreement of JMH and CHNw.

352. A few months later, based on an email dated May 7, 2013, from Ms. Heddon to the Relator, the agreement appeared to be in full effect. Johnson Memorial cut "the first check related to the [monitoring agreement]," in the amount of $709,251 representing 2.25% of net patient revenues for several nursing home facilities.

-----Original Message-----
From: Liz Hedden [LHedden@johnsonmemorial.org]
Sent: Tuesday, May 07, 2013 12:44 PM Eastern Standard Time
To: Fischer, Thomas P.
Cc: Larry Heydon
Subject: FY2012 Payment of Management Oversight Agreement fees

Hi, Tom

We're in the process of cutting the first check related to the nursing homes' Management Oversight Agreement between JMH & CHNw. The check amount will be $709,251 which represents 2.25% of Net Patient Revenues for the two CarDon facilities and three Millers' Health System facilities for FY2012.

We are in the process of drafting a revised Management Agreement with the three CLTC facilities, and funds will be allocated a little differently for those transactions in relation to the JMH/CHNw agreement. We can discuss this in greater length once I get the language drafted. (As you recall, ownership transferred for these three facilities on December 1, 2012.

Will you please confirm for me to whose attention you want this check directed at CHNw so that it is properly credited to the JMH relationship. Also, is there any additional financial information/support documentation you would like related to this first payment?

Thanks.

Liz Hedden
Chief Operating Officer Extended Services
1125 W. Jefferson Street
Franklin, IN 46131
Office: 317-736-3396
Fax: 317-736-2692

353. In addition, the monitoring agreement also gave Community 100% of the UPL payments Johnson Memorial received on the nursing homes purchased from a wholly-owned subsidiary of Community Anderson's Hospitals.

354. As a result of the monitoring agreement, in 2013, Johnson Memorial paid Community a total of $3.36 million in management fees and $3.46 million in UPL payments.

355. However, this was a sham monitoring agreement in which Community received payments far in excess of the fair market value for little-to-no nursing facility oversight. In exchange, Community directly referred patients to Johnson Memorial and its nursing homes.

356. First, the amount paid to Community was substantially in excess of the fair market value of the oversight services given the expected costs of the services to be provided, which cost less than $500,000.

357. At one point, Mr. Heydon conducted an analysis of the work required to provide the monitoring services compared to the expected payments to Community. He categorized the excessive profit as a risk subject to fair market value and/or cost equivalent review/scrutiny.

358. Moreover, Community was not providing much, if any, of the oversight services listed in the agreement, which included the following: Interaction with Managers; Operational Meetings; Quality Reports; Medicaid Audits; Case Mix Reports; Survey Review; Vendor Support; Quality Assurance Site Visits; Reports/Recommendations to Johnson Memorial; Provider interaction and additional oversight and strategic services.

359. Community hired Doug Roberts as director to provide a nursing facility oversight and consulting role under the monitoring agreement with Johnson Memorial. In practice, Mr. Roberts simply outsourced clinical help when Johnson Memorial really needed it.

360. For Community, this was one of the most lucrative deals where Mr. Mills had the unfettered authority to control the negotiations between Johnson Memorial and Miller's Merry. For instance, when the terms of the deal were too low for Community, Mr. Mills negotiated with Mr. Heydon, one-on-one, until he got the terms he wanted for Community.

361. In other words, Mr. Mills had common control and common knowledge about the sham monitoring agreement and knew how to set it up in a way that worked to Community's financial advantage and in which Community benefitted in the greatest possible way as a result of the kickbacks.

362. The monitoring agreement was a pretext to pay Community for nursing home referrals directed to Johnson Memorial's nursing home facilities from Community facilities.

363. In early 2014, during a meeting on an unrelated matter, Mr. Heydon told the Relator that, "[He did not] want to go to jail over the Community nursing home deal." At the time, the Relator found it odd that Mr. Heydon would make such a comment.

364. In sum, the monitoring agreement requiring Community to provide minimal services, was just a means of papering an illegal kickback arrangement where Community received excessive payment based on its ability to steer patients to Johnson Memorial's nursing homes.

365. As a result, Community pocketed about $6 million in profit annually from the arrangement. In fact, Community's costs for providing oversight of nursing facilities accounted for about 6.5% of the revenue it received from the arrangement. The rest was pure profit.

366. In late 2018, Johnson Memorial terminated the monitoring agreement with Community. The termination occurred just weeks after the Department of Justice informed Community that its arrangement with Johnson Memorial was included in the Relator's original qui-tam complaint.

367. Community had an illegal pay-for-referrals deal with the Johnson Memorial nursing homes, splitting revenues and other government reimbursement payments under the deal. These payments included sums for which no actual nursing home service was performed, and thus violated the federal and Indiana AKS.

368. Accordingly, any and all claims submitted by Johnson Memorial's nursing homes based on referrals from Community are false claims within the meaning of the FCA.

F) Community Retaliated Against Relator in Response to His Efforts to Address Community's Misconduct

369. Relator dedicated a significant portion of his professional career working for Community as the CFO and COO.

370. Community hired the Relator as the CFO in October 2005. Prior to October 2005, Relator worked with Community in a consulting and investment banking capacity.

371. In December 2012, Mr. Mills asked the Relator to assume the duties of COO, in addition to his CFO role, upon the former COO's retirement.

372. In these two roles, Community tasked the Relator with significant responsibilities, including oversight of finances, operations, supply chains and managed care contracts of the network's eight hospitals.

373. Notably, in 2012, Relator played a key role in successfully leading Community's cost reduction efforts across the network. In early 2010, based on its belief that healthcare reform would require lower prices, the Board of Directors directed Community's management to initiate a phased cost reduction process. The first phase called for $100 million in cost reductions and revenue enhancement within 18 months.

374. Under the Relator's leadership, the majority of the network subsidiaries participated in the cost reduction effort.

375. Despite CPN's consistent and exceptional losses, CPN and VEI contributed minimally to this board-directed initiative.

376. As a result of the efforts of Relator and his large team of associates operating costs across the network, with the exception of CPN and VEI, non-physician operating costs were reduced by more than $100 million annually.

377. In the midst of his work to reduce network costs, Relator was aware of the substantial, unexplained costs (losses) reported by CPN and his suspicions of potentially illegal

physician compensation arose. Relator began to ask questions of Mr. Mills, Dr. Yeleti, Mr. Javorka, Dr. Hobbs and other CPN employees about the large and unexpected losses reported by CPN and why CPN was apparently excluded from the Network board's directive to reduce costs.

378. Mr. Mills ignored Relator's questions and made no effort to investigate the CPN irregularities.

379. For example, the Relator discovered that in 2011, CPN budgeted an operating loss of approximately $38 million, but the actual operating loss totaled at least $80 million. When the Relator asked CPN executives, including Mr. Javorka, Dr. Yeleti and Dr. Hobbs, to explain the variance, nobody provided a substantive answer.

380. Similarly, in 2012, CPN experienced an operating loss of $103 million, which exceeded its budgeted operating loss by approximately $40 million. When the Relator asked CPN executives, including Mr. Javorka, Dr. Yeleti and Dr. Hobbs to explain the variance, the Relator received no clear answers.

381. This pattern of unexplained operating loss variances continued for the third consecutive year in 2013. To emphasize his growing concerns, during the period March to October 2013, Relator demanded monthly meetings with Dr. Yeleti and Mr. Javorka and other CPN employees. Despite Relator's demands, Community provided no explanations for the extraordinary, unexplained CPN losses. In October 2013, CPN revised its full year operating loss expectation to $140 million, approximately $40 million more than its budget for the year.

382. Despite Relator's numerous requests for explanations, Dr. Yeleti, Mr. Javorka and Dr. Hobbs skirted Relator's concerns and ignored Relator's inquiries. In fact, they were unwilling and unable to explain the differences indicated in the budgeted losses versus the actual operating loss. During this time, Relator pled with Mr. Mills to address his concerns over CPN operating

losses. Mr. Mills refused to take action. Instead, during a conversation with Relator in November 2013, Mr. Mills suggested that Relator was "not a team player."

383. By the end of 2013, Relator realized that the increase in CPN's annual losses since 2011 completely offset the work that he and hundreds of other CPN employees had put in to reduce costs successfully in the other parts of the network.

384. Moreover, he also realized ironically that such savings was largely borne by thousands of lower level employees (including all patient care providers) through the reduction of hundreds of jobs, salaries and pension benefits. He was shocked that the financial sacrifices of thousands of employees funded physician compensation, rather than lowering the overall cost of providing health care to patients as directed by the Community board.

385. After two years of unsuccessful efforts to obtain explanations for the unexplained losses, Relator surmised that the losses were associated with the physician compensation agreements.

386. Relator also expressed concerns to Mr. Mills, Dr. Yeleti, Dr. Hobbs and Mr. Javorka that the losses generated by CPN were a direct result of overpayments to physicians.

387. Relator was particularly concerned with the losses that CPN experienced because between 2011 and 2013, CHN employed numerous physicians who were current investors in surgery centers operated by VEI (physician-owners) and those who acted as referral sources.

388. Pursuant to the employment agreements, these surgeons retained their ownership shares in ASCs. In return, as surgeons, they received compensation from Community through guaranteed salaries and/or based on their production as practicing physicians. As physician-investors, they also received distributions from their investments in the VEI ambulatory surgery centers.

389. Between July and November of 2013, Relator repeatedly asked VEI management, including Karen Ann Lloyd, Community's general counsel, Mr. Fisher and Mr. Weitzel for financial information regarding the operations of its surgery centers.

390. In fact, Relator communication orally to Mr. Mills, Mr. Fisher, Mr. Weitzel and Ms. Lloyd that a physician compensation review should be conducted and that such review should include disclosure of salaries plus distributions from shares in surgery centers. Relator was concerned about the excessive compensation package and the possibility of an illegal transfer of funds from Community to the physician owners of VEI surgery centers.

391. Mr. Mills, Mr. Fisher, Mr. Weitzel and Ms. Lloyd refused Relator's requests to provide any physician compensation information.

392. Acting as CFO and COO of Community, Relator found that it was customary among CPN management to encourage employed physicians to refer cases to other employed surgeons practicing at VEI's ASCs.

393. Relator voiced concerns to senior management including, but not limited to, Mr. Mills, Mr. Fischer, Dr. Hobbs and the CEOs of all Community hospitals. Relator explained that by allowing the physicians with ownership interests in surgery centers to retain their ownership interests in the surgery centers even after they became Community employees, Community was at risk of overcompensating physician-owners.

394. Based on Relator's discussions with Ms. Shannon Arrendale, VEI's Executive Director of the North Surgery Center in 2013, Relator was concerned that unusually high investor returns to the physician owners of the building housing the North Surgery Center was a result of physicians steering lucrative commercial business to the physician-owned surgery centers, and

steering government, charity, and uninsured patients to the higher-cost non-profit hospital-owned facilities.

395. In late 2013, Relator also orally expressed concern about additional methods Community used to overcompensate referring physicians, such as excessive salaries. These concerns were communicated to Mr. Mills, Dr. Yeleti, Mr. Javorka and Dr. Hobbs.

396. For example, throughout 2013, Relator made a number of inquiries to Dr. Yeleti regarding the expiration of approximately thirty cardiologists' employment contracts and the need for the new contracts to negotiate a reduced compensation level that reflected market norms and met Community's cost reduction goals.

397. Dr. Yeleti was not only a practicing cardiologist and principal of a cardiology agreement with Community, but also the President of CPN.

398. Dr. Yeleti repeatedly told Relator that he intended to delay the negotiation of new employment contracts for cardiologists until the middle of 2014 or later.

399. Relator informed Mr. Mills that delaying the effective date of a new cardiology agreement was unacceptable since he believed that the existing agreement was likely a significant contributor to the unexplained CPN losses.

400. Relator also stated his concerns to Mr. Mills that Dr. Yeleti, as a principal and cardiologist, should not negotiate the new contracts because Dr. Yeleti had a clear conflict of interest.

401. In early October 2013, Mr. Mills indicated that he was pleased with Relator's performance in the COO role, and that he had decided that Relator should be the permanent, full-time COO. Mr. Mills notified the Network Board of the decision and the company initiated an official search for a CFO to replace Relator in that role.

402. By mid-October 2013, Community and Mr. Mills refused to address Relator's ongoing concerns.

403. However, Relator continued to focus on his investigation efforts into potential wrongdoing at CPN and VEI. Relator notified Mr. Mills of his suspicions, and that he was investigating Mr. Fischer, Dr. Hobbs and Dr. Yeleti, each of whom were part of Mr. Mills' Executive Committee.

404. Relator told Mr. Mills, "I cannot stomach this stuff." Subsequently, Relator told Community's General Counsel, "I am not going to jail for these people."

405. Relator stated to Mr. Mills in early November 2013 that compensating the approximately thirty cardiologists at the same rate as their previous contracts would overcompensate them and violate the law by illegally funneling money from a non-profit entity. to private physicians.

406. On November 27, 2013, Mr. Mills informed Relator that he had changed his mind about promoting Relator to the permanent COO role, and removed Relator from his position. Mr. Mills gave no reason for this sudden reversal, but implied that he expected Relator to be a team player and wanted Relator to stop asking questions about the legality of physician contracts.

407. Mr. Mills suggested that Relator return to his former position as CFO.

408. However, when Relator declined to take the demotion, on November 28, 2013, Mr. Mills told Relator that he was fired and to leave Community over the Thanksgiving weekend - November 29-December 1, 2013.

409. On or about November 28, 2013, Community terminated Relator's employment.

410. At no point during or after Relator's employment with Community did anyone state or articulate that Relator's termination was for cause.

411. Community terminated Relator in retaliation for his stated concerns regarding illegal activity at Community, specifically with regard to physician compensation, physician referral patterns, and certain business practices he believed to be illegal within VEI and which activities could lead to violations of the FCA.

412. Relator took actions to stop one or more violations of the FCA Community engaged in illegal retaliatory actions against Relator for his protected activity by first demoting him, and then terminating his employment.

413. When Community hired Relator, Community and Relator entered into a Severance Benefit Agreement ("Severance Agreement") *see* attached Exhibit 1.

414. The Severance Agreement provides that unless Relator is terminated for "Cause," as defined in the Severance Agreement, upon the cessation of Relator's employment, Community is obligated to provide Relator with certain severance pay and benefits.

415. "Cause" is defined in the Severance Agreement in Section 1 as "[a]n act or acts of dishonesty (other than insubstantial or inadvertent acts) taken by the Employee at the expense of the Network," "[w]illful misconduct of the Employee in the performance of his/her duties," or the "conviction of the Employee of a felony."

416. At no point during his employment with Community did Relator commit an act of dishonesty at the expense of the Network.

417. At no point during his employment with Community did Relator commit willful misconduct in the performance of his duties.

418. At no point during his employment with Community was Relator convicted of a felony.

419. At no time did Community have "Cause" to terminate Relator, as defined in Relator's Severance Agreement.

420. Community terminated Relator without "Cause" as defined in his Severance Agreement.

421. Relator demanded payment of the severance pay and benefits provided for in his Severance Agreement.

422. Community has failed to provide Relator with the severance pay and benefits to which he is entitled under the Severance Agreement.

423. In December 2012 when Relator began to perform the duties of COO of Community in addition to his ongoing duties as CFO, he was not immediately given an increase in compensation in exchange for his increased workload.

424. Relator agreed to take on the additional responsibility of COO without immediate compensation on the condition that after Relator's full-time employment at Community ended, Community would pay the Relator as a consultant, at a rate of $200,000 per year for a period of five years.

425. Community agreed to pay Relator, after the end of his employment, $200,000 a year for a period of five years as a consultant in exchange for him agreeing to assume the responsibilities of COO without additional immediate compensation.

426. Relator relied on Community honoring the oral agreement reached between himself and Mr. Mills in accepting the additional responsibility of COO without immediate additional compensation.

427. By the terms of the oral agreement, Relator would be paid $200,000 immediately upon the cessation of his full-time employment with Community.

428. By the terms of the oral agreement, Relator and Mr. Mills could terminate the agreement by mutual consent, or Relator could terminate the agreement unilaterally.

429. Community has not remunerated Relator for the work he did for Community as its COO.

430. Subsequent to the termination of Relator's employment with Community, Relator sought new employment opportunities.

431. In June 2015, Relator interviewed with Hartford Healthcare for the position of CFO.

432. Based on his discussions with Hartford's recruiter as well as others involved in the interviewing process, Relator was led to believe he was the leading candidate for the CFO position.

433. During the interview process, the CEO of Hartford Healthcare questioned Relator about his departure from Community.

434. The CEO of Hartford Healthcare indicated that he had received negative information about Relator from the CEO of Community, Mr. Mills.

435. Based on information and belief, the information provided to Hartford Healthcare by Mr. Mills was false.

436. Based on information and belief, Mr. Mills knowingly provided false information about Relator to the CEO of Hartford Healthcare in the context of Relator's job application at Hartford Healthcare.

437. After the communication between the Hartford Healthcare CEO and Mr. Mills, Hartford Healthcare declined to hire Relator.

438. In 2015, Relator engaged in conversations with the CEO of CarDon & Associates, Inc. ("CarDon"), about becoming CFO of CarDon upon the then-CEO's retirement.

439. The CEO of CarDon subsequently communicated with Mr. Mills about Relator's departure from Community.

440. Based on information and belief, Mr. Mills communicated false, negative information about Relator to the CarDon CEO in the context of Relator's job application at CarDon.

441. Based on information and belief, Mr. Mills knowingly provided false information about Relator to the CarDon CEO.

442. CarDon did not hire Relator to be the successor to its then-current CFO.

443. The failure to abide by the terms of the severance agreement and the terms of the oral agreement, and the negative information communicated, upon information and belief, to prospective employers of the Relator, constitute further acts of retaliation by Community against Relator in violation of the False Claims Act.

COUNT I
False Claims Act
31 U.S.C. §§ 3729(a)(1)(A)-(C) and (G)

444. Relator realleges and incorporates by reference the allegations contained in all paragraphs of the Second Amended Complaint as if fully set forth herein.

445. This is a claim for treble damages and penalties under the False Claims Act, 31 U.S.C. § 3729, *et seq.*, as amended.

446. By virtue of the acts described above, Defendants knowingly presented or caused to be presented, false or fraudulent claims to the U.S. Government for payment or approval.

447. By virtue of the acts described above, Defendants knowingly made or used, or caused to be made or used, false or fraudulent records or statements material to false or fraudulent claims.

448. By virtue of the acts described above, Defendants, their agents, employees and other co-conspirators knowingly conspired to submit false claims to the United States and to deceive the United States for the purpose of getting the United States to pay or allow false or fraudulent claims, including those tainted by the Stark Law and/or federal and state AKS laws.

449. By virtue of the acts described above, Defendants knowingly concealed overpayments from the U.S. Government and failed to remit such overpayments.

450. The Government, unaware of the falsity of the records, statements and claims made or caused to be made by Defendants, paid claims that would not be paid but for Defendants' illegal conduct.

451. Compliance with the Stark and/or AKS laws are material to government payers' decisions to pay and are conditions of payment under the Medicare program and other government-funded healthcare programs and that compliance is material to the federal and state healthcare program's decisions to pay on the claims. *See e.g.,* 42 U.S.C. §§ 1395nn(a)(1), (g)(1).

452. By reason of Defendants' acts, the United States has been damaged, and continues to be damaged, in a substantial amount to be determined at trial.

453. Additionally, the United States is entitled to the maximum penalty of up to $23,331 for each and every violation alleged herein.

COUNT II
Indiana False Claims Act
Ind. Code §§ 5-11-5.5-2(b)(1)-(2), (6), and (8)

454. Relator realleges and incorporates by reference the allegations contained in all paragraphs of the Second Amended Complaint as if fully set forth herein.

455. This is a claim for treble damages and penalties under the Indiana False Claims and Whistleblower Protection Act.

456. By virtue of the acts described above, Defendants knowingly presented or caused to be presented, false or fraudulent claims to Indiana for payment or approval.

457. By virtue of the acts described above, Defendants knowingly made, used, or caused to be made or used false records and statements, to induce Indiana to approve and pay such false and fraudulent claims.

458. By virtue of the acts described above, Defendants, their agents, employees and other co-conspirators knowingly conspired to submit false claims to Indiana and to deceive Indiana for the purpose of getting Indiana to pay or allow false or fraudulent claims.

459. By virtue of the acts described above, Defendants knowingly and improperly made or used a false statement to avoid an obligation to pay or transmit money or property to Indiana.

460. Indiana, unaware of the falsity of the records, statements and claims made, used, presented or caused to be made, used or presented by Defendants, paid and continues to pay the claims that would not be paid but for Defendants' unlawful conduct.

461. By reason of Defendants' acts, Indiana has been damaged, and continues to be damaged, in a substantial amount to be determined at trial.

462. Additionally, Indiana is entitled to civil penalties in the maximum amount, at least $5,000, for each and every violation alleged herein.

COUNT III
Federal False Claims Act (Retaliation)
31 U.S.C. § 3730(h)

463. Relator realleges and incorporates by reference the allegations contained in all paragraphs of the Second Amended Complaint as if fully set forth herein.

464. This is a claim for damages for retaliation against Relator Thomas P. Fischer in violation of the False Claims Act, 31 U.S.C. § 3730(h).

465. Starting in 2012, Relator repeatedly raised concerns about potential illegalities related to physician compensation levels at Community, and in doing so he engaged in protected activity.

466. Relator engaged in protected activity when he stated to his direct supervisor, Mr. Mills, as well as to Community management, that physician compensation within the Network may be in violation of federal law and subjected Community to potential legal liability.

467. Community refused to address Relator's stated concerns about illegalities related to physician compensation and certain VEI business practices.

468. Community took adverse action against and removed Relator from the COO position because of his attempts to investigate and because of his stated concerns about illegal activities at Community, particularly related to physician compensation, physician patient referral patterns, and VEI business practices.

469. Community terminated Relator's employment because of his attempts to investigate and because of his stated concerns about illegal activities at Community, particularly related to physician compensation, physician patient referral patterns, and VEI business practices.

470. Community removed Relator from the COO position in retaliation for Relator conducting activity protected by federal law, including, but not limited to, investigating illegal physician compensation and illegal patient referral practices.

471. Community terminated Relator's employment in retaliation for conducting activity protected by federal law, including, but not limited to, investigating illegal physician compensation and illegal patient referral practices.

472. Community further retaliated against Relator by interfering with his prospective new employers, subsequent to his departure from Community, including but not limited to Hartford Healthcare and CarDon.

473. As a result of these wrongful actions, Relator suffered and continues to suffer substantial damage, including but not limited to lost earnings, lost benefits, loss of future earning capacity, reputational injury and emotional distress in an amount to be determined at trial.

COUNT IV
Indiana False Claims Act (Retaliation)
Ind. Code § 5-11-5.5-8

474. Relator realleges and incorporates by reference the allegations contained in all paragraphs of the Second Amended Complaint as if fully set forth herein.

475. This is a claim for damages for retaliation against Relator Thomas P. Fischer in violation of the Indiana False Claims Act, Ind. Code § 5-11-5.5-8.

476. Starting in 2012, Relator repeatedly raised concerns about and objected to potential illegalities related to physician compensation levels at Community.

477. Relator stated to his direct supervisor, Mr. Mills, as well as to Community management, that physician compensation within the Community network may be in violation of state law and subjected Community to potential legal liability.

478. Community refused to address Relator's stated concerns about illegalities related to physician compensation and certain VEI business practices.

479. Community removed Relator from the COO role, and terminated Relator's employment, because of his attempts to investigate and because of his stated concerns about and objections to illegal activities at Community, particularly related to physician compensation, physician patient referral patterns, and VEI business practices.

480. Community removed Relator from the COO role, and terminated Relator's employment, in retaliation for conducting activity protected by state law, including, but not limited to, investigating and objecting to illegal physician compensation and illegal patient referral practices.

481. Community retaliated against Relator by interfering with his prospective new employers, including but not limited to Hartford Healthcare and CarDon subsequent to his departure from Community.

482. As a result of these wrongful actions, Relator suffered and continues to suffer substantial damage, including but not limited to lost earnings lost benefits, loss of future earning capacity, reputational injury and emotional distress in an amount to be determined at trial.

COUNT V
Breach of Contract

483. Relator realleges and incorporates by reference the allegations contained in all paragraphs of the Second Amended Complaint as if fully set forth herein.

484. Community did not terminate Relator from his employment at Community for "Cause" as defined by the Severance Agreement.

485. Community did not have "Cause" as defined by the Severance Agreement, to terminate Relator's employment at Community.

486. To date, Community has refused to provide Relator with the severance pay and benefits to which he is entitled under the Severance Agreement.

487. Community's failure to provide Relator with severance pay and benefits is a breach of the Severance Agreement.

488. Specifically, Community has breached its obligations under the Severance Agreement by:

a. Failing to pay Relator an amount equal to his base salary rate immediately prior to termination of his employment for a period of 18 months commencing on the effective date of Relator's termination; and

b. Failing to allow Relator to participate in all employee benefit, bonus, and incentive plans and programs available to salaried employees of Community on the same terms as such plans and programs are offered to full time salaried employees of Community.

489. Community has breached its obligations under the Severance Agreement.

490. Relator seeks damages by virtue of Community's breach of the Severance Agreement.

COUNT VI
Breach of Oral Contract

491. Relator realleges and incorporates by reference the allegations contained in all paragraphs of the Second Amended Complaint as if fully set forth herein.

492. Relator accepted the additional responsibilities of COO on the condition that Community agreed that after Relator's full-time employment with Community came to an end, Community would pay Relator $200,000 a year for a period of five years to be a consultant to Community after his employment at Community ended.

493. Relator performed the duties and responsibilities of COO of Community from December 2012 until he was terminated on November 27, 2013.

494. Community's termination of Relator's employment on or about November 27, 2013, triggered the oral agreement between Relator and Mr. Mills, requiring that Community immediately pay to Relator $200,000 and to retain him as a consultant at the annual rate of $200,000 for a period of five years.

495. Community has not paid Relator the $200,000 per year for five years to which he was entitled under the oral contract upon termination of his employment.

496. Community has not retained Relator as a consultant as required by the oral contract.

497. Community's failure to pay Relator $200,000 per year as a consultant for a period of five years, constitute breaches of the oral contract.

498. Relator seeks damages by virtue of Community's breach of the Severance Agreement.

COUNT VII
Promissory Estoppel

499. Relator realleges and incorporates by reference the allegations contained in all paragraphs of the Second Amended Complaint as if fully set forth herein.

500. Relator reasonably relied on Community's promise that after his full-time employment with Community ended, Community would pay Relator $200,000.00 a year for a period of five years in accepting the additional responsibilities of the COO position.

501. In reliance on Community's promise of post-employment consulting earnings, Relator performed the duties and responsibilities of COO for Community from December 2012 until he was terminated on November 27, 2013.

502. Community benefited by Relator performing the additional duties and responsibilities of COO from December 2012 through November 2013.

503. Community's failure to pay Relator to be a consultant at a rate of $200,000 per year for a period of five years after the cessation of his full-time employment with Community on November 27, 2013, provided Community with the benefit of Relator's services as COO without any payment for those services.

504. Community's refusal to carry out the terms of the agreement to pay Relator as a consultant after his full-time employment with Community ended after Relator having performed

the duties of COO for eleven months constitutes an unjust and unconscionable injury and loss to Relator.

505. Relator has been damaged by Community's refusal to honor its agreement to pay Relator as a consultant for a period of five years after his full-time employment with Community ended.

COUNT VIII
Quantum Meruit

506. Relator realleges and incorporates by reference the allegations contained in all paragraphs of the Second Amended Complaint as if fully set forth herein.

507. Relator accepted the additional duties and responsibilities of COO of Community in December 2012.

508. Based on Community's promises to him, Relator reasonably expected payment for performing the responsibility of COO of Community; specifically, he expected five years as a paid consultant for Community at an annual pay rate of $200,000 after his full-time employment with Community ended.

509. Relator performed the duties and responsibilities of COO of Community from December 2012 until November 27, 2013.

510. Relator's work as COO of Community conferred a substantial benefit to Community.

511. Allowing Community to retain the benefit of Relator's eleven months of work as COO of Community without paying Relator for his work would be unjust.

512. Relator has been damaged by Community's failure to pay Relator for performing the job of COO of Community from December 2012 through November 27, 2013.

COUNT IX

Ind. Code § 22-5-3 (Blacklisting)

513. Relator realleges and incorporates by reference the allegations contained in all paragraphs of the Second Amended Complaint as if fully set forth herein.

514. Subsequent to Relator's departure from Community, Mr. Mills communicated with Relator's prospective employers, including but not limited to Hartford Healthcare and CarDon.

515. Based on information and belief, Mr. Mills provided Relator's prospective employers with false, negative information about Relator.

516. Based on information and belief, Mr. Mills knowingly provided false information about Relator to Relator's prospective employers.

517. Community denied Relator employment with at least two potential employers because of the information Mr. Mills provided to those employers.

518. Relator has been damaged by Community's actions, including but not limited to lost earnings, lost benefits, loss of future earning capacity, reputational injury and emotional distress.

PRAYER

WHEREFORE, Mr. Fischer prays for judgment against the Defendants as follows:

1. That Defendants cease and desist from violating 31 U.S.C. § 3729 *et seq*. and Ind. Code § 5-11-5.5-1 *et seq.*;

2. That this Court enter judgment against Defendants in an amount equal to three times the amount of damages the United States has sustained because of Defendants' actions in the maximum amount, plus a civil penalty of not less than $11,463 and not more than $23,331 for each violation of 31 U.S.C. § 3729;

3. That this Court enter judgment against Defendants in an amount equal to three times the amount of damages Indiana has sustained because of Defendants' actions, plus a civil penalty of at least $5,000 for each violation of Ind. Code § 5-11-5.5-1;

4. That Plaintiff-Relator Mr. Fischer be awarded the maximum amount allowed pursuant to §3730(d) of the FCA and the comparable provisions of the Indiana False Claims Act;

5. That Plaintiff-Relator Mr. Fischer be awarded all costs of this action, including attorneys' fees and expenses;

6. That Plaintiff-Relator Mr. Fischer be awarded compensatory damages, including but not limited to double back pay, lost earnings, front pay, lost benefits, loss of future earning capacity, reputational injury and emotional distress damages;

7. That Plaintiff-Relator Mr. Fischer be awarded contractual damages under the Severance Agreement;

8. That Plaintiff-Relator Mr. Fischer be awarded contractual damages under the oral agreement, including $1,000,000 in consulting fees;

9. That Plaintiff-Relator Mr. Fischer be awarded lost earnings, lost benefits, loss of future earning capacity, punitive damages, damages for emotional distress, liquidated damages, and pre-judgment and post-judgment interest; and

10. That Plaintiff-Relator Mr. Fischer recover such other relief as the Court deems just and proper.

Dated: December 2, 2020

By: *<u>/s/ Kathleen A. Delaney</u>*

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DEMAND FOR JURY TRIAL

Pursuant to Rule 38 of the Federal Rules of Civil Procedure, Plaintiff-Relator Thomas P. Fischer hereby demands a trial by jury on all claims so triable.

Dated: December 2, 2020

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