U.S. Department of Justice

Criminal Division

September 21, 2018

Richard A. Sauber
Robbins, Russell, Englert, Orseck, Untereiner, & Sauber LLP
1801 K Street, N.W. Suite 411L
Washington, DC 20006

Re: Health Management Associates, LLC

Dear Mr. Sauber:

The United States Department of Justice, Criminal Division, Fraud Section (the "Fraud Section") and Health Management Associates, LLC, formerly known as Health Management Associates, Inc. (on its behalf and on behalf of its subsidiaries) (collectively, "HMA"), pursuant to authority granted by the Board of Directors of HMA, enter into this Non-Prosecution Agreement ("Agreement"). As indicated below, HMA's parent ("HMA Parent"), pursuant to authority granted by the Board of Directors of HMA Parent, is undertaking certain obligations under the Agreement.

1. Relevant Considerations. The Fraud Section enters into this Agreement based on the individual facts and circumstances presented by this case, including those described below:

(a) In January 2014, Health Management Associates, Inc., a publicly-traded company that operated over 70 general acute care hospitals and other health care facilities in 15 states, was acquired by and became a wholly-owned indirect subsidiary of HMA Parent and is now known as Health Management Associates, LLC ("HMA"). When HMA was acquired, it was facing multiple *qui tam* lawsuits and was the subject of criminal and civil investigations.

(b) Following the HMA acquisition in January 2014, HMA and HMA Parent engaged in remedial measures, including: (1) removing the HMA Board of Directors and senior executives; and (2) integrating the HMA hospitals into HMA Parent's compliance program and implementing certain compliance initiatives to address and remediate the inpatient admission medical necessity and Anti-Kickback Statute issues that were alleged in certain of the *qui tam* lawsuits and were part of the criminal and civil investigations;

(c) HMA and HMA Parent received credit for their cooperation with the Fraud Section's investigation and related civil and criminal investigations following the HMA acquisition in January 2014. HMA and HMA Parent's cooperation has included, among other things, making regular factual presentations and collecting, analyzing, and organizing voluminous evidence and information for the Fraud Section and the United States Department of Justice, Civil

Division, Fraud Section, and providing substantial cooperation to the U.S. Attorney's Office for the Middle District of Florida in connection with the prosecution of a former HMA executive;

(d) HMA and HMA Parent have enhanced and have committed to continuing to enhance their compliance and ethics program and internal controls, including ensuring that their compliance program satisfies the elements set forth in the Corporate Integrity Agreement ("CIA") between the Office of Inspector General of the Department of Health and Human Services (HHS-OIG) and HMA Parent, which is incorporated by reference into this Agreement as Attachment B;

(e) Based on HMA and HMA Parent's remediation and the state of their compliance program, the CIA between HHS-OIG and HMA Parent, and their agreement to report to the Fraud Section as set forth in Attachment C to this Agreement (Corporate Compliance Reporting), the Fraud Section determined that an independent compliance monitor was unnecessary;

(f) HMA and HMA Parent have agreed to a global resolution of HMA's criminal and civil liability related to the conduct described in the Statement of Facts attached hereto (Attachment A), which includes this Agreement and the following components:

i. Carlisle HMA, LLC, an indirect subsidiary of HMA, has agreed to plead guilty to one count of conspiracy to commit health care fraud, in violation of Title 18, United States Code, Section 1349, and to pay a criminal fine in the amount of $2,548,000 pursuant to a negotiated plea agreement, which is incorporated by reference into this Agreement (Attachment D);

ii. HMA has agreed to pay $74,970,802 to the United States and the Medicaid Participating States to resolve its civil liability for certain civil claims, including under the federal False Claims Act and state Medicaid False Claims Acts, pursuant to a civil Settlement Agreement, which is incorporated by reference into this Agreement (Attachment E); and

iii. HMA Parent has agreed to a Corporate Integrity Agreement with HHS-OIG, which is incorporated by reference into this Agreement (Attachment B).

(g) the nature and seriousness of the offense conduct, including that senior corporate and division executives at HMA and administrators at HMA hospitals participated in a scheme to defraud Federal health care programs, that is Medicare, Medicaid, and TRICARE, by unlawfully pressuring and inducing physicians serving HMA hospitals to increase the number of emergency department patient admissions without regard to whether the admissions were medically necessary so that HMA hospitals could bill and obtain reimbursement for higher-paying inpatient hospital care, as opposed to observation or outpatient care, from Federal health care programs and increase HMA's revenue;

(h) HMA has no prior criminal history; and

(i) HMA and HMA Parent have agreed to continue to cooperate with the Fraud Section as provided in Paragraph 5, below.

2. Acceptance of Responsibility. HMA admits, accepts, and acknowledges that it is responsible under United States law for the acts of its officers, directors, employees, and agents as set forth in the attached Statement of Facts, and that the facts described therein are true and accurate. HMA also admits, accepts, and acknowledges that the facts described in the attached Statement of Facts constitute a violation of law, specifically a conspiracy to commit health care fraud, in violation of Title 18, United States Code, Section 1349.

3. HMA and HMA Parent expressly agree that they shall not, through present or future attorneys, officers, directors, employees, agents or any other person authorized to speak for HMA or HMA Parent make any public statement, in litigation or otherwise, contradicting the acceptance of responsibility set forth above or the facts described in the attached Statement of Facts. HMA and HMA Parent agree that if they issue a press release or hold any press conference in connection with this Agreement, HMA and HMA Parent shall first consult the Fraud Section to determine (a) whether the text of the release or proposed statements at the press conference are true and accurate with respect to matters relating to this Agreement; and (b) whether the Fraud Section has any objection to the release.

4. Term of the Agreement. HMA and HMA Parent's obligations under this Agreement shall have a term of 3 years from the date on which the Agreement is executed (the "Term"). HMA and HMA Parent agree, however, that, in the event the Fraud Section determines, in its sole discretion, that HMA or HMA Parent has knowingly violated any provision of this Agreement or has failed to completely perform or fulfill each of their obligations under this Agreement, an extension or extensions of the Term may be imposed by the Fraud Section, in its sole discretion, for up to a total additional time period of one year, without prejudice to the Fraud Section's right to proceed as provided in the breach provisions of this Agreement below. Any extension of the Agreement extends all terms of this Agreement, including the terms of the reporting requirement in Attachment C, for an equivalent period. Conversely, in the event the Fraud Section finds, in its sole discretion, that there exists a change in circumstances sufficient to eliminate the need for the reporting requirement in Attachment C, and that the other provisions of this Agreement have been satisfied, the Agreement may be terminated early.

5. Future Cooperation and Disclosure Requirements. HMA and HMA Parent shall cooperate fully with the Fraud Section in any and all matters relating to the conduct described in this Agreement and the attached Statement of Facts and other conduct under investigation by the Fraud Section at any time during the term. HMA and HMA Parent agree that their cooperation shall include, but not be limited to, the following:

a. HMA and HMA Parent shall truthfully disclose all factual information not protected by a valid claim of attorney-client privilege or attorney work product doctrine with respect to their activities, those of their parent companies and affiliates, and those of their present and former directors, officers, employees, agents, and consultants, including any evidence or allegations and internal or external investigations, about which they have any knowledge or about which the Fraud Section may inquire. This obligation of truthful disclosure includes, but is not

limited to, the obligation of HMA and HMA Parent to provide to the Fraud Section, upon request, any document, record or other tangible evidence about which the Fraud Section may inquire of HMA or HMA Parent.

b. Upon request of the Fraud Section, HMA and HMA Parent shall designate knowledgeable employees, agents or attorneys to provide to the Fraud Section the information and materials described above on behalf of HMA and HMA Parent. It is further understood that HMA and HMA Parent must at all times provide complete, truthful, and accurate information.

c. HMA and HMA Parent shall use their best efforts to make available for interviews or testimony, as requested by the Fraud Section, present or former officers, directors, employees, agents, and consultants of HMA and HMA Parent. This obligation includes, but is not limited to, sworn testimony before a federal grand jury or in federal trials, as well as interviews with domestic or foreign law enforcement and regulatory authorities. Cooperation shall include identification of witnesses who, to the knowledge of HMA or HMA Parent, may have material information regarding the matters under investigation.

d. With respect to any information, testimony, documents, records or other tangible evidence provided to the Fraud Section pursuant to this Agreement, HMA and HMA Parent consent to any and all disclosures, subject to applicable law and regulations, to other governmental authorities of such materials as the Fraud Section, in its sole discretion, shall deem appropriate.

e. In addition, during the Term, should HMA or HMA Parent learn of any evidence or allegation of violations of Federal health care offenses, as that term is defined in Title 18, United States Code, Section 24, they shall promptly report such evidence or allegation to the Fraud Section. On the date that the Term expires, HMA Parent, by the Chief Executive Officer of HMA Parent and the Chief Financial Officer of HMA Parent, will certify to the Fraud Section that HMA and HMA Parent have met their disclosure obligations pursuant to this Agreement. Each certification will be deemed a material statement and representation by HMA and HMA Parent to the executive branch of the United States for purposes of 18 U.S.C. § 1001.

6. Corporate Compliance Program. HMA and HMA Parent represent that they have implemented and will continue to maintain a compliance and ethics program designed to prevent and detect violations of Federal health care offenses, as that term is defined in Title 18, United States Code, Section 24, throughout its operations, including those of its affiliates, agents, and joint ventures (to the extent that HMA or HMA Parent manages or controls such joint ventures), including, but not limited to, the elements set forth in the CIA between HHS-OIG and HMA Parent, which is incorporated by reference into this Agreement as Attachment B. In addition, HMA and HMA Parent agree that they will report to the Fraud Section annually during the Term regarding remediation and implementation of the compliance measures described in Attachment B. These reports will be prepared in accordance with Attachment C (Corporate Compliance Reporting).

7. Monetary Penalty. HMA agrees to pay a monetary penalty in the amount of $35,007,846 to the United States Treasury no later than ten business days after the Agreement is fully executed. The Fraud Section and HMA agree that this disposition is appropriate given the

relevant considerations outlined above, including (1) Carlisle HMA, LLC entering its guilty plea and paying a $2,548,000 criminal fine within ten business days after its sentencing; and (2) HMA paying $74,970,802 to the United States and the Medicaid Participating States under a related civil Settlement Agreement. HMA and HMA Parent acknowledge that no tax deduction may be sought in connection with the payment of any part of this $35,007,846 penalty. HMA and HMA Parent shall not seek or accept directly or indirectly reimbursement or indemnification from any source with regard to the penalty or disgorgement amounts that HMA pays pursuant to (1) this Agreement, or (2) any other agreement entered into with an enforcement authority or regulator concerning the facts set forth in the attached Statement of Facts, except as amounts identified as restitution in a settlement agreement or court order pursuant to 26 U.S.C. § 6050x.

8. Conditional Release from Liability. The Fraud Section agrees, except as provided herein, that it will not bring any criminal or civil case (except for criminal tax violations, as to which the Fraud Section does not make any agreement) against HMA or any of its present or former subsidiaries, affiliates, or parents, including HMA Parent and its subsidiaries and affiliates, relating to any of the conduct described in the attached Statement of Facts. To the extent there is conduct disclosed by HMA and HMA Parent that is not set forth in the attached Statement of Facts, such conduct will not be exempt from prosecution and is not within the scope of or relevant to this Agreement. The Fraud Section, however, may use any information related to the conduct described in the attached Statement of Facts against HMA or HMA Parent or any of their present or former subsidiaries, affiliates and parents: (a) in a prosecution for perjury or obstruction of justice; (b) in a prosecution for making a false statement; (c) in a prosecution or other proceeding relating to any crime of violence; or (d) in a prosecution or other proceeding relating to a violation of any provision of Title 26 of the United States Code. This Agreement does not provide any protection against prosecution for any future conduct by HMA, HMA Parent or any of their present or former subsidiaries, affiliates or parents. In addition, this Agreement does not provide any protection against prosecution of any individuals, regardless of their affiliation with HMA, HMA Parent or any of their present or former subsidiaries, affiliates or parents.

9. Breach. If, during the Term, (a) HMA commits any felony under U.S. federal law; (b) HMA or HMA Parent provides in connection with this Agreement deliberately false, incomplete, or misleading information, including in connection with its disclosure of information about individual culpability; (c) HMA or HMA Parent fails to cooperate as set forth in this Agreement; (d) HMA or HMA Parent fails to continue to implement and maintain a compliance and ethics program as set forth in this Agreement and Attachment B; or (e) HMA or HMA Parent otherwise fails to completely perform or fulfill each of their obligations under the Agreement, regardless of whether the Fraud Section becomes aware of such a breach after the Term is complete, HMA and HMA's subsidiaries and affiliates shall thereafter be subject to prosecution for any federal criminal violation of which the Fraud Section has knowledge, including, but not limited to, the conduct described in the attached Statement of Facts, which may be pursued by the Fraud Section in the U.S. District Court for the District of Columbia or any other appropriate venue. Determination of whether HMA or HMA Parent has breached the Agreement and whether to pursue prosecution of HMA or HMA's subsidiaries or affiliates shall be in the Fraud Section's sole discretion. Any such prosecution may be premised on information provided by HMA, HMA Parent, or HMA Parent's subsidiaries or affiliates. Any such prosecution relating to the conduct described in the attached Statement of Facts or relating to conduct known to the Fraud Section

prior to the date on which this Agreement was signed that is not time-barred by the applicable statute of limitations on the date of the signing of this Agreement may be commenced against HMA or HMA's subsidiaries or affiliates, notwithstanding the expiration of the statute of limitations, between the signing of this Agreement and the expiration of the Term plus one year. Thus, by signing this Agreement, HMA and HMA Parent agree that the statute of limitations with respect to any such prosecution that is not time-barred on the date of the signing of this Agreement shall be tolled for the Term plus one year. In addition, HMA and HMA Parent agree that the statute of limitations as to any violation of U.S. federal law that occurs during the Term will be tolled from the date upon which the violation occurs until the earlier of the date upon which the Fraud Section is made aware of the violation or the duration of the Term plus five years, and that this period shall be excluded from any calculation of time for purposes of the application of the statute of limitations.

10. In the event the Fraud Section determines that HMA or HMA Parent has breached this Agreement, the Fraud Section agrees to provide HMA and HMA Parent with written notice of such breach prior to instituting any prosecution resulting from such breach. Within thirty days of receipt of such notice, HMA and HMA Parent shall have the opportunity to respond to the Fraud Section in writing to explain the nature and circumstances of such breach, as well as the actions HMA and HMA Parent has taken to address and remediate the situation, which explanation the Fraud Section shall consider in determining whether to pursue prosecution of HMA or HMA's subsidiaries or affiliates.

11. In the event that the Fraud Section determines that HMA or HMA Parent has breached this Agreement: (a) all statements made by or on behalf of HMA, HMA Parent, or their subsidiaries or affiliates to the Fraud Section or to the Court, including the attached Statement of Facts, and any testimony given by HMA, HMA Parent, or their subsidiaries or affiliates before a grand jury, a court, or any tribunal, or at any legislative hearings, whether prior or subsequent to this Agreement, and any leads derived from such statements or testimony, shall be admissible in evidence in any and all criminal proceedings brought by the Fraud Section against HMA or HMA's subsidiaries or affiliates; and (b) HMA, HMA Parent, and their subsidiaries and affiliates shall not assert any claim under the United States Constitution, Rule 11(f) of the Federal Rules of Criminal Procedure, Rule 410 of the Federal Rules of Evidence, or any other federal rule that any such statements or testimony made by or on behalf of HMA, HMA Parent or their subsidiaries or affiliates prior or subsequent to this Agreement, or any leads derived therefrom, should be suppressed or are otherwise inadmissible. The decision whether conduct or statements of any current director, officer or employee, or any person acting on behalf of, or at the direction of, HMA, HMA Parent, or their subsidiaries or affiliates, will be imputed to HMA or HMA Parent for the purpose of determining whether HMA or HMA Parent has violated any provision of this Agreement shall be in the sole discretion of the Fraud Section.

12. Sale or Merger. Except as may otherwise be agreed by the parties in connection with a particular transaction, HMA and HMA Parent agree that in the event that, during the Term, they sell, merge, or transfer all or substantially all of their respective business operations, whether such sale is structured as a sale, asset sale, merger, transfer or other change in corporate form, they shall include in any contract for sale, merger, transfer, or other change in corporate form a provision binding the purchaser, or any successor in interest thereto, to the obligations described

in this Agreement. The purchaser or successor in interest must also agree in writing that the Fraud Section's ability to determine there has been a breach under this Agreement is applicable in full force to that entity. HMA and HMA Parent agree that the failure to include this Agreement's breach provisions in the transaction will make any such transaction null and void. HMA and HMA Parent shall provide notice to the Fraud Section at least thirty days prior to undertaking any such sale, merger, transfer, or other change in corporate form. If the Fraud Section notifies HMA or HMA Parent prior to such transaction (or series of transactions) that it has determined that the transaction(s) has the effect of circumventing or frustrating the enforcement purposes of this Agreement, as determined in the sole discretion of the Fraud Section, HMA and HMA Parent agrees that such transaction(s) will not be consummated. In addition, if at any time during the Term the Fraud Section determines in its sole discretion that HMA or HMA Parent has engaged in a transaction(s) that has the effect of circumventing or frustrating the enforcement purposes of this Agreement, it may deem it a breach of this Agreement pursuant to the breach provisions of this Agreement. Nothing herein shall restrict HMA or HMA Parent from indemnifying (or otherwise holding harmless) the purchaser or successor in interest for penalties or other costs arising from any conduct that may have occurred prior to the date of the transaction, so long as such indemnification does not have the effect of circumventing or frustrating the enforcement purposes of this Agreement, as determined by the Fraud Section.

13. Limitations on Binding Effect of Agreement. This Agreement is binding on HMA, HMA Parent, and the Fraud Section but specifically does not bind any other component of the Department of Justice, other federal agencies, or any state, local or foreign law enforcement or regulatory agencies, or any other authorities, although the Fraud Section will bring the cooperation of HMA and HMA Parent, and their compliance with their other obligations under this Agreement to the attention of such agencies and authorities if requested to do so by HMA or HMA Parent.

14. The Fraud Section, HMA and HMA Parent agree that this Agreement is null and void if: (a) Carlisle HMA, LLC does not enter its guilty plea and does not pay a criminal fine in the amount of $2,548,000 within ten business days of its sentencing; and (b) HMA does not pay $74,970,802 to the United States and the Medicaid Participating States under the terms of the related civil Settlement Agreement.

15. It is further understood that HMA, HMA Parent, and the Fraud Section may disclose this Agreement to the public.

16. Complete Agreement. This Agreement sets forth all the terms of the agreement between HMA, HMA Parent, and the Fraud Section. No amendments, modifications or additions to this Agreement shall be valid unless they are in writing and signed by the Fraud Section, the attorneys for HMA and HMA Parent, and duly authorized representatives of HMA and HMA Parent.

Sincerely,

Date: _____ BY: Sandra Moser by RZ 9/17/18

Sandra L. Moser
Acting Chief, Fraud Section
Criminal Division
United States Department of Justice

Robert A. Zink
Acting Principal Deputy Chief, Fraud Section

Joseph S. Beemsterboer
Deputy Chief, Fraud Section

Sally B. Molloy
Assistant Deputy Chief, Fraud Section

AGREED AND CONSENTED TO:

Date: _____ BY: _____

Christopher G. Cobb
Corporate Secretary of HMA and
Vice President Legal and Corporate Secretary of HMA Parent

Date: _____ BY: _____

Richard A. Sauber
Robbins, Russell, Englert, Orseck, Untereiner, & Sauber, LLP
Counsel for HMA and HMA Parent

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Acting Chief, Fraud Section
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United States Department of Justice

Robert A. Zink
Acting Principal Deputy Chief, Fraud Section

Joseph S. Beemsterboer
Deputy Chief, Fraud Section

Sally B. Molloy
Assistant Deputy Chief, Fraud Section

AGREED AND CONSENTED TO:

Date: 9/21/2018 BY: _____

Christopher G. Cobb
Secretary of HMA and
Vice President-Legal and Corporate Secretary of HMA Parent

Date: _____ BY: _____

Richard A. Sauber
Michael L. Waldman
Robbins, Russell, Englert, Orseck, Untereiner & Sauber LLP
Counsel for HMA and HMA Parent

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Sincerely,

Date: _____ BY: _____

Sandra L. Moser
Acting Chief, Fraud Section
Criminal Division
United States Department of Justice

Robert A. Zink
Acting Principal Deputy Chief, Fraud Section

Joseph S. Beemsterboer
Deputy Chief, Fraud Section

Sally B. Molloy
Assistant Deputy Chief, Fraud Section

AGREED AND CONSENTED TO:

Date: _____ BY: _____

Christopher G. Cobb
Secretary of HMA and
Vice President-Legal and Corporate Secretary of HMA Parent

Date: 11/15/2016 BY: _____

Richard A. Sauber
Michael L. Waldman
Robbins, Russell, Englert, Orseck, Untereiner & Sauber LLP
Counsel for HMA and HMA Parent

ATTACHMENT A

STATEMENT OF FACTS

The following Statement of Facts is incorporated by reference as part of the non-prosecution agreement (the "Agreement") between the United States Department of Justice, Criminal Division, Fraud Section (the "Fraud Section") and Health Management Associates, LLC, formerly known as Health Management Associates, Inc. (on its behalf and on behalf of its subsidiaries) (collectively, "HMA"). HMA hereby agrees and stipulates that the following information is true and accurate. HMA admits, accepts, and acknowledges that it is responsible for the acts of its officers, directors, employees, and agents as set forth below:

The Federal Health Care Programs and
The Provision of and Reimbursement for Hospital Care

1. The Medicare Program ("Medicare") was a Federal health care program providing benefits to persons who were 65 or over or disabled. Medicare was administered by the United States Department of Health and Human Services ("HHS") through its agency, the Centers for Medicare and Medicaid Services ("CMS"), and its contractors.

2. The Medicaid Program ("Medicaid") was a Federal health care program providing benefits for low-income patients. Funding for Medicaid is shared between the federal and state governments. At the Federal level, Medicaid is administered by CMS.

3. TRICARE was a federally-funded medical insurance program for military personnel, their spouses and unmarried dependent children under the age of 22, administered by the TRICARE Management Activity, pursuant to 10 U.S.C. §§ 1071-1177.

4. Medicare, Medicaid and TRICARE were each a "health care benefit program," as defined by Title 18, United States Code, Section 24(b), and a "Federal health care program," as defined by Title 42, United States Code, Section 1320a-7b(f).

5. Health care providers who furnished health care services that were reimbursed by Federal health care programs had to ensure that such services would "be provided economically and only when, and to the extent, medically necessary." 42 U.S.C. § 1320c-5(a)(1); 42 C.F.R. § 1004.10.

6. When a patient visited a hospital's emergency department (hereafter referred to as the "ED"), a patient was typically examined by an ED physician who determined the patient's medical condition. Based on the severity of a patient's condition and the expected course of treatment, an ED physician would make a recommendation to an admitting physician (the patient's personal physician or a hospitalist) about whether the patient should be:

a. admitted to the hospital for inpatient treatment;

b. observed in a hospital bed for a period typically lasting up to 24 hours

but not exceeding 48 hours, after which time a decision could be made about whether the patient required hospital admission; or

c. treated in the ED and discharged.

7. The Medicare Program Integrity Manual provided that "[i]npatient care, rather than outpatient care, is required **only if** the beneficiary's medical condition, safety or health would be significantly and directly threatened if care was provided in a less intensive setting." Chapter 6, Section 6.5.2 (emphasis added).

8. The decision whether to (a) admit a patient, (b) treat a patient in observation status, or (c) treat a patient as an outpatient in the ED and discharge the patient had significant financial consequences for the hospital. Hospitals derived a large portion of their revenues from payments for inpatient care, and were generally paid thousands of dollars more to treat a patient who was billed as an admitted patient than one who was billed as an outpatient or under observation.

9. Medicare Part A (Hospital Insurance) covered **inpatient hospital services**. Hospitals submitted claims for payment for inpatient hospital services under Medicare Part A after a patient was discharged from the hospital. Initially, hospitals submitted a patient-specific claim for interim payment for each discharged patient.

10. Medicare Part B (Medical Insurance) covered **outpatient hospital services**. Hospitals submitted claims for payment for outpatient hospital services, which included both (a) observation services and (b) treatment provided to a patient in an ED under Medicare Part B. Outpatient services provided to a patient were assigned a classification and reimbursed at a rate set by Medicare for that classification. Generally, the more complex the services, the higher the reimbursement.

11. Medicare Part B also reimbursed physicians for their professional services provided in a hospital setting, pursuant to a Physician Fee Schedule. Physicians billed Medicare for their examinations of patients in hospital EDs under one of five evaluation and management codes, depending on the complexity of the examination. Generally, the more complex the examination, the higher the reimbursement.

12. Patient-specific hospital services were billed to and reimbursed by Medicaid and TRICARE in generally the same manner as Medicare.

13. In addition to patient specific claims for both inpatient and outpatient hospital services, hospitals who were Medicare providers were required to annually submit a hospital cost report. The cost report was the hospital's final claim for payment from Medicare for the services rendered to all program beneficiaries for a fiscal year. Medicare relied on the hospital cost report to determine whether the provider was entitled to more reimbursement than it had already received through interim payments, or whether the provider had been overpaid and had to reimburse Medicare.

14. The federal Anti-Kickback Statute, in general terms, criminalized the offer, payment, solicitation, and receipt of remuneration in exchange for ordering, or arranging for, or recommending ordering any service or item for which payment may be made, in whole or in part, by a federal health care program. 42 U.S.C. § 1320a-7b(b).

15. In order for hospitals and physicians to participate as Medicare providers and receive payment from Medicare, they had to enter into Provider Agreements with CMS. As part of that agreement, the provider had to certify that:

> I agree to abide by the Medicare laws, regulations, and program instructions that apply to [me]. The Medicare laws, regulations, and program instructions are available through the [Medicare] contractor. I understand that payment of a claim by Medicare is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, the Federal anti-kickback statute and the Stark law), and on the [provider's] compliance with all applicable conditions of participation in Medicare.

16. Medicare would not pay a hospital's claims for services that it knew were not medically necessary or that were provided in violation of the Anti-Kickback Statute.

17. Every hospital cost report also contained a certification page that had to be signed by the chief administrator of the hospital provider or his or her designee, who had to certify that he or she was "familiar with the laws and regulations regarding the provision of health care services and that the services identified in this cost report were provided in compliance with such laws and regulations," including the laws and regulations that required services to be medically necessary and comply with the Anti-Kickback Statute.

18. Similarly, in order to participate as Medicaid and TRICARE providers and receive payment from the Medicaid and TRICARE programs, hospitals and physicians had to sign Medicaid provider agreements, which vary from state to state, and TRICARE provider agreements, and certify, among other things, that the provider would comply with all applicable federal and state laws and regulations, including the law and regulations that required services to be medically necessary and the Anti-Kickback Statute. State Medicaid programs and TRICARE would not pay a hospital's claims for services that they knew were not medically necessary or provided in violation of the Anti-Kickback Statute.

Health Management Associates, Inc. and Relevant Entities

19. Until its acquisition in January 2014, Health Management Associates, Inc. ("HMA") was a publicly-traded, Delaware-based corporation headquartered in Naples, Florida that indirectly owned and operated, at various times, over 70 general acute care for-profit hospitals primarily in rural communities across the United States (collectively, "the HMA Hospitals").

20. From at least 2008 to at least 2013, the HMA Hospitals, at various times, were enrolled as providers in the Medicare, Medicaid and TRICARE programs and billed and received payment from these federal health care programs for hospital services.

21. From at least 2008 to at least 2014, the HMA Hospitals, at various times, submitted annual hospital cost reports to the Medicare program.

22. The HMA Hospitals did not employ physicians to provide ED personnel and management services. Instead, HMA Hospitals contracted with other companies or local ED physician practice groups to provide ED personnel and management services.

23. Company A was one of the companies that HMA contracted with to provide ED services at HMA Hospitals. HMA was Company A's largest hospital customer. Under its arrangement with HMA, Company A billed and received payment from Federal health care programs for physician services provided at HMA Hospitals. Some HMA Hospitals also paid a management fee to Company A for managing the ED.

24. Company A hired or contracted with emergency medicine physicians to provide professional services at HMA Hospitals, who were paid an hourly rate. Company A also employed physicians as medical directors at the HMA Hospitals it serviced, who were paid a monthly salary for their services and an hourly fee for clinical services provided to hospital patients.

25. HMA Hospitals' contracts with Company A generally provided that the parties to the contract could terminate the contract with 60-90 days' notice without cause after the first year and that the HMA Hospital CEO could direct Company A to remove any ED physician working at an HMA hospital at any time without cause.

Overview and Purpose of the Conspiracy

26. Beginning in 2008 and continuing through at least 2012, in the Middle District of Florida and elsewhere, (1) certain executives of HMA and certain administrators of HMA Hospitals, acting as agents of HMA and the HMA Hospitals, at least in part for the benefit of HMA and the HMA Hospitals, and within the scope of their employment and authority at HMA and the HMA Hospitals, (2) certain executives and administrators of Company A, and (3) others conspired to execute a scheme and artifice to defraud Federal health care programs, that is, Medicare, Medicaid and TRICARE. As part of the scheme to defraud, HMA offered and paid unlawful remuneration to Company A, in the form of service contracts at HMA Hospitals and payments, in return for ED inpatient admission recommendations and admissions at HMA Hospitals that were not medically necessary.

27. It was a purpose of the conspiracy for certain executives at HMA, certain administrators at the HMA Hospitals, certain executives and administrators of Company A, and others to unlawfully enrich and benefit HMA, the HMA Hospitals, Company A, and themselves, by unlawfully pressuring and inducing physicians serving HMA Hospitals, including physicians who worked for Company A, to increase the number of ED patient admissions without regard to whether the admissions were medically necessary, all so that the HMA Hospitals could bill and obtain reimbursement for higher-paying inpatient hospital care, as opposed to observation or outpatient care, from Federal health care programs, and increase HMA's revenue.

Execution of the Conspiracy

28. Beginning in or around September 2008, HMA executives instituted a formal and aggressive plan to improperly increase overall ED inpatient admission rates at all HMA Hospitals. As part of the plan, HMA executives set mandatory company-wide admission rate benchmarks for patients presenting to HMA Hospital EDs - a range of 15-20% for all patients presenting to the ED, depending on the HMA Hospital, and then 50% for patients 65 and older (i.e. Medicare beneficiaries) – solely to increase HMA revenue.

29. These mandatory benchmarks were not put in place to improve the level of patient care, and were not based on an assessment of the medical needs of the patient mix at particular hospitals or the medical services that particular hospitals were equipped to provide to patients. In fact, most HMA hospitals lacked specialty care to treat many seriously ill patients – they were not designated Level One or Level Two Trauma Centers and did not have 24-hour interventional cardiology, cardiac surgery, neurology, or neurosurgery services to treat heart attack or stroke victims or inpatient pediatric units.

30. The scheme to increase ED inpatient admission rates and maximize revenue was executed through various improper means, including by HMA executives pressuring and coercing HMA Hospital administrators, contracted ED physician practice groups, including Company A, and medical directors and physicians treating HMA's ED patients to meet mandatory admission rate benchmarks in the following ways, among others:

a. HMA executives directed HMA Hospital administrators to generate daily "Physician's Activity Reports" using a customized software program that tracked each ED physician's admissions statistics relating to patients he or she treated and corresponding color-coded "Physician's Scorecards," which indicated in red whether the physician had failed to meet the mandatory admissions benchmark. At some HMA Hospitals, these scorecards were posted in the physicians' workspace and improperly used to pressure physicians with "failing" admission grades to admit patients who did not require inpatient admission;

b. HMA executives and HMA Hospital administrators tracked ED physicians' "admission overrides" in the "Physician's Activity Report." These were instances in which an ED patient met pre-programmed criteria for inpatient admission in the customized software program but the ED physician, using his or her clinical judgment, disagreed and manually overrode the computerized designation. At some HMA Hospitals, ED physicians whose admission override rates were over a mandatory benchmark were given "failing" admission grades and these override rates were improperly used to pressure ED physicians with "failing" grades to admit patients who did not require inpatient admission;

c. HMA executives ordered HMA Hospital administrators to interrogate ED physicians about alleged "missed" admissions and admission overrides during daily meetings which was designed to improperly pressure the ED physicians to admit patients who did not require inpatient admission. Certain HMA Hospital administrators threatened to fire ED physicians and medical directors if the ED physicians did not increase the number of admissions of patients they treated, regardless of whether the patients required inpatient admission. In some instances, HMA

executives fired HMA Hospital administrators who were unwilling to improperly challenge ED physicians' admission status determinations;

d. HMA executives prepared, distributed, and improperly used "Forced Rank Reports" that ranked HMA Hospital EDs according to ED inpatient admission rates and grouped HMA Hospitals that met the mandatory corporate benchmark for the month above the line, and those that failed to meet it below the line. HMA executives warned HMA Hospital administrators whose hospitals fell below the line that they would be fired unless their admission rates increased. In turn, HMA Hospital administrators pressured Company A executives and administrators, ED medical directors and physicians to admit more patients and demanded that Company A fire medical directors and ED physicians who refused to "get with the program" and maximize admissions through improper methods;

e. HMA executives instructed HMA Hospital administrators to pressure their ED physicians not to place patients in observation status, and to admit them as inpatients regardless of whether they met medical necessity criteria. In some instances, HMA executives instructed HMA Hospital administrators to disregard communications from patients' primary care physicians and case managers to place patients in observation status. At some HMA Hospitals, the option for physicians to place patients in observation status was removed from admission paperwork for a period of time;

f. HMA executives and HMA Hospital administrators also implemented mandatory benchmarks for calls from ED physicians to patients' primary care physicians to discuss admission status determinations, and tracked and reviewed individual ED physicians' compliance with these benchmarks for the improper purpose of increasing inpatient admissions without medical necessity. HMA executives instructed Company A administrators and ED physicians that the purpose of these calls was to "sell admissions" to primary care physicians. If an ED physician's admission rate for the patients he or she treated fell below the mandatory corporate benchmark, HMA executives directed Company A management to train the ED physician on how to sell admissions during telephone calls with primary care physicians. ED physicians were told not to solicit the primary care physician's advice about the admission status determination, but instead to tell the physician that the patient should be admitted; and

g. HMA used monetary bonuses to induce ED physicians to increase their rates of hospital admissions without regard to whether inpatient admission was required. At certain HMA Hospitals, HMA contracted with Company A to pay bonuses to ED physicians who satisfied the mandatory corporate benchmarks for admission overrides and calls to primary care physicians, which was designed by HMA to increase inpatient admissions without regard to medical necessity.

31. Company A executives and administrators collaborated with HMA executives and HMA Hospital administrators in pressuring and inducing ED medical directors and physicians to recommend the hospitalization of ED patients who did not need and did not qualify for inpatient admission by, among other means:

a. enforcing HMA's mandatory corporate benchmarks for ED admissions without regard to whether inpatient admission was required, requiring calls

to primary care physicians to sell improper admissions, and improperly using data such as admission overrides to pressure its ED physicians to admit patients who did not meet medical necessity criteria;

b. agreeing to HMA's payment of bonuses to ED medical directors and physicians who met mandatory corporate benchmarks designed to increase improper admissions;

c. training its physicians to "sell admissions" in telephone calls to primary care physicians rather than engage in a meaningful consultation about the patients' medical needs;

d. instructing ED medical directors and physicians to admit patients who did not meet medical necessity criteria;

e. at HMA's request, threatening to terminate and terminating medical directors and physicians who refused to follow HMA's improper procedures to maximize admissions; and

f. firing its own corporate managers who refused to comply with HMA's orders to maximize admissions through improper methods.

32. As a result of the above-described pressure to admit and inducements from HMA executives, HMA Hospital administrators, Company A executives and administrators, and others, ED physicians staffing HMA Hospital EDs recommended, in certain instances, inpatient admissions that were not medically necessary, and physicians with admitting privileges at HMA Hospitals admitted, in certain instances, patients who did not need inpatient admission.

33. As a result, HMA Hospitals billed and received payments from Federal health care programs for inpatient admissions that were not medically necessary, were tainted by kickbacks, or both.

34. As a further result, HMA Hospitals submitted cost reports to Medicare in which HMA Hospital administrators made materially false, fraudulent and misleading representations that the services identified in the cost report "were provided in compliance with the laws and regulations" regarding the provision of health care services, when in fact certain services were not medically necessary, were tainted by kickbacks, or both.

ATTACHMENT B

CORPORATE INTEGRITY AGREEMENT
BETWEEN THE
OFFICE OF INSPECTOR GENERAL
OF THE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
AND
COMMUNITY HEALTH SYSTEMS, INC.,
AMENDED

I. PREAMBLE

Effective July 28, 2014, Community Health Systems, Inc. (CHSI) entered into a Corporate Integrity Agreement (CIA) with the Office of Inspector General (OIG) of the United States Department of Health and Human Services (HHS) to promote compliance with the statutes, regulations, and written directives of Medicare, Medicaid, and all other Federal health care programs (as defined in 42 U.S.C. § 1320a-7b(f)) (Federal health care program requirements). That CIA is hereby amended and extended for an additional period. Specifically, this amended CIA (hereafter "CIA") will be in effect for three years commencing on its Effective Date. Contemporaneously with this CIA, CHSI is entering into a Settlement Agreement with the United States.

CHSI represents that, prior to this CIA, CHSI voluntarily established a Compliance Program which provides for a Corporate Compliance and Privacy Officer, various compliance committees, a compliance training and education program, a confidential disclosure reporting hotline, and auditing and monitoring activities, and which includes various policies and procedures aimed at ensuring that CHSI's participation in the federal health care programs conforms to all federal and state laws and federal health care program requirements. CHSI shall continue its Compliance Program throughout the term of this CIA and shall do so in accordance with the terms set forth below. CHSI may modify its Compliance Program, as appropriate, but at a minimum, CHSI shall ensure that during the term of this CIA, it shall comply with the obligations set forth herein.

For purposes of this CIA, "CHSI" shall mean the following: (1) Community Health Systems, Inc. and its directly or indirectly wholly-owned subsidiaries and affiliates that provide hospital services; and (2) any other corporation, limited liability company, partnership, or any other legal entity or organization in which CHSI, or a directly or indirectly wholly-owned subsidiary or affiliate of CHSI, owns a direct or indirect equity interest of 50% or more and that provides hospital services.

II. TERM AND SCOPE OF THE CIA

A. The period of the compliance obligations assumed by CHSI under this amended CIA shall be three years from the effective date of this CIA. The "Effective Date" shall be the date on which the final signatory of this CIA executes this CIA. Each one-year period, beginning with the one-year period following the Effective Date, shall be referred to as a "Reporting Period."

B. Sections VII, X, and XI shall expire no later than 120 days after OIG's receipt of: (1) CHSI's final annual report; or (2) any additional materials submitted by CHSI pursuant to OIG's request, whichever is later.

C. The scope of this CIA shall be governed by the following definitions:

1. "Covered Persons" includes:

   a. all owners who are natural persons (other than shareholders who: (1) have an ownership interest of less than 5% and (2) acquired the ownership interest through public trading), officers, directors, and employees of CHSI;

   b. all contractors, subcontractors, agents, and other persons who provide patient care items or services or who perform billing or coding functions on behalf of CHSI, excluding vendors whose sole connection with CHSI is selling or otherwise providing medical supplies or equipment and who do not bill the Federal health care programs for such medical supplies or equipment to CSHI; and

   c. all physicians and other non-physician practitioners who are members of the active medical staff at CHSI.

   Notwithstanding the above, this term does not include part-time or per diem employees, contractors, subcontractors, agents, and other persons who are not reasonably expected to work more than 160 hours per year, except that any such individuals shall become

"Covered Persons" at the point when they work more than 160 hours

during the calendar year.

2. "Covered Facility" or "Covered Facilities" includes all CHSI hospitals, but shall not include any CHSI hospital that has been designated as a Critical Access Hospital pursuant to 42 U.S.C. § 1395i-4(c)(2).

3. "Relevant Billing Covered Persons" includes Covered Persons involved in the preparation or submission of claims or cost reports for reimbursement from any Federal health care program on behalf of CHSI's Covered Facilities.

4. "Relevant Clinical Covered Persons" includes Covered Persons involved in the delivery of patient care items or services at or on behalf of CHSI's Covered Facilities.

5. "Relevant Case Management Covered Persons" includes Covered Persons who work in or for a Case Management Department and who are involved in case management or utilization review functions relating to inpatient admissions or discharge decisions.

6. "Arrangements" shall mean every arrangement or transaction that:

   a. involves, directly or indirectly, the offer, payment, solicitation, or receipt of anything of value; and is between CHSI and any actual or potential source of health care business or referrals to CHSI or any actual or potential recipient of health care business or referrals from CHSI. The term "source of health care business or referrals" shall mean any individual or entity that refers, recommends, arranges for, orders, leases, or purchases any good, facility, item, or service for which payment may be made in whole or in part by a Federal health care program and the term "recipient of health care business or referrals" shall mean any individual or entity (1) to whom CHSI refers an individual for the furnishing or arranging for the furnishing of any item or service, or (2)

from whom CHSI purchases, leases or orders or arranges for or recommends the purchasing, leasing, or ordering of any good, facility, item, or service for which payment may be made in whole or in part by a Federal health care program; or

b. is between CHSI and a physician (or a physician's immediate family member (as defined at 42 C.F.R. § 411.351)) who makes a referral (as defined at 42 U.S.C. § 1395nn(h)(5)) to CHSI for designated health services (as defined at 42 U.S.C. § 1395nn(h)(6)).

7. "Focus Arrangements" means every Arrangement that:

a. is between CHSI and any actual source of health care business or referrals to CHSI and involves, directly or indirectly, the offer, payment, or provision of anything of value; or

b. is between CHSI and any physician (or a physician's immediate family member) (as defined at 42 C.F.R. § 411.351)) who makes a referral (as defined at 42 U.S.C. § 1395nn(h)(5)) to CHSI for designated health services (as defined at 42 U.S.C. §1395nn(h))(6)).

Notwithstanding the foregoing provisions of Section II.C.7, any Arrangement that satisfies the requirements of 42 C.F.R. § 411.356 (ownership or investment interests), 42 C.F.R. § 411.357(g) (remuneration unrelated to the provision of designated health services); 42 C.F.R. § 411.357(i) (payments by a physician for items and services); 42 C.F.R. § 411.357(k) (non-monetary compensation); 42 C.F.R. § 411.357(m) (medical staff incidental benefits), 42 C.F.R. § 411.357(o) (compliance training), 42 C.F.R. § 411.357(q) (referral services), 42 C.F.R. § 411.357(s) (professional courtesy), 42 C.F.R. § 357(u) (community-wide health information systems), any exception to the prohibitions of 42 U.S.C. § 1395nn enacted following the Effective Date that does not require a written agreement or that does not constitute a "financial relationship" as

defined by 42 C.F.R. § 411.354 shall not be considered a Focus Arrangement for purposes of this CIA.

8. "Relevant Arrangements Covered Persons" includes all Covered Persons involved in the negotiation, preparation, review, maintenance, and approval for payment of all Arrangements, as defined above, involving CHSI.

III. CORPORATE INTEGRITY OBLIGATIONS

CHSI shall maintain a Compliance Program that includes the following elements:

A. Compliance Management and Oversight

1. *Corporate Compliance and Privacy Officer.* CHSI has appointed a Corporate Compliance and Privacy Officer and shall maintain a Corporate Compliance and Privacy Officer for the term of the CIA. The Corporate Compliance and Privacy Officer shall be responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements set forth in this CIA and with Federal health care program requirements. The Corporate Compliance and Privacy Officer shall be a member of senior management of CHSI, shall report directly to the Chief Executive Officer of CHSI, shall make periodic (at least quarterly) reports regarding compliance matters directly to the Audit and Compliance Committee of the Board of Directors of CHSI ("Board of Directors"), and shall be authorized to report on such matters to the Board of Directors at any time. Written documentation of the Corporate Compliance and Privacy Officer's reports to the Board of Directors shall be made available to OIG upon request. The Corporate Compliance and Privacy Officer shall not be or be subordinate to the General Counsel or Chief Financial Officer. The Corporate Compliance and Privacy Officer shall be responsible for monitoring the day-to-day compliance activities engaged in by CHSI as well as for any reporting obligations created under this CIA. Any noncompliance job responsibilities of the Corporate Compliance and Privacy Officer shall be limited and must not interfere with the Corporate Compliance and Privacy Officer's ability to perform the duties outlined in this CIA.

CHSI shall report to OIG, in writing, any change in the identity of the Corporate Compliance and Privacy Officer, or any actions or changes that would affect the

Corporate Compliance and Privacy Officer's ability to perform the duties necessary to meet the obligations in this CIA, within five days after such a change.

2. *Regional and Facility Compliance Officers*. CHSI has appointed individuals to serve as Regional Compliance Officers known as Corporate Compliance Directors. CHSI also has appointed a Facility Compliance Officer for each CHSI Covered Facility. CHSI shall maintain the Corporate Compliance Directors and Facility Compliance Officers for the duration of the CIA. The Corporate Compliance Directors shall be responsible for implementing policies, procedures, and practices designed to ensure compliance with the requirements set forth in this CIA and with Federal health care program requirements for the applicable regions, and shall monitor the day-to-day compliance activities for the applicable regions. The Facility Compliance Officers shall be responsible for implementing policies, procedures, and practices designed to ensure compliance with the requirements set forth in this CIA and with Federal health care program requirements for the Covered Facilities, and shall monitor the day-to-day compliance activities of the Covered Facilities. The Corporate Compliance Directors shall report to the Corporate Compliance and Privacy Officer (through Senior Compliance Directors), and shall be members of the Corporate Compliance Work Group. The Facility Compliance Officers shall report to their assigned Corporate Compliance Directors for ethics and compliance purposes and shall be independent from CHSI's Legal Department. The Facility Compliance Officers shall make periodic (at least quarterly) written reports regarding compliance matters directly to the Corporate Compliance Directors, and shall be authorized to report on such matters directly to the Corporate Compliance Work Group, the Corporate Compliance and Privacy Officer, and the Board of Directors at any time. CHSI shall report to OIG, in writing any actions or changes that would affect any Facility Compliance Officer's ability to perform the duties necessary to meet the obligations in this CIA, within 30 days after such a change.

3. *Corporate Compliance Committee*. CHSI has an existing Corporate Compliance Committee known as the Corporate Compliance Work Group. CHSI shall maintain this Corporate Compliance Work Group for the duration of the CIA. The Corporate Compliance Work Group shall, at a minimum, include the Corporate Compliance and Privacy Officer, Senior Compliance Directors, Corporate Compliance Directors, and other members of senior management necessary to meet the requirements of this CIA (e.g., senior executives of relevant departments, such as billing, clinical, human resources, audit, and operations). The Corporate Compliance and Privacy Officer shall chair the Corporate Compliance Work Group, and the Corporate Compliance Work Group shall support the Corporate Compliance and Privacy Officer in fulfilling his/her

responsibilities (e.g., shall assist in the analysis of the CHSI's risk areas and shall oversee monitoring of internal and external audits and investigations). The Corporate Compliance Work Group shall meet at least quarterly. The minutes of the Corporate Compliance Work Group meetings shall be made available to OIG upon request.

CHSI shall report to OIG, in writing, any changes in the composition of the Corporate Compliance Work Group, or any actions or changes that would affect the Corporate Compliance Work Group's ability to perform the duties necessary to meet the obligations in this CIA, within 30 days after such a change.

4. *Facility Compliance Committees.* CHSI has established a Facility Compliance Committee at each CHSI Covered Facility. The Facility Compliance Committees shall be maintained for the duration of the CIA and shall include appropriate personnel and other members of senior management at each of CHSI's Covered Facilities necessary to meet the requirements of this CIA (e.g., senior executives of relevant departments, such as billing, clinical, human resources, audit, and operations). The Facility Compliance Committees shall support the Corporate Compliance Directors and Facility Compliance Officers in fulfilling their responsibilities (e.g., shall assist in the analysis of the organization's risk areas and shall oversee monitoring of internal and external audits and investigations). CHSI shall report to OIG, in writing, any actions or changes that would affect any Facility Compliance Committee's ability to perform the duties necessary to meet the obligations of the CIA, within 30 days after such a change.

5. *Board of Directors Compliance Obligations.* The Board of Directors of CHSI shall be responsible for the review and oversight of matters related to compliance with Federal health care program requirements and the obligations of this CIA. The Board of Directors must include independent (i.e., non-executive) members.

The Board of Directors shall, at a minimum, be responsible for the following:

a. meeting at least quarterly to review and oversee CHSI's Compliance Program, including but not limited to the performance of the Corporate Compliance and Privacy Officer and Corporate Compliance Work Group; and

b. for each Reporting Period of the CIA, adopting a resolution, signed by each member of the Board of Directors summarizing its review and oversight of CHSI's compliance

with Federal health care program requirements and the obligations of this CIA.

At minimum, the resolution shall include the following language:

"The Board of Directors of the Board of Directors has made a reasonable inquiry into the operations of CHSI's Compliance Program including the performance of the Corporate Compliance and Privacy Officer and the Corporate Compliance Work Group. Based on its inquiry and review, the Board of Directors has concluded that, to the best of its knowledge, CHSI has implemented an effective Compliance Program to meet Federal health care program requirements and the obligations of the CIA."

If the Board of Directors is unable to provide such a conclusion in the resolution, the Board of Directors shall include in the resolution a written explanation of the reasons why it is unable to provide the conclusion and the steps it is taking to implement an effective Compliance Program at CHSI.

CHSI shall report to OIG, in writing, any changes in the composition of the Board of Directors, or any actions or changes that would affect the Board of Directors' ability to perform the duties necessary to meet the obligations in this CIA, within 30 days after such a change.

B. Written Standards

1. *Code of Conduct.* CHSI has developed, implemented and distributed a written Code of Conduct to all Covered Persons and shall maintain this Code of Conduct for the duration of the CIA. CHSI shall make the promotion of, and adherence to, the Code of Conduct an element in evaluating the performance of all employees. To the extent not already accomplished, within 120 days after the Effective Date, the Code of Conduct shall, at a minimum, set forth:

a. CHSI's commitment to full compliance with all Federal health care program requirements, including its commitment to prepare and submit accurate claims consistent with such requirements;

b. CHSI's requirement that all of its Covered Persons shall be expected to comply with all Federal health care program requirements and with CHSI's own Policies and Procedures;

c. the requirement that all of CHSI's Covered Persons shall be expected to report to the Corporate Compliance and Privacy Officer, or other appropriate individual designated by CHSI, suspected violations of any Federal health care program requirements or of CHSI's own Policies and Procedures; and

d. the right of all individuals to use the Disclosure Program described in Section III.F, and CHSI's commitment to nonretaliation and to maintain, as appropriate, confidentiality and anonymity with respect to such disclosures.

CHSI currently requires all newly employed Covered Persons to certify in writing or electronic form that he or she has received, read, understood, and shall abide by CHSI's Code of Conduct. CHSI shall maintain this practice for the duration of the CIA and shall ensure that New Covered Persons receive the Code of Conduct and shall complete the required certification within 30 days after becoming a Covered Person. CHSI shall distribute the Code of Conduct to all active medical staff members as described above and shall use its best efforts to encourage such active medical staff members to submit the required certification. The Corporate Compliance and Privacy Officer shall maintain records indicating that the Code of Conduct was distributed to all active medical staff members and whether the certification was completed.

CHSI shall periodically review the Code of Conduct to determine if revisions are appropriate and shall make any necessary revisions based on such review. The Code of Conduct shall be distributed at least annually to all Covered Persons.

2. *Policies and Procedures.* CHSI has developed, implemented, and distributed written Policies and Procedures regarding the operation of its compliance program, including the compliance program requirements outlined in this CIA and in compliance with Federal health care program requirements, and shall maintain these Policies and Procedures for the duration of the CIA.

Within 120 days after the Effective Date, the Policies and Procedures shall address, at a minimum:

a. the subjects relating to the Code of Conduct identified in Section III.B.1;

b. the compliance program requirements outlined in this CIA;

c. CHSI's compliance with Federal health care program requirements, including Federal health care program rules governing medical necessity determinations for inpatient admission; and

d. billing and reimbursement, including:

   i. ensuring proper and accurate submission of claims and cost reports to Federal health care programs;

   ii. ensuring the proper and accurate documentation of medical records;

   iii. ensuring the proper and accurate assignment and designation of patients into inpatient, outpatient, or observation status; and

   iv. ensuring the necessary and appropriate length of stays and timely discharges for all patients.

e. documentation of medical records, including:

   i. ensuring proper and accurate documentation in the pre-admission, admission, case management, billing, coding and reimbursement process;

   ii. ensuring that physicians are aware of relevant Federal health care program requirements governing admission, and any relevant Medicare regulations regarding treatment of a patient as an inpatient;

iii. the personal obligation of each individual involved in the medical documentation process to ensure that such documentation is accurate;

iv. ensuring proper order authentication practices to ensure: (1) physician orders are not implemented without physician knowledge and consent; and (2) unauthorized markings are not added to physician orders without physician knowledge or consent;

v. ensuring that employees do not disregard physician orders relating to the admission of a patient;

vi. the legal sanctions for violations of the Federal health care program requirements; and

vii. examples of proper and improper medical documentation practices.

f. requirements for Case Management employees, including:

i. the Policies and Procedures for determining the medical necessity and appropriateness of inpatient admissions, including applicable Medicare rules and regulations; and

ii. the policies and procedures for proper order authentication and modification.

Within 120 days after the Effective Date, the Policies and Procedures shall be made available to all Covered Persons. Appropriate and knowledgeable staff shall be available to explain the Policies and Procedures.

At least annually (and more frequently, if appropriate), CHSI shall assess and update, as necessary, the Policies and Procedures. Within 30 days after the effective date of any revisions, a description of the revisions shall be communicated to all affected Covered Persons and any revised Policies and Procedures shall be made available to all Covered Persons.

Within 120 days after the Effective Date, CHSI shall implement written Policies and Procedures addressing the following: (1) 42 U.S.C. § 1320a-7b(b) (Anti-Kickback Statute) and 42 U.S.C. § 1395nn (Stark Law), and the regulations and other guidance documents related to these statutes, and business or financial arrangements or contracts that generate unlawful Federal health care program business in violation of the Anti-Kickback Statute or the Stark Law; and (2) the requirements set forth in Section III.D (Compliance with the Anti-Kickback Statute and Stark Law). Within 120 days after the Effective Date, these Policies and Procedures shall be made available to all Relevant Arrangements Covered Persons. Appropriate and knowledgeable staff shall be available to explain the Policies and Procedures. At least annually (and more frequently, if appropriate), CHSI shall assess and update, as necessary, the Policies and Procedures. Within 30 days after the effective date of any revisions, a description of the revisions shall be communicated to all affected Relevant Arrangements Covered Persons and any revised Policies and Procedures shall be made available to all Relevant Arrangements Covered Persons.

C. Training and Education

CHSI represents that it provides training to its employees on a regular basis concerning a variety of topics. The training covered by this CIA need not be separate and distinct from the regular training provided by CHSI, but instead may be integrated fully into such regular training so long as the training covers the areas specified below.

1. *General Training*. Within 120 days after the Effective Date, CHSI shall provide at least one hour of General Training to each Covered Person. This training, at a minimum, shall explain CHSI's:

a. CIA requirements; and

b. Compliance Program, including the Code of Conduct.

New Covered Persons shall receive the General Training described above within 30 days after becoming a Covered Person or within 120 days after the Effective Date, whichever is later. After receiving the initial General Training described above, each Covered Person shall receive at least one hour of General Training in each subsequent Reporting Period.

2. *Specific Training*. Within 120 days after the Effective Date, each Relevant Covered Person shall receive Specific Training in addition to the General Training required above. This Specific Training shall include the following:

a. Billing and Reimbursement Specific Training. Each Relevant Billing and Reimbursement Covered Person shall receive at least two hours of Billing and Reimbursement Specific Training, which shall include a discussion of:

i. the Federal health care program requirements regarding the accurate coding and submission of claims;

ii. policies, procedures, and other requirements applicable to the documentation of medical records;

iii. the personal obligation of each individual involved in the claims submission process to ensure that such claims are accurate;

iv. applicable reimbursement statutes, regulations, and program requirements and directives;

v. the legal sanctions for violations of the Federal health care program requirements; and

vi. examples of proper and improper claims submission practices.

b. Clinical Documentation and Decision-Making Specific Training. Each Relevant Clinical Covered Person shall receive at least two hours of Clinical Documentation and Decision-Making Specific Training, which shall include a discussion of:

i. policies, procedures, and other Federal health care program requirements applicable to the documentation of medical records;

ii. the role of individual medical necessity determinations in the admission decision;

iii. the importance of accurate documentation in the billing, coding, and reimbursement process;

iv. the personal obligation of each individual involved in the medical documentation process to ensure that such documentation is accurate;

v. the legal sanctions for violations of the Federal healthcare program requirements; and

vi. examples of proper and improper medical documentation practices.

c. Case Management Specific Training. Each Relevant Case Management Covered Person shall receive at least two hours of Case Management Specific Training, which shall include a discussion of:

i. policies, procedures, and applicable Federal health care program requirements for determining the medical necessity and the appropriateness of inpatient admissions; and

ii. the role and function of any bodies or groups, including contractors, at CHSI that review admission decisions.

d. Arrangements Specific Training. Each Relevant Arrangements Covered Person shall receive at least three hours of Arrangements Specific Training, which shall include a discussion of:

i. Arrangements that potentially implicate the Anti-Kickback Statute or the Stark Law, as well as the regulations and other guidance documents related to these statutes;

ii. CHSI's policies, procedures, and other requirements relating to Arrangements and Focus Arrangements, including but not limited to the Focus Arrangements Tracking System, the

internal review and approval process, and the tracking of remuneration to and from sources of health care business or referrals required by Section III.D of the CIA;

iii. the personal obligation of each individual involved in the development, approval, management, or review of CHSI's Arrangements to know the applicable legal requirements and the CHSI's policies and procedures;

iv. the legal sanctions under the Anti-Kickback Statute and the Stark Law; and

v. examples of violations of the Anti-Kickback Statute and the Stark Law.

New Relevant Covered Persons shall receive Specific Training within 30 days after the beginning of their employment or becoming Relevant Covered Persons, or within 120 days after the Effective Date, whichever is later.

After receiving the initial Specific Training described in this Section, each Relevant Billing Covered Person shall receive at least two hours of Billing and Reimbursement Specific Training, in addition to the General Training, in each subsequent Reporting Period. Each Relevant Clinical Covered Person shall receive at least two hours of Clinical Documentation and Decision-Making Specific Training, in addition to the General Training, in each subsequent Reporting Period. Each Relevant Case Management Covered Person shall receive at least two hours of Case Management Specific Training, in addition to the General Training, in each subsequent Reporting Period. Each Relevant Arrangements Covered Person shall receive at least two hours of Arrangements Specific Training, in addition to the General Training, in each subsequent Reporting Period.

3. *Board Member Training.* Within 120 days after the Effective Date, CHSI shall provide at least one hour of training to each member of the Board of Directors, in addition to the General Training. This training shall address the responsibilities of board members and corporate governance.

New members of the Board of Directors shall receive the Board Member Training described above within 30 days after becoming a member or within 120 days after the Effective Date, whichever is later.

4. *Certification.* Each individual who is required to attend training shall certify, in writing or in electronic form, that he or she has received the required training. The certification shall specify the type of training received and the date received. The Corporate Compliance and Privacy Officer (or designee) shall retain the certifications, along with all course materials.

5. *Qualifications of Trainer.* Persons providing the training shall be knowledgeable about the subject area.

6. *Update of Training.* CHSI shall review the training annually, and, where appropriate, update the training to reflect changes in Federal health care program requirements, any issues discovered during internal audits or the Inpatient Medical Necessity and Appropriateness Review , and any other relevant information.

7. *Computer-based Training.* CHSI may provide the training required under this CIA through appropriate computer-based training approaches. If CHSI chooses to provide computer-based training, it shall make available appropriately qualified and knowledgeable staff or trainers to answer questions or provide additional information to the individuals receiving such training. In addition, if CHSI chooses to provide computer based General or Specific Training, all applicable requirements to provide a number of "hours" of training in this Section may be met with respect to computer-based training by providing the required number of "normative" hours as that term is used in the computer-based training industry.

8. *Exception for Active Medical Staff Members.* CHSI shall make the General Training and Specific Training (as appropriate) described in this section available to all of CHSI's active medical staff members and shall use its best efforts to encourage such active medical staff members to complete the training. The Corporate Compliance and Privacy Officer shall maintain records of all active medical staff members who receive training, including the type of training and the date received.

D. Compliance with the Anti-Kickback Statute and Stark Law

1. *Focus Arrangements Procedures.* Within 120 days after the Effective Date, CHSI shall create procedures reasonably designed to ensure that each existing and new or renewed Focus Arrangement does not violate the Anti-Kickback Statute and/or the Stark Law or the regulations, directives, and guidance related to these statutes (Focus Arrangements Procedures). These procedures shall include the following:

a. creating and maintaining a centralized tracking system for all existing and new or renewed Focus Arrangements (Focus Arrangements Tracking System);

b. tracking remuneration to and from all parties to Focus Arrangements;

c. tracking service and activity logs to ensure that parties to the Focus Arrangement are performing the services required under the applicable Focus Arrangement(s) (if applicable);

d. monitoring the use of leased space, medical supplies, medical devices, equipment, or other patient care items to ensure that such use is consistent with the terms of the applicable Focus Arrangement(s) (if applicable);

e. establishing and implementing a written review and approval process for all Focus Arrangements, the purpose of which is to ensure that all new and existing or renewed Focus Arrangements do not violate the Anti-Kickback Statute and Stark Law, and that includes at least the following: (i) a legal review of all Focus Arrangements by counsel with expertise in the Anti-Kickback Statute and Stark Law, (ii) a process for specifying the business need or business rationale for all Focus Arrangements, and (iii) a process for determining and documenting the fair market value of the remuneration specified in the Focus Arrangement;

f. requiring the Corporate Compliance and Privacy Officer to review the Focus Arrangements Tracking System, internal

review and approval process, and other Focus Arrangements Procedures on at least an annual basis and to provide a report on the results of such review to the Board of Directors; and

g. implementing effective responses when suspected violations of the Anti-Kickback Statute and Stark Law are discovered, including disclosing Reportable Events and quantifying and repaying Overpayments pursuant to Sections III.I and III.J when appropriate.

2. *New or Renewed Arrangements.* Prior to entering into new Focus Arrangements or renewing existing Focus Arrangements, in addition to complying with the Focus Arrangements Procedures set forth above, CHSI shall comply with the following requirements (Focus Arrangements Requirements):

a. Ensure that each Focus Arrangement is set forth in writing and signed by CHSI and the other parties to the Focus Arrangement;

b. Include in the written agreement a requirement that each party to a Focus Arrangement who meets the definition of a Relevant Arrangements Covered Person shall complete at least one hour of training regarding the Anti-Kickback Statute and the Stark Law and examples of arrangements that potentially implicate the Anti-Kickback Statute or the Stark Law. Additionally, CHSI shall provide each party to the Focus Arrangement with a copy of its Code of Conduct and Stark Law and Anti-Kickback Statute Policies and Procedures;

c. Include in the written agreement a certification by the parties to the Focus Arrangement that the parties shall not violate the Anti-Kickback Statute and the Stark Law with respect to the performance of the Arrangement.

3. *Records Retention and Access.* CHSI shall retain and make available to OIG, upon request, the Focus Arrangements Tracking System and all supporting documentation of the Focus Arrangements subject to this Section and, to the

extent available, all non-privileged communications related to the Focus Arrangements and the actual performance of the duties under the Focus Arrangements.

E. Review Procedures

1. *General Description*

a. *Engagement of Independent Review Organization.* Within 120 days after the Effective Date, CHSI shall engage an entity (or entities), such as an accounting, auditing, or consulting firm (hereinafter "Independent Review Organization" or "IRO"), to perform the reviews listed in this Section III.E. The applicable requirements relating to the IRO are outlined in Appendix A to this CIA, which is incorporated by reference.

b. *Retention of Records.* The IRO and CHSI shall retain and make available to OIG, upon request, all work papers, supporting documentation, correspondence, and draft reports (those exchanged between the IRO and CHSI) related to the reviews.

c. *Responsibilities and Liabilities.* Nothing in this Section III.E affects CHSI's responsibilities or liabilities under any criminal, civil, or administrative laws or regulations applicable to any Federal health care program including, but not limited to, the Anti-Kickback Statute and/or the Stark Law.

2. *Claims Review.* The IRO shall review claims submitted by CHSI Covered Facilities and reimbursed by Medicare, to determine whether the items and services furnished were medically necessary and appropriately documented and whether the claims were correctly coded, submitted and reimbursed (Claims Review) and shall prepare a Claims Review Report, as outlined in Appendix B to this CIA, which is incorporated by reference.

3. *Arrangements Review.* The IRO shall perform an Arrangements Review and prepare an Arrangements Review Report as outlined

in Appendix C to this CIA, which is incorporated by reference. CHSI may engage an IRO to perform the Arrangements Review that is different from the IRO engaged to perform the Claims Review.

4. *Unallowable Cost Review.* For the first Reporting Period, the IRO shall conduct a review of CHSI's compliance with the unallowable cost provisions of the Settlement Agreement. The IRO shall determine whether CHSI has complied with its obligations not to charge to, or otherwise seek payment from, federal or state payors for unallowable costs (as defined in the Settlement Agreement) and its obligation to identify to applicable federal or state payors any unallowable costs included in payments previously sought from the United States, or any state Medicaid program. This unallowable costs analysis shall include, but not be limited to, payments sought in any cost reports, cost statements, information reports, or payment requests already submitted by CHSI or any affiliates. To the extent that such cost reports, cost statements, information reports, or payment requests, even if already settled, have been adjusted to account for the effect of the inclusion of the unallowable costs, the IRO shall determine if such adjustments were proper. In making this determination, the IRO may need to review cost reports and/or financial statements from the year in which the Settlement Agreement was executed, as well as from previous years.

5. *Unallowable Cost Review Report.* The IRO shall prepare a report based upon the Unallowable Cost Review performed (Unallowable Cost Review Report). The Unallowable Cost Review Report shall include the IRO's findings and supporting rationale regarding the Unallowable Cost Review and whether CHSI has complied with its obligation not to charge to, or otherwise seek payment from, federal or state payors for unallowable costs (as defined in the Settlement Agreement) and its obligation to identify to applicable federal or state payors any unallowable costs included in payments previously sought from such payor.

6. *Validation Review.* In the event OIG has reason to believe that: (a) CHSI's Claims Review, Arrangements Review, or Unallowable Cost Review fails to conform to the requirements of this CIA; or (b) the IRO's findings or Claims Review, Arrangements Review, or Unallowable Cost Review results are inaccurate, OIG may, at its sole discretion, conduct its own review to determine whether the Claims Review, Arrangements Review, or Unallowable Cost Review complied with the requirements of the CIA and/or the findings or Claims Review, Arrangements Review, or Unallowable

Cost Review results are inaccurate (Validation Review). CHSI shall pay for the reasonable cost of any such review performed by OIG or any of its designated agents. Any Validation Review of Reports submitted as part of CHSI's final Annual Report shall be initiated no later than one year after CHSI's final submission (as described in Section II) is received by OIG.

Prior to initiating a Validation Review, OIG shall notify CHSI of its intent to do so and provide a written explanation of why OIG believes such a review is necessary. To resolve any concerns raised by OIG, CHSI may request a meeting with OIG to: (a) discuss the results of any Claims Review, Arrangements Review, or Unallowable Cost Review submissions or findings; (b) present any additional information to clarify the results of the Claims Review, Arrangements Review, or Unallowable Cost Review or to correct the inaccuracy of the Claims Review, Arrangements Review, or Unallowable Cost Review; and/or (c) propose alternatives to the proposed Validation Review. CHSI agrees to provide any additional information as may be requested by OIG under this Section III.E.6in an expedited manner. OIG will attempt in good faith to resolve any Claims Review, Arrangements Review, or Unallowable Cost Review issues with CHSI prior to conducting a Validation Review. However, the final determination as to whether or not to proceed with a Validation Review shall be made at the sole discretion of OIG.

7. *Independence and Objectivity Certification*. The IRO shall include in its report(s) to CHSI a certification that the IRO has (a) evaluated its professional independence and objectivity with respect to the reviews conducted under this Section III.E and (b) concluded that it is, in fact, independent and objective, in accordance with the requirements specified in Appendix A to this CIA.

F. Disclosure Program

CHSI has an established Disclosure Program that includes a mechanism (e.g., a toll-free compliance telephone line) to enable individuals to disclose, to the Corporate Compliance and Privacy Officer or some other person who is not in the disclosing individual's chain of command, any identified issues or questions associated with CHSI's policies, conduct, practices, or procedures with respect to a Federal health care program believed by the individual to be a potential violation of criminal, civil, or administrative law. CHSI shall continue to maintain this Disclosure Program for the duration of the CIA. CHSI shall continue to publicize appropriately the existence of the disclosure

mechanism (e.g., via periodic e-mails to employees or by posting the information in prominent common areas).

The Disclosure Program shall continue to emphasize a nonretribution, nonretaliation policy, and shall include a reporting mechanism for anonymous communications for which appropriate confidentiality shall be maintained. Upon receipt of a disclosure, the Corporate Compliance and Privacy Officer (or designee) shall gather all relevant information from the disclosing individual. The Corporate Compliance and Privacy Officer (or designee) shall make a preliminary, good faith inquiry into the allegations set forth in every disclosure to ensure that he or she has obtained all of the information necessary to determine whether a further review should be conducted. For any disclosure that is sufficiently specific so that it reasonably: (1) permits a determination of the appropriateness of the alleged improper practice; and (2) provides an opportunity for taking corrective action, CHSI shall conduct an internal review of the allegations set forth in the disclosure and ensure that proper follow-up is conducted.

The Corporate Compliance and Privacy Officer (or designee) shall maintain a disclosure log, which shall include a record and summary of each disclosure received (whether anonymous or not), the status of the respective internal reviews, and any corrective action taken in response to the internal reviews.

G. Ineligible Persons

1. *Definitions*. For purposes of this CIA:

a. an "Ineligible Person" shall include an individual or entity who:

i. is currently excluded, debarred, suspended, or otherwise ineligible to participate in the Federal health care programs or in Federal procurement or nonprocurement programs; or

ii. has been convicted of a criminal offense that falls within the scope of 42 U.S.C. § 1320a-7(a), but has not yet been excluded, debarred, suspended, or otherwise declared ineligible.

b. "Exclusion Lists" shall include:

i. the HHS/OIG List of Excluded Individuals/Entities (available through the Internet at http://www.oig.hhs.gov); and

ii. the General Services Administration's System for Award Management (available through the Internet at http://www.sam.gov).

2. *Screening Requirements.* CHSI shall ensure that all prospective and current Covered Persons are not Ineligible Persons, by implementing the following screening requirements.

a. CHSI shall screen all prospective Covered Persons against the Exclusion Lists prior to engaging their services and, as part of the hiring or contracting process, shall require such Covered Persons to disclose whether they are Ineligible Persons.

b. CHSI shall screen all Covered Persons against the Exclusion Lists within 120 days after the Effective Date and on a monthly basis thereafter.

c. CHSI shall implement a policy requiring all Covered Persons to disclose immediately any debarment, exclusion, suspension, or other event that makes that person an Ineligible Person.

Nothing in Section III.G affects CHSI's responsibility to refrain from (and liability for) billing Federal health care programs for items or services furnished, ordered, or prescribed by excluded persons. CHSI understands that items or services furnished, ordered or prescribed by excluded persons are not payable by Federal health care programs and that CHSI may be liable for overpayments and/or criminal, civil, and administrative sanctions for employing or contracting with an excluded person regardless of whether CHSI meets the requirements of Section III.G.

3. *Removal Requirement.* If CHSI has actual notice that a Covered Person has become an Ineligible Person, CHSI shall remove such Covered Person from

responsibility for, or involvement with, CHSI's business operations related to the Federal health care programs and shall remove such Covered Person from any position for which the Covered Person's compensation or the items or services furnished, ordered, or prescribed by the Covered Person are paid in whole or part, directly or indirectly, by Federal health care programs or otherwise with Federal funds at least until such time as the Covered Person is reinstated into participation in the Federal health care programs. If a physician or other non-physician practitioner with staff privileges at CHSI is determined to be an Ineligible Person, CHSI shall ensure that (i) the medical staff member does not furnish, order, or prescribe any items or services payable in whole or in part by any Federal health care program; and (ii) the medical staff member is not "on call" at CHSI.

4. *Pending Charges and Proposed Exclusions.* If CHSI has actual notice that a Covered Person is charged with a criminal offense that falls within the scope of 42 U.S.C. §§ 1320a-7(a), 1320a-7(b)(1)-(3), or is proposed for exclusion during the Covered Person's employment or contract term or during the term of a physician's or other practitioner's medical staff privileges, CHSI shall take all appropriate actions to ensure that the responsibilities of that Covered Person have not and shall not adversely affect the quality of care rendered to any beneficiary, patient, or resident, or any claims submitted to any Federal health care program.

H. Notification of Government Investigation or Legal Proceedings

Within 30 days after discovery, CHSI shall notify OIG, in writing, of any ongoing investigation or legal proceeding known to CHSI conducted or brought by a governmental entity or its agents involving an allegation that CHSI has committed a crime or has engaged in fraudulent activities. This notification shall include a description of the allegation, the identity of the investigating or prosecuting agency, and the status of such investigation or legal proceeding. CHSI shall also provide written notice to OIG within 30 days after the resolution of the matter, and shall provide OIG with a description of the findings and/or results of the investigation or proceedings, if any.

I. Repayment of Overpayments

1. *Definition of Overpayments.* For purposes of this CIA, an "Overpayment" shall mean the amount of money CHSI has received in excess of the amount due and payable under any Federal health care program requirements.

2. *Repayment of Overpayments*

a. If, at any time, CHSI identifies or learns of any Overpayment, CHSI shall repay the Overpayment to the appropriate payor (e.g., Medicare contractor) within 60 days after identification of the Overpayment and take remedial steps within 90 days after identification (or such additional time as may be agreed to by the payor) to correct the problem, including preventing the underlying problem and the Overpayment from recurring. If not yet quantified, within 60 days after identification, CHSI shall notify the payor of its efforts to quantify the Overpayment amount along with a schedule of when such work is expected to be completed. Notification and repayment to the payor shall be done in accordance with the payor's policies.

b. Notwithstanding the above, notification and repayment of any Overpayment amount that routinely is reconciled or adjusted pursuant to policies and procedures established by the payor should be handled in accordance with such policies and procedures.

J. Reportable Events

1. *Definition of Reportable Event*. For purposes of this CIA, a "Reportable Event" means anything that involves:

a. a substantial Overpayment;

b. a matter that a reasonable person would consider a probable violation of criminal, civil, or administrative laws applicable to any Federal health care program for which penalties or exclusion may be authorized;

c. the employment of or contracting with a Covered Person who is an Ineligible Person as defined by Section III.G.1.a; or

d. the filing of a bankruptcy petition by CHSI.

A Reportable Event may be the result of an isolated event or a series of occurrences.

2. *Reporting of Reportable Events.* If CHSI determines (after a reasonable opportunity to conduct an appropriate review or investigation of the allegations) through any means that there is a Reportable Event, CHSI shall notify OIG, in writing, within 30 days after making the determination that the Reportable Event exists.

3. *Reportable Events under Section III.J.1.a.* For Reportable Events under Section III.J.1.a, the report to OIG shall be made within 30 days of the identification of the Overpayment, and shall include:

a. a description of the steps taken by CHSI to identify and quantify the Overpayment;

b. a complete description of the Reportable Event, including the relevant facts, persons involved, and legal and Federal health care program authorities implicated;

c. a description of CHSI's actions taken to correct the Reportable Event; and

d. any further steps CHSI plans to take to address the Reportable Event and prevent it from recurring.

Within 60 days of identification of the Overpayment, CHSI shall provide OIG with a copy of the notification and repayment to the payor required in Section III.I.2.

4. *Reportable Events under Section III.J.1.b and c.* For Reportable Events under Section III.J.1.b and III.J.1.c, the report to OIG shall include:

a. a complete description of the Reportable Event, including the relevant facts, persons involved, and legal and Federal health care program authorities implicated;

b. a description of CHSI's actions taken to correct the Reportable Event;

c. any further steps CHSI plans to take to address the Reportable Event and prevent it from recurring; and

d. if the Reportable Event has resulted in an Overpayment, a description of the steps taken by CHSI to identify and quantify the Overpayment.

5. *Reportable Events under Section III.J.1.d.* For Reportable Events under Section III.J.1.d, the report to the OIG shall include documentation of the bankruptcy filing and a description of any Federal health care program authorities implicated.

6. *Reportable Events Involving the Stark Law.* Notwithstanding the reporting requirements outlined above, any Reportable Event that involves only a probable violation of section 1877 of the Social Security Act, 42 U.S.C. §1395nn (the Stark Law) should be submitted by CHSI to the Centers for Medicare & Medicaid Services (CMS) through the self-referral disclosure protocol (SRDP), with a copy to the OIG. The requirements of Section III.I.2 that require repayment to the payor of any identified Overpayment within 60 days shall not apply to any Overpayment that may result from a probable violation of only the Stark Law that is disclosed to CMS pursuant to the SRDP. If CHSI identifies a probable violation of the Stark Law and repays the applicable Overpayment directly to the CMS contractor, then CHSI is not required by this Section III.J to submit the Reportable Event to CMS through the SRDP.

IV. SUCCESSOR LIABILITY; CHANGES TO BUSINESS UNITS OR LOCATIONS

A. Sale of Business, Business Unit or Location.

In the event that, after the Effective Date, CHSI proposes to sell any or all of its business, business units or hospitals (whether through a sale of assets, sale of stock, or other type of transaction) that are subject to this CIA, CHSI shall notify OIG of the proposed sale at least 30 days prior to the sale of its business, business unit or location. This notification shall include a description of the business, business unit or location to be sold, a brief description of the terms of the sale, and the name and contact information of the prospective purchaser. This CIA shall be binding on the purchaser of the business,

business unit or location, unless otherwise determined and agreed to in writing by the OIG.

B. Change or Closure of Business, Business Unit or Location

In the event that, after the Effective Date, CHSI changes locations or closes a business, business unit or hospital related to the furnishing of items or services that may be reimbursed by Federal health care programs, CHSI shall notify OIG of this fact as soon as possible, but no later than within 30 days after the date of change or closure of the business, business unit or hospital.

C. Purchase or Establishment of New Business, Business Unit or Location

In the event that, after the Effective Date, CHSI purchases or establishes a new business, business unit or hospital related to the furnishing of items or services that may be reimbursed by Federal health care programs, CHSI shall notify OIG at least 30 days prior to such purchase or the operation of the new business, business unit or hospital. This notification shall include the address of the new business, business unit or hospital, phone number, fax number, the hospital's Medicare and state Medicaid program provider number and/or supplier number(s); and the name and address of each Medicare and state Medicaid program contractor to which CHSI currently submits claims. Each new business, business unit or hospital and all Covered Persons at each new business, business unit or hospital shall be subject to the applicable requirements of this CIA unless otherwise agreed to in writing by the OIG.

V. IMPLEMENTATION AND ANNUAL REPORTS

A. Implementation Report

Within 150 days after the Effective Date, CHSI shall submit a written report to OIG summarizing the status of its implementation of the requirements of this CIA (Implementation Report). The Implementation Report shall, at a minimum, include:

1. The name, address, phone number, and position description of the Corporate Compliance and Privacy Officer required by Section III.A.1, and a summary of other noncompliance job responsibilities the Corporate Compliance and Privacy Officer may have;

2. the name, address, phone number, and position description of each Senior Compliance Director, Corporate Compliance Director, and Facility Compliance Officers required by Section III.A.2, and a summary of other noncompliance job responsibilities each Senior Compliance Director, Corporate Compliance Director, and Facility Compliance officers may have;

3. the names and positions of the members of the Corporate Compliance Work Group required by Section III.A.3;

4. the names and positions of the members of each Facility Compliance Committee required by Section III.A.4;

5. the names of the Board members who are responsible for satisfying the Board of Directors compliance obligations described in Section III.A.5;

6. a copy of CHSI's Code of Conduct required by Section III.B.1;

7. the number of individuals required to complete the Code of Conduct certification required by Section III.B.1, the percentage of individuals who have completed such certification, and an explanation of any exceptions (the documentation supporting this information shall be available to OIG upon request);

8. a summary of all Policies and Procedures required by Section III.B.2 (copies of the Policies and Procedures shall be made available to OIG upon request);

9. the following information regarding each type of training required by Section III.C:

   a. a description of such training, including a summary of the topics covered, the length of sessions, and a schedule of training sessions;

   b. the number of individuals required to be trained, percentage of individuals actually trained, and an explanation of any exceptions; and

   c. with respect to active medical staff members, the number and percentage who completed the training, the type of training

and the date received, and a description of CHSI's efforts to encourage medical staff members to complete the training.

A copy of all training materials and the documentation supporting this information shall be made available to OIG upon request.

10. a description of (a) the Focus Arrangements Tracking System required by Section III.D.1.a, (b) the internal review and approval process required by Section III.D.1.e; and (c) the tracking and monitoring procedures and other Focus Arrangements Procedures required by Section III.D.1;

11. a description of the Disclosure Program required by Section III.F;

12. the following information regarding the IRO(s): (a) identity, address, and phone number; (b) a copy of the engagement letter; (c) information to demonstrate that the IRO has the qualifications outlined in Appendix A to this CIA; (d) a summary and description of any and all current and prior engagements and agreements between CHSI and the IRO; and (e) a certification from the IRO regarding its professional independence and objectivity with respect to CHSI;

13. a description of the process by which CHSI fulfills the requirements of Section III.G regarding Ineligible Persons;

14. a list of all of CHSI's Covered Facilities (including locations and mailing addresses); the corresponding name under which each location is doing business; the corresponding phone numbers and fax numbers; each location's Medicare and state Medicaid program provider number and/or supplier number(s); and the name and address of each Medicare and state Medicaid program contractor to which CHSI currently submits claims;

15. a description of CHSI's corporate structure, including identification of any parent and sister companies, subsidiaries, and their respective lines of business; and

16. the certifications required by Section V.C.

B. Annual Reports

CHSI shall submit to OIG annually a report with respect to the status of, and findings regarding, CHSI's compliance activities for each of the five Reporting Periods (Annual Report). Each Annual Report shall include, at a minimum:

1. any change in the identity, position description, or other noncompliance job responsibilities of the Corporate Compliance and Privacy Officer, Senior Compliance Directors, Corporate Compliance Directors, and Facility Compliance Officers, and any change in the membership of the Corporate Compliance Work Group described in Section III.A;

2. the dates of each report made by the Corporate Compliance and Privacy Officer to the Board (written documentation of such reports shall be made available upon request);

3. the Board of Directors resolution required by Section III.A.5;

4. a summary of any changes or amendments to CHSI's Code of Conduct required by Section III.B.1 and the reason for such changes, along with a copy of the revised Code of Conduct;

5. the number of individuals required to complete the Code of Conduct certification required by Section III.B.1, the percentage of individuals who have completed such certification, and an explanation of any exceptions (the documentation supporting this information shall be made available to OIG upon request);

6. a summary of any significant changes or amendments to the Policies and Procedures required by Section III.B.2 and the reasons for such changes (e.g., change in contractor policy);

7. the following information regarding each type of training required by Section III.C:

   a. a description of the initial and annual training, including a summary of the topics covered, the length of sessions, and a schedule of training sessions;

b. the number of individuals required to complete the initial and annual training, the percentage of individuals who actually completed the initial and annual training, and an explanation of any exceptions; and

c. with respect to active medical staff members, the number and percentage who completed the training, the type of training and the date received, and a description of CHSI's efforts to encourage medical staff members to complete the training.

A copy of all training materials and the documentation to support this information shall be made available to OIG upon request;

8. a complete copy of all reports prepared pursuant to Section III.E, along with a copy of the IRO's engagement letter(s);

9. CHSI's response to the reports prepared pursuant to Section III.E, along with corrective action plan(s) related to any issues raised by the reports;

10. a summary and description of any and all current and prior engagements and agreements between CHSI and the IRO (if different from what was submitted as part of the Implementation Report);

11. a certification from the IRO regarding its professional independence and objectivity with respect to CHSI;

12. a summary of Reportable Events (as defined in Section III.J) identified during the Reporting Period and the status of any corrective action relating to all such Reportable Events;

13. a report of the aggregate Overpayments that have been returned to the Federal health care programs. Overpayment amounts shall be broken down into the following categories: Medicare, Medicaid (report each applicable state separately, if applicable), and other Federal health care programs. Overpayment amounts that are routinely reconciled or adjusted pursuant to policies and procedures established by the payor do not need to be included in this aggregate Overpayment report;

14. a summary of the disclosures in the disclosure log required by Section III.F that relate to Federal health care programs (the complete disclosure log shall be made available to OIG upon request);

15. any changes to the process by which CHSI fulfills the requirements of Section III.G regarding Ineligible Persons;

16. a summary describing any ongoing investigation or legal proceeding required to have been reported pursuant to Section III.H. The summary shall include a description of the allegation, the identity of the investigating or prosecuting agency, and the status of such investigation or legal proceeding;

17. a description of all changes to the most recently provided list of CHSI's locations (including addresses) as required by Section V.A.14; the corresponding name under which each location is doing business; the corresponding phone numbers and fax numbers; each location's Medicare and state Medicaid program provider number(s) and/or supplier number(s); and the name and address of each Medicare and state Medicaid program contractor to which CHSI currently submits claims; and

18. the certifications required by Section V.C.

The first Annual Report shall be received by OIG no later than 60 days after the end of the first Reporting Period. Subsequent Annual Reports shall be received by OIG no later than the anniversary date of the due date of the first Annual Report.

C. Certifications

The Implementation Report and each Annual Report shall include a certification by the Corporate Compliance and Privacy Officer that:

1. to the best of his or her knowledge, except as otherwise described in the report, CHSI is in compliance with all of the requirements of this CIA;

2. he or she has reviewed the report and has made reasonable inquiry regarding its content and believes that the information in the report is accurate and truthful; and

3. to the best of his or her knowledge, CHSI has complied with its obligations under the Settlement Agreement: (a) not to resubmit to any Federal health care program payors any previously denied claims related to the Covered Conduct addressed in the Settlement Agreement, and not to appeal any such denials of claims; (b) not to charge to or otherwise seek payment from federal or state payors for unallowable costs (as defined in the Settlement Agreement); and (c) to identify and adjust any past charges or claims for unallowable costs.

D. Designation of Information

CHSI shall clearly identify any portions of its submissions that it believes are trade secrets, or information that is commercial or financial and privileged or confidential, and therefore potentially exempt from disclosure under the Freedom of Information Act (FOIA), 5 U.S.C. § 552. CHSI shall refrain from identifying any information as exempt from disclosure if that information does not meet the criteria for exemption from disclosure under FOIA.

VI. NOTIFICATIONS AND SUBMISSION OF REPORTS

Unless otherwise stated in writing after the Effective Date, all notifications and reports required under this CIA shall be submitted to the following entities:

OIG:

Administrative and Civil Remedies Branch
Office of Counsel to the Inspector General
Office of Inspector General
U.S. Department of Health and Human Services
Cohen Building, Room 5527
330 Independence Avenue, S.W.
Washington, DC 20201
Telephone: 202.619.2078
Facsimile: 202.205.0604

CHSI:

Andi Bosshart
Senior Vice President, Corporate Compliance and Privacy Officer
Community Health Systems, Inc.
4000 Meridian Boulevard
Franklin, TN 37067
Telephone: 615.465.7150
Facsimile: 615.465.3004

Unless otherwise specified, all notifications and reports required by this CIA may be made by certified mail, overnight mail, hand delivery, or other means, provided that there is proof that such notification was received. For purposes of this requirement, internal facsimile confirmation sheets do not constitute proof of receipt. Upon request by OIG, CHSI may be required to provide OIG with an electronic copy of each notification or report required by this CIA in searchable portable document format (pdf), in addition to a paper copy.

VII. OIG INSPECTION, AUDIT, AND REVIEW RIGHTS

In addition to any other rights OIG may have by statute, regulation, or contract, OIG or its duly authorized representative(s) may examine or request copies of CHSI's books, records, and other documents and supporting materials and/or conduct on-site reviews of any of CHSI's locations for the purpose of verifying and evaluating: (a) CHSI's compliance with the terms of this CIA; and (b) CHSI's compliance with the requirements of the Federal health care programs. The documentation described above shall be made available by CHSI to OIG or its duly authorized representative(s) at all reasonable times for inspection, audit, or reproduction. Furthermore, for purposes of this provision, OIG or its duly authorized representative(s) may interview any of CHSI's employees, contractors, or agents who consent to be interviewed at the individual's place of business during normal business hours or at such other place and time as may be mutually agreed upon between the individual and OIG. CHSI shall assist OIG or its duly authorized representative(s) in contacting and arranging interviews with such individuals upon OIG's request. CHSI's employees may elect to be interviewed with or without a representative of CHSI present.

VIII. DOCUMENT AND RECORD RETENTION

CHSI shall maintain for inspection all documents and records relating to reimbursement from the Federal health care programs and to compliance with this CIA for six years (or longer if otherwise required by law) from the Effective Date.

IX. DISCLOSURES

Consistent with HHS's FOIA procedures, set forth in 45 C.F.R. Part 5, OIG shall make a reasonable effort to notify CHSI prior to any release by OIG of information submitted by CHSI pursuant to its obligations under this CIA and identified upon submission by CHSI as trade secrets, or information that is commercial or financial and privileged or confidential, under the FOIA rules. With respect to such releases, CHSI shall have the rights set forth at 45 C.F.R. § 5.65(d).

X. BREACH AND DEFAULT PROVISIONS

CHSI is expected to fully and timely comply with all of its CIA obligations.

A. Stipulated Penalties for Failure to Comply with Certain Obligations

As a contractual remedy, CHSI and OIG hereby agree that failure to comply with certain obligations as set forth in this CIA may lead to the imposition of the following monetary penalties (hereinafter referred to as "Stipulated Penalties") in accordance with the following provisions.

1. A Stipulated Penalty of $2,500 (which shall begin to accrue on the day after the date the obligation became due) for each day CHSI fails to establish and implement any of the following obligations as described in Section III:

   a. a Corporate Compliance and Privacy Officer, Corporate Compliance Directors, and/or Facility Compliance Officers;

   b. a Corporate Compliance Work Group; and/or Facility Compliance Committees;

   c. the Board of Directors compliance obligations;

d. a written Code of Conduct;

e. written Policies and Procedures;

f. the training of Covered Persons, Relevant Covered Persons, and Board Members;

g. a Disclosure Program;

h. Ineligible Persons screening and removal requirements;

i. notification of Government investigations or legal proceedings; and

j. reporting of Reportable Events.

2. A Stipulated Penalty of $2,500 (which shall begin to accrue on the day after the date the obligation became due) for each day CHSI fails to engage and use an IRO, as required in Section III.E, Appendix A, and Appendix B.

3. A Stipulated Penalty of $2,500 (which shall begin to accrue on the day after the date the obligation became due) for each day CHSI fails to submit the Implementation Report or any Annual Reports to OIG in accordance with the requirements of Section V by the deadlines for submission.

4. A Stipulated Penalty of $2,500 (which shall begin to accrue on the day after the date the obligation became due) for each day CHSI fails to submit any Claims Review Report, Unallowable Cost Review Report, or Arrangements Review Report in accordance with the requirements of Section III.E, Appendix B, and Appendix C.

5. A Stipulated Penalty of $1,500 for each day CHSI fails to grant access as required in Section VII. (This Stipulated Penalty shall begin to accrue on the date CHSI fails to grant access.)

6. A Stipulated Penalty of $50,000 for each false certification submitted by or on behalf of CHSI as part of its Implementation Report, Annual Report,

additional documentation to a report (as requested by the OIG), or otherwise required by this CIA.

7. A Stipulated Penalty of $1,000 for each day CHSI fails to comply fully and adequately with any obligation of this CIA. OIG shall provide notice to CHSI stating the specific grounds for its determination that CHSI has failed to comply fully and adequately with the CIA obligation(s) at issue and steps CHSI shall take to comply with the CIA. (This Stipulated Penalty shall begin to accrue 10 days after CHSI receives this notice from OIG of the failure to comply.) A Stipulated Penalty as described in this Subsection shall not be demanded for any violation for which OIG has sought a Stipulated Penalty under Subsections 1- 6 of this Section.

B. Timely Written Requests for Extensions

CHSI may, in advance of the due date, submit a timely written request for an extension of time to perform any act or file any notification or report required by this CIA. Notwithstanding any other provision in this Section, if OIG grants the timely written request with respect to an act, notification, or report, Stipulated Penalties for failure to perform the act or file the notification or report shall not begin to accrue until one day after CHSI fails to meet the revised deadline set by OIG. Notwithstanding any other provision in this Section, if OIG denies such a timely written request, Stipulated Penalties for failure to perform the act or file the notification or report shall not begin to accrue until three business days after CHSI receives OIG's written denial of such request or the original due date, whichever is later. A "timely written request" is defined as a request in writing received by OIG at least five business days prior to the date by which any act is due to be performed or any notification or report is due to be filed.

C. Payment of Stipulated Penalties

1. *Demand Letter*. Upon a finding that CHSI has failed to comply with any of the obligations described in Section X.A and after determining that Stipulated Penalties are appropriate, OIG shall notify CHSI of: (a) CHSI's failure to comply; and (b) OIG's exercise of its contractual right to demand payment of the Stipulated Penalties. (This notification shall be referred to as the "Demand Letter.")

2. *Response to Demand Letter*. Within 10 days after the receipt of the Demand Letter, CHSI shall either: (a) cure the breach to OIG's satisfaction and pay the applicable Stipulated Penalties or (b) request a hearing before an HHS administrative law

judge (ALJ) to dispute OIG's determination of noncompliance, pursuant to the agreed upon provisions set forth below in Section X.E. In the event CHSI elects to request an ALJ hearing, the Stipulated Penalties shall continue to accrue until CHSI cures, to OIG's satisfaction, the alleged breach in dispute. Failure to respond to the Demand Letter in one of these two manners within the allowed time period shall be considered a material breach of this CIA and shall be grounds for exclusion under Section X.D.

3. *Form of Payment.* Payment of the Stipulated Penalties shall be made by electronic funds transfer to an account specified by OIG in the Demand Letter.

4. *Independence from Material Breach Determination.* Except as set forth in Section X.D.1.c, these provisions for payment of Stipulated Penalties shall not affect or otherwise set a standard for OIG's decision that CHSI has materially breached this CIA, which decision shall be made at OIG's discretion and shall be governed by the provisions in Section X.D, below.

D. Exclusion for Material Breach of this CIA

1. *Definition of Material Breach.* A material breach of this CIA means

a. a repeated or flagrant violation of the obligations under this CIA, including, but not limited to, the obligations addressed in Section X.A.

b. a failure by CHSI to report a Reportable Event, take corrective action, and make the appropriate refunds, as required in Section III.J;

c. a failure to respond to a Demand Letter concerning the payment of Stipulated Penalties in accordance with Section X.C; or

d. a failure to engage and use an IRO in accordance with Section III.E, Appendix A, and Appendix B.

2. *Notice of Material Breach and Intent to Exclude.* The parties agree that a material breach of this CIA by CHSI constitutes an independent basis for CHSI's

exclusion from participation in the Federal health care programs. Upon a determination by OIG that CHSI has materially breached this CIA and that exclusion is the appropriate remedy, OIG shall notify CHSI of: (a) CHSI's material breach; and (b) OIG's intent to exercise its contractual right to impose exclusion. (This notification shall be referred to as the "Notice of Material Breach and Intent to Exclude.")

3. *Opportunity to Cure.* CHSI shall have 30 days from the date of receipt of the Notice of Material Breach and Intent to Exclude to demonstrate to OIG's satisfaction that:

a. CHSI is in compliance with the obligations of the CIA cited by OIG as being the basis for the material breach;

b. the alleged material breach has been cured; or

c. the alleged material breach cannot be cured within the 30 day period, but that: (i) CHSI has begun to take action to cure the material breach; (ii) CHSI is pursuing such action with due diligence; and (iii) CHSI has provided to OIG a reasonable timetable for curing the material breach.

4. *Exclusion Letter.* If, at the conclusion of the 30 day period, CHSI fails to satisfy the requirements of Section X.D.3, OIG may exclude CHSI from participation in the Federal health care programs. OIG shall notify CHSI in writing of its determination to exclude CHSI. (This letter shall be referred to as the "Exclusion Letter.") Subject to the Dispute Resolution provisions in Section X.E, below, the exclusion shall go into effect 30 days after the date of CHSI's receipt of the Exclusion Letter. The exclusion shall have national effect. Reinstatement to program participation is not automatic. After the end of the period of exclusion, CHSI may apply for reinstatement by submitting a written request for reinstatement in accordance with the provisions at 42 C.F.R. §§ 1001.3001-.3004.

E. Dispute Resolution

1. *Review Rights.* Upon OIG's delivery to CHSI of its Demand Letter or of its Exclusion Letter, and as an agreed-upon contractual remedy for the resolution of disputes arising under this CIA, CHSI shall be afforded certain review rights comparable to the ones that are provided in 42 U.S.C. § 1320a-7(f) and 42 C.F.R. Part 1005 as if they

applied to the Stipulated Penalties or exclusion sought pursuant to this CIA. Specifically, OIG's determination to demand payment of Stipulated Penalties or to seek exclusion shall be subject to review by an HHS ALJ and, in the event of an appeal, the HHS Departmental Appeals Board (DAB), in a manner consistent with the provisions in 42 C.F.R. § 1005.2-1005.21. Notwithstanding the language in 42 C.F.R. § 1005.2(c), the request for a hearing involving Stipulated Penalties shall be made within 10 days after receipt of the Demand Letter and the request for a hearing involving exclusion shall be made within 25 days after receipt of the Exclusion Letter.

2. *Stipulated Penalties Review.* Notwithstanding any provision of Title 42 of the United States Code or Title 42 of the Code of Federal Regulations, the only issues in a proceeding for Stipulated Penalties under this CIA shall be: (a) whether CHSI was in full and timely compliance with the obligations of this CIA for which OIG demands payment; and (b) the period of noncompliance. CHSI shall have the burden of proving its full and timely compliance and the steps taken to cure the noncompliance, if any. OIG shall not have the right to appeal to the DAB an adverse ALJ decision related to Stipulated Penalties. If the ALJ agrees with OIG with regard to a finding of a breach of this CIA and orders CHSI to pay Stipulated Penalties, such Stipulated Penalties shall become due and payable 20 days after the ALJ issues such a decision unless CHSI requests review of the ALJ decision by the DAB. If the ALJ decision is properly appealed to the DAB and the DAB upholds the determination of OIG, the Stipulated Penalties shall become due and payable 20 days after the DAB issues its decision.

3. *Exclusion Review.* Notwithstanding any provision of Title 42 of the United States Code or Title 42 of the Code of Federal Regulations, the only issues in a proceeding for exclusion based on a material breach of this CIA shall be:

a. whether CHSI was in material breach of this CIA;

b. whether such breach was continuing on the date of the Exclusion Letter; and

c. whether the alleged material breach could not have been cured within the 30-day period, but that: (i) CHSI had begun to take action to cure the material breach within that period; (ii) CHSI has pursued and is pursuing such action with due diligence; and (iii) CHSI provided to OIG within that period a

reasonable timetable for curing the material breach and CHSI has followed the timetable.

For purposes of the exclusion herein, exclusion shall take effect only after an ALJ decision favorable to OIG, or, if the ALJ rules for CHSI, only after a DAB decision in favor of OIG. CHSI's election of its contractual right to appeal to the DAB shall not abrogate OIG's authority to exclude CHSI upon the issuance of an ALJ's decision in favor of OIG. If the ALJ sustains the determination of OIG and determines that exclusion is authorized, such exclusion shall take effect 20 days after the ALJ issues such a decision, notwithstanding that CHSI may request review of the ALJ decision by the DAB. If the DAB finds in favor of OIG after an ALJ decision adverse to OIG, the exclusion shall take effect 20 days after the DAB decision. CHSI shall waive its right to any notice of such an exclusion if a decision upholding the exclusion is rendered by the ALJ or DAB. If the DAB finds in favor of CHSI, CHSI shall be reinstated effective on the date of the original exclusion.

4. *Finality of Decision.* The review by an ALJ or DAB provided for above shall not be considered to be an appeal right arising under any statutes or regulations. Consequently, the parties to this CIA agree that the DAB's decision (or the ALJ's decision if not appealed) shall be considered final for all purposes under this CIA.

XI. EFFECTIVE AND BINDING AGREEMENT

CHSI and OIG agree as follows:

A. This CIA shall become final and binding on the date the final signature is obtained on the CIA.

B. This CIA constitutes the complete agreement between the parties and may not be amended except by written consent of the parties to this CIA.

C. OIG may agree to a suspension of CHSI's obligations under this CIA based on a certification by CHSI that it is no longer providing health care items or services that will be billed to any Federal health care program and that it does not have any ownership or control interest, as defined in 42 U.S.C. §1320a-3, in any entity that bills any Federal health care program. If CHSI is relieved of its CIA obligations, CHSI will be required to notify OIG in writing at least 30 days in advance if CHSI plans to resume providing health care items or services that are billed to any Federal health care program or to

obtain an ownership or control interest in any entity that bills any Federal health care program. At such time, OIG shall evaluate whether the CIA will be reactivated or modified.

D. The undersigned CHSI signatories represent and warrant that they are authorized to execute this CIA. The undersigned OIG signatories represent that they are signing this CIA in their official capacities and that they are authorized to execute this CIA.

E. This CIA may be executed in counterparts, each of which constitutes an original and all of which constitute one and the same CIA. Facsimiles of signatures shall constitute acceptable, binding signatures for purposes of this CIA.

ON BEHALF OF CHSI

Andi Bosshart — DATE: 9/20/2018
CHSI
Senior Vice President, Corporate Compliance and Privacy Officer

Richard A. Sauber — DATE
Counsel for CHSI
Robbins, Russell, Englert, Orseck, Untereiner & Sauber LLP

Michael L. Waldman — DATE
Counsel for CHSI
Robbins, Russell, Englert, Orseck, Untereiner & Sauber LLP

ON BEHALF OF CHSI

_____ _____

Andi Bosshart DATE
CHSI
Senior Vice President, Corporate Compliance and Privacy Officer

Richard A. Sauber /TSP 9/21/18

Richard A. Sauber DATE
Counsel for CHSI
Robbins, Russell, Englert, Orseck, Untereiner & Sauber LLP

Michael L. Waldman 9/21/18

Michael L. Waldman DATE
Counsel for CHSI
Robbins, Russell, Englert, Orseck, Untereiner & Sauber LLP

ON BEHALF OF THE OFFICE OF INSPECTOR GENERAL
OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

Lisa M Re — 9/21/2018

LISA RE — DATE
Assistant Inspector General for Legal Affairs
Office of Inspector General
U. S. Department of Health and Human Services

Candace Holford on behalf of Sandra Sands — 9/21/2018

SANDRA JEAN SANDS — DATE
Senior Counsel
Office of Inspector General
U.S. Department of Health and Human Services

APPENDIX A

INDEPENDENT REVIEW ORGANIZATION

This Appendix contains the requirements relating to the Independent Review Organization (IRO) required by Section III.E of the CIA.

A. IRO Engagement

1. CHSI shall engage an IRO to perform the Unallowable Cost Review and the Claims Review that possesses the qualifications set forth in Paragraph B, below, to perform the responsibilities in Paragraph C, below. The IRO shall conduct the reviews in a professionally independent and objective fashion, as set forth in Paragraph E.

2. CHSI shall also engage an IRO to perform the Arrangements Review that possesses the qualifications set forth in Paragraph B, below, to perform the responsibilities in Paragraph C, below. The IRO shall not have a prohibited relationship to CHSI as set forth in Paragraph F.

3. Within 30 days after OIG receives the information identified in Section V.A.12 of the CIA or any additional information submitted by CHSI in response to a request by OIG, whichever is later, OIG will notify CHSI if the IRO is unacceptable. Absent notification from OIG that the IRO is unacceptable, CHSI may continue to engage the IRO.

4. If CHSI engages a new IRO during the term of the CIA, that IRO must also meet the requirements of this Appendix. If a new IRO is engaged, CHSI shall submit the information identified in Section V.A.12 of the CIA to OIG within 30 days of engagement of the IRO. Within 30 days after OIG receives this information or any additional information submitted by CHSI at the request of OIG, whichever is later, OIG will notify CHSI if the IRO is unacceptable. Absent notification from OIG that the IRO is unacceptable, CHSI may continue to engage the IRO.

B. IRO Qualifications

The IRO shall:

1. assign individuals to conduct the Arrangements Review who are knowledgeable in the requirements of the Anti-Kickback Statute and the Stark Law and the regulations and other guidance documents related to these statutes;

2. possess expertise in fair market valuation issues or have the ability to associate a valuation firm to assist in conducting the transactions review component of the Arrangements Review;

3. assign individuals to conduct the Claims Review who have expertise in the Medicare program requirements applicable to the claims being reviewed;

4. assign individuals to design and select the Claims Review sample who are knowledgeable about the appropriate statistical sampling techniques;

5. assign individuals to conduct the coding review portions of the Claims Review who have a nationally recognized coding certification and who have maintained this certification (e.g., completed applicable continuing education requirements);

6. assign licensed nurses or physicians with relevant education, training and specialized expertise (or other licensed health care professionals acting within their scope of practice and specialized expertise) to make the medical necessity determinations required by the Claims Review; and

7. have sufficient staff and resources to conduct the reviews required by the CIA on a timely basis.

C. IRO Responsibilities

The IRO shall:

1. perform each Arrangements Review, Unallowable Cost Review, and Claims Review in accordance with the specific requirements of the CIA;

2. follow all applicable Medicare program rules and reimbursement guidelines in making assessments in the Claims Review;

3. request clarification from the appropriate authority (e.g., Medicare contractor), if in doubt of the application of a particular Medicare program policy or regulation;

4. respond to all OIG inquires in a prompt, objective, and factual manner; and

5. prepare timely, clear, well-written reports that include all the information required by Appendix B and Appendix C (as applicable) to the CIA.

D. CHSI Responsibilities

CHSI shall ensure that the IRO has access to all records and personnel necessary to complete the reviews listed in Section III.E of this CIA and that all records furnished to the IRO are accurate and complete.

E. IRO Independence and Objectivity

The IRO engaged to perform the Unallowable Cost Review and the Claims Review must perform the reviews in a professionally independent and objective fashion, as defined in the most recent Government Auditing Standards issued by the U.S. Government Accountability Office.

F. IRO Relationship to CHSI

The IRO engaged to perform the Arrangements Review shall not (1) currently represent or currently be employed or engaged by CHSI or (2) have a current or prior relationship to CHSI or its owners, officers, or directors that would cause a reasonable person to question the IRO's objectivity in performing the Arrangements Review.

G. Assertions of Privilege

CHSI shall not assert claims of attorney-client privilege in order to avoid disclosing to OIG information related to or resulting from the IRO's engagement to perform the Arrangements Review. CHSI's engagement letter with the IRO shall include a provision stating that the IRO agrees not to assert claims of work product privilege in order to avoid disclosing to OIG information related to or resulting from its engagement.

H. IRO Removal/Termination

1. *CHSI and IRO.* If CHSI terminates its IRO or if the IRO withdraws from the engagement during the term of the CIA, CHSI must submit a notice explaining (a) its reasons for termination of the IRO or (b) the IRO's reasons for its withdrawal to OIG, no later than 30 days after termination or withdrawal. CHSI must engage a new IRO in accordance with Paragraph A of this Appendix and within 60 days of termination or withdrawal of the IRO.

2. *OIG Removal of IRO.* In the event OIG has reason to believe that the IRO does not possess the qualifications described in Paragraph B, is not independent and objective as set forth in Paragraph E or has a prohibited relationship as set forth in paragraph F (as applicable), or has failed to carry out its responsibilities as described in

Paragraph C, OIG shall notify CHSI in writing regarding OIG's basis for determining that the IRO has not met the requirements of this Appendix. CHSI shall have 30 days from the date of OIG's written notice to provide information regarding the IRO's qualifications, independence, relationship to CHSI or performance of its responsibilities in order to resolve the concerns identified by OIG. If, following OIG's review of any information provided by CHSI regarding the IRO, OIG determines that the IRO has not met the requirements of this Appendix, OIG shall notify CHSI in writing that CHSI shall be required to engage a new IRO in accordance with Paragraph A of this Appendix. CHSI must engage a new IRO within 60 days of its receipt of OIG's written notice. The final determination as to whether or not to require CHSI to engage a new IRO shall be made at the sole discretion of OIG.

APPENDIX B

CLAIMS REVIEW

A. Claims Review. The IRO shall perform the Claims Review annually to cover each of the five Reporting Periods. The IRO shall perform all components of each Claims Review. The Claims Review shall be conducted at four of CHSI's Covered Facilities for each Reporting Period.

1. *Definitions*. For the purposes of the Claims Review, the following definitions shall be used:

a. Overpayment: The amount of money CHSI has received in excess of the amount due and payable under Medicare program requirements, as determined by the IRO in connection with the Claims Review performed under this Appendix B.

b. Paid Claim: A claim submitted by CHSI and for which CHSI has received reimbursement from the Medicare program.

c. Population: The Population shall be defined as all Paid Claims during the 12-month period covered by the Claims Review. In OIG's discretion, OIG may limit the Population to one or more subset(s) of Paid Claims to be reviewed and shall notify CHSI and the IRO of its selection of the Population at least 30 days prior to the end of each Reporting Period. In connection with limiting the Population, OIG may also select the CHSI facilities that will be subject to the Claims Review in each Reporting Period. In order to facilitate OIG's selection, at least 90 days prior to the end of the Reporting Period, CHSI shall furnish to OIG the following information for each CHSI facility for the prior reporting year: (1) Federal health care program revenues, (2) Federal health care program patient census, and (3) Federal health care program payor mix.

CHSI, or its IRO on behalf of CHSI, may submit proposals identifying suggestions for the subset(s) of Paid Claims to be reviewed and the CHSI facilities to be reviewed at least 90 days prior to the end of each Reporting Period. In connection with limiting the Population, OIG may consider (1) proposals submitted by CHSI or its IRO or (2) information furnished to OIG regarding the results of CHSI's internal risk assessment and internal auditing.

The determination of whether, and in what manner, to limit the Population shall be made at the sole discretion of OIG.

2. *Claims Review Sample.* The IRO shall randomly select and review a sample of 100 Paid Claims (Claims Review Sample) at each CHSI facility selected for review. The Paid Claims shall be reviewed based on the supporting documentation available at CHSI's office or under CHSI's control and applicable Medicare program requirements to determine whether the items and services furnished were medically necessary and appropriately documented, and whether the claim was correctly coded, submitted, and reimbursed. For each Paid Claim in the Claims Review Sample that results in an Overpayment, the IRO shall review the system(s) and process(es) that generated the Paid Claim and identify any problems or weaknesses that may have resulted in the identified Overpayments. The IRO shall provide its observations and recommendations on suggested improvements to the system(s) and the process(es) that generated the Paid Claim.

3. *Other Requirements.*

a. Supplemental Materials. The IRO shall request all documentation and materials required for its review of the Paid Claims in the Claims Review Sample and CHSI shall furnish such documentation and materials to the IRO prior to the IRO initiating its review of the Claims Review Sample. If the IRO accepts any supplemental documentation or materials from CHSI after the IRO has completed its initial review of the Claims Review Sample (Supplemental Materials), the IRO shall identify in the Claims Review Report the Supplemental Materials, the date the Supplemental Materials were accepted, and the relative weight the IRO gave to the Supplemental Materials in its review. In addition, the IRO shall include a narrative in the Claims Review Report describing the process by which the Supplemental Materials were accepted and the IRO's reasons for accepting the Supplemental Materials.

b. Paid Claims without Supporting Documentation. Any Paid Claim for which CHSI cannot produce documentation shall be considered an error and the total reimbursement received by CHSI for such Paid Claim shall be deemed an Overpayment. Replacement sampling for Paid Claims with missing documentation is not permitted.

c. Use of First Samples Drawn. For the purposes of the Claims Review Sample discussed in this Appendix, the first set of Paid Claims selected shall be used (i.e., it is not permissible to generate more

than one list of random samples and then select one for use with the Claims Review Sample).

4. *Repayment of Identified Overpayments.* CHSI shall repay within 60 days the Overpayment(s) identified by the IRO in the Claims Review Sample, in accordance with the requirements of 42 U.S.C. § 1320a-7k(d) and any applicable regulations or Centers for Medicare and Medicaid Services (CMS) guidance (the "CMS overpayment rule"). If CHSI determines that the CMS overpayment rule requires that an extrapolated Overpayment be repaid, CHSI shall repay that amount at the mean point estimate as calculated by the IRO. CHSI shall make available to OIG all documentation that reflects the refund of the Overpayment(s) to the payor. OIG, in its sole discretion, may refer the findings of the Claims Review Sample (and any related work papers) received from CHSI to the appropriate Medicare program contractor for appropriate follow up by the payor.

B. Claims Review Report. The IRO shall prepare a Claims Review Report as described in this Appendix for each Claims Review performed. The following information shall be included in the Claims Review Report.

1. *Claims Review Methodology.*

   a. Claims Review Population. A description of the Population subject to the Claims Review.

   b. Claims Review Objective. A clear statement of the objective intended to be achieved by the Claims Review.

   c. Source of Data. A description of (1) the process used to identify Paid Claims in the Population and (2) the specific documentation relied upon by the IRO when performing the Claims Review (e.g., medical records, physician orders, certificates of medical necessity, requisition forms, local medical review policies (including title and policy number), CMS program memoranda (including title and issuance number), Medicare carrier or intermediary manual or bulletins (including issue and date), other policies, regulations, or directives).

   d. Review Protocol. A narrative description of how the Claims Review was conducted and what was evaluated.

   e. Supplemental Materials. A description of any Supplemental Materials as required by A.3.a., above.

2. *Statistical Sampling Documentation.*

   a. A copy of the printout of the random numbers generated by the "Random Numbers" function of the statistical sampling software used by the IRO.

   b. A description or identification of the statistical sampling software package used by the IRO.

3. *Claims Review Findings.*

   a. Narrative Results.

      i. A description of CHSI's billing and coding system(s), including the identification, by position description, of the personnel involved in coding and billing.

      ii. A description of controls in place at CHSI to ensure that all items and services billed to Medicare are medically necessary and appropriately documented.

      iii. A narrative explanation of the IRO's findings and supporting rationale (including reasons for errors, patterns noted, etc.) regarding the Claims Review, including the results of the Claims Review Sample.

   b. Quantitative Results.

      i. Total number and percentage of instances in which the IRO determined that the coding of the Paid Claims submitted by CHSI differed from what should have been the correct coding and in which such difference resulted in an Overpayment to CHSI.

      ii. Total number and percentage of instances in which the IRO determined that a Paid Claim was not appropriately documented and in which such documentation errors resulted in an Overpayment to CHSI.

      iii. Total number and percentage of instances in which the IRO determined that a Paid Claim was for items or services that were not medically necessary and resulted in an Overpayment to CHSI.

iv. Total dollar amount of all Overpayments in the Claims Review Sample.

v. Total dollar amount of Paid Claims included in the Claims Review Sample.

vi. Error Rate in the Claims Review Sample. The Error Rate shall be calculated by dividing the Overpayment in the Claims Review Sample by the total dollar amount associated with the Paid Claims in the Claims Review Sample.

vii. An estimate of the actual Overpayment in the Population at the mean point estimate.

viii. A spreadsheet of the Claims Review results that includes the following information for each Paid Claim: Federal health care program billed, beneficiary health insurance claim number, date of service, code submitted (e.g., DRG, CPT code, etc.), code reimbursed, allowed amount reimbursed by payor, correct code (as determined by the IRO), correct allowed amount (as determined by the IRO), dollar difference between allowed amount reimbursed by payor and the correct allowed amount.

c. Recommendations. The IRO's report shall include any recommendations for improvements to CHSI's billing and coding system or to CHSI's controls for ensuring that all items and services billed to Medicare are medically necessary and appropriately documented, based on the findings of the Claims Review.

4. *Credentials*. The names and credentials of the individuals who: (1) designed the statistical sampling procedures and the review methodology utilized for the Claims Review and (2) performed the Claims Review.

APPENDIX C

ARRANGEMENTS REVIEW

The Arrangements Review shall consist of two components: a systems review and a transactions review. The IRO shall perform all components of each Arrangements Review. If there are no material changes to CHSI's systems, processes, policies, and procedures relating to Arrangements, the Arrangements Systems Review shall be performed for the first Reporting Period only. If CHSI materially changes the Arrangements systems, processes, policies and procedures, the IRO shall perform an Arrangements Systems Review for the Reporting Period in which such changes were made in addition to conducting the systems review for the first Reporting Period. The Arrangements Transactions Review shall be performed annually and shall cover each of the three Reporting Periods.

A. Selection of CHSI Covered Facilities To Be Reviewed. OIG may select four CHSI Covered Facilities that will be subject to the Arrangements Review in each Reporting Period. In order to facilitate OIG's selection, at least 90 days prior to the end of the Reporting Period, CHSI shall furnish to OIG the following information for each CHSI Covered Facility for the prior Reporting Period: the number of arrangements entered into for each Covered Facility.

B. Arrangements Systems Review. The Arrangements Systems Review shall be a review of CHSI's systems, processes, policies, and procedures relating to the initiation, review, approval, and tracking of Arrangements. Specifically, the IRO shall review the following:

1. CHSI's systems, policies, processes, and procedures with respect to creating and maintaining a centralized tracking system for all current existing and new and renewed Focus Arrangements (Focus Arrangements Tracking System), including a detailed description of the information captured in the Focus Arrangements Tracking System;

2. CHSI's systems, policies, processes, and procedures for tracking remuneration to and from all parties to Focus Arrangements;

3. CHSI's systems, policies, processes, and procedures for tracking service and activity logs to ensure that parties to the Focus Arrangement are performing the services required under the applicable Focus Arrangement(s) (if applicable);

4. CHSI's systems, policies, processes, and procedures for monitoring the use of leased space, medical supplies, medical devices, equipment, or other patient care items to ensure that such use is consistent with the terms of the applicable Focus Arrangement(s) (if applicable);

5. CHSI's systems, policies, processes, and procedures for initiating arrangements, including those policies that identify the individuals with authority to initiate an Arrangement and that specify the business need or business rationale required to initiate an Arrangement;

6. CHSI's systems, policies, processes, and procedures for the internal review and approval of all Arrangements, including those policies that identify the individuals required to approve each type or category of Arrangement entered into by CHSI, the internal controls designed to ensure that all required approvals are obtained, and the processes for ensuring that all Focus Arrangements are subject to a legal review by counsel with expertise in the Anti-Kickback Statute and Stark Law;

7. the Compliance Officer's annual review of and reporting to the Compliance Committee on the Focus Arrangements Tracking System, CHSI's internal review and approval process, and other Arrangements systems, process, policies, and procedures;

8. CHSI's systems, policies, processes, and procedures for implementing effective responses when suspected violations of the Anti-Kickback Statute and Stark Law are discovered, including disclosing Reportable Events and quantifying and repaying Overpayments when appropriate; and

9. CHSI's systems, policies, processes, and procedures for ensuring that all new and renewed Focus Arrangements comply with the Focus Arrangements Requirements set forth in Section III.D.2 of the CIA.

C. Arrangements Systems Review Report. The IRO shall prepare a report based upon each Arrangements Systems Review performed. The Arrangements Systems Review Report shall include the following information:

1. a description of the documentation (including policies) reviewed and personnel interviewed;

2. a detailed description of CHSI's systems, policies, processes, and procedures relating to the items identified in Section B.1-9 above;

3. findings and supporting rationale regarding weaknesses in CHSI's systems, processes, policies, and procedures relating to Arrangements described in Section B.1-9 above; and

4. recommendations to improve CHSI's systems, policies, processes, or procedures relating to Arrangements described in Section B.1-9 above.

D. Arrangements Transactions Review. The Arrangements Transactions Review shall consist of a review by the IRO of 25 randomly selected Focus Arrangements that were entered into or renewed by CHSI during the Reporting Period. The IRO shall assess whether CHSI has complied with the Focus Arrangements Procedures and the Focus Arrangements Requirements described in Sections III.D.1 and III.D.2 of the CIA, with respect to the selected Focus Arrangements.

The IRO's assessment with respect to each Focus Arrangement that is subject to review shall include:

1. verifying that the Focus Arrangement is maintained in CHSI's centralized tracking system in a manner that permits the IRO to identify the parties to the Focus Arrangement and the relevant terms of the Focus Arrangement (i.e., the items/services/equipment/space to be provided, the amount of compensation, the effective date, the expiration date, etc.)

2. verifying that the Focus Arrangement was subject to the internal review and approval process (including both a legal and business review) and obtained the necessary approvals and that such review and approval is appropriately documented;

3. verifying that the remuneration related to the Focus Arrangement is properly tracked;

4. verifying that the service and activity logs are properly completed and reviewed (if applicable);

5. verifying that leased space, medical supplies, medical devices, and equipment, and other patient care items are properly monitored (if applicable); and

6. verifying that the Focus Arrangement satisfies the Focus

Arrangements Requirements of Section III.D.2 of the CIA.

E. Arrangements Transaction Review Report. The IRO shall prepare a report based on each Arrangements Transactions Review performed. The Arrangements Transaction Review Report shall include the following information:

1. *Review Methodology*

a. Review Protocol: A detailed narrative description of the procedures performed and a description of the sampling unit and universe utilized in performing the procedures for the sample reviewed.

b. Sources of Data: A full description of the documentation and other information, if applicable, relied upon by the IRO in performing the Arrangements Transaction Review.

c. Supplemental Materials. The IRO shall request all documentation and materials required for its review of the Focus Arrangements selected as part of the Arrangements Transaction Review and CHSI shall furnish such documentation and materials to the IRO, prior to the IRO initiating its review of the Focus Arrangements. If the IRO accepts any supplemental documentation or materials from CHSI after the IRO has completed its initial review of the Focus Arrangements (Supplemental Materials), the IRO shall identify in the Arrangements Transaction Review Report the Supplemental Materials, the date the Supplemental Materials were accepted, and the relative weight the IRO gave to the Supplemental Materials in its review. In addition, the IRO shall include a narrative in the Arrangements Transaction Review Report describing the process by which the Supplemental Materials were accepted and the IRO's reasons for accepting the Supplemental Materials.

2. *Review Findings*. The IRO's findings with respect to whether CHSI has complied with the Focus Arrangements Procedures and Focus Arrangements Requirements with respect to each of the randomly selected Focus

Arrangements reviewed by the IRO. In addition, the Arrangements Transactions Review Report shall include observations, findings and recommendations on possible improvements to CHSI's policies, procedures, and systems in place to ensure that all Focus Arrangements comply with the Focus Arrangements Procedures and Focus Arrangements Requirements.

ATTACHMENT C

REPORTING REQUIREMENTS

Health Management Associates, LLC ("HMA") and its parent ("HMA Parent") agree that they will report to the Fraud Section periodically, at no less than twelve-month intervals during a three-year term, regarding remediation and implementation of the compliance program and internal controls, policies, and procedures described in the Corporate Integrity Agreement between HHS-OIG and HMA Parent (Attachment B). During this three-year period, HMA and HMA Parent shall: (1) conduct an initial review and submit an initial report, and (2) conduct and prepare at least two (2) follow-up reviews and reports, as described below:

a. By no later than fifteen months from the date this Agreement is executed, HMA and HMA Parent shall submit to the Fraud Section a written report setting forth a complete description of its remediation efforts to date, its proposals reasonably designed to improve HMA and HMA Parent's internal controls, policies, and procedures for ensuring compliance with Federal health care program requirements, and the proposed scope of the subsequent reviews. The Fraud Section agrees that the first Annual Report submitted by HMA Parent to the Office of Inspector General of the Department of Health and Human Services (HHS-OIG) pursuant to its Corporate Integrity Agreement shall satisfy this requirement for an initial report. The report shall be transmitted to Deputy Chief – Health Care Fraud Unit, Fraud Section, Criminal Division, U.S. Department of Justice, 1400 New York Avenue, NW, Bond Building, Eighth Floor, Washington, DC 20530. HMA and HMA Parent may extend the time period for issuance of the report with prior written approval of the Fraud Section.

b. HMA and HMA Parent shall undertake at least two follow-up reviews and reports, incorporating the Fraud Section's views on HMA and HMA Parent's prior reviews and

reports, to further monitor and assess whether HMA and HMA Parent's policies and procedures are reasonably designed to detect and prevent violations of Federal health care offenses, as that term is defined in Title 18, United States Code, Section 24. The Fraud Section agrees that the Annual Reports submitted by HMA Parent to HHS-OIG pursuant to its Corporate Integrity Agreement shall satisfy this requirement for follow-up reviews and reports.

c. The first follow-up review and report shall be completed by no later than one year after the initial report is submitted to the Fraud Section. The second follow-up review and report shall be completed and delivered to the Fraud Section no later than thirty days before the end of the Term.

d. The reports will likely include proprietary, financial, confidential, and competitive business information. Moreover, public disclosure of the reports could discourage cooperation, impede pending or potential government investigations and thus undermine the objectives of the reporting requirement. For these reasons, among others, the reports and the contents thereof are intended to remain and shall remain non-public, except as otherwise agreed to by the parties in writing, or except to the extent that the Fraud Section determines in its sole discretion that disclosure would be in furtherance of the Fraud Section's discharge of its duties and responsibilities or is otherwise required by law.

e. HMA and HMA Parent may extend the time period for submission of any of the follow-up reports with prior written approval of the Fraud Section.

ATTACHMENT D

UNITED STATES DISTRICT COURT
DISTRICT OF COLUMBIA

UNITED STATES OF AMERICA	**CRIMINAL NO. _____**
v.	**VIOLATION:**
CARLISLE HMA, LLC,	**18 U.S.C. § 1349**
Defendant.	

_____ /

PLEA AGREEMENT

The United States of America, by and through the Department of Justice, Criminal Division, Fraud Section (the "Fraud Section"), and the Defendant, Carlisle HMA, LLC formerly doing business as Carlisle Regional Medical Center (the "Defendant" or "Carlisle RMC"), by and through its undersigned attorneys, and through its authorized representative, pursuant to authority granted by the Board of Directors of Health Management Associates, LLC ("HMA"), the Defendant's indirect parent company, hereby submit and enter into this plea agreement (the "Agreement"), pursuant to Rule 11(c)(1)(C) of the Federal Rules of Criminal Procedure. The terms and conditions of this Agreement are as follows:

The Defendant's Agreement

1. Pursuant to Fed. R. Crim. P. 11(c)(1)(C), the Defendant agrees to waive its right to grand jury indictment and its right to challenge venue in the District Court for the District of Columbia, and to plead guilty to a one-count criminal Information charging the Defendant with conspiring under Title 18, United States Code, Section 1349 to commit health care fraud, Title 18, United States Code, Section 1347. The Defendant further agrees to persist in that plea through sentencing.

2. The Defendant understands that, to be guilty of these offenses, the following essential elements of the offense must be satisfied:

a. The Defendant and one or more persons, in some way or manner, agreed to try to accomplish a common and unlawful plan;

b. The Defendant knew the unlawful purpose of the plan, that is, a plan to commit health care fraud, as charged in the Information;

c. The Defendant willfully joined in the unlawful plan;

d. Each element of the offense listed above was committed by one or more of Defendant's agents;

e. In committing those acts, the agent or agents intended, at least in part, to benefit the Defendant; and

f. Each act was within the course and scope of the agent's or the agents' employment.

3. The Defendant understands and agrees that this Agreement is between the Fraud Section and the Defendant and does not bind any other division or section of the Department of Justice or any other federal, state, or local prosecuting, administrative, or regulatory authority. Nevertheless, the Fraud Section will bring this Agreement to the attention of other prosecuting authorities or other agencies, if requested by the Defendant.

4. The Defendant agrees that this Agreement will be executed by an authorized corporate representative. The Defendant further agrees that a resolution duly adopted by the Board of Directors of HMA, the Defendant's indirect parent company, authorizes the Defendant to enter into this Agreement and take all necessary steps to effectuate this Agreement, and that the

signatures on this Agreement by the Defendant and its counsel are authorized by the Board of Directors of HMA, the Defendant's indirect parent company, on behalf of the Defendant.

5. The Defendant agrees that it has the full legal right, power, and authority to enter into and perform all of its obligations under this Agreement.

6. The Fraud Section enters into this Agreement based on the individual facts and circumstances presented by this case and the Defendant. Among the factors considered were the following:

a. HMA and its subsidiaries (including Carlisle RMC), affiliates, and parent company ("HMA Parent") have agreed to a global resolution of HMA's criminal and civil liability related to the United States' investigation of a fraudulent scheme to increase admissions at HMA hospitals, which has the following components:

1. Carlisle RMC has agreed to plead guilty to one count of conspiracy to commit health care fraud, in violation of Title 18, United States Code, Section 1349, and to pay a $2,548,000 fine pursuant to this Agreement in relation to the conduct described in the Information and the Statement of Facts attached hereto (Exhibit 1);

2. HMA has entered into a Non-Prosecution Agreement ("NPA"), which is incorporated by reference to this Agreement (Exhibit 2). The NPA requires, among other things: (1) HMA and HMA Parent to cooperate with the Fraud Section in any and all matters relating to the conduct under investigation by the Fraud Section; (2) HMA and HMA Parent to report evidence or allegations of actual or potential violations of Federal health care offenses to the Fraud

Section; and (3) HMA to pay a monetary penalty of $35,007,846;

3. HMA has agreed to pay $74,970,802 to the United States and the Medicaid Participating States to resolve its civil liability for certain related civil claims, including under the federal False Claims Act and state Medicaid False Claims Acts, pursuant to a civil Settlement Agreement, which is incorporated by reference into this Agreement (Exhibit 3);

4. HMA Parent has agreed to a Corporate Integrity Agreement with the Office of Inspector General of the Department of Health and Human Services (HHS-OIG) which is incorporated by reference into this Agreement (Exhibit 4); and

5. The global resolution, including the civil and administrative remedies, is contingent upon the Court's acceptance of the plea and recommended sentence in this case;

b. The nature and seriousness of the offense conduct, including that Carlisle RMC administrators participated in a scheme to defraud Federal health care programs, that is Medicare, Medicaid, and TRICARE, by unlawfully pressuring and inducing physicians to increase the number of emergency department patient admissions without regard to whether the admissions were medically necessary so that Carlisle RMC could bill and obtain reimbursement for higher-paying inpatient hospital care, as opposed to observation or outpatient care, from Federal health care programs and increase HMA's revenue;

c. In June 2017, HMA sold substantially all of Carlisle RMC's assets and

business operations pursuant to an asset sale agreement. Carlisle RMC currently has no operating assets and no plans to resume business operations.

7. The Defendant agrees to abide by all terms and obligations of this Agreement as described herein, including, but not limited to, the following:

a. to plead guilty as set forth in this Agreement;

b. to abide by all sentencing stipulations contained in this Agreement;

c. to appear, through its duly appointed representatives, as ordered for all court appearances, and obey any other ongoing court order in this matter, consistent with all applicable U.S. and foreign laws, procedures, and regulations;

d. to commit no further crimes;

e. to be truthful at all times with the Court; and

f. to pay the applicable fine and special assessment.

The United States' Agreement

8. In exchange for the guilty plea of the Defendant and the complete fulfillment of all of its obligations under this Agreement, the Fraud Section agrees it will not file additional criminal charges against the Defendant or any of its direct or indirect affiliates, parents, subsidiaries, or joint ventures relating to (a) any of the conduct described in Exhibit 1, or (b) information made known to the Fraud Section prior to the date of this Agreement, except for the charges specified in the NPA between the Fraud Section and HMA. This Agreement does not close or preclude the investigation or prosecution of any natural persons, including any officers, directors, employees, agents, or consultants of the Defendant or its parent companies, direct or indirect affiliates, subsidiaries, or joint ventures, who may have been involved in any of the matters set forth in the Information, Exhibit 1, or in any other matters. The Defendant agrees that nothing in this

Agreement is intended to release the Defendant from any and all of the Defendant's excise and income tax liabilities and reporting obligations for any and all income not properly reported and/or legally or illegally obtained or derived.

Factual Basis

9. The Defendant is pleading guilty because it is guilty of the charges contained in the Information. The Defendant admits, agrees, and stipulates that the factual allegations set forth in the Information and Exhibit 1 are true and correct, that it is responsible for the acts of its officers, directors, employees, and agents described in the Information and Exhibit 1, and that the Information and Exhibit 1 accurately reflect the Defendant's criminal conduct.

The Defendant's Waiver of Rights, Including the Right to Appeal

10. Federal Rule of Criminal Procedure 11(f) and Federal Rule of Evidence 410 limit the admissibility of statements made in the course of plea proceedings or plea discussions in both civil and criminal proceedings, if the guilty plea is later withdrawn. The Defendant expressly warrants that it has discussed these rules with its counsel and understands them. Solely to the extent set forth below, the Defendant voluntarily waives and gives up the rights enumerated in Federal Rule of Criminal Procedure 11(f) and Federal Rule of Evidence 410. Specifically, the Defendant understands and agrees that any statements that it makes in the course of its guilty plea or in connection with the Agreement are admissible against it for any purpose in any U.S. federal criminal proceeding if, even though the Fraud Section has fulfilled all of its obligations under this Agreement and the Court has imposed the agreed-upon sentence, the Defendant nevertheless withdraws its guilty plea.

11. The Defendant is satisfied that the Defendant's attorneys have rendered effective assistance. The Defendant understands that by entering into this agreement, the Defendant

surrenders certain rights as provided in this agreement. The Defendant understands that the rights of criminal defendants include the following:

(a) the right to plead not guilty and to persist in that plea;

(b) the right to a jury trial;

(c) the right to be represented by counsel – and if necessary have the court appoint counsel – at trial and at every other stage of the proceedings;

(d) the right at trial to confront and cross-examine adverse witnesses, to be protected from compelled self-incrimination, to testify and present evidence, and to compel the attendance of witnesses; and

(e) pursuant to Title 18, United States Code, Section 3742, the right to appeal the sentence imposed.

Nonetheless, the Defendant knowingly waives the right to appeal or collaterally attack the conviction and any sentence within the statutory maximum described below (or the manner in which that sentence was determined) on the grounds set forth in Title 18, United States Code, Section 3742, or on any ground whatsoever except those specifically excluded in this Paragraph, in exchange for the concessions made by the United States in this plea agreement. This agreement does not affect the rights or obligations of the United States as set forth in Title 18, United States Code, Section 3742(b). The Defendant also knowingly waives the right to bring any collateral challenge challenging either the conviction, or the sentence imposed in this case. The Defendant hereby waives all rights, whether asserted directly or by a representative, to request or receive from any department or agency of the United States any records pertaining to the investigation or prosecution of this case, including without limitation any records that may be sought under the Freedom of Information Act, Title 5, United States Code, Section 552, or the Privacy Act, Title 5,

United States Code, Section 552a. The Defendant waives all defenses based on the statute of limitations and venue with respect to any prosecution related to the conduct described in Exhibit 1 or the Information, including any prosecution that is not time-barred on the date that this Agreement is signed in the event that: (a) the conviction is later vacated for any reason; (b) the Defendant violates this Agreement; or (c) the plea is later withdrawn, provided such prosecution is brought within one year of any such vacation of conviction, violation of agreement, or withdrawal of plea plus the remaining time period of the statute of limitations as of the date that this Agreement is signed. The Fraud Section is free to take any position on appeal or any other post-judgment matter. The parties agree that any challenge to the Defendant's sentence that is not foreclosed by this Paragraph will be limited to that portion of the sentencing calculation that is inconsistent with (or not addressed by) this waiver. Nothing in the foregoing waiver of appellate and collateral review rights shall preclude the Defendant from raising a claim of ineffective assistance of counsel in an appropriate forum.

Penalty

12. The statutory maximum sentence that the Court can impose for a violation of Title 18, United States Code, Section 1349, is a fine of $500,000 or twice the gross pecuniary gain or gross pecuniary loss resulting from the offense, whichever is greatest, Title 18, United States Code, Section 3571(c), (d); five years' probation, Title 18, United States Code, Section 3561(c)(1); and a mandatory special assessment of $400 per count, Title 18, United States Code, Section 3013(a)(2)(B).

Sentencing Recommendation

13. The parties agree that pursuant to *United States v. Booker*, 543 U.S. 220 (2005), the Court must determine an advisory sentencing guideline range pursuant to the United States

Sentencing Guidelines. The Court will then determine a reasonable sentence within the statutory range after considering the advisory sentencing guideline range and the factors listed in Title 18, United States Code, Section 3553(a). The parties' agreement herein to any guideline sentencing factors constitutes proof of those factors sufficient to satisfy the applicable burden of proof. The Defendant also understands that if the Court accepts this Agreement, the Court is bound by the sentencing provisions in Paragraph 15.

14. The Fraud Section and the Defendant agree that Defendant's Guidelines fine range is calculated as follows:

a. The 2016 U.S.S.G. are applicable to this matter.

b. Offense Level. Based upon U.S.S.G. § 2B1.1, the total offense level is 21, calculated as follows:

(a)(1)	Base Offense Level	7
(b)(1)(G)	Amount of Loss	+12
(b)(10)	Sophisticated Means	+2
	TOTAL	21

c. Base Fine. Based upon U.S.S.G. § 8C2.4(a)(2) and § 8C2.4(e), the base fine is $910,000.

d. Culpability Score. Based upon U.S.S.G. § 8C2.5, the culpability score is 7, calculated as follows:

(a)	Base Culpability Score	5
(b)(3)(A)(i)	the organization had 200 or more employees and an individual within high-level personnel of the organization participated in, condoned, or was willfully ignorant of the offense	+3
(g)(3)	The organization clearly demonstrated recognition and affirmative acceptance of responsibility for its	

criminal conduct	- 1
TOTAL	7

Calculation of Fine Range:

Base Fine	$910,000
Multipliers	1.4(min)/2.8 (max)
Fine Range	$1,274,000 (min)/ $2,548,000 (max)

15. Pursuant to Rule 11(c)(1)(C) of the Federal Rules of Criminal Procedure, the Fraud Section and the Defendant agree that the appropriate disposition of the case is as follows, taking into consideration all of the factors outlined in Paragraph 6 and in 18 U.S.C. §§ 3553(a) and 3572:

a. Fine. The Defendant shall pay a criminal fine of $2,548,000, payable in full within 10 business days after the sentencing. The Defendant shall not seek or accept directly or indirectly reimbursement or indemnification from any source with regard to the penalty amounts that Defendant pays (1) pursuant to the Agreement, or (2) any other agreement entered into with an enforcement authority or regulator concerning the facts set forth in Exhibit 1, except as amounts identified as restitution in a settlement agreement or court order pursuant to 26 U.S.C. § 6050x. The Defendant further acknowledges that no tax deduction may be sought in connection with the payment of any part of this $2,548,000 fine.

b. Mandatory Special Assessment. The Defendant shall pay to the Clerk of the Court for the United States District Court for the District of Columbia within ten business days of the time of sentencing the mandatory special assessment of $400 per count.

c. Restitution. The Department agrees that it will not seek a separate

restitution order and the parties agree that the appropriate disposition of this case does not include a restitution order under 18 U.S.C. § 3663A(c)(1)(A)(ii) for the Federal health care program victims in light of HMA's agreement to pay a civil settlement amount of $74,970,802 to the United States and the Medicaid Participating States under the related civil Settlement Agreement, a portion of which will satisfy the restitution amount owed by the Defendant to the Federal health care program victims.

16. This Agreement is presented to the Court pursuant to Fed. R. Crim. P. 11(c)(1)(C). The Defendant understands that the Court retains complete discretion to accept or reject the recommended sentence provided for in Paragraph 15 of this Agreement. The Defendant understands that, if the Court rejects this Agreement, the Court must: (a) inform the parties that the Court rejects the Agreement; (b) advise the Defendant's counsel that the Court is not required to follow the Agreement and afford the Defendant the opportunity to withdraw its plea; and (c) advise the Defendant that if the plea is not withdrawn, the Court may dispose of the case less favorably toward the Defendant than the Agreement contemplated. The Defendant further understands that if the Court refuses to accept any provision of this Agreement, neither party shall be bound by the provisions of the Agreement.

17. The Fraud Section and the Defendant jointly submit that this Plea Agreement, together with the record that will be created by the Fraud Section and the Defendant at the plea and sentencing hearings, will provide sufficient information concerning the Defendant, the crime charged in this case, and the Defendant's role in the crime to enable the meaningful exercise of sentencing authority by the Court under 18 U.S.C. § 3553(a).

18. The Fraud Section and the Defendant agree, subject to the Court's approval, to waive the requirement for a presentence report, pursuant to Federal Rule of Criminal Procedure

32(c)(1)(A), based on a finding by the Court that the record contains information sufficient to enable the Court to meaningfully exercise its sentencing power and to seek sentencing by the Court immediately following the Rule 11 plea hearing. However, the parties agree that in the event the Court orders that the entry of the guilty plea and sentencing occur at separate proceedings, such an order will not affect the agreement set forth herein. Additionally, if the Court directs the preparation of a presentence report, the Fraud Section and the Defendant have the right to inform the Court and the Probation Office of all facts, circumstances, and law related to the Defendant's case, and to respond to any questions from the Court and the Probation Office, and to any misstatements of law or fact. At the time of the plea hearing, the parties will suggest mutually agreeable and convenient dates for the sentencing hearing with adequate time for any objections to the presentence report, and consideration by the Court of the presentence report and the parties' sentencing submissions.

Breach of Agreement

19. This Plea Agreement is effective when signed by the Defendant, the Defendant's attorney, and an attorney representative of the Fraud Section.

20. In the event the Fraud Section determines that the Defendant has breached this Agreement, the Fraud Section agrees to provide the Defendant with written notice of such breach prior to instituting any prosecution resulting from such breach. Within thirty days of receipt of such notice, the Defendant shall have the opportunity to respond to the Fraud Section in writing to explain the nature and circumstances of such breach, as well as the actions the Defendant has taken to address and remediate the situation, which explanation the Fraud Section shall consider in determining whether to pursue prosecution of the Defendant.

21. In the event the Fraud Section determines that the Defendant has breached the Agreement, the Fraud Section may, at its sole discretion, be released from its commitments under this Plea Agreement in its entirety by notifying the Defendant, through counsel, in writing. The Fraud Section may also pursue all remedies available under the law, even if it elects not to be released from its commitments under the Agreement.

22. In the event that the Fraud Section determines that the Defendant has breached any material provision of this Agreement: (a) all statements made by or on behalf of the Defendant to the Fraud Section or to the Court, including the attached Statement of Facts, and any testimony given by the Defendant before a grand jury, a court, or any tribunal, or at any legislative hearings, whether prior or subsequent to this Agreement, and any leads derived from such statements or testimony, shall be admissible in evidence in any and all criminal proceedings brought by the Fraud Section against the Defendant; and (b) the Defendant shall not assert any claim under the United States Constitution, Rule 11(f) of the Federal Rules of Criminal Procedure, Rule 410 of the Federal Rules of Evidence, or any other federal rule that any such statements or testimony made by or on behalf of the Defendant prior or subsequent to this Agreement, or any leads derived therefrom, should be suppressed or are otherwise inadmissible. The decision whether conduct or statements of any current director, officer or employee, or any person acting on behalf of, or at the direction of, the Defendant, will be imputed to the Defendant for the purpose of determining whether the Defendant has violated any provision of this Agreement shall be in the sole discretion of the Fraud Section.

23. The Defendant understands and agrees that this Rule 11(c)(1)(C) plea agreement and its agreed-upon disposition:

a. are wholly dependent upon: (1) HMA and HMA Parent's compliance with the material terms of the attached NPA; and (2) HMA's timely compliance with the material terms of the attached civil Settlement Agreement; and

b. failure by (1) the Defendant to comply fully with the material terms of this Agreement, (2) by HMA and HMA Parent to comply fully with the terms of the attached NPA, or by HMA to comply fully with the material terms of the civil Settlement Agreement will constitute a breach of this Agreement.

24. In the event the Defendant at any time hereafter breaches any material term of this Agreement, the Defendant understands that (1) the Fraud Section will, as of the date of the breach, be relieved of any obligations it may have in this Agreement and the attached NPA, including but not limited to the promise to not further prosecute the Defendant as set forth in the Agreement; and (2) the Defendant will not be relieved of its obligation to make the payments set forth in this Agreement, nor will it be entitled to a return of any monies paid. Moreover, in the event of a material breach of this Agreement, the Defendant agrees and understands that the Fraud Section may pursue any and all charges that might otherwise not have been brought but for this Agreement, and the Defendant hereby waives, and agrees it will not interpose, any defense to any charges brought against it which it might otherwise be able to assert under the Constitution for pre-indictment delay, any statute of limitations, or the Speedy Trial Act.

Public Statements by the Defendant

25. The Defendant expressly agrees that it shall not, through present or future attorneys, officers, directors, employees, agents or any other person authorized to speak for the

Defendant make any public statement, in litigation or otherwise, contradicting the acceptance of responsibility by the Defendant set forth above or the facts described in the Information and Exhibit 1. Any such contradictory statement shall, subject to cure rights of the Defendant described below, constitute a material breach of this Agreement, and the Defendant thereafter shall be subject to prosecution as set forth in Paragraphs 19-24 of this Agreement. The decision whether any public statement by any such person contradicting a fact contained in the Information or Exhibit 1 will be imputed to the Defendant for the purpose of determining whether it has breached this Agreement shall be at the sole discretion of the Fraud Section. If the Fraud Section determines that a public statement by any such person contradicts in whole or in part a statement contained in the Information or Exhibit 1, the Fraud Section shall so notify the Defendant, and the Defendant may avoid a breach of this Agreement by publicly repudiating such statement(s) within five business days after notification. The Defendant shall be permitted to raise defenses and to assert affirmative claims in other proceedings relating to the matters set forth in the Information and Exhibit 1 provided that such defenses and claims do not contradict, in whole or in part, a statement contained in the Information or Exhibit 1. This Paragraph does not apply to any statement made by any present or former officer, director, employee, or agent of the Defendant in the course of any criminal, regulatory, or civil case initiated against such individual, unless such individual is speaking on behalf of the Defendant.

26. The Defendant agrees that if it or any of its direct or indirect parents, subsidiaries or affiliates issues a press release or holds any press conference in connection with this Agreement, the Defendant shall first consult the Fraud Section to determine (a) whether the text of the release or proposed statements at the press conference are true and accurate with respect to matters

between the Fraud Section and the Defendant; and (b) whether the Fraud Section has any objection to the release or statement.

Complete Agreement

27. This document states the full extent of the Agreement between the parties. There are no other promises or agreements, express or implied. Any modification of this Agreement shall be valid only if set forth in writing in a supplemental or revised plea agreement signed by all parties.

AGREED:

FOR CARLISLE HMA, LLC:

Date: _____ By: _____
Christopher G. Cobb
Vice President – Legal and Corporate Secretary of HMA

Date: _____ By: _____
Richard A. Sauber
Robbins, Russell, Englert, Orseck,
Untereiner & Sauber LLP
Outside Counsel for Carlisle HMA, LLC

FOR THE DEPARTMENT OF JUSTICE:

Date: 9/24/2018

SANDRA L. MOSER
Acting Chief, Fraud Section
Criminal Division
U.S. Department of Justice

ROBERT A. ZINK
Acting Principal Deputy Chief, Fraud Section

JOSEPH S. BEEMSTERBOER
Deputy Chief, Fraud Section

Sally B. Molloy
SALLY B. MOLLOY
Assistant Chief, Fraud Section

Complete Agreement

27. This document states the full extent of the Agreement between the parties. There are no other promises or agreements, express or implied. Any modification of this Agreement shall be valid only if set forth in writing in a supplemental or revised plea agreement signed by all parties.

AGREED:

FOR CARLISLE HMA, LLC:

Date: 9/21/2018 By: _____
Christopher G. Cobb
Secretary of HMA

Date: _____ By: _____
Richard A. Sauber
Michael L. Waldman
Robbins, Russell, Englert, Orseck,
Untereiner & Sauber LLP
Outside Counsel for Carlisle HMA, LLC

FOR THE DEPARTMENT OF JUSTICE:

Date: _____

SANDRA L. MOSER
Acting Chief, Fraud Section
Criminal Division
U.S. Department of Justice

ROBERT A. ZINK
Acting Principal Deputy Chief, Fraud Section

JOSEPH S. BEEMSTERBOER
Deputy Chief, Fraud Section

_____
SALLY B. MOLLOY
Assistant Chief, Fraud Section

Complete Agreement

27. This document states the full extent of the Agreement between the parties. There are no other promises or agreements, express or implied. Any modification of this Agreement shall be valid only if set forth in writing in a supplemental or revised plea agreement signed by all parties.

AGREED:

FOR CARLISLE HMA, LLC:

Date: _____ By: _____
Christopher G. Cobb
Secretary of HMA

Date: 9/21/2016 By: _____
Richard A. Sauber
Michael L. Waldman
Robbins, Russell, Englert, Orseck,
Untereiner & Sauber LLP
Outside Counsel for Carlisle HMA, LLC

FOR THE DEPARTMENT OF JUSTICE:

Date: _____

SANDRA L. MOSER
Acting Chief, Fraud Section
Criminal Division
U.S. Department of Justice

ROBERT A. ZINK
Acting Principal Deputy Chief, Fraud Section

JOSEPH S. BEEMSTERBOER
Deputy Chief, Fraud Section

_____
SALLY B. MOLLOY
Assistant Chief, Fraud Section

EXHIBIT 1

STATEMENT OF FACTS

The following Statement of Facts is incorporated by reference as part of the Plea Agreement between the United States Department of Justice, Criminal Division, Fraud Section (the "Fraud Section") and Carlisle HMA, LLC formerly doing business as Carlisle Regional Medical Center ("Carlisle RMC"), and the parties hereby agree and stipulate that the following information is true and accurate. Carlisle RMC admits, accepts, and acknowledges that it is responsible for the acts of its officers, directors, employees, and agents as set forth below. Had this matter proceeded to trial, Carlisle RMC acknowledges that each element of the offense charged in the criminal information would be established by the facts stated herein.

The Federal Health Care Programs and The Provision of and Reimbursement for Hospital Care

1. The Medicare Program ("Medicare") was a Federal health care program providing benefits to persons who were 65 or over or disabled. Medicare was administered by the United States Department of Health and Human Services ("HHS") through its agency, the Centers for Medicare and Medicaid Services ("CMS"), and its contractors.

2. The Medicaid Program ("Medicaid") was a Federal health care program providing benefits for low-income patients. Funding for Medicaid is shared between the federal and state governments. At the Federal level, Medicaid is administered by CMS.

3. TRICARE was a federally-funded medical insurance program for military personnel, their spouses and unmarried dependent children under the age of 22, administered by the TRICARE Management Activity, pursuant to 10 U.S.C. §§ 1071-1177.

4. Medicare, Medicaid and TRICARE were each a "health care benefit program," as defined by Title 18, United States Code, Section 24(b), and a "Federal health care program," as defined by Title 42, United States Code, Section 1320a-7b(f).

5. Health care providers who furnished health care services that were reimbursed by Federal health care programs had to ensure that such services would "be provided economically and only when, and to the extent, medically necessary." 42 U.S.C. § 1320c-5(a)(1); 42 C.F.R. § 1004.10.

6. When a patient visited a hospital's emergency department (hereafter referred to as the "ED"), a patient was typically examined by an ED physician who determined the patient's medical condition. Based on the severity of a patient's condition and the expected course of treatment, an ED physician would make a recommendation to an admitting physician (the patient's personal physician or a hospitalist) about whether the patient should be:

   a. admitted to the hospital for inpatient treatment;

b. observed in a hospital bed for a period typically lasting up to 24 hours but not exceeding 48 hours, after which time a decision could be made about whether the patient required hospital admission; or

c. treated in the ED and discharged.

7. The Medicare Program Integrity Manual provided that "[i]npatient care, rather than outpatient care, is required **only if** the beneficiary's medical condition, safety or health would be significantly and directly threatened if care was provided in a less intensive setting." Chapter 6, Section 6.5.2 (emphasis added).

8. The decision whether to (a) admit a patient, (b) treat a patient in observation status, or (c) treat a patient as an outpatient in the ED and discharge the patient had significant financial consequences for the hospital. Hospitals derived a large portion of their revenues from payments for inpatient care, and were generally paid thousands of dollars more to treat a patient who was billed as an admitted patient than one who was billed as an outpatient or under observation.

9. Medicare Part A (Hospital Insurance) covered **inpatient hospital services**. Hospitals submitted claims for payment for inpatient hospital services under Medicare Part A after a patient was discharged from the hospital. Initially, hospitals submitted a patient-specific claim for interim payment for each discharged patient.

10. Medicare Part B (Medical Insurance) covered **outpatient hospital services**. Hospitals submitted claims for payment for outpatient hospital services, which included both (a) observation services and (b) treatment provided to a patient in an ED under Medicare Part B. Outpatient services provided to a patient were assigned a classification and reimbursed at a rate set by Medicare for that classification. Generally, the more complex the services, the higher the reimbursement.

11. Medicare Part B also reimbursed physicians for their professional services provided in a hospital setting, pursuant to a Physician Fee Schedule. Physicians billed Medicare for their examinations of patients in hospital EDs under one of five evaluation and management codes, depending on the complexity of the examination. Generally, the more complex the examination, the higher the reimbursement.

12. Patient-specific hospital services were billed to and reimbursed by Medicaid and TRICARE in generally the same manner as Medicare.

13. In addition to patient specific claims for both inpatient and outpatient hospital services, hospitals who were Medicare providers were required to annually submit a hospital cost report. The cost report was the hospital's final claim for payment from Medicare for the services rendered to all program beneficiaries for a fiscal year. Medicare relied on the hospital cost report to determine whether the provider was entitled to more reimbursement than it had already received through interim payments, or whether the provider had been overpaid and had to reimburse Medicare.

14. The federal Anti-Kickback Statute, in general terms, criminalized the offer, payment, solicitation, and receipt of remuneration in exchange for ordering, or arranging for, or recommending ordering any service or item for which payment may be made, in whole or in part, by a federal health care program. 42 U.S.C. § 1320a-7b(b).

15. In order for hospitals and physicians to participate as Medicare providers and receive payment from Medicare, they had to enter into Provider Agreements with CMS. As part of that agreement, the provider had to certify that:

> I agree to abide by the Medicare laws, regulations, and program instructions that apply to [me]. The Medicare laws, regulations, and program instructions are available through the [Medicare] contractor. I understand that payment of a claim by Medicare is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, the Federal anti-kickback statute and the Stark law), and on the [provider's] compliance with all applicable conditions of participation in Medicare.

16. Medicare would not pay a hospital's claims for services that it knew were not medically necessary or that were provided in violation of the Anti-Kickback Statute.

17. Every hospital cost report also contained a certification page that had to be signed by the chief administrator of the hospital provider or his or her designee, who had to certify that he or she was "familiar with the laws and regulations regarding the provision of health care services and that the services identified in this cost report were provided in compliance with such laws and regulations," including the laws and regulations that required services to be medically necessary and comply with the Anti-Kickback Statute.

18. Similarly, in order to participate as Medicaid and TRICARE providers and receive payment from the Medicaid and TRICARE programs, hospitals and physicians had to sign Medicaid provider agreements, which vary from state to state, and TRICARE provider agreements, and certify, among other things, that the provider would comply with all applicable federal and state laws and regulations, including the law and regulations that required services to be medically necessary and the Anti-Kickback Statute. State Medicaid programs and TRICARE would not pay a hospital's claims for services that they knew were not medically necessary or provided in violation of the Anti-Kickback Statute.

The Defendant and Relevant Entities

19. Health Management Associates, Inc. ("HMA") was a publicly-traded, Delaware-based for-profit corporation headquartered in Naples, Florida that indirectly owned and operated, at various times, over 70 general acute care for-profit hospitals primarily in rural communities across the United States (collectively, "the HMA Hospitals").

20. Defendant Carlisle HMA, LLC formerly doing business as Carlisle Regional Medical Center (hereafter, "Carlisle RMC") was a wholly-owned indirect subsidiary of HMA and operated a small rural hospital located in Carlisle, Pennsylvania.

21. Company A was one of the companies that HMA contracted with to provide ED physician and management services at HMA Hospitals. HMA was Company A's largest hospital customer. Under its arrangements with HMA Hospitals, Company A billed and received payment from Federal health care programs for physician services provided at HMA Hospitals. Some HMA Hospitals also paid a management fee to Company A for managing the ED.

22. Company A hired or contracted with emergency medicine physicians and hospitalists to provide professional services at HMA Hospitals, who were paid an hourly rate. Company A also employed physicians as medical directors at the HMA Hospitals it serviced, who were paid a monthly salary for their services and an hourly fee for clinical services provided to hospital patients.

23. HMA Hospitals' contracts with Company A generally provided that the parties to the contract could terminate the contract with 60 to 90 days' notice without cause after the first year and that the HMA Hospital CEO could direct Company A to remove any ED physician working at an HMA hospital at any time without cause.

24. From in or around May 2008 to in or around February 2012, HMA contracted with Company A to staff Carlisle RMC's ED. From in or around September 2010 to February 2012, HMA contracted with Company A to provide hospitalist services at Carlisle RMC. From in or around February 2012 to at least December 2012, HMA contracted with another third party ED physician and management service to staff the ED at Carlisle RMC.

25. From at least 2008 to at least 2013, Carlisle RMC was enrolled as a provider in the Medicare, Medicaid and TRICARE programs and billed and received payment from these federal health care programs. At certain times between 2010 and 2014, Carlisle RMC submitted annual hospital cost reports to the Medicare program covering the time periods July 2009 to June 2012.

Overview and Purpose of the Conspiracy

26. Beginning in 2008 and continuing through at least 2012, (1) certain administrators at Carlisle RMC, acting as agents of Carlisle RMC, at least in part for the benefit of Carlisle RMC, and within the scope and course of their employment and authority at Carlisle RMC, (2) certain executives at HMA; (3) certain administrators at the HMA Hospitals, (4) certain administrators and executives of Company A, and (5) others, conspired to execute a scheme and artifice to defraud Federal health care programs, that is, Medicare, Medicaid and TRICARE. As part of the scheme to defraud, HMA offered and paid unlawful remuneration to Company A, in the form of service contracts at HMA Hospitals (including at Carlisle RMC) and payments, in return for ED inpatient admission recommendations and admissions at HMA Hospitals (including at Carlisle RMC) that were not medically necessary.

27. It was a purpose of the conspiracy for certain administrators at Carlisle RMC, certain executives at HMA, certain administrators at the HMA Hospitals, certain executives and administrators of Company A, and others to unlawfully enrich and benefit the HMA Hospitals (including Carlisle RMC), HMA, Company A, and themselves, by unlawfully pressuring and

inducing physicians serving HMA Hospitals (including Carlisle RMC), including but not limited to physicians who worked for Company A, to increase the number of ED patient admissions without regard to whether the admissions were medically necessary, all so that the HMA Hospitals (including Carlisle RMC) could bill and obtain reimbursement for higher-paying inpatient hospital care, as opposed to observation or outpatient care, from Federal health care programs and increase HMA's revenue.

Execution of the Conspiracy

28. Beginning in or around September 2008, HMA executives instituted a formal and aggressive plan to improperly increase overall ED inpatient admission rates at all HMA Hospitals. As part of the plan, HMA executives set mandatory company-wide admission rate benchmarks for patients presenting to HMA Hospital EDs - a range of 15-20% for all patients presenting to the ED, depending on the HMA Hospital, and then 50% for patients 65 and older (i.e. Medicare beneficiaries) - solely to increase HMA revenue.

29. These mandatory admission rate benchmarks were not put in place to improve the level of patient care, and were not based on an assessment of the medical needs of the patient mix at particular hospitals or the medical services that particular hospitals were equipped to provide to patients. The benchmark admission rate set by HMA executives for Carlisle RMC was 20% for all patients presenting to the ED and then 50% for patients 65 and older, even though Carlisle RMC's historical ED admission rate was around 10-13%, which was in line with ED admission rates for other similar hospitals, and Carlisle RMC lacked specialty care to treat many seriously ill patients. Specifically, Carlisle RMC was not a trauma center and did not have 24-hour interventional cardiology, cardiac surgery, neurology, or neurosurgery services to treat heart attack or stroke victims, and did not have an inpatient pediatric unit. Hershey Medical Center, a major university hospital and Level 1 trauma center, was located within 40 miles of Carlisle RMC.

30. The scheme to increase ED inpatient admission rates and maximize revenue was executed through various improper means, including by HMA executives pressuring and coercing HMA Hospital administrators (including Carlisle RMC Administrators A and B), contracted ED physician practice groups, including Company A, and medical directors and physicians treating HMA's ED patients to meet mandatory admission rate benchmarks in the following improper ways, among others:

a. HMA executives directed HMA Hospital administrators, including Carlisle RMC Administrators A and B, to generate daily "Physician's Activity Reports" using a customized software program that tracked each ED physician's admissions statistics relating to patients he or she treated and corresponding color-coded "Physician's Scorecards," which indicated in red whether the physician had failed to meet the mandatory admissions benchmark. At some HMA Hospitals, these scorecards were posted in the physicians' workspace and improperly used to pressure physicians with "failing" admission grades to admit patients who did not require inpatient admission;

b. HMA executives and HMA Hospital administrators, including Carlisle

RMC Administrators A and B, tracked ED physicians' "admission overrides" in the "Physician's Activity Report." These were instances in which an ED patient met pre-programmed criteria for inpatient admission in the customized software program but the ED physician, using his or her clinical judgment, disagreed and manually overrode the computerized designation. At some HMA Hospitals, ED physicians whose admission override rates were over a mandatory benchmark were given "failing" admission grades and these override rates were improperly used to pressure ED physicians with "failing" grades to admit patients who did not require inpatient admission;

c. HMA executives ordered HMA Hospital administrators, including Carlisle RMC Administrators A and B, to interrogate ED physicians about alleged "missed" admissions and admission overrides during daily meetings which was designed to improperly pressure the ED physicians to admit patients who did not require inpatient admission. Certain HMA Hospital administrators, including Carlisle RMC Administrator A, threatened to fire ED physicians and medical directors if the ED physicians did not increase the number of admissions of patients they treated, regardless of whether the patients required inpatient admission. In some instances, HMA executives fired HMA Hospital administrators who were unwilling to improperly challenge ED physicians' admission status determinations;

d. HMA executives prepared, distributed, and improperly used "Forced Rank Reports" that ranked HMA Hospital EDs according to ED inpatient admission rates and grouped HMA Hospitals that met the mandatory corporate benchmark for the month above the line, and those that failed to meet it below the line. HMA executives warned HMA Hospital administrators whose hospitals fell below the line, including Carlisle RMC Administrator A, that they would be fired unless their admission rates increased. In turn, HMA Hospital administrators, including Carlisle RMC Administrators A and B, pressured Company A executives and administrators, ED medical directors and physicians to admit more patients and demanded that Company A fire medical directors and ED physicians who refused to "get with the program" and maximize admissions through improper methods;

e. HMA executives instructed HMA Hospital administrators to pressure their ED physicians not to place patients in observation status, and to admit them as inpatients regardless of whether they met medical necessity criteria. In some instances, HMA executives instructed HMA Hospital administrators to disregard communications from patients' primary care physicians and case managers to place patients in observation status. At some HMA Hospitals, the option for physicians to place patients in observation status was removed from admission paperwork for a period of time;

f. HMA executives and HMA Hospital administrators, including Carlisle RMC Administrators A and B, also implemented mandatory benchmarks for calls from ED physicians to patients' primary care physicians to discuss admission status determinations, and tracked and reviewed individual ED physicians' compliance with these mandatory benchmarks, for the improper purpose of increasing inpatient admissions without medical necessity. HMA executives instructed Company A administrators and ED physicians that the purpose of these calls was to "sell admissions" to primary care physicians. If an ED physician's admission rate for the patients he or she treated fell below the mandatory corporate benchmark, HMA executives directed Company A management to train the ED physician on how to sell admissions during telephone

calls with primary care physicians. ED physicians were told not to solicit the primary care physician's advice about the admission status determination, but instead to tell the physician that the patient should be admitted; and

g. HMA used monetary bonuses to induce ED physicians to increase their rates of hospital admissions without regard to whether inpatient admission was required. At certain HMA Hospitals, HMA contracted with Company A to pay bonuses to ED physicians who satisfied the mandatory corporate benchmarks for admission overrides and calls to primary care physicians, which was designed by HMA to increase inpatient admissions without regard to medical necessity.

31. Company A executives and administrators collaborated with HMA executives and HMA Hospital administrators, including Carlisle RMC Administrators A and B, in pressuring, coercing, and offering inducements to ED medical directors and physicians to recommend the admission of and admit ED patients who did not need and did not qualify for inpatient admission by, among other means:

a. enforcing HMA's mandatory corporate benchmarks for ED admissions without regard to whether inpatient admission was required, requiring calls to primary care physicians to sell improper admissions, and improperly using data such as admissions overrides to pressure its ED physicians to admit patients who did not meet medical necessity criteria;

b. agreeing to HMA's payment of bonuses to ED medical directors and physicians who met mandatory corporate benchmarks designed to increase improper admissions;

c. training its physicians to "sell admissions" in telephone calls to primary care physicians rather than engage in a meaningful consultation about the patients' medical needs;

d. instructing ED medical directors and physicians to admit patients who did not meet medical necessity criteria;

e. at HMA's request, threatening to terminate and terminating medical directors and physicians who refused to follow HMA's improper procedures to maximize admissions; and

f. firing its own corporate managers who refused to comply with HMA's orders to maximize admissions through improper methods.

32. As a result of the above-described pressure to admit from HMA executives, Carlisle RMC Administrators A and B, Company A executives and administrators, and others, ED physicians staffing Carlisle RMC's ED recommended, in certain instances, inpatient admissions that were not medically necessary, and physicians with admitting privileges at Carlisle RMC admitted, in certain instances, patients who did not need inpatient admission.

33. As a result, Carlisle RMC billed and received payments from Federal health care programs for inpatient admissions that were not medically necessary.

34. As a further result, in or around January 2012, Carlisle RMC submitted a cost report to Medicare covering the time period July 2010 to June 2011, in which Carlisle RMC Administrator A made materially false, fraudulent and misleading representations that the services identified in the Carlisle RMC cost report "were provided in compliance with the laws and regulations" regarding the provision of health care services, when in fact certain services were not medically necessary.

Specific Conduct at Carlisle RMC Regarding Threats to Terminate Physicians if They Did Not Increase Inpatient Admissions

35. During telephone calls and in-person meetings in 2009 and 2010, Carlisle RMC Administrator A told Company A Administrator A that HMA executives had warned him that if Carlisle RMC did not achieve an overall 20% admission rate for patients presenting to the Carlisle RMC ED, HMA would fire him. Carlisle RMC Administrator A instructed Company A Administrator A to get the ED physicians to admit more patients immediately, because an HMA executive wanted the admission rate to go up "overnight." When Company A Administrator A told Carlisle RMC Administrator A that it was illegal to pressure physicians to admit patients without regard to whether the admission was medically necessary, Carlisle RMC Administrator A responded, in substance, "I would rather be testifying in court than telling my wife I lost my job."

36. Carlisle RMC Administrator A also told Company A Administrator A on numerous occasions to get rid of the Carlisle RMC Assistant ED Medical Director and Carlisle RMC ED Physician A, and that an HMA executive wanted to get rid of the Carlisle RMC ED Medical Director because the ED admission rate was too low at Carlisle RMC and he was not pressuring physicians to admit enough patients.

37. During the summer of 2010, Carlisle RMC Administrator A instructed certain Company A executives and administrators that HMA wanted Company A to "clean house" and get rid of all of the ED physicians at Carlisle RMC because they weren't admitting enough patients. The Company A executives agreed to fire two physicians every two months, and told Carlisle RMC Administrator A that they had warned the Carlisle RMC ED Medical Director that his continued employment and all the Carlisle RMC ED physicians' continued employment would be in jeopardy if the Carlisle RMC ED Medical Director did not raise the admission rate at Carlisle RMC.

38. During the summer of 2010, Company A executives held a meeting with the Carlisle RMC ED physicians at the Boiling Springs Tavern during which Company A Executive A told them, in substance, "I'm going to tell you how it is. You're going to admit 20% or you're going to get fired." The Carlisle RMC Assistant ED Medical Director responded, in substance, "I understand you are telling us that if we don't admit 20% of patients you're going to fire us," and Company A Executive A agreed that was his message.

39. In an August 24, 2010 e-mail to the Carlisle RMC ED Medical Director, the Carlisle RMC Assistant ED Medical Director wrote:

> Unfortunately, I feel that my continuing in that role would compromise me ethically, morally, and professionally as I think it would make me complicit in what I personally feel borders on fraud and it most certainly would require me to endorse a policy that undermines the scope of medical practice by allowing others, non-physicians, to dictate to me and the other emergency medicine physicians in our department what is a medical, not administrative, decision.

40. In or around August 2010, a Company A executive told Company A Administrator A to tell the Carlisle RMC ED Medical Director that the Carlisle RMC ED physicians needed to admit more patients or they would all be fired. After Company A Administrator A admitted to the Company A executive that she had not delivered this message as requested, the Company A executive called the Carlisle RMC ED Medical Director to deliver the message himself.

41. At a dinner meeting held during the summer of 2010, certain Company A executives informed the Carlisle RMC ED Medical Director that this was his last chance to get it right and partner with HMA to "drive the metrics" at Carlisle RMC. The Carlisle RMC ED Medical Director explained the hurdles and impossibility of reaching the mandatory admission rate benchmark at Carlisle RMC, and asked if Company A could push back on HMA's pressure. The Company A executives said there would be no pushing back – HMA was the client and Company A had to hit the metrics – and that he would be fired if he did not "play ball" when it came to meeting the mandatory 20% admission rate benchmark and the mandatory benchmark for primary care physician consults and getting things turned around. During this meeting, the Company A executives also told the Carlisle RMC ED Medical Director that they were going to fire the Carlisle RMC Assistant ED Medical Director, and that it would be a "wake-up call" to the other ED physicians.

42. In fall 2010, the Carlisle RMC Assistant ED Director resigned from his position. If he had not resigned, the Carlisle RMC ED Medical Director would have had to fire him. When the Carlisle RMC Assistant ED Director resigned, he met with Carlisle RMC Administrator A and told him that he was leaving because of the pressure to improperly admit 20% of ED patients without consideration of whether those patients met criteria for inpatient admission.

43. In or around late September or early October 2010, Carlisle RMC Administrator A requested a meeting with Carlisle RMC ED Medical Director during which he told him that he would be a great medical director in a non-profit hospital, but that he did not cut it in the for-profit arena, that he failed to meet HMA's goals, and that an HMA executive had directed him to let him go. Carlisle RMC Administrator A told the Carlisle RMC ED Director that HMA was planning to open a wound care center and could offer him the position of medical director at the facility. Carlisle RMC Administrator A told the Carlisle RMC ED Medical Director that if he did not accept the medical directorship position, he would have to resign and he could save face by going to work at the wound care center.

44. In October 2010, the Carlisle RMC ED Medical Director announced his "resignation" and began his new position at the wound care center in April 2011.

ATTACHMENT E

SETTLEMENT AGREEMENT

This Settlement Agreement (Agreement) is entered into among the United States of America, acting through the United States Department of Justice and on behalf of the Office of Inspector General (OIG-HHS) of the Department of Health and Human Services (HHS), the Defense Health Agency (DHA), acting on behalf of the TRICARE Program (collectively, the "United States"), Health Management Associates, Inc., now known as Health Management Associates, LLC, its subsidiaries and affiliates, and its parent ("HMA Parent") (collectively, "HMA"), and Relators Craig Brummer, M.D., Ralph Williams, Scott Plantz, M.D., Thomas L. Mason, M.D., Steven G. Folstad, M.D., Mid-Atlantic Emergency Medical Associates, Jacqueline Meyer, J. Michael Cowling, and Paul Meyer (collectively, the "Relators"), through their authorized representatives. Relators Mason, Folstad, and Mid-Atlantic Emergency Medical Associates are collectively referred to herein as the "MEMA Relators." Collectively, all of the above will be referred to as "the Parties."

RECITALS

A. Health Management Associates, Inc. is a for-profit health care system that, during the relevant period, through its subsidiaries, indirectly owned and/or operated hospitals throughout the United States. HMA Parent, a Delaware corporation with its principal place of business in Franklin, Tennessee, acquired Health Management Associates, Inc., now known as Health Management Associates, LLC in January 2014.

B. On November 24, 2009, Relator Craig Brummer, M.D. filed a *qui tam* action in the United States District Court for the Northern District of Georgia, captioned *United States ex rel. Brummer v. Health Management Associates, Inc., et al.*, No. 1:09-CV-3287 (N.D. Ga.), pursuant to the *qui tam* provisions of the False Claims Act, 31 U.S.C. § 3730(b). On December

14, 2009, Relator's motion to transfer venue to the Middle District of Georgia was granted. The case was assigned case number Civil Action No. 3:09-CV-135 (CDL) following its transfer to the Middle District of Georgia (the "Brummer Civil Action"). On December 16, 2013, the United States intervened in the Brummer Civil Action.

C. On December 1, 2009, Relator Ralph D. Williams filed a *qui tam* action in the United States District Court for the Middle District of Georgia, captioned *United States ex rel. Williams v. Health Mgmt. Assocs., et al.*, No. 3:09-CV-130 (CDL), pursuant to the *qui tam* provisions of the False Claims Act, 31 U.S.C. § 3730(b). On November 30, 2012, Relator Williams severed certain claims, and filed a separate complaint with respect to the severed claims, captioned *United States ex rel. Williams v. Health Mgmt. Assocs., et al.*, No. 3:12-CV-151 (CDL) (the "Williams Civil Action"). On December 16, 2013, the United States intervened in the Williams Civil Action.

D. On February 11, 2010, Relator Scott H. Plantz, M.D. filed a *qui tam* action in the United States District Court for the Northern District of Illinois, captioned *United States ex rel. Plantz v. Health Management Associates, et al.*, Case No. 10C 0950, pursuant to the *qui tam* provisions of the False Claims Act, 31 U.S.C. § 3730(b). On February 14, 2013, Relator Plantz filed his severed complaint against the HMA defendants and ProMed, which was assigned Case No. 13 C 1212 (the "Plantz Civil Action"). On December 16, 2013, the United States intervened in the Plantz Civil Action with regard to certain claims against the HMA defendants.

E. On September 23, 2010, Relators Thomas Mason, M.D., Stephen Folstad, M.D. and their medical practice Mid-Atlantic Emergency Medical Associates ("MEMA") filed a *qui tam* action in the United States District Court for the Western District of North Carolina, captioned *United States ex rel. Mason, Folstad & MEMA v. Health Mgmt. Assocs., et al.*, No. 3:10-cv-472, pursuant to the *qui tam* provisions of the False Claims Act, 31 U.S.C. § 3730(b)

(the "MEMA Civil Action"). On April 18, 2011, the MEMA Relators filed their sealed First Amended Complaint. On April 12, 2012, the MEMA Relators filed their sealed Second Amended Complaint. At the United States' request, the MEMA Relators severed certain claims and filed their Severed Second Amended Complaint on January 9, 2013. On December 16, 2013, the United States intervened in the MEMA Civil Action with regard to certain claims against the HMA defendants.

F. On July 15, 2011, Relators Jacqueline Meyer and J. Michael Cowling filed a *qui tam* action in the United States District Court for the District of South Carolina, captioned *United States ex rel. Meyer and Cowling v. Health Mgmt. Assocs., et al.*, No. 0-11-cv-01713-JA, pursuant to the *qui tam* provisions of the False Claims Act, 31 U.S.C. § 3730(b) (the "Meyer and Cowling Civil Action"). On December 16, 2013, the United States intervened in the Meyer and Cowling Civil Action with regard to certain claims against the HMA defendants.

G. On November 15, 2011, Relator Paul Meyer filed a *qui tam* action in the United States District Court for the Southern District of Florida, captioned *United States ex rel. Paul Meyer v. Health Management Associates, Inc., et al.*, Civil Action No. 11-62445, pursuant to the *qui tam* provisions of the False Claims Act, 31 U.S.C. § 3730(b) (the "Paul Meyer Civil Action"). On December 16, 2013, the United States intervened in the Paul Meyer Civil Action.

H. The Brummer, Williams, Plantz, MEMA, Meyer and Cowling, and Paul Meyer Civil Actions are hereafter collectively referred to as "the Civil Actions."

I. On January 14, 2014, the United States filed a motion with the Judicial Panel on Multidistrict Litigation to consolidate the Civil Actions with three other False Claims Act *qui tam* actions. On April 2, 2014, the Judicial Panel on Multidistrict Litigation granted the United States' motion and assigned the cases to the Honorable Reggie Walton, United States District Judge for the District of the District of Columbia, for pre-trial proceedings. The HMA MDL is

Miscellaneous Action No. 14-0339 (RBW), MDL Docket No. 2524. Within the MDL, the Brummer Civil Action is assigned Case No. 1:14-cv-00573-RBW, the Williams Civil Action is assigned Case No.1:14-cv-00574-RBW, the Plantz Civil Action is assigned Case No. 1:14-cv-00653-RBW, the MEMA Civil Action is assigned Case No. 1:14-cv-00579-RBW, the Meyer and Cowling Civil Action is assigned Case No. 1:14-cv-00586-RBW, and the Paul Meyer Civil Action is assigned Case No. 1:14-cv-00585-RBW.

J. The United States contends that HMA hospitals submitted claims for payment to the Medicare Program, Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395-1395kkk-1 ("Medicare"), the Medicaid Program, 42 U.S.C. §§ 1396-1396w-5 ("Medicaid"); and the TRICARE Program, 10 U.S.C. §§ 1071-1110b ("TRICARE") (collectively "Government Healthcare Programs").

K. In order to resolve claims asserted pursuant to state law in the Civil Actions, HMA will be entering into separate settlement agreements (the "Medicaid State Settlement Agreements") with certain states. The states that enter into settlement agreements with HMA (the "Medicaid Participating States") will be receiving settlement funds from HMA pursuant to Paragraph 1 below.

L. Covered Conduct: The United States contends that it has certain civil claims against HMA arising from the conduct described in this Recital L.1, L.2, L.3 and L.4 at the hospitals listed and during the time periods specified on Attachments A, B, and C (hereinafter referred to as the "Covered Conduct"):

1. Medically Unnecessary Emergency Department Admissions

The United States contends that, from January 1, 2008 through December 31, 2012, HMA hospitals submitted claims for payment to the Government Healthcare Programs for certain inpatient admissions of Government Healthcare Program beneficiaries that were

medically unnecessary and should have been billed as outpatient or observation services. HMA discouraged the use of outpatient and observation status for emergency department ("ED") patients in favor of higher-paying inpatient admissions. HMA pressured ED physicians and physician staffing groups to increase inpatient admissions by recommending admission to admitting physicians without regard to medical necessity. The Covered Conduct in this Recital L.1 is specifically limited to claims submitted by the HMA hospitals listed on Attachment A hereto during the time periods listed therein that were related to the inpatient admission and treatment of Government Healthcare Program beneficiaries that meet all of the following criteria:

(a) For beneficiaries who originally presented to the ED of the HMA hospitals;

(b) For beneficiaries whose length of stay after inpatient admission was two (2) days or less;

(c) For beneficiaries who were 65 years or older at the time they originally presented to the ED of an HMA hospital;

(d) For beneficiaries who were not transferred or discharged to another acute care facility, did not leave the HMA hospital to which they originally presented against medical advice, and did not die while in a HMA hospital; and

(e) That were billed to the Government Healthcare programs under one of the following Medical Severity DRGs ("MS-DRGs"):

(i) MS-DRG 069 (transient ischemia); 149 (disequilibrium), 192 (chronic obstructive pulmonary disease without CC/MCC); 195 (simple pneumonia and pleurisy without CC/MCC), 203 (bronchitis and asthma without CC/MCC), 204 (respiratory signs and symptoms), 293 (heart failure and shock without CC/MCC); 303

(atherosclerosis without MCC), 305 (hypertension without MCC), 310 (cardiac arrhythmia & conduction disorder without CC/MCC); 312 (syncope and collapse); 313 (chest pain); 392 (esophagitis, gastroenteritis and miscellaneous digestive disorders without MCC); 639 (diabetes without CC/MCC), 641 (nutritional and miscellaneous metabolic disorders without MCC); 690 (kidney and urinary tract infections without MCC), 812 (red blood cell disorders without MCC) and 948 (signs and symptoms without MCC).

(ii) For hospitals acquired by HMA during the covered period of January 1, 2008 through December 31, 2012, claims for services rendered 365 days after the facility was acquired by HMA through December 31, 2012. The relevant time period for each HMA hospital is listed on Attachment A.

(f) For Medicare claims only, inpatient admissions billed and paid under fee for service Medicare Part A, where Medicare was the primary payor of the claim and the claim resulted in payment by Medicare.

(g) For Medicaid claims only, inpatient admissions of Medicare-Medicaid dual eligible patients billed and paid under fee for service Medicare Part A and the Medicaid program of one of the States, and the claim resulted in payment by Medicaid.

(h) For TRICARE claims only, inpatient admissions of Medicare-TRICARE dual eligible patients billed and paid under fee for service Medicare Part A and TRICARE, and the claim resulted in payment by TRICARE.

2. Violations of the Medicare and Medicaid Anti-Kickback Statute Relating to Medically Unnecessary Emergency Department Admissions

The United States contends that HMA offered and provided remuneration to EmCare, a physician staffing company, in the form of service contracts and payments, in return for ED physician inpatient admission recommendations of Government Healthcare Program beneficiaries made without regard to the medical necessity of admission, in violation of the Medicare and Medicaid Anti-Kickback Statute, 42 U.S.C. § 1320-7b(b). The illegal remuneration included the award of service contracts, the retention of service contracts that HMA threatened to terminate unless ED admissions increased, payments under the HMA-EmCare hospital ED physician and hospitalist contracts, and bonus payments made to ED physicians where the bonuses were tied, in part, to meeting numerical targets for the percentage of attending physicians called by the ED physician. The Covered Conduct in this Recital L.2 is specifically limited to claims submitted by the HMA hospitals that are listed on Attachments B and C during the time periods listed therein.

3. Overbilling of Emergency Department Acuity Levels

The United States contends that, from January 1, 2009 through December 31, 2011, HMA manipulated acuity points, and the HMA hospitals submitted claims to Medicare Part B and Medicaid for falsely inflated Emergency Department facility charges billed using evaluation and management CPT codes 99281-99285 and 99191-99292. The Covered Conduct in this Recital L.3 is specifically limited to claims submitted by the HMA hospitals listed on Attachment A for the time period January 2009 through December 2011.

4. Stark Law Claims

The United States contends that Crossgates River Oaks Hospital f/k/a Rankin Medical Center, an HMA-owned facility in Brandon, Mississippi, leased space to Dr. Lucius F. Sams III, M.D., from January, 15, 2005 through January 14, 2007, but required Dr. Sams to pay

rent for only half of the space he was actually occupying, allegedly in return for patient referrals to Crossgates River Oaks Hospital. The Covered Conduct in this Recital L.4 is specifically limited to claims submitted by Crossgates River Oaks Hospital during the period January 2005 through January 2007.

M. Except to the extent admitted in the guilty plea of Carlisle HMA, LLC or in the Statement of Facts in support of the Non-Prosecution Agreement (NPA) entered into between Health Management Associates, LLC and the United States, HMA denies the allegations and contentions of the United States and Relators.

N. This Settlement Agreement is neither an admission of liability by HMA nor a concession by the United States or Relators in the Civil Actions that their claims are not well founded.

O. Relators claim entitlement under 31 U.S.C. § 3730(d) and analogous provisions of state false claims laws to a share of the proceeds of this Settlement Agreement, the Medicaid State Settlement Agreements, and to each Relator's reasonable expenses, attorneys' fees and costs. Relators intend to argue that 31 U.S.C. § 3730(b)(5), 31 U.S.C. § 3730(e), or other provisions have no effect on Relators' entitlement to an award of expenses, attorneys' fees, and costs.

P. HMA denies that each of the Relators is entitled to expenses, attorneys' fees, and costs. HMA intends to argue that provisions in the False Claims Act, including but not limited to 31 U.S.C. § 3730(b)(5) and 3730(e), bar one or more Relators from receiving an award of expenses, attorneys' fees, and costs.

To avoid the delay, uncertainty, inconvenience, and expense of protracted litigation of the above claims, and in consideration of the mutual promises and obligations of this Settlement Agreement, the Parties agree and covenant as follows:

TERMS AND CONDITIONS

1. HMA shall pay to the United States and the Medicaid Participating States, collectively, the sum of seventy-four million, nine hundred seventy thousand, eight hundred and two dollars ($74,970,802) ("Settlement Amount"). Of the Settlement Amount, $62,545,802 is allocated to settle the United States' and the Medicaid Participating States' claims described in Recitals L.1 and L.2, $12,000,000 is allocated to settle the United States' and the Medicaid Participating States' claims described in Recital L.3, and $425,000 is allocated to settle the United States' claims described in Recital L.4. Interest on the Settlement Amount shall accrue at an annual rate of 2.250% from September 1, 2017, and shall be proportionately allocated by the United States to the claims identified in this paragraph. The Settlement Amount shall constitute a debt immediately due and owing to the United States and the Medicaid Participating States on the Effective Date of this Agreement. This debt shall be discharged by payments to the United States and the Medicaid Participating States, under the following terms and conditions:

a. HMA shall pay to the United States the sum of $73,292,717.95, of which $36,715,032 is restitution to the United States, plus accrued interest as set forth above ("Federal Settlement Amount"). The Federal Settlement Amount shall be paid to the United States no later than 10 business days after the Effective Date of this Agreement by electronic funds transfer pursuant to written instructions to be provided by the Civil Division of the United States Department of Justice; and

b. No later than 10 business days after the Effective Date of this Agreement, HMA shall pay the sum of $1,678,084.05, of which $839,042.02 is restitution to the States, plus accrued interest as set forth above ("Medicaid State Settlement Amount") pursuant to written instructions from the

NAMFCU Negotiating Team and under the terms and conditions of the Medicaid State Settlement Agreements that HMA will enter into with the Medicaid Participating States.

2. Subject to the exceptions in Paragraph 11 (concerning excluded claims) below, and conditioned upon HMA's full payment of the Federal Settlement Amount, plus accrued interest, and subject to Paragraph 23 below (concerning bankruptcy proceedings commenced after the Effective Date of this Agreement or any payment made under this Agreement), the United States releases HMA, together with its current and former parent corporations, partnerships, joint ventures, limited liability company owners and other parent entities; direct and indirect subsidiaries; brother or sister corporations, and other HMA-owned entities; divisions; affiliates; current or former corporate partnerships, joint ventures and limited liability companies; and the successors and assigns of any of them (collectively, the "HMA Releasees") from any civil or administrative monetary claim the United States has for the Covered Conduct under the False Claims Act, 31 U.S.C. §§ 3729-3733; the Civil Monetary Penalties Law, 42 U.S.C. § 1320a-7a; the Program Fraud Civil Remedies Act, 31 U.S.C. §§ 3801-3812; or the common law theories of payment by mistake, unjust enrichment, disgorgement, and fraud.

3. Subject to the exceptions in Paragraphs 11 and 13 below (concerning excluded claims), and conditioned upon HMA's full payment of the Federal Settlement Amount, plus accrued interest, and subject to Paragraph 23 below (concerning bankruptcy proceedings commenced after the Effective Date of this Agreement or any payment made under this Agreement), Relator Craig Brummer, M.D., for himself and for his heirs, successors, attorneys, agents, and assigns, releases the HMA Releasees and their officers, directors, agents, employees, and assigns from any civil monetary claim related to the Brummer Civil Action that the Relator has on behalf of the United States under the False Claims Act, 31 U.S.C. §§ 3729-3733, except

that Relator Brummer does not waive or release his entitlement under 31 U.S.C. § 3730(d) and analogous state FCA statutes for expenses, attorneys' fees, and costs.

4. Subject to the exceptions in Paragraphs 11 and 13 below (concerning excluded claims), and conditioned upon HMA's full payment of the Federal Settlement Amount, plus accrued interest, and subject to Paragraph 23 below (concerning bankruptcy proceedings commenced after the Effective Date of this Agreement or any payment made under this Agreement), Relator Ralph D. Williams, for himself and for his heirs, successors, attorneys, agents, and assigns, releases the HMA Releasees and their officers, directors, agents, employees, and assigns from any civil monetary claim related to the Williams Civil Action that the Relator has on behalf of the United States under the False Claims Act, 31 U.S.C. §§ 3729-3733, except that Relator Williams does not waive or release his entitlement under 31 U.S.C. § 3730(d) and analogous state FCA statutes for expenses, attorneys' fees, and costs.

5. Subject to the exceptions in Paragraphs 11and 13 below (concerning excluded claims) below, and conditioned upon HMA's full payment of the Federal Settlement Amount, plus accrued interest, and subject to Paragraph 23 below (concerning bankruptcy proceedings commenced after the Effective Date of this Agreement or any payment made under this Agreement), Relator Scott H. Plantz, M.D., for himself and for his heirs, successors, attorneys, agents, and assigns, releases the HMA Releasees and their officers, directors, agents, employees, and assigns from any civil monetary claim related to the Plantz Civil Action that the Relator has on behalf of the United States under the False Claims Act, 31 U.S.C. §§ 3729-3733, except that Relator Plantz does not waive or release his entitlement under 31 U.S.C. § 3730(d) and analogous state FCA statutes for expenses, attorneys' fees and costs.

6. Subject to the exceptions in Paragraphs 11 and 13 below (concerning excluded claims), and conditioned upon HMA's full payment of the Federal Settlement Amount, plus

accrued interest, and subject to Paragraph 23 below (concerning bankruptcy proceedings commenced after the Effective Date of this Agreement or any payment made under this Agreement), Relators Thomas Mason, M.D., Stephen Folstad, M.D. and their medical practice, MEMA, for themselves and for itself, and for their respective heirs, successors, attorneys, agents, and assigns, release the HMA Releasees and their officers, directors, agents, employees, and assigns from any civil monetary claim related to the MEMA Civil Action that the MEMA Relators have on behalf of the United States under the False Claims Act, 31 U.S.C. §§ 3729-3733, except that the MEMA Relators do not waive or release their entitlement under 31 U.S.C. § 3730(d) and analogous state FCA statutes for expenses, attorneys' fees and costs.

7. Subject to the exceptions in Paragraphs 11 and 13 below (concerning excluded claims), and conditioned upon HMA's full payment of the Federal Settlement Amount, plus accrued interest, and subject to Paragraph 23 below (concerning bankruptcy proceedings commenced after the Effective Date of this Agreement or any payment made under this Agreement), Relators Jacqueline Meyer and Michael Cowling, for themselves, and for their respective heirs, successors, attorneys, agents, and assigns, release the HMA Releasees and their officers, directors, agents, employees, and assigns with the exception of former HMA CEO Gary Newsome, from any civil monetary claim related to the Meyer and Cowling Civil Action that the Relators have on behalf of the United States under the False Claims Act, 31 U.S.C. §§ 3729-3733, except that Relators do not waive or release their entitlement under 31 U.S.C. § 3730(d) and analogous state FCA statutes for expenses, attorneys' fees and costs.

8. Subject to the exceptions in Paragraphs 11 and 13 below (concerning excluded claims), and conditioned upon HMA's full payment of the Federal Settlement Amount, plus accrued interest, and subject to Paragraph 23 below (concerning bankruptcy proceedings commenced after the Effective Date of this Agreement or any payment made under this

Agreement), Relator Paul Meyer for himself and for his heirs, successors, attorneys, agents, and assigns, releases the HMA Releasees and their officers, directors, agents, employees, and assigns from any civil monetary claim related to the Meyer Civil Action that Relator has on behalf of the United States under the False Claims Act, 31 U.S.C. §§ 3729-3733, except that Relator does not waive or release his entitlement under 31 U.S.C. § 3730(d) and analogous state FCA statutes for expenses, attorneys' fees and costs.

9. In consideration of the obligations of HMA in this Agreement and the Corporate Integrity Agreement (CIA) entered into between OIG-HHS and HMA Parent, and conditioned upon HMA's full payment of the Federal Settlement Amount, the OIG-HHS agrees to release and refrain from instituting, directing, or maintaining any administrative action seeking exclusion from Medicare, Medicaid, and other Federal health care programs (as defined in 42 U.S.C. § 1320a-7b(f)) against HMA under 42 U.S.C. § 1320a-7a (Civil Monetary Penalties Law) or 42 U.S.C. § 1320a-7(b)(7) (permissive exclusion for fraud, kickbacks, and other prohibited activities) for the Covered Conduct, except as reserved in this Paragraph and in Paragraph 11 (concerning excluded claims), below. The OIG-HHS expressly reserves all rights to comply with any statutory obligations to exclude HMA from Medicare, Medicaid, and other Federal health care programs under 42 U.S.C. § 1320a-7(a) (mandatory exclusion) based upon the Covered Conduct. Nothing in this Paragraph precludes the OIG-HHS from taking action against entities or persons, or for conduct and practices, for which claims have been reserved in Paragraph 11, below, and as reserved in this Paragraph.

10. In consideration of the obligations of HMA set forth in this Agreement, and conditioned upon HMA's full payment of the Federal Settlement Amount, DHA agrees to release and refrain from instituting, directing, or maintaining any administrative action seeking exclusion from the TRICARE Program against HMA under 32 C.F.R. § 199.9 for the Covered

Conduct, except as reserved in this Paragraph and in Paragraph 11 (concerning excluded claims), below. DHA expressly reserves authority to exclude HMA from the TRICARE Program under 32 C.F.R. §§ 199.9 (f)(1)(i)(A), (f)(1)(i)(B), and (f)(1)(iii) (mandatory exclusion), based upon the Covered Conduct. Nothing in this Paragraph precludes DHA or the TRICARE Program from taking action against entities or persons, or for conduct and practices, for which claims have been reserved in Paragraph 11, below.

11. Notwithstanding the releases given in paragraphs 2, 9 and 10 of this Agreement or any other term of this Agreement, the following claims of the United States are specifically reserved and are not released:

a. Any liability arising under Title 26, U.S. Code (Internal Revenue Code);

b. Any criminal liability;

c. Except as explicitly stated in this Agreement, any administrative liability, including mandatory exclusion from Federal health care programs;

d. Any liability to the United States (or its agencies) for any conduct other than the Covered Conduct;

e. Any liability based upon obligations created by this Agreement;

f. Any liability of any other defendants named in the Plantz, MEMA, or Meyer and Cowling Civil Actions; and

g. Any liability of individuals.

12. Relators and their respective heirs, successors, attorneys, agents, and assigns shall not object to this Agreement but agree and confirm that this Agreement is fair, adequate, and reasonable under all the circumstances, pursuant to 31 U.S.C. § 3730(c)(2)(B), and that the allocations of the Settlement Amount for each individual claim outlined in Paragraph 1 and as previously disclosed to Relators are also fair, adequate, and reasonable under all the

circumstances. In connection with this Agreement and the Civil Actions, Relators and their respective heirs, successors, attorneys, agents, and assigns agree that neither this Agreement, prior intervention by the United States in the Civil Actions, nor any dismissal of claims in the Civil Actions, shall waive or otherwise affect the ability of the United States to contend that provisions in the False Claims Act, including 31 U.S.C. §§ 3730(d)(3) and 3730(e), bar any of the Relators from sharing in the proceeds of this Agreement. Moreover, the United States and Relators and their respective heirs, successors, attorneys, agents, and assigns agree that they each retain all of their rights pursuant to the False Claims Act on the issue of the share percentage, if any, that any of the Relators should receive of any proceeds of the settlement of their respective claims, and that no agreements between any Relator and the United States concerning Relator share have been reached to date, other than the allocations of the Settlement Amount as stated above in Paragraph 1.

13. Each Relator, for himself, herself, or itself, and for his, her, or its respective heirs, successors, attorneys, agents, and assigns, fully and finally releases the HMA Releasees, and their officers, directors, agents, employees, and assigns from any liability accruing prior to the Effective Date of this Agreement to that Relator arising from the filing of his, her or their Civil Action, and from any claims (including indemnification), allegations, demands, actions or cause of action whatsoever, known or unknown, fixed or contingent, in law or in equity, in contract or in tort, under any federal or state statute or regulation, or under common law, accruing prior to the Effective Date of this Agreement, that each Relator, his, her or their respective heirs, successors, attorneys, agents and assigns otherwise would have standing to bring, have asserted, could have asserted, or may assert in the future against the HMA Releasees, including, without limitation, any claim related to each Relator's respective Civil Action and each Relator's

respective investigation and prosecution of his or her or their Civil Action. However, the following claims are specifically reserved and not released:

a. Each Relator's claims under 31 U.S.C. § 3730(d) and analogous state FCA statutes for expenses, attorneys' fees and costs;

b. The MEMA Relators' claims for damages, expenses, attorneys' fees and costs under 31 U.S.C. § 3730(h) and under N.C. Gen. Stat. § 1-613;

c. Claims that the MEMA Relators have filed against HMA for damages, attorney's fees, and costs in Counts X through XII of the MEMA Relators' Severed Second Amended Complaint;

d. Relator Jacqueline Meyer's claims against HMA for damages, expenses, attorneys' fees, and costs under 31 U.S.C. § 3730(h) and for tortious interference with a business relationship; and

e. Relators Jacqueline Meyer and Michael Cowling's claims against Gary Newsome alleged in Counts One through Nine of the Meyer and Cowling Civil Action.

14. HMA waives and shall not assert any defenses HMA may have to any criminal prosecution or administrative action relating to the Covered Conduct that may be based in whole or in part on a contention that, under the Double Jeopardy Clause in the Fifth Amendment of the Constitution, or under the Excessive Fines Clause in the Eighth Amendment of the Constitution, this Agreement bars a remedy sought in such criminal prosecution or administrative action.

15. HMA fully and finally releases the United States, its agencies, officers, agents, employees, and servants, from any claims (including attorneys' fees, costs, and expenses of every kind and however denominated) that HMA has asserted, could have asserted, or may assert

in the future against the United States, its agencies, officers, agents, employees, and servants, related to the Covered Conduct and the United States' investigation and prosecution thereof.

16. HMA, its successors, attorneys, and agents, and HMA Releasees fully and finally release each Relator (including his/her, their, or its attorneys, agents, employees, successors, family members, and heirs) from any claims (including, for example, indemnification, attorneys' fees, costs, and expenses of every kind and however denominated) that HMA has asserted, could have asserted, or may assert in the future against each Relator, including, without limitation, any claim related to the Civil Actions and each Relator's investigation and prosecution thereof. In keeping with Recitals O and P above, HMA and Relators and their respective heirs, successors, attorneys, agents, and assigns agree that they each retain all of their rights pursuant to the False Claims Act and have not, through this Agreement, waived any of their rights on the issue of whether a Relator is entitled to and, if so, the amount of an award of expenses, attorneys' fees, and costs, and that no agreements concerning entitlement to or the amounts of expenses, attorneys' fees, and costs have been reached to date between HMA and any Relator.

17. The Settlement Amount shall not be decreased as a result of the denial of claims for payment now being withheld from payment by any Medicare contractor (e.g., Medicare Administrative Contractor, fiscal intermediary, carrier) or TRICARE contractor or any state payer, related to the Covered Conduct; and HMA agrees not to resubmit to any Medicare or TRICARE contractor or any state payer any previously denied claims related to the Covered Conduct, agrees not to appeal any such denials of claims, and agrees to withdraw any such pending appeals.

18. HMA agrees to the following:

a. Unallowable Costs Defined: All costs (as defined in the Federal Acquisition Regulation, 48 C.F.R. § 31.205-47; and in Titles XVIII and

XIX of the Social Security Act, 42 U.S.C. §§ 1395-1395kkk-1 and 1396-1396w-5; and the regulations and official program directives promulgated thereunder) incurred by or on behalf of HMA, HMA's present or former officers, directors, employees, shareholders, and agents in connection with:

(1) the matters covered by this Agreement, the Carlisle HMA, LLC plea agreement, and the NPA between Health Management Associates, LLC and the United States;

(2) the United States' audits and civil and criminal investigations of the matters covered by this Agreement;

(3) HMA's investigation, defense, and corrective actions undertaken in response to the United States' audits and civil and criminal investigations in connection with the matters covered by this Agreement (including attorneys' fees);

(4) the negotiation and performance of this Agreement, the Carlisle HMA, LLC plea agreement, and the NPA between Health Management Associates, LLC and the United States;

(5) the payment HMA makes to the United States pursuant to this Agreement and any payments that HMA may make to the Relators, including costs and attorneys' fees; and

(6) the negotiation of, and obligations undertaken pursuant to the CIA to: (i) retain an independent review organization to perform annual reviews as described in Section III of the CIA; and (ii) prepare and submit reports to the OIG-HHS,

are unallowable costs for government contracting purposes and under the Medicare Program, Medicaid Program, TRICARE Program, and Federal Employees Health Benefits Program (FEHBP) (hereinafter referred to as Unallowable Costs). However, nothing in paragraph 18 a.(6) that may apply to the obligations undertaken pursuant to the CIA affects the status of costs that are not allowable based on any other authority applicable to HMA.

b. Future Treatment of Unallowable Costs: Unallowable Costs shall be separately determined and accounted for in nonreimbursable cost centers by HMA, and HMA shall not charge such Unallowable Costs directly or indirectly to any contracts with the United States or any State Medicaid program, or seek payment for such Unallowable Costs through any cost report, cost statement, information statement, or payment request submitted by HMA or any of its subsidiaries or affiliates to the Medicare, Medicaid, TRICARE, or FEHBP Programs.

c. Treatment of Unallowable Costs Previously Submitted for Payment: HMA further agrees that within 90 days of the Effective Date of this Agreement it shall identify to applicable Medicare and TRICARE fiscal intermediaries, carriers, and/or contractors, and Medicaid and FEHBP fiscal agents, any Unallowable Costs (as defined in this Paragraph) included in payments previously sought from the United States, or any State Medicaid program, including, but not limited to, payments sought in any cost reports, cost statements, information reports, or payment requests already submitted by HMA, or any of its subsidiaries or affiliates, and shall request, and agree, that such cost reports, cost statements,

information reports, or payment requests, even if already settled, be adjusted to account for the effect of the inclusion of the Unallowable Costs. HMA agrees that the United States, at a minimum, shall be entitled to recoup from HMA any overpayment plus applicable interest and penalties as a result of the inclusion of such Unallowable Costs on previously-submitted cost reports, information reports, cost statements, or requests for payment.

Any payments due after the adjustments have been made shall be paid to the United States pursuant to the direction of the Department of Justice and/or the affected agencies. The United States reserves its rights to disagree with any calculations submitted by HMA or any of its subsidiaries or affiliates on the effect of inclusion of Unallowable Costs (as defined in this Paragraph) on HMA or any of its subsidiaries or affiliates' cost reports, cost statements, or information reports.

d. Nothing in this Agreement shall constitute a waiver of the rights of the United States to audit, examine, or re-examine HMA's books and records to determine that no Unallowable Costs have been claimed in accordance with the provisions of this Paragraph.

19. HMA agrees to cooperate fully and truthfully with the United States' investigation of individuals and entities not released in this Agreement. Upon reasonable notice, HMA shall encourage, and agrees not to impair, the cooperation of its directors, officers, and employees, and shall use its best efforts to make available, and encourage, the cooperation of former directors, officers, and employees for interviews and testimony, consistent with the rights and privileges of such individuals. HMA further agrees to furnish to the United States, upon request, complete and unredacted copies of all non-privileged documents, reports, memoranda of

interviews, and records in its possession, custody, or control concerning any investigation of the Covered Conduct that it has undertaken, or that has been performed by another on its behalf.

20. This Agreement is intended to be for the benefit of the Parties only. The Parties do not release any claims against any other person or entity, except to the extent provided for in Paragraph 21 (waiver for beneficiaries paragraph), below.

21. HMA agrees that it waives and shall not seek payment for any of the health care billings covered by this Agreement from any health care beneficiaries or their parents, sponsors, legally responsible individuals, or third party payors based upon the claims defined as Covered Conduct.

22. HMA warrants that it has reviewed its financial situation and that it is currently solvent within the meaning of 11 U.S.C. §§ 547(b)(3) and 548(a)(1)(B)(ii)(I), and shall remain solvent following payment to the United States of the Settlement Amount. Further, the Parties warrant that, in evaluating whether to execute this Agreement, they (a) have intended that the mutual promises, covenants, and obligations set forth constitute a contemporaneous exchange for new value given to HMA within the meaning of 11 U.S.C. § 547(c)(1), and (b) conclude that these mutual promises, covenants, and obligations do, in fact, constitute such a contemporaneous exchange. Further, the Parties warrant that the mutual promises, covenants, and obligations set forth herein are intended to and do, in fact, represent a reasonably equivalent exchange of value that is not intended to hinder, delay, or defraud any entity to which HMA was or became indebted to on or after the date of this transfer, within the meaning of 11 U.S.C. § 548(a)(1).

23. If HMA commences, or a third party commences, any case, proceeding, or other action under any law relating to bankruptcy, insolvency, reorganization, or relief of debtors (a) seeking to have any order for relief of HMA's debts, or seeking to adjudicate HMA as bankrupt

or insolvent; or (b) seeking appointment of a receiver, trustee, custodian, or other similar official for HMA or for all or any substantial part of HMA's assets, HMA agrees as follows:

a. HMA's obligations under this Agreement may not be avoided pursuant to 11 U.S.C. § 547, and HMA shall not argue or otherwise take the position in any such case, proceeding, or action that: (i) HMA's obligations under this Agreement may be avoided under 11 U.S.C. § 547; (ii) HMA was insolvent at the time this Agreement was entered into, or became insolvent as a result of the payment made to the United States; or (iii) the mutual promises, covenants, and obligations set forth in this Agreement do not constitute a contemporaneous exchange for new value given to HMA.

b. If HMA's obligations under this Agreement are avoided for any reason, including, but not limited to, through the exercise of a trustee's avoidance powers under the Bankruptcy Code, the United States, at its sole option, may rescind the releases in this Agreement and bring any civil and/or administrative claim, action, or proceeding against HMA for the claims that would otherwise be covered by the releases provided in Paragraphs 2, 9 and 10, above. HMA agrees that (i) any such claims, actions, or proceedings brought by the United States are not subject to an "automatic stay" pursuant to 11 U.S.C. § 362(a) as a result of the action, case, or proceedings described in the first clause of this Paragraph because it would be an exercise of the United States' police and regulatory power to protect public policy and public health, safety and welfare, and HMA shall not argue or otherwise contend that the United States' claims, actions, or proceedings are subject to an automatic stay; (ii) HMA shall not plead,

argue, or otherwise raise any defenses under the theories of statute of limitations, laches, estoppel, or similar theories, to any such civil or administrative claims, actions, or proceeding that are brought by the United States within sixty (60) calendar days of written notification to HMA that the releases have been rescinded pursuant to this Paragraph, except to the extent such defenses were available on November 24, 2009; and (iii) the United States has an undisputed, noncontingent, and liquidated allowed claim against HMA in its successor capacity in the amount of $119,142,096, and the United States may pursue its claim in the case, action, or proceeding referenced in the first clause of this Paragraph, as well as in any other case, action, or proceeding.

c. HMA acknowledges that its agreements in this Paragraph are provided in exchange for valuable consideration provided in this Agreement.

24. Upon receipt of the payment described in Paragraph 1 above, the Parties shall promptly sign and file in each of the Civil Actions a Joint Stipulation of Dismissal of the claims against HMA pursuant to Rule 41(a)(1) as follows:

Each notice of dismissal shall be with prejudice as to the United States' and each Relator's respective claims against HMA and all named HMA defendants (except Gary Newsome) as to the Covered Conduct in each Civil Action pursuant to and consistent with the terms and conditions of this Agreement;

Each notice of dismissal shall be without prejudice as to the United States and with prejudice as to each Relator as to all other claims by that Relator against HMA and all named HMA defendants (except Gary Newsome), and without prejudice as to the United States and each

Relator as to all other persons and entities named as defendants in that Relator's Civil Action pursuant to and consistent with the terms and conditions of this Agreement.

Provided, however, that the following claims shall not be dismissed, unless they are settled, adjudicated, or otherwise resolved, and any required consent by the United States and any applicable State is obtained, and the Court is so informed:

Any claims each Relator may have for reasonable attorneys' fees, expenses, and costs pursuant to 31 U.S.C. § 3730(d) and analogous state statutes, to which HMA reserves all rights to challenge and object, including as to entitlement to any fees, expenses, or costs;

Any claims excluded under paragraph 13 of this agreement;

Any claims each Relator may have under § 3730(h) and comparable state laws;

Each Relator's claims for a relator's share under § 3730(d); and

Each Relator's claims for a relator's share under the Medicaid state settlement agreements.

The claims of the Plaintiff States which will be governed by the terms and conditions of the Medicaid State Settlement Agreements that HMA will enter into with the Medicaid Participating States.

25. Except for each Relator's claims against HMA for attorneys' fees, costs, and expenses under 31 U.S.C. § 3730(d) and analogous state statutes, and any claims which are excluded from this Agreement in Paragraph 13, each Party shall bear its own legal and other costs incurred in connection with these matters, including the preparation and performance of this Agreement.

26. Each party and signatory to this Agreement represents that it freely and voluntarily enters into this Agreement without any degree of duress or compulsion.

27. This Agreement is governed by the laws of the United States. The exclusive jurisdiction and venue for any dispute relating to this Agreement is the United States District Court for the District of Columbia, except for disputes arising from those claims excluded under Paragraph 13 of this Agreement that may be remanded to another district court pursuant to 28 U.S.C. § 1407(a). For purposes of construing this Agreement, this Agreement shall be deemed to have been drafted by all Parties to this Agreement and shall not, therefore, be construed against any Party for that reason in any subsequent dispute.

28. This Agreement constitutes the complete agreement between the Parties. This Agreement may not be amended except by written consent of the Parties.

29. The undersigned counsel represent and warrant that they are fully authorized to execute this Agreement on behalf of the persons and entities indicated below.

30. This Agreement may be executed in counterparts, each of which constitutes an original and all of which constitute one and the same Agreement.

31. This Agreement is binding on HMA's successors, transferees, heirs, and assigns.

32. This Agreement is binding on Relators' successors, transferees, heirs, and assigns.

33. All parties consent to the United States' disclosure of this Agreement, and information about this Agreement, to the public.

34. This Agreement is effective on the date of signature of the last signatory to the Agreement (Effective Date of this Agreement). Facsimiles and electronic transmissions of signatures shall constitute acceptable, binding signatures for purposes of this Agreement.

THE UNITED STATES OF AMERICA

DATED: 9-24-18 BY: Laurie A. Oberembt
Marie V. Bonkowski
Laurie A. Oberembt
Arthur Di Dio
Vanessa Reed
Attorneys
Commercial Litigation Branch
Civil Division
United States Department of Justice

DATED: 9.21.18 BY: _____
Todd P. Swanson
Assistant United States Attorney
Middle District of Georgia

DATED: 9/24/18 BY; Linda Wawzenski (by LAO)
Linda Wawzenski
Assistant United States Attorney
Northern District of Illinois

DATED: _____ BY: _____
Jonathan Ferry
Assistant United States Attorney
Western District of North Carolina

DATED: _____ BY: _____
Jennifer Aldrich
Assistant United States Attorney
District of South Carolina

THE UNITED STATES OF AMERICA

DATED: _____ BY: _____
Marie V. Bonkowski
Laurie A. Oberembt
Arthur Di Dio
Vanessa Reed
Attorneys
Commercial Litigation Branch
Civil Division
United States Department of Justice

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Assistant United States Attorney
Middle District of Georgia

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Assistant United States Attorney
Northern District of Illinois

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Assistant United States Attorney
Western District of North Carolina

DATED: _____ BY: _____
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Assistant United States Attorney
District of South Carolina

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Arthur Di Dio
Vanessa Reed
Attorneys
Commercial Litigation Branch
Civil Division
United States Department of Justice

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Assistant United States Attorney
Middle District of Georgia

DATED: _____ BY; _____
Linda Wawzenski
Assistant United States Attorney
Northern District of Illinois

DATED: _____ BY: _____
Jonathan Ferry
Assistant United States Attorney
Western District of North Carolina

DATED: 9/21/18 BY: _____
Jennifer Aldrich
Assistant United States Attorney
District of South Carolina

DATED: 9/21/18 BY: _____

Susan Torres
Assistant United States Attorney
Southern District of Florida

DATED: _____ BY: _____

Lisa M. Re
Assistant Inspector General for Legal Affairs
Office of Counsel to the Inspector General
Office of Inspector General
United States Department of Health and Human Services

DATED: _____ BY: _____

Leigh A. Bradley
General Counsel
Defense Health Agency
United States Department of Defense

DATED: _____ BY: _____

Susan Torres
Assistant United States Attorney
Southern District of Florida

DATED: 9/21/2018 BY: _____

Lisa M. Re
Assistant Inspector General for Legal Affairs
Office of Counsel to the Inspector General
Office of Inspector General
United States Department of Health and Human Services

DATED: _____ BY: _____

Leigh A. Bradley
General Counsel
Defense Health Agency
United States Department of Defense

DATED: _____ BY: _____

Susan Torres
Assistant United States Attorney
Southern District of Florida

DATED: _____ BY: _____

Lisa M. Re
Assistant Inspector General for Legal Affairs
Office of Counsel to the Inspector General
Office of Inspector General
United States Department of Health and Human Services

DATED: 09/24/2018 BY: 8LEY.PAUL.NICHOLAS.1099873821 Digitally signed by 8LEY.PAUL.NICHOLAS.1099873821 Date: 2018.09.24 12:22:16 -04'00'

for

Leigh A. Bradley
General Counsel
Defense Health Agency
United States Department of Defense

DEFENDANTS HEALTH MANAGEMENT ASSOCIATES, INC., NOW KNOWN AS HEALTH MANAGEMENT ASSOCIATES, LLC, HMA PARENT and HMA SUBSIDIARIES.

DATED: 9/21/2018 BY: _____

Christopher G. Cobb
Secretary
Health Management Associates, LLC and HMA Subsidiaries
Vice President-Legal and Corporate Secretary
HMA Parent

DATED: _____ BY: _____

Richard A. Sauber
Michael L. Waldman
Counsel for Health Management Associates, LLC, HMA Parent and HMA Subsidiaries

DEFENDANTS HEALTH MANAGEMENT ASSOCIATES, INC., NOW KNOWN AS HEALTH MANAGEMENT ASSOCIATES, LLC, HMA PARENT and HMA SUBSIDIARIES.

DATED: _____ BY: _____

Christopher G. Cobb
Secretary
Health Management Associates, LLC and HMA Subsidiaries
Vice President-Legal and Corporate Secretary
HMA Parent

DATED: 9/21/06 BY: _____

Richard A. Sauber
Michael L. Waldman
Counsel for Health Management Associates, LLC, HMA Parent and HMA Subsidiaries

[illegible] GROUP
[illegible], Esquire

[illegible] for Relator Craig Brunner, M.D.

[illegible] Williams

[illegible]

[illegible] BY: ______________________
WILBANKS & GOUINLOCK
Marlan Wilbanks, Esquire
Susan Gouinlock, Esquire

BY: ______________________
HORNSBY LAW GROUP
D. Brandon Hornsby, Esquire

Counsel for Relator Ralph Williams

RELATORS

Relator Craig Brummer, M.D.

DATED: _____ BY: _____
Craig Brummer, M.D.

DATED: 9/21/18 BY: _____
WILBANKS & GOUINLOCK
Marlan Wilbanks, Esquire
Susan Gouinlock, Esquire

BY: _____ THW
HORNSBY LAW GROUP
D. Brandon Hornsby, Esquire

Counsel for Relator Craig Brummer, M.D.

Relator Ralph Williams

DATED: 9/21/18 BY: _____
Ralph Williams

DATED: 9/21/18 BY: _____
WILBANKS & GOUINLOCK
Marlan Wilbanks, Esquire
Susan Gouinlock, Esquire

BY: _____ THW
HORNSBY LAW GROUP
D. Brandon Hornsby, Esquire

Counsel for Relator Ralph Williams

Relator Scott H. Plantz, M.D.

DATED: Sept 21, 2018 BY: Scott H. Plantz, M.D.

DATED: 9/24/18 BY: Goldberg Kohn LTD
David J. Chizewer
Matthew K. Organ

Counsel for Relator Scott H. Plantz, M.D.

Relator Thomas L. Mason, M.D., FACEP.

DATED: 9/21/18 BY: Thomas L. Mason, M.D.

Relator Steven G. Folstad, M.D., FACEP

DATED: _____ BY: _____
Steven G. Folstad, M.D.

Relator Mid-Atlantic Emergency Medical Associates, P.A.

DATED: _____ BY: _____
Timothy E. Lietz, MD, FACEP, President/CEO

DATED: 9/21/2018 BY: Marc S. Raspanti
PIETRAGALLO GORDON ALFANO
BOSICK & RASPANTI, LLP
Marc S. Raspanti, Esquire
Pamela Coyle Brecht, Esquire
Michael A. Morse, Esquire

James F. Wyatt, III
WYATT & BLAKE, LLP
James F. Wyatt, III, Esquire

Counsel for Relators Mason, Folstad, and Mid-Atlantic Emergency Medical Associates

Relator Thomas L. Mason, M.D., FACEP.

DATED: _____ BY: _____
Thomas L. Mason, M.D.

Relator Steven G. Folstad, M.D., FACEP

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Pamela Coyle Brecht, Esquire
Michael A. Morse, Esquire

WYATT & BLAKE, LLP
James F. Wyatt, III, Esquire

Counsel for Relators Mason, Folstad, and Mid-Atlantic Emergency Medical Associates

Relator Jacqueline Meyer

DATED: 9/21/2018 BY: Jacqueline Meyer
Jacqueline Meyer

Relator Michael Cowling

DATED: _____ BY: _____
Michael Cowling

DATED: _____ BY: _____
VOGEL, SLADE & GOLDSTEIN, LLP
Janet L. Goldstein, Esquire

_____
WYCHE, PA
John C. Moylan, Esquire

Counsel for Relators Jacqueline Meyer
and Michael Cowling

Relator Jacqueline Meyer

DATED: _____ BY: _____
Jacqueline Meyer

Relator Michael Cowling

DATED: 9/21/18 BY: _____
Michael Cowling

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Janet L. Goldstein, Esquire

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WYCHE, PA
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Counsel for Relators Jacqueline Meyer
and Michael Cowling

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DATED: _____ BY: _____
Jacqueline Meyer

Relator Michael Cowling

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and Michael Cowling

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Jacqueline Meyer

Relator Michael Cowling

DATED: _____ BY: _____
Michael Cowling

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Janet L. Goldstein, Esquire

_____
WYCHE, PA
John C. Moylan, Esquire

Counsel for Relators Jacqueline Meyer
and Michael Cowling

Relator Paul Meyer

DATED: SEPT. 21, 2018

BY: Paul W Meyer Jr.
Paul Meyer

DATED: 9/21/18

BY:
ISICOFF & RAGATZ, PLLC
Eric D. Isicoff, Esq.
Teresa Ragatz, Esq.

Counsel for Relator Paul Meyer