IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

UNITED STATES OF AMERICA, *ex rel.* JOHN W. SCHILLING,	)	
Plaintiff,	)	Case No.99-3289 (RCL) (Part of 01-MS-50 (RCL))
v.	)	
HCA - THE HEALTHCARE COMPANY; COLUMBIA MANAGEMENT COMPANIES, INC.; ALASKA REGIONAL HOSPITAL; SAN JOSE MEDICAL CENTER; WEST HILLS REGIONAL MEDICAL CENTER; LOS ROBLES REGIONAL MEDICAL CENTER; CHINO VALLEY HOSPITAL; LAS ENCINAS HOSPITAL; PRESBYTERIAN/ST. LUKE'S MEDICAL CENTER; ROSE MEDICAL CENTER; SWEDISH MEDICAL CENTER; NORTH SUBURBAN MEDICAL CENTER; SPALDING REHABILITATION HOSPITAL; CEDARS MEDICAL CENTER; TWIN CITIES HOSPITAL; JFK MEDICAL CENTER; EAST POINTE HOSPITAL; MEDICAL CENTER - OSCEOLA; AVENTURA MEDICAL CENTER; LAKE CITY MEDICAL CENTER; CENTRAL FLORIDA REGIONAL MEDICAL CENTER; DOCTORS HOSPITAL OF SARASOTA; PLANTATION GENERAL HOSPITAL; MEMORIAL HOSPITAL OF JACKSONVILLE; ST. PETERSBURG MEDICAL CENTER; NORTHWEST MEDICAL CENTER; NEW PORT RICHEY HOSPITAL; SPECIALTY HOSPITAL OF JACKSONVILLE; NORTH FLORIDA REGIONAL MEDICAL CENTER; DEERING HOSPITAL; KENDALL REGIONAL MEDICAL CENTER; OCALA REGIONAL MEDICAL CENTER;	)	

BLAKE MEDICAL CENTER;)
SOUTHWEST FLORIDA REGIONAL)
MEDICAL CENTER;)
FORT WALTON BEACH MEDICAL CENTER;)
UNIVERSITY HOSPITAL and MEDICAL)
CENTER;)
ORANGE PARK MEDICAL CENTER;)
WESTSIDE REGIONAL MEDICAL CENTER)
WEST FLORIDA REGIONAL MEDICAL)
CENTER;)
COLUMBIA HOSPITAL;)
FAWCETT MEMORIAL HOSPITAL;)
NORTHSIDE MEDICAL CENTER;)
EDWARD WHITE HOSPITAL;)
GULF COAST MEDICAL CENTER)
(PANAMA CITY);)
BRANDON REGIONAL MEDICAL CENTER;)
LAWNWOOD REGIONAL MEDICAL CENTER;)
LARGO MEDICAL CENTER;)
RAULERSON HOSPITAL;)
TALLAHASSEE COMMUNITY HOSPITAL;)
REGIONAL MEDICAL CENTER AT)
BAYONET POINT;)
SOUTH BAY HOSPITAL;)
MEDICAL CENTER - PORT ST. LUCIE;)
OAK HILL HOSPITAL;)
ENGLEWOOD COMMUNITY HOSPITAL;)
PALMS WEST HOSPITAL;)
GULF COAST HOSPITAL (FT. MYERS);)
PEACHTREE REGIONAL HOSPITAL;)
CARTERSVILLE MEDICAL CENTER;)
NORTHLAKE REGIONAL MEDICAL CENTER;)
FAIRVIEW PARK HOSPITAL;)
PALMYRA MEDICAL CENTER;)
COLISEUM MEDICAL CENTER;)
REDMOND REGIONAL MEDICAL CENTER;)
METROPOLITAN HOSPITAL;)
DUNWOODY MEDICAL CENTER;)
DOCTORS HOSPITAL OF AUGUSTA;)
PARKWAY MEDICAL CENTER;)
DOCTORS HOSPITAL (COLUMBUS);)
LANIER PARK REGIONAL HOSPITAL;)
EASTSIDE MEDICAL CENTER;)
HUGHSTON SPORTS MEDICINE HOSPITAL;)
COLISEUM PSYCHIATRIC HOSPITAL;)
WEST VALLEY MEDICAL CENTER;)

EASTERN IDAHO REGIONAL MEDICAL;)
CENTER;)
CHICAGO LAKESHORE HOSPITAL;)
TERRE HAUTE REGIONAL HOSPITAL;)
WESLEY MEDICAL CENTER;)
SAMARITAN HOSPITAL;)
GREENVIEW REGIONAL HOSPITAL;)
FRANKFORT MEDICAL CENTER;)
DAUTERIVE HOSPITAL;)
RAPIDES REGIONAL MEDICAL CENTER;)
AVOYELLES HOSPITAL;)
TULANE UNIVERSITY HOSPITAL AND)
CLINIC;)
LAKEVIEW REGIONAL MEDICAL CENTER;)
LAKESIDE HOSPITAL;)
WOMEN'S & CHILDREN'S HOSPITAL;)
NORTH MONROE HOSPITAL;)
GARDEN PARK COMMUNITY HOSPITAL;)
SUNRISE HOSPITAL & MEDICAL CENTER;)
MOUNTAIN VIEW HOSPITAL;)
PARKLAND MEDICAL CENTER;)
PORTSMOUTH REGIONAL HOSPITAL;)
BRUNSWICK HOSPITAL;)
HOLLY HILL HOSPITAL;)
PRESBYTERIAN HOSPITAL;)
SOUTHWESTERN MEDICAL CENTER;)
EDMOND REGIONAL MEDICAL CENTER;)
COLLETON REGIONAL HOSPITAL;)
TRIDENT REGIONAL MEDICAL CENTER;)
GRAND STRAND REGIONAL MEDICAL)
CENTER;)
GRANDVIEW MEDICAL CENTER;)
ATHENS REGIONAL MEDICAL CENTER;)
SUMMIT MEDICAL CENTER;)
PARKRIDGE MEDICAL CENTER;)
CENTENNIAL MEDICAL CENTER;)
HENDERSONVILLE HOSPITAL;)
SOUTHERN HILLS MEDICAL CENTER;)
NORTH HILLS HOSPITAL;)
BAYSHORE MEDICAL CENTER;)
LAS PALMAS MEDICAL CENTER;)
DOCTORS REGIONAL MEDICAL CENTER;)
NORTHWEST REGIONAL MEDICAL CENTER;)
CONROE REGIONAL MEDICAL CENTER;)
SOUTHWEST TEXAS METHODIST HOSPITAL;)
NORTH CENTRAL MEDICAL CENTER;)

BELLAIRE MEDICAL CENTER;)
MAINLAND MEDICAL CENTER;)
NORTH BAY HOSPITAL;)
CLEAR LAKE REGIONAL MEDICAL CENTER;)
SPRING BRANCH MEDICAL CENTER;)
METROPOLITAN METHODIST HOSPITAL;)
DENTON REGIONAL MEDICAL CENTER;)
WEST HOUSTON MEDICAL CENTER;)
DEL SOL MEDICAL CENTER;)
MEDICAL CITY DALLAS;)
MEDICAL CENTER OF PLANO;)
VALLEY REGIONAL MEDICAL CENTER;)
MEDICAL CENTER OF LEWISVILLE;)
PLAZA MEDICAL CENTER OF FORT WORTH;)
MEDICAL CENTER OF ARLINGTON;)
RIO GRANDE REGIONAL HOSPITAL;)
SOUTH AUSTIN HOSPITAL;)
ROUND ROCK MEDICAL CENTER;)
NORTHEAST METHODIST HOSPITAL;)
KINGWOOD MEDICAL CENTER;)
BAY AREA MEDICAL CENTER;)
TEXAS ORTHOPEDIC HOSPITAL;)
OGDEN REGIONAL MEDICAL CENTER;)
MOUNTAIN VIEW HOSPITAL;)
BRIGHAM CITY COMMUNITY HOSPITAL;)
LAKEVIEW HOSPITAL;)
ST. MARK'S HOSPITAL;)
JOHN RANDOLPH MEDICAL CENTER;)
LEWIS-GALE MEDICAL CENTER;)
RESTON HOSPITAL CENTER;)
MONTGOMERY REGIONAL HOSPITAL;)
CHIPPENHAM/JOHNSTON-WILLIS;)
PULASKI COMMUNITY HOSPITAL;)
HENRICO DOCTORS HOSPITAL;)
DOMINION HOSPITAL;)
CAPITAL MEDICAL CENTER;)
ST. FRANCIS HOSPITAL;)
RALEIGH GENERAL HOSPITAL; and)
PUTNAM GENERAL HOSPITAL;)
)
Defendants.)
_____)

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For its complaint, the United States of America, alleges as follows:

I. NATURE OF ACTION

1. Plaintiff brings this action to recover treble damages and civil penalties under the False Claims Act, 31 U.S.C. §§ 3729-33. The United States also brings this action to recover all available damages and other monetary relief under the common law or equitable theories of fraud, unjust enrichment, payment under mistake of fact, recoupment of overpayments, disgorgement of illegal profits, and restitution.

2. These claims are based upon defendants' false and fraudulent claims and false statements made or caused to be made in hospital cost reports and claims submitted to the Medicare, Medicaid, and TRICARE/CHAMPUS programs by hospitals owned, operated, or managed by defendant HCA - The Healthcare Company or its predecessor companies (collectively "HCA") from January 1, 1987 through December 31, 1997.

3. The Medicare, Medicaid and TRICARE/CHAMPUS programs provide health services for the nation's elderly, disabled, poor, and military personnel and their dependants.

4. Since complete and routine audits of all hospitals' cost reports and claims to federal healthcare programs would be prohibitively costly and time-consuming, those programs depend on hospitals to submit complete and truthful information in cost reports submitted to the government and the government contractors which process Medicare claims, known as fiscal intermediaries ("FIs").

5. If hospitals intend to seek reimbursement for costs they know to be presumptively non-reimbursable, they must do so openly and honestly, describing the costs accurately while challenging the presumption and seeking reimbursement. Absent such a requirement, providers

could slip in unallowable costs with impunity and leave the government to a game of cat and mouse. That is precisely what HCA did in the cost reports at issue here.

6. For most of the period relevant to this lawsuit, in making their own determinations about what cost report claims they would submit for reimbursement, defendants prepared and maintained a second "reserve" set of Medicare cost reports, workpapers and summaries.

7. The “reserve” documents identify the particular items included in the filed cost reports that defendants knew or expected would be disallowed if all facts and circumstances material to the reimbursement decision and evaluation became known to the government.

8. These reserve cost reports usually were prepared by the same personnel of the defendants who prepared the cost reports and claims that were actually filed with the government healthcare programs. The reserve costs reports contained descriptions of the true nature of the costs and the reasons why the government should not pay for them.

9. In many instances, the reserve cost reports reflect that defendants knew they were seeking payment for costs which, when they had been included by defendants in earlier cost reports, were specifically disallowed by the government’s auditors.

10. The reserve documents also estimated, as a matter of each defendant's policy or practice, the impact that the false items, claims, or information would have on the amount of Medicare reimbursement (and sometimes also the Medicaid and TRICARE/CHAMPUS reimbursement) that would be received. Defendants used the estimates of reimbursement impact developed in the “reserve cost reports” to ensure that sufficient funds were set aside to repay the government in the event the false or fraudulent claims or false statements were discovered.

11. Although defendants knew the information contained in the reserve cost reports, workpapers and summaries was necessary for the proper evaluation and assessment of the items and expenses contained in the filed cost reports, this information was not fairly, openly, and adequately disclosed to the government.

12. In fact, defendants intentionally concealed their reserve cost reports, workpapers, summaries and analyses from government auditors in order to hide the true nature of the expenses and information in the filed cost reports and so that the fraudulent scheme to increase the hospitals' payments from the federal healthcare programs would not be discovered.

13. On numerous occasions, defendants marked the reserve cost reports and their supporting workpapers with the words "CONFIDENTIAL DO NOT DISCUSS OR RELEASE TO MEDICARE AUDITORS." Ex. 1.

14. Defendants also filed Medicaid cost reports and requests for reimbursement to TRICARE/CHAMPUS based on their Medicare cost reports that included claims for reimbursement that defendants knew were false .

15. In filing such false claims, defendants also routinely concealed from the United States and its agents information critical to the proper treatment of such claims that would have reduced or eliminated reimbursement had the truth been told.

16. Later, when as a result of the investigation launched by the government it became known to defendants that the government was aware of the existence of their reserve cost reports and associated papers, defendants often discontinued the practice of creating such materials out of concern that such documentation would direct government investigators and auditors to continuing reimbursement claims that defendants knew were false and improper.

17. Defendants, nevertheless, continued knowingly to submit false cost report claims for Medicare, Medicaid, and TRICARE/CHAMPUS reimbursement. Some such continued false claims were of the same nature as the false claims for which reserves had previously been prepared.

18. Other false claims involved newly developed approaches designed improperly to increase federal and state reimbursement for defendants' hospitals. These included, for example, shifting inpatient hospital costs to home health agencies in order to illegally exploit the special reimbursement treatment given to the costs incurred by such units.

19. Defendants' failure to disclose and the intentional concealment of information material to proper reimbursement violated the defendants' certifications that a filed Medicare cost report "is a true, correct, and complete report prepared from the books and records of the provider in accordance with applicable instructions," as required by federal law and regulation. 42 C.F.R. § 413.24(f)(4)(iii).

20. In violation of their duty to make such matters known, 42 U.S.C. § 1320a-7b(a)(3), defendants likewise failed to disclose and, at times actively concealed, mistakes in their own preparation of cost reports and errors of Medicare auditors that defendants discovered after their filed cost reports were submitted and/or audited by Medicare.

21. As a result of defendants' false statements, false or fraudulent claims and false cost report submissions, defendants wrongfully obtained hundreds of millions of dollars from Medicare, Medicaid and TRICARE/CHAMPUS to which they were not entitled.

22. The causes of action alleged herein are timely brought on the basis of the filing of relator's complaint in this action and when an official of the United States with responsibility to

act under the circumstances knew or reasonably could have known the facts material to this right of action.

23. HCA and the United States have entered into a series of agreements under which HCA tolled and/or waived the statue of limitations and all related time-based defenses with respect to claims and potential claims of the United States stated against HCA and all of the HCA affiliated entities named as defendants herein.

II. CRIMINAL PLEA SUMMARY

24. In December, 2000, defendant Columbia Management Companies, Inc. ("CMC"), was charged in an eight count Information filed in the United States District Court for the Middle District of Florida alleging that CMC submitted fraudulent cost reports to Medicare, in violation of 18 U.S.C. § 1001. A copy of the Information is attached hereto as Ex. 2, and is incorporated by reference herein.

25. On January 25, 2001, defendant CMC pled guilty to eight counts of criminal fraud as charged in that Information, and the court imposed a fine of $22,600,000, plus a special assessment of $3,200.

26. Six of the eight counts to which CMC entered pleas of guilty are at issue in this civil action. Those counts (Counts Two, Three, Four, Five, Seven and Eight) describe occasions on which CMC prepared and filed false costs reports and then prepared "reserve" cost reports intended solely for internal HCA use reflecting the estimated reimbursement impact of the false information contained on the filed cost reports.

27. Pursuant to the terms of a plea agreement entered into by CMC, the United States and CMC agreed that restitution for the activity underlying the criminal plea regarding the

counts identified in ¶ 26 would be reserved for resolution in this action. A copy of the Plea Agreement and Judgment are attached hereto as Ex. 3, and incorporated herein by reference.

28. Among the hospitals whose activities were implicated in the CMC criminal plea and which is at issue in this civil action is Fawcett Memorial Hospital. On July 2, 1999, in a separate criminal proceeding, two HCA executives were convicted in the United States District Court for the Middle District of Florida on charges of fraud for misrepresenting the nature of that hospital's true expenses on cost reports submitted to Medicare, Medicaid and CHAMPUS.

29. One of those convicted in the separate 1999 criminal trial was the Chief Executive Officer of HCA's Southwest Florida Division, and the other was HCA's Director of Reimbursement for certain hospitals located throughout the United States.

30. In support of its January 25, 2001 criminal plea, defendant CMC stipulated to certain facts relating to the counts charged in the Information. Because many of those stipulated facts are relevant to this Complaint, a copy of the stipulated facts is attached hereto as Ex. 4, is incorporated herein, and will later be referenced where pertinent.

III. JURISDICTION

31. The Court has subject matter jurisdiction to entertain this action under 28 U.S.C. §§ 1331 and 1345 and supplemental jurisdiction to entertain the common law and equitable causes of action pursuant to 28 U.S.C. § 1367(a). The Court may exercise personal jurisdiction over the defendants pursuant to 31 U.S.C. § 3732(a) because at least one of the defendants to this action resides or transacts business in the Middle District of Florida, the transferor Court, and because at least one of the agencies to whom defendants submitted false claims or caused false claims to be submitted maintains their headquarters in this District. Moreover, 28 U.S.C. § 1407

necessarily confers the jurisdiction of the transferor Court over the parties on this Court for this Multidistrict proceeding.

IV. VENUE

32. Venue is proper in the Middle District of Florida, the transferor Court, under 31 U.S.C. § 3732 and 28 U.S.C. § 1391(b) and (c) because at least one of the defendants resides or transacts business in that District, and in this District pursuant to 28 U.S.C. § 1407 because this action has been consolidated in this District for pre-trial proceedings.

V. PARTIES

33. The United States brings this action on behalf of its agency, the Department of Health and Human Services ("HHS"), and its agency, the Health Care Financing Administration ("HCFA"), which administers the Medicare and Medicaid programs, and on behalf of the Department of Defense, which administers the Civilian Health and Medical Program of the Uniformed Services ("CHAMPUS"), now known as TRICARE.

34. Relator James F. Alderson is a resident of Vancouver, Washington and a former employee of North Valley Hospital, Inc., in Whitefish, Montana, which was managed by Quorum Health Resources, Inc. (“QHG”), a former defendant in this action. QHG is a spin-off of Hospital Corporation of America (the “original HCA”). QHG was formed in 1989 to purchase HCA Management Company, a subsidiary of the original HCA that had been responsible for fulfilling management contracts that HCA entered with hospitals it did not own. Mr. Alderson worked for QHG shortly after its spin off from the original HCA had been completed, at which time QHG continued to follow the same cost-reporting policies and practices — and, indeed, even to use the same pre-printed reserve templates — as its corporate

predecessors that remain defendants in this action, the original HCA and HealthTrust, Inc.- The Hospital Company ("HealthTrust"). QHG was severed as a defendant in this action in February, 1999 without objection. Mr. Alderson named the original HCA, Columbia/HCA Healthcare Corporation ("Columbia/HCA"), HealthTrust, and all former original HCA and HealthTrust hospitals as defendants. Mr. Alderson's Third Amended Complaint filed October 9, 1997, named Columbia/HCA, HealthTrust and "All Hospitals Owned or Managed by them Since January 1, 1984" which would encompass hospitals acquired by Columbia/HCA through October 9, 1997. Mr. Alderson's allegations against the HCA and HealthTrust hospitals do not extend to the additional allegations made by relator Schilling of violations of the False Claims Act for improper cost-shifting to cost-based units for which reserves were not set aside.

35. Relator John W. Schilling is a resident of Fort Myers, Florida and a former employee of defendants Columbia Healthcare Corporation (a/k/a Columbia Hospital Corporation) ("Columbia") and its successor, Columbia/HCA. Mr. Schilling named as defendants Columbia/HCA, Columbia and all hospitals that were part of the Columbia chain prior to its February 1994 merger with the original HCA.

36. The United States sues additional defendants not named by Mr. Alderson or Mr. Schilling, that is, all hospitals acquired by Columbia/HCA between October 9, 1997 and December 31, 1997. In addition, the United States adds claims against defendants in the Alderson action for violations of the False Claims Act for improper cost-shifting to cost-based units which was not reserved for.

37. Defendant HCA, formerly Columbia/HCA, is a Delaware corporation that currently operates 189 hospitals and ancillary health care facilities in at least thirty states,

including approximately 46 in Florida. During the time period relevant to this complaint, HCA operated over 400 hospitals in at least thirty-five states, including approximately 60 in Florida. Columbia/HCA was formed on or about February 10, 1994, when Columbia Healthcare Corporation merged with the original HCA. The merged company changed its name to HCA — The Healthcare Company on May 25, 2000.

38. Columbia Healthcare Corporation was a Delaware corporation formed in July 1993, having its principal place of business in Louisville, Kentucky, that owned, operated and managed hospitals in several states and the Middle District of Florida.

39. Columbia Hospital Corporation was incorporated on November 19, 1987 by Richard L. Scott as a Texas corporation, and reincorporated on July 26, 1990 as a Nevada corporation, with its principal place of business in Fort Worth, Texas. Columbia Hospital Corporation owned, operated and managed hospitals in several states and the Middle District of Florida. Columbia Healthcare Corporation and Columbia Hospital Corporation will be collectively referred to as "Columbia".

40. Basic American Medical, Inc. ("BAMI") was an Indiana corporation having its principal place of business in Indianapolis, Indiana. BAMI owned five hospitals located in the Middle District of Florida and one in Kentucky. On or about July 15, 1992, BAMI merged with Columbia Hospital Corporation.

41. Hospital Corporation of America (the "original HCA") was a Tennessee corporation with its principal place of business in Nashville, Tennessee. The original HCA owned and operated hospitals in numerous states and in the Middle District of Florida. The February 1994 Columbia/ HCA merger created the largest hospital chain in the United States.

42. HealthTrust, Inc. - The Hospital Company ("HealthTrust" or "HTI") was a Delaware corporation with its principal place of business in Nashville, Tennessee. HTI owned and operated hospitals the Middle District of Florida and elsewhere. A subsidiary of HCA acquired HTI on April 24, 1995.

43. Epic Healthcare Management Company was a Delaware corporation incorporated on or about September 30, 1988, and having its principal place of business in Dallas, Texas, that owned and operated hospitals in the Middle District of Florida. Epic was a spinoff of American Medical, Inc. "AMI" and is successor in interest to and responsible for the liabilities of AMI.

44. Epic Healthcare Group, Inc. was a Delaware corporation formed on December 14, 1993 which, upon information and belief, became the parent to and responsible for the liabilities of Epic Healthcare Management Company (collectively, "Epic"). HTI acquired Epic by merger on May 5, 1994.

45. As a result of these various mergers and acquisitions, HCA now owns former original HCA, Columbia, BAMI, HTI and Epic hospitals, located in the Middle District of Florida and elsewhere, and is the successor in interest to and responsible for the liabilities of the original HCA, Columbia, BAMI, HTI and Epic.

46. Defendant Columbia Management Companies, Inc. ("CMC") is a Delaware corporation formed on December 31, 1996, which has its principal place of business in Nashville, Tennessee. CMC is a subsidiary of defendant HCA.

47. Columbia Homecare Group, Inc. is a wholly owned subsidiary of HCA which was responsible for managing home health care operations with hospitals owned, operated or managed by HCA.

48. HCA is liable in this action for the conduct of its predecessors; of each subsidiary between it and the hospitals and other entities it and its predecessors owned or operated as general or managing partner; and of the hospitals it and each of these predecessors owned or operated as general or managing partner. HCA is liable for that conduct directly, because it or its predecessors committed, participated in or caused the acts described herein, or derivatively, because it or its predecessors operated their various subsidiaries and hospitals as an alter ego of the parent corporations. The United States alleges, upon information and belief, that HCA and its predecessors: (a) created separate legal entities through which they owned or operated hospitals and other healthcare providers while dominating and controlling them all, operating them in an integrated manner, and disregarding the subsidiary corporations' basic corporate form; (b) shared common ownership, board membership and management with their various subsidiaries, affiliates and hospitals; (c) shared corporate, group and divisional resources to perform operational, administrative, financial and reimbursement functions for their various subsidiaries, affiliates and hospitals; and (d) precluded the subsidiaries and affiliates from conducting business except that which was directed by and in the interests of the ultimate parent corporation. The United States alleges, upon information and belief, that HCA and its predecessors historically operated various subsidiaries and affiliates as mere shell corporations through which corporate directives flowed to hospitals, and profits and other revenue flowed from hospitals.

49. Attached hereto as Ex. 5, and incorporated by reference herein, is a chart listing the "Hospital Defendants" to this action. The Hospital Defendants are 154 hospitals currently

owned, operated or managed by HCA that submitted false claims in their cost reports reflected in their reserves.

50. Attached hereto as Ex. 6 and incorporated herein by reference is a chart listing all hospitals whose cost reports are at issue in this action, including those which HCA no longer owns, that submitted false claims in cost reports during a period in which HCA owned the hospital, managed the hospital as general or managing partner, or is the successor in interest to the corporation that owned or operated the hospital during the relevant time period ("HCA Hospitals"). To the extent HCA's liability for the conduct of those hospitals it no longer owns resides in other intermediate corporate entities, those entities will be identified in discovery and named as defendants to this action by amended complaint.

VI. FALSE CLAIMS ACT

51. The False Claims Act ("FCA") provides, in pertinent part that:

> (a) Any person who (1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval; (2) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; (3) conspires to defraud the Government by getting a false or fraudulent claim paid or approved by the Government;. . . or (7) knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government,
>
> * * *
>
> is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, plus 3 times the amount of damages which the Government sustains because of the act of that person . . . .

> (b) For purposes of this section, the terms "knowing" and "knowingly" mean that a person, with respect to information (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.

31 U.S.C. § 3729.

VII. THE MEDICARE PROGRAM

52. In 1965, Congress enacted Title XVIII of the Social Security Act ("Medicare" or the "Medicare Program") to pay for the costs of certain health services and health care. Entitlement to Medicare is based on age, disability or affliction with end-stage renal disease. See 42 U.S.C. §§ 426, 426A. Part A of the Medicare program authorizes payment for institutional care, including hospital, skilled nursing facility and home health care. See 42 U.S.C. §§ 1395c-1395i-4. Most hospitals, including nearly all of the HCA Hospitals, derive a substantial portion of their revenue from the Medicare program.

53. Prior to October 1983, Medicare reimbursements were based on the "reasonable cost" of inpatient services provided to Medicare beneficiaries. Under the reasonable cost payment system, providers were reimbursed for the actual costs they incurred, provided that the costs fell within certain cost limits. 42 U.S.C. § 1395f(b). Thus, as hospital costs increased, so too did Medicare reimbursements to those hospitals.

54. Concerned about escalating Medicare expenditures, Congress in 1983 revised the scheme for reimbursing inpatient hospital costs by establishing the prospective payment system ("PPS"). Under PPS, most hospitals, including almost all of the HCA Hospitals, are paid on the basis of prospectively determined fixed rates, which vary according to the type and category of

hospital treatment received. 42 U.S.C. § 1395ww(d). The specific rate to be paid depends upon which diagnosis related group best characterizes the patient's condition and treatment. Id.

55. After 1983, hospitals could request that Medicare exempt them from the PPS system and permit them to remain under the reasonable cost reimbursement system. In addition, by statute, some specialty hospitals, including psychiatric hospitals, are exempt from PPS. 42 C.F.R. §§ 412.20, 412.27.

56. Some of the HCA hospitals are exempt from PPS.

57. Because during the time period relevant to this complaint PPS reimbursement did not apply to outpatient hospital costs or the costs of certain hospital subproviders, including home health agencies ("HHAs"), which were reimbursed on the basis of the provider's reasonable costs, providers had an incentive to assign costs to outpatient areas and to cost-based subproviders such as HHAs in order to obtain more Medicare reimbursement than they would have had the costs been properly assigned to the inpatient areas covered by the fixed rate PPS. Medicare has been in the process of phasing in PPS reimbursement for hospital capital costs such as the costs of buildings and equipment since the early 1990s. Prior to cost reporting periods beginning on or after October 1, 1991, Medicare reimbursed the full amount of a hospital's capital costs attributable to care provided to Medicare beneficiaries. The phase-in of PPS reimbursement for capital costs began for cost reporting periods beginning on or after October 1, 1991 and will be completed as of cost reporting periods beginning on or after October 1, 2001. During the phase-in period hospitals have been reimbursed for capital costs based in part on fixed national rates and in part on their actual costs. 42 C.F.R. § 412.304.

58. During the time period relevant to this complaint providers had an incentive to characterize costs as capital costs in order to increase the provider's Medicare reimbursement.

59. HHS is responsible for the administration and supervision of the Medicare program. HCFA is an agency of HHS and is directly responsible for the administration of the Medicare program.

60. To assist in the administration of Medicare Part A, HCFA contracts with fiscal intermediaries (" FIs"). 42 U.S.C. § 1395h. FIs typically are insurance companies that provide a variety of services, including processing and paying claims and auditing cost reports.

61. During the year, providers, such as hospitals, submit claims to their assigned FIs for reimbursement, based upon hospital utilization by Medicare beneficiaries. 42 C.F.R. §§ 413.1, 413.60, 413.64. Providers receive interim payments on these claims. Within a specified time after the end of the hospital's fiscal year, the hospital must submit its cost report to its FI so that the FI can make year-end adjustments to the interim payments, as needed. 42 C.F.R. § 413.20(b). Cost reports are the final claim that a provider submits to its FI for items and services rendered to Medicare beneficiaries.

62. Cost reports contain extremely detailed financial data relating to the provider and form the basis for a determination by Medicare whether the provider is entitled to more reimbursement than already paid, or whether the provider has been overpaid and must reimburse Medicare. 42 C.F.R. §§ 405.1803, 413.60 and 413.64(f)(1).

63. The HCA Hospitals were, at all times relevant to this complaint, required to submit cost reports to their FIs.

64. Under the rules applicable at all times relevant to this complaint, Medicare, through its FIs, had the right to audit the cost reports and financial representations made by the HCA Hospitals. This right includes the right to make retroactive adjustments to cost reports previously submitted by a provider if any overpayments have been made. 42 C.F.R. § 413.64(f).

65. Shortly after hospitals submit cost reports, the FI makes a tentative settlement and payment on the cost report based on the data reported.

66. Under the rules applicable at all times relevant to this complaint, when the FI makes the final settlement of the cost report, it issues a written Notice of Amount of Program Reimbursement ("NPR"). 42 C.F.R. § 405.1803(a). The NPR either involves a determination that the provider must repay funds received from Medicare, or that Medicare owes the provider.

67. The provider has the right to contest an NPR requiring repayment to Medicare by the provider by requesting a hearing before the FI. 42 C.F.R. § 405.1811.

68. The provider may appeal certain determinations by the FI by requesting a hearing before the Provider Reimbursement Review Board ("PRRB"). 42 C.F.R. § 405.1835.

69. The Administrator of the Health Care Financing Administration ("Administrator"), at his or her discretion, has the authority to review final decisions rendered by the PRRB under certain circumstances, including pursuant to a request by the provider. 42 C.F.R. § 405.1875.

70. The provider has the right to appeal certain decisions of the PRRB or the Administrator by filing an action in United States District Court. 42 C.F.R. § 405.1877.

71. Under the rules applicable at all times relevant to this complaint, a FI and the PRRB must reopen and revise a determination or hearing decision if, within three years of the FI's decision, HCFA notifies the FI that such determination or decision is inconsistent with the application, regulations, or general instructions issued by HCFA. 42 C.F.R. § 405.1883(b). The FI and the PRRB must also reopen and revise a determination or hearing decision at any time if it is established that such determination or decision was procured by fraud or similar fault of any party to the determination or decision. 42 C.F.R. § 405.1885(d).

VIII. PREPARATION OF THE MEDICARE COST REPORT

72. HCFA requires hospitals, as a prerequisite to payment by Medicare, to annually submit a form HCFA-2552, titled the "Hospital and Hospital Health Care Complex Cost Report."

73. Before completing the cost report, a provider reviews its own books and records. The provider then breaks down its costs into a trial balance of expenses.

74. The cost report contains four major parts, referred to as “Worksheets.”

75. First, the provider completes Worksheet A, titled the "Reclassification and Adjustment of Trial Balance of Expenses." Worksheet A starts with the provider's trial balance of expenses. The provider's trial balance of expenses includes all of the provider's costs whether they are allowable or unallowable for Medicare reimbursement purposes.

76. The provider then reclassifies the trial balance of expenses in accordance with the Medicare statute, regulations and HCFA program instructions.

77. Next, a provider makes certain adjustments on Worksheet A also in accordance with the Medicare statute, regulations and HCFA program instructions in order to separate out its costs which are unallowable for Medicare reimbursement purposes.

78. Second, the provider fills out Worksheet B, titled "Cost Allocation." A provider has to allocate (assign) all of its allowable overhead costs, such as housekeeping or depreciation, to all its revenue producing cost centers, such as operating rooms or laboratories.

79. Third, the provider prepares Worksheet C, titled "Computation of Ratio of Costs to Charges." Charges are the amounts billed throughout the year to patients for services rendered. Since Medicare reimburses hospitals based (in part) on their costs, the hospitals need to compute this ratio to determine whether Medicare charges have covered Medicare costs. On Worksheet C, a provider develops cost-to-charge ratios by specific departments, or "cost centers," within the hospital, e.g, the emergency room. The ratio is derived by dividing the total costs, direct and indirect, allocable to the cost center by the amount of the charges generated by the cost center during the same time period. This cost-to-charge ratio allows the provider to apportion costs to Medicare patients on the Worksheet D series.

80. Fourth, the provider completes the Worksheet D series. In order to determine Medicare's share of the provider's total costs, the Worksheet D series apportions these costs to Medicare on the basis of cost-to-charge ratios and per diem amounts.

81. For items and services subject to reasonable cost reimbursement, the Worksheet D series completes the process of determining Medicare reimbursement. For items and services payable under PPS, the Worksheet D series determines Medicare's liability for the provider's inpatient costs.

82. Medicare’s inpatient liability for acute care hospitals is determined by the claims submitted by the provider for particular patient discharges during the course of the fiscal year. These claims are then summarized on the Provider Statistical and Reimbursement Report and

entered on the settlement worksheets as the program liability for inpatient acute care hospital services.

83. After determining Medicare's share of the provider's cost and/or determining Medicare's liability under PPS, the provider brings these costs forward to the Worksheet E series. These costs are then totaled to determine Medicare's liability for services rendered to Medicare beneficiaries during the year. The Worksheet E series then subtracts the amount of payments made to the provider based upon the payments made on a claim-by-claim basis. The difference is the amount due the Medicare program or the amount due the provider.

84. Every cost report contains a "Certification," which must be signed by the chief administrator of the provider or a responsible designee of the administrator.

85. Providers that file their cost reports electronically are required to submit a paper certification to the FI, which must be signed and dated. 42 C.F.R. § 413.24(f)(4).

86. For cost reporting periods prior to September 30, 1994, the certification provision required the responsible provider official to certify, in pertinent part, that

> to the best of my knowledge and belief, it [the cost report] is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted.

87. Thus, the provider must certify that the filed cost report is (1) truthful, i.e., that the cost information contained in the report is true and accurate, (2) correct, i.e., that the provider is entitled to reimbursement for the reported costs in accordance with applicable instructions, and (3) complete, i.e., that the cost report is based upon all of the provider's cost information pertaining to the determination of reasonable cost.

88. As to cost reports for years from September 30, 1994 on, the certification provision of the cost report was revised by Medicare to include, in addition to the above, the following sentence:

> I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

89. The Medicare program depends heavily upon the truthfulness of providers in completing their cost reports. At all times relevant to this complaint it was common knowledge in the healthcare industry that the government lacks adequate resources to conduct a full-scope audit of each of the over 35,000 providers nationwide, including hospitals, which file cost reports with Medicare each year.

90. To address this problem HCFA has devised a methodology that subjects all cost reports to an automated uniform "desk review" process. Based on the results of the desk review, and the funds available for audit, intermediaries select providers for field audits.

91. In 1997, for example, of 35,709 provider cost reports received from hospitals, skilled nursing facilities (commonly known as nursing homes), home health agencies, and other institutional providers of patient care, just over 5,000 (or approximately 14%) were selected for a field audit. Because of limited resources, field audits are usually limited to specific issues.

92. Defendants took advantage of Medicare's limited resources by submitting false claims and false statements in the HCA Hospitals' cost reports with the expectation that they would not be discovered upon audit.

93. Defendants established reserves for the possibility that the false claims and false statements made in their Medicare cost reports would be caught by their FIs and that the reserve amounts would have to be repaid to Medicare.

94. HCFA conditions payments on the truthfulness of the statements contained in the cost report and relies on this information in determining the provider's payment. 42 C.F.R. §§ 413.20(e); 413.24(f).

IX. APPLICABLE INSTRUCTIONS

95. Medicare requires providers to maintain complete and accurate cost information and to prepare their cost reports based on that information.

96. HCFA's Provider Reimbursement Manual ("PRM") contains additional instructions to providers for the preparation of their cost reports. The PRM requires providers to maintain and make available to their FIs current, accurate cost information from its books and records. PRM Pt. I §§ 2300; 2304; 2304.1.

97. Thus, under the applicable regulations and instructions, a Medicare cost report must be based upon all of the hospital's cost records, which must then be made available to Medicare for examination. 42 C.F.R. §§ 413.20(d), 413.24; PRM Pt. I §§ 2300, 2304, 2304.1.

98. A hospital may not conceal or withhold pertinent financial data it knows, or should know, potentially affects the amount of Medicare reimbursement properly owing to the hospital.

99. The applicable instructions contain "protest" procedures for a provider to dispute regulatory and policy interpretations through the appeals process established by the Social Security Act. In order to establish an appeal issue, the provider must include the unallowable

item in the cost report, and the disputed item must pertain to the cost reporting period for which the cost report is filed. PRM Pt. II § 115.

100. The instructions further provide that when a provider files a cost report under protest, the disputed items and the amount for each issue must be specifically identified in footnotes to the settlement worksheet of the cost report, and the fact that the cost report is filed under protest must be disclosed. PRM Pt. II § 115.1.

101. The instructions also provide that providers who deliberately include cost, without disclosing the fact in the provider cost report, that is nonreimbursable under the regulations are subject to the provisions concerning fraud and abuse. PRM Pt. II. § 115.3.

102. Defendants are, and were at all times relevant to this complaint, familiar with the Medicare law, regulations, instructions, and the PRM governing the preparation and submission of Medicare cost reports.

103. In addition, if a hospital discovers errors and omissions in its claims submitted for reimbursement to Medicare (including its cost reports), it is required to disclose those matters to its FI. 42 U.S.C. § 1320a-7b(a)(3) creates a duty to disclose known errors in cost reports:

> Whoever . . . having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment . . . conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized . . . shall in the case of such a . . . concealment or failure . . . be guilty of a felony.

X. FALSE CLAIMS AND FALSE STATEMENTS TO MEDICARE

104. At all times relevant to this complaint, the HCA Hospitals followed a practice and policy of including on their cost reports unallowable costs and of reporting otherwise allowable costs incorrectly to increase Medicare reimbursement without filing the cost reports under

protest following the procedures in the PRM, and without otherwise disclosing the items to their FIs.

105. The HCA Hospitals selectively disclosed only certain reserves, while failing to disclose the inclusion in their cost reports of other reserve items that were required to be disclosed under the governing PRM provision.

106. Thus, in preparing Medicare cost reports, defendants' policies and practices have been routinely to conceal from the FIs and HCFA claims for cost reimbursement that they knew would probably be lost if disclosed, including many items that were contrary to clearly expressed program policy.

107. The cost reports submitted by the HCA Hospitals whether, at the time, they were owned by HCA, Columbia, HTI, original HCA, Epic, or BAMI, were, at all times material to this complaint, prepared by persons employed by HCA, Columbia, HTI, original HCA, Epic, and BAMI in the companies' Reimbursement Departments, with the assistance of hospital employees and Division or Regional officials.

108. In a few cases, defendants contracted with consultants for the preparation of certain hospital cost reports. However, cost reports prepared by consultants were always reviewed by defendants' employees.

109. Defendants' Reimbursement Department employees and/or consultants who prepared the cost reports for the HCA Hospitals also prepared "reserve" cost reports prior to, contemporaneously with, or shortly after preparing the filed cost reports.

110. Epic employees and consultants did not use the term reserve but, instead used the term "known disallowances," abbreviated "k.d." in Epic workpapers.

111. As with the “reserves,” Epic’s practice was to establish known disallowances for items that would have been lost if caught on audit and which should have been protested or otherwise disclosed to the Epic hospitals’ FIs, but were not protested or disclosed.

112. Cost reports submitted by the HCA Hospitals were, at all times material to this complaint, signed by defendants’ employees, usually a hospital official and, in some cases a Reimbursement Department employee, who attested to the certification quoted in ¶ 86 above.

113. The HCA Hospitals established reserves or “known disallowances” for items that would be lost if discovered by the FI.

114. As a result of their established policies or practices, the HCA Hospitals have repeatedly falsely certified to the government that their cost reports were a "true, correct, and complete report . . . except as noted."

115. Indeed, the HCA Hospitals’ cost reports were incomplete to the extent that they failed to disclose what defendants knew, that certain items listed in the corresponding reserves or known disallowances, would be disallowed if discovered by FI auditors.

116. Contrary to their certifications, the cost reports filed by the HCA Hospitals were not "complete" as long as defendants failed to include in the filed cost report adequate cost information regarding reimbursability that was considered in preparing the reserve cost report and reserve workpapers.

117. Because defendants also took affirmative steps to conceal the financial information contained in their reserve cost reports, workpapers and summaries by marking and or keeping the reserve records confidential and by not giving them to Medicare auditors, the

certifications by the HCA Hospitals that the filed cost reports were a "complete statement . . . except as noted," were false.

118. In addition, the HCA Hospitals filed cost reports that defendants knew contained untruthful or incorrect claims for reimbursement, contrary to their certifications that the filed cost reports were true and correct to the best of their knowledge.

119. As alleged above, it was defendants' policy or practice to maintain a reserve or known disallowance for all reimbursement requests that would be lost if discovered by FI auditors.

120. Thus a cost item that defendants believed would be lost if discovered was, necessarily, an "incorrect" item in the filed cost report.

121. Under these circumstances, the certification by defendants' employees that each of their filed cost reports is a "correct . . . statement . . . except as noted," was knowingly false.

XI. FALSE CLAIMS AND FALSE STATEMENTS TO MEDICAID

122. Medicaid is a joint federal-state program that provides health care benefits for certain groups, primarily the poor and disabled. Federal involvement in Medicaid is largely limited to providing matching funding and ensuring that the states comply with minimum standards in the administration of the program.

123. The federal Medicaid statute sets forth the minimum requirements for state Medicaid programs to qualify for federal funding, which is called federal financial participation ("FFP"). 42 U.S.C. § 1396, et seq.

124. Each state's Medicaid program must provide hospital services. 42 U.S.C. § 1396a(10)(A), 42 U.S.C. § 1396d(a)(1)-(2).

125. Provider hospitals participating in the Medicaid program file annual cost reports with the single state agency administering the particular state's Medicaid program, or its FI, in a protocol similar to the one governing the submission of Medicare cost reports.

126. In some states provider hospitals participating in the Medicaid program file a copy of their Medicare cost report with the Medicaid program which is then used by Medicaid or its intermediaries to calculate Medicaid reimbursement. In other states provider hospitals file a separate Medicaid cost report.

127. Providers incorporate in these separate Medicaid cost reports the same type of financial data contained in their Medicare cost reports, and include data concerning the number of Medicaid patient days at a given facility.

128. Typically, each state requiring the submission of a Medicaid cost report also requires that an authorized agent of the provider expressly certify that the information and data contained within the submitted cost report is true and correct.

129. This Medicaid patient data is then utilized by individual Medicaid programs to determine the reimbursement to which the facility is entitled, and the facility receives a proportion of its costs equal to the proportion of Medicaid patients in the facility.

130. Where a provider submits the Medicare cost report to Medicaid, false or incorrect data or information contained in the Medicare cost report necessarily causes the submission of false or incorrect data or information to the state Medicaid program.

131. Where a provider submits the Medicare cost report to Medicaid, the false certification on the Medicare cost report necessarily causes a false certification to Medicaid as well.

132. Where a provider submits a Medicaid cost report that contains the same false or incorrect information contained in the provider's Medicare cost report, false statements and false claims have been made for reimbursement from Medicaid.

133. Defendants created reserves for amounts that would have to be repaid to Medicaid if the falsely inflated and improper costs were caught by the Medicare or Medicaid program auditors. However, in some cases, defendants did not create reserves for Medicaid although they created Medicare reserves for costs that were also being claimed for reimbursement from Medicaid.

134. The United States has been damaged whenever a state Medicaid program has been damaged by the HCA Hospitals' submission of false claims and false statements because the United States funds a portion of each state's Medicaid program as described above at ¶¶ 122 - 123.

135. All HCA Hospitals listed on Ex. 6, which is incorporated herein by reference, sought reimbursement from designated state Medicaid programs for the time period pertinent to this complaint, and made false claims for reimbursement that were based on the false claims they made to Medicare that are identified in Exs.8 - 12.

XII. FALSE CLAIMS AND FALSE STATEMENTS TO TRICARE/CHAMPUS

136. At all times relevant to this complaint many of the HCA Hospitals were enrolled in, and sought reimbursement from TRICARE/CHAMPUS.

137. TRICARE/CHAMPUS is a federally-funded program that provides medical benefits, including hospital services, to the spouses and unmarried children of active duty retired service members, to the spouses and unmarried children of reservists who were ordered to active

duty for thirty days or longer, and to the unmarried spouses and children of deceased service members and to retirees. Hospital services at non-military facilities are sometimes provided for active duty members of the armed forces, as well. 10 U.S.C. §§ 1071-1109; 32 C.F.R. § 199 *et seq*.

138. TRICARE/CHAMPUS reimburses hospitals for two types of costs, both of which are based on the Medicare cost report: capital costs and direct medical education costs. 32 C.F.R. § 199.14(a).

139. A provider seeking reimbursement from TRICARE/CHAMPUS for these costs is required to submit a TRICARE/CHAMPUS prescribed form entitled, "Request for Reimbursement of CHAMPUS Capital and Direct Medical Education Costs" ("Request for Reimbursement)."

140. In the Request for Reimbursement, the provider sets forth its number of TRICARE/CHAMPUS patient days and financial information which relate to these two cost areas covered by TRICARE/CHAMPUS (i.e. capital costs and direct medical education costs), which is derived from the Medicare cost report for that facility.

141. Upon receipt of a hospital's Request for Reimbursement and the provider's financial data, TRICARE/CHAMPUS or its FI applies a formula for reimbursement wherein the hospital receives a percentage of its capital and medical education costs equal to the percentage of TRICARE/CHAMPUS patient days as a percentage of total patient days in the facility.

142. This Request for Reimbursement requires that the provider expressly certify that the information contained therein is "accurate and based upon the hospital's Medicare cost report."

143. In addition, a hospital is required to be familiar with its duties and responsibilities under the TRICARE/CHAMPUS program. 32 C.F.R. §§ 199.6(a), 199.9(a)(4).

144. In the event that a Medicare FI disallows capital or medical education costs claimed in the provider's cost report after an audit, the provider is required to inform TRICARE/CHAMPUS of the disallowance.

145. Indeed, the Request for Reimbursement requires that the provider expressly certify that the provider will notify CHAMPUS of "any changes which are the result of an audit of the hospital's Medicare cost report" within thirty days of the date the hospital is notified of the change.

146. TRICARE/CHAMPUS does not receive Medicare audit results directly from Medicare intermediaries but rather relies upon the honesty of the provider in disclosing any and all adjustments made by Medicare or its FIs to the Medicare cost report, so that similar adjustments can be made by TRICARE/CHAMPUS.

147. Defendants submitted Requests for Reimbursement for the HCA Hospitals to TRICARE/CHAMPUS that were based on their Medicare cost reports. Whenever the HCA Hospitals' Medicare cost reports contained falsely inflated or incorrect data or information from which they derived their Requests for Reimbursement submitted to TRICARE/CHAMPUS, those Requests for Reimbursement were also false.

148. Whenever the HCA Hospitals' Requests for Reimbursement were false due to falsity in their Medicare cost reports, defendants employees falsely certified that the information contained in their Requests for Reimbursement was "accurate and based upon the hospital's Medicare cost report."

149. Upon information and belief, defendants and the HCA Hospitals knowingly failed to notify TRICARE/CHAMPUS of changes that were the result of audits of their hospitals' Medicare cost reports as required when those changes would have decreased the amount of reimbursement the HCA Hospitals were entitled to receive from TRICARE/CHAMPUS.

150. Whenever the HCA Hospitals did not notify TRICARE/CHAMPUS of changes that were the result of audits of their hospitals' Medicare cost reports, they accepted reimbursement from TRICARE/CHAMPUS of more than they were entitled to receive.

151. While defendants and the HCA Hospitals generally did not create separate reserves for TRICARE/ CHAMPUS, they knew that false claims contained in their Medicare cost reports often would affect TRICARE/CHAMPUS reimbursement as well.

152. Attached hereto as Ex. 7, and incorporated herein by reference, is a chart of HCA Hospitals which identifies the hospitals that made claims to TRICARE/CHAMPUS for reimbursement of capital costs. To the extent that Ex. 8 identifies false claims made by these HCA Hospitals that would affect TRICARE/CHAMPUS reimbursement of capital costs, the claims to TRICARE/CHAMPUS identified in Ex. 7 are false as well.

XIII. EXHIBITS IDENTIFYING THE FALSE CLAIMS

153. Attached hereto at Ex. 6, and incorporated by reference herein, is a chart of HCA Hospitals which lists: the hospital's Medicare provider number, the hospital name, the cost report year end date, the Medicare FI, the hospital's Medicaid provider number, and the Medicaid FI.

154. In ¶¶ 215 - 537 below, the United States details the major types of false and fraudulent claims and false statements contained within the cost reports submitted by the HCA Hospitals.

155. The examples that follow in ¶¶ 215 - 537 below are not, by far, an exhaustive list of the false and fraudulent statements and claims allegedly submitted by the HCA Hospitals in their cost reports and claims for reimbursement. Defendants' false claims are too numerous to catalogue exhaustively in the text of this complaint while remaining in compliance with Fed. R. Civ. P. 8(a). In each example, the United States identifies only the hospital and the fiscal year for which the cost report was submitted for convenience, but pleads that the Hospital Defendant (where applicable) and HCA are both liable for the false and fraudulent claim and false statement.

156. The United States attaches and incorporates herein by reference Exs. 8 - 12 which are summary exhibits that identify each instance of defendants' submission of false claims that are reflected in defendants' reserves. Exhibits 8 - 12 identify the hospital name, Medicare provider number, the issue reserved for that is reflected in the filing of a false claim in the filed cost report, and, in most instances, the amount of the reserve established to pay Medicare if the false claim was caught upon audit. Exhibit 8 is organized by the type of issue. Exhibit 8 contains the following information for all entries: Medicare provider number ("prov #"), cost reporting period ("year"), provider name, issue description, the general category to which the issue was grouped by the United States, the specific category to which the issue was grouped by the United States, and the reserve amount ("Reserve $"). Where the far right column of Ex. 8 entitled "Prior Year Audit Adjustment" contains the word "yes," the issue reserved for was the

subject of a prior year audit adjustment by the hospital's FI, as pled more fully below at ¶¶ 215 - 226. The United States organized the HCA Hospitals' reserves and associated false and fraudulent claims and false statements into categories based on the common issue descriptions used by defendants in the reserves.

157. Attached hereto at Ex. 13 is a non-exhaustive list of false claims for reimbursement for improper cost-shifting to cost-based units for which defendants did not establish reserves. Upon information and belief, defendants filed cost reports for additional hospitals and years not identified in Ex.13 that included claims for reimbursement of costs that were improperly shifted from the hospital to one or more of its cost-based subunits that were not reflected in reserves established by defendants.

158. Attached hereto at Ex. 14, and incorporated by reference herein, is a list of 983 instances in which the preparer of the cost report was aware, or should have been aware, of a prior year audit adjustment by the FI and disregarded it by claiming costs on cost reports filed in subsequent years, which are described more fully at ¶¶ 215 - 226 below.

XIV. ISSUES TO WHICH DEFENDANT COLUMBIA MANAGEMENT COMPANIES PLED GUILTY

A. Fawcett

159. Medicare will reimburse hospitals for portions of interest expense incurred on certain long term debt. PRM Pt. I §§ 202.1, 2806.2. Because interest attributable to loans which

were used to secure "capital" expenses of the hospital were reimbursed at a substantially higher rate than interest attributable to loans used for administrative ("A&G") purposes, there was a financial incentive for hospitals to claim an interest expense as "capital" related.

160. On January 25, 2001, CMC pled guilty to violating the rule described in ¶ 159 by knowingly and willfully causing the preparation of cost reports for Fawcett Memorial Hospital ("Fawcett") which fraudulently mischaracterized the nature of interest expenses contained in certain cost reports submitted to FIs.

161. As part of its criminal plea, CMC stipulated to the facts set forth in ¶¶ 162 - 165.

162. From 1990 through July 1992, Fawcett was owned and operated by BAMI. In July 1992, Fawcett was purchased by Columbia.

163. In 1981, Fawcett obtained a loan from Manufacturer's Hanover Trust Company, which consolidated and refinanced a number of smaller loans obtained by the hospital. This debt was refinanced in 1983.

164. During 1990 through 1994, Fawcett was entitled to claim only 39% of the interest on this debt as capital-related. Despite this fact, Fawcett knowingly and willfully caused its 1990, 1991, 1992 and 1993 cost reports to fraudulently reflect 100% of the interest expense attributable to that debt as capital-related.

165. The aggregate loss to Medicare attributable to this fraudulent characterization on the cost reports for the years 1990-1993 was $1,683,000.

B. Senior Friends

166. On January 25, 2001, defendant CMC pled guilty to including certain marketing and advertising costs designed to increase the utilization of hospital services despite its

knowledge that such costs were not allowable under Medicare. CMC pled guilty to fraudulently, knowingly and willfully including Senior Friends program costs as allowable "A&G" costs on the Worksheet A portion of the: a) December 31, 1995 cost report for Doctor's Hospital of Sarasota; b) June 30, 1995 and June 30, 1996 cost reports for Columbia Four Rivers Medical Center; c) December 31, 1994 cost report for Rosewood Medical Center; and d) August 31, 1996 cost report for Alice Physicians & Surgeons Hospital.

167. As part of the stipulated facts supporting its criminal plea, CMC stipulated to the facts in ¶¶ 168 - 171.

168. Senior Friends was a national, not-for-profit organization created to provide a variety of benefits to its membership of adults ages 50 and over. Over 225 HCA hospitals nationwide participated in Senior Friends by establishing local chapters at participating hospitals.

169. Among the benefits Senior Friends offered to its members were VIP hospital privileges; major local and national merchant discounts; medical supplemental insurance information; discounts on mail order pharmacy services; fitness and wellness programs; free health screenings; physician and services referrals; insurance claim filings; social, travel, and volunteer opportunities; and local and national Senior Friends newsletters. These benefits also included, marketing elements designed specifically to increase the utilization of these hospital services.

170. Internal documents that were not provided to the FI auditors for the hospitals identified in ¶ 166 referred to the Senior Friends program as "nonreimburseable Seniors."

171. The Medicare loss resulting from the improper filing of cost reports for the hospitals and years identified in ¶ 166 for the unallowable Senior Friends program costs was approximately $155,173.

172. In addition to the hospitals listed in ¶ 166 , defendants included false claims for unallowable marketing and advertising costs for Senior Friends program expenses in other HCA Hospitals' cost reports which were reflected in reserves established by defendants as identified at pages 101 to 104 of Ex. 8, which is attached hereto and incorporated by reference herein.

C. Idle Space

173. Medicare will reimburse providers for all necessary and proper costs incurred in furnishing services and care to Medicare beneficiaries. 42 C.F.R. § 413.9.

174. Medicare also will reimburse providers for appropriate costs incurred in the development and maintenance of Medicare patient care facilities and activities. 42 C.F.R. § 413.9(b)(2). These costs include direct, indirect and normal standby costs. 42 C.F.R.§413.9(c)(3).

175. Medicare will not reimburse providers for costs unrelated to the rendering of patient care or for costs unnecessary to maintain the operation of a patient care facility. PRM Pt. I § 2102.3.

176. Costs associated with "idle space" not used or intended to be used for patient-related services are not reimburseable by Medicare.

177. On January 25, 2001, defendant CMC pled guilty to violating the rules in ¶¶ 173 - 176 by seeking reimbursement from Medicare for idle space at Cedars Medical Center ("Cedars") for 1994 and 1995.

178. In support of its January 25, 2001 criminal plea, CMC stipulated to the facts contained in ¶¶ 179 through 186.

179. Cedars and Victoria Hospital ("Victoria") were both HCA Hospitals located in Miami, Florida, and managed by defendant CMC.

180. In February 1993, Cedars and Victoria merged operations and facilities. The merged entity operated under Cedars' name and Medicare provider number.

181. The consolidation of Cedars' and Victoria's services resulted in approximately 100,000 square feet of idle space at the Victoria facility. This space was neither used nor intended to be used for patient care related purposes.

182. Despite CMC's knowledge that the idle space was not an allowable cost under Medicare, because it was neither used nor intended for use for patient care related purposes, the December 31, 1994 Cedars cost report included idle space as an allowable and reimburseable cost.

183. CMC's knowledge is evidenced by a reserve cost report which stated, "[i]nclude 100,000 square feet of idle space at Victoria campus in statistics," and listed $280,283 under the "Medicare change" column.

184. Cedars' December 31, 1995 cost report also contained a fraudulent claim for the idle space at the Victoria facility. Again, the cost for idle space was included despite CMC's knowledge that such cost was not allowable or reimburseable by Medicare.

185. CMC's knowledge in this instance was revealed in a December 18, 1995 memorandum from reimbursement personnel to Cedars' chief financial officer, which stated that 146,000 square feet was "all non-reimburseable."

186. The inclusion of idle space costs in the Cedars cost reports for 1994 and 1995 resulted in a loss of approximately $257,000 to Medicare.

187. In addition to Cedars, defendants included false claims for costs for unallowable idle space in the cost reports of others of the HCA Hospitals.

188. In addition to Cedars, defendants included false claims for idle space in other HCA Hospitals' cost reports which were reflected in reserves established by defendants as identified at pages 131 to 137 of Ex. 8, which is attached hereto and incorporated by reference herein.

D. HHA Allocations

189. On January 25, 2001, defendant CMC pled guilty to making false statements regarding the allocations of costs associated with the operation of the hospital cafeteria and records general service cost centers to certain hospitals-based home health-agencies ("HHAs").

190. In support of its January 25, 2001 criminal plea, defendant CMC, stipulated to the facts contained in ¶¶ 191 - 193.

191. CMC caused certain HCA Hospitals to increase their claims for reimbursement by fraudulently allocating cafeteria costs to HHAs that were considerable distances from the hospitals.

192. These cafeteria allocations were not appropriate because there was no reasonable expectation that home health agency employees would use the hospitals' cafeterias.

193. Fraudulent cafeteria allocations were made for the following providers and years: (a) Miami Heart: 1995, 1996; (b) Columbia JFK Medical Center: 1997; (c) Central Florida Regional Hospital: 1996; (d) Winter Park Memorial Hospital: 1997; (e) North Florida Regional

Medical Center: 1997; (f) Dade City Hospital: 1996; (g) Westside Regional Medical Center: 1995, 1997; and (h) Columbia South Bay Hospital: 1996.

194. In addition to the hospitals identified in ¶ 193 , defendants made other such fraudulent allocations of cafeteria costs at other hospitals.

195. Attached herein at pages 702 through 709 of Ex. 8 is a listing of false claims submitted by defendants for cost shifting to HHAs, which includes false claims for fraudulent cafeteria allocations to HHAs which are reflected in the defendants' reserves.

196. Attached hereto as Ex. 13 and incorporated by reference herein is a listing of false claims for cost shifting to cost-based units for which no reserves were created by defendants which includes false claims for cafeteria allocations to HHAs. Upon information and belief, Ex. 13 is not an exhaustive list.

197. Medical records allocations to the HHAs attached to Brandon Regional Medical Center ("Brandon") were fraudulently made when no services were provided.

198. In 1995, Brandon allocated $98,751 of medical records costs to the HHAs while withholding a reserve of $72,443.

199. In addition to Brandon, fraudulent medical records allocations were made in the cost reports for the following providers for the following years: (a) St. Petersburg Hospital: 1995, 1997; (b) Bayonet Point Hospital: 1997; and (c) Blake Hospital: 1994, 1995.

200. Attached herein at pages 702 through 709 of Ex. 8 is a listing of false claims submitted by defendants for cost shifting to HHAs, which includes false claims for fraudulent medical records allocations to HHAs which are reflected in the defendants' reserves.

201. Attached hereto as Ex. 13 and incorporated by reference herein is a listing of false claims for cost shifting to cost-based units for which no reserves were created by defendants which includes false claims for medical records allocations to HHAs. Upon information and belief, Ex. 13 is not an exhaustive list.

E. Senior Health Center

202. On January 25, 2001, defendant CMC pled guilty to including the costs of an unlicensed off-site Senior Health Center in the 1996 cost report for Clearwater Community Hospital ("Clearwater") while knowing that unlicensed off-site facilities did not qualify for Medicare reimbursement.

203. In support of its January 25, 2001 criminal plea, defendant CMC stipulated to the facts contained in ¶¶ 205 - 213.

204. Medicare reimburses qualifying providers for reasonable and necessary treatment costs actually incurred and paid, in connection with treatment received by Medicare beneficiaries at various off-site locations, including senior health centers.

205. Clearwater was managed by defendant CMC and offered various services connected with patient care, including services at off-site locations.

206. Clearwater had as part of its internal records a letter from the Department of Health and Human Services, dated December 4, 1991, entitled "Regional Health Standards and Quality Letter No. 91-32 to All State Agencies re Accreditation of Hospitals with Multiple Components." That letter stated, in pertinent part, that "[h]ospitals that fail to obtain accreditation for off-site locations will not be deemed to meet Medicare requirements for coverage of hospital services for those off-site locations."

207. In January 1995, Clearwater formed a Senior Health Center at an off-site physician's office building. The Senior Health Center cares for the medical needs of a geriatric patient population.

208. The Senior Health Center was required to be licensed by the State of Florida Agency for Health Care Administration ("AHCA"). Although Clearwater was so licensed, its off-site senior health center was not.

209. A January 27, 1995 letter from AHCA to the architectural company involved with the construction of the Clearwater senior health center stated that the facility's mechanical and electrical deficiencies were so serious that AHCA was unable to approve it for licensing at that time.

210. Nevertheless, in February 1995, the Clearwater Senior Health Center opened for business because CMC anticipated that the licensing would be granted. In early 1996, however, CMC was aware that the continued lack of licensure was a "problem."

211. Despite the lack of licensure by AHCA, Clearwater filed its 1996 cost report and claimed expenses associated with the Senior Health Center.

212. During 1996, the total program costs for the Clearwater senior health center, as reported on Clearwater's Medicare cost report, Worksheet D, Part V, was $475,000. During 1996, a reserve in the amount of $475,000 was established for Clearwater in connection with its senior health center.

213. The Medicare loss associated with this fraudulent claim was $475,000.

F. HealthTrust ESOP/401(k)

214. In addition to the charges identified at ¶¶ 159 to 213 above, CMC also pled guilty to the HTI ESOP 401(k) issue, as alleged more fully in ¶¶ 462 to 483 below.

XV. DEFENDANTS' FAILURE TO INCORPORATE PRIOR YEAR AUDIT ADJUSTMENTS INTO SUBSEQUENT COST REPORTS

215. At the conclusion of their audits of defendants' cost reports, the FIs issued an NPR notifying the provider of the FIs' determination of whether the provider owed funds to Medicare or Medicare owed funds to the provider. NPRs typically include numerous audit adjustments.

216. The FIs issued NPRs for the majority of the cost reports at issue in this complaint.

217. The NPRs that were issued to the HCA Hospitals for cost reports at issue in this complaint, and for cost reports filed prior to the years at issue in this complaint, served to bring improper handling of cost reporting of various cost items to defendants' attention and to put them on notice of the FIs' determination that the inclusion of those costs was unallowable for Medicare purposes.

218. Following receipt of NPRs from the FIs, defendants regularly disregarded the adjustments in these NPRs when filing cost reports for subsequent years. On numerous occasions, defendants claimed expenses on their cost reports which the FIs had previously notified them were not allowable for Medicare purposes, and did not protest these items on their cost reports.

219. Defendants ignored prior year audit adjustments with the expectation that their failure to incorporate prior year audit adjustments either would not be discovered upon audit or, if discovered, would only result in another audit adjustment for the same item in the current year.

220. Defendants expected that the FI audit that might result in a repetitive audit adjustment would not be complete for at least one to two years after the cost report was filed.

221. Defendants expected to be paid nearly all of their reimbursement by Medicare through the interim payments received during the year and the payment at the time of the tentative settlement of the cost report as pled in ¶¶ 61 - 65 above.

222. Defendants knew that Medicare would not charge interest for any item disallowed upon audit until after the NPR was issued, so even if the prior year audit adjustments were caught and defendants had to pay the money back, they would receive an interest-free loan of that amount until the NPR was issued.

223. Defendants calculated the Medicare reimbursement impact of including items the FIs had previously advised them were not allowable for Medicare purposes and prepared reserve cost reports that reflected the amounts defendants would owe in the event that the intermediaries disallowed these costs.

224. Defendants set aside and retained reserves to cover the amounts they would owe Medicare in the event that the FIs disallowed the amounts claimed for costs which the FIs had advised them were not allowable following audits of prior year cost reports.

225. Attached hereto as Ex. 14 is a list of 829 instances in which the preparer of the cost report was aware, or should have been aware, of a prior year audit adjustment by the FI and disregarded it by claiming costs on cost reports filed in subsequent years. On information and belief, the United States alleges that defendants did not protest or otherwise disclose to the FI, as required by the provisions of PRM Pt. II § 115, that the cost reports claiming these amounts included claims that the FI had determined were not allowable for Medicare purposes.

226. At the time the HCA Hospitals submitted the cost reports claiming the costs identified in Ex 14. defendants knew that the amounts claimed were not allowable for Medicare purposes.

XVI. UNALLOWABLE COSTS

227. As a general rule, only the reasonable costs of those items which are reasonable and related to the care of beneficiaries are allowable for Medicare reimbursement. 42 C.F.R. §413.9; PRM Pt. I §§ 2100, 2102.2.

228. Reasonable costs include necessary and proper costs that are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. 42 C.F.R. § 413.9.

229. Costs that usually are not common or accepted occurrences in the field of the provider's activity are not considered necessary and proper costs. 42 C.F.R. § 413.9; PRM Pt. I §2102.3.

230. The PRM sets out extensive categories and specific examples of items and expenses that are deemed allowable as related to patient care and, in contrast, unallowable as not related to patient care. PRM Pt. I, ch. 21.

231. Defendants repeatedly ignored the regulations and instructions and claimed costs that were not related to patient care and which are not, therefore, deemed to be unallowable.

232. Defendants knowingly made each of the following types of false claims that claimed reimbursement for unallowable costs, among others:

A. <u>Personal Comfort Items</u>

233. Medicare will not reimburse a provider for the costs of providing items or services to patients solely for the personal comfort of the patients. 42 C.F.R. § 411.15(j), PRM Pt. I §2104.3.

234. The full costs of items or services such as telephone, television, and radio that are located in patient accommodations are not includable in allowable costs of providers under Medicare. PRM Pt. I § 2106.1.

235. Defendants violated the rules described in ¶¶ 233 - 234.

236. For example, in cost reports submitted by Los Robles Regional Medical Center ("Los Robles") for fiscal years ending 12/31/90 and 12/31/91, the hospital claimed reimbursement for patient telephone costs that defendants knew were unallowable and that had already been disallowed by FI auditors who reviewed the hospital's cost reports in prior years.

237. Reserve workpapers prepared in conjunction with Los Robles' 12/31/90 cost report specifically noted the prior year audit adjustments on patient telephones and established a reserve to repay Medicare overcharges included in that year's filed cost report totaling $11,372 for patient telephones. Similarly, for fiscal year ending 12/31/91, Los Robles created reserves totaling $7,162 associated with overcharges for patient telephones that were included in the cost report it filed that year.

238. As a result of the misrepresentations alleged in ¶¶ 236 - 237, Medicare was induced to pay Los Robles a total of $18,534 which it otherwise would not have paid but for the false representation in the cost reports.

239. Attached hereto at pages 1 through 19 of Ex.8, and incorporated by reference herein, is a listing of false claims made by defendants for unallowable personal comfort items which are reflected in reserves established by defendants.

B. Advertising Costs

240. Medicare reimburses advertising costs when such costs are reasonable, common and accepted occurrences in the field of the provider's activity and related to patient care. PRM Pt. I § 2136.

241. Advertising costs incurred in connection with the provider's public relations activities are allowable if the advertising is primarily concerned with the presentation of a good public image and directly or indirectly related to patient care. PRM Pt. I § 2136.1.

242. Advertising costs incurred for the purpose of recruiting medical, paramedical, administrative and clerical personnel are allowable if the personnel would be involved in patient care activities or in the development and maintenance of the facility. PRM Pt. I § 2136.1.

243. Medicare will not reimburse advertising costs to promote and increase patient utilization of services not properly related to the care of patients. PRM Pt. I § 2136.2.

244. Defendants violated the rules described in ¶¶ 240 - 243 .

245. As an example, in a cost report submitted by Indian Path Pavilion for the fiscal year ending 2/29/92 to the hospital claimed $120,348 in costs for "community relations" accounts that it knew were unallowable and that the cost report preparer noted had been excluded from reimbursable costs by FI auditors in prior years.

246. A reserve analysis calculated the Medicare impact of the $120,348 overcharge to be $89,540. The reserve workpaper identified four community relations accounts to be

excluded for reserve purposes, noting "since these accounts are all that have been excluded in the past by Medicare auditors, I will only exclude this amount on RSV [reserve] report." The workpaper and reserve cost report were stamped, "RESERVE DO NOT COPY."

247. As a result of the misrepresentations alleged in ¶¶ 245 - 246, Medicare was induced to pay Indian Path Pavilion an amount of at least $89,540 which it otherwise would not have paid but for the false representations of defendants.

248. Attached hereto at pages 20 through 100 of Ex. 8, and incorporated by reference herein, is a listing of false claims made by defendants for unallowable advertising and marketing costs which are reflected in reserves established by defendants with the exception of the Senior Friends costs, which are separately listed at pages 101 through 104 of Ex.8.

C. Unallowable Meals

249. Medicare reimburses providers for the costs of all meals that are provided to patients receiving care from a provider. Medicare also reimburses a portion of the cost of meals provided to hospital staff as a fringe benefit related to patient care. However, Medicare will not reimburse providers for cost of meals not related to patient care, for example, the cost of meals provided to guests of patients, to visitors to the provider, or to physicians. PRM Pt. I §§ 2102.3, 2105.2, 2145.

250. Defendants violated the rule described in ¶ 248 .

251. As an example, for fiscal year ending January 1987, Brotman Medical Center ("Brotman") submitted a cost report including claims relating to its Dietary and Cafeteria cost centers without making necessary adjustments for costs attributable to "Physician," "VIP," and "Visitor" meals that defendants knew were non-reimbursable.

252. The hospital's reserve analysis and workpapers reveal that $285,000 in claimed costs should have been removed from the filed cost report to account for such unallowable meals, and reserves were established to repay the $14,880 Medicare overcharge and the $4,142 Medi-Cal [Medicaid] overcharge that was calculated to have resulted.

253. As a result of the misrepresentations alleged in ¶¶ 251 - 252, Medicare was induced to pay Brotman $14,880 and Medi-Cal was induced to pay Brotman $4,142 which those programs otherwise would not have paid but for the false representation of defendants.

254. Attached hereto at pages 105 through 121 of Ex. 8, and incorporated by reference herein, is a listing of false claims made by defendants for unallowable meal costs which are reflected in reserves established by defendants.

D. Revenue Offsets

255. Where reimbursable cost centers also accrue revenue relating to the expenditures, a provider must reduce costs claimed for purposes of reimbursement by related income received. Examples of these types of income are 1) interest income, 2) dividends from joint ventures, 3) incidental supply sales, 4) purchase discounts, and 5) cafeteria revenue. 42 C.F.R. § 413.153; PRM Pt. I §§ 2145, 2328; HCFA 2552 cost reporting instruction forms and Worksheet A-8.

256. Defendants violated the rules described in ¶ 255.

257. For example, for fiscal year ending 12/31/89, Bayshore Medical Center claimed reimbursement for $410,961 in costs for which defendants had identified appropriate income offsets that were not included in the filed cost report.

258. Reserve workpapers and a reserve analysis prepared in conjunction with that cost report itemized the improperly omitted offsets, including $28,125 in dividend income, $26,140

in interest income, $8,726 in income generated from sales of supplies, $12,000 received as Pathology Department rent, $4,600 received as management fees, $400,902 received as Cafeteria/Nutrition income, and $4,493 received as miscellaneous revenue and calculated the $70,311 overcharge that resulted on the filed cost report. Indeed, while the filed cost report was being prepared, a review note from Mel Harris asked specifically what was being done by the cost report preparer with respect to the Pathology Department rent income: "How are we handling the Pathology Dept. lease? I don't see an offset." In response, the cost report preparer wrote, "Reserve — A-8 Revenue offset."

259. As a result of the misrepresentation alleged in ¶¶ 257 - 259, Medicare was induced to pay Bayshore Medical Center $70,311 which it otherwise would not have paid but for the false representations of defendants.

260. Attached hereto at pages 138 through 158 of Ex. 8, and incorporated by reference herein, is a listing of false claims made by defendants for unallowable revenue offsets which are reflected in reserves established by defendants.

261. Attached hereto at pages 122 through 130 and pages 159 through 250 of Ex. 8, and incorporated herein, is a listing of all other false claims made by defendants for unallowable costs which are reflected in reserves established by defendants, other than those for personal comfort items, Senior Friends, unallowable meals, idle space, and revenue offsets.

XVII. CAPITAL RELATED COSTS

262. Medicare will pay a share of certain capital-related costs. HCFA has adopted specific policies to determine whether a cost is reimbursable as a capital expense.

263. Medicare regulations and instructions define allowable capital costs to include net depreciation expense adjusted by gains and losses from the disposal of depreciable assets; taxes on land and depreciable assets used for patient care; certain lease and rental payments; the costs of betterments and improvements; the costs of certain minor equipment; insurance expense on depreciable assets; net interest expense where related to capital assets; in limited circumstances return on equity capital; reasonable capital costs of related organizations; and debt-related costs where the debt was used to acquire capital assets. 42 C.F.R. § 413.130(a); PRM Pt. I § 2806.1.

264. Specifically excluded from capital costs are, among other things, costs for repair and maintenance, certain types of interest, insurance, and taxes, and costs of certain minor equipment. 42 C.F.R. 413.130(h)(1987), recodified in 42 C.F.R. 413.130(b)(7) (2001).

265. To qualify as capital-related, a cost must not only meet the statutory and regulatory definitions but must also be supported by proper documentation demonstrating that the cost is in fact capital-related. In addition, a capital-related cost must be verifiable by the hospital's FI. 42 C.F.R. §§ 413.20(a), 413.24.

266. Capital-related costs are strictly defined for a number of reasons. Among others, during much of the period covered by this complaint, reimbursement for capital-related costs was not subjected to "PPS" reimbursement.

267. Prior to 1991, capital-related costs were directly reimbursed. Beginning with cost reporting periods beginning on or after October 1, 1991, Medicare began a transition toward PPS for capital costs. During the transition period, capital costs are paid based on complicated formulae that depend to some extent on the provider's actual costs. The transition will be complete with cost reporting periods beginning on or after October 1, 2001, at which time capital

cost reimbursement will be based solely on a federal rate. 42 C.F.R. § 412.304; PRM Pt. I §§ 2807-2807.6.

268. Operating (working capital) costs for inpatient care have been reimbursed through PPS since cost report periods beginning on or after October 1, 1983.

269. During the period relevant to this complaint, it was almost always to the financial advantage of a provider to characterize a particular expense as a capital-related cost rather than an operating cost.

270. Defendants knowingly violated the rules defining capital costs in the cost reports they and submitted to Medicare, which is evidenced by entries in the reserves that they prepared.

271. For example, in a cost report for the period ending on February 28, 1991, Portsmouth Regional Hospital claimed the costs associated with a general liability insurance policy as a capital related expense.

272. PRM Pt. I § 2806.2 states:

> Exclusions from capital-related costs include:
>
> * * * * *
>
> d. General liability insurance or any other form of insurance to provide protection other than the replacement of depreciable assets or to pay capital-related costs in the case of business interruption;

273. A reserve analysis prepared for Portsmouth estimated that the impact of the miscategorization of the insurance expense was that the hospital would receive an additional $20,214 in reimbursement.

274. As a result of Portsmouth's false claim pled in ¶¶ 271 - 273, defendants received substantial Medicare reimbursement to which they knew they were not entitled.

275. Similarly, in a cost report for the period ending on September 30, 1987, Athens Community Hospital ("Athens") classified expenses associated with certain maintenance contracts as capital-related lease costs.

276. A reserve analysis prepared by the hospital estimated that by mischaracterizing the contract, the hospital would receive an additional $10,805 in reimbursement in connection with its fiscal year end cost report.

277. As a result of Athens' false claim pled in ¶¶ 275 - 276, defendants received substantial Medicare reimbursement to which they knew they were not entitled.

278. The cost of capital assets are reimbursed during the years in which the assets are used, rather than in a lump sum at the time such assets are purchased.

279. The amount attributable to the portion of an asset's cost that is consumed during a particular accounting period constitutes the annual depreciation cost of that asset.

280. Medicare regulations prescribe which assets are subject to depreciation. Generally, buildings, building equipment, major movable equipment, land improvements and leasehold improvements constitute depreciable assets. Nonetheless, land improvements, e.g., roads and sewers, are depreciable only if the provider, rather than a governmental entity, is responsible for replacing them. PRM Pt. I § 104.7. In addition, there are other costs associated with land improvements that are not depreciable. PRM Pt. I § 104.6

281. The method of depreciation permitted generally is the straight line method, under which the cost of an asset is amortized in equal amounts in each year of the asset's useful life. Nonetheless, other methods of depreciation, including the accelerated and declining balance

methods, are allowed under certain circumstances. 42 C.F.R. § 413.134(a)(3)(ii) and (iii); PRM Pt. I § 116.

282. The estimated useful life of an asset is defined in the regulations as its "normal operating or service life to the provider."

283. Providers ordinarily must use the American Hospital Association's Useful Life Guidelines, although these can be overridden by specific useful life guidelines issued by HCFA, if any. The Internal Revenue Service Guidelines may be used for assets acquired before 1981.

284. Even though a useful life different from that specified in the above-referenced guidelines may be approved by an FI, any significant departure from published guidelines must be based on convincing reasons generally describing the realization of some unexpected event.

285. In order for depreciation to be allowed, it must be (a) identifiable and recorded in the provider's accounting records; (b) based on the historical cost of the asset; and (c) prorated over the estimated useful life of the asset using an allowable method of depreciation.

286. Defendants regularly calculated depreciation expenses based on a formula that assigned shorter lives to assets than those specified in AHA guidelines, resulting in claims to Medicare for inflated depreciation costs.

287. Reserve workpapers reveal that defendants often effectively kept two depreciation schedules, one for the as-filed Medicare cost report using incorrect shorter lives, and one for purposes of the reserve report using the appropriate lives as required by AHA guidelines. Defendants' reserve analyses then calculated the reimbursement differential between the two schedules and reserved that amount so that payment could be made in the event Medicare discovered this deception.

288. HCFA regulation requires that providers maintain sufficient financial records and statistical data for proper determination of costs payable under the program. 42 C.F.R. § 413.9. Defendants often utilized depreciation costs without supporting the estimated useful life of the assets with documentation.

289. For example, when Putnam General Hospital ("Putnam") filed its cost report for the fiscal year ending on September 30, 1990, it established a reserve in connection with its use of an improper useful life of major moveable equipment owned by the hospital.

290. At the time Putnam filed the cost report, its failure to use the correct useful life to calculate the annual depreciation expense associated with the equipment had already been the subject of an adjustment by the FI with respect to a prior year's cost report.

291. The hospital estimated that, by using the incorrect asset life, it would receive an additional $21,085 in reimbursement in connection with its cost report for the year ending September 30, 1990.

292. As a result of Putnam's false claim pled in ¶¶ 289 - 291, defendants received substantial Medicare reimbursement to which they knew they were not entitled.

293. Attached hereto at pages 251 through 376 of Ex. 8, and incorporated by reference herein, is a listing of false claims made by defendants for capital-related expenses which are reflected in reserves established by defendants.

XVIII. HOSPITAL-BASED PHYSICIAN SERVICES

294. Providers may claim costs for administrative duties performed by physicians. This time is referred to as the provider component. The provider component time includes physician time spent on teaching, administration, serving on committees, attending conferences,

supervising professional or technical personnel, and performing laboratory quality control activities. PRM Pt. I § 2108.1 (B) (2).

295. The time a physician spends which is directly related to the medical care of individual patients is referred to as the professional component. PRM Pt. I §§ 2108.1 (B) (1), 2182.1 The professional component time may not be included in the provider's cost report seeking reimbursement from Medicare Part A because these services are reimbursed by Part B. PRM Pt. I § 2182.4.

296. In order to claim reimbursement for the provider component, a provider must (1) maintain the time records or other information it used to allocate physician compensation in a form that permits the information to be verfied by the FI; (2) report the information on which the physician compensation is based to the FI and promptly notify the FI of any revisions to the compensation allocation; and (3) retain each physician compensation allocation, and the information on which it is based, for at least four years after the end of each cost reporting period to which the allocation applies. 42 C.F.R. §405.481(g).

297. Defendants often falsely claimed reimbursement for administrative hours of their physicians without having the necessary supporting documentation to attribute hours of physician time to administrative functions.

298. Defendants' reserve analyses typically indicate that defendants possessed no support for such claims and established reserves for the amounts claimed.

299. For example, in a cost report for fiscal year August 31, 1991, Northern Virginia Doctors Hospital ("Northern Virginia") claimed reimbursement for hospital based-physician fees. Reserve workpapers prepared about the time the cost report was filed indicate that the

hospital was reserving an amount to cover $14,129 of this claim because it "does not [have] any Support for Part A hours."

300. As a result of its claim for reimbursement for physician Part A hours, Northern Virginia Doctors Hospital received at least $14,129 in Medicare reimbursement to which defendants knew it was not entitled.

301. In its cost report for the fiscal year ending February 28, 1990, Indian Path Medical Center claimed reimbursement for physician professional component costs that totaled $1,303,964. These costs were for services performed for specific patients. Upon information and belief, these professional component services were also billed directly to Part B on behalf of those patients.

302. One of the workpapers that accompanied the corresponding reserve cost report for Indian Path Medical Center is entitled, "Physician Professional Component Charges." That workpaper reads, in part: "Cost report was filed with all P.C. charges included because it maximizes reimbursement. Will remove all P.C. charges for the reserve" (emphasis in original).

303. The reserve cost report duly noted the creation of a $20,468 reserve to cover the reimbursement impact of the false claim for professional component services.

304. As a result of Indian Path Medical Center's false claim seeking reimbursement in its cost report for the professional component of physician services which should have been billed to Part B, defendants received substantial Medicare reimbursement to which they knew they were not entitled.

305. Attached hereto at pages 377 through 430 of Ex. 8, and incorporated by reference herein, is a listing of false claims made by defendants for unallowable costs for hospital-based physician services which are reflected in reserves established by defendants.

XIX. IMPROPER STATISTICS

306. Overhead (indirect) costs are those costs incurred by general service cost centers that are necessary for hospital operations, but cannot directly be associated with revenue producing and unallowable cost centers. Overhead (indirect) costs include departments that usually benefit several or all areas of the hospital. Examples of indirect costs include housekeeping, laundry, operation of plant, maintenance, and dietary. PRM Pt. I § 2302.9. To the extent these overhead costs benefit Medicare patients, they are reimbursed by Medicare.

307. Overhead (indirect) costs are by definition not capable of being allocated based on actual usage, but instead must be allocated based on a statistic that estimates usage of general services by each cost center. PRM Pt. I §§ 2302.4 (B), 2307.

308. Statistical bases for allocation of indirect costs include, for example, square footage, poundage of laundry, and meals served. A provider is required to maintain adequate cost information to support payments made for services rendered to Medicare beneficiaries. Such data must be accurate and in sufficient detail to accomplish the purpose for which it is intended. 42 C.F.R. §413.24.

309. The allocation statistics for indirect costs must include statistics for areas that are not reimbursed by Medicare. These areas are called "non-reimbursable cost centers." PRM Pt. I § 2306.

310. Defendants often failed to use the correct statistical bases to allocate indirect costs.

311. Defendants often knew that they possessed the necessary statistics for non-reimbursable cost centers, but chose not to record those statistics, and used estimates based on prior years instead.

312. For example, in the cost reports filed for the fiscal years ending February 28, 1990, February 28, 1991, and February 29, 1992 by Portsmouth Regional Hospital ("Portsmouth"), improper statistical allocations were used to claim reimbursement.

313. In the filed 1990 cost report, on Worksheet B-1, Portsmouth included statistics that allocated the medical records costs among various cost centers. In contrast, the hospital's "Analysis of Medicare Reserves" allocated 100% of the medical records costs to the Adult and Pediatrics routine cost center, and reserved $13,269. The accompanying workpapers explained the reason for the reserve: "On the '88 audit, 100% of the Medical Records stats were allocated to Routine due to lack of time studies. For reserve purposes we will do the same here."

314. The following year, the hospital's filed cost report again allocated the medical records cost center statistics among various cost centers while allocating 100% of the medical records time to the routine cost center in its reserves. In the 1991 cost report, the reimbursement impact of the mis-allocation of the medical records costs was $11,283.

315. By the time the fiscal year 1992 cost report was filed, the FI had audited the hospital's 1990 cost report, and had adjusted the claimed medical records statistical allocation because the provider had no support to justify its favorable allocation. Nonetheless, in 1992,

although the hospital still had no statistical data that would allow it to do so, the filed cost report once again allocated the medical records costs across cost centers.

316. Moreover, the reserves allocated 100% of the medical records costs to the routine cost center. These reserve workpapers noted that "Medical Records costs will be allocated 100% to adult and pediatrics to be consistent with [the] FYE 1/28/90 Medicare Audit." The amount of the reserve for FY 1992 was $12,885.

317. Defendants thus knowingly and repeatedly filed claims for reimbursement for Portsmouth based on medical records statistics that they knew were invalid.

318. As a result of Portsmouth's false claims for reimbursement of medical records costs, Portsmouth received substantial Medicare reimbursement to which it was not entitled.

319. Attached hereto at pages 431 through 478 of Ex.8, and incorporated by reference herein, is a listing of false claims made by defendants for improper statistics used in filed cost reports which are reflected in reserves established by defendants.

XX. NON-REIMBURSABLE COST AREAS

320. Medicare reimburses hospitals only for reasonable costs that are related to and necessary for the care of Medicare beneficiaries. These reimbursable costs include "all necessary and proper expenses incurred in furnishing services, such as administrative costs, maintenance costs, and premium payments for employee health and pension plans. It includes both direct and indirect costs and normal standby costs." 42 C.F.R. § 413.9.

321. Because hospital have both reimbursable and non-reimbursable costs, the provider's cost report must allocate both direct and indirect, overhead costs among both the reimbursable and non-reimbursable costs areas.

322. Absent special approval from the FI, overhead costs are properly allocated to and apportioned among both reimbursable cost centers and non-reimbursable cost centers through the "step-down method" of cost allocation. 42 C.F.R. § 413.24(d)(1).

323. As a limited exception to this rule, PRM Pt. 1 § 2338 provides that where general service costs attributable to the unallowable area are inapplicable, an adjustment for the non-reimbursable costs will be reported on Worksheet A-8 of the cost report. In any case, a provider must exclude all costs associated with unallowable cost areas. Regardless of the method of removing non-reimbursable costs, the bottom line is that all direct and indirect costs are to be removed and therefore not subject to Medicare reimbursement.

324. Defendants often knowingly failed to remove the total costs attributable to nonallowable cost areas by improperly failing to exclude total costs, including indirect or overhead costs.

325. Sometimes the defendants made no attempt to remove the unallowable costs from their cost reports, when the unallowable costs should have been removed through the establishment of a non-reimbursable cost center.

326. For example, in its cost report filed for the fiscal year ending July 31, 1994, Douglas Community Hospital ("Douglas") failed to establish a non-reimbursable cost center for its outside pharmacy sales.

327. Douglas maintained a pharmacy that sold drugs to persons who were not hospital patients. As such, the direct costs associated with the outside pharmacy sales should have been included on the cost report as a non-reimbursable cost center in order that the unallowable costs of the outside pharmacy would pick up its proper share of indirect costs.

328. The hospital's working trial balance showed that the reimbursable Outpatient Pharmacy Account included $110,963 in costs attributable to these non-reimbursable outside pharmacy sales, and this entire amount was claimed on the filed cost report as reimbursable pharmacy costs.

329. Douglas' reserve workpapers show knowledge that this was improper. Notes on the reserve workpapers indicate that, although the initial reserve cost report reclassified only $58,294 of this amount from the reimbursable account to a non-reimbursable account, as the result of an internal reserve cost report review an adjustment was made to move the entire balance to a non-reimbursable cost center.

330. The reserve cost report thus correctly accounts for all of the non-reimbursable effects of including the outside pharmacy sales costs by establishing a non-reimbursable cost center for the outside pharmacy sales. The reserve created for this correction was $28,692.

331. As a result of Douglas' false claim for reimbursement of non-reimbursable outside pharmacy costs, Douglas received substantial Medicare reimbursement to which it was not entitled.

332. More frequently, defendants did not set up non-reimbursable cost centers when they should have but, instead, removed only the direct costs through Worksheet A-8 adjustments. When defendants did this, their use of A-8 adjustments to expenses to remove unallowable costs improperly avoided allocation of overhead costs to non-reimbursable cost centers. This resulted in the inflation of overhead costs allocated to reimbursable cost centers, thus increasing defendants' Medicare reimbursement.

333. Defendants routinely established non-reimbursable cost centers in their reserve cost reports and reserve workpapers, thus demonstrating that they knew which cost centers should be set up as non-reimbursable and the extent to which any Worksheet A-8 adjustment that had been made failed to exclude total non-reimbursable costs.

334. Areas in which defendants knowingly failed to set up non-reimbursable cost centers include, but are not limited to: medical office buildings owned by the hospital where physicians have their private offices, physicians' services, fitness and sports medicine centers, dietary and cafeteria, catering, and public relations and marketing.

335. For example, for the fiscal year ending August 31, 1992, Terre Haute Regional Hospital ("Terre Haute") failed to include the hospital's medical office building ("MOB") as a non-reimbursable cost center.

336. Instead, according to the reserve workpaper, on the filed cost report, the hospital sought to remove the direct MOB costs only through an A-8 adjustment.

337. The reserve workpaper notes that the reserve was to "Set-up MOB as unallowable cost center as per 1990 audit." The reserve papers calculate the cost to Medicare of the failure to properly remove the total MOB costs at $28,124.

338. On audit, the FI discovered that the hospital improperly sought to claim MOB indirect costs and made an adjustment "To eliminate the MOB cost offsets and to set up square feet to ensure proper step down of costs in accordance with HCFA Pub. 15-1, Section 2304."

339. As a result of Terre Haute's false claim Medicare paid Terre Haute $28,124 (on an interim basis) to which the hospital was not entitled.

340. Attached hereto at pages 479 through 560 of Ex. 8, and incorporated by reference herein, is a listing of false claims made by defendants for MOB and other non-reimbursable cost center costs which are reflected in reserves established by defendants.

XXI. MANIPULATION OF COST CENTERS

341. A guiding principle of Medicare cost report reimbursement is that allowable costs of a provider shall be apportioned between program beneficiaries and other patients so that the share borne by the Medicare program is based upon actual services received by program beneficiaries. 42 C.F.R. § 413.53(a).

342. Application of this principle requires recognition that Medicare beneficiaries are not a cross section of the total population and that they will not constitute a cross section of all patients receiving services for most providers participating in the Medicare program. Thus, to achieve the objective of ensuring that Medicare bears only its fair share of costs attributable to providing care for program beneficiaries, methods of cost allocation used by providers in preparing cost reports must take into account differences in the amount of services received by patients who are program beneficiaries and other patients served by the provider. 42 C.F.R. §413.50(c).

343. To accurately determine what portion of costs attributable to different kinds of medical services are fairly attributable to Medicare patients, providers are required to separately account for costs accrued and Medicare usage relating to different "cost centers." A cost center is defined as "[a]n organizational unit, generally a department or its subunit, having a common functional purpose for which direct and indirect costs are accumulated, allocated and apportioned. In addition, those natural expense classifications (e.g., depreciation) and

unallowable cost centers (e.g., research) specifically required by the instructions to be shown on the cost report fall under this definition." PRM Pt. I § 2302.8.

344. While, for cost-finding purposes, a provider may elect to use its unique cost centers in lieu of the recommended cost centers on the cost reporting forms, certain requirements must be met. These include, among others, the requirement that each cost center to be established must be separately identified in the provider's accounting system with any direct costs recorded on a regular ongoing basis throughout the accounting period, not only at the end of the fiscal year. It also must be demonstrated to the FI that the provider's use of its unique cost centers will result in a more accurate cost finding. PRM Pt. I § 2313.1.

345. As with all cost finding for Medicare purposes, cost finding associated with any particular cost center used on a Medicare cost report must be based on adequate cost data, based on the provider's financial and statistical records which must be capable of verification by qualified auditors. Costs and revenues, moreover, must be attributed to the cost centers to which they properly belong. 42 C.F.R. §§ 413.20, 413.24; PRM Pt. I § 2302.8.

346. If a provider has properly identified and accounted for a cost center, that cost center must be reported separately on the cost report. If a provider does not have adequate cost data – based on its financial and statistical records maintained on a regular ongoing basis throughout the accounting period – to separate a routine cost center into parts that will result in a more accurate cost finding with respect to Medicare utilization and its fair share of reimbursement, no such separation should occur for cost reporting purposes.

347. It is not appropriate to combine or separate cost centers for the sole or primary purpose of increasing Medicare reimbursement, especially if doing so renders cost findings less

accurate and verifiable and/or if doing so undermines the accuracy of the allocation of costs to the Medicare program for services actually provided to Medicare beneficiaries.

348. Defendants frequently knowingly manipulated cost centers in order to increase Medicare reimbursement improperly.

349. For example, in a cost report submitted by Knollwood Park Medical Center ("Knollwood Park") for fiscal year ending 9/30/89 the hospital combined its Sleep Lab cost center with Respiratory Therapy, and its Psychology cost center with Occupational Therapy on its cost report solely because Sleep Lab and Psychology had no Medicare utilization and creating the new combined cost centers thus increased the hospital's Medicare reimbursement.

350. Review notes written as the filed cost report for Knollwood Park was being drafted asked, "Could Psychology and Sleep Lab be combined with [a]ny other cost center for filed purposes? They have NO Medicare utilization." (Emphasis in original.) In response, the cost report preparer wrote, "Combined Psych. with Occ. Therapy and Sleep Lab with Resp. Therapy, which includes EEG."

351. For reserve purposes, the cost report preparer then created a reserve analysis entry to "Separate Psychology from O/T and Sleep Lab from Resp. Therapy," and a reserve summary calculated the Medicare overpayment to be $117,241.

352. As a result of the misrepresentations alleged in ¶¶ 349 - 351, Medicare paid Knollwood Park $117,241 to which it was not entitled.

353. Several other examples of improper manipulation of cost centers to increase Medicare reimbursement appear in the cost report submitted by Spring Branch Medical Center ("Spring Branch") for fiscal year ending 4/30/91. In preparing that cost report, the preparer ran a

series of test runs on the Medicare effect of combining and separating various real and potential cost centers on the cost report and then chose whichever test result created higher Medicare reimbursement without consideration of which result more accurately reflected the true cost of treating Medicare beneficiaries.

354. Because such an approach increased Medicare reimbursement for the hospital, the preparer created a separate cost center for Lithotripsy on the cost report notwithstanding the fact that such an approach was inconsistent with results of the hospital's 1989 audit requiring that Lithotripsy be included in the Operating Room cost center. A reserve analysis noted with respect to this charge that, for reserve purposes, the preparer would "combine Litho into OR as shown on '89 ACR [audited cost report]."

355. Where their test runs showed Medicare reimbursement would be increased by combining properly separated cost centers, defendants created combined cost centers for purposes of the cost report and reserved for overcharges that resulted. On the Spring Branch 1991 cost report, defendants thus (a) combined the Day Surgery cost center into its Operating Room cost center; (b) combined the hospital's JL Fitness department cost center into its Physical Therapy cost center; (c) combined the hospital's MRI and CT scan cost centers; (d) combined the hospital's Psychiatric Therapy cost center with its Adults & Pediatrics cost center; (e) combined the hospital's Rader Ancillary cost center with its Physical Therapy cost center; and (f) combined the hospital's Special Lab cost center with its Lab cost center.

356. As a result of the misrepresentations alleged in ¶¶ 353 - 355, Medicare paid Spring Branch a total of $157,418 to which it was not entitled.

357. Attached hereto at pages 561 through 637 of Ex.8, and incorporated by reference herein, is a listing of false claims made by defendants for costs derived from the improper manipulation of cost centers which are reflected in reserves established by defendants.

XXII. DISPROPORTIONATE SHARE PAYMENTS

358. Around May 1, 1986, Medicare began making additional payments for inpatient operating costs to hospitals that serve a disproportionate share of low-income patients. 42 C.F.R. § 412.90(h). These payments are commonly referred to as "DSH" payments.

359. The factors to be considered in determining whether a hospital qualifies for DSH payments include the number of beds in the hospital, the number of patient days attributable to areas of the hospital subject to PPS, and whether the hospital is located in a urban or rural area. The amount of any DSH payment equals the federal portion of the DRG payment and outlier payments (but excluding any additional payments for the costs of indirect medical education) multiplied by an adjustment percentage, which is calculated differently for operating and capital costs. 42 C.F.R. §§ 412.106, 412.312, 412.320; PRM Pt. I § 2807.2(B)(5); Medicare Intermediary Manual §§ 3610.15.

360. Defendants knowingly falsified DSH claims by misrepresenting hospitals' eligibility and by miscalculating proper reimbursement.

361. Some DSH reserves related to manipulation of statistics relating to the bed count, which determines whether the hospital qualifies for DSH payments at all.

362. For example, in the cost report filed for fiscal year ending 9/30/92 by Community Hospital of DeQueen ("DeQueen"), although the hospital no longer qualified for DSH because the hospital had been reclassified from a "rural" to an "urban" hospital and did not meet the

greater-than-100-bed DSH requirement for urban hospitals, the hospital claimed Medicare reimbursement for DSH.

363. A reserve workpaper for DeQueen for 1992 noted: "Hospital was Geograph Reclassed 10/1/91 to urban. Determine (sic) made by intermediary to pay DSH based on assumption of >100 beds. Due to fact that hospital does not have >100 bed days available propose to reserve 100% of DSH." In the reserve summary, the amount of the overcharge was calculated to be the total $310,088 DSH payment claimed since the hospital did not qualify for DSH.

364. The FI adjusted only $27,392 of the overpayment.

365. As a result of the misrepresentations alleged in ¶¶ 362 - 364, Medicare paid to DeQueen substantial DSH payments to which it was not entitled.

366. Where mistakes regarding DSH reimbursement were made or discovered after the cost report was filed, defendants remained silent or concealed the overpayments notwithstanding their knowledge of the overpayments and their duty to disclose them.

367. For example, in a cost report submitted by Southside Community Hospital ("Southside") for fiscal year ending 12/31/91, 2,283 Medicaid psychiatric patient days were misreported as acute patient days, with the result that the hospital was paid $650,618 more than was warranted.

368. While the initial overpayment may have been claimed by mistake, any such mistake was recognized before the NPR was issued by Southside's FI in September 1993, and yet was not disclosed. A reserve summary created in early 1993 created a $650,618 Medicare reserve for DSH with the explanation, "RECALC DSH USING UPDATED MCAID DAYS."

369. Another reserve summary, apparently created prior to 1993, created a $506,394 reserve labeled "Recalculate DSH using updated Medicaid Days."

370. On September 20, 1993, shortly after the hospital's Medicare audit adjustments for 1991 had been completed, Bonnie Reid of Columbia's Reimbursement Department wrote a memo to John Gilbert noting that the hospital had a "pickup" of $544,401 more Medicare dollars after the FI's audit than had been expected. She explained, "[T]he primary cause of the pickup is the DSH reserve. Medicaid 1990 utilization of 11.78% was used. The days actually paid represents 33.16%. I allocated the days between Psych (excluded from DSH) and Acute based on the filed report. If the filed report is misstated, i.e. Medicaid Psych days understated, you may want to book an additional reserve. I can assist you with this if you deem it is necessary." (Parenthetical in original.) Attached to that memoranda was a comparison of audit results to "Booked" results that demonstrated that no adjustment had been made to DSH where a $650,618 downward adjustment previously had been reserved.

371. Despite defendants' knowledge both before and after the hospital's NPR for fiscal 1991 was issued in September 1993 that reported Medicaid days needed to be adjusted to properly state the hospital's entitlement to DSH reimbursement, no disclosure of that fact was made to Medicare until January 31, 2000, over a year after the United States intervened in this lawsuit. At this time, a letter was sent by Norman R. Belcher, HCA's Director of Operations, to Paul Hula of Mutual of Omaha (the hospital's FI) noting that "we have identified an issue related to the patient days used in" calculating DSH payments in Southside's 1991 cost report. Even then, HCA's letter did not disclose that it was aware of the overcharge for well over six years:

> Part of Columbia/HCA's ongoing responsibility is to constantly monitor the billing, accounting, and cost reporting processes in place throughout the company. . . . As a result of our retroactive review of cost reports we have identified a patient days error in [Southside 1991 cost report] for which the days error resulted in an apparent overpayment to the provider.

372. The letter further stated that, because of this "error," defendants had "reason to believe the hospital may have been overpaid on Medicare DSH reimbursement by approximately $452,000." The letter does not reveal that HCA's most recent reserve calculations showed that the total overcharge to Medicare was $650,618.

373. The FI missed the overpayment on audit and issued an NPR in September 1993 that did not correct for the ovepayment.

374. As a result of the misrepresentations and concealment alleged in ¶¶ 367 - 373, Medicare was induced to pay Southside substantial DSH payments which it otherwise would not have paid but for the false representations and fraudulent concealment of defendants.

375. Attached hereto at pages 638 through 639 of Ex. 8, and incorporated by reference herein, is a listing of false claims made by defendants for DSH payments which are reflected in reserves established by defendants.

XXIII. RELATED PARTIES

376. Medicare reimbursement rules require that reimbursement for services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control, be limited to the cost incurred by the related organization in providing the services, facilities, and supplies. 42 C.F.R. § 413.17.

377. As used in Medicare regulations, "related to the provider" means that the provider, to a significant extent, is associated or affiliated with or has control of or is controlled by the organization furnishing the services, facilities, or supplies.

378. Common ownership exists if an individual or individuals possess significant ownership or equity in the provider and the institution or organization serving the provider.

379. Control exists if an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution. PRM Pt. I § 1002.3.

380. Providers seeking Medicare reimbursement are required to identify for Medicare all related organizations from which they receive services, facilities, or supplies.

381. Upon information and belief, defendants failed to make such disclosure and instead sought reimbursement from Medicare for amounts over and above the costs incurred by such related parties supplying services, facilities, or supplies to the defendants.

382. For example, Clearwater Community Hospital ("Clearwater"), for the fiscal year ending September 30, 1995, sought reimbursement from Medicare for costs it incurred in paying a skilled nursing management fee to Cornerstone Health Management ("Cornerstone").

383. Epic owned Clearwater for several years prior to Epic's merger with HTI in May, 1994. HTI owned Clearwater from 1994 to its acquisition by HCA in April, 1995. HCA owned Clearwater from April, 1995 until the hospital closed.

384. Cornerstone was on or about on September 30, 1995, 80% owned and operated by HCA through its wholly owned subsidiary HTI by virtue of its merger with Epic.

385. Defendants' knowledge that Cornerstone was a related party to the defendant Clearwater is evidenced by a request for an exception to the related party requirements, filed by defendants with the FI for Clearwater, Blue Cross Blue Shield of Florida, on January 8,1993, in which they disclose that Epic owned 80% of Cornerstone.

386. That request for an exception to the related party rule was denied by the FI on May 5, 1994.

387. Nevertheless, in a cost report filed with Medicare for the fiscal year ending September 30, 1995, defendants expressly indicated that all costs of related organizations contained on that report were reduced to the cost of the related organization.

388. In this same cost report, defendants failed to make the required disclosure on the appropriate space on Worksheet A-8 of the cost report that Cornerstone was a related organization.

389. In fact, Cornerstone's entire management fee for skilled nursing, in the amount of $339,938, was included on this cost report and was not reduced to Cornerstone's cost for rendering that management service.

390. In internal reserve workpapers, the defendants estimate that the allowable cost of this management fee was only 50% of the amount charged to Medicare, and reserved the excess of $169,969 in the event the Medicare program discovered it had been overcharged.

391. As a result of the false claim in Clearwater's 1995 cost report for the related party Cornerstone management fee that was not reduced to cost, Medicare was induced to pay Clearwater substantial Medicare reimbursement to which Clearwater was not entitled.

392. Attached hereto at pages 640 through 642 and pages 229 through 237 of Ex.8, and incorporated by reference herein, is a listing of false claims made by defendants for related party costs which are reflected in reserves established by defendants.

XXIV. COST AND CHARGE RECLASSIFICATION AND CHARGE DISCREPANCIES

393. Two fundamental objectives of the Medicare program are that the cost of providing services to Medicare beneficiaries not be borne by non-beneficiaries and, conversely, that the cost of services provided to non-beneficiaries not be borne by the Medicare program. 42 C.F.R. § 413.50 (b).

394. In order to apportion costs between the Medicare program and non-Medicare patients, a hospital may use the charges reflecting itemized services actually rendered as a basis for allocating costs between the categories of patients who received the provider's services. 42 C.F.R. § 413.50 (h); PRM Pt. I § 2203.

395. A hospital must report both charges and costs in accord with the particular department in which they were incurred. 42 C.F.R. § 413.53; PRM Pt. I §§ 2200.1, 2202.9, 2203.

396. A provider using charges as a measure of Medicare's responsibility for costs must have a charge structure that is uniform for Medicare beneficiaries and other paying patients and for inpatients and outpatients. PRM Pt. I § 2202.4.

397. In order to determine Medicare's share of the costs incurred by a department at a hospital, the ratio of charges for ancillary services provided to Medicare beneficiaries to total patient charges is calculated and that ratio is then applied to the costs of the department where the charges were incurred. 42 C.F.R. § 413.53; PRM Pt. I § 2200.1.

398. The charges used to develop an apportionment ratio must be recorded at gross value, that is, at the provider's regular charge before any allowance, discount, or deduction. PRM Pt. I § 2202.4.

399. Defendants violated the rules described in ¶¶ 393 - 398.

400. For example, in a cost report for the period ending December 31, 1989, Centennial Medical Center used charges that included discounts at the hospital's Same Day Surgery thereby understating the amount of total charges at thirteen ancillary cost centers at the hospital. The effect of defendants' knowing failure to record charges in the manner required by the cost report instructions was to increase the ratio of beneficiary charges to total inpatient charges for the thirteen cost centers.

401. By increasing the ratio of beneficiary charges to total inpatient charges for the thirteen cost centers, Centennial Medical Center received $54,560 in Medicare reimbursement to which it was not entitled.

402. In Ex. 8, the false claim by Centennial Medical Center described above and other similar occurrences in which the HCA Hospitals violated the regulations and instructions relating to the proper reporting of hospital charges are included in the category "Charge Discrepancy."

403. In the cost report for the fiscal year ending August 31, 1992 filed by Encino Hospital, the hospital under-recorded total patient charges at its emergency department and, by so doing, increased the ratio of Medicare charges to total charges in that department.

404. Encino Hospital under-recorded total patient charges at its emergency department for the fiscal year ending August 31, 1992 despite the fact that it was on notice from its FI adjustment of this issue in a prior year of the proper way to record these charges.

405. The effect of this mis-recording of Encino Hospital's ratio of cost to charges for its emergency department was that the hospital received an additional $47,842 in Medicare reimbursement to which it was not entitled.

406. In Ex. 8, the false claim by Encino Hospital described above and other similar occurrences in which the HCA Hospitals violated the regulations and instructions relating to the proper reporting of hospital charges are included in the category "Charge Reclassification."

407. In the cost report for fiscal year ending July 31, 1988 filed by Medical Plaza Hospital, the hospital mis-assigned costs incurred in connection with certified registered nurse anesthetists to a physical therapy department rather than to anesthesiology, which was the appropriate cost center.

408. By failing to assign the expenses to the appropriate cost center, Medical Plaza Hospital received $35,125 in Medicare reimbursement to which it was not entitled.

409. In Ex. 8, the false claim by Medical Plaza Hospital described above and other similar occurrences in which the HCA Hospitals violated the regulations and instructions relating to the proper reporting of hospital charges are included in the category "Cost Reclassification."

410. Attached hereto at pages 643 through 701 of Ex. 8, and incorporated by reference herein, is a listing of false claims made by defendants for cost reclassification, costs discrepancy and charge discrepancy which are reflected in reserves established by defendants.

XXV. FALSE STATEMENTS IN HOME OFFICE COST STATEMENTS

411. HCA, HTI, the original HCA, Epic and BAMI each conducted business for Medicare and Medicaid purposes as chain organizations that consisted of groups of two or more health care facilities which were owned and controlled by one organization. For Medicare and Medicaid purposes, the various facilities included within each chain organization were controlled through the chain's home office. PRM Pt. I § 2150, PRM Pt. II § 1000.

412. Medicare rules provide that the home office of a chain is not in itself certified by Medicare, and its costs may not be directly reimbursed by Medicare. PRM Pt. I § 2150, PRM Pt. II § 1000.

413. Rather, the home office is treated as a related organization to the participating providers. 42 C.F.R. § 413.17; PRM Pt. I § 2150, PRM Pt. II § 1000. To the extent the home office furnishes services related to patient care to a provider, the reasonable costs of such services are reimbursable as part of the provider's costs. 42 C.F.R. §§ 413.9, 413.17; PRM Pt. I § 2150, PRM Pt. II § 1000.

414. Allowable costs incurred by the home office may be included in the provider's cost report, which is submitted for reimbursement to the FI for that provider. PRM Pt. I § 2150, PRM Pt. II § 1000.

415. HCFA requires home offices to submit annually a form HCFA-287, entitled the "Home Office Cost Statement," to the FI for the home office, in which the home office reports

specific financial and statistical data relating to the home office's costs. The home office statement forms the basis for a determination by Medicare as to whether a home office's costs are allowable for purposes of the Medicare program and whether these costs are reimbursable to the provider components of the chain organization. PRM Pt. I § 2153, PRM Pt. II §§ 1011, 3111.

416. At all times relevant to this complaint, every home office cost statement has contained a "certification" which must be signed by an officer or director of the home office. PRM Pt. II §§ 1014(B), 3114.2. At all times, the certification provision in the home office cost statement required the responsible home office official to certify, in pertinent part:

> To the best of my knowledge and belief, [the cost statements] are true and correct statements prepared from the books and records of the Home Office in accordance with applicable instructions, except as noted (attach statement with exceptions if necessary).

417. At all times relevant to this complaint, BAMI, the original HTI, and HCA submitted home office cost statements to their FIs containing the above certification.

A. <u>The Original HCA/HealthTrust Reorganization</u>

418. In May 1987, the original HCA's Chairman and Chief Executive Officer Thomas Frist announced a corporate reorganization to strengthen its financial position and operating performance.

419. In accordance with the reorganization plan, the original HCA spun off one-hundred and four (104), mostly rural, acute care hospitals, referred to as the "Class B hospitals," in September 1987 to HTI. HTI purchased the Class B hospitals pursuant to the financing arrangements detailed below in ¶¶ 429 - 434.

420. In accordance with the reorganization plan, HTI formed an Employee Stock Ownership Plan ("ESOP") in September 1987. An ESOP is a pension type employee

contribution plan, designed to invest in employer securities. The ESOP purchased most of the stock of HTI pursuant to the financing arrangements detailed below in ¶¶ 462 - 464.

421. The spin-off of the Class B hospitals and the acquisition of the HTI stock by the ESOP did not involve the arms-length sale of any interest or assets to a bona fide third party and constituted a corporate reorganization for purposes of the Medicare program. PRM Pt. I §2134.10. The parties to the transaction were related parties for purposes of the Medicare program. 42 C.F.R. § 413.17.

1. HealthTrust Interest

422. The home offices of the original HCA and HTI engaged in the practice of borrowing funds for the benefit of and/or use by the hospital providers within the chain.

423. The home offices of the original HCA and HTI further engaged in the practice of allocating the interest expenses incurred by the home office to the hospital providers within the chain, which claimed the interest expenses on their provider cost reports.

424. Medicare rules provide that if the home office borrows funds from sources unrelated to the chain organization, the interest expense incurred on such loans is allowable to a provider member of the chain for Medicare purposes to the extent that the provider uses the loan proceeds either to acquire assets for use in patient care activities or to provide funds for operations related to patient care. 42 C.F.R. § 413.9(a); PRM Pt. II §§ 1002 (D), 3102(D).

425. All payments to providers must be based on the reasonable cost of services covered under Medicare and related to the care of beneficiaries. Reasonable cost includes all necessary and proper costs incurred in furnishing the services to program beneficiaries.

Necessary and proper costs are costs that are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. 42 C.F.R. §§ 413.9(a) and (b).

426. Reorganization costs are not allowable for Medicare purposes. PRM Pt. I § 2134.10; PRM Pt. II §§ 1002(B), 3102(A) and (B)(1).

427. Interest on loans taken out by the home office for purposes of a corporate reorganization is not allowable for Medicare purposes and may not be claimed on a provider's cost report. 42 C.F.R. § 413.9(a); PRM Pt. I § 2134.10; PRM Pt. II §§ 1002 (B) and (D), 3102 (A), (B)(1) and (D).

428. Interest on loans taken out by the home office to refinance loans taken out for purposes of a corporate reorganization is also not allowable for Medicare purposes and may not be claimed on a provider's cost report to the extent that the amount of interest paid on the refinancing exceeds the amount that would have been paid had the corporate reorganization not occurred. Id.; PRM Pt. I § 233.4.

429. In accordance with the reorganization plan alleged above in ¶¶ 418 - 421, the original HCA did not transfer the Class B hospitals directly to HTI. Instead, the original HCA first transferred the Class B hospitals to another subsidiary known as HCA Investments, Inc. ("HCAII").

430. At the time of the reorganization, the original HCA owed debt on funds it had borrowed for the benefit of and/or use by the Class B hospitals. The original HCA had allocated this debt to the Class B hospitals, who claimed the interest on this debt on the provider cost reports they submitted to the FIs. In accordance with the reorganization plan, HCAII refinanced most of this preexisting debt, referred to as the "Existing Debt," through Bridge Loans, obtained

from lenders unrelated to defendants, totaling $526 million at variable interest rates. The interest rates on the Existing Debt varied from hospital to hospital but were typically lower than the interest rates on the Bridge Loans.

431. In accordance with the reorganization plan, immediately after acquiring the Class B hospitals from the original HCA, HCAII transferred these hospitals to HTI. HTI assumed HCAII's Bridge Loans.

432. In June 1988, HTI refinanced the Bridge Loans with fixed rate loans ("the Fixed Rates Loans") at interest rates that were higher than the variable rate Bridge Loans and were also typically higher than the interest rates on the Existing Debt the original HCA had carried on the Class B hospitals.

433. In December 1991, HTI refinanced the Fixed Rate Loans taken out in 1988 to replace the Bridge Loans.

434. The December 1991 refinancing of the Fixed Rate Loans ("1991 Refinancing") was at interest rates that were lower than interest rates on the Fixed Rate Loans but higher than the interest rates on many of the Existing Debt loans the original HCA had carried on the Class B hospitals prior to the corporate reorganization.

435. The Bridge Loans, the Fixed Rates Loans, and the 1991 Refinancing were not necessary and proper costs related to the care of Medicare beneficiaries and were necessitated by, and borrowed for the purpose of effectuating, a corporate reorganization. The interest HTI paid on the Bridge Loans, the Fixed Rate Loans, and the 1991 Refinancing was therefore not allowable for Medicare purposes to the extent that it exceeded the amount of interest that the original HCA would have paid on the Existing Debt had this debt not been refinanced pursuant

to the corporate reorganization plan. 42 C.F.R. § 413.9; PRM Pt. I § 2134.10; PRM Pt. II §§1002(B), 3102(B)(1).

436. HTI allocated the full amount of the interest it paid on the Bridge Loans, the Fixed Rate Loans, and the 1991 Refinancing to the Class B hospitals that comprised the HTI chain. The Class B hospital providers in turn claimed that portion of the interest allocated to each of them by HTI's home office on the provider cost reports they submitted to their respective FIs for cost reporting periods commencing September 1987 through April 1994.

437. Pursuant to directions from individuals in HTI's Reimbursement Department, including Director of Reimbursement Tom Johnson, Reimbursement Manager Richard Parker, and Reimbursement Coordinator (and later Manager) Mel Harris ("the Reimbursement Department"), HTI and the Class B hospitals in the HTI chain calculated the amount by which the interest paid on the Bridge Loans, the Fixed Rate Loans, and the 1991 Refinancing exceeded the amount that would have been paid on the Existing Debt carried by the original HCA. HTI and the Class B providers further calculated the amount of additional Medicare reimbursement they received as a result of claiming the excess amount of the interest paid on the Bridge Loans, the Fixed Rate Loans, and the 1991 Refinancing on the provider's cost reports for each year that such interest was claimed.

438. HTI's Reimbursement Department prepared a pre-printed template captioned "CONFIDENTIAL" that it used to record, among other things, the reimbursement effect of claiming the "HTI Interest Expense exceeding the original HCA's" on the providers' cost reports.

439. The HTI Reimbursement Department prepared reserve cost reports for the Class B providers that reflected the amounts of interest claimed for the Bridge Loans, the Fixed Rate Loans, and the 1991 Refinancing that exceeded the amounts that would have been paid on the Existing Debt owed by the original HCA and the corresponding reimbursement effect of claiming such interest on the cost reports actually filed with Medicare.

440. Pursuant to directions from the Reimbursement Department, HTI and the Class B providers set aside and retained reserves to cover the amounts they would owe to the Medicare program in the event that the FIs disallowed the amount of interest paid on the Bridge Loans, the Fixed Rates Loans, and the 1991 Refinancing in excess of the interest that would have been paid had the Existing Debt owed by the original HCA on the Class B hospitals not been refinanced pursuant to the corporate reorganization plan.

441. At the time the HTI hospitals submitted cost reports claiming interest on the Bridge Loans, the Fixed Rate Loans, and the 1991 Refinancing, HTI knew that these loans had been occasioned by a corporate reorganization between related parties and that the interest on these loans was not allowable for Medicare purposes to the extent that it exceeded the amount of the interest on the Existing Debt that the original HCA had carried.

442. Following the acquisition of HTI by HCA in April 1994, HTI's Reimbursement Department was consolidated with the Reimbursement Department of HCA and Tom Johnson became the Director of Reimbursement of HCA, and Richard Parker his top deputy. The home office of HCA continued HTI's practice of allocating the entire amount of the interest the home office paid on the 1991 Refinancing to the Class B providers HCA acquired from HTI. The Class B providers also continued the practice of claiming that portion of the interest allocated to

each of them by HCA's home office on the provider cost reports they submitted to their respective FIs for cost reporting periods commencing April 1994.

443. HCA and the Class B providers further continued HTI's practice of calculating the amount by which the interest paid on the 1991 Refinancing exceeded the amount that would have been paid on the Existing Debt carried by the original HCA prior to the corporate reorganization. HCA and the Class B providers also continued HTI's practice of calculating the amount of additional Medicare reimbursement they claimed on their providers' cost reports based on the amount of interest paid on the 1991 Refinancing in excess of the amount that would have been paid on the Existing Debt.

444. HCA and the Class B providers further continued HTI's practice of setting aside and retaining reserves to cover the amounts they would owe to the Medicare program in the event that the FIs disallowed the amount of interest paid on the 1991 Refinancing in excess of the interest that would have been paid had the Existing Debt owed by the original HCA on the Class B hospitals not been refinanced pursuant to the corporate reorganization plan.

445. At the time HCA and the Class B providers submitted cost reports claiming interest on the 1991 Refinancing, HCA knew that the loans had been occasioned by a corporate reorganization between related parties and that the interest on these loans was not allowable for Medicare purposes.

446. HCA and the Class B providers also retained the Medicare funds HTI had received and retained the reserves HTI had previously set aside to cover the amounts it would have owed to the Medicare program in the event that the FIs disallowed the amount of interest

HTI paid on the Bridge Loans, the Fixed Rate Loans, and the 1991 Refinancing in excess of the interest that would have been paid had the Existing Debt not been refinanced.

447. HCA did not release into income the reserves set aside and retained by it and HTI to cover the amounts they would have owed to the Medicare program in the event that the FIs disallowed the excess interest payments until the 3-year expiration of the limitation period set forth in 42 C.F.R. § 405.1885(b) for HCFA to notify FIs to reopen and revise their decisions.

448. At all times while HCA retained the Medicare funds and the reserves that HTI had previously set aside to cover its liability to Medicare as alleged in ¶ 440 above, HCA knew that the amount of interest HTI had paid on the Bridge Loans, the Fixed Rate Loans, and the 1991 Refinancing was not allowable for Medicare purposes to the extent that it exceeded the interest that would have been paid had the Existing Debt not been refinanced pursuant to the corporate reorganization.

449. Attached hereto at Ex. 9 is a list of false claims for instances where Class B providers claimed the excess interest expense allocated to them by the home offices of HTI and HCA for the Bridge Loans, Fixed Rate Loans, and 1991 Refinancing, together with the corresponding reserves defendants set aside made in the event that the FIs disallowed the interest claimed in excess of the original HCA interest.

2. HealthTrust Loss on Refinancing

450. HTI paid certain fees and other costs associated with obtaining the Fixed Rate Loans that refinanced the Bridge Loans in 1988.

451. The home office of HTI engaged in the practice of allocating financing costs incurred by the home office on financing secured for the benefit of and/or use by the hospital providers within the HTI chain.

452. Medicare rules provide that if the home office secures financing from sources unrelated to the chain organization, costs paid to obtain the financing are allowable to a provider member of the chain for Medicare purposes if the provider uses the loan proceeds either to acquire assets for use in patient care activities or to provide funds for operations related to patient care. 42 C.F.R. § 413.17; PRM Pt. I § 212. Such financing costs must be amortized over the life of the financing. PRM Pt. I § 212.

453. Costs paid by the home office to obtain financing for a corporate reorganization are not allowable for Medicare purposes. PRM Pt. I § 2134.10; PRM Pt. II §§ 3102(A) and (B).

454. Medicare rules further provide that the financing costs incurred to obtain allowable debt that is subsequently refinanced remain allowable costs and may be claimed on the provider's cost reports following the refinancing. PRM Pt. I § 233.3 (C). When claimed under these circumstances, such costs are sometimes referred to as "loss on refinancing."

455. Costs paid by the home office to secure financing obtained to refinance loans that were necessitated by a corporate reorganization are not allowable for Medicare purposes and may not be claimed on a provider's cost report. 42 C.F.R. § 413.9(a); PRM Pt. I § 2134.10; PRM Pt. II §§ 1002 (A), 3102 (A) and (B).

456. The costs paid by HTI to obtain the Fixed Rate Loans were not necessary and proper costs related to the care of Medicare beneficiaries and were incurred as a result of a corporate reorganization. These costs were therefore not allowable for Medicare reimbursement.

457. Following the 1991 Refinancing, HTI allocated to the Class B providers the costs that had been paid to obtain the Fixed Rate Loans, and the Class B providers claimed these costs on their cost reports for periods following December 1991.

458. Following the 1991 Refinancing, HTI and the Class B providers calculated the amount of additional Medicare reimbursement they would receive as a result of claiming the costs incurred to obtain the Fixed Rate Loans.

459. HTI and the Class B providers set aside and retained reserves to cover the amounts they would owe to Medicare in the event that the FIs disallowed the costs paid to obtained the Fixed Rate Loans.

460. At the time the HTI hospitals submitted cost reports claiming the costs incurred to obtain the Fixed Rate Loans, HTI knew that these costs had been occasioned by a corporate reorganization between related parties and that the costs incurred to obtain the Fixed Rate Loans were not allowable for Medicare purposes.

461. Attached hereto at Ex. 10 is a list of false claims for instances where the Class B providers claimed the loss on refinancing allocated to them by the home office of HTI following the 1991 Refinancing, together with the corresponding amounts the providers reserved in the event that those claims were disallowed.

3. HealthTrust ESOP

462. In accordance with the reorganization plan described in ¶¶ 418 - 421 above, HTI also borrowed $810 million from lenders unrelated to defendants. HTI in turn loaned these funds to the ESOP it formed in 1987 under the same terms as HTI's loan from unrelated lenders. The ESOP used the $810 million to purchase most of HTI's stock at $30 per share. The shares of

stock were pledged as collateral for the loan from HTI, and the shares were held by a Trustee in a suspense account.

463. When interest and principal payments on the $810 million in borrowed funds were due, HTI made a payment to the ESOP for the amount due. The ESOP then repaid HTI for the principal and interest due to the lenders. Those payments were made from the monies disbursed by HTI to the ESOP. Only then would HTI make the principal and interest payments due the lender.

464. As the ESOP paid off the principal on the loan (through payments to HTI), shares of HTI stock equivalent to the reduction in principal were to be released from the suspense account and allocated to HTI employee/"participants" accounts up to the limits established in the plan governing the ESOP ("the ESOP Plan"). The ESOP Plan specified benefit limits, consistent with applicable law, of the lesser of 25% of salaries or $30,000 for each covered employee.

465. ESOP pension benefits credited to employee/participants, such as those provided for the ESOP Plan, may be reimbursable under the Medicare program as a fringe benefit to the extent that such ESOP benefits are actually paid to employee/participants. PRM Pt. I §§ 2144, 2142.

466. Thus, amounts equal to the principal repaid on the funds borrowed by the ESOP were allowable for Medicare purposes where the principal repaid equaled to the amount of HTI stock allocated to the employee/participants and, therefore, represented a true fringe benefit paid to employees.

467. Interest expenses paid on the funds borrowed by the ESOP were not allowable for Medicare purposes because they did not represent a fringe benefit to employees, were incurred in

connection with a corporate reorganization, were not necessary to satisfy a financial need of a provider, and were not reasonably related to patient care. 42 C.F.R. §413.9; PRM Pt. I § 2144; PRM Pt. II §§ 1002 (D), 3102 (D).

468. Pursuant to instructions from the HTI Reimbursement Department, for cost reporting periods from 1988 through 1992, HTI and the Class B providers claimed as ESOP expenses amounts substantially in excess of the benefits actually paid to the employee/participants. While claiming inflated ESOP contributions on the cost reports filed with Medicare, HTI's policy was secretly to reserve all or part of the amounts HTI claimed for ESOP expense. On the pre-printed template captioned "CONFIDENTIAL" described in ¶ 438 above, the line "Eliminate ESOP Expense" was used by HTI and the Class B providers to record the reserve amounts associated with the ESOP. Upon information and belief, the United States alleges that the reserve amounts HTI set aside for the ESOP reflected the amounts that HTI claimed but did not pay for allowable ESOP expenses and may also have included, in many instances, the amounts HTI actually paid for ESOP benefits.

469. In 1988, HTI included on its home office cost statement approximately $175 million as the amount it contributed to the ESOP. At that time, HTI knew that its employees had actually received far less in authorized ESOP pension benefits and that its reimbursement should be based solely on the amounts it actually paid for these pension benefits.

470. In or about 1989, HTI began allocating its ESOP expenses directly to its hospitals. HTI's Reimbursement Department established a corporate policy of claiming a percentage of its total salaries as the ESOP expense, typically between 28 and 30 percent, even

though those amounts bore no relationship to the expenses HTI actually incurred for pension benefits.

471. To effectuate claiming approximately 30 percent of salaries as ESOP expenses, HTI's Reimbursement Department instructed the hospitals to calculate the difference between that amount and the amounts actually accrued over the year and recorded for account number 945960 on the hospitals' working trial balance as having been paid for the ESOP expense. The difference between these amounts was then added as an adjustment on Worksheet A-8 of each hospital's cost report, resulting in a claim for ESOP expenses in excess of the amount actually paid by HTI for pension benefits. For example, as shown on Ex. 15, the cost report preparer for Orthopedic Hospital in 1991 calculated the difference between 30 percent of salaries, in that case $2,623,293, and the amount in the hospital's ESOP account, $1,540,668, a difference of $1,082,625. The preparer then added that amount to the ESOP expense line 56.08 on Worksheet A-8 on the cost report filed with the Medicare program, as shown on Ex. 16.

472. In January 1992, HTI converted its ESOP to a 401(k) employee pension plan. The 401(k) plan had significantly lower Medicare reimbursable costs than did the ESOP, being limited to 6.5 percent of employee salaries.

473. After the conversion to the 401(k), HTI hospitals continued to claim on cost reports amounts in excess of their actual pension contributions to their covered employees. The reserve analysis template used by HTI's Reimbursement Department to calculate reserves, as alleged above in ¶¶ 438 and 468, was revised after the conversion to the 401(k) and contained an item instructing the preparer to "Reduce ESOP/pension to 6 ½ % of salaries/wages."

474. For HTI and most of its hospitals, the fiscal year for cost reporting purposes ended on August 31. Accordingly, for fiscal year 1992, the four month period from September through December 1991 was included on the 1992 cost report.

475. On January 25, 2001, defendant CMC pled guilty to knowingly and willingly filing a cost report for Ed White Memorial Hospital that claimed a percentage of costs as reimbursable by the Medicare program for employee pension-related expense, when CMC knew that those claims overstated the correct percentage.

476. In support of its January 25, 2001 criminal plea, CMC stipulated to the facts contained in ¶¶ 477 through 479.

477. For four months of fiscal year 1992, HTI hospitals were entitled to reimbursement of ESOP expenses at a rate of approximately 15 percent of employee salaries and for eight months at the 401(k) pension rate of approximately 6.5%.

478. Nevertheless, CMC knowingly and willfully filed cost reports for approximately eighty (80) HTI hospitals fraudulently claiming excessive Medicare reimbursement for contributions to the 401(k) pension plan.

479. The loss incurred by the government until mid-1993 as a consequence of CMC's conduct in claiming excessive Medicare reimbursement for contributions to the 401(k) Plan was $520,000.

480. The United States alleges that the loss figure stipulated to by CMC of $520,000 was only for the loss incurred by the government until mid-1993, and represents the government's minimum damages for restitution.

481. Following the acquisition of HTI by HCA in April 1994, HCA retained the Medicare reimbursement improperly received by HTI for the ESOP and 401(k) expenses and maintained the reserves previously set aside by HTI for the amounts HTI would have owed to Medicare in the event that the FIs or HCFA disallowed the amounts improperly claimed for the pension benefits.

482. At all times while HCA retained the Medicare funds improperly received by HTI and the reserves that HTI had previously set aside to cover its liability for the ESOP, HCA knew that the amounts HTI had claimed for ESOP and 401(k) expenses exceeded the amounts HTI had actually paid for employee pension benefits.

483. Attached hereto at Ex. 11 is a listing of instances in which HTI submitted false claims made for unallowable ESOP expenses.

B. BAMI

484. As is pled above at ¶ 411, BAMI conducted business for Medicare and Medicaid purposes as a chain organization.

485. Prior to its purchase by Columbia, BAMI owned six of the HCA Hospitals whose cost reports are at issue in this action.

486. As is pled above at ¶¶ 412 - 416, home office costs are not directly reimbursed by Medicare, but to the extent a hospital in a chain uses resources provided by the home office when delivering services related to patient care, certain organization costs may be included in the hospital's cost report. PRM Pt. I § 2150, PRM Pt. II § 1000.

487. As with the other expenses on a cost report, Medicare reimbursement is limited to the reasonable costs of such services and to expenses that are necessary and proper to the care of beneficiaries. 42 C.F.R. §§ 413.9, 413.17; PRM Pt. I § 2150; PRM Pt. II §§ 1000, 3111.

488. The former BAMI hospitals in the period during which BAMI was the owner routinely sought reimbursement for home office costs that were not properly subject to reimbursement by Medicare.

489. For example, in the home office cost statement for 1990, BAMI included unallowable "investor relations" expenses.

490. The PRM specifically states that "Stockholder Servicing Costs" are not expenses related to patient care and, therefore, "are excluded from allowable costs." PRM Pt. I § 2134.9.

491. Cost report workpapers prepared in connection with its 1990 home office cost report indicate that BAMI knew about the controlling instruction and that the claimed "investor relations" expenses were not allowable, but included these expenses in its home office cost statement submitted to Medicare.

492. As a result of the inclusion of unallowable investor relations costs in the 1990 BAMI home office cost statement, those costs were allocated to each of the facilities in the BAMI chain, including Southwest Florida Regional Medical Center, Fawcett Memorial Hospital, Englewood Hospital, Kissimmee Memorial Hospital, and Tri-County Community Hospital and included in those hospitals' costs reports for reimbursement of home office costs.

493. As a result of the false claim identified in ¶¶ 489 - 492 above, Southwest Florida Regional Medical Center, Fawcett Memorial Hospital, Englewood Hospital, Kissimmee

Memorial Hospital, and Tri-County Community Hospital each received substantial Medicare reimbursement to which defendants were not entitled.

494. Attached at Ex. 12, and incorporated by reference herein, is a chart listing false claims made in HCA Hospital cost reports for the allocation of BAMI home office costs that included false claims and false statements.

XXVI. COST SHIFTING TO COST-BASED AREAS OF THE HOSPITAL

495. At all times relevant to this complaint, some of the services provided by the HCA Hospitals to Medicare beneficiaries, including certain ancillary and outpatient services, and the services provided by home health agencies, psychiatric units, comprehensive outpatient rehabilitation facilities, and rural health clinics were paid by Medicare on the basis of the reasonable costs incurred by the department or subprovider which provided the services. 42 C.F.R. § 413.64; PRM Pt. I § 2300.

496. At all times relevant to this complaint, certain of the cost-based subproviders were reimbursed based on their reasonable costs up to a limit.

497. Among the cost-based subproviders that were reimbursed their reasonable costs up to a limit were HHAs. 42 U.S.C. § 1395yy; 42 C.F.R. § 413.30.

498. Beginning in or around 1994, HCA aggressively pursued a strategy of acquisition of HHAs and other cost-based subproviders, and attaching those cost-based units to HCA Hospitals.

499. By 1997, HCA owned over 500 HHAs, almost all of which were operated as hospital-based subproviders of over 200 of the HCA Hospitals.

500. Among other reasons HCA sought to acquire cost-based subproviders was the potential to cost-shift overhead (general service costs) from the hospital to the cost-based subproviders.

501. As is pled above, the HCA Hospitals were reimbursed for inpatient care based on PPS. Under PPS, reimbursement for the overhead (general service costs) applicable to inpatient care is fixed by the DRG assigned to the patient's stay.

502. General service costs allocated to cost-based areas of the hospital, including HHAs, were reimbursed up to the cost limits applicable to the HHA.

503. HCA, and its various subsidiaries, including Columbia Homecare Group and the HCA Hospitals, kept track of which HCA Hospitals' HHAs were operating under the cost limits and which were operating over the cost limits.

504. HCA Hospitals with HHAs that operated under the cost limits were viewed by Columbia Homecare Group and other HCA and HCA Hospital employees as "leaving money on the table" since they were eligible for reimbursement by Medicare of their costs up to the cost limit.

505. HCA Reimbursement Department employees in Florida were instructed to "load up" the HHAs with hospital general service costs until the HHAs reached the cost limits.

506. As is plead above at ¶¶ 24 - 30, defendant CMC pled guilty to fraudulently allocating cafeteria and medical records to HHAs that were attached to certain of the HCA Hospitals whose cost reports are at issue in this action.

507. The United States alleges, upon information and belief, that essentially the same conduct – false and fraudulent statements regarding the allocations of general service costs to

HHAs and other cost-based units – was done by HCA and certain of the HCA Hospitals with HHAs or other cost-based units in addition to the hospitals and instances for which defendant CMC pled guilty.

508. When submitting a cost report, Medicare providers are required to provide "adequate information" so that expenses can be properly allocated to the cost center(s) for which they were incurred. 42 C.F.R. 413.24; PRM, Pt. I, § 2306.

509. A "cost center" is "an organization unit, generally a department or its subunit, having a common functional purpose for which direct and indirect costs are accumulated, allocated and apportioned." PRM Pt. I § 2302.8.

510. General and indirect costs, such as housekeeping expenses and other expenses associated with operating and maintaining a hospital's physical plant, should be allocated to other cost centers based on the extent to which such cost centers actually use the general services of the hospital. PRM Pt. I § 2302.9.

511. The principal way that general and indirect costs are allocated to all the cost centers which use the services associated with these expenses is known as the "step-down method." 42 C.F.R. § 413.24. This method uses statistics and data reflecting the level at which a department or subunit actually used the services provided by the general service cost centers as the basis for apportioning indirect and overhead costs to individual cost centers. 42 C.F.R. §413.50.

512. "The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended." 42 C.F.R. 413.24 at (c); PRM Pt. I § 2304.

513. At all times relevant to this complaint, with respect to the services to beneficiaries for which Medicare paid the HCA Hospitals on a cost-reimbursed basis, increased costs of a department or subunit (including the general service expenses allocated to the cost center) which rendered the care and treatment resulted in an increased payment by Medicare.

514. At all times relevant to this complaint, where a cost-reimbursed department or subunit was reimbursed its costs up to a limit, costs in excess of the limit would not be reimbursed or would be reimbursed at a reduced rate (and not at cost).

515. The HCA Hospitals improperly exploited this feature of the Medicare program by apportioning expenses to hospital cost centers that provided cost-reimbursed care and treatment even though defendants knew these expenses were for services that had not been used at or by the cost centers to which they were allocated.

516. With respect to off-site HHAs, defendants also often effectively inflated at least one of the expenses incurred for these cost centers in hospital cost reports. One of the principal expenses incurred by an HHA located away from its affiliated hospital is the lease of the off-site space which it occupies. Because the lease for an off-site HHA is a discrete cost which is specific to the home health agency services, it must be reported as a direct expense of that subunit. PRM Pt. II § 3610.

517. The lease for an off-site HHA is not properly considered to be a component of the general service cost center that comprises the overall cost of the space occupied by the rest of the hospital's physical plant. Id., PRM Pt. I § 2302.9.

518. Because the cost of the space leased by an off-site HHA is usually less than the cost of hospital space, use of the step-down method apportioning a share of overall hospital costs

(rather than just the lower lease cost) to an off-site HHA occupying leased space will result in that subunit being assigned a higher cost for the space it occupies than its actual, identifiable, lease expense.

519. For example, in the cost report for the fiscal year ending December 31, 1995, Southwest Florida Regional Medical Center ("Southwest") improperly recorded the lease of an off-site HHA with multiple locations (subprovider 10-7350) as a capital-related expense by the hospital rather than as a specific expense assigned directly to the HHA. The hospital then apportioned a share of the total costs associated with the space occupied by its physical plant and the HHA to the HHA, thereby increasing the cost assigned to the HHA space by almost $354,000.

520. For the fiscal year ending December 31, 1995, Southwest also improperly apportioned costs associated with the hospital's operation of plant cost center to the off-site HHA that occupied leased space.

521. The apportionment of expense from this general service cost center to the HHA was improper because there was no adequate and sufficiently documented basis for shifting these general service costs to this cost-reimbursed subunit.

522. As a result of the conduct described in ¶¶ 520 - 521 above, Southwest received substantial Medicare reimbursement to which it was not entitled.

523. Another example is the cost report for fiscal year ending December 31, 1995, filed by Columbia Medical Center - East. In that cost report, the hospital allocated costs from its housekeeping, dietary and cafeteria meals, nursing administration, and medical records cost centers to an affiliated HHA (subprovider 45-7491).

524. The apportionment of expenses from these general service cost centers to the HHA was improper because there was no adequate and sufficiently documented basis for shifting these general service costs to a cost-reimbursed subunit that was self-sufficient and which did not use the services of the cost centers noted above.

525. As a result of the conduct described in ¶¶ 523 - 524 above, Columbia Medical Center - East received substantial Medicare reimbursement to which it was not entitled.

526. Another example is the cost report for the period ending on November 30, 1995, filed by Mission Bay Hospital ("Mission Bay") in which that facility improperly shifted costs to an off-site HHA which it operated as a subunit. More specifically, the hospital apportioned expenses to the HHA from the operation of plant, housekeeping, and medical records cost centers. The apportionment of expenses from these general service cost centers to the HHA was improper because there was no adequate and sufficiently documented basis for shifting hospital costs to this cost-reimbursed subunit. Moreover, when filing the November 30, 1995 cost report, the hospital was aware that its allocation of these expenses to the HHA had been the subject of adjustment by the Medicare FI during a prior audit.

527. As a result of the conduct described above, Mission Bay received substantial Medicare reimbursement to which it was not entitled.

528. Attached hereto at pages 702 through 709 of Ex. 8, is a listing of false claims for reimbursement for improper cost-shifting to HHAs that are reflected in the reserves established by defendants.

529. Attached hereto at Ex.17, is a listing of false claims for reimbursement for improper cost-shifting to cost-based subunits other than HHAs that are reflected in the reserves

established by defendants. The reserves identified in Ex. 17 are also included at various pages in the summary exhibit 8 but are reproduced in Ex. 17 for ease of reference.

530. Attached hereto at Ex. 13 is a non-exhaustive list of false claims for reimbursement for improper cost-shifting to HHAs for which defendants did not establish reserves. Upon information and belief, defendants filed cost reports for additional HCA Hospitals and cost report years not identified in Ex. 13 that included claims for reimbursement of costs that were improperly shifted from hospitals to HHAs that were not reflected in reserves established by defendants.

531. Attached hereto at Ex. 18 is a non-exhaustive list of false claims for reimbursement for improper cost-shifting to cost-based units other than HHAs for which defendants did not establish reserves. Upon information and belief, defendants filed cost reports for additional HCA Hospitals and cost report years not identified in Ex. 18 that included claims for reimbursement of costs that were improperly shifted from hospitals to one or more cost-based subunits (other than HHAs) that were not reflected in reserves established by defendants.

XXVII. CONCEALMENT OF DISCOVERED OVERPAYMENTS AND AUDIT ERRORS

532. Defendants also have ignored their duty to report discovered errors that result in overpayments by the government health care programs. When defendants discovered that errors favorable to them had been made either in their preparation of filed cost reports or in the treatment of the reports by the FIs on audit, defendants remained silent and retained the overpayments. Indeed, when necessary to preserve an unwarranted windfall, defendants actively concealed the overpayments.

533. Fawcett, for example, remained silent when an auditor for its FI mistakenly relied on the fraudulent cost reports Fawcett had filed in 1987 and 1988 to change the proper allocation of interest that appeared in Fawcett's 1989 cost report to the incorrect 100% capital allocation contained in the prior cost reports. Notwithstanding the fact that defendants knew the change was being made in error and was based on hospitals' prior false claims, they accepted the overpayment and later used it as an excuse to resume making identical fraudulent claims on cost reports filed for subsequent years. Thereafter, Fawcett actively concealed the issue from auditors.

534. Similarly, defendants failed to disclose a known clerical error by the FI auditor during the review of Fawcett's 1989 cost report. Defendants' silence permitted them to improperly retain an additional $100,000.

535. Another example of defendants' knowing retention of overpayments occurred at Mission Bay where the September 30, 1989 cost report was settled by the FI including an erroneous overpayment for Skilled Nursing Facility ("SNF") costs. Defendants' workpapers from the review of the 1989 NPR issued by the FI on September 25, 1991 indicate that defendants were aware that the FI mistakenly overpaid Mission Bay because the FI included over $1 million in excess SNF costs. Defendants' internal documents indicate their knowledge of this FI error and their conscious decision to not disclose the error. Defendants decided not to file an appeal on other issues because of the risk that filing an appeal would cause the FI to reopen the cost report and detect its error and recoup the overpayment.

XXVIII. SOUTHWEST FLORIDA DIVISION MARKETING COSTS

536. The United States alleges that at least in cost report year 1996 and, upon information and belief, in other years, the hospitals in the Southwest Florida Division of HCA (i.e., Southwest Florida Regional Medical Center, Gulf Coast – Ft. Myers, Englewood Community Hospital, Fawcett Memorial Hospital, and Doctor's Hospital of Sarasota ("Southwest Florida Division Hospitals")), reclassified through journal entries all hospital marketing and advertising costs (including HHA marketing and advertising costs), to the Southwest Florida Division office ("Southwest Division"), so that no marketing and advertising costs would appear on the general ledgers of the Southwest Florida Division Hospitals.

537. The Southwest Division totaled the marketing and advertising costs of the Southwest Florida Division Hospitals, and added to that the costs of marketing and advertising personnel employed by the Division to determine the total marketing and advertising costs of the Southwest Florida Division Hospitals and the Southwest Division ("Marketing Costs").

538. The United States alleges that at least a portion of the Marketing Costs are unallowable for Medicare purposes.

539. The Southwest Division allocated the Marketing Costs back to the Southwest Florida Division Hospitals based on a ratio of each hospital's cost related to total cost.

540. The Southwest Division office forwarded to each of the Southwest Florida Division hospitals a journal entry for the Marketing Costs which was recorded as a "management fee for contract services."

541. On the cost reports of each of the Southwest Florida Division Hospitals, the hospitals' marketing and advertising costs which were reclassified to the Southwest Division appear on Worksheet A-8 as unallowable costs.

542. Upon information and belief, the United States alleges that on the cost reports of the Southwest Florida Division Hospitals, the "management fee for contract services" which was, in fact, the Marketing Costs, does not appear on Worksheet A-8 as unallowable costs, nor was it set up as a non-reimbursable cost center. Upon information and belief, the United States alleges that on the cost reports of the Southwest Florida Division Hospitals, the "management fee for contract services" which was the Marketing Costs was claimed as allowable costs for reimbursement by Medicare.

543. As a result of the conduct described in ¶¶ 536 - 542 above, the Southwest Florida Division Hospitals received substantial Medicare reimbursement to which they were not entitled.

XXIX. IMPROPERLY CLAIMED PHYSICIAN PRACTICE COSTS

544. The United States alleges that many of the HCA Hospitals provided services to physician practices that were affiliated with the hospitals. These services included accounting services and other administrative services.

545. The United States alleges that each of the physician practices were set up with a separate company identification number (co-id) since at least 1996, and possibly earlier.

546. The United States alleges that many of the HCA Hospitals, including, but not limited to, the Southwest Florida Division Hospitals and the South Florida Division Hospitals (Aventura Medical Center, Deering Hospital, Cedars Medical Center, Columbia Hospital, JFK Medical Center, Northwest Medical Center, Westside Medical Center, Kendall Medical Center, University Hospital and Medical Center, and Miami Heart Institute), for at least the cost reports filed for the year 1996, did not report the hospitals' unallowable costs associated with the physician practices on their cost reports.

547. The United States alleges, upon information and belief, that the HCA Hospitals referenced in ¶ 546 also did not report the co-ids of the physician practices on the cost report, nor did they provide the Working Trial Balances ("WTBs") for the co-ids for the physician practices to their FIs along with the WTB of the hospital which is required to be submitted to the FI with the filed cost report.

548. As a result of the conduct described in ¶¶ 544 - 547, defendants received substantial Medicare reimbursement to which they were not entitled.

XXX. DAMAGES

549. As set forth above, defendants knowingly submitted or caused to be submitted untruthful, incorrect or incomplete hospital cost reports to Medicare and Medicaid containing false certifications that the cost reports were true, correct and complete, in violation of 31 U.S.C. § 3729.

550. As set forth above, defendants knowingly submitted or caused to be submitted untruthful and inaccurate Requests for Reimbursement to TRICARE/CHAMPUS containing false certifications that the requests were accurate and based on the hospitals' Medicare cost report.

551. As set forth above, in violation of 31 U.S.C. § 3729 and 42 U.S.C. § 1320A-7b(a)(3), defendants knowingly concealed the existence of discovered overpayments paid to them by Medicare, Medicaid, and TRICARE/CHAMPUS by maintaining silence about auditor or their own errors and oversights in order to retain the overpayment, by knowingly filing subsequent cost reports in the same incorrect fashion as the original mistaken report so as not to draw attention to a change in treatment of improperly reimbursed costs, and by taking

affirmative steps to mislead or distract FI auditors and personnel so that such overpayments would not be recognized and corrected by FI auditors and personnel.

552. Defendants' false certifications of completeness damaged the Government as reflected in reserves that defendants established. Defendants' false certifications of truthfulness, correctness and accuracy damaged the Government because they caused defendants to be paid for non-reimbursable costs. Defendants' concealment of discovered overpayments damaged the Government because funds improperly paid were not recovered and often were perpetuated in subsequent cost-reporting periods.

COUNTS

FIRST CAUSE OF ACTION

(False Claims Act: Presentation of False Claims)
(31 U.S.C. § 3729(a)(1))
(All Defendants)

553. Plaintiff repeats and realleges each allegation in ¶¶ 1 through 552, as if fully set forth herein.

554. Defendants knowingly presented or caused to be presented false or fraudulent claims for payment or approval to the United States.

555. By virtue of the false or fraudulent claims made by the defendants, the United States suffered damages and therefore is entitled to treble damages under the False Claims Act, to be determined at trial, plus a civil penalty of $5,000 to $10,000 for each violation.

SECOND CAUSE OF ACTION

(False Claims Act: Making or Using False Record or Statement)
(31 U.S.C. § 3729 (a)(2))
(All Defendants)

556. Plaintiff repeats and realleges each allegation in ¶¶ 1 through 552, as if fully set forth herein.

557. Defendants knowingly made, used, or caused to be made or used, false records or statements to get false or fraudulent claims paid or approved by the United States.

558. By virtue of the false records or statements made by the defendants, the United States suffered damages and therefore is entitled to treble damages under the False Claims Act, to be determined at trial, plus a civil penalty of $5,000 to $10,000 for each violation.

THIRD CAUSE OF ACTION
(False Claims Act: Reverse False Claims)
(31 U.S.C. § 3729(a)(7))
(All Defendants)

559. Plaintiff repeats and realleges each allegation in ¶¶ 1 through 552, as if fully set forth herein.

560. Defendants knowingly made, used or caused to be made or used a false record or statement to conceal, avoid or decrease an obligation to pay or transmit money or property to the United States.

561. By virtue of the false records or statements made by the defendants, the United States suffered damages and therefore is entitled to treble damages under the False Claims Act, to be determined at trial, plus a civil penalty of $5,000 to $10,000 for each violation.

FOURTH CAUSE OF ACTION
(Unjust Enrichment)
(All Defendants)

562. Plaintiff United States repeats and realleges each allegation in ¶¶ 1 through 552, as if fully set forth herein.

563. This is a claim for the recovery of monies by which all defendants have been unjustly enriched.

564. By directly or indirectly obtaining Government funds to which they were not entitled, all defendants were unjustly enriched, and are liable to account and pay such amounts, or the proceeds therefrom, which are to be determined at trial, to the United States.

FIFTH CAUSE OF ACTION
(Payment By Mistake)
(All Defendants)

565. Plaintiff United States repeats and realleges each allegation in ¶¶ 1 through 552, as if fully set forth herein.

566. This is a claim for the recovery of monies paid by the United States to the defendants as a result of mistaken understandings of fact.

567. The United States, acting in reasonable reliance on the accuracy and truthfulness of the information contained in the cost reports submitted by HCA and the HCA Hospitals, paid the Hospital Defendants and the other HCA Hospitals identified in Ex. 6 certain sums of money to which they were not entitled, and HCA and the Hospital Defendants are thus liable to account and pay such accounts, which are to determined at trial to the United States.

SIXTH CAUSE OF ACTION
(Disgorgement of Illegal Profits)
(All Defendants)

568. Plaintiff United States repeats and realleges each allegation in ¶¶ 1 through 552, as if fully set forth herein.

569. By this claim, the United States requests a full accounting of all revenues (and interest thereon) and costs incurred by the Medicare, Medicaid and TRICARE/CHAMPUS

programs as a result of all defendants' actions alleged herein, disgorgement of all profits obtained by HCA and the Hospital defendants through the submission of the HCA Hospitals' inflated Hospital Cost Reports and Requests for Reimbursement, and/or imposition of a constructive trust in favor of the United States upon those profits.

570. Defendants made such false, fictitious or fraudulent statements, reports and claims to the United States to obtain illegal profits from the Medicare, Medicaid and TRICARE/CHAMPUS programs, and equity requires the disgorgement of such profits and their payment to the United States.

SEVENTH CAUSE OF ACTION

(Common Law Fraud)
(All Defendants)

571. Plaintiff United States repeats and realleges each allegation in ¶¶ 1 through 552, as if fully set forth herein.

572. Defendants HCA and the Hospital defendants made material and false representations in the HCA Hospitals' Hospital cost reports and Requests for Reimbursement with knowledge of their falsity or reckless disregard for their truth, with the intention that the Government act upon the misrepresentations to its detriment. The Government acted in justifiable reliance upon defendants' misrepresentations by settling the HCA Hospitals' cost reports at an inflated amount and by paying inflated interim payments and tentative settlements to the HCA Hospitals.

573. Had the true facts been known to plaintiff, HCA and the Hospital defendants would not have received payment of the inflated amounts.

574. By reason of its inflated payments, plaintiff has been damaged in an as yet undetermined amount.

EIGHTH CAUSE OF ACTION
(Common Law Recoupment)
(All Defendants)

575. Plaintiff United States repeats and realleges each allegation in ¶¶ 1 through 552, as if fully set forth herein.

576. This is a claim for common law recoupment, for the recovery of monies unlawfully paid by the United States to the Hospital Defendants and the other HCA Hospitals identified in Ex. 6 contrary to statute or regulation.

577. The United States paid the Hospital Defendants and the other HCA Hospitals idenfied in Ex. 6 certain sums of money to which they were not entitled; HCA and the Hospital Defendants are thus liable under the common law of recoupment to account and return such amounts, which are to be determined at trial, to the United States.

NINTH CAUSE OF ACTION
(Restitution Against Defendants HCA and CMC)

578. Plaintiff United States repeats and realleges each allegation in ¶¶ 1 through 552, as it fully set forth herein.

579. The United States has suffered a loss of at least $3,090,173.00 as a result of violations of 18 U.S.C. §§ 1001 and 1002 to which defendant CMC pled guilty in the Middle District of Florida on January 25, 2001. Mandatory restitution for those losses was reserved for resolution in this matter. HCA and its subsidiary CMC are thus liable to the United States under the common law and in equity to account for and return those sums, which are to be determined at trial, as restitution to the United States.

PRAYER FOR RELIEF

WHEREFORE, the United States demands and prays that judgment be entered in its favor, as follows:

1. On the First, Second, and Third Causes of Action under the False Claims Act, as amended, for the amount of the United States' damages, trebled as required by law, and such civil penalties as are required by law, together with all such further relief as may be just and proper.

2. On the Fourth, Fifth, and Eighth Causes of Action, for unjust enrichment, payment by mistake, and common law recoupment, for the damages sustained and/or amounts by which the defendants were unjustly enriched or by which defendants retained illegally obtained monies, plus interest, costs, and expenses, and such further relief as may be just and proper.

3. On the Sixth Cause of Action, for disgorgement of illegal profits, for an accounting of all revenues unlawfully obtained by defendants, the imposition of a constructive trust upon such revenues, and the disgorgement of the illegal profits obtained by defendants and such further equitable relief as may be just and proper.

4. On the Seventh Cause of Action, for common law fraud, for compensatory and punitive damages in an undetermined amount, together with costs and interest, and for such further relief as may be just and proper.

5. On the Eighth Cause of Action, for common law recoupment, for damages in an undetermined amount, together with costs and interest, and for such further relief as may be just and proper.

6. On the Ninth Cause of Action, for restitution, for the losses sustained by the United States.

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