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

[UNDER SEAL], Plaintiffs, v. [UNDER SEAL], Defendants.	Case No. COMPLAINT **FILED IN CAMERA AND UNDER SEAL PURSUANT TO 31 U.S.C. §3730(b)(2)**

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

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

Plaintiffs,

vs.

COMMUNITY HEALTH NETWORK, INC., COMMUNITY HEALTH NETWORK FOUNDATION, INC., COMMUNITY PHYSICIANS OF INDIANA, INC., VISIONARY ENTERPRISES, INC., COMMUNITY SURGERY CENTER-NORTH, COMMUNITY SURGERY CENTER-SOUTH, COMMUNITY SURGERY CENTER-EAST, COMMUNITY SURGERY CENTER-HAMILTON, COMMUNITY SURGERY CENTER-KOKOMO, COMMUNITY SURGERY CENTER-NORTHWEST, HANCOCK SURGERY CENTER, COMMUNITY ENDOSCOPY CENTER, and COMMUNITY DIGESTIVE CENTER,

Defendants.

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

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

FILED IN CAMERA AND UNDER SEAL PURSUANT TO 31 U.S.C. §3730(b)(2)

JURY TRIAL DEMANDED

Plaintiff-Relator Thomas P. Fischer, through his attorneys, on behalf of the United States of America (the "Government," or the "Federal Government") and the State of Indiana ("the State" or the "Plaintiff-State"), for his Complaint against Defendants Community Health Network, Inc., Community Health Network Foundation, Inc., Community Physicians of Indiana, Inc., Visionary Enterprises, Inc., Community Surgery Center-North, Community Surgery Center-

South, Community Surgery Center-East, Community Surgery Center-Hamilton, Community Surgery Center-Kokomo, Community Surgery Center-Northwest, Hancock Surgery Center, Community Endoscopy Center, and Community Digestive Center (collectively "Defendants" or "Community"), alleges, based upon personal knowledge, relevant documents, and information and belief, as follows:

I. INTRODUCTION

1. This is an action to recover: (a) damages and civil penalties on behalf of the United States of America and the State of Indiana arising from false and/or fraudulent records, statements, and claims made and caused to be made by Defendants and/or their agents and employees in violation of the federal False Claims Act, 31 U.S.C. §§ 3729 *et seq*. (the "FCA" or the "Act"), and the Indiana False Claims and Whistleblower Protection Act, Ind. Code §§ 5-11-5.5-1 *et seq*. (the "Indiana False Claims Act"); (b) damages arising from Defendants' wrongful harassment of and retaliation against Relator in violation of the anti-retaliation provisions of the FCA, 31 U.S.C. § 3730(h), and the Indiana False Claims Act, Ind. Code § 5-11-5.5-8; and (c) damages for breach of contract, breach of oral contract, promissory estoppel, and quantum meruit.

2. This *qui tam* case is brought against Defendants for knowingly defrauding the Federal Government and the State of Indiana, in connection with Medicare, Medicaid, and other government-funded healthcare programs. As alleged below, for at least the last five years, Community has engaged in a scheme to pay improper compensation to physicians to induce them to illegally refer patients, including Medicare and Medicaid patients, to its hospitals and

associated medical facilities for medical services paid for by government-funded healthcare programs, including "designated health services" as defined by the Stark Law.

3. Community is an integrated health network with locations throughout central Indiana. It is one of the four largest health networks in the region by market share – but not the largest network. Beginning in approximately 2009, coinciding with the appointment of Bryan Mills ("Mr. Mills") as Community CEO, Community began an aggressive strategy to expand its network of employed and affiliated physicians (and, correspondingly, its access to their referrals) to gain leverage against its competitor networks and the health insurance companies with which it regularly negotiated.

4. To do this, Community knowingly and willfully made, and continues to make, illegal and improper payments to its employed and affiliated physicians to ensure that they refer all, or substantially all, of their patients to Community rather than to any of its competitor hospitals or health networks. Such payments, and Community's subsequent submission of claims related to those illegally referred patients, violate the Anti-Kickback Statute, the Stark Law, and the False Claims Act.

5. As alleged in greater detail below, Community's illegal physician payments take a variety of forms. Different physicians and physician groups get different deals depending on the nature of their practice and their prior relationship with Community. The various compensation structures include a combination of, *inter alia*, high base salaries, generous performance and retention bonuses, lump sum payments, inflated purchase of assets owned by the physicians, and provision of surgical center investment opportunities. Community also offers to steer high-

margin commercial business to surgical centers owned (or partially owned) by the physicians, and/or to give the physicians access to lucrative contracts Community has negotiated with commercial insurers.

6. Community's systematic overcompensation of its employed and affiliated physicians is so extreme that Community's physician group has, for the past five or more years, lost tens of millions of dollars per year. For the last two years, these losses have topped $100 million each year.

7. Defendants have submitted and caused to be submitted tens, if not hundreds, of thousands of fraudulent claims to federal and state-funded health care programs for services provided pursuant to kickback-tainted referrals and/or based on referrals from physicians with whom defendants had financial relationships not falling within a Stark safe harbor. Each submission is a false or fraudulent claim in violation of the federal and Indiana False Claims Acts.

8. Defendants' conduct alleged herein violates the federal and Indiana False Claims Acts. The FCA was originally enacted during the Civil War. Congress substantially amended the Act in 1986 – and again in 2009 and 2010 – to enhance the ability of the U. S. Government to recover losses sustained as a result of fraud against it. The Act was amended after Congress found that fraud in federal programs was pervasive and that the Act, which Congress characterized as the primary tool for combating government fraud, was in need of modernization. Congress intended that the amendments would create incentives for individuals with knowledge of fraud against the Government to disclose the information without fear of reprisals or

Government inaction, and to encourage the private bar to commit legal resources to prosecuting fraud on the Government's behalf.

9. The FCA prohibits, *inter alia*: (a) knowingly presenting (or causing to be presented) to the Federal Government a false or fraudulent claim for payment or approval; (b) knowingly making or using, or causing to be made or used, a false or fraudulent record or statement material to a false or fraudulent claim; (c) knowingly making, using, or causing to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly concealing or knowingly and improperly avoiding or decreasing an obligation to pay or transmit money or property to the Government; and (d) conspiring to violate any of these three sections of the FCA. 31 U.S.C. §§3729(a)(1)(A)-(C), and (G). Any person who violates the FCA is liable for a civil penalty of up to $11,000 for each violation, plus three times the amount of the damages sustained by the United States. 31 U.S.C. §3729(a)(1).

10. The FCA allows any person having information about an FCA violation to bring an action on behalf of the United States, and to share in any recovery. The FCA requires that the Complaint be filed under seal for a minimum of 60 days (without service on the defendant during that time) to allow the government time to conduct its own investigation and to determine whether to join the suit.

11. The Indiana False Claims and Whistleblower Protection Act prohibits similar conduct as that prohibited by the FCA, allows plaintiffs to bring an action on the State's behalf, and provides analogous remedies to those provided in the FCA. As set forth below, Defendants'

actions alleged in this Complaint also constitute violations of the Indiana False Claims Act, Ind. Code §§ 5-11-5.5-1 *et seq*.

12. Based on the foregoing laws, *qui tam* plaintiff Thomas P. Fischer seeks, through this action, to recover damages and civil penalties arising from the false or fraudulent records, statements and/or claims that the Defendants made or caused to be made by seeking payment from government-funded healthcare programs for services performed pursuant to referrals from physicians to whom the Defendants had made improper payments.

II. PARTIES

13. Plaintiff-Relator Thomas P. Fischer is a resident of Indianapolis, Indiana. He has worked in the fields of healthcare finance and operations for decades. In October 2005, Relator was recruited from his private practice, where he offered investment banking and advisory services to large healthcare organizations, to serve as the Chief Financial Officer for Community Health Network. In December 2012, he was promoted to serve concurrently as the Chief Operating Officer and Chief Financial Officer. In these roles, Relator was tasked with significant responsibility, including leading teams of administrators in overseeing the finances, operations, supply chains, and managed care contracts of the network's eight hospitals. As set forth in greater detail below, on November 27, 2013, Community constructively discharged Relator in retaliation for his efforts to reform Community's illegal practices.

14. Defendant Community Health Network, Inc. ("CHN") is a 501(c)(3) non-profit integrated health system located in Indianapolis, Indiana. It is incorporated in the State of Indiana with its principal place of business at 1500 N. Ritter Avenue, Indianapolis, Indiana,

which is located in Marion County, Indiana. It includes 8 hospitals, several surgery centers, urgent care centers, and outpatient facilities, bringing its total sites of care to over 200. It employs over 350 physicians through subsidiaries and affiliates, primarily wholly-owned subsidiary Community Physician Network ("CPN"). CHN derives a substantial portion of its revenues from government payers. Medicare accounts for approximately 33% of CHN's revenues and Indiana Medicaid accounts for another 10%.

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

16. Defendant Community Physicians of Indiana, Inc. d/b/a Community Physician Network (referred to herein as "CPN") is a non-profit subsidiary of CHN headquartered in Indianapolis, Indiana. It is a large multi-specialty physician group which employs over 350 primary care and specialty physicians on behalf of the Community network either directly or through subsidiaries and affiliates. CHN employs or otherwise contracts with physicians through a variety of subsidiaries, affiliates, and intermediaries. CPN is currently the primary vehicle through which CHN contracts with physicians.

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

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

19. Visionary Enterprises, Inc. ("VEI") is a for-profit subsidiary of CHN. VEI's primary business is the acquisition and management of ambulatory surgical centers ("ASCs") on behalf of CHN. VEI, through a variety of partnerships and other corporate forms, currently co-owns and manages 9 ASCs in Indiana and 3 in Michigan. Ownership of many of the Indiana ASCs is shared with physicians employed by CPN.

20. Community Surgery Center-North, Community Surgery Center-South, Community Surgery Center-East, Community Surgery Center-Hamilton, Community Surgery Center-Kokomo, Community Surgery Center-Northwest, Hancock Surgery Center, Community Endoscopy Center, and Community Digestive Center are outpatient surgery centers in Indiana. CHN holds an equity stake in each center.

21. Hereinafter, CHN and all of its affiliates, including those named here as defendants, will be referred to as "Community" or "Defendants."

III. JURISDICTION AND VENUE

22. This Court has jurisdiction over the subject matter of this action pursuant to 28 U.S.C. § 1331, and 31 U.S.C. § 3732, the latter of which specifically confers jurisdiction on this Court for actions brought pursuant to 31 U.S.C. §§ 3729 and 3730. This Court has jurisdiction over the claims under the Indiana False Claims Act pursuant to 31 U.S.C. § 3732(b), and over the remaining state law claims asserted in this Complaint pursuant to 28 U.S.C. § 1367.

23. Under 31 U.S.C. § 3730(e), and the analogous provisions of Indiana's False Claims Act, there has been no statutorily relevant public disclosure of the "allegations or transactions" in this Complaint. Even if there had been any such public disclosure, Relator is an original source of the allegations herein because he has direct, independent and material knowledge of the information that forms the basis of this complaint, and voluntarily disclosed that information to the Government and the State before filing.

24. This Court has personal jurisdiction over Defendants pursuant to 31 U.S.C. § 3732(a) because that section authorizes nationwide service of process and because Defendants have minimum contacts with the United States. Moreover, Defendants can be found in and have transacted business in the Southern District of Indiana.

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

IV. APPLICABLE LAW

A. Federal and State-Funded Health Care Programs

1. The Medicare Program

26. Medicare is a federally-funded health insurance program which provides for certain medical expenses for persons who are over 65, who are disabled, or who suffer from End

Stage Renal Disease. The Medicare program is administered through the Department of Health and Human Services, Centers for Medicare and Medicaid Services ("CMS").

27. The Medicare program has four parts: Part A, Part B, Part C and Part D. Medicare Part A, the Basic Plan of Hospital Insurance, covers the cost of hospital services and post-hospital nursing facility care. Medicare Part B, the Voluntary Supplemental Insurance Plan, covers the cost of services performed by physicians and certain other health care providers, such as services provided to Medicare patients by physicians, laboratories, and diagnostic testing facilities. *See* 42 U.S.C. §§ 1395k, 1395l, 1395x(s). Medicare Part C covers certain managed care plans, and Medicare Part D provides subsidized prescription drug coverage for Medicare beneficiaries.

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

a. Medicare Contracts and Claims Submission

29. Medicare reimburses health care providers for the costs of providing covered health services to Medicare beneficiaries. *See* 42 U.S.C. § 1395x(v)(1)(A). In order to bill Medicare Part A, a provider must submit an electronic or hard-copy claim form called the UB-04

(also known as the CMS 1450) to the appropriate Medicare carrier. To bill Medicare Part B, a provider must submit an electronic or hard-copy claim form called the CMS 1500 (formerly known as HCFA 1500) to the appropriate Medicare carrier. These forms describe, among other things, the provider, the patient, the referring physician, the service(s) provided by procedure code, the related diagnosis code(s), the dates of service, and the amount charged. The provider certifies on the CMS 1500 claim form that the information provided is truthful and that the services billed on the form were "medically indicated and necessary." The provider certifies in the UB-04 that "[s]ubmission of this claim constitutes certification that the billing information as shown on the face hereof is true, accurate, and complete."

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

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

32. As a prerequisite to payment, Medicare also requires hospitals to submit annually a Form CMS-2552-10 (previously 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.

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

b. Medicare Payments for Hospital and Physician Services

34. Medicare pays hospitals for providing inpatient and outpatient care. Since 1983, Medicare, Medicaid, and other federally-funded health insurance programs have reimbursed hospitals for inpatient care through a prospective payment system based on classification of patients through Diagnosis Related Groups ("DRGs"). DRGs are groups of clinically similar diagnoses and/or procedure codes, which are presumed to have similar resource utilization. Medicare pays a fixed amount per case by DRG.

35. Payments for outpatient hospital services are also based on a bundled, per-case payment system. Hospitals use Ambulatory Payment Classification ("APC") codes to bill for costs associated with outpatient services. Similar to the DRG-based payment system for inpatient services, Medicare reimburses hospitals for outpatient services through standardized payments determined by the APC to which the claim is assigned.

36. Each claim is assigned one or more APCs based on the procedure codes (*i.e.*, HCPCS code, as described below) included on the claim form. Unlike inpatient DRG payments, where the hospital generally receives only one DRG payment per case, hospitals can receive multiple APC payments for the same outpatient case, depending on the nature of the services provided.

37. Physician services provided to either inpatients or outpatients are billed and reimbursed separately from the hospital's DRG or APC-based payment. Physician services are reimbursed through a payment system based on the Healthcare Common Procedure Coding System ("HCPCS"). HCPCS is a standardized coding system that groups procedures based on the level of professional effort required to render the service. Medicare pays physicians a fixed "global" amount for their services when they are performed in a physician's office. This payment includes both a "professional" component to compensate for the physician's services and a "technical" component to compensate for the cost of office space, supplies, etc.

38. When a physician performs services in a hospital setting (either inpatient or outpatient), Medicare pays the physician a "professional" fee, but does not pay the physician the "technical" component. Instead, the hospital is reimbursed for these costs through the DRG or APC payment.

39. The dichotomy between the professional and technical components of the Medicare payment is more complicated where the physicians provide services through "provider-based" physicians' offices. Medicare allows certain physician practices to be considered part of the hospital facility, even when they are not physically located in a traditional

hospital facility. If a provider practice qualifies as "provider based," the physicians may bill for their professional services the same way they would bill for services performed in a traditional hospital outpatient department, and then the hospital may bill the "technical" component of the service using the APC system. *See* 42 CFR § 413.65. As a general matter, Medicare pays hospitals substantially more for the "technical" component of provider-based physician services than it pays to independent physicians who provide the same services in an office setting.

2. The Medicaid Program

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

41. Federal regulations require each state to designate a single state agency responsible for the Medicaid program. The agency must create and implement a "plan for medical assistance" that is consistent with Title XIX and with the regulations of the Secretary of HHS. Although Medicaid is administered on a state-by-state basis, the state programs adhere to federal guidelines. Federal statutes and regulations restrict the items and services for which the Federal Government will pay through its funding of state Medicaid programs.

42. Each provider that participates in the Medicaid program must sign a provider agreement with his or her state. For example, the State of Indiana requires any prospective Medicaid provider to certify that he or she will only submit claims that: 1) can be documented as medically necessary medical assistance services actually provided to the person in whose name

the claim is being made; and 2) are for compensation that the provider is legally entitled to receive.

3. Other Federal and State-Funded Health Care Programs

43. The Federal Government administers other health care programs including, but not limited to, TRICARE/CHAMPUS, CHAMPVA, and federal workers' compensation programs.

44. TRICARE/CHAMPUS, administered by the U.S. Department of Defense, is a health care program for individuals and dependents affiliated with the armed forces. 10 U.S.C. §§ 1071 *et seq.*; 32 C.F.R. § 199.4(a).

45. CHAMPVA, administered by the U.S. Department of Veterans Affairs, is a health care program for the families of veterans with 100 percent service-connected disability. 38 U.S.C. §§ 1781 *et seq.*; 38 C.F.R. § 17.270(a).

46. The Federal Employees' Compensation Act provides workers' compensation coverage, including coverage of medical care received as a result of a workplace injury, to federal and postal employees. The Act is administered by the Department of Labor, Division of Federal Employees' Compensation. 5 U.S.C. § 8101 *et seq.*; 20 C.F.R. § 10.0 *et seq.*

47. Indiana provides health care benefits to certain individuals, based either on the person's financial need, employment status, or other factors. To the extent those programs are covered by Indiana's False Claims Act, those programs are referred to in this Complaint as "state-funded health care programs."

B. The Stark Law

48. A section of the Social Security Act, 42 U.S.C. § 1395nn (commonly known as the "Stark Law"), prohibits a hospital (or other entity providing healthcare items or services) from submitting claims to Medicare or Medicaid (*see* 42 U.S.C. § 1396b(s)) for payment based on patient referrals from physicians who have an improper "financial relationship" (as defined in the statute) with the hospital.

49. The Stark Law establishes that providers may not submit claims for items or services referred by physicians with whom the providers have financial relationships, unless the relationship falls within the confines of defined safe harbors. In enacting the statute, Congress found that improper financial relationships between physicians and entities to which they refer patients can compromise the physician's professional judgment as to whether an item or service is medically necessary, safe, effective, and of good quality. Congress relied on various academic studies consistently showing that physicians who had financial relationships with medical service providers used more of those providers' 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.

50. Congress enacted the Stark Law 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, Pub. Law 101-239, § 6204.

51. In 1993, Congress amended the Stark Law (Stark II) to cover referrals for ten additional designated health services. *See* Omnibus Budget Reconciliation Act of 1993, Pub. Law 103-66, § 13562, Social Security Act Amendments of 1994, Pub. Law 103-432, § 152. As of January 1, 1995, Stark II applied to patient referrals by physicians with a prohibited financial relationship for the following twelve "designated health services" ("DHS"); (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; (10) home health services; (11) clinical laboratory services; and (12) outpatient speech-language pathology services. *See* 42 U.S.C. § 1395nn(h)(6).

52. In pertinent part, the Stark Law provides:

> "(a) Prohibition of certain referrals
>
> (1) In general. Except as provided in subsection (b), 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 [by Medicare or Medicaid]; and (B) the entity may not present or cause to be presented a claim under this title or bill to any individual, third party payor, or other entity for designated health services furnished pursuant to a referral prohibited under (A)."

42 U.S.C. § 1395nn(a)(1) (emphasis added).

53. Therefore, a physician is prohibited from making referrals to an entity with which he or she has a financial relationship for DHS payable by Medicare or Medicaid. In addition, providers may not bill Medicare or Medicaid for DHS furnished as a result of a prohibited referral.

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

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

56. The Stark Law broadly defines prohibited financial relationships to include any "direct or indirect compensation arrangement . . . with an entity that furnishes DHS." 42 C.F.R. § 411.354(a)(1). An entity is defined to "furnish" DHS if it performs or bills for the service. 42 C.F.R. § 411.351. The statute's exceptions then identify specific transactions that will not trigger its referral and billing prohibitions.

1. Direct Financial Arrangements

57. A "direct financial arrangement" exists when remuneration passes between the referring physician and the entity furnishing the DHS "without any intervening persons or

entities." 42 C.F.R. § 411.354(a)(2). There are several safe harbors for direct financial arrangements, but the requirements must be met precisely to apply.

58. For example, compensation paid pursuant to a "bona fide employment relationship" may be considered proper under the Stark Law, but only if: (1) the employment is for identifiable services; (2) the amount of remuneration under the employment (i) is consistent with the fair market value of the services and (ii) is not determined in a manner that takes into account (directly or indirectly) the volume or value of any referrals by the referring physician; and (3) the remuneration is provided pursuant to an agreement which would be commercially reasonable even if no referrals were made to the employer. 42 C.F.R. § 411.357(c).

59. Similarly, compensation paid pursuant to a "personal services arrangement" between a hospital and a physician may be considered proper under the Stark Law, but only if: (1) the arrangement is set out in writing, signed by the parties, and specifies the services covered by the arrangement; (2) the arrangement covers all of the services to be provided by the physician to the entity; (3) the aggregate services contracted for do not exceed those that are reasonable and necessary for the legitimate business purposes of the entity of the arrangement; (4) the term of the arrangement is for at least 1 year; (5) the compensation to be paid over the term of the arrangement is to be set in advance, does not exceed the fair market value for the services, is not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties (unless the agreement falls within the narrowly defined physician incentive plan); and (6) the services do not involve promoting any activity that violates state or federal law. 42 C.F.R. § 411.357(d).

60. Physicians employed by hospitals either as employees or through personal service arrangements may be paid "productivity bonuses," but only if, and to the extent, that those bonuses are based solely on the value of services personally performed by the physician and not based on the volume or the value of the physician's referrals. 42 C.F.R. § 411.357(c)(4).

61. Finally, there is a catch-all safe harbor allowing entities to compensate physicians with whom they have an arrangement for the provision of items or services, so long as several provisions are met, including that the arrangement is commercially reasonable and the compensation is set in advance, consistent with fair market value, and not determined in a manner that takes into account the volume or value of the physician's referrals. 42 C.F.R. § 411.357(l).

2. Indirect Financial Arrangements

62. An indirect compensation arrangement exists when: (1) an unbroken chain of persons or entities with financial relationships between them links the referring physician to the entity furnishing DHS; (2) the referring physician receives aggregate compensation from the entity with which the physician has a direct financial relationship that varies with, or otherwise takes into account, the volume or value of referrals or other business generated by the physician for the entity furnishing the DHS; and (3) the entity furnishing the DHS has actual knowledge of, or acts in reckless disregard or deliberate ignorance of, the fact that the referring physician receives compensation that so varies. 42 C.F.R. § 411.354(c)(2).

63. To qualify for the Stark Law's exception for indirect compensation arrangements, several elements must be established, including that the compensation received is fair market

value for the services actually provided and is not determined "in any manner that takes into account the volume or value of referrals or other business generated" by the referring physician. 42 C.F.R. § 411.357(p).

64. Fixed aggregate compensation "takes into account" the volume or value of referrals or other business generated by a referring physician when the payment rate is set based on historical or expected referrals. *See United States ex rel. Drakeford v. Tuomey Healthcare Sys.*, 675 F.3d 394, 408 (4th Cir. 2012); *United States ex rel. Singh v. Bradford Reg'l Med. Ctr.*, 752 F. Supp. 2d 602, 631 (W.D. Pa. 2010); 69 Fed. Reg. 16054, 16059 (Mar. 26, 2004) ("It is important to bear in mind that, depending on the circumstances, fixed aggregate compensation can form the basis for a prohibited direct or indirect compensation arrangement. This will be the case if such fixed aggregate compensation takes into account the volume or value of referrals (for example, the fixed compensation exceeds fair market value for the items or services provided or is inflated to reflect the volume or value of a physician's referrals or other business generated).").

3. Group Practice Compensation for Physicians

65. There are also special compensation provisions for physician members of "group practices" as defined by the Stark Law. 42 C.F.R. § 411.352. Physicians in group practices can be compensated through profit shares and productivity bonuses so long as these payments are not calculated in any manner directly related to the volume or value of the physician's referral of DHS. 42 C.F.R. § 411.352(i). The requirements for a physician group to qualify as a "group

practice" are extensive and must be met precisely for these compensation methodologies to be available.

66. Significantly, the "group practice" rules only protect from Stark Law scrutiny referrals from physician group members to other members of the group or the group itself.

67. The "group practice" rules do not protect referrals to a hospital or other non-group entity. If a hospital pays physicians who are members of a group (either directly, or indirectly by way of payments to the group that are then funneled to the individual physicians) any amounts that vary with or take into account the volume or value of the referrals from the physician to the hospital, then the Stark Law is implicated. *See* 66 Fed. Reg. 856, 869 (Jan. 4, 2001) ("Phase I of this rulemaking would require that the compensation to the physicians not vary with or otherwise reflect either referrals to the group (to comply with the employee exception) or referrals to, or other business generated for, the hospital (so that it does not qualify as an indirect compensation relationship).").

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

C. The Federal Anti-Kickback Statute

69. The Medicare and Medicaid Fraud and Abuse Statute ("Anti-Kickback Statute"), 42 U.S.C. § 1320a-7b(b), was enacted under the Social Security Act in 1977. The Anti-Kickback Statute arose out of Congressional concern that payoffs to those who can influence health care decisions will result in goods and services being provided that are medically inappropriate, unnecessary, of poor quality, or even harmful to a vulnerable patient population. To protect the integrity of federal health care programs from these difficult to detect harms, Congress enacted a prohibition against the payment of kickbacks in any form, regardless of whether the particular kickback actually gives rise to overutilization or poor quality of care.

70. 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 the purchase of any item for which payment may be made under a federally-funded health care program. 42 U.S.C. § 1320a-7b(b). The statute ascribes liability to both sides of an impermissible kickback relationship.

71. Claims for reimbursement for services that result from kickbacks are rendered false under the False Claims Act. 42 U.S.C. § 1320a-7b(g).

72. The Anti-Kickback Statute contains statutory safe harbors that exempt certain transactions from its prohibitions such as contracts for employment or personal services. The personal services safe harbor applies to payments to an agent as long as: (1) the agency agreement is in writing and signed by the parties; (2) the agreement specifies all of the services that the agent is to provide for the principal; (3) if "the agency agreement is intended to provide

the services of the agent on a periodic, sporadic, or part-time basis" then the agreement must specify the intervals and their schedules and charges with specificity; (4) the term of the agreement must be not less than 1 year; (5) the aggregate compensation to the agent must be set in advance, "consistent with fair-market value," and not be determined "in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties;" (6) the services must not involve promotion of any activity that violates state or federal law; and (7) the aggregate services contracted for must not exceed those reasonably necessary to accomplish the business purpose of the entity. 42 C.F.R. § 1001.952(d).

73. The employment safe harbor applies to all remuneration paid by an employer to a bona fide employee "for employment in the furnishing of any item or service for which payment may be made in whole or in part under" any federal health care program. 42 C.F.R. § 1001.952(i). This safe harbor provides a defense against Anti-Kickback Statute liability only where a bona fide employee is compensated exclusively for the provision of professional services that are covered by a federal health care program. Any payments to an employee that are not, in fact, made for the provision of covered professional services do not fall within the safe harbor.

74. The act of referring a patient to a hospital or other provider is not a "covered item or service." Therefore, any payments made to an employee to compensate that employee for making referrals are not covered by the employee Anti-Kickback safe harbor. This is true even if the majority of an employee's compensation is for the provision of legitimate professional covered services. As to that portion of the payments that is made to induce referrals and to

compensate for an employee's act of referring a patient, the Anti-Kickback Statute is violated and the safe harbor does not apply.

75. As relevant here, there is also a separate safe harbor for returns on investments in ambulatory surgical centers. "Remuneration" under the Anti-Kickback statute will not include return on an investment in an ASC so long as a number of requirements are met. Notably here, if a hospital is a partial owner of the ASC, to fall within the safe harbor, "the hospital may not be in a position to make or influence referrals directly or indirectly to any investor or the [ASC]." 42 C.F.R. § 1001.952(r)(4)(viii).

76. Once the Government has demonstrated each element of a violation of the Anti-Kickback Statute, the burden shifts to the defendant to establish that the defendant's conduct at issue was protected by a safe harbor. The Government need not prove as part of its affirmative case that defendant's conduct at issue does not fit within a safe harbor.

77. Violation of the Anti-Kickback Statute subjects the violator to exclusion from participation in federal health care programs, civil monetary penalties, and imprisonment of up to five years per violation. 42 U.S.C. § 1320a-7(b)(7), 1320a-7a(a)(7).

78. Compliance with the Anti-Kickback Statute is a precondition to participation as a health care provider under the Medicare and Medicaid programs.

79. Either pursuant to provider agreements, claim forms, or in some other appropriate manner, hospitals and physicians who participate in federal health care programs generally must certify that they have complied with the applicable federal rules and regulations, including the Anti-Kickback Statute.

80. Any party convicted under the Anti-Kickback Statute must be excluded *(i.e.*, not allowed to bill for services rendered) from federal health care programs for a term of at least five years. 42 U.S.C. § 1320a-7(a)(1). Even without a conviction, if the Secretary of HHS finds administratively that a provider has violated the statute, the Secretary may exclude that provider from the federal health care programs for a discretionary period (in which event the Secretary must direct the relevant state agencies to exclude that provider from the state health program), and may consider imposing administrative sanctions of $50,000 per kickback violation. 42 U.S.C. § 1320a-7(b).

81. The enactment of these various provisions and amendments demonstrates Congress' commitment to the fundamental principle that federal health care programs will not tolerate the payment of kickbacks. Thus, compliance with the Stark Law and Anti-Kickback Statute is a prerequisite to a provider's right to receive or retain payments from Medicare, Medicaid and other federal health care programs.

V. ALLEGATIONS

82. Since at least 2009, Defendants have paid kickbacks and other illegal remuneration to physicians to induce those physicians to refer their patients to Defendants' hospitals, physicians and other providers, in violation of the Stark Law, the Anti-Kickback Statute and the False Claims Act. Every claim submitted to Medicare, Medicaid or other government-funded health care program for services rendered pursuant to a referral from a physician that had been paid such illegal remuneration is a false and/or fraudulent claim within the meaning of the FCA and Indiana False Claims Acts. In addition, since around 2012,

Community has solicited and received kickbacks from a chain of Indianapolis-based nursing homes in exchange for directing patients to its centers. Claims submitted to Medicare, Medicaid, or other government-funded health care programs for services rendered pursuant to these kickback-tainted referrals are similarly false and/or fraudulent claims within the meaning of the FCA and Indiana False Claims Acts. Finally, Defendant CHN terminated Relator in retaliation for his expression of concern regarding, and work to halt, these improper financial arrangements.

A. Community's Strategy To Use Financial Inducements To Capture Physician Referrals

83. Around 2009, when Mr. Mills became CEO of CHN, Community began a campaign, at Mr. Mills' direction, for the network to employ a greater number of physicians, including specialists who could refer large numbers of patients to Community's hospitals and surgery centers for expensive procedures, and primary care physicians who could direct patients to not only the hospitals but also to these specialists.

84. Community decided that it needed to increase its number of affiliated, referring physicians and physician practice groups to gain a market advantage vis a vis both its competitor health networks and the health insurance companies with which it contracted. At that time, by total revenue, Community was the smallest of the four large provider networks in the Indianapolis region.

85. Community was concerned that if it did not continue to grow, it would lose the ability to compete with the other networks, especially in its leverage to secure favorable terms when contracting with private health insurance companies. Thus, for example, in a December 2011 presentation titled "CHNw Strategic Plan Refresh: Strategic Issues Discussion," the

primary "strategic question" posed was "[h]ow big do we need to be (regionally and state-wide) to ensure we are an 'essential player' in the current and emerging payer marketplace?"

86. In addition, during that time period, Community witnessed several key physician groups defect from one network to another, bringing their referral base with them. Concerned about defections within its own ranks, Community acted to "lock up" its referring physicians and physician groups, and lure others, with employment and other contracts – routinely paying commercially unreasonable, above fair-market-value rates to do so.

87. According to a December 2009 presentation to Community's Finance Committee, a primary risk to the network was "competition," specifically from efforts by the St. Francis hospital system to "align physicians in the South market." The presentation listed as "strategies" in response to this risk the need to "retain/recruit specialists" and "aggressive[ly]" pursue physicians in the South region of Indianapolis.

88. Over the last several years, Community has repeatedly entered into employment agreements that pay physicians (especially specialists in a position to refer patients to Community) far in excess of what they made previously in private practice. Further, Community regularly loses tens or hundreds of thousands of dollars per year per physician. These deals only make commercial sense if, and because, the value of the physician referrals to Community's hospitals, surgical centers and other facilities are taken into account. Of course, under the Anti-Kickback Statute and Stark Law, physician compensation arrangements must be commercially reasonable and fair market value excluding the value of any downstream referrals.

89. These arrangements appear to be working to meet Community's ends. In 2013, Community's market share in the central Indiana market rose from 21.5% to 23.1%, the largest annual increase in its market share in over 25 years, while the market shares of its three major competitor hospital systems—IU Health, Franciscan Alliance, and St. Vincent Health—all dropped during the same time period.

90. But because of these agreements, while revenues and patient visits are up, Community's losses on its employed physicians have ballooned. In 2008, Community lost about $29 million on its employed physicians. According to a November 2013 report by CPN, this loss has grown steadily since then, increasing dramatically over the last few years as many specialists have been brought on:

Year	**# of physicians employed by Community**	**Losses by Community on its employed physicians**
2008	191	$29.1 million
2009	253	$51.4 million
2010	286	$56.5 million
2011	289	$82.6 million
2012	358	$102.9 million
2013	360	$132 million (est.)

91. Between January and October 2013, Community lost $25.1 million on the 158 primary care doctors (about $158,000 per physician) and $70.4 million on the 178 specialists (about $393,000 per physician) employed through Defendant Community Physicians Network.

This excludes the losses Community accepted on physicians employed through other CHN affiliates and subsidiaries.

92. Additionally, a November 2013 analysis of CPN's operations showed that between January and October 2013, the net income to Community from the professional services of CPN's physicians before physician compensation was considered was only $12.29 per "work relative value unit" or "wRVU." (A wRVU is a common unit of measurement used to judge the relative effort required for different medical services.) Once loaded with physician compensation, CPN lost over $55 per wRVU.

93. Community is aware that its physicians are overpaid. Not only does it track these losses in absolute terms, labeling physicians and acquired physician groups as "sources of investment," but it also analyzes how these losses compare to regional and national benchmarks. In Relator's experience based on conversations with other Indianapolis-area healthcare professionals, Community's per physician losses are two to four times the losses experienced by other networks in the region. In addition, despite its status as the smallest of the four large Indianapolis healthcare networks, a majority of the most highly compensated physicians in the market are employed by Community.

94. In addition, as described in greater detail below, based on Community's own analysis, many of Community's specialists are paid substantially above the 90th percentile compensation benchmark for physicians in their specialty, even though the revenue Community receives from their professional services is often substantially below the benchmark for similarly situated specialists.

95. Community accepts these losses and perpetuates these relationships because the physicians refer patients to Community's hospitals and other facilities for a range of services including, but not limited to, laboratory work, diagnostic imaging, surgeries, and physician services from Community-employed specialists.

96. Community also knows that many of its employed physicians have ownership interests in ASCs which are co-owned by the network. Community goes out of its way to ensure the profitability of these surgical centers – by steering surgeries with the highest profit margins to these centers, and emphasizing surgical center reimbursement at the expense of other categories in negotiations with commercial insurers – in order to reward the physician co-owners of the centers for their referrals to Community.

1. Community Pays Employed Physicians Artificially High Salaries and Benefits.

97. Although Mr. Mills and others at Community repeatedly obstructed Relator's access to information about the financial performance of its contracts with employed and affiliated physicians, Relator was often able to get information about new relationships because they were typically approved by Community's Physician Integration Committee ("PIC"). Members of the PIC included, *inter alia*, CHN CEO Mr. Mills, VEI President Kyle Fisher, CHN Chief Physician Executive Dr. Timothy Hobbs ("Dr. Hobbs"), and CPN President Dr. Ramarao Yeleti ("Dr. Yeleti").

98. Based on this information, Relator came to understand that Community was routinely paying physicians compensation packages (salary, bonuses, benefits, etc.) that far exceeded the fair market value for their services. That these commercially unreasonable

payments were being made in exchange for and on account of the referrals these physicians made to Community was often made explicit in the presentations to the PIC. Specifically, the financial analysis of the deals, as presented to the PIC, routinely analyzed not only the expected performance of the physician group itself, but also the volume of "downstream referrals," including laboratory and diagnostic testing, imaging services, surgeries, physical therapy services, and other procedures and services, that Community expected to be performed at its hospitals, surgical centers, and other facilities.

99. Although the details of Community's compensation arrangements with different physicians often vary in form, they are similar in two key respects: (a) Community pays the physicians so much that it routinely loses substantial amounts on the physicians' practices excluding the value of their downstream referrals; and (b) when Community analyzes the financial performance of these practices it evaluates the overall financial performance (including the value of downstream referrals) rather than just the value of the physician practice on its own.

100. Below are several examples of the employment agreements Community entered into with physicians in a position to refer business to Community's hospitals, surgical centers, and other facilities. These are but some examples of many such deals Community has entered into as part of its campaign to build its network of referring physicians by paying them for their referrals. Community has entered into commercially unreasonable arrangements and pays above fair-market-value rates to dozens more of its employed physicians as evidenced by its consistent losses on a majority of its employed primary care doctors and specialists.

a. The Orthopedic Surgeons

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

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

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

104. CMS has specifically cautioned that substantial increases in physician compensation following a hospital's acquisition of a physician practice and/or employment of a physician could be strong evidence that the payments are intended to be remuneration in exchange for physician referrals. *See* Letter from D. McCarty Thorton, Associate General Counsel, Department of Health and Human Services, Inspector General Division, to T.J. Sullivan, Technical Assistant (Health Care Industries), Office of the Associate Chief Counsel, Internal Revenue Services, December 22, 1992,

http://oig.hhs.gov/fraud/docs/safeharborregulations/acquisition122292.htm ("We believe a revealing inquiry would be to compare the financial welfare of the physicians involved before and after the acquisition. (One can expect to find projections on this subject among the materials given to prospective physician participants in these arrangements.) If the economic position of these physicians is expected to significantly improve as a result of the acquisition, it is likely that a purpose of the acquisition is to offer remuneration for the referrals which these physicians can make to the buyer.").

105. In this instance, however, it is not necessary to rely on inference to establish that Community employed these physicians to get access to their referrals. The PowerPoint and financial analysis presented during the September 13, 2011 PIC meeting, as well as similar analyses presented before and after the meeting, make it clear that Community entered into these commercially unreasonable financial arrangements because of the value of the referrals from these surgeons.

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

107. Prior to the acquisition, the orthopedic surgeons at the Indiana Orthopedic Center offered physical therapy services in their offices. After the consolidation of the orthopedic surgery practices, the physical therapy facility became a department of the hospital and, as such, Community was able to bill for these services at hospital outpatient rates.

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

109. Community expected that the increase in compensation for the employed orthopedic surgeons would have a significant negative effect on the financial performance of the integrated orthopedic physician practice. While independent, the practices had experienced a modest loss of $225,336 in 2010. Community expected that following acquisition of the practices, in large part due to increased physician compensation, it would lose more than $4.4 million on the integrated practices in 2012, the first year following integration.

110. The financial analysis presented at the September 2011 meeting similarly relied on the value of the physicians' referrals to justify the deal. When analyzing the overall financial outcome of the deal, Community netted the loss it expected from compensation of the orthopedic surgeons against the value of the expected referrals the surgeons would send to Community's hospitals and affiliated surgical centers. Thus, although Community expected to lose $4.4 million on the orthopedic physician practices, Community expected that the referrals to its hospitals would be worth $4.9 million and Community's share of the value of referrals to its surgical centers would be worth an additional $4 million. Thus, Community projected that hiring the surgeons would produce a $4.5 million dollar profit – considering the value of the referrals from these surgeons.

111. The financial analysis specifically noted that the substantial decrease in operating margin for the practices was due to "the increase in physician compensation due to integration." It also noted that the operating margin for the hospitals included the value of the recaptured physical therapy and imaging referrals.

112. By 2013, the fundamental commercial unreasonableness of these employment contracts was clear. In an analysis of the productivity and compensation of these physicians through June 30, 2013, on average each of them was paid $943,418 per year, but the practice's net collections for each doctor was only $755,313. Thus, Community was paying the surgeons almost $1.25 for every $1 the surgeons generated in revenue from their professional services. This remarkable loss considers only physician compensation. Therefore, the network's losses were even greater once overhead costs such as, administrative costs, staff salaries, etc., are factored in.

b. The Cardiologists

113. In January 2009, Community hired approximately 30 cardiologists at commercially unreasonable, above fair-market-value rates to secure their referrals. Although Community had been looking to lock up the referrals from these physicians for several years before executing this deal, those efforts were intensified by Community's fear that if they did not hire the cardiologists, a competitor would.

114. In 2008, Community was in discussion with two cardiology groups about employing the cardiologists in the group directly. These two cardiology practices primarily referred their patients for tests and procedures to Community. In the middle of those

negotiations, however, one of the groups "defected" and became affiliated with Indiana University Health Care ("IU"). That event prompted Community to redouble its efforts to hire the remaining cardiologists.

115. Ultimately, Community entered into five year employment agreements with the remaining physicians. The cardiologists were each to be paid a set amount of money per wRVU, plus a quality incentive up to 15%, and a "retention payment" if they stayed for the full 5 years. Altogether, these compensation packages provided the cardiologists with upwards of 50% increases over what they had been making in private practice.

116. Although these provisions appear to be based on objective productivity and quality-based metrics, in fact the numbers were "backed into" with an eye towards paying the physicians a set sum of money. Community calculated how much extra money it would make by billing for the ancillary tests ordered by the cardiologists, and then "found a way" to ensure that the cardiologists were paid not only for the services they personally performed, but also for the value of these ancillary services.

117. As part of this deal, Community also bought out the cardiologists' shares of a heart hospital that Community and the cardiologists jointly owned.

118. Relator was present at a PIC meeting at which the deal to hire these cardiologists was discussed. Documents presenting the financial and operational terms of the deal, similar to those discussed above with respect to the orthopedic surgeons, were presented to justify the transaction. As in the analysis of the orthopedic deal, Community justified the substantial

payments to the cardiologists by highlighting the value of the "downstream referrals" the cardiologists would send to Community's hospitals, surgical centers, and other facilities.

119. Although Relator does not have copies of the presentations made to justify this deal, or the other employment deals for other specialists described herein, in his experience, similar analyses, showing the details of the physician compensation packages and the value of the downstream referrals that would be secured in exchange, were presented to the Community Board for each such deal.

120. By 2013, the fundamental commercial unreasonableness of these employment contracts was clear. In an analysis of the productivity and compensation of 26 of Community's 30 employed cardiologists through June 30, 2013, on average each of them was paid $1,026,733 per year, but the practice's net collections for each doctor was only $460,665. Thus, Community was paying the surgeons almost $2.23 for every $1 the surgeons generated in revenue from their professional services. Additionally, an income statement for fiscal year 2010 shows that Community's heart hospital lost almost $19 million on its physician group (excluding the value of their downstream referrals).

c. The Oncologists

121. As with the cardiologists, Community's efforts to employ oncologists were driven not only by its general desire to grow its referral stream, but also in reaction to the defection of a high profile practice to IU.

122. In 2007 or 2008 a group of oncologists that had previously referred its patients to Community was purchased by US Oncology and began referring its patients to IU. Thereafter, Community began looking for oncologists it could hire to secure their referrals.

123. In April 2009 Community hired five breast surgeons, operating together as Community Breast Center ("CBC"), to serve the northern and southern Indianapolis regions. As with the other groups, Community paid these physicians commercially unreasonable and above fair-market-value rates in order to capture their downstream referrals.

124. The effect of this overcompensation was clear in the first year of the CBC's operations. A May 2010 executive summary of the first year of CBC's operations shows that the physician practice lost $3.2 million. However, the CBC made more than $2.5 million on imaging services referred to it by the breast surgeons.

125. The financial performance of the CBC physician practice did not improve over time. In a 2013 analysis of revenue for each of Community's employed physicians as compared to his or her total compensation and associated practice expenses, Community lost (or, in Defendants' terms, "invested") more than $3.5 million in the six oncologists employed through CBC in fiscal year 2012, and an additional $2.5 million from January to September 2013. These losses were driven by the significant overcompensation of the CBC oncologists.

126. Community accepted these losses year after year because of the value of these physicians' referrals. The executive summary referenced above describes the CBC as "driv[ing] downstream revenue for Community Health Network," and calculates that the breast cancer referrals from the CBC physicians resulted in operating margin for the network of about $3

million. Specifically, the 2010 analysis notes that the CBC physicians were responsible for more than $2.66 million in referrals to Community's surgery centers and an additional $350,000 in referrals to another Community cancer center.

127. Of the services CBC provided in 2009, 24% was to Medicare patients, 1.1% to Medicaid patients, and 1.4% to Tricare patients.

128. One prominent breast surgeon was particularly valuable to Community. Before her employment by Community as part of the CBC she was an independent physician with an imaging center. She sent patients requiring hospital admission to the St. Francis hospital network and her radiology patients to another non-Community provider. She referred almost no business to Community. Because she sees hundreds of cancer patients a year, Community was eager to employ her and bring her referrals into its network. This was done by offering her a heavily subsidized compensation package. In 2012, Community lost almost $1 million on her practice ($989,416). By September 2013 it had lost an additional $648,112 on her practice. In exchange, during those years, she referred all, or nearly all, of her patients to Community hospitals or other facilities for radiation and surgical treatment. That Community describes such losses as physician "investments" further demonstrates that it views the losses as an amount it must spend to get back the valuable referrals to its hospitals and other facilities.

d. The Obstetricians / Gynecologists

129. As with other practices, Community significantly overpays its obstetrician / gynecologists ("OB/Gyns") to prevent them from defecting to another health care network. Between 2007 and 2009 several OB/Gyn groups in the Indianapolis market switched their

affiliations. For example, St. Vincent's network expanded an ASC 10 miles north of Community's North Hospital, and turned it into a hospital with a strong obstetrics department. With this new facility, St. Vincent's lured several prominent OB/Gyns from IU. IU then responded by building a hospital with a strong obstetrics department in North Meridian and luring away several St. Vincent OB/Gyns.

130. To prevent its OB/Gyns from affiliating with other networks, Community has responded by employing them at commercially unreasonable, above fair-market-value rates. For example, in 2013, according to a national survey of physician compensation, an OB/Gyn whose salary was at the 90th percentile of all OB/Gyn compensation made $522,162 per year. The 25 Community OB/Gyns who are paid salaries tied to their productivity were paid, on average, $116,000 more than that ($638,542).

131. This contrast is even more glaring, given that the amount the hospital collected for their services was substantially below the 90th percentile. According to the survey, the 90th percentile for collections was $999,147 per physician. Community's physicians only had collections of $640,391 per physician. Thus, while other hospitals only paid their top (90th percentile) OB/Gyns an average of 52.3% of their collections, Community paid its OB/Gyns 99.7% of their collections.

132. That Community pays its OB/Gyns commercially unreasonable and above fair-market-value rates to induce and control their referrals is clear in materials created to justify their employment. For example, in September 2009, a presentation was made to Community's Finance Committee to lay out the business case for acquiring the Clearvista Women's Care

OB/Gyn practice. The practice consisted of 7 physicians with offices near Community Hospital North. Acquisition of the practice was described as a "[d]efensive strategy to retain patient access and *protect existing revenue streams*." "Defense" of the practice was necessary because Community believed it faced a risk of losing the group to St. Vincent or IU. Further, maintaining the group's referrals was crucial, because they were responsible for 29% of Community North's deliveries and 20% of the hospital's inpatient gynecological surgeries, generating net revenue of about $9.5 million for Community Hospital North and East.

e. The Vascular Surgeons

133. Similarly, Community's own analysis shows that it substantially overpays the five vascular surgeons that it employs through production-based contracts. In 2013, Community's vascular surgeons made, on average, $1,311,189 per year, while the national survey data showed that the 90th percentile salary for vascular surgeons was $619,735. By contrast, the 90th percentile for collections for vascular surgeons was $958,055, while Community's highly paid vascular surgeons only had average collections of $902,833. Thus, while other hospitals only paid their top (90th percentile) vascular surgeons an average of 64.7% of their collections, Community paid its vascular surgeons 145.2% of their collections.

2. Community Pays Illegal Remuneration to Referring Physicians by Funneling Money to them through their Equity Interests in ASCs.

134. Community, through several subsidiaries, holds equity interests in multiple ASCs in the Indianapolis region. Generally, the remainder of the centers are owned by Community-employed physicians who utilize the centers for procedures.

135. These centers are extremely lucrative for Community physicians. In fact, many of them make at least as much through their ownership interests in the ASCs as they do through salary, often several hundred thousand dollars a year.

136. These sorts of centers are often profitable for physician-investors, but they are particularly so for physicians here because of the way Community has structured the arrangements.

137. First, Community grants physicians complete autonomy over whether their patients' procedures are performed at a Community hospital or at the ASC – as long as it is performed somewhere affiliated with Community. As a result, physicians largely refer patients with well-paying insurance to the ASCs (where they have a profit interest) and those with low-paying or no insurance to the hospital (where they will still be paid for their professional work but will not have to accept the losses of taking on charity care patients).

138. Not only does this increase the physicians' personal profits, it increases costs for government payers. Federal and state-sponsored healthcare plans, such as Medicare and Medicaid, typically pay higher rates for services performed in a hospital outpatient setting, than when the same services are performed in an ASC. Therefore, the practice of sending Medicare and Medicaid patients to Community hospitals for treatment that could be performed in an ASC raises prices for patients and for government payers.

139. Second, when Community negotiates its contracts with commercial insurers, it routinely prioritizes higher reimbursement for ASCs, even if that comes at the expense of the reimbursement rates for hospital or other services. In this way, the hospital ensures that

physician owners of ASCs reap higher profits on commercial business. This is done as a further inducement to these physicians to refer their Medicare, Medicaid and other government-funded patients to Community. It also reinforces physicians' incentives to send government-funded patients to Community hospitals for services that could otherwise be performed in ASCs. This operates to Community's benefit because the reimbursement rates from Medicare and Medicaid are higher for services performed at hospital facilities.

140. Community often uses a combination of these strategies to secure physician referrals. For example, in January 2012, Community-subsidiary VEI purchased a 51% interest in the Foot and Ankle Surgery Center, LLC, a single-specialty podiatric surgery center in the northwest region of Indianapolis. The center was owned and primarily used by the members of an 11-member podiatry group, Achilles Podiatry.

141. The center was owned primarily by one doctor who held 94% of the shares. Five other members of Achilles Podiatry owned between .5% and 2% each. The four remaining members of Achilles Podiatry used the center, but did not have an ownership stake.

142. VEI offered several forms of valuable consideration in exchange for a majority ownership interest. First, VEI paid a purchase price ($1,421,063) based on five times the 2009 profit. Because this purchase price was based, in part, on the value of services previously referred to the ASC by the physician investors, and an expectation that such referrals would continue, this purchase price improperly took into account the value of such referrals in violation of the Stark Law and Anti-Kickback Statute.

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

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

145. In exchange, Community expected to get access to a variety of lucrative referrals from the podiatrists. Specifically, a PowerPoint presentation by Kyle Fisher, VEI CEO, Bret Weitzel, VEI CFO, and Larry Monn, M.D., VEI Chief Medical Officer, explained that, as part of the transaction, Community planned to use non-competition agreements with the Achilles Podiatry members to "mitigate [the] risk[]" of "[c]ompetitors attempts to recruit/employ Podiatrists who are owners and/or users of the Center." As a result, Community expected that "our other [Network] Hospitals and Surgery Centers, will also have opportunity to capture cases that are going to our competition." The presentation quantified those expected "downstream

referrals" Community would capture in exchange for the purchase of the surgical center as: (a) 1,800 imaging services; (b) 2,500 physical therapy services; and (c) 150 inpatient surgery cases.

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

147. Finally, as part of the deal, the center's majority owner agreed to "make an additional 19% of his [then] owned units available for subsequent purchase [by] other surgeons who VEI identifies." This was a significant concession because it gave VEI the power to offer these shares to other surgeons who would agree to refer their patients to the ASC and/or other Community facilities.

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

3. Community Provides Additional Improper Compensation to Physicians in Return for Referrals through Lucrative Medical Directorship Positions.

149. Community also overpays physicians in exchange for their referrals by offering lucrative medical directorship positions to referring physicians in exchange for little or no work. These positions are offered to CPN-employed physicians but also to otherwise unaffiliated specialists in Indianapolis with whom Community wishes to curry favor.

150. At a meeting on May 9, 2013 regarding Community's cost restructuring efforts, attended by Steve Bell, CHN VP, Network Supply Chain, Kyle Fisher, VEI President, Kelly George, CHN Treasurer, CHN Chief Physician Officer Dr. Hobbs, CPN COO Javorka, Tom Malasto, CHN senior executive, now Chief Patient Experience Officer, Charles Meadows, CHN VP, Network Supply Chain, Jill Parris, CHN VP, Human Resources, Bret Weitzel, CPN VP, Finance, and Jeff Kirkham, CHN VP, Finance, Mr. Javorka told Relator that Community was spending approximately $5 million a year on medical directorships, despite the fact that many of these positions were unnecessary and/or the physicians filling the positions were doing little to no work to justify their pay. By cutting back on the medical directorship positions, cutting pay to fair-market-value rates, and paying only for work that was necessary and actually provided, Mr. Javorka calculated that Community could save $2 to $3 million a year.

151. Again, in the fall of 2013, Mr. Javorka made a presentation to Community's Cost Restructuring Committee which stated that all Community medical directorships were to be terminated as of September 1st, and "only those critical to the business, with role summary and goals will be re-established using Administrative Medical Director rates." This was estimated to save the network $1.5 to $2 million annually.

152. While Community contemplated eliminating unnecessary positions and cutting pay to fair-market-value rates, as of Relator's constructive termination in November 2013 this had not been done.

B. Community Receives Kickbacks from Indianapolis Nursing Homes in Exchange for Patient Referrals.

153. In 2011, Johnson Memorial Health, a county-owned hospital system, purchased about 35 nursing homes from Miller's Merry Manor, a nursing home provider in Indiana. The purchase was carried out to permit Johnson Memorial Health to take advantage of higher Medicaid rates it would be eligible for as a municipal provider of nursing home services. Miller's Merry Manor continued to provide all operational and administrative services at the facilities.

154. As part of the deal, Miller's Merry Manor also wanted to secure referrals from Community's hospitals to its nursing homes in the Indianapolis region. As such, Miller's Merry Manor asked Johnson to enter into a "monitoring agreement" with Community.

155. Under this agreement, signed in 2013 but retroactive to 2012 when Johnson started receiving increased Medicaid payments, Johnson pays Community about one-half of the increased Medicaid payments it receives as a municipal provider of services, approximately $5 to $9 million a year.

156. This arrangement was negotiated by Community's CEO, Mr. Mills, and the CEO of Johnson Memorial Hospital. Relator is familiar with the particulars of the arrangement because he was tasked by Mr. Mills with formalizing the agreement.

157. Under this arrangement, Community receives payments far in excess of the fair market value of the services it provides. According to a generous estimate prepared in November 2012 by the CEO of Johnson Memorial Hospital, by the time the agreement was fully operational and Community was responsible for the monitoring of 35 nursing homes, the

expected cost to Community to provide these "monitoring" services was at most $2.2 million per year (including a 35% profit/additional overhead allocation). At the same time, once the agreement was fully operational, Community expected to earn in excess of $5.65 million under the agreement, potentially significantly more. In fact, just three months later, Johnson's CEO provided a revised analysis estimating annual revenues of over $6.8 million to be paid to Community under the arrangement.

158. Johnson's CEO, when analyzing the work required to provide the "monitoring services" as compared to the expected payments to Community, categorized the excessive profit as "[r]isk subject to FMV and/or cost equivalent review/scrutiny."

159. Based on other financial data Relator reviewed, even these estimates substantially overstate Community's monitoring costs and understate Community's income from the deal. Thus, the amount of illegal remuneration Community receives in this arrangement is likely substantially higher.

160. In early 2014, Relator met with Johnson's CEO on an unrelated matter. Towards the end of their meeting, Relator was shocked when the CEO blurted out, "I don't want to go to jail over the Community nursing home deal." Relator found this comment very odd given that they had not been discussing Johnson's nursing home operations. Relator came to understand that Johnson's CEO's comment was based on his concern and knowledge that in reality, the monitoring contract is merely a pretext to pay Community for nursing home referrals from Community's hospitals to Johnson's nursing home facilities.

161. In addition, under the terms of the deal, Johnson also purchased three nursing homes that had been owned by Community. The entire value of the increased Medicaid payments from these nursing homes goes back to Community.

162. Hospitals are a key source of referrals for nursing homes. These payments are made to induce Community to increase its referrals of patients being discharged from the hospital to Johnson's nursing homes.

163. All claims submitted by Johnson's nursing homes based on referrals from Community are false claims within the meaning of the federal and Indiana False Claims Acts. Community is liable for to the Federal Government and to the State of Indiana for causing the submission of these false claims and conspiring to cause these false claims to be submitted.

C. Community Retaliated Against Relator In Response To His Efforts To Address Community's Misconduct.

164. Relator has dedicated a significant portion of his professional career to assisting Community. In fact, in one position or another, Relator has been working for Community for decades. Prior to October 2005, Relator worked with Defendant Community Health Network, Inc. ("CHN") in a consulting and investment banking capacity. In October 2005, CHN hired Relator as CFO. And in December 2012, CHN CEO Mr. Mills asked Relator to assume the duties of Chief Operating Officer in addition to his ongoing duties as CFO.

165. In these roles, Relator was tasked with significant responsibility, including leading teams of administrators in overseeing the finances, operations, supply chains, and managed care contracts of the network's eight hospitals.

166. In early 2010, the Board of Directors of CHN directed CHN's management to initiate a phased cost reduction process. The first phase called for $100 million in cost reductions and revenue enhancement within 18 months. Relator spearheaded and directed this initiative.

167. The entire Community network participated in the cost reduction effort, with the exception of CPN and VEI which contributed only minimally, despite CPN's consistent and exceptional losses.

168. In his capacity as CFO and COO, and in connection with his work to reduce network costs, Relator began asking questions about the large and unexpected losses at CPN.

169. In fiscal year 2011, CPN had budgeted for an operating loss of approximately $38 million but realized an actual operating loss of over $80 million. In fiscal year 2012, CPN had an operating loss of $103 million, which exceeded its budgeted operating loss by approximately $40 million.

170. By October 2013, CPN estimated it would have an operating loss in fiscal year 2013 of approximately $141 million, about $39 million more than the operating loss budgeted for CPN earlier in the year.

171. Relator repeatedly asked CPN management officials, including, but not limited to, CPN President Dr. Yeleti, Chief Physician Executive of CHN Dr. Hobbs, and CPN COO Javorka, for explanations for the operating losses and budget variances.

172. Relator was never provided with a satisfactory explanation for these losses.

173. In addition, Relator expressed concern to Mr. Mills and management for CPN and CHN that the losses exhibited by CPN were a direct result of CPN paying physicians at commercially unreasonable rates.

174. These unexplained and consistent losses by CPN were of particular concern to Relator because he was aware that between 2011 and 2013 (the years with the most extreme losses), CHN began employing a number of previously-independent physicians, many of whom were current investors in surgery centers operated by VEI ("physician-owners") and were also in a position to refer to CHN hospitals and other facilities.

175. As part of their employment agreements, the physician-owners were allowed to retain their ownership shares in the for-profit ASCs.

176. Therefore, the physician-owners received compensation from CHN through guaranteed salaries and/or based on their production as physicians. In addition to this compensation, the physician-owners also received distributions from their investments in the VEI ambulatory surgery centers.

177. From July through November of 2013, Relator asked VEI management for financial information regarding the operations of its for-profit surgery centers. He expressed concern that the compensation received by the physician-owners was higher than average for the region, and that this represented an illegal transfer of funds from a non-profit entity, CHN, to the for-profit VEI surgery centers.

178. VEI refused Relator's requests. Further, VEI refused to provide meaningful information as part of the network-wide quarterly, annual, and three-year reporting requirements

outlining financial and service goals and objectives, as well as progress toward those goals and objections.

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

180. Relator began to voice concerns to senior management including, but not limited to, Mr. Mills, Dr. Hobbs, Kyle Fisher, and the CEOs of all CHN hospitals that by allowing the physicians with ownership interests in surgery centers to retain their ownership interests in the surgery centers even after they became CHN employees, CHN was providing the physician-owners with excessive, commercially unreasonable compensation in violation of federal law.

181. Relator also began voicing concerns to Mr. Mills, Kyle Fisher, Dr. Hobbs, and others that the excessive compensation was in large part a result of physicians steering lucrative commercial business to the for-profit surgery centers, and steering government, charity, and uninsured patients to the higher-cost hospital facilities.

182. Relator also expressed concern about additional methods CHN used to overcompensate referring physicians, such as excessive salaries.

183. For example, throughout 2013, Relator made a number of inquiries to Dr. Yeleti regarding the expiration (as of December 31, 2013) of approximately thirty cardiologists' employment contracts and the need for the new contracts to be negotiated to a reduced compensation level that reflected market norms and met CHN's cost reduction goals.

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

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

186. Relator informed Mr. Mills repeatedly that overcompensating cardiologists under the expired contracts was an illegal transfer of funds from Community to the physicians.

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

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

189. On or about November 27, 2013, CHN terminated Relator's employment with CHN.

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

191. CHN terminated Relator in retaliation for his stated concerns regarding illegal activity at Community, specifically with regard to physician compensation, physician referral patterns, and certain business practices he believed to be illegal within VEI.

192. When CHN hired Relator, CHN and Relator entered into a Severance Benefit Agreement ("Severance Agreement"). A true and accurate copy of the Severance Agreement is attached hereto as Exhibit 1.

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

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

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

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

197. At no point during his employment with CHN was Relator convicted of a felony.

198. CHN did not have "Cause" to terminate Relator, as defined in Relator's Severance Agreement.

199. CHN terminated Relator without "Cause" as defined in his Severance Agreement.

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

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

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

203. Relator agreed to take on the additional responsibility of COO without immediate compensation on the condition that CHN agreed that after his full-time employment at CHN ended, he would be paid as a consultant to CHN at a rate of $200,000 per year for a period of five years.

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

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

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

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

208. Relator has not been remunerated for the work he did for CHN as its COO.

209. Subsequent to the termination of Relator's employment with Defendant, Relator sought new employment opportunities.

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

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

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

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

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

215. Based on information and belief, Mr. Mills knowingly provided false information about Relator to the CEO of Hartford Healthcare.

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

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

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

219. Based on information and belief, Mr. Mills communicated false, negative information about Relator to the CarDon CEO.

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

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

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

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

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

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

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

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

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

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

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

230. Additionally, the United States is entitled to the maximum penalty of up to $11,000 for each and every violation alleged herein.

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

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

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

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

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

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

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

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

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

239. Additionally, Indiana is entitled to civil penalties of at least $5,000 for each and every violation alleged herein.

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

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

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

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

243. Relator stated to his direct supervisor, Mr. Mills, as well as to CHN management, that physician compensation within the Network may be in violation of federal law and subjected CHN to potential legal liability.

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

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

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

247. CHN retaliated against Relator by interfering with his prospective new employers, subsequent to his departure from CHN.

248. As a result of these wrongful actions, Relator suffered and continues to suffer substantial damage in an amount to be determined at trial.

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

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

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

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

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

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

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

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

256. CHN retaliated against Relator by interfering with his prospective new employers, subsequent to his departure from CHN.

257. As a result of these wrongful actions, Relator suffered and continues to suffer substantial damage in an amount to be determined at trial.

COUNT V
Breach of Contract

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

259. CHN did not terminate Relator from his position as COO of Community for "Cause" as defined by the Severance Agreement.

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

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

262. Specifically, CHN has breached its obligations under the Severance Agreement by:

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

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

263. CHN has breached its obligations under the Severance Agreement.

264. Relator has been damaged by CHN's breach of the Severance Agreement.

COUNT VI
Breach of Oral Contract

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

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

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

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

269. CHN has not paid Relator the $200,000 to which he was entitled under the oral contract upon termination of his employment.

270. CHN has not retained Relator as a consultant as required by the oral contract.

271. CHN's failure to pay Relator $200,000 upon the termination of his employment, and CHN's failure to retain Relator as a consultant for a period of five years and continue to pay him at an annual rate of $200,000, constitute breaches of the oral contract.

272. Relator has been damaged by CHN's breach of the oral contract.

COUNT VII
Promissory Estoppel

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

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

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

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

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

278. CHN's refusal to carry out the terms of the agreement to pay Relator as a consultant after his full-time employment with CHN ended after Relator having performed the duties of COO for eleven months constitutes an unjust and unconscionable injury and loss to Relator.

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

COUNT VIII
Quantum Meruit

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

281. Relator accepted the additional duties and responsibilities of COO of CHN in December 2012.

282. Relator expected payment for performing the responsibility of COO of CHN; specifically, he expected five years as a paid consultant for CHN at an annual pay rate of $200,000 after his full-time employment with CHN ended.

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

284. Relator's work as COO of CHN conferred a substantial benefit to CHN.

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

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

COUNT IX
Ind. Code § 22-5-3 (Blacklisting)

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

288. Subsequent to Relator's departure from CHN, Mr. Mills communicated with Relator's prospective employers.

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

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

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

292. Relator has been damaged by CHN's actions.

PRAYER

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

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

2. That this Court enter judgment against Defendants in an amount equal to three times the amount of damages the United States has sustained because of Defendants' actions, plus a civil penalty of not less than $5,500 and not more than $11,000 for each violation of 31 U.S.C. § 3729;

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

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

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

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

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

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

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

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

Dated: October 30, 2015

By: /Kathleen A. DeLaney/

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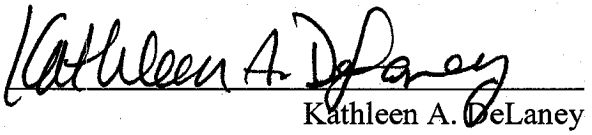
Mr. Thomas P. Fischer

DEMAND FOR JURY TRIAL

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

Dated: October 30, 2015

By: 

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The undersigned hereby certifies that a copy of the foregoing was served via first class U.S. Mail, postage prepaid, on the 30th day of October 2105, to the following parties:

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