**IN THE UNITED STATES DISTRICT COURT**
**FOR THE DISTRICT OF COLUMBIA**

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| UNITED STATES OF AMERICA, *ex rel.* JAMES M. THOMPSON,<br><br>Plaintiff,<br><br>v.<br><br>HCA–THE HEALTHCARE COMPANY, COLUMBIA MANAGEMENT COMPANIES, INC., LAS PALMAS MEDICAL CENTER, COLUMBIA DOCTORS REGIONAL MEDICAL CENTER, NORTHWEST REGIONAL HOSPITAL, BELLAIRE MEDICAL CENTER, METHODIST SPECIALTY & TRANSPLANT HOSPITAL, WEST HOUSTON MEDICAL CENTER, DEL SOL MEDICAL CENTER, MEDICAL CITY DALLAS, BAY AREA MEDICAL CENTER, NORTH AUSTIN MEDICAL CENTER, COLUMBIA BAYVIEW PSYCHIATRIC CENTER, COLUMBIA SURGICARE SPECIALITY HOSPITAL, RIVERSIDE COMMUNITY HOSPITAL, ROSE MEDICAL CENTER, MEDICAL CENTER OF AURORA, AVENTURA HOSPITAL AND MEDICAL CENTER, PLANTATION GENERAL HOSPITAL, SOUTHWEST FLORIDA REGIONAL MEDICAL CENTER, PALMS WEST HOSPITAL, PARKWAY MEDICAL CENTER, HUGHSTON SPORTS MEDICINE HOSPITAL, SAVOY MEDICAL CENTER, EDMOND REGIONAL MEDICAL CENTER, MEDICAL CENTER DALLAS SOUTHWEST,<br><br>Defendants. | Case No. 99-3302 (RCL)<br>(Part of 01-MS-50 (RCL))<br><br>**COMPLAINT OF THE UNITED STATES**<br><br>False Claims Act,<br>31 U.S.C. §§ 3729, *et seq*.,<br>and Common Law Causes of Action |

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

## I. NATURE OF ACTION

1. The United States brings this action to recover treble damages and civil penalties under the False Claims Act, 31 U.S.C. §§ 3729-33 (FCA), and to recover damages and other monetary relief under the common law or equitable theories of fraud, unjust enrichment, payment by mistake of fact, recoupment and disgorgement of illegal profits, and to recover statutory restitution for criminal offenses.

2. These claims are based upon defendants' submission of false and fraudulent patient claims and hospital cost reports to the United States in order to obtain hundreds of millions of dollars in payments for various healthcare services from January 1, 1988 through December 31, 1999. These false claims and false statements were part of defendants' unlawful scheme to obtain business by paying kickbacks and illegal remuneration to physicians, and entering into prohibited financial relationships with physicians, to induce such physicians to refer patients to defendants' facilities.

3. Defendant HCA-The Healthcare Company (HCA) and its predecessors used and concealed a variety of illegal arrangements to induce physicians to refer patients to HCA facilities. Top management of HCA participated in offering and paying kickbacks to physicians, and failed to discontinue the unlawful practices even after being sued under the FCA, repeated warnings by their own Internal Audit personnel, and knowledge of the government's investigation into these activities. Management and officers of HCA and its various subsidiaries and affiliates, from the highest executive ranks at its corporate headquarters to management at its local hospitals, knew that paying kickbacks to and engaging in particular types of relationships with physicians was unlawful. Nevertheless, they negotiated, authorized, reviewed, approved

and/or failed to rectify the payment of kickbacks, illegal remuneration and unlawful financial relationships like those described in this Complaint.

4. Defendants, in accord with established company practice, paid kickbacks to physicians in return for patient referrals and engaged in financial relationships with physicians, in violation of the Anti-kickback Statute, 42 U.S.C. § 1320a-7b(b), the Stark Statute, 42 U.S.C. § 1395nn, and various state laws and ethical canons of the medical profession, and then submitted false and/or fraudulent claims, and false and/or fraudulent statements, to the United States to receive payments for services rendered to patients referred by those physicians.

5. Defendants offered remuneration to physicians in various forms, including but not limited to (1) payments enabling the physicians to purchase partnership interests in defendants' local hospitals; (2) loans offered to physicians with the understanding that no interest and/or repayment would be required; (3) various lease benefits, including free and reduced rent and free remodeling; (4) directorship contracts that provided for payments to physicians not required to perform any duties; (5) lavish trips for physicians and their spouses; (6) free pharmaceuticals; (7) salary payments to physicians' employees; and (8) excessive payments for businesses owned by physicians.

6. On December 14, 2000, Columbia Management Companies, Inc. (CMC), a subsidiary of HCA, pled guilty to conspiring, from November 1987 through June 1997, to knowingly and willfully pay illegal remuneration (including kickbacks, bribes and rebates), in cash and in kind, to physicians to induce them to refer patients for services reimbursable by Medicare, Medicaid and other federal health care programs, in violation of the Anti-kickback Statute. The Plea Agreement, Judgment, Information and Stipulation of Factual Basis are

incorporated herein by reference and attached as Exhibit 1. The Information identified at least twenty-eight physicians to whom HCA hospitals in El Paso paid kickbacks in furtherance of the conspiracy over a ten-year period. The kickback schemes identified in the Information and numerous other payments to and financial relationships with physicians from other HCA hospitals form the basis for this civil action.

7. The physicians to whom defendants provided illegal remuneration and kickbacks and with whom defendants entered into illegal financial relationships referred large volumes of patients, including Medicare and Medicaid patients and beneficiaries of other government healthcare programs, to HCA hospitals in violation of federal law. Defendants, in turn, submitted claims to Medicare, Medicaid, and other government healthcare programs and obtained hundreds of millions of dollars worth of payments from the United States. Under the False Claims Act, 31 U.S.C. § 3729(a)(1), such claims were false and/or fraudulent because defendants had no entitlement to payment for services provided on referrals from such physicians.

8. Defendants also violated the False Claims Act, 31 U.S.C. § 3729(a)(2), by making or causing to be made false statements when submitting these claims for payment to Medicare and other government programs. Defendants falsely certified the claims and statements were "true" and/or "correct" and as such were entitled to payment.

9. To conceal their unlawful conduct and avoid refunding payments made on the false claims, defendants also falsely certified, in violation of the False Claims Act, 31 U.S.C. § 3729(a)(7), that the services identified in their annual cost reports were provided in compliance with federal law, including the prohibitions against kickbacks, illegal remuneration

to physicians, and improper financial relationships with physicians. The false certifications, made with each annual cost report submitted to the government, were part of defendants' unlawful scheme to defraud Medicare and other government healthcare programs.

10. Based in whole or large part on this unlawful, fraudulent scheme, since 1988, defendants grew rapidly from a small hospital chain to the largest hospital chain in the United States. Defendants now have a combined net worth of billions of dollars.

11. 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 know facts material to the right of action.

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

## II. JURISDICTION

13. 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 resides or transacts business in the Southern District of Texas, 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 its 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.

## III. VENUE

14. Venue is proper in the Southern District of Texas, 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. Venue is proper in this District pursuant to 28 U.S.C. § 1407 because the action has been consolidated in this District for pre-trial proceedings.

## IV. PARTIES

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

16. Relator James M. Thompson ("Dr. Thompson") is an individual residing in Rockport, Texas, Aransas County, in the Corpus Christi Division of the Southern District of Texas. At all times material hereto, Dr. Thompson was a medical doctor engaged in the private practice of medicine in Corpus Christi, Texas. Pursuant to 31 U.S.C. § 3730(b)(1), Dr. Thompson brought this action against Columbia/HCA Healthcare Corporation and several of its predecessors, including CHC Holdings, Inc., Columbia Hospital Corporation of Bay Area, Columbia Hospital Corporation of Corpus Christi, and Columbia Surgicare Specialty Hospital, on behalf of himself and the United States.

17. Defendant HCA, formerly Columbia/HCA Healthcare Corporation, is a Delaware corporation that currently operates 189 hospitals and ancillary health care facilities in at least thirty states. During the time period relevant to this complaint, HCA operated over 400 hospitals in at least thirty-five states. HCA was formed on or about February 10, 1994, when defendant Columbia Healthcare Corporation merged with defendant Hospital Corporation of America ("the original HCA") . The merged company changed its name to HCA – The Healthcare Company on May 25, 2000.

18. Columbia Healthcare Corporation ("Columbia") was a Delaware corporation formed in July 1993, with its principal place of business in Louisville, Kentucky, that owned and operated and managed hospitals in numerous states.

19. Columbia Hospital Corporation was incorporated on November 19, 1987 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.

20. Galen Health Care, Inc. ("Galen") was formed on or about February 12, 1993 as a Delaware corporation with its principal place of business in Louisville, Kentucky as a holding company for the 73 hospitals owned by Humana, Inc. Humana "spun off" Galen in March 1993. Galen is successor in interest to and responsible for the liabilities of Humana for those hospitals. Galen owned and operated hospitals in several states. Galen merged with Columbia in September 1993.

21. 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. The February 1994 Columbia/HCA merger created the largest hospital chain in the United States.

22. HealthTrust, Inc. - The Hospital Company ("HealthTrust") was a Delaware corporation with its principal place of business in Nashville, Tennessee. HealthTrust owned and operated hospitals in numerous states. A Columbia/HCA subsidiary acquired HealthTrust on April 24, 1995.

23. 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 several states.

24. 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"). HealthTrust acquired Epic by merger on May 5,1994.

25. As a result of these various mergers and acquisitions, HCA now owns hospitals formerly owned by the original HCA, Columbia, Galen, HealthTrust and Epic, located throughout the United States and is the successor in interest to and responsible for the liabilities of the original HCA, Columbia, Galen, HealthTrust and Epic and each of their hospitals.

26. HCA is liable in this action for the conduct of (1) its predecessors; (2) each subsidiary between it and the hospitals and other entities it and its predecessors owned or operated as general or managing partner; and (3) 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, and

derivatively, because it or its predecessors operated their various subsidiaries and hospitals as alter egos of the parent corporations. The United States alleges, on information and belief, that HCA and its predecessors: (a) created separate legal entities through which they owned or operated hospitals and other health care 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, on 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 hospital operations.

27. 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. Defendant CMC is a subsidiary of defendant HCA. CMC is the successor in interest to certain unincorporated operating groups of Columbia and its predecessors, including the Midwestern Group, the Eastern Group, and others. CMC, its predecessors, and its subsidiaries operated and managed HCA's hospitals and health care facilities, including those facilities located in El Paso, Texas.

28. Attached hereto as Exhibit 2 and incorporated herein by reference, is a chart listing all hospitals currently or formerly owned, operated or managed by HCA now known by the United States to have submitted the false claims and made the false statements at issue in this action. Attached hereto as Exhibit 3 and incorporated by reference herein, is a chart listing the "Hospital Defendants" to this action. The United States has presently limited the "Hospital Defendants" to those hospitals currently owned by HCA. The United States has not named hospitals no longer owned by HCA based upon the United States' belief that HCA assumed and/or maintained the liabilities of any hospitals which it has sold to third parties. To the extent that HCA's liability for the conduct of those former HCA hospitals now resides with other corporate entities, the United States will seek to learn the identity of those other entities through discovery and will name them as defendants to this action by an amended complaint if necessary.

## V. THE LAW

### A. The False Claims Act

29. 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,
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> * * *
>
> 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.

**B**. **The Anti-kickback Statute**

30. The Anti-kickback Statute, 42 U.S.C. § 1320a-7b(b), arose out of congressional concern that payoffs to those who can influence healthcare decisions will result in goods and services being provided that are medically unnecessary, of poor quality, or even harmful to a vulnerable patient population. To protect the integrity of the program from these difficult to detect harms, Congress enacted a *per se* prohibition against the payment of kickbacks in any form, regardless of whether the particular kickback gave rise to overutilization or poor quality of care. First enacted in 1972, Congress strengthened the statute in 1977 and 1987 to ensure that kickbacks masquerading as legitimate transactions did not evade its reach. *See* Social Security Amendments of 1972, Pub. L. No. 92-603, §§ 242(b) and (c); 42 U.S.C. § 1320a-7b, Medicare-Medicaid Antifraud and Abuse Amendments, Pub. L. No. 95-142; Medicare and Medicaid Patient and Program Protection Act of 1987, Pub. L. No. 100-93.

31. The Anti-kickback Statute prohibits any person or entity from making or accepting payment to induce or reward any person for referring, recommending or arranging for federally-funded medical services, including services provided under the Medicare, Medicaid and (as of January 1, 1997) TRICARE programs. In pertinent part, the statute states:

> (b) Illegal remuneration

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

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

42 U.S.C. § 1320a-7b(b). Violation of the statute can also subject the perpetrator to exclusion from participation in federal health care programs and, effective August 6, 1997, civil monetary penalties of $50,000 per violation and three times the amount of remuneration paid. 42 U.S.C. § 1320a-7(b)(7) and 42 U.S.C. § 1320a-7a(a)(7).

**C. The Stark Statute**

32. Enacted as amendments to the Social Security Act, 42 U.S.C. § 1395nn (commonly known as the "Stark Statute") prohibits a hospital (or other entity providing healthcare items or services) from submitting Medicare claims for payment based on patient referrals from physicians having a "financial relationship" (as defined in the statute) with the hospital. The regulations implementing 42 U.S.C. § 1395nn expressly require that any entity collecting payment for a healthcare service "performed under a prohibited referral must refund all collected amounts on a timely basis." 42 C.F.R. § 411.353.

33. The Stark Statute establishes the clear rule that the government will not pay for items or services prescribed by physicians who have improper financial relationships with other providers. In enacting the statute, Congress found that improper financial relationships between physicians and entities to whom they refer patients can compromise the physicians' professional judgment as to whether an item or service is medically necessary, safe, effective, and of good quality. Congress relied upon various academic studies consistently showing that physicians who had financial relationships with hospitals and other entities used more of those entities' services than similarly situated physicians who did not have such relationships. The statute was designed specifically to reduce the loss suffered by the Medicare program due to such increased questionable utilization of services.

34. Congress enacted the Stark Statute in two parts, commonly known as Stark I and Stark II. Enacted in 1989, Stark I applied to referrals of Medicare patients for clinical laboratory services made on or after January 1, 1992 by physicians with a prohibited financial relationship with the clinical lab provider. *See* Omnibus Budget Reconciliation Act of 1989, P.L. 101-239, § 6204.

35. In 1993, Congress extended the Stark Statute (Stark II) to referrals for ten additional designated health services. *See* Omnibus Reconciliation Act of 1993, P.L. 103-66, § 13562, Social Security Act Amendments of 1994, P.L. 103-432, § 152.

36. As of January 1, 1995, Stark II applied to patient referrals by physicians with a prohibited financial relationship for the following ten additional "designated health services": (1) inpatient and outpatient hospital services; (2) physical therapy; (3) occupational therapy; (4) radiology; (5) radiation therapy (services and supplies); (6) durable medical equipment and supplies; (7) parenteral and enteral nutrients, equipment, and supplies; (8) prosthetics, orthotics, and prosthetic devices and supplies; (9) outpatient prescription drugs; and (10) home health services. See 42 U.S.C. § 1395nn(h)(6).

37. In pertinent part, the Stark Statute provides:

> (a) Prohibition of certain referrals
>
> (1) In general
>
> Except as provided in subsection (b) of this section, if a physician (or an immediate family member of such physician) has a financial relationship with an entity specified in paragraph (2), then --
>
> > (A) the physician may not make a referral to the entity for the furnishing of designated health services for which payment otherwise may be made under this subchapter, and

> (B) the entity may not present or cause to be presented a claim under this subchapter or bill to any individual, third party payor, or other entity for designated health services furnished pursuant to a referral prohibited under subparagraph (A).

42 U.S.C. § 1395nn (emphasis added).

38. The Stark Statute broadly defines prohibited financial relationships to include any "compensation" paid directly or indirectly to a referring physician. The statute's exceptions then identify specific transactions that will not trigger its referral and billing prohibitions.

39. For example, compensation paid to a referring physician serving as a consultant to a hospital will fall within an exception to the statute if the contract (1) is in writing and signed by the parties; (2) is for a term of at least a year; (3) specifies the services covered, covers all the services to be provided by the physician, and the aggregate of such services is reasonable and necessary for the legitimate business purposes of the hospital; and (4) sets the payment for contract services in advance, consistent with fair market value for services actually rendered, not taking into account the volume or value of the referrals or other business generated between the parties. 42 U.S.C. § 1395nn(e)(3). Thus, compensation paid to a physician (directly or indirectly) under a medical directorship that exceeds fair market value, or for which no actual services are required, triggers the referral and payment prohibitions of Stark II with respect to designated health services referred by that physician.

40. Similarly, office space leased to a referring physician falls within such an exception if (1) the lease is in writing signed by the parties; (2) the lease is for a term of at least a year; (3) the space does not exceed that which is reasonable and necessary for the legitimate business purposes of the hospital; (4) the rent for that space is set in advance; (5) the total

payment over the term of the lease is consistent with fair market value and is not determined in a way that takes into account the volume or value of referrals or other business generated between the parties; and (6) the lease would be commercially reasonable even if no referrals were made between the parties. 42 U.S.C. § 1395nn(e)(1)(A). Thus, rents paid (directly or indirectly) by a physician to a hospital that are below fair market value trigger the referral and payment prohibitions of Stark II with respect to designated health services ordered, referred or arranged for by that physician.

41. Violation of the statute may subject the physician and the billing entity to exclusion from participation in federal health care programs and various financial penalties, including (a) a civil money penalty of $15,000 for each service included in a claim for which the entity knew or should have known that payment should not be made under Section 1395nn(g)(1); and (b) an assessment of three times the amount claimed for a service rendered pursuant to a referral the entity knew or should have known was prohibited. *See* 42 U.S.C. §§ 1395nn(g)(3), 1320a-7a(a).

42. In sum, the Stark Statute prohibits hospitals from billing Medicare for certain designated services referred by a physician with whom the hospital has a financial relationship of any type not falling within specific statutory exceptions. 42 U.S.C. § 1395nn. The statute specifically prohibits hospitals from billing for such services. In-patient and out-patient hospital services and home health services are among the designated health services to which the Stark II referral and billing prohibitions apply.

## VI. THE FEDERAL HEALTHCARE PROGRAMS

### A. The Medicare Program

43. In 1965, Congress enacted Title XVIII of the Social Security Act, known as the Medicare Program, to pay for the costs of certain healthcare services. 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 all of HCA's hospitals, derive a substantial portion of their revenue from the Medicare Program.

44. 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.

45. Under the Medicare Program, HCFA makes payments retrospectively (after the services are rendered) to hospitals for inpatient services. Medicare enters into provider agreements with hospitals in order to establish the hospitals' eligibility to participate in the Medicare Program. However, Medicare does not prospectively contract with hospitals to provide particular services for particular patients. Any benefits derived from those services are derived solely by the patients and not by Medicare or the United States.

46. As detailed below, HCA submitted claims both for specific services provided to individual beneficiaries and claims for general and administrative costs incurred in treating Medicare beneficiaries.

47. To assist in the administration of Medicare Part A, HCFA contracts with "fiscal intermediaries." 42 U.S.C. § 1395h. Fiscal intermediaries, typically insurance companies, are responsible for processing and paying claims and auditing cost reports.

48. Upon discharge of Medicare beneficiaries from a hospital, the hospital submits claims for interim reimbursement for items and services delivered to those beneficiaries during their hospital stays. 42 C.F.R. §§ 413.1, 413.60, 413.64. Hospitals submit patient-specific claims for interim payments on a HCFA Form UB-92 (and prior to 1992, on a HCFA Form UB-82).

49. As a prerequisite to payment by Medicare, HCFA requires hospitals to submit annually a form HCFA-2552, more commonly known as the Hospital Cost Report. Cost Reports are the final claim that a provider submits to the fiscal intermediary for items and services rendered to Medicare beneficiaries.

50. After the end of each hospital's fiscal year, the hospital files its Hospital Cost Report with the fiscal intermediary, stating the amount of reimbursement the provider believes it is due for the year. *See* 42 U.S.C. § 1395g(a); 42 C.F.R. § 413.20. *See also* 42 C.F.R. § 405.1801(b)(1). Hence, Medicare relies upon the Hospital Cost Report to determine whether the provider is entitled to more reimbursement than already received through interim payments, or whether the provider has been overpaid and must reimburse Medicare. 42 C.F.R. §§ 405.1803, 413.60 and 413.64(f)(1).

51. HCA hospitals were, at all times relevant to this complaint, required to submit Hospital Cost Reports to their fiscal intermediaries.

52. Medicare payments for inpatient hospital services are determined by the claims submitted by the provider for particular patient discharges (specifically listed on UB-92s/UB-82s) during the course of the fiscal year. On the Hospital Cost Report, this Medicare liability for inpatient services is then totaled with any other Medicare liabilities to the provider. This total

determines Medicare's true liability for services rendered to Medicare beneficiaries during the course of a fiscal year. From this sum, the payments made to the provider during the year are subtracted to determine the amount due the Medicare Program or the amount due the provider.

53. Under the rules applicable at all times relevant to this complaint, Medicare, through its fiscal intermediaries, had the right to audit the Hospital Cost Reports and financial representations made by all of HCA's hospitals to ensure their accuracy and preserve the integrity of the Medicare Trust Funds. This right includes the right to make retroactive adjustments to Hospital Cost Reports previously submitted by a provider if any overpayments have been made. 42 C.F.R. § 413.64(f).

54. Every Hospital Cost Report contains a "Certification" that must be signed by the chief administrator of the provider or a responsible designee of the administrator.

55. For cost reporting periods prior to September 30, 1994, the responsible provider official was required to certify, in pertinent part:

> to the best of my knowledge and belief, it [the Hospital 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.

Form HCFA-2552-81.

56. Thus, the provider was required to certify that the filed Hospital 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 Hospital Cost Report is based upon all information known to the provider.

57. The "applicable instructions" contained in the pre-September 1994 certification included the requirement that services described in the cost report complied with Medicare program requirements, including the provision outlawing kickbacks, codified in 42 U.S.C. § 1320a-7b(b).

58. The pre-September 1994 Hospital Cost Report (HCFA-2552-81) reminded providers that "intentional misrepresentation or falsification of any information contained in this cost report may be punishable by fine and/or imprisonment under federal law."

59. On September 30, 1994, Medicare revised the certification provision of the Hospital Cost Report to add the following:

> 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.

Form HCFA-2552-92.

60. Subsequently, in or about 1996, the Hospital Cost Report was revised again to include the following notice:

> Misrepresentation or falsification of any information contained in this cost report may be punishable by criminal, civil and administrative action, fine and/or imprisonment under federal law. Furthermore, if services identified in this report were provided or procured through the payment directly or indirectly of a kickback or where otherwise illegal, criminal, civil and administrative action, fines and/or imprisonment may result.

61. Under all versions of the HCFA Form 2552 certification, the provider certified that the services provided in the cost report were not infected by a kickback. Once the Stark Statute became effective, the provider certified that the services provided in the cost report were billed in compliance with the Stark Statute.

62. HCA is familiar with the laws and regulations governing the Medicare Program, including requirements relating to the completion of cost reports.

63. A hospital is required to disclose all known errors and omissions in its claims for Medicare reimbursement (including its cost reports) to its fiscal intermediary. 42 U.S.C. § 1320a-7b(a)(3) specifically 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.

64. Hospital Cost Reports submitted by HCA hospitals were, at all times material to this complaint, signed by HCA employees (including employees of its various predecessors), usually a hospital official and, in some cases, a Corporate Reimbursement Department employee, who attested, among other things, to the certification quoted above.

**B. <u>The Medicaid Program</u>**

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

66. 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*.

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

68. In many states, provider hospitals participating in the Medicaid program file annual cost reports with the state's Medicaid agency, or its intermediary, in a protocol similar to that governing the submission of Medicare cost reports.

69. 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.

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

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

72. Individual Medicaid programs use the Medicaid patient data in the cost report to determine the reimbursement to which the facility is entitled. The facility receives a proportion of its costs equal to the proportion of Medicaid patients in the facility.

73. Where a provider submits the Medicare cost report with false or incorrect data or information to Medicaid, this necessarily causes the submission of false or incorrect data or information to the state Medicaid program, and the false certification on the Medicare cost report necessarily causes a false certification to Medicaid as well.

74. Where a provider submits a Medicaid cost report containing the same false or incorrect information from the Medicare cost report, false statements and false claims for reimbursement are made to Medicaid.

75. All HCA hospitals listed on Exhibit 4, which is incorporated herein by reference, sought reimbursement from designated state Medicaid programs for the time period pertinent to this Complaint.

**C. The TRICARE/CHAMPUS Program**

76. At all times relevant to this Complaint, many HCA hospitals were enrolled in, and sought reimbursement from, the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), now known as TRICARE Management Activity/CHAMPUS ("TRICARE/CHAMPUS").

77. TRICARE/CHAMPUS is a federally-funded program that provides medical benefits, including hospital services, to (a) the spouses and unmarried children of (1) active duty and retired service members, and (2) reservists who were ordered to active duty for thirty days or longer; (b) the unmarried spouses and children of deceased service members; and (c) retirees. Hospital services at non-military facilities are sometimes provided for active duty members of the armed forces, as well. 10 U.S.C. §§ 1971-1104; 32 C.F.R. § 199.4(a).

78. In addition to individual patient costs, TRICARE/CHAMPUS reimburses hospitals for two types of costs based on the Medicare cost report: capital costs and direct medical education costs. 32 C.F.R. § 199.6.

79. A facility seeking reimbursement from TRICARE/CHAMPUS for these costs is required to submit a TRICARE/CHAMPUS form, "Request for Reimbursement of CHAMPUS

Capital and Direct Medical Education Costs" ("Request for Reimbursement") in which the provider sets forth its number of TRICARE/CHAMPUS patient days and financial information which relates to these two cost areas and which is derived from the Medicare cost report for that facility.

80. 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."

81. Upon receipt of a hospital's Request for Reimbursement and its financial data, TRICARE/CHAMPUS or its fiscal intermediary 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 patients in the facility.

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

83. Whenever defendants' Requests for Reimbursement were false due to falsity in their Medicare cost reports, defendants falsely certified that the information contained in their Requests for Reimbursement was "accurate and based upon the hospital's Medicare cost report." (emphasis added).

84. Defendants knew that false claims contained in their Medicare cost reports often would affect TRICARE/CHAMPUS reimbursement as well.

85. Attached hereto as Exhibit 5, and incorporated herein by reference, is a chart listing HCA hospitals that sought reimbursement from TRICARE/CHAMPUS by submitting the Request for Reimbursement during the relevant time period.

## VII. DEFENDANTS' SCHEME

### A. Summary of HCA's Unlawful Conduct

86. During the time period relevant hereto, HCA was aware of the prohibitions against kickbacks and the legal restrictions on financial relationships with physicians. This awareness was based on information obtained by HCA from various sources, including its counsel, outside training programs, trade associations, and the government. Despite this information, HCA embarked on a strategy of paying kickbacks to and engaging in unlawful financial relationships with physicians to induce patient referrals to HCA facilities. HCA in turn billed for and collected hundreds of millions of dollars in reimbursement from the United States based on patient referrals from these same physicians.

87. In order to induce physicians to refer patients to HCA hospitals and other facilities, HCA provided the following unlawful inducements and kickbacks to physicians who were in a position to refer patients to HCA facilities and entered into the following prohibited relationships with such physicians:

(a) Preferential and Sham Investment Opportunities. HCA offered and provided these physicians preferential opportunities (not available to the general public) to obtain equity/financial interests in HCA healthcare operations (including the HCA hospitals) through partnerships or other arrangements. Furthermore, in some instances, HCA provided

these physicians with equity/financial interests in HCA healthcare operations without requiring that the physicians make any investment (in cash or in kind) in the operations.

(b) Preferential or Sham Investment Financing Opportunities. HCA offered and provided loans to these physicians for them to invest in HCA healthcare operations and HCA offered and provided assistance to these physicians in obtaining such loans.

(c) Sham Personal Service Agreements (PSAs). HCA paid monies, disguised as fees paid for services under medical directorships, physician consultancies or other PSAs, to these physicians to enable them to invest in HCA healthcare operations on a risk-free basis, i.e., without expending any of their own money on the investment, when, in fact, HCA had no true need or intent to utilize the services identified in these agreements. HCA's practice of entering into sham PSAs included, but was not limited to, the following: (i) HCA entered into contracts for the physicians to serve odd or inappropriate functions not necessary to the operation of the hospitals or contracting entities; (ii) HCA paid physicians under two or more contracts that required them to serve in two or more part-time positions while they were also engaged full-time in the private practice of medicine; (iii) HCA paid several physicians under separate contracts to do the same job; (iv) HCA paid physicians sums well in excess of the value of the services to be provided under the agreements; and (v) HCA paid physicians for services not rendered.

(d) Sham Leases of Physician Owned Property or Equipment. HCA "rented" offices and equipment from these physicians in order to induce them to relocate their offices at or near HCA hospitals and other facilities when HCA had no actual need for the leased property or equipment.

(e) Sham Medical Office Building (MOB) Leases. HCA provided these physicians with free or substantially reduced rents, or forgave substantially overdue rents, for office space in facilities owned or operated by HCA at or near the HCA hospitals or other healthcare facilities.

(f) Sham or Uncollected Loans and Credit Lines. HCA paid these physicians monies disguised as the proceeds of a loan or credit line that HCA never intended to collect or decided not to collect.

(g) Improper Gratuities. HCA provided these physicians with free or reduced-rate vacations, hunting trips, fishing trips, or similar recreational opportunities.

(h) Improper Recruitment Packages. HCA paid for the cost of recruiting new physicians into the existing practices of "loyal" physicians as a reward and inducement to the existing physicians for referring patients to HCA facilities and to induce the recruited physicians to observe similar referral practices.

(i) Financing Physician Practice Expenses. HCA enabled physicians to avoid expenses attendant to their own private practices by financing or paying for their employees, equipment or other expenses.

**B. The Scheme Begins in El Paso, Texas in 1987**

88. HCA's business strategy in El Paso targeted potentially high referring physicians for special treatment, offered such physicians remuneration under various guises, including illegitimate participation in the profits earned by the hospitals, forgiveness of loans, sham directorship contracts, discounted or free lease arrangements and other benefits.

89. In 1987, as the first step in this plan, HCA purchased two acute care hospitals in El Paso, Texas: Sun Towers Hospital and Vista Hills Medical Center.

90. From the start, HCA planned to form a partnership with physicians and pay remuneration to physician partners that would induce referrals to Vista Hills and Sun Towers, and thereby guarantee income for HCA. HCA even informed its bankers that El Paso Healthcare Systems, Ltd. (EPHS), the partnership formed to own the two hospitals, would succeed financially because physician partners would be induced to refer patients to Sun Towers and Vista Hills. The physicians in turn would share in the profits of the hospital through the partnership.

91. In connection with the formation of EPHS, HCA sought and obtained a legal opinion on the partnership in May 1988, that was subsequently provided to investors in the partnership. The opinion detailed the prohibitions of the Anti-kickback Statute, 42 U.S.C. § 1320a-7b(b), warned of the "potential illegal remuneration implications of the structure of the Partnership," and identified the "Physician Partners' investment opportunity and benefits" as potentially illegal remuneration.

92. HCA executives, however, ignored counsel's advice and structured the transaction exactly as the lawyer warned them not to do. Specifically, HCA controlled EPHS and conducted its business affairs so as to provide illegal remuneration to physicians by, among other things, selecting physician partners based on the value or volume of their anticipated referrals, providing partnership interests for no consideration, and financing investments for physicians through non-recourse notes.

**1. <u>Preferential Investment Opportunities</u>**

93. In 1988, counsel advised HCA and the executives tasked with forming and selling subscriptions for the partnership "to avoid determining a potential investor's eligibility to invest on the basis of the number of promised or projected patient admissions or referrals to the Hospitals . . . ."

94. Contrary to advice of counsel, HCA targeted and solicited only those physicians in the El Paso medical community who maintained the types of practices that routinely refer patients to hospitals and other health care facilities for inpatient and/or outpatient care. HCA did not solicit those physicians who, as a result of their type of practice, did not routinely refer patients to a hospital.

95. In November 1988, EPHS purchased Landmark Medical Center (formerly the Sister's of Charity Hotel Dieu Hospital). Landmark Medical Center was a 355 licensed bed general medical/surgical hospital. Upon EPHS's purchase of Landmark, HCA closed the hospital and targeted significant referring Landmark physicians for recruitment into the EPHS partnership.

96. Sometime in 1988, HCA compiled an internal list of potential physician investors in the EPHS Limited Partnership (the "Target List"). The Target List identified physicians not capable of making substantial patient referrals to the facilities in which HCA had an interest. Handwritten comments in the margin revealed the selection criteria: "wrong specialty-loser [sic]"; "due to specialty you may not want him;" "62 yrs retiring soon"; "close to retirement-practice diminished;" "wrong specialty for revenue." However, physicians who were in a position to refer large numbers of patients to medical facilities in which HCA had an interest were described as follows: "Sierra-good target;" "is using Sierra and VH- needs incentive to use

VH and ST;" "big ENT practice;" "could do more at ST;" "Sierra-could swing business to ST;" "really could hurt Prov, big $ practice- this would be a big catch."

97. Active members of the medical staff of Sun Towers and Vista Hills who were not approached to join the partnership (consistent with the Target List), but who wished to join the partnership and were eligible under the official terms of the deal, were unable to obtain even minimal information from HCA executives on the deal.

98. HCA executives told physicians that projected distributions were directly linked to patient referrals. HCA executives in El Paso, including Richard L. Scott, an attorney and the Chief Executive Officer of HCA until 1997, and Russ Schneider, President and CEO of EPHS at the time, told physicians that if they referred X number of patients, their expected distribution would be Y, and that as their referrals increased, so would their distributions. HCA employees typically did not exclude Medicare referrals from their return on investment analysis in these discussions.

99. EPHS partnership meetings stressed the need for continued admissions from physician investors to ensure profitability. HCA management reiterated the linkage on numerous occasions.

a. HCA executives provided at least one physician, Dr. ELP 81,[1] with exact figures for how much revenue the hospital would earn from his referrals, and Dr. ELP 81 calculated that the figures had to be based on the assumption that he would send every single patient to HCA, including the 25-30% that represented Medicare and Medicaid. HCA officials

[1] Consistent with the Information and Stipulation of Factual Basis (Exhibit 1) filed against CMC in the criminal case, the United States has not publicly identified physicians by name here, but has provided that information to HCA.

made clear that they were only interested in his referrals, and not his capital investment or participation in management.

b. Another physician, Dr. ELP 82, recalled HCA executives describing a direct link to his surgeries and lab referrals. If he ordered an EKG, he would receive approximately $10.00 in distributions and if he ordered a urinalysis, he would receive approximately $1.50 in distributions.

c. HCA executives told another physician, Dr. ELP 77, that the revenues from Medicare and Medicaid patients would help hospital overhead.

d. On or about November 30, 1988, HCA told the accountant for Dr. ELP 29 and Dr. ELP 39 that HCA was soliciting investments in EPHS to secure referral commitments from doctors.

100. Similarly again, on or about October 18, 1988, HCA, in an attempt to entice Dr. ELP 80 to purchase EPHS units, showed Dr. ELP 80 projections specific to his medical practice, which demonstrated the income that Dr. ELP 80 could generate for HCA from patient admissions and referrals, and how much revenue would then be paid to Dr. ELP 80 in the form of distributions if he were a partner. The projections did not specifically exclude patient referrals of individuals whose services were paid for by federal health care programs.

101. Consistent with those statements, HCA distributed profits of EPHS to its physician partners based on the physician's referrals of patients.

102. The original EPHS partnership offering based partner distributions of profit on a formula driven by the physician partner's referrals to EPHS, excluding Medicare and Medicaid referrals, as well as on the actual percentage ownership interest in EPHS of the physician

partner. In practice, however, HCA did compensate certain partners based on total patient referrals, including Medicare and Medicaid referrals.

103. As one HCA executive told one physician, revenues from those referrals would be used to cover overhead and, thereby, increase profit distributable under the referral driven formula. Moreover, when in April 1989, HCA claimed to abandon the referral driven formula for profit distributions, it first declared a reallocation of ownership interests to establish "equity" under the new payment scheme. The reallocation itself took into account each physician partner's referral history or "performance" in determining each physician's reallocated holdings. Top referrers got a bigger piece of the reallocated pie than physicians who had referred less than expected. When one physician later complained that his total referrals weren't adequately compensated for when HCA altered the distribution of partnership units based on referrals, HCA acknowledged his complaint by giving him free rent.

**2. Sham Equity Investments**

104. In addition to the prohibition on recruiting physicians based on referrals, counsel also told HCA, "If Physician Partners could obtain Partnership interests for no consideration, distribution of Partnership benefits [profits] would likely be viewed as value given in exchange for patient admissions by the Physician Partners to the Hospitals." (Emphasis added.) Counsel went on to state, "By way of illustration, if partnership interests were acquired at below fair market value or for nominal consideration (e.g., nonrecourse notes), the rate of return on investment could appear unreasonably high, thereby raising the implication that the return on investment is, in part, payment for patient admissions or referrals to the Hospitals." (Emphasis added.)

105. Notwithstanding this advice, HCA executives such as Richard Scott, Russ Schneider and Lonnie L. Busby, President of EPHS, offered and provided investments to physicians at minimal or no out of pocket cost to the physicians for the express purpose of inducing referrals.

106. HCA's initial offering as reviewed by counsel offered each solicited physician one EPHS unit for the price of $30,000. Under the terms of the Confidential Offering Memorandum, each physician was required to pay $10,000 in cash, up front, and would then be permitted to sign a promissory note with HCA for payment of the $20,000 balance. In fact, HCA reduced the out of pocket investment to $5,000, and for many targeted physicians, HCA paid some or all of the $5,000 investment itself. With respect to the remaining $25,000, HCA provided non-recourse financing and told physicians they would not be held personally liable. Further, HCA did not even require that the physician pay off the $25,000 owed on the note, and in many cases, continued to make profit distributions despite the physician being in default on the note.

107. HCA executives, including Richard Scott and Russ Schneider, actually gave certain physicians $2,500-$5,000 to put down as the physicians' initial investment. Further, the balance of the note was paid from partnership distributions on the units, rather than legitimate investment capital.

108. Some physicians were not required to contribute capital out of their own pocket for their down payment, but instead were provided with their $5,000 initial capital contribution in cash or in kind. Some physicians were provided with their down payment through the "return" of charitable contributions which the physicians had previously made to Landmark

Medical Center. Other physicians were issued a check by Vista Hills or Sun Towers, which check they then endorsed back to EPHS to cover their down payment. Others had their down payments covered by the application of rent payments which were actually already owed to HCA, since the doctor was a tenant in one of HCA's medical office buildings.

109. For example, in exchange for and to induce patient referrals from Dr. ELP 59, on or about November 18, 1988, HCA issued a check made payable to Dr. ELP 59 from Landmark Medical Center, in the amount of $5,000, which Dr. ELP 59 endorsed payable to Sun Towers/Vista Hills Holding Company as his capital contribution for the purchase of one EPHS unit. On or about October 31, 1988, HCA loaned Dr. ELP 59 $25,000 to purchase the EPHS unit, upon the execution of a promissory note, which was due and payable on October 31, 1991. The subscription agreement related to this promissory note reflected that Dr. ELP 59 paid the $5,000 capital contribution, when in fact he had not.

110. Similarly, in exchange for and to induce patient referrals from Dr. ELP 38, on or about October 29, 1988, HCA, pursuant to a promissory note, loaned Dr. ELP 38 $25,000 to purchase an EPHS unit. The terms of the subscription agreement included the fact that Dr. ELP 38 had paid a $5,000 initial capital contribution for the purchase of the unit. However, instead of collecting the $5,000 from Dr. ELP 38, HCA applied $5,000 in rent payments already owed by Dr. ELP 38 to HCA, since Dr. ELP 38 was a tenant in HCA's Stanton Medical Building.

111. HCA executives assured physicians that the promissory note investment vehicles were "risk free," and that "no personal money" would be involved. This belief is evidenced by one physician's failure to list the note on a loan application, despite listing other debts. Another

physician made routine payments on all his other debts, but did not believe he was obligated to make payments on the HCA note.

112. Despite the clear language of the note, HCA completely failed to collect interest or principal payments in some instances, while, in others, simply applied a portion of the partnership distributions and failed to collect the remaining note payments from the physicians. Moreover, HCA apparently never executed on the collateral and required a defaulting physician to return the units. When physicians with long overdue notes asked HCA to buy back their partnership units (often based on personal needs for cash), HCA did so by valuing the unit, and then simply subtracting the unpaid principal, and paying the physician the remainder, even though under the note, HCA could have taken back the unit.

113. In July 1991, HCA allowed partners to exchange up to forty-four percent (44%) of their EPHS units, which could not be freely sold by their terms, for stock in HCA, which could be sold profitably on the open market. HCA issued an offering document requiring that any shares of HCA stock acquired in exchange for EPHS units already pledged as collateral for any unpaid promissory notes be substituted as collateral on the note. HCA, however, did not enforce this requirement and instead allowed EPHS partners to trade for the HCA stock (and sell it if they chose) without paying the outstanding loans.

114. For example, in exchange for and to induce patient referrals from Dr. ELP 44, on or about September 23, 1988, HCA loaned Dr. ELP 44 $25,000, to purchase an EPHS unit, upon the execution of a promissory note, which was due and payable on September 23, 1991. On or about June 25, 1991, HCA authorized the conversion of 44% of Dr. ELP 44's EPHS units to HCA common stock, at a rate of $61,345.00 per EPHS unit, even though the units were pledged

as collateral to HCA in the promissory note. The stock was not substituted as collateral on the unpaid note and could be freely sold by the physician. On the date of maturity, Dr. ELP 44's note maintained a balance due.

115. On October 4, 1992, Dr. ELP 44's note maintained a balance due of approximately $17,469.94. On the date of maturity and thereafter, HCA neither required the note to be paid in full, nor caused to be surrendered the collateral pledged on the note, namely, Dr. ELP 44's ownership interest in EPHS.

116. On or about October 9, 1992, HCA provided Dr. ELP 44 with another $25,000 pursuant to a promissory note. The check from HCA contained a memo: "partnership buyout," implying that HCA was purchasing the remainder of Dr. ELP 44's EPHS units. However, HCA never acquired Dr. ELP 44's units, but rather continued to pay him distributions for the units, and applied the distributions to the first loan of September 23, 1988. Dr. ELP 44 never paid the second loan.

**3. Sham Investment Financing Opportunities**

117. The promissory notes signed in connection with the acquisition of partnership units provided that the note balance could be paid by applying partnership distributions to pay down the note balance. The notes were secured by the physician's ownership interest in EPHS and all proceeds of that interest. HCA allowed at least one physician to pay off the balance of his outstanding note by applying the amounts of the physician's existing rental payments for office space in one of the defendant's leased properties. Partnership distributions were applied by HCA to offset the note balances, but HCA did not require the promissory notes to be paid in full on the date of maturity.

118. For example, in exchange for and to induce patient referrals from Dr. ELP 77, on or about November 22, 1988, HCA loaned Dr. ELP 77 $25,000 to purchase EPHS units, pursuant to a promissory note. However, HCA told Dr. ELP 77 that the loan "would go away" if Dr. ELP 77 admitted two patients per week to HCA medical facilities. HCA did not exclude federal health care program patient referrals.

119. Similarly, in exchange for and to induce patient referrals from Dr. ELP 67, on or about March 1, 1990, HCA loaned Dr. ELP 67 $25,000 to purchase an EPHS unit, upon the execution of a promissory note, which was due and payable on March 1, 1993. On the date of maturity, Dr. ELP 67's note maintained a balance due. On that date, HCA neither required the note to be paid in full, nor caused to be surrendered the collateral pledged on the note, namely, Dr. ELP 67's ownership interest in EPHS. On February 15, 1995, although Dr. ELP 67 still owed approximately $17,444.84 on the note and was almost two years in default, HCA did not cause the surrender of the collateral pledged, and instead purchased Dr. ELP 67's interest in Dr. ELP 67's business, valued at approximately $7,500 and declined to deduct that amount from Dr. ELP 67's loan balance. Instead of deducting $7,500 from the outstanding note balance, HCA gave Dr. ELP 67 an additional interest in one half of an EPHS unit.

120. On or about July 24, 1989, HCA agreed to apply an additional $5,000 rent paid to HCA by Dr. ELP 38 for his rental space in the Stanton Medical Building, to the outstanding balance of the October 29,1988 note.

121. On or about August 22, 1990, HCA agreed to apply future rent payments paid by Dr. ELP 38 to HCA for his rental space in the Stanton Medical Building to pay off the then $7,451.04 balance of the October 29, 1988 note.

**4. Sham Loans Not Related to Partnership Units**

122. On a number of occasions, HCA made certain personal and business loans to physicians to garner their patient referrals, including referrals of patients whose medical services were paid for by federal health care programs. HCA made some of these loans to physicians who already had outstanding non-performing promissory notes with HCA. HCA made the loans with the understanding that no repayment would be required. In most instances, HCA made minimal or no collection efforts on such loans and took no efforts to enforce the terms of the promissory note if a physician was delinquent or in default.

123. For example, on or about August 5, 1992, HCA, pursuant to a promissory note, loaned Dr. ELP 51 $75,000 for the purpose of paying college tuition for his children and two personal debts. The loan was due and payable on or about August 5, 1993. The loan was secured with the EPHS units owned by Dr. ELP 51. As of August 26, 1994, Dr. ELP 51 was in default of the terms of the promissory note and still owed HCA approximately $69,999.19. However, HCA, instead of causing the surrender of the collateral pledged, purchased the collateral, Dr. ELP 51's EPHS units, from him for approximately $86,521.50.

124. In exchange for and to induce patient referrals from Dr. ELP 72, on or about May 31, 1989, HCA loaned Dr. ELP 72 $33,000, upon the execution of a promissory note, to use as a down payment on Dr. ELP 72's new medical office, which was due and payable May 31, 1994. The promissory note was collateralized by Dr. ELP 72's EPHS unit and the balance of the loan was to be retired by applying the distributions derived from Dr. ELP 72's EPHS unit. HCA assured Dr. ELP 72 that he would never have to pay any money out of his pocket to retire this note. On the date of maturity, Dr. ELP 72's note maintained a balance due and Dr. ELP 72 was

in default. On that date, HCA neither required the note to be paid in full, nor caused to be surrendered the collateral pledged on the note, namely, Dr. ELP 72's ownership interest in EPHS. On or about February 1, 1995, while Dr. ELP 72 was still in default, HCA purchased 2.8316 EPHS units from Dr. ELP 72 for $42,474 and did not require Dr. ELP 72 to retire his debt with the proceeds of this sale. On or about May 1, 1996, Dr. ELP 72 was in default of the note and still owed HCA approximately $13,326.17.

125. Similarly, on or about February 8, 1993, HCA provided an Association with a $200,000 line of credit. HCA represented to Drs. ELP 70 and ELP 61, the physician members of this Association, that the loan would only have to be repaid if their medical practices flourished. Drs. ELP 70 and ELP 61 understood that they would never be personally liable on the debt and that the doctors would have to refer all of their patients to Columbia East, formerly Vista Hills Medical Center. Eventually, this Association drew $35,000 on the $200,000 line of credit, none of which was ever repaid.

**5. Sham Medical Office Building (MOB) Leases**

126. To secure patient referrals to its facilities, HCA entered into certain lease agreements with physicians for office space in HCA's medical office buildings. HCA entered into certain "side letter" agreements with the physicians which provided the physicians with additional remuneration including free rent, free parking spaces, reduced rent, and free remodeling among other things. In one case, HCA paid the rent for the balance of a lease the physician had in a building not owned by HCA.

127. For example, in exchange for and to induce patient referrals from Dr. ELP 26 on or about January 14, 1992, HCA provided Dr. ELP 26 with a "side letter" to his lease agreement

with HCA for office space at the Oregon Medical Office Building which provided additional benefits to Dr. ELP 26 of approximately $82,995.

128. Similarly, in exchange for and to induce patient referrals from Dr. ELP 58, on or about February 20, 1991, HCA provided Dr. ELP 58 with a "side letter" to his lease agreement with HCA for office space at the Oregon Medical Office Building which provided additional benefits of approximately $50,195. As a further inducement for Dr. ELP 58 to make patient referrals, HCA agreed to pay Dr. ELP 58's rent at the Providence Medical Building for approximately 18 months until his new space at HCA's Oregon Medical Office Building was completed. Additionally, HCA paid Dr. ELP 58 $10,000 for architectural fees Dr. ELP 58 incurred in relation to a building privately owned by Dr. ELP 58.

129. Again similarly, in exchange for and to induce patient referrals from Dr. ELP 36, on or about March 8, 1993, HCA provided Dr. ELP 36 with a "side letter" to his lease agreement with HCA for office space at the Oregon Medical Office Building which provided additional benefits to Dr. ELP 36 of approximately $60,171.

**6. Sham Personal Service Agreements (PSAs)**

130. To encourage patient referrals, HCA provided remuneration by entering into certain medical directorship and/or consulting agreements (also known as personal service agreements or PSAs) with physicians. These physicians were not required or expected to perform the services delineated in the agreements.

131. For example, EPHS acquired the Columbia Behavioral Center (CBC) as an outpatient facility in 1988. On or about December of 1991, CBC became an 80 licensed beds psychiatric hospital, in El Paso, Texas, which provided both inpatient and outpatient care. The

average patient occupancy rate of CBC in 1991 was 54.8%. At one time, HCA had in existence twenty-two directorships with physicians, at least seventeen of whom performed no work as directors.

132. On or about February 1, 1993, HCA entered into one year Medical Directorship Agreements with sixteen referring physicians at the CBC, pursuant to which the physicians were to be paid a collective total of $73,990 per month. The sham directorships included, among others: medical directors of "Bicultural," "Advertising," "P.R.," "Spiritual Programming," and "Adjunctive."

133. On or about April 1, 1993, HCA entered into three additional Medical Directorship Agreements with three other physicians at the CBC, pursuant to which the physicians were to be paid a total of $9,666.33 per month, although HCA did not require the doctors to perform any services as medical directors, contrary to the terms of the Medical Directorship Agreements.

134. Similar to the CBC directorships, on or about July 1991, HCA entered into a Medical Directorship Agreement with Dr. ELP 50 pursuant to which Dr. ELP 50 was to be paid $2,000 a month for five years. HCA did not require or expect Dr. ELP 50 to perform any services as a medical director, contrary to the terms specified by the Medical Directorship Agreement.

135. On at least two occasions, HCA entered into directorship agreements for the purpose of providing funds which were then credited as payment on loans.

136. For example, in early 1990, HCA sought to induce three orthopedic surgeons, Drs. ELP 55, ELP 2, and ELP 16, who, at that time referred a vast majority of their patients to competing acute care hospitals, to switch their patient referrals to HCA's medical facility.

137. On or about June 1990, HCA offered to purchase the physical therapy clinic owned by Dr. ELP 16. HCA then offered Dr. ELP 16 and two other physicians, Drs. ELP 55 and ELP 2, sham directorships to ensure the flow of patient referrals after the clinic purchase. On or about December 7, 1991, as part of the purchase agreement, notwithstanding that Drs. ELP 55 and ELP 2 had no ownership interest in Dr. ELP 16's physical therapy business, HCA agreed to pay $120,000 per year for five years as medical directorships for Drs. ELP 55 and ELP 2, and HCA agreed to pay $100,000 per year to Dr. ELP 16 for five years in the form of a medical consulting agreement.

138. From on or about January 1, 1992 through approximately October, 1996, HCA paid and continued to pay Drs. ELP 16, ELP 55 and ELP 2, although none of them provided the services delineated in their respective agreements as required for payment.

139. On or about December 6, 1991, HCA also loaned Dr. ELP 55 $200,000, pursuant to a promissory note. The note provided that the debt could be offset by the directorship fees to be paid Dr. ELP 55 as part of the sale of Dr. ELP 16's physical therapy practice.

140. Subsequent to that loan, on or about September 14, 1992, HCA loaned Dr. ELP 55 $50,000, again pursuant to a promissory note. The note again permitted the debt to be offset by the directorship fees to be paid Dr. ELP 55.

**7. <u>Improper Gratuities</u>**

141. On several occasions, HCA provided illegal remuneration in the form of lavish out of town trips for physicians, their spouses and their families as a reward for reaching specific referral goals with respect to and to induce future referrals by the physicians to HCA's health care facilities.

142. For example, in 1989, HCA paid the complete expenses for several physicians' vacation to Caracas, Venezuela and Manzanillo, Mexico. Subsequent to the Manzanillo, Mexico trip, HCA told Dr. ELP 13, a beneficiary of that trip, that there would be more such vacations provided at HCA's expense if HCA could maintain an average daily census of 40 patients at CBC. 143. In 1990, HCA paid all of the expenses for a "fun-filled weekend visit to San Diego" for 37 physicians and their spouses, which included physicians who practiced medicine in El Paso, Texas. In 1992, HCA paid the complete expenses for a fishing vacation to Alaska, and trips to the Bahamas and Puerto Rico of several physicians. In 1993, HCA paid the complete expenses for a vacation to Alaska of several physicians. In 1994, HCA paid the complete expenses for a vacation fishing trip to the Amazon of several physicians.

**8. Free Pharmaceuticals**

144. In certain instances, HCA provided illegal remuneration to certain physicians in the form of free pharmaceuticals at the pharmacies at HCA's health care facilities as an inducement for patient referrals. Certain physicians received pharmaceuticals for themselves, their families and their patients from HCA's pharmacies and were not required to pay for the medication. At least one of these physicians in turn sold the medication he acquired for free from HCA to his patients, and kept the proceeds for himself.

**9. Financing Physician Practice Expenses**

145. HCA paid the salaries of some employees of certain physicians to secure patient referrals. Although the employees worked for the physicians, HCA paid the salary of the employees through its payroll.

**10. Sham Business Transactions**

146. HCA purchased medically related businesses from physicians to secure patient referrals. HCA provided illegal remuneration by purchasing certain physicians' medical clinics, medically related businesses and/or buildings, for a value including but not limited to: money, directorships, consulting agreements and other in kind benefits, which combined value significantly exceeded the fair market value of the interest or property being sold.

147. With certain physicians, HCA engaged in a variety of the schemes alleged above. For example, on or about July 15, 1988, HCA wrote, in a letter to Dr. ELP 3, that Dr. ELP 3's "support of the system" was essential for the success of EPHS.

148. On or about April 1, 1989, HCA reallocated the ownership interest of Dr. ELP 3 in EPHS by increasing his unit ownership interest of 3.0664 units to 10.88 units, an additional ownership interest valued at approximately $234,408, as a result of Dr. ELP 3's large number of patient referrals to HCA's health care facilities.

149. Beginning on or about 1988 and continuing through and including 1995, HCA permitted Dr. ELP 3 to remove and use pharmaceuticals from HCA's pharmacies without requiring payment for the pharmaceuticals.

150. Beginning on or about December 3, 1990 and continuing through May 31, 1996, HCA paid, through its payroll, the salary of one employee, a medical assistant, who worked exclusively for Dr. ELP 3.

151. On or about August 31, 1988, HCA loaned Dr. ELP 58 $25,000 to purchase an EPHS unit, pursuant to a promissory note. On that same date, HCA issued a check made payable to Dr. ELP 58 from Sun Towers Hospital, in the amount of $5,000, which Dr. ELP 58 endorsed payable to Sun Towers/Vista Hills Holding Company as his capital contribution for the purchase of one EPHS unit. In addition, HCA assured Dr. ELP 58 that he would never incur any out of pocket expense associated with his unit purchase. To facilitate that assurance, HCA and Dr. ELP 58 entered in to a medical directorship agreement where Dr. ELP 58 was to be paid $30,000 over the term of the agreement. Dr. ELP 58 was assured he did not have to perform any services as a Medical Director.

152. On or about April 16, 1990, HCA gave Dr. ELP 58 $35,000 in fees for his "services" in appraising three medical clinics owned by HCA when HCA knew Dr. ELP 58 did not perform these services for HCA.

153. On or about June 2, 1992, HCA gave Dr. ELP 58 10 EPHS units valued at approximately $150,000 as a "finder's fee," for assisting HCA in purchasing a medical diagnostic company, when HCA knew that Dr. ELP 58 did not act as a "finder" for HCA in this transaction.

154. From sometime in 1988 and continuing through1995, HCA permitted Dr. ELP 58 to remove and use pharmaceuticals from HCA's pharmacies without requiring payment for the pharmaceuticals.

155. Beginning on or about August 11, 1994 and continuing through May 31, 1996, HCA paid, through its payroll, the salary of one employee, a medical assistant, who did not work for HCA, but worked exclusively for Dr. ELP 58.

156. HCA facilities in El Paso, Texas, paid $6,895,957 in such remuneration to 77 physicians during the years 1988 to 1999 and the hospitals or other HCA entities identified in Exhibit 6 received at least $103,328,473 in payments on 71,809 claims submitted to Medicare on referrals from those physicians during the period in which the remuneration was paid.

## C. HCA Management Continued The Scheme In Corpus Christi, Texas

157. HCA management selected Corpus Christi, Texas as the next market into which they would introduce the El Paso model of tying physician financial interests to those of the hospitals HCA acquired. As in El Paso, HCA management paid kickbacks and illegal remuneration and engaged in prohibited financial relationships with physicians from whom HCA facilities in Corpus Christi received patient referrals.

158. In 1989, HCA formed its first limited partnership in Corpus Christi, Corpus Christi Healthcare Group (CCHG), in which an HCA subsidiary held a controlling interest and served as managing partner. In 1989, CCHG acquired Osteopathic or "Doctors" Hospital. In approximately the fall of 1990, CCHG purchased Southside Community Hospital (Southside).

159. In 1993, HCA offered a second partnership opportunity to Corpus Christi physicians to replace CCHG. HCA formed Bay Area Healthcare Group (BAHG) to build and operate a new hospital, Bay Area Medical Center.

160. In 1996, HCA solicited physician investors for yet another partnership to operate a new heart hospital in Corpus Christi.

### 1. Preferential Investment Opportunities

161. HCA's business strategy in Corpus Christi targeted potentially high referring physicians for special treatment, offered such physicians remuneration under various guises,

including illegitimate participation in the profits earned by the hospitals, sham directorship contracts, discounted or free lease arrangements and other benefits.

162. HCA management, including Russ Schneider, then President of Columbia Hospital Corporation, Southwest Division, and Gary Looper, later CEO of HCA hospitals in Corpus, approached physicians in Corpus Christi and solicited them to purchase partnership units to induce those partner-physicians to refer patients. In recruiting Corpus Christi physicians, HCA management touted the lucrative rewards paid to physician partners of EPHS, their El Paso partnership.

163. In late 1989 or early 1990, HCA representatives made a presentation to a group of 30-50 local Corpus Christi physicians, including Dr. James Thompson, about the possible purchase of Osteopathic Hospital, a struggling facility in Corpus Christi, and the formation of a joint venture, including physicians, to purchase and operate the hospital.

164. As in El Paso, HCA executives Schneider and Looper told the physicians that their own referrals would put money back in their pockets.

165. Shortly thereafter, Looper and Schneider made an appointment to visit with Dr. Thompson, a family practitioner, at his office located on the campus of Southside Community Hospital. Schneider and Looper informed Dr. Thompson (a) that family practitioners like him would be central to the new venture because they attracted specialists to a hospital, admitted the most patients, and therefore were most responsible for hospital census and profitability, (b) that they knew him to be influential among the local physicians, and (c) that they wanted him to invest because others would follow.

166. As with its partnership venture in El Paso and the first partnership in Corpus Christi (CCHG), in 1993, HCA again offered investment opportunities in Bay Area Health Care Group (BAHG) to influential physicians on the staffs of certain hospitals that were to be owned by BAHG, including Southside. HCA did not offer BAHG units to the public or the investment community. With the exception of certain HCA executives, HCA restricted investment opportunities in BAHG to physicians who would be in a position to refer patients to HCA facilities owned by the entity.

167. HCA executives continued the practice of targeting high referring physicians through the formation of a third partnership to operate a new heart hospital. In the summer of 1996, just as the offering for the sale of the units was about to expire, the Director of Physician Relations at Bay Area Medical Center, Craig Adams, met with the Chief Executive Officer of the Heart Hospital and reviewed the Bay Area Medical Center Medical Staff Member list to identify potential investors based on the expected volume of referrals. Preference was given to younger physicians with a potentially high volume of referrals, because they were expected to continue as a source of referrals for a longer period of time than older physicians. Few interests were sold to older physicians.

168. The CEO of the Heart Hospital enlisted Adams to pursue additional physician investors from a marked-up “Staff Member List” similar to the El Paso “Target List.” If the physician’s name was underlined, this meant that the physician was a preferred potential investor. Physician names crossed out with an "x" meant that the physician was too poor a referral source, or was too old, to be offered an investment interest.

169. As with the earlier partnerships, HCA sold investment interests in the new heart hospital almost exclusively to physicians in a position to make or influence referrals to or otherwise generate business for the HCA Heart Hospital. HCA did not offer units for sale to the public.

**2. Sham Investment Opportunities**

170. At a meeting with Dr. Thompson and the physicians comprising his "call group" in connection with the initial partnership in Corpus Christi (CCHG), HCA representatives explained that HCA was forming a limited partnership, and that each unit/share was being sold for $12,000.00. CCHG was to purchase and operate a local hospital. At the time of the discussions, the purchase under consideration was of Corpus Christi Osteopathic Hospital. HCA would serve as managing partner.

171. When Dr. Thompson expressed concern about the offering price, Schneider and Looper offered to fund loan payments for him by paying him $500 a month for 24 months under what proved to be a sham medical directorship.

172. In subsequent pre-formation meetings with Dr. Thompson and his call group, Looper further offered that HCA would return the cash outlay/investment which the physicians were making in the partnership, by having the hospital engage the doctors as "consultants" and pay them each a $500 monthly fee.

173. As promised, as soon as Dr. Thompson signed on as a partner in March or April 1990 and paid for his unit, $500 checks began to arrive monthly, even though HCA did not ask him to do any work for the money.

174. HCA repaid the $12,000 to Thompson by checks sent over 30 months; in addition, however, the payments by HCA continued for six months thereafter, until HCA opened its flagship hospital in Corpus Christi, Bay Area Medical Center, in September 1993.

175. Seven other physicians received similar payments. In April and May 1990, Dr. Thompson and these other physicians began receiving payments from HCA Doctors Hospital (f/k/a Osteopathic Hospital prior to its acquisition by HCA) under 2-year physician service agreements. Such payments represented the return of their original investment in monthly payments.

176. The first payment for each physician came within days of their "investment" in CCHG. The amount of monthly payment to each ensured that each physician recouped the amount of their investment after 24 months. The titles given each physician under the contracts confirm that they served no reasonable business purpose and strongly suggest their only purpose was to fund physician investment in CCHG. Four physicians were given the same title of "JCAHO Consultant." Three physicians were given the same title of "Endocrinology Director," although one did not even practice in that specialty. One physician was given the title of "Addictionology Director." At the hospital's then current average daily census, this resulted in HCA having one consultant for every 2.5 patients.

177. The internal CCHG partnership file maintained by HCA contained these physicians' signed offering memoranda and other documentation of their ownership interests, as well as handwritten notes and in the case of one physician, a letter that corroborates the linkage between the sham contracts and their investment money.

178. CCHG partners ultimately received tremendous returns on their sham investments. For example, in less than two and a half years, Dr. Thompson's investments with HCA appreciated over 1,000 percent.

**3. Distributions Tied to Referrals**

179. Schneider and Looper told Dr. Thompson that if he and his call group shifted just 5 of their 30 to 40 monthly hospital admissions from a competing hospital to the HCA hospital, the partnership would be a profitable investment. Corporate documents confirm that HCA intended physician investment in Corpus Christi to instantly induce a shift in referrals from that competitor to Doctors Hospital. At an October 1990 meeting of physician partners, Schneider and Looper appealed to the personal financial interests of physician partners to generate referrals and improve performance. At the meeting, HCA management specifically linked census, distributions, and referrals.

180. During partnership meetings, HCA employees provided financial and operational updates, including reports on the "average daily census" (ADC) which refers to the average daily number of paying patients in hospital beds; information as to the "target" or "projected" ADC, and whether the hospital or other entity was performing to projections. HCA related the overall financial performance of the entity to the ADC, reported the number of ER visits and surgeries, and discussed other specific aspects of hospital utilization related to the financial performance of the entity.

181. The financial reporting at partnership meetings made clear that the financial performance of the partnership, and the distribution to the physician-investors, was dependent on hospital utilization in terms of ADCs, surgeries performed, and other criteria.

182. The financial reports also made clear that the financial performance of the entity was dependent upon physicians restricting the length of Medicare patient stays to the "suggested length of stay" according to Medicare "diagnostic related group" codes (DRGs). It was clearly understood and reported in the financial meetings that Medicare referrals and timely Medicare discharges were critical to avoiding financial loss to the hospital and, thus, to the partnership and its physician-investors.

183. By September 1991, HCA considered partnership distributions so important to maintaining referral relationships that HCA senior management was willing to pay distributions to physicians even when the partnership was not yet making money. Russ Schneider asked Richard L. Scott for permission to borrow $2.5 million from HCA to cover partnership expenses and to delay repayment until completion of the new hospital being built by HCA.

184. Schneider justified his request by stating that cash flow was needed in the short run to "STRENGTHEN OUR MARKET POSITION. . . ." by paying distributions to physicians. Schneider circulated his memo to other senior managers as well.

185. Consistent with Schneider's plan, HCA paid CCHG partners a distribution for the fourth quarter of 1991.

**4. Sham PSAs and MOB Leases**

186. Prior to HCA's purchase of Southside in late 1990, the hospital had been paying Dr. Thompson a fee of $1700 per month and providing him free office rent on the campus of the hospital. The fee had originally begun as an incentive for Dr. Thompson and other members of his call group to move to the hospital campus, to reimburse Dr. Thompson for "expenses" of moving his office, and to pay Dr. Thompson for "physician recruitment."

187. Looper and HCA continued the payment of the fee and the free rent for the duration of the operation of Southside (through August 1993).

188. HCA continued to provide either free or below market rent to other physicians, including other members of Thompson's call group, on the South campus of Southside Community Hospital after it was purchased by HCA, as an incentive for them to locate their offices near, practice at, and refer patients to Southside.

189. Looper told Dr. Thompson that HCA had decided to continue payments under Doctors (Osteopathic) Hospital and Southside contracts, even those contracts that had expired, to avoid angering any of the physicians prior to moving them all over to the new hospital being built by HCA, Bay Area Medical Center.

190. When HCA prepared to open Bay Area Medical Center, HCA offered many physicians various financial inducements to move their offices to the MOB on the Bay Area campus and refer patients to HCA facilities.

191. In 1993, HCA gave several physicians and three large practice groups deeply discounted rent deals. Some physicians received one year's worth of free rent, with discounts for the next four years, while others received deeply discounted rent for all 5 years of their lease.

192. Nine of 22 leases at the Bay Area MOB went for less than half the rent charged the highest paying practice groups. At least four of those half-price leases went to Dr. Thompson and the other original investor consultants.

193. Dr. Thompson was offered and accepted the opportunity to rent space in the Bay Area MOB for approximately 70¢ per square foot per month, on a five-year lease. HCA offered other members of his call group the same rental opportunities, and some accepted. The fair

market rental value of such space was approximately twice the rent being charged to Dr. Thompson and the other members of his call group who accepted the company's offer.

194. Although HCA management was aware that HCA Internal Audit had identified the half price leases as problematic in April 1994, HCA and Bay Area management did nothing.

195. In November 1994, the CEO of Bay Area approached Dr. Thompson concerning the rental rates for the MOB, and told him that "corporate" was concerned that they might have problems under Medicare Fraud and Abuse Regulations because some of the office building rental rates were too low, and that they might have to ask some of the physicians to pay increased rents. The MOB rental problems, however, continued at Bay Area until at least 1996.

196. Bay Area management justified the leases based on referrals, stating: "These physicians have been supporters of Columbia in the community since its inception four years ago."

197. In addition to lease benefits, HCA provided referring physicians with generous cash moving expenses and build-out allowances for the physicians' office space. In early 1993, HCA management at Southside offered doctors up to $5,000 to offset relocation expenses as well as advertising and announcement support. Other records show that build out expenses incurred for Dr. Thompson and three other physicians exceed the allowances stated in their leases by thousands of dollars.

198. HCA also forgave the costs of leasehold improvement buildouts for certain physicians.

199. When Dr. Thompson's new offices were built at the Bay Area MOB, the cost of building out the leasehold improvements exceeded the amount allowed for the buildout by

approximately $17,000. When Dr. Thompson expressed reluctance to pay for the cost overruns, HCA agreed that he would not be required to pay for them.

**5. Sham Property Transactions**

200. Internal HCA documents demonstrate that, as late as 1995, MOB construction was not evaluated by HCA on the merits of rental revenue the market could generate for the space, but on the combination of revenue and "Hospital Impact from Recruitment." HCA management justified the construction of medical office buildings to be rented at a loss based on the expected referrals from physician tenants.

201. In 1995, the senior management of HCA, including Richard L. Scott and David Vandewater, approved construction of a medical office building at Doctors Regional Medical Center in Corpus Christi purely on the basis of the value and volume of referrals the new building's primary tenant could generate.

202. In October 1995, Doctors Regional sought permission from corporate to build a third medical office building. They proposed to construct the building even though the proposed rents would not cover the building's expenses. Doctors Regional management justified construction because the primary tenant would be the XYZ Clinic, a large practice group in Corpus Christi. The XYZ Clinic would relocate to the hospital's campus if the hospital would purchase a building 5 miles away from a sub-group of XYZ physicians for $1 million, and discount their rent in the new building by about $60,000 per year off the rent to be charged to other tenants.

203. When the Chief Operating Officer of HCA Doctors Regional Medical Center in Corpus Christi was asked what HCA was going to do with the XYZ clinic's old building, the

CEO responded that he needed the building like he needed a hole in his head, but that Doctors Regional Medical Center would get referrals from the clinic and business in return for buying the property from the group. Another HCA employee stated at the time that the purchase price for the building was "chump change" compared to the business Doctors Regional would get from the clinic. The clinic property remained vacant and had to be guarded by an HCA security guard.

204. The documents used to obtain authorization from Scott and Vandewater show that the hospital attempted to justify the deal solely on the basis of the revenue from the referrals made by physicians at XYZ Clinic to the hospital. The HCA analyst who drafted the *pro forma* concluded that the "proposed rental structure on the MOB itself does not provide a positive return on investment."

205. Scott and Vandewater personally approved not only the construction proposal, but also the significant concessions to the XYZ Clinic. They then specifically set a financial target for the project's success based on not just rental revenue, but on the value of referrals generated from the new MOB.

206. HCA purchased and leased real property from referring physicians to induce referrals. HCA frequently overpaid and/or had no legitimate purpose for the space acquired or leased. HCA management in Corpus Christi also incurred unnecessary expense to relieve physicians of lease or ownership burdens to enable them to move their practices, and their referrals, to HCA facilities.

207. For example, HCA provided an orthopedic surgeon with a large practice what amounted to free rent at the Bay Area MOB by renting the building he owned for his practice at

a higher rate than he would pay Bay Area. HCA had no real use for the building, and it sat unused for nearly three years.

208. With respect to a different physicians' group, HCA assumed the leasehold obligation of the group and paid the rental owed by the group to their landlord, thereby enabling the group to move into HCA's medical office building. The arrangement, however, was commercially unreasonable, because the rental value was fixed on the basis of the value for medical office space, which was substantially greater than the fair market rental value for commercial office space, the use to which the space was being put by HCA. The rental being paid by HCA on behalf of the group exceeded the fair market value which HCA would be required to pay to obtain commercial office space.

**6. Improper Recruitment Packages**

209. HCA management in Corpus Christi also used recruiting to maintain referrals from existing physicians. HCA bore the costs of recruiting physicians for doctors who wanted to grow their practices, enabling the physicians to avoid all of the costs normally attendant to adding a physician to an existing practice. HCA typically covered the headhunter costs, income guarantees, office expansion and overhead, student loans and marketing expenses for the new bigger practice. In some cases, guarantee payments went to the practice, and the practice paid the new physician less than the guarantee amount.

210. Internal HCA documents reveal that recruitment results were evaluated on the basis of their impact on net hospital revenue – impact that can only be attributed to patient referrals.

211. HCA exploited its illegal physician recruitment arrangement with the XYZ clinic, to obtain the clinic's assistance in pressuring a group surgery practice in Corpus Christi to perform surgical cases at Bay Area instead of at an HCA competitor.

212. The surgery practice's principal medical offices were located next door to the competing hospital, where its physicians perform most of their surgical cases. XYZ clinic was the primary source of surgery case referrals to this practice group.

213. The Director of Physician Relations and the CEO of Bay Area met with the practice group on or about March 22, 1996 to pressure them to perform the surgery referrals it received from the XYZ clinic at Bay Area. The implied threat communicated to the practice group at that meeting was that if its physicians did not change their referral patterns, Bay Area would recruit new surgeons onto the Bay Area campus to compete with the practice group and perform the XYZ clinic's surgery referrals at Bay Area. The CEO said that the pressure to "put the squeeze" on the practice group was coming from the HCA South Texas Division President.

214. In or about March, 1996, to increase the pressure on the practice group, Bay Area in fact hired Fox Hill Associates, Ltd., a health care industry consulting firm, to publish an ad in a surgical journal for an immediate opening for 4 general surgeons. The practice group saw the ad in the journal and were enraged.

215. HCA continued its efforts to pressure the practice group to move its cases to Bay Area after Kirk Wilson became the CEO of Bay Area. Bay Area agreed to provide financial assistance to recruit physicians to the XYZ clinic on the condition that the group's physicians would continue to deliver 100% of their admissions to Bay Area, and, in addition, encourage the practice group to perform their surgical cases at Bay Area.

216. The practice group opened an office on the Bay Area campus in the fall of 1996 and, on information and belief, HCA earned substantial revenues from surgeries performed by the practice group.

**7. Financing Physician Practice Expenses**

217. HCA also paid remuneration by financing physician practice expenses.

218. For example, in 1996, fearing that a different practice group upon which Bay Area and Doctors Regional depended heavily for referrals was close to dissolving, HCA paid for a practice consultant, Frost & Company, P.C., to assist the group to stay together for an estimated fee of $15,000.

219. To conceal that HCA would be paying for a practice analysis of a physician group, HCA executives told the Director of Physician Relations at Bay Area to reference the project as "Hospital Strategic Planning." Steve Woerner, the CEO of Doctors Regional, and Steve Erixon, CEO of Bay Area, each agreed that his hospital would pay up to $7,500.00 for the practice evaluation, based on the estimated cost of $15,000.00.

220. The study was completed in July of 1996. Bay Area Medical Center was billed and paid its agreed portion of the cost of the analysis in the amount of $7,500.00.

221. Woerner initially refused to authorize the payment of Doctors Regional's agreed portion of the cost of the study, and expressed concern that the payment for the evaluation would violate federal health care fraud and abuse laws.

222. Woerner subsequently authorized the payment of Doctors Regional's portion of the study after a paper trail was fabricated to conceal the true nature of the payment.

223. The physicians at the XYZ clinic continued to be a major source of referrals and revenue for HCA.

**8. Improper Gratuities**

224. Beginning as early as April 1991, HCA invited Dr. Thompson to join other physicians who were in a position to refer patients to HCA facilities on an expense-paid bass fishing trip to Venezuela. The group included approximately ten other doctors from HCA hospitals in Houston, Fort Worth and Florida.

225. Over the succeeding years, HCA sponsored additional expense-paid trips in which Dr. Thompson participated, to New Orleans in or around September 1991, to Chicago in or around November 1991 and in or around the fall of 1992, to Mexico (dove hunting) in or around the summer of 1992 and again in or around the summer of 1993, and to Costa Rica (fishing) in or around March 1994.

226. All of the trips included not only Dr. Thompson, but other physicians who practice at HCA's facilities. The Venezuela trips included physicians from other localities, which Dr. Thompson recalls as including Houston, Fort Worth and Miami.

227. Based on conversations with physicians from such other localities on these trips, Dr. Thompson learned that HCA provided free or below-market rent at or near its hospital facilities, and arranged "consultation fees" to induce physicians to practice at its hospitals in such other localities.

228. Based upon conversations with other physicians in the Corpus Christi area, Dr. Thompson believes that HCA sponsored additional trips, in which he did not participate, for physicians in a position to refer patients to HCA facilities, on additional occasions, including

cruises to the Caribbean, dude ranch vacations in Arizona and trips to the Super Bowl. HCA continued to sponsor trips through at least 1997. A trip scheduled for the Spring of 1998 was canceled only after the United States conducted its raid on the El Paso, Texas, HCA facilities.

229. In addition, HCA sponsored local hunting trips to nearby facilities such as the Herra Dura Ranch in South Texas. Although Dr. Thompson participated in only one trip to the Herra Dura Ranch, it is his recollection that HCA sponsored weekly trips to the ranch during the hunting season of 1992. Subsequently, HCA sponsored frequent hunting trips during hunting season to other local or regional facilities.

230. HCA facilities located in or around Corpus Christi, Texas, paid $2,348,727 in such remuneration to 75 physicians during the years 1991 to 1999 and the hospitals or other HCA entities identified in Exhibit 7 received at least $19,864,682 in payments on 12,223 claims submitted to Medicare on referrals from those physicians during the period in which the remuneration was paid.

**D. HCA Management Continued The Scheme In Miami, Florida**

231. HCA continued its unlawful practices as it expanded beyond Texas to the rest of the country. HCA purchased Miami Heart Hospital in 1993, and its operations there illustrate HCA's pattern of providing physician inducements and management's refusal to cease such practices.

232. Two HCA El Paso employees, Tim Parker and Tim Adams, assumed significant positions at Miami Heart during the 1990's. Tim Parker, the former CFO of Columbia West (formerly Sun Towers Hospital) in El Paso until November 1993, held various positions at Miami Heart, ultimately becoming the CEO of Miami Heart. Likewise, Parker recruited Adams

to Miami Heart and Adams became the Assistant Vice-President of Operations. In El Paso, Adams was involved in providing free employees to El Paso physicians as described above.

233. In or around late 1991or early 1992, just prior to its acquisition by HCA, Miami Heart entered into various questionable physician contracts, including a directorship contract with three pulmonologists that called for compensation of almost $1 million for 3 years, as well as various other benefits. HCA continued the arrangement and these physicians ultimately referred patients worth more than $20 million in Medicare payments to Miami Heart.

234. In November 1993, HCA Internal Audit reported the following at Miami Heart: payments to physicians based on oral directions from Miami Heart administration, physicians receiving free office space, and questionable physician recruitment practices.

235. After listing the circumstances under which free rent might be permissible, Internal Audit stated, "many of the current arrangements do not fall under one of these exceptions."

236. Internal Audit stated in 1993 that the transaction with the three physicians was highly questionable. Nevertheless, HCA continued the arrangement and paid the three pulmonologists until well into 1997.

237. In April 1994, an in-house Columbia attorney informed Columbia management at Miami Heart that the regulatory guidance issued by HHS "squarely addressed" the illegality of providing free office space and secretarial services to physicians when that remuneration is coupled with an intent to induce or reward referrals.

238. In 1997, Internal Audit again reviewed this transaction and discovered clear evidence that the agreement with the three physicians was a sham – the physicians were creating

and submitting their time sheets a month in advance of when the work allegedly was to be performed. HCA did not terminate the contract with these three physicians until 1997.

239. Even after search warrants were executed against HCA facilities in El Paso in 1997, Tim Parker concluded yet another unlawful transaction known as the "Senior Center" deal, with two local physicians.

240. In May 1997, Miami Heart recruited another HCA employee from El Paso, Ana De Paola Mroz, to become Director of Senior Health Services for Miami Heart. As Director of Senior Health Services, Ms. Mroz's primary responsibility was to develop and manage as many as six Centers which HCA planned to open in the Miami area. HCA intended to open its first Center by July 7, 1997.

241. The Centers were to be located in a building near Miami Heart. Each Center was to be staffed by two to three physicians designated as Medical Directors and responsible for administering the Center. The physicians were to be compensated on an hourly basis for this work as Medical Directors.

242. HCA intended to use the Centers as a vehicle to induce referrals by the medical directors. HCA intended to hire, as Medical Directors, physicians who had established practices with a large number of Medicare clients. Those doctors referred some of their patients to Miami Heart, but sent many of their patients to other local hospitals. Tim Parker, then CEO of Miami Heart, told Ms. Mroz that the purpose of opening these Centers was to increase Miami Heart's market share of patients. In particular, employing physicians with large, established practices who sent many patients to other hospitals could induce them to send more of their patients to Miami Heart.

243. In addition to providing Medical Director positions in exchange for hourly compensation, HCA offered the physicians office space at each Center to see their private practice patients. HCA also would pay for the salary and other benefits to the physicians' staff, whom they were permitted to bring from their existing practices. By providing these benefits, HCA intended to induce the physicians to refer their patients to Miami Heart for treatment.

244. The first Center that HCA intended to open was located on Alton Road in Miami Beach. The Center entered into contracts with the two long-established primary care and gastroenterologist practitioners, Drs. MIA 24 and MIA 39, to serve as Medical Directors. Ms. Mroz learned that both physicians would be moving their offices into the Center. There would be no separate space for them to see private patients, and they had not been advised that they would have to pay rent for the space, because HCA had no intention of charging them rent. In addition, she learned that two of their staff members, a medical assistant and office manager, would be working for them at the Center, and that HCA would pay their full-time salaries and benefits.

245. On June 11, 1997, in light of her concerns, Ms. Mroz wrote a memorandum regarding the hiring of physicians' staff and the use of the Centers by physicians to treat non-medicare patients to Parker; Dianne Alemann, Chief of Nursing Operations for Miami Heart; Tim Adams, Assistant Vice President for Operations of Miami Heart; and Lori Johnson, Special Projects Manager.

246. Ms. Mroz advised Miami Heart management that it was not permissible under Medicare regulations for HCA to pay the salaries of physicians' staff who saw non-Medicare patients in addition to Medicare (i.e., Senior Center) patients, nor was it permissible for HCA to

pay for office space in which physicians treated private, non-Medicare (i.e., non-Senior Center) patients. In the memorandum, Ms. Mroz expressed concern that the planned payment of the doctors' staff and office space, as well as that of other physicians intended to be recruited for other Centers, might violate the Anti-kickback Statute.

247. On June 12, 1997, Ms. Mroz was summoned to Parker's office, where Alemann also was present. Parker demanded to know why she had written the June 11 memorandum, saying that the memorandum could create "a paper trial" that would be a "red flag" to anyone who would review it.

248. On June 14, 1997, Ms. Mroz again was summoned to Parker's office. This time Ms. Johnson was present. At this meeting, Parker instructed Ms. Mroz to erase the memorandum from the memory of her computer. Because Ms. Mroz did not have her computer (a personal laptop) at the office that day, she brought it to work the following day, and, in the presence of Adams, erased the memorandum from her computer. Prior to erasing the memorandum, however, she copied it onto a diskette, which she kept.

249. As a result of Ms. Mroz's memorandum, no changes were made in the plans to pay for the Center's physicians' staff, nor to have separate areas for the physicians to treat private, non-Medicare patients.

250. Later on June 17, 1997, Ms. Mroz was called to Alemann's office. Charlene Welker, Assistant Director of Nursing, was present. Alemann reiterated to Ms. Mroz that she had displayed "poor judgment" in writing the June 11 memorandum. Alemann told her that she needed to think about what she wanted to do, and that she did not have to return to her job after a

planned vacation if she did not want to do so. Alemann then told Ms. Mroz that she had until Monday, June 23, to decide how she wanted to proceed.

251. Since there had been no change in the plans for operating the Centers, it was clear to Ms. Mroz that she either had to accept a role managing the Centers under those conditions, or resign. On June 23, 1997, Ms. Mroz submitted her resignation.

252. During July 1997, the first of the Miami Heart Senior Centers opened. HCA paid the salary and benefits of the two physicians' staff, and did not charge the physicians any rent, although they were treating both Medicare and non-Medicare patients in the Center.

253. HCA also paid for the physicians' previous office lease, leased equipment from the physicians at $2,000/month, and paid off another equipment lease for the physicians. The physicians then shifted their referrals from a competing hospital to Miami Heart.

254. HCA facilities located in Florida, paid $7,948,385 in such remuneration to 82 physicians during the years 1991 to 1999 and the hospitals or other HCA entities identified in Exhibit 8 received at least $50,763,308 in payments on 28,420 claims submitted to Medicare on referrals from those physicians during the period in which the remuneration was paid.

## VIII. FALSE AND FRAUDULENT CLAIMS AND STATEMENTS

255. Pursuant to the scheme, pattern and practice described above, the HCA hospitals provided illegal remuneration, inducements and kickbacks to hundreds of physicians, submitted false and fraudulent claims, and fraudulently obtained payments from the United States on referrals by these physicians in violation of the Stark Statute, the Anti-kickback Statute and the False Claims Act.

256. Through the practices outlined above, HCA's founders and top management established a corporate climate that tolerated and encouraged illegal remuneration as one way to insure the success of its various enterprises. Based on the pattern and practice of kickbacks, illegal remuneration and prohibited relationships at the dozens of HCA hospitals specifically identified in this Complaint and its attachments, combined with the participation of HCA management in this conduct, the United States alleges, on information and belief, that additional violations of the Anti-kickback Statute, the Stark Statute and/or the FCA likely occurred at these HCA hospitals and other HCA hospitals throughout the United States. At such time as these additional violations become known to the United States, the United States will seek leave to amend this Complaint accordingly. The United States is also in the process of identifying the false claims submitted to the Medicaid and TRICARE/CHAMPUS Programs resulting from the false claims made to the Medicare Program, and will seek leave to amend this Complaint accordingly.

## A. False Claims Resulting from Violations of the Anti-kickback Statute and, During Applicable Time Periods, the Stark Statute

257. Attached as Exhibit 9 hereto is a list of the HCA hospitals currently known by the United States to have engaged in such illegal practices and submitted false and fraudulent claims as a result. Furthermore, Exhibits 2, 4 and 5 hereto inventory each false and fraudulent cost report known to have been submitted by HCA hospitals as a result of these practices during the relevant time period and the HCFA fiscal intermediary to whom it was submitted. For the years in which each HCA Hospital submitted those false and fraudulent cost reports and certified to compliance with laws and regulations prohibiting such practices, each HCA Hospital is believed to have paid illegal remuneration in at least the total amount stated on Exhibit 9, to at least as many physicians and/or physician groups as indicated on Exhibit 9. Each HCA Hospital submitted at least the

number of Medicare claims on referrals from those physicians and received at least as much reimbursement on those claims as indicated on Exhibit 9.

**B. False Claims Resulting from Violations of the Stark Statute Alone**

258. The HCA hospitals identified on Exhibit 10 also provided remuneration to and engaged in prohibited financial relationships with various physicians, submitted claims to Medicare, and obtained payments from Medicare on referrals from those physicians in violation of the Stark Statute. In contrast to the claims listed in Exhibit 9, at this time, the United States is not alleging that the claims listed in Exhibit 10 were also submitted in violation of the Anti-kickback Statute. In addition to the false and fraudulent claims identified in Exhibit 9, each hospital identified on Exhibit 10 paid remuneration to physicians with whom the hospital had no written PSA or other document memorializing the purpose or consideration the hospital received for the payment.

259. Each HCA Hospital identified on Exhibit 10 is believed to have paid remuneration in at least the total amount stated on Exhibit 10 in relationships that violate the Stark Statute, to at least as many physicians and/or physician groups as indicated on Exhibit 10. Each HCA Hospital submitted at least the number of Medicare claims on referrals from those physicians, in violation of the Stark Statute, and received at least as much reimbursement on those claims as indicated on Exhibit 10.

260. Contemporaneous with and prior to the filing of this Complaint, the United States provided HCA with documentation identifying the relationships, by physician name, remuneration, by type and year, and the false and fraudulent Medicare claims summarized in Exhibits 9 and 10.

## IX. DAMAGES

261. The United States was damaged because of the acts of defendants in submitting, causing to be submitted, or conspiring to submit false claims, statements and records in that it paid HCA hospitals for items and services for which they were not entitled to reimbursement.

262. Defendants profited unlawfully from the payment of illegal remuneration and kickbacks to physicians.

**FIRST CAUSE OF ACTION**

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

263. Plaintiff repeats and realleges ¶¶ 1 through 262 as if fully set forth herein.

264. Defendants knowingly presented or caused to be presented false or fraudulent claims for payment or approval to the United States, including claims for reimbursement for services rendered to patients unlawfully referred to HCA facilities by physicians to whom defendants provided kickbacks and/or illegal remuneration and/or with whom defendants entered into prohibited financial relationships in violation of the Anti-kickback Statute and/or the Stark Statute.

265. By virtue of the false or fraudulent claims made by the defendants, the United States suffered damages and therefore is entitled to multiple 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 to Cause Claim to be Paid)
(31 U.S.C. § 3729(a)(2))

266. Plaintiff repeats and realleges ¶¶ 1 through 262 as if fully set forth herein.

267. Defendants knowingly made, used, or caused to be made or used, false records or statements – *i.e.*, the false certifications and representations made or caused to be made by defendants when initially submitting the false claims for interim payments and the false certifications made or caused to be made by defendants in submitting the cost reports – to get false or fraudulent claims paid or approved by the United States.

268. By virtue of the false records or false 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; Making or Using False Record
or Statement to Avoid an Obligation to Refund)
(31 U.S.C. § 3729(a)(7))

269. Plaintiff repeats and realleges ¶¶ 1 through 262 as if fully set forth herein.

270. Defendants knowingly made, used or caused to be made or used false records or false statements – *i.e.*, the false certifications made or caused to be made by defendants in submitting the cost reports – to conceal, avoid or decrease an obligation to pay or transmit money or property to the United States.

271. By virtue of the false records or false 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**

(False Claims Act; Conspiring to Submit False Claims)
(31 U.S.C. § 3729(a)(3))

272. Plaintiff repeats and realleges ¶¶ 1 through 262 as though fully set forth herein.

273. Defendants entered into agreements with certain physicians and conspired to defraud the United States by submitting false or fraudulent claims for reimbursement from the United States for monies to which they were not entitled, in violation of 31 U.S.C. § 3729(a)(3). As part of schemes and agreements to obtain reimbursement from the United States in violation of federal laws, defendants conspired to provide kickbacks and illegal remuneration to physicians and to engage in prohibited financial relationships with physicians in violation of the Anti-kickback Statute and/or the Stark Statute, and to cause the United States to pay claims for health care services based on false claims and false statements that the services were provided in compliance with all laws regarding the provision of health care services whereas they were not so provided.

274. By virtue of defendants' conspiracy to defraud the United States, 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.

## FIFTH CAUSE OF ACTION

(Payment by Mistake of Fact)

275. Plaintiff repeats and realleges ¶¶ 1 through 262 as if fully set forth herein.

276. 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.

277. The false claims which defendants submitted to the United States' agents were paid by the United States based upon mistaken or erroneous understandings of material fact.

278. The United States, acting in reasonable reliance on the truthfulness of the claims and the truthfulness of defendants' certifications and representations, paid defendants certain sums of

money to which they were not entitled, and defendants are thus liable to account and pay such amounts, which are to be determined at trial, to the United States.

**SIXTH CAUSE OF ACTION**

(Unjust Enrichment)

279. Plaintiff repeats and realleges ¶¶ 1 through 262 as if fully set forth herein.

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

281. By directly or indirectly obtaining Government funds to which they were not entitled, 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.

**SEVENTH CAUSE OF ACTION**

(Disgorgement of Illegal Profits,
For Imposition of a Constructive Trust and an Accounting)

282. Plaintiff repeats and realleges ¶¶ 1 through 262 as if fully set forth herein.

283. This is a claim for disgorgement of profits earned by HCA, the HCA hospitals and the Hospital Defendants because of illegal kickbacks these defendants paid to physicians.

284. Defendants concealed their illegal activity through false statements, claims and records, and failed to abide by their duty to disclose such information to the United States.

285. The United States did not detect defendants' illegal conduct.

286. This Court has the equitable power to, among other things, order HCA and the Hospital Defendants to disgorge the entire profit the HCA hospitals earned from business generated as a result of their violations of the Anti-kickback Statute, the Stark Statute, state laws and the False Claims Act.

287. By this claim, the United States requests a full accounting of all revenues (and interest thereon) and costs incurred by HCA and the HCA hospitals on referrals from physicians to whom they paid kickbacks, disgorgement of all profits earned and/or imposition of a constructive trust in favor of the United States on those profits.

**EIGHTH CAUSE OF ACTION**

(Restitution Against CMC and HCA)

288. Plaintiff repeats and realleges each allegation in ¶¶ 1 through 262, as it fully set forth herein.

289. The United States has suffered losses as a result of violations of 18 U.S.C. § 371 and 42 U.S.C. § 1320a-7b to which defendant CMC pled guilty in the Western District of Texas on December 14, 2000. Mandatory restitution for that loss was reserved for resolution in this matter. CMC and HCA 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.

**NINTH CAUSE OF ACTION**

(Recoupment of Overpayments)

290. Plaintiff repeats and realleges ¶¶ 1 through 262 as if fully set forth herein.

291. This is a claim for recoupment, for the recovery of monies unlawfully paid by the United States to defendants contrary to statute or regulation.

292. The United States paid defendants certain sums of money to which they were not entitled, and defendants are thus liable under the law of recoupment to account and return such amounts, which are to be determined at trial, to the United States.

**TENTH CAUSE OF ACTION**

(Common Law Fraud)

293. Plaintiff repeats and realleges ¶¶ 1 through 262 as if fully set forth herein.

294. Defendants made material and false representations in their initial requests for interim payments and in their cost reports with knowledge of their falsity or reckless disregard for their truth, with the intention that the United States act upon the misrepresentations to its detriment. The United States acted in justifiable reliance upon defendants' misrepresentations by making interim payments on the false claims and then by settling the cost reports at inflated amounts.

295. Had the true facts been known to the United States, defendants would not have received the interim payments or the inflated amounts on the cost reports.

296. By reason of these interim payments and the inflated amounts on the cost reports, the United States has been damaged in an as yet undetermined amount.

**PRAYER FOR RELIEF**

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

1. On the First, Second, Third and Fourth 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 Fifth, Sixth and Ninth Causes of Action, for payment by mistake, unjust enrichment, and 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 all such further relief as may be just and proper.

3. On the Seventh 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 Eighth Cause of Action, restitution for criminal offenses.

5. On the Tenth Cause of Action, for common law fraud, for compensatory and punitive damages in an amount to be determined, together with costs and interest, and for all such further relief as may be just and proper.

Respectfully submitted,

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